Somerset
NHS Foundation Trust

Annual Report and Accounts

2020/21

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

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Welcome from the Chairman

Welcome to our first annual report for Somerset NHS Foundation Trust (Somerset FT). We created Somerset FT on 1 April 2020 by merging our two predecessor Trusts, Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust. Our aim is to provide our patients with seamless integrated mental health, community and acute services – the first Trust of its kind on the English mainland.

At Somerset FT we share a mission to deliver outstanding care through a culture of listening, learning and continuous improvement. Our vision is to be an organisation that gets it right for our patients, carers, colleagues and communities through an inclusive culture of partnership, learning and continuous improvement. The way that we work is underpinned by our values – Outstanding care, Working together, Listening and leading – which colleagues across all parts of our Trust helped to develop.

Our vision for how we could improve patient care came from clinical teams working across all our many services which is distilled in our clinical objectives to:

- Provide safe, effective, high quality, person-centred care in the most appropriate setting
- Deliver care closer to home in neighbourhood areas with an emphasis on self-management and prevention
- Give equal priority to mental and physical health, and value all people alike
- Improve outcomes for people with complex conditions through personalised, co-ordinated care.

When we planned our new organisation we could never have imagined what a tumultuous first year we would have! In the final weeks of our preparations to create Somerset FT a global pandemic was declared and we came together as one organisation to respond, caring for patients with COVID-19 in all our inpatient and community-based services and changing how we care for our non-COVID patients.

I am privileged and humbled to be chairman of this organisation which employs over 9,000 dedicated colleagues and has had 2,965 inpatient admissions and 953,109 contacts with patients in the community this year, many of them going through some of the most difficult times in their lives. Personally and on behalf of the Board I thank each and every one of my colleagues for their exceptional work this year and their determination to do the very best for our patients and their families and carers in these difficult times. The global pandemic has altered the way we all live our lives and many of our colleagues themselves have been personally affected. All, whether in frontline clinical services or in corporate functions, have pulled out all the stops to do their very best for our patients and to support their colleagues.

The role of our new organisation during its first year was to:

- Work in a true collaboration with health and care partners in Somerset to support our local population

- Alter and adapt our services to potentially large numbers of patients with COVID-19, many of whom needed breathing support
- Continue to care for those patients without COVID-19 who need our care, altering and adapting services to enable us to do this
- Provide practical and emotional support to our colleagues and do all we can to keep them safe
- Continue to forge on with our work to integrate mental health, community and acute hospital services as appropriate and create the kind of organisation that we want to be.

Across our services, in the first two waves of the pandemic, we cared for over 1,200 patients with COVID-19 in our inpatient services and sadly about 200 of them died. We reconfigured Musgrove Park Hospital and the inpatient beds in our community hospitals in order to care for more patients needing breathing support and to run those facilities as efficiently as possible. We responded to the rapidly changing environment, continually providing guidance to colleagues, and supported them to work in COVID-safe environments on site or from home.

Our sites changed very quickly as a result of the need to maintain social distancing and wear face masks, and we embraced digital ways of working to provide patient appointments by telephone and video. By the end of February 2021, our clinical teams had run a total of 70,000 patient appointments across a range of services using Attend Anywhere, a secure NHS video call service for patients with pre-arranged appointments. We know that getting to an appointment at our hospitals or units can often be time consuming and worrying for people especially in the current circumstances so being able to offer appointments online in this way has been an enormous benefit for our patients as we know from their positive feedback.

In the latter part of the year the Trust took on the role of accountable provider for the COVID-19 vaccination programme in Somerset. As I write, the programme has delivered more than half a million vaccinations to people in the county, with over 350,000 residents having received at least one dose of first vaccination. It has been a great success in such an important programme and has been built on the engagement of all parts of the Somerset Health and Care system, including primary care, Yeovil District Hospital, Somerset County Council and the voluntary sector.

During the pandemic we remain extremely mindful of the need to provide mental health support as well as physical health services. Open Mental Health, the alliance of local voluntary organisations, the NHS and social care in Somerset of which we are a part, accelerated its plans to launch the Somerset Mindline which provides support to adults in Somerset 24 hours a day, 7 days a week. This service is part of our wider joint redesign of mental health services in Somerset that was a finalist in the category of “mental health trust of the year” of the Health Service Journal (HSJ) Awards and has also been shortlisted in the “public and preventative health service redesign Initiative” category of the HSJ Value Awards for 2021.

Our work to integrate mental health, community and acute services continued during the pandemic and accelerated in some instances. One example is our short stay frailty assessment service, introduced in 2020, that helps our elderly and frail

patients return home to their familiar surroundings more quickly with the right level of support. Elderly and frail patients are now assessed by a geriatrician, specialist nurse and therapist as soon as they arrive at hospital, helping to avoid an overnight stay where possible so they can return home with appropriate care from our community services teams. In another example from April 2020 to January 2021 our new joint emergency therapies team has seen a total of 2,976 patients and helped to prevent 2,004 patients from being admitted to hospital – an average of 202 patients a month.

We have built on and strengthened our partnership working with the other health and social care organisations in Somerset by working together to pre-empt and respond to the needs of our population. Together in April 2020 we launched a hospital discharge and admission avoidance service, supporting people to remain at home and helping them to get home from hospital as quickly as possible. The way in which we work in partnership to coordinate health and social care services for people in 12 “neighbourhoods” across the county has continued to grow and develop. Our colleagues work in multidisciplinary teams alongside primary care and the voluntary sector to provide a coordinated single point of access in local communities to assess patients and provide the support they need to keep them safe, well and happy in their own homes.

It was very clear throughout this year how much more we can achieve by working together across our county, both by responding to the immediate demands of the COVID-19 pandemic, and planning how we will support the people of Somerset to improve their own health and wellbeing whilst providing consistent access to outstanding, joined up services when they are needed. In December 2020, Somerset was designated as an Integrated Care System, recognising the work we have done to bring health and social care services together for the benefit of the people of our county. In line with this, earlier in the year we had signed a memorandum of understanding with Yeovil District Hospital NHS Foundation Trust (YDH). We have now jointly with YDH completed a strategic case that sets out in detail what we could achieve together, and the process that would be followed, if we merged our two Trusts. The strategic case was agreed by both our Trust Boards in early April 2021 and has subsequently been submitted to our regulator NHS England & Improvement for review. If the regulator approves the strategic case, it enables us to complete a business case that will also be reviewed by both Trust Boards, our Councils of Governors and the regulator with a view to merge in 2022/23. This potential merger builds on the work that we have already done bringing mental health, community and acute services together to create Somerset FT and on YDH’s Symphony Programme that has brought primary care and acute services together. It is a fundamental component of the future development of our Integrated Care System for Somerset in line with the national direction of travel.

As we move forward into 2021, we are very mindful of the needs of our patients many of whom have had to wait longer than we would like due to the necessities of fighting the pandemic. We are also mindful of our colleagues who have worked so incredibly hard through 2019/20. We want to assist them as they care for our patients, to give them the tools and support to do their jobs to the best of their abilities and to help them to maintain their physical and emotional wellbeing. 2021/2

will bring a host of challenges but caring for our patients and supporting our colleagues will be our priorities.

The COVID-19 pandemic and world events this year have thrown an important spotlight on inequalities, diversity and inclusion. In February this year we approved a new Inclusion Strategy for the Trust which sets out our commitments and plans for delivering our vision of being an inclusive organisation, supporting our colleagues and our communities. We have established really vibrant multicultural, women's, lived experience, LGBT+ and armed forces networks and are working with our partner organisations across Somerset to improve our inclusiveness and address the inequalities that we see here in the county.

I would like to finish my introduction with more thanks. We saw during this year how beloved the NHS is by many. In the early part of 2020, communities and families clapped for the NHS and other key workers on a Thursday night; throughout the year in Somerset community groups, local businesses and volunteers bowled us over with their support and generosity. I would like to thank the many charities, companies and other organisations, governors, volunteers and individuals in our community who have stood alongside us during a challenging year. There is something special about Somerset. Your support has meant so much and as ever makes us try still harder to do our very best for you all

Signed

COLIN DRUMMOND OBE DL **11 June 2021**
Chairman

PERFORMANCE REPORT

The purpose of the overview is to provide a brief summary about Somerset NHS Foundation Trust (The Trust), its purpose, strategic objectives (and any key risks to the achievement of those objectives) as well as details of how we have performed over the year.

Purpose and activities of the Trust

Somerset NHS Foundation Trust was formed on 1 April 2020 when Somerset Partnership NHS Foundation Trust (SPFT) and Taunton and Somerset NHS Foundation Trust (TST) merged. The transaction was ground-breaking because it created the first Trust in mainland England to provide integrated community, mental health and acute hospital services.

Somerset Partnership and Taunton and Somerset NHS Foundation Trusts established a close working relationship when we formed an alliance in May 2017. In late 2017, we established a joint executive team that oversaw all aspects of both Trusts' operations and worked to a single set of strategic objectives covering hospital, community and mental health services. With services working more closely together than ever before, we made improvements to the care and support our patients and service users receive. However, it became clear that we needed to merge in order to remove the barriers that add unnecessary delay and cost to the care we provide, and to truly integrate community, mental health and hospital services.

The impetus for our merger came from colleagues who saw the improvements that we can make if these services work together differently. Our clinical strategy is built from the ground up, based on the experience of our colleagues and services, and our knowledge of the growing needs of our population.

Somerset NHS Foundation Trust provides a wide range of services for the whole of Somerset, as well as acute services for people in the north, west and centre of the county (population c.350,000) and more specialist services across the county and beyond. The Trust runs four GP practices in the west of the county (total list size c.24,000). We work with health and social care partners in Somerset to ensure that we deliver outstanding services that meet the needs of our population.

The Trust provides acute services from its main site, Musgrove Park Hospital (MPH) in Taunton, which has around 700 inpatient beds. We also operate 13 community hospitals (with 190 beds), providing inpatient, outpatient and diagnostic services, and seven Minor Injuries Units.

The Community Dental Service provides dental care to a caseload of 6,000 patients with Additional Needs across Somerset and Dorset. In addition, children with high dental needs attend the service for a single course of treatment which often includes inhalation sedation or general anaesthetic. During the COVID-19 pandemic the Community Dental Service were also asked to provide urgent dental care for the general population. A total of 8,630 patients were triaged by telephone with 3,859 patients attending for urgent appointments

Somerset NHS Foundation Trust's community services are wide-ranging and include district nursing, stroke services, podiatry and diabetic eye screening. These services are provided in a range of settings including community team facilities, GP surgeries, local clinics, and patients' homes.

Somerset NHS Foundation Trust provides mental health inpatient services and specialist healthcare for adults with learning disabilities from ten mental health wards across four sites. Its community mental health services include Talking Therapies, Early Intervention in Psychosis, a community eating disorder service, and services for patients with autism and personality disorder. The Trust is also an early implementer of the new model of community mental health services called Open Mental Health. The Trust was a finalist for Mental Health Trust of the year at the 2020 Health Service Journal awards.

Somerset NHS Foundation Trust cares for some people from neighbouring counties who live close to the county border. In 2020/21, the Trust treated around 7,400 people in total from across north Somerset, Devon, Bristol and Bath & North East Somerset (BANES), Wiltshire, Swindon, and South Gloucestershire.

We are privileged to work with over 9,000 colleagues who deliver or support our patient services. From therapists to nurses, doctors, researchers, scientists, porters, cleaners, kitchen staff, accountants, those who teach the next generation of clinicians and the receptionists who welcome our patients, the contribution of all of our colleagues is invaluable.

Working together we provide services from the cradle to the grave including:

- Services delivered in people's own homes such as Somerset's Rapid Response service that cares for patients to support them during a period of crisis and avoided over 1,000 patients going to hospital in its first year
- Primary care from four GP practices
- A range of services from 13 community hospitals including outpatient and diagnostic services, 190 inpatient beds and seven Minor Injuries Units.
- A range of specialist mental health services
- Specialist healthcare for adults with learning disabilities
- Community dental health services
- Regional, specialist and hospital services from Musgrove Park Hospital in Taunton including medical and surgical care, maternity services and cancer treatment services.

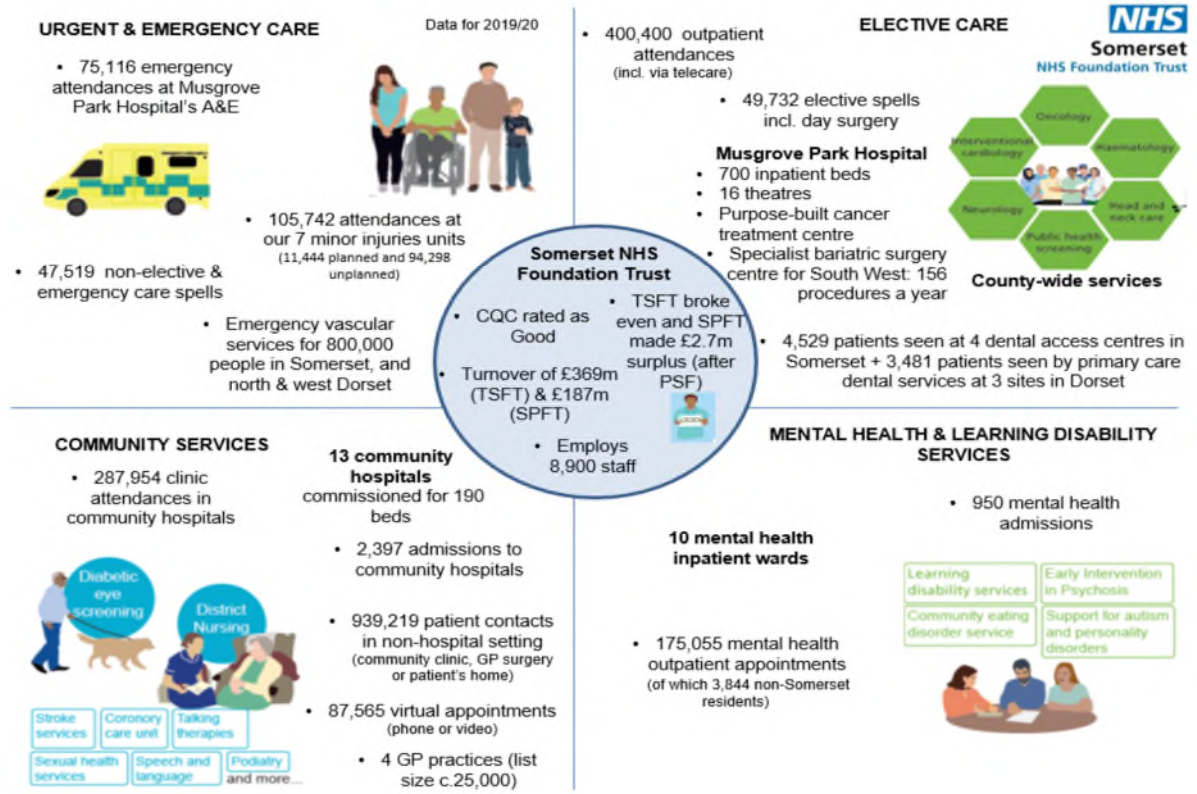
The Trust's general services are commissioned by the local clinical commissioning groups while specialist services are nationally commissioned.

In addition to providing a wide range of patient services, we also contribute to training the next generation of nurses, doctors and therapists and conduct research that will help to advance clinical practice and treatments in the future.

We scored above average in 8 of the 10 themes of the 2020 NHS Staff Survey and particularly well on colleague engagement and the quality of immediate managers. The Trust was also among the top ten Trusts in England for the lowest level of minority ethnic staff experiencing discrimination from colleagues/managers.

Some key facts about Somerset NHS Foundation Trust and our services are shown in Figure 1 below:

Figure 1: Key facts about Somerset NHS Foundation Trust



As a foundation trust we benefit from the support of and dedication of our volunteers, our Council of Governors, our Leagues of Friends, Love Musgrove, charities and partners – and we thank them for their contribution.

Equality of service delivery

Work we have undertaken during 2020/21 to ensure equality of service delivery includes:

- the rollout of 'Attend Anywhere' clinics across Somerset was successfully adopted within most outpatient services, enabling the continued delivery of care to patients across Somerset during the pandemic;
- interpretation services adapted to remote working through virtual and telephone appointments, take-up for which has remained high;
- Open Mental Health Services, were co-produced and developed with service users to improve access among all groups;

- there were just over 100 rough sleepers who were temporarily housed in hostel accommodation during the first wave of the virus, many of whom have now moved into more permanent accommodation; targeted, cross-organisational working was undertaken to improve health outcomes for this group;
- the Homeless and Rough Sleeper team launched on 1 March 2021. The team has now completed their initial introductions and induction visits with prospective patients and partner agencies across the county and with the hostels and other support services. The team is a countywide preventative and earlier intervention service for people where they are, as opposed to offering more traditional clinic-based services;
- considerable liaison work was undertaken with groups of travellers including Gypsy and Traveller communities, particularly around the Mendip area, with targeted work by dental and community mental health services;
- the impact of COVID-19 on all communities has been recognised and the planned Somerset Pandemic Archive Project 2021 will support community recovery from COVID-19 through sharing of experience and cross-organisational system working to analyse equality impact of pandemic recovery across all services, to ensure that mitigating actions are built into the design of recovery of services, in particular, across mental health provision, employment and housing support and reducing digital exclusion. The purpose of the project is:
    - to develop an archive for current and future communities;
    - to get people talking and sharing their experience, across diverse communities; and
    - to integrate opportunities for individuals to access support for their wellbeing.
- the COVID-19 vaccination programme ensured accessibility. At risk, clinically vulnerable people in the homeless population were identified by the Public Health team at Somerset County Council. Vaccinations were supported by the Homeless Outreach teams and venues for vaccinations were flexible to ensure accessibility, including at YMCA hostels. Clinical teams in each mental health ward engaged their patients to seek consent and consider Best Interest decisions prior to vaccination visits. A roving team was supported by Primary Care Network doctors.

A summary of the principal risks faced and how these have affected the delivery of objective

Inevitably the most significant issue affecting the Trust this year, like the whole of the NHS, the country and all parts of the world, has been the global pandemic.

Across the year, we saw around 1,200 patients admitted to our wards with COVID-19, of whom sadly, around 200 died. We reconfigured our acute and community hospital services and our mental health inpatient wards to respond to the demands of the pandemic. This involved rapid redesign of services to release capacity for treating patients with COVID-19. This included postponing planned treatment, shifting appointments online where possible and redeploying colleagues across

different settings. We also needed to set up and maintain a year-long emergency planning response to oversee and co-ordinate the activities and changes, as well as respond to the guidance, policy and information requests issued during 2020/21.

In November 2020 the Trust took up the role of lead provider for the National Vaccination Programme in Somerset and again redeployed a number of senior colleagues to lead the programme, as well as many clinical and support colleagues to run the vaccination centres and hospital hubs. By the end of 2020/21 more than 370,000 people in Somerset had received at least one dose of the vaccine.

In the context of these over-arching issues and risks, the other most significant risks (managed in year) were:

- **Performance Targets** - The delivery of a number of performance targets has remained a significant challenge throughout the year, including Referral to Treatment (RTT) times, cancer waits, A&E waiting times, diagnostic tests and dental general anaesthetics for children in Dorset. This has been significantly impacted by the reduction in elective activity and requirement for major changes to pathways due to the COVID-19 pandemic. Each of these performance areas has been subject to detailed review and planning at a system level to address the issues of capacity and demand.

- **Finance** - Although the Trust achieved its control total this year, in line with arrangements put in place for the COVID-19 pandemic, the system-wide risks in relation to the financial position have also been significant again during the year and the Trust has worked with the Clinical Commissioning Group (CCG), Somerset County Council and partner organisations to manage these risks.

- **Sustainability and Transformation Partnership (STP)/Integrated Care System (ICS)** – the continued difficult progress of the development and implementation of the Somerset STP – and the Somerset Clinical Commissioning Group's Fit for My Future programme - has again presented a number of risks for the Trust in terms of its impact on existing strategic plans, capacity within the Trust to support the STP while maintaining focus on our core services, and the financial sustainability of the Trust within the wider Somerset health and social care system. In December 2020 Somerset STP was designated as an Integrated Care System (ICS). Senior members of the Trust, including the Chief Executive, continue to occupy central roles in the ICS Programme. An engagement programme was undertaken by the STP in 2019/20 relating to the future of community services and community hospitals but this was paused during 2020/21 due to the impact of COVID-19. The delay in development of plans has continued to have an impact on the Trust delivering some of its plans, although significant work was undertaken to ensure that Trust's aims and objectives align with those of the wider ICS and FFMF programme.

- **Staffing Pressures** - The Trust has continued to identify risks in a number of services around staffing pressures arising from vacancies, sickness absence and increasing levels of demand, all exacerbated by the COVID-19 pandemic. This has led to the temporary closure or reduction of some services; in

particular, the temporary closure of inpatient wards in some community hospitals. An extensive recruitment campaign was maintained during the year, including continued overseas recruitment, but was not sufficiently successful and significant pressures remain.

- **Aging Estate** - The condition of some of the estate and the extent of the backlog maintenance continues to be a challenge for the delivery of services at Musgrove Park Hospital. Priorities for investment are constantly kept under review, based on risk assessment, to ensure that risks are minimised.

As we move into 2021/22, the pandemic remains the most significant risk for the Trust, as it does for all of the NHS. While we have a restoration plan for our elective surgery and diagnostic procedures, the level of the backlog, the need to manage in a continuing COVID-19 secure environment, the pressure and impact on colleagues from the last year of living with the pandemic and the potential for further surges add significant risk to achieving our objectives.

We will also be developing during 2021/22 our business case for merger with Yeovil District Hospital NHS Foundation Trust and the plans in Somerset to respond to the NHS White Paper *Integration and innovation: working together to improve health and social care for all* and forthcoming legislative changes. Any period of organisational change brings with it a number of risks and we will seek to ensure that our focus on delivering outstanding care and supporting our colleague wellbeing remain at the centre of activities in the coming year.

PERFORMANCE REPORT ANALYSIS

During 2020/21 Somerset NHS Foundation Trust continued to maintain performance across a broad range of indicators linked to the delivery of high quality care to patients.

Review of Trust Strategy and Business Model

April 2020 saw the creation of Somerset NHS Foundation Trust following the merger of Somerset Partnership and Taunton and Somerset NHS Foundation Trusts. As part of the work towards merger, an independent review of governance against NHS Improvement's Well Led Framework was undertaken by both predecessor trusts which informed the development of our vision and strategy, our board assurance framework and our performance framework.

Our vision and mission, developed as part of the merger, emphasise outstanding patient care, a commitment to continuous improvement, and partnership working. The vision and mission support our clinical, corporate and workforce objectives as shown below:

Mission, Vision and Values

At Somerset NHS Foundation Trust we share a mission to deliver outstanding care through a culture of listening, learning and continuous improvement.

Our vision is to be an organisation that gets it right for our patients, carers, colleagues and communities through an inclusive culture of partnership, learning and continuous improvement.

The way that we work and our vision for our organisation is underpinned by our values – Outstanding care, Working together, Listening and leading. Our colleagues across all parts of our trust helped to develop these values and we use them in our work every day. Our values are at the heart of service planning, recruitment and the operational running of services for patients.

Our clinical objectives set out what we aim to achieve by integrating community, mental health and hospital services. We aim to:

- Provide safe, effective, high quality, person-centred care in the most appropriate setting.
- Deliver care closer to home in neighbourhood areas with an emphasis on self-management and prevention.
- Give equal priority to physical and mental health, and value all people alike.
- Improve outcomes for people with complex conditions through personalised, co-ordinated care.

Our corporate objectives are to get it right for our communities by:

- Promoting a culture of learning to transform and innovate services, including through digital working to improve safety, outcomes and efficiency.
- Delivering the benefits of integrated care in our merged organisation and work with primary care, social care, public health and voluntary sector partners to deliver integrated, high quality services.

- Working with partners to deliver the Fit for My Future strategy, prioritising prevention and neighbourhood working, to maintain a sustainable county health economy.
- Delivering levels of performance that are in line with our plans and national standards.
- Achieving long term financial sustainability, enabling investment in the delivery of outstanding care.

Our colleagues are the lifeblood of our services and we want to support and get it right for our colleagues by developing a workforce that is:

- Resourced appropriately, flexible and agile to support seven-day working and the provision of care in the right place.
- Diverse, engaged, rewarded and resilient, demonstrating the values and the behaviours we expect.
- Safe, confident and competent, to enable innovation and the provision of quality service.

Delivering our vision

The delivery of the clinical model has been spearheaded by five flagship programmes of work encompassing our services and taking the early priorities of the clinical strategy.

Implementation of our clinical model is supported by our people, estates and digital strategies, which form our corporate strategy. These are objectives are set out below:

- To develop our inclusive culture of learning, research and continuous improvement to improve safety, outcomes, efficiency and effectiveness
- To work in collaboration with our partners in Somerset to develop an Integrated Care System and deliver the Fit for My Future strategy
- To develop a workforce that is:
    - Safe, with the skills and expertise needed to enable innovation and provision of a high quality service
    - Diverse, engaged, motivated and resilient, demonstrating the values and behaviours we expect
    - Resourced appropriately, flexible and agile to support outstanding care in the most appropriate setting
- To deliver levels of performance that are in line with our operational plans, system ambitions and can demonstrate progress towards the delivery of outstanding care
- To achieve financial sustainability, enabling appropriate investment in the delivery of outstanding care

New and Enhanced Services

During the year we made a number of changes to the way services have been delivered due to the impact and implications of responding to the COVID-19 pandemic. A small selection of these includes the use of electronic communication for patients, virtual outpatients and remote working, the development of intermediate care services with Somerset County Council and the voluntary sector and the continued implementation of the Open Mental Health service.

During the year the Trust took on the role of accountable provider for the COVID-19 vaccination programme, the success of the roll out to date has been due to the engagement of all parts of the Somerset Health and Care system, including primary care, Yeovil District Hospital, Somerset County Council and the voluntary sector.

During the year the Trust entered into two new partnerships which will enable us to expand our services.

- **Rutherford Diagnostics:** The Trust entered into an initial five year contract for the provision of imaging diagnostic services at a community based location. The partnership will increase the number of MRI, CT, Ultrasound and X-ray capacity at a designated centre at Blackbrook Park in Taunton which will support the reduction of waiting times for these services. This will provide additional high quality services which can be accessed on an outpatient basis and will allow both increased capacity for both outpatients and for inpatients within Musgrove Park Hospital. The facility is planned to open in the autumn of 2021.

- **Sensyne Health:** In November 2020 the Trust entered into a five year non-exclusive research agreement with Sensyne Health PLC. This agreement will enable the application of clinical artificial intelligence to improve patient care and accelerate research into new medicines. This will be undertaken through the provision of anonymised data under the Trust's ethical oversight. Under the agreement the Trust will receive a shareholding within the company, investment to further develop its analytical capacity and potential future share of revenue and benefits from future developments by the company.

Key issues and risks to the achievement of Trust objectives

During the year the most significant risks (managed in year) were:

- **COVID-19** - The impact of the coronavirus pandemic meant that the Trust, in partnership with all partner agencies locally, regionally and nationally has had to make unprecedented changes in a very short period of time. Our acute, community, mental health and corporate services have responded to the coronavirus pandemic by refocusing services, standing some up and stepping others down, to ensure that we can care for the people who need our support. The impact of the pandemic has been seen across the last year with a second wave of infections significantly impacting on the delivery of services from January 2021.

- **Staffing Pressures** - The Trust has continued to identify risks in a number of services around staffing pressures arising from vacancies, sickness absence and increasing levels of demand. This has led to the temporary closure or reduction of some services specifically within community hospital services and ongoing pressures within our acute hospital wards.

- **Finance** - Although the Trust achieved financial balance, the system-wide risks in relation to the financial position have also been significant during the year specifically in the context of the uncertainty of the impact of COVID-19 and the Trust has worked with the CCG, Somerset County Council and partner organisations to manage these risks during the year. The Trust will start the new financial year with an underlying financial deficit

- **Waiting Times** – During the year the impact of COVID-19 has further deteriorated the waiting times for planned care and the length of time patients are waiting. This is reflected across our acute services in diagnostics, surgery and also a number of our community based services including dental services. Whilst meeting its trajectory for the restoration of services during the autumn of 2020, the second wave of the pandemic further impacted upon these services. The restoration and managing the resultant backlog is a key focus during 2021.

KEY PERFORMANCE MEASURES

Oversight Framework targets

The NHS Improvement / NHS England Oversight Framework sets out the key national standards which are applicable to Somerset NHS Foundation Trust as a service provider. The table below sets out our performance levels across the year:

Target	Threshold	Performance				
		Q1	Q2	Q3	Q4	Full year total
A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge*	95%	95.5%	94.0%	91.1%	88.1%	92.3%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway**	92%	51.1%	44.5%	60.2%	59.2%	-
Number of patients waiting over 52 weeks from referral to treatment (RTT)	Zero (year-end)	906	1,639	1,953	3,097	-
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	56%	83.3%	75.0%	61.1%	76.9%	-
Improving access to psychological therapies (IAPT): • people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral • people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	75% 95%	89.4% 99.5%	87.3% 99.6%	91.8% 99.6%	92.5% 99.8%	90.0% 99.6%
Cancer 62 Day Waits for first treatment***: • urgent GP referral for suspected cancer	85%	77.8%	72.0%	72.9%	72.1%	74.2%

Target	Threshold	Performance				
		Q1	Q2	Q3	Q4	Full year total
• NHS cancer screening service referral	90%	64.9%	60.0%	80.8%	78.7%	70.3%
6-week diagnostic wait	99%	37.2%	50.9%	65.9%	62.2%	-
Clostridium difficile (all cases including community associated)	36	10	18	11	8	47
MRSA (Trust apportioned cases)	0	0	1	1	1	3
Improving Access to Psychological Therapies (IAPT)/talking therapies: Percentage of people completing a course of IAPT treatment moving to recovery	50%	59.2%	60.9%	63.4%	65.2%	61.9%
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period	95%	99.3%	99.3%	98.7%	99.2%	99.1%
Inappropriate out-of-area placements for adult mental health services (cumulative numbers shown)	0	50	30	22	0	102
Data Quality Maturity Index (DQMI) – MHSDS dataset score	95%	95.4%	96.1%	96.5%	96.5%	96.1%
Admissions to adult facilities of patients under 16 years old	0	0	0	0	0	0
Mental health scores from Friends and Family Test – % positive	85%	Reporting suspended due to COVID-19. Recommenced from December 2020		100%	100%	100%
Community health scores from Friends and Family Test – % positive	95%			98.5%	98.3%	98.4%

**A&E maximum waiting times - the indicator is expressed as a percentage of all A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge*

*** RTT incomplete pathways – the indicator is expressed as the percentage of patients on an incomplete pathway (i.e. those still awaiting first consultant led treatment) who have waited less than 18 weeks from referral.*

**** Cancer figures are for April 2020 to March 2021; but please note that due to national reporting of March 2021 performance taking place in May the March figures have been estimated and may be subject to change.*

More detailed analysis and explanation of the development and performance during the year

Throughout 2020/21 the priority was to keep all patients safe in the face of unprecedented pressure on services as a result of the COVID-19 pandemic. This meant making sure we could treat any COVID-19 patients who came into hospital, but also making sure other emergencies and patients needing urgent elective care received the treatment when they needed it. Significant focus was maintained on ensuring patients were appropriately triaged and monitored whilst they were waiting for treatment. National clinical prioritisations processes were adopted early in the first wave of COVID-19 and remain in place to support the prioritisation of patients whilst routine waiting list backlogs are reduced.

As part of our arrangements to keep patients safe and ensure that our services were accessible, our community-based physical and mental health services offered patients, where appropriate, appointments via telephone and a virtual video clinic 'Attend Anywhere'. This enabled patients to continue to receive advice and support throughout the pandemic and was instrumental in ensuring that we met the NHS Oversight Framework waiting times standards relating to Improving access to psychological therapies and early intervention in psychosis. All of our mental health services continued to operate during the whole of the pandemic and we did not close or suspend any services. The expansion of services also continued during this period, including our Community Mental Health Service Transformation work, establishing Open Mental Health. Appointment outcomes remained favourable, with the standard for the percentage of people completing a course of IAPT treatment moving to recovery consistently being met and exceeded throughout the year.

Only one of the national cancer waiting times standards was met during the year, which was the 31-day wait for drug treatment (e.g. chemotherapy), as a follow-up treatment for cancer or for a recurrence of cancer. The other national cancer waiting times standards were not met for a range of reasons. These included reduced service capacity to see patients in outpatients or for their diagnostic tests, both as a direct result of COVID-19 impacts but also underlying pressures due to recruitment challenges and levels of demand, patients deciding not to attend for tests or have treatment due to COVID-19, or a clinical decision having been made with patients to delay tests or treatment because the risk of COVID-19 infection outweighed the benefits of proceeding with their care plan.

During 2021/22 the Trust will continue to focus its attention on the most urgent patients, including those patients needing diagnosis and treatment for a potential cancer, but also reducing the number of routine, longest waiting patients. This includes work underway to redesign cancer pathways to speed up the diagnosis period, including one-stop services and additional diagnostic equipment. The Trust will also be hosting a new Rapid Diagnostic Service (RDS) hub for Somerset, for patients with vague symptoms of cancer or a significant benign condition. This will enable patients to have an early diagnosis so that they can then be appropriately managed by the most appropriate service for their condition.

The Trust's performance against the 18-week referral to treatment (RTT) standard remained below the national 92% standard and was heavily impacted by COVID-19.

By the middle of April 2020 the level of routine referrals had dropped to around a quarter of the levels seen before the start of pandemic. Referral levels slowly recovered over the year, but by the end of the year were still just under 90% of the usual levels. After an initial drop in demand which resulted in a big fall in the waiting list, the overall number of patients on the waiting list stabilised until November, when it then started to grow as demand outstripped the new level of service capacity. Because fewer patients were being treated during 2020/21 the number of 52-week waiters rose across the year. However, until February 2020 when the second wave of COVID-19 arrived, the Trust had fewer longer patients waiting at each month-end than expected from our initial forecasts.

In addition to demand being affected by COVID-19, so was the capacity of many services to see and treat patients. Operating capacity was significantly reduced because a number of the Trust's theatres were closed in order to create additional critical care capacity. The impact was most severe during the second wave of COVID-19 when the Trust closed ten out of its fifteen theatres. This was necessary not only to free-up physical space to create critical care beds, but also the staff in order to support critical care. This enabled critical care capacity to be increased from a core number of 14 beds to 26 beds during the peak of wave 2. However, having only five theatres available for urgent and emergency operating significantly reduced the number of operations undertaken, with only essential operating taking place for a number of weeks. Additional Infection Prevention & Control (IP&C) precautions were also taken, involving the wearing of personal protective equipment (PPE) and fallow time in between patients to ensure enough time for full cleaning of the theatre environment. This also reduced the number of patients who could be operated on in a theatre session.

Outpatient capacity was also affected by COVID-19, due to the need to ensure patients were socially distanced in waiting areas, but also again to allow cleaning between patients. Two of the Trust's three Outpatient Departments were used for other services during the first wave of COVID-19, including one being used to create a Discharge Lounge to support timely discharge of patients from wards. The Discharge Lounge remains in situ in Outpatients, but with a reduced footprint. Plans are in place to relocate the Discharge Lounge during the first quarter of 2021/22 to free-up Outpatients to see more patients.

The impact of measures taken to reduce the risk of COVID-19 transmission in hospital also had a significant effect on capacity within diagnostic services such as radiology, endoscopy and echo. As a result, the diagnostic waiting list grew over the year. The Trust continued to prioritise patients needing urgent diagnostic tests and made sure an effective triage process was in place to identify those patients needing to have their tests undertaken as soon as possible. Additional steps were taken for patients waiting for endoscopies and CT colonograms, where there was a potential risk of the patient having cancer. Capacity for both these diagnostic tests was significantly impacted by necessary IP&C measures. Patients were asked to take a simple test at home. This provided additional information on a patient's likelihood of having cancer and enabled the list of waiting patients to be appropriately triaged.

In addition to taking additional IP&C measures to reduce the risk of COVID-19 transmission to patients, such as enhanced cleaning and social distancing, where

possible patients were not brought into hospital. Video and telephone consultations replaced face-to-face attendances where patients did not need to be physically examined or be present for diagnostic tests in clinic. This approach has worked well for many patients and is something the Trust will be focusing on again during 2021/22. This will help us to continue to keep patients safe and reduce un-necessary trips to patients, making hospital services more convenient for patients and reducing the impact on the environment.

Trust performance against the target of treating all patients within four hours of their arrival at A&E was below the national target during the year. However, in most months performance remained strong relative to the national picture, especially with Minor Injuries Unit (MIU) attendances included in a like-for-like comparison with other Trusts. During the first wave of COVID-19 A&E attendances dropped to around half of pre-COVID levels and then slowly recovered to around 90% of normal levels. During each period of lockdown levels of attendances dropped again, although less significantly. Levels of emergency admissions also fell but the acuity of patients was higher, which presented significant challenges for provision of beds. The Trust established an additional assessment and admission area for patients arriving with symptoms consistent with COVID-19, and ensured patients were tested promptly so that they could be managed safely away from other emergency and elective patients.

The Somerset A&E Delivery Board maintains oversight of a work programme aimed at reducing unnecessary emergency demand by providing alternatives to patients being admitted and also schemes to reduce extended stays in hospital. This has included over recent years, the development of rapid response hubs, work to support care homes and implementation of Home First project, which first commenced in 2017/18. The Home First model of care facilitates the discharge of medically fit patients out of the hospital. Patients receive an intensive period of reablement in three settings to promote independence and keep patients (for as long as possible) in their usual place of residence. During 2020/21 there was also significant focus on understanding the reasons why patients remain in hospital and what needs to happen to make sure they can go back to their home or usual place of residence as soon as possible. This focus on the more extended stays in hospital was one of the ways in which the Trust worked hard to manage the additional demands on inpatient beds as a result of the high volumes of COVID patients needing to be in hospital during the peak of the pandemic.

Good performance was maintained throughout the year, in respect of patients on the Care Programme Approach being followed up within 7 days after discharge from psychiatric inpatient care, with compliance of 99.1% being achieved against a required standard of at least 95%

Our numbers of inappropriate out-of-area placements for adult mental health services remained amongst the lowest nationally. With only 10 Psychiatric Intensive Care Unit (PICU) beds available, there are occasions when, due to clinical acuity or gender, it would be unsafe to admit a patient. During COVID-19, maintaining the required isolation arrangements increased the possibility that a patient would need to be placed out of county. When any patient is so placed, a key worker is immediately assigned to maintain daily contact with the patient until the patient is either transferred back to our wards, discharged, or moved to secure services. The

placements sought are always as close to Somerset as possible. A number of episodes relate to patients awaiting transfer to secure services. Working closely with other NHS providers, we are exploring opportunities to ease such transfers and cohort such patients.

We also had no admissions to adult facilities of patients under 16 years old in 2020/21.

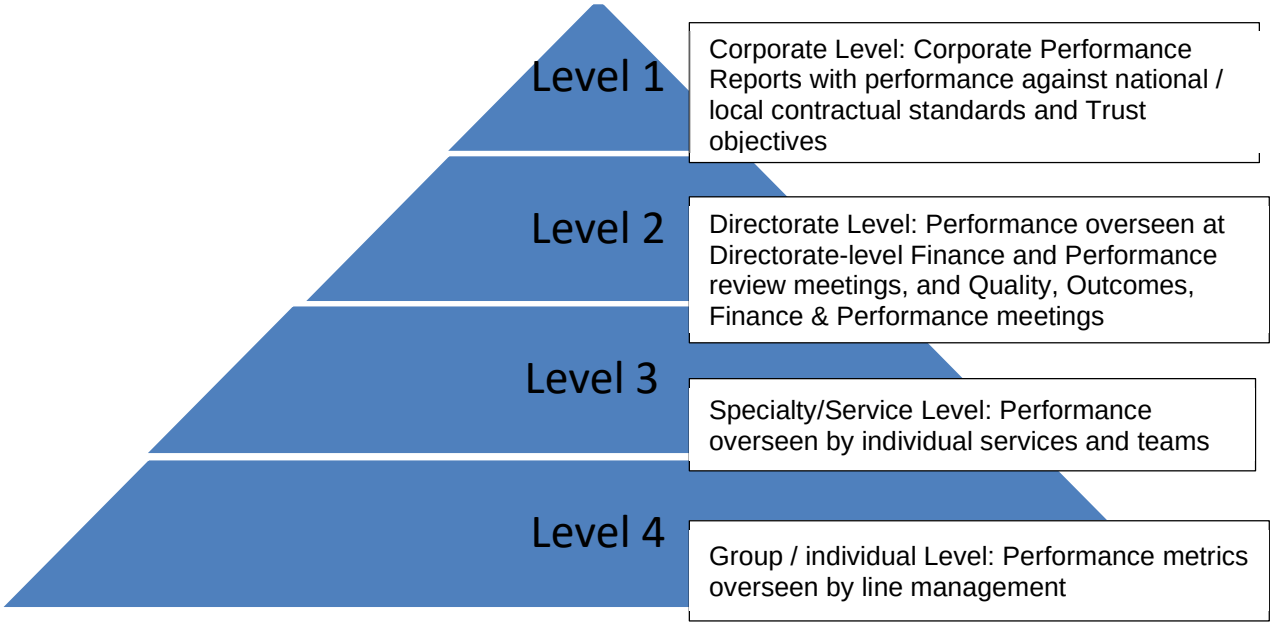
The Trust had three cases of MRSA bloodstream infection in 2020/21. No lapses in care were identified. Forty-seven Clostridium difficile cases were recorded during the year, which is higher than the threshold for the year of 36. All Trust associated cases are thoroughly investigated to assess whether there was any lapse in care that may have contributed. These assessments are subsequently peer reviewed and validated with the Trust's commissioners. To date, 44 reviews have been completed with 13 lapses in care identified, relating to antimicrobial prescribing, low environmental cleanliness and low hand hygiene compliance. Learning has included ensuring appropriate compliance with environmental cleaning and hand hygiene standards. This learning has been shared with the appropriate clinical and non-clinical staff and improvement actions taken. Further information about this is contained within the quality report.

Monitoring Performance, Improvements in Quality and Meeting National Targets

Somerset NHS Foundation Trust has a comprehensive quality monitoring and performance management framework in place, to ensure that high standards of care are delivered to patients and that all applicable performance targets are delivered.

Our Performance Management Framework is based upon on a hierarchy of performance management arrangements, ranging from the Trust Board to individuals and line managers. This is represented diagrammatically in Figure 3 below:

Figure 3: Performance Management System Hierarchy



We have developed and employ an integrated approach to quality and patient safety and performance management, which is evidenced through the monthly Quality and Performance exception report, presented to our Trust Board. The reports incorporate metrics which span key national and local frameworks, including the NHS Improvement / NHS England Oversight Framework, the framework for Commissioning for Quality and Innovation (CQUIN), and local commissioning intentions, with an emphasis on monitoring key aspects of quality improvement, harm reduction, patient safety and patient satisfaction.

The Quality and Performance report is published monthly on our website and provides our Trust Board with regular information, across a broad range of quality and safety measures including slips, trips and falls, medication incidents, pressure ulcers, incidents involving restraint, ligatures and ligature points, harm-free care and safer staffing.

The Quality and Performance Report is continually reviewed, to ensure that it reflects the most current and relevant metrics and analysis. The report presents information relating to the five key questions which the Care Quality Commission considers when reviewing and inspecting services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well-led?
- Are they responsive to people's needs?

The monthly Quality and Performance Report and accompanying dashboards assist the Board in its assessment of the achievement of our strategic and annual objectives and key targets, and all of the measures are linked to the five Care Quality Commission themes.

The Quality and Performance Report is accompanied by a range of supporting information which sets out performance data for the reporting year, including:

- a dashboard of quality and patient safety measures
- a corporate balanced scorecard, with all measures linked to our corporate objectives
- referral, caseload and activity levels for community physical and mental health services for the current year, compared to the previous year
- acute service activity levels for the current year, compared to the previous year, including day cases, elective and non-elective inpatient activity, attendances at Accident & Emergency, and outpatient attendances
- average length of stay and bed occupancy levels for our community hospitals and mental health inpatient wards for the current year, compared to the previous year
- details of our Care Quality Commission ratings

These reports help the Board to evaluate whether we are meeting national and local standards and targets and operating safely, efficiently and effectively, whilst improving the quality of our services. The Quality and Performance Report sets out what we are doing in respect of increased levels of reported incident or where performance falls below set compliance standards

Our Quality and Governance Committee, a sub-committee of the Trust Board, provides high-level challenge and assurance, in relation to key quality and performance metrics. This detailed analysis and challenge complements Board discussions on performance, enabling a balance to be struck between effective Non-Executive Director scrutiny of the operational detail, whilst enabling the Board to remain focused on the key strategic issues. The Quality and Governance Committee receives a range of detailed tabulated and graphical performance information, at the level of individual service / ward, together with other key performance information and also requests, as necessary, focused information on particular aspects of service delivery and patient safety.

In addition to our Quality and Performance report and corporate balanced scorecard, we also maintain directorate-level performance dashboards for each of our six operational service directorates, and our Estates and Facilities service. Each directorate dashboard sets out the performance of the service directorate, in relation to key targets relating to the services managed within that directorate. This allows our key corporate performance measures to be managed at a more granular level, and to identify any areas of concern which may lie below an overall incidence of underperformance, or even areas of concern which are component elements of an aggregate level of performance which meets the required corporate level standard.

The key forums, via which performance management arrangements for divisions are managed, are:

- a monthly senior operational managers' team meeting, chaired by the Chief Executive, combining review and challenge of service directorate progress against key objectives outlined on each dashboard, with an opportunity for Service Directors to share with the executive team issues of concern;
- a Finance and Performance (F&P) Group meeting for each of the Trust's service directorates, held every other month, with the Performance section of the meeting chaired by the Trust's Associate Director of Performance. The Finance and Performance Group focuses on the principal performance issues for each directorate, and considers the exceptions arising from the directorate scorecards;
- a Quality, Outcomes, Finance and Performance (QOFP) Group, held in the intervening months, with a similar remit to the Finance and Performance Group, but extended to include a more in-depth focus on patient safety and quality issues and a more detailed review of performance issues relating to People.

The key purposes of these meetings include:

- undertaking detailed scrutiny of performance against key indicators and agreeing:

  - actions as necessary to address underperformance
  - recovery trajectories as necessary to restore or achieve compliance against performance standards
- undertaking detailed scrutiny of trends and incidence levels of patient safety and quality measures and outcomes, and agreeing actions as necessary to address any identified issues
- reviewing data and other feedback in relation to patient experience, and agreeing any actions as necessary in the light of notable positive or adverse areas
- monitoring activity levels, identifying variances against plans and the underlying causes, and agreeing actions as necessary to address variances
- providing support and challenge to teams, in relation to their performance position and to gain assurance that performance issues are being addressed effectively;
- assessing risks to future delivery and agree mitigation plans;
- identifying and agreeing future performance management arrangements;
- rewarding directorates which perform well, by reducing the degree of performance management involvement;
- identifying the contributory issues behind any declines in performance and to have a clear escalation and de-escalation process;
- focusing on early performance management intervention, where directorates might be at risk of failing to meet required standards.

Monthly review meetings are also held by each service directorate, chaired by the service director, and with representation from individual services managed within the service directorate, as well as from corporate teams including Performance, enabling a discussion of operational issues relating to each service.

Commissioning for Quality and Innovation (CQUIN) Targets

Somerset Clinical Commissioning Group, our principal commissioner of services, sets annual targets under the framework for Commissioning for Quality and Innovation (CQUIN), the aim of which is to improve the quality of services delivered to patients. The achievement of the CQUIN standards generates additional income for the Trust, of up to 1.25%.

In 2020/21 CQUIN was suspended, due to the impact of COVID-19, with the expectation that arrangements would recommence in 2021/22.

ENVIRONMENTAL SUSTAINABILITY

Introduction

In January 2020, the campaign for a greener NHS was launched to mobilise more than 1.3 million NHS staff and set an ambitious, evidence-based route map and date for the NHS to reach net zero carbon emissions. A key deliverable of this campaign is reaching net zero emissions for the care we provide (the NHS Carbon Footprint) by 2040, and zero emissions across the entire scope of our emissions (the NHS Carbon Footprint Plus) by 2045.

Somerset NHS Foundation Trust aims continually to improve health and wellbeing and deliver quality health care. All NHS providers have a responsibility to provide high quality health care whilst protecting human health and minimising negative impacts on the environment. A Green Plan will be the mechanism for organisations to take a coordinated, strategic and action-orientated approach to sustainability. Green Plans form a key part of sustainable healthcare delivery to ensure services remain fit for purpose today and for the future. The NHS Standard Contract mandates that all healthcare services are required to have a Green Plan in place.

This report outlines the challenges and achievements experienced in 2020/21 whilst developing the Trust's Green Plan and delivering on its sustainability and energy reduction targets

Challenges

COVID-19 has had a significant impact on the ability of the Estates and Facilities team and the wider trust to focus on delivering the sustainability agenda. There are, however key learnings from the Trust's response to the pandemic that may be evaluated and retained for the long term, with future carbon reduction benefits. This includes the roll out of digitised care and the reduction in travel between and home and the workplace as well as between sites.

Conversely, some elements of our response to COVID-19 have led to an increase in our impact on the environment, including increased need for personal protective equipment (PPE), cleaning products, ventilators, single-use plastics and other associated equipment.

This year has also seen the merger between the legacy Trusts which has led to a number of significant changes to the leadership of the Trust's single Estates and Facilities senior leadership team which in turn has also meant that there has not been the same management focus on sustainability that there would be under business as usual activities.

Achievements

Despite the challenges described above the Trust has made real progress on delivering on the sustainability agenda:

- In year the Estates and Facilities team have successfully created and recruited to the position of Energy Manager. This role will provide the necessary focus and scrutiny of energy use and utilities across the whole Trust.

- The creation of the Trust's Energy Action Team, chaired by the energy manager in attendance with key estates engineers is providing a robust process for challenging and improving our use of key utilities.

- Over the past year the LED project funded by NHSI has been completed across the acute site and at Medical records in Priorswood which has resulted in a reduction of 148 tonnes of carbon emissions.

- The reusable sharps containers, and "bag to bedside" clinical waste system was rolled out across the acute site. Approximately a third of sharps waste is attributed to the weight of the container, a significant percentage, and the introduction of the offensive waste stream via the 'bag to bedside' system tonnage has made a significant contribution to the reduction in clinical waste tonnage.

- The Trust has signed up to the NHS Plastic Pledge to reduce single use plastic in particular from Catering and provided its first report to NHS E&I. Introduction of three sports water bottle machines at the Acute has resulted in 44,000 single use beverage bottles not being purchased and together with the water dispensers at community and mental health sites has increased free hydration for patients, visitors and colleagues.

- After a tender process, new macerators have been purchased and deployed across the Trust, which are not only energy efficient, but also have antimicrobial coating to help reduce infection in clinical areas.

- The Trust has increased covered bicycle provision as part of active travel and joined with Somerset County Council to provide E-Scooter parking on site as part of a wider trial being undertaken by the Department of Transport.

- An area of land behind the Maternity Building at the acute site and at Dene Barton has been approved by Somerset Wildlife Trust as a wildlife corridor, which is part of a wider plan across the County to help increase biodiversity.

- The Trust has resolved a long running contractual dispute with Schneider Plc, its partner in an energy performance contract. The Trust is now free to develop its own energy strategy and has since initiated plans to reinvest in its existing Combined Heat and Power (CHP) plant. The plant is expected to be operational again by the end summer 2021 at which time it will be delivering significant energy savings and reducing or electrical demand from the grid.

Monitoring and Performance

Table 1 below summarises the position of Somerset NHS Foundation Trust from the baseline figure of 2007/8 to date. As this is the first year of the merged Trust the year on year progress will be set from this position.

The figures are absolute and need to be viewed on the basis of increased patient numbers year on year and the change in technology for example MRI, CT, and increased use of IT which add a significant load.

The reduction in waste sent to clinical waste reflects the change to offensive waste streams together with recycling opportunities.

Table 1	**2007/08 Base Year**	**2007/08 Carbon emissions Tonne**	**2020/21**	**2020/21 Carbon emissions Tonne**	**Cumulative % difference from 2007/08 baseline figure to date**	**Carbon emission reduction from baseline**
Gas - kWh	40,273,658	7394	31,878,020	5879	-21%	-20%
Electricity -kWh	14,584,970	7890	18,143,020	5031	24%	-36%*
Water m^3	189,106		190,097		0.5%	
Clinical waste – tonnes	547		424		-22%	

*The reduction in carbon emissions for electricity is due to the impact of renewable and nuclear contributions to the National Grid and subsequent reduction in fossil fuel content

2021/22 Plan

The potential merger of Somerset FT and Yeovil District Hospital NHS Foundation Trust has led to further collaboration between the Trusts' estates teams and this in turn has led to the creation of a joint post on sustainability. The Head of Sustainability, Carbon and Energy role will provide the necessary senior leadership and focus to achieve the ambitious targets on net zero and sustainability provided by the government across the Somerset NHS system. Both Trust Boards have approved this post and it is expected to be recruited by early summer 2021.

A key objective of this role in year will be to develop and roll out a Somerset-wide green plan to provide a framework to achieve the NHS Net zero targets for the Somerset system.

HUMAN RIGHTS

We recognise our responsibilities under the European Convention on Human Rights (included in the Human Rights Act 1998 in the UK), which are relevant to health and social care. These rights include the:

- right to life;
- right not to be subjected to torture, inhuman or degrading treatment or punishment;
- right to liberty; and
- right to respect for private and family life.

The Trust is committed to ensuring it fully takes into account all aspects of Human Rights in its work, following on from the *Human Rights in Healthcare: A Framework for Local Action* (Department of Health, March 2007). This will ensure the Trust continues to meet its duty to respect human rights in all that it does.

Going Concern

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

The Trust has prepared its financial plans and cash flow forecasts on the assumption that funding will be received from the Department of Health. Discussions to date indicate this funding will be forthcoming. These funds are expected to be sufficient to enable the Trust to meet its obligations as they fall due. These funds will be accessed through the nationally agreed process published by NHS Improvement and the Department of Health.

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

Financial Instruments

It is Trust policy to avoid the use of financial instruments when possible, thus minimising financial risk to the Trust. This means that the Trust's exposure to risks created by financial instruments is much lower than commercial organisations of the same size. The accounts state the Trust's accounting policies (note 1.14) and the nature and value of the risk that the Trust faces (note 29).

To the best of my knowledge, the information in this document is accurate.

Signed

PETER LEWIS **11 June 2021**
Chief Executive

FINANCIAL OVERVIEW AND REVIEW

Overview

Somerset NHS Foundation NHS Trust was established on 1 April 2020. In the final weeks of preparations to merge our two predecessor organisations, a global pandemic was declared and we came together as one organisation to respond, caring for patients with COVID-19 in our mental health, community and acute services and changing how we care for our non-COVID-19 patients.

2020/21 was a challenging year for everyone and services were put under huge pressure as a result of the pandemic. The business as usual financial and contracting frameworks were suspended to reduce the burden on NHS organisations and allow them to focus their efforts on responding to the pandemic.

Interim financial frameworks were introduced during the year which provided additional funding for the impact of COVID-19. The Trust continued to deliver safe and high quality services within the level of funding provided.

In 2020/21 we delivered an operational surplus of £0.9million (before the impact of technical adjustments arising from the annual revaluation of its estate, see page 27; note 7 annual accounts. The Trust investment in capital infrastructure and equipment totalled over £53million in year and will ensure the Trust has the buildings, equipment and IT to deliver high quality services for its patients.

The Trust financial performance is also assessed by NHS England and Improvement (NHS E&I) on a control total basis. The Trust exceeded the breakeven control total set out by NHS E&I by recording a small surplus (on a control total basis) of £0.026million.

The delivery of the financial plan becomes increasingly more difficult with each passing year. The financial challenges for the Trust will continue in 2021/22 and securing savings of the magnitude required over the coming years can only be achieved if the Trust is more radical in its approach to the delivery of services and for all the health and social care organisations in Somerset to work in closer collaboration to ensure the services are delivered as efficiently as possible.

Regulatory Ratings

The NHS Oversight framework, as part of the NHS provider licence requirements, enables NHS E&I to monitor five themes relating to providers' performance and to consider their support needs. These themes are:

- Quality of Care
- Finance and Use of Resources
- Operational Performance
- Strategic Change
- Leadership and improvement capability

This aims to identify a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of these services and/or poor governance. Under the theme 'Finance and Use of Resources', regional teams oversee and support providers in improving financial sustainability, efficiency and value for money. This includes a provider's compliance with current sector controls such as agency staffing, capital expenditure and financial control totals. Identifying providers' support needs under this theme may take into account:

- a monthly finance score, calculated by scoring providers on a scale of 1 (best) to 4 against the following five metrics, and averaging these scores to derive an overall figure:
  - capital service capacity
  - liquidity
  - income and expenditure margin
  - distance from financial plan
  - agency spend
- a use of resources assessment
- other relevant information on financial performance, operational productivity and whether a provider is making optimal use of its resources

Based on the extent to which a provider is triggering a concern under one, or more, of the five themes, providers are placed into one of four segments:

1. Maximum autonomy
2. Targeted support
3. Mandated support
4. Special measures

In 2020/21, Somerset NHS Foundation Trust was in segment 2.

Internal Audit

The Trust engaged BDO to provide an internal audit function during 2020/21 in order to evaluate and continually improve the effectiveness of the risk management and internal control processes in place.

External Audit

The financial statements were reviewed by the Trust's external auditors, KPMG, who issued an unqualified opinion, and the statements were approved by the Board of Directors on 20 May 2021.

Statutory audit costs for 2020/21 were £133,200 with no audit-related assurance services. (2019/20: £59,500 for statutory audit and £3,250 for audit-related assurance services). The costs include unrecoverable vat.

Income Disclosure

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. In 2020/21 the Trust has not received any income for goods and services not related to the health service and there are no plans to do so within the five year business plan.

Directors' Responsibilities Statement

For each individual who is a director at the time this annual report was approved, so far as the directors are aware, there is no relevant audit information of which the auditors are unaware and the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Political Donations

Somerset NHS Foundation Trust has not made any political or charitable donations in 2020/21.

Better Payments Practice Code

The Better Payments Practice Code requires the Trust to aim to pay all undisputed invoices by the due date, or within 30 days of receipt of goods or receipt of invoice, or from the invoice date, whichever is the later. The results against this target for the financial year 2020/21 are shown below.

	Number	£000
Total non-NHS trade invoices paid in period	101,136	270,729
Total non-NHS trade invoices paid within target	83,249	237,505
Percentage of non-NHS trade invoice paid within target	82.3%	87.7%
Total NHS trade invoices paid in period	1,604	24,506
Total NHS trade invoices paid within target	1,122	18,856
Percentage of NHS trade invoices paid within target	70%	76.9%

There were no amounts paid or payable under The Late Payment of Commercial Debts (Interest) Act 1998.

Financial Statements and Accounting Policies

The complete set of financial accounts is provided in full within this report. They have been prepared in accordance with International Financial Reporting Standards (IFRS), completed in accordance with directions given by NHS Improvement, and are designed to show a true and fair view of the Trust's financial activities. The

accounting policies used comply with the NHS Foundation Trust Annual Reporting Manual and form the basis on which the financial statements have been compiled.

Signed

PETER LEWIS **11 June 2021**
Chief Executive

REMUNERATION AND STAFF REPORT

On 1 April 2020, Somerset Partnership and Taunton and Somerset NHS Foundation Trusts merged forming Somerset NHS Foundation Trust; reporting for 2020/21 will show on this basis and the equivalent disclosure for 2019/20 will report Somerset Partnership NHS FT with any associated recharge to/from Taunton and Somerset NHS FT.

Overview

This report is made by the Board of Somerset NHS Foundation Trust in compliance with:

- Sections 420 to 422 of the Companies Act 2006 (that apply to NHS Foundation Trusts);
- Parts 2 and 4 of schedule 8 of the Regulations as adopted by NHS Improvement;
- Regulation 11 and parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008; and
- Elements of the NHS Foundation Trust Code of Governance.

The term “senior manager” covers those who influence the decisions of the Trust as a whole rather than the decisions of individual directorates or departments and the board has decided that disclosures will be made in respect of Executive Directors and Non-Executive Directors.

Nomination and Remuneration Committee

The Nomination and Remuneration Committee of the Board comprises the non-executive directors and determines the level of remuneration, terms of service for the Chief Executive and other executive directors. It supports the work of the Chairman in assessing the size, structure and skill requirements of the Board. The remuneration element of the Committee is chaired by the Senior Independent Director, Kate Fallon, and the nomination element of the Committee is chaired by the Trust’s Chairman, Colin Drummond.

The Committee met twice in the financial year 2020/21 with attendance as follows:

✓ **– in attendance** X **– not in attendance** **Members**		**4 April 2020**	**9 June 2020**
Colin Drummond	Chairman	✓	✓
Barbara Clift	Non-Executive Director	✓	✓
David Allen	Non-Executive Director	✓	✓
Barbara Gregory	Non-Executive Director	✓	✓
Jan Hull (Deputy Chairman)	Non-Executive Director	✓	✓

✓ – in attendance X – not in attendance Members		4 April 2020	9 June 2020
Kate Fallon	Non-Executive Director	x	✓
Stephen Harrison	Non-Executive Director	✓	✓
Alexander Priest	Non-Executive Director	✓	✓

The Remuneration Committee's meetings covered the following items:

- **4 April 2020 –** interim arrangements to cover the secondment of the Chief Nurse to the Bristol Nightingale team.

- **9 June 2020** - executive director's salary review**;** feedback from the executive directors performance review; and succession planning talent management review.

There was no requirement for the Director of People and Organisational Development to attend any of these meetings to provide further advice.

Statement of Policy on the Remuneration of Senior Managers for Current and Future Years

The pay policy for Executive Director remuneration aims to deliver the main principles for director remuneration under Section E of the NHS Foundation Trust Code of Governance.

Levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the NHS Foundation Trust successfully, but an NHS Foundation Trust should avoid paying more than is necessary for this purpose.

The Trust will set executive remuneration taking account of data on pay available elsewhere for each particular role within the benchmark data. The benchmark data will be reviewed annually and will be based on the Hay scores. The principal benchmark will be the national public sector and the foundation trusts with an annual turnover of £125-£150 million will be used as a secondary benchmark. Additional factors, as defined by the Nomination and Remuneration Committee, will also be taken into account.

Remuneration packages for Non-Executive Directors

The remuneration package for non-executive directors is made up of:

Salary	£14,000 per annum for all non-executive directors
Salary	£50,500 per annum for non-executive chairman
Salary	£3,000 per annum for the additional roles of Senior Independent Director, Deputy Chairman and Chairman of the Audit Committee.

Remuneration packages and any changes made to it for Executive Directors

Element	Rationale
Salary	The Board approved the Trust Strategy. These are delivered by the Directors. This success measure is one of the ways in which the Directors performance is monitored. All executive director remuneration is subject to satisfactory performance of duties in line with their employment and monitored through regular 1:1 with the Chief Executive and annual appraisal. The Chief Executive performance review is led by the Trust Chairman. There is no performance related pay and Directors receive 100% of their salary subject to the relevant deductions. Salary is benchmarked and there are no automatic rises for executive directors.
Taxable Benefits	Any taxable benefit is agreed by the Nomination and Remuneration Committee. This forms part of the recruitment and retention of executive directors by ensuring that the Trust remains competitive. There is no maximum amount payable.
Bonus	No bonus scheme operates at the Trust therefore the maximum that could be paid is £0.
Pension	Standard pension arrangements are in place for 2020/21.

The Chairman of the Nomination and Remuneration Committee confirms that for the 2020/21 financial year no substantial changes (changes higher than 10% of basic salary) were made to Executive Directors' remuneration and that no new components of the remuneration package were introduced in 2020/21.

In some cases, an additional responsibility payment may be paid where individual senior managers are required to take on significant responsibilities outside of their core role for an extended period. The allowance should be linked to the proportion of time spent on the additional responsibilities and would not normally exceed 10% of basic salary. Executive members of the Board are employed on contracts with no fixed or specified term, save for the Chief Medical Officer, who is subject to a three year fixed term in respect of his executive role. Notice periods for executive members of the Board are set at six months. No provision is made for additional termination payments.

The Trust had one interim director in 2020/21 to cover the secondment of the Chief Nurse into the Bristol Nightingale Team and there were no payments made to past senior managers. There are no provisions for the recovery of sums paid to directors nor have we withheld any payment to a director.

Expenditure on consultancy

A total of £374,359 was spent on consultancy in 2020/21 (2019/20: £225,035).

Off payroll arrangements

There were no off-payroll engagements of board members and/or senior officials with significant financial responsibility.

The Trust policy is not to use such off-payroll engagements unless in exceptional circumstances, and then for the minimum time demanded by such circumstances.

Payments for Loss of Office

The Nomination and Remuneration Committee is the body charged with determining payments for loss of office. There is no policy for such payments. Instead, the Committee makes individual decisions on the rare occasions where such payments may be warranted. These decisions relate to both the award of a loss of office payment and on the value of any such payment. The Committee is free to exercise its discretion, and bases its decisions on the circumstances of the loss of office, the performance of the officeholder, and any other factors deemed relevant

Statement on remuneration levels higher than the British Prime Minister

Following guidance from the Secretary of State the Trust is required to disclose the steps it has taken to satisfy itself that the remuneration is reasonable in cases where senior managers are paid more than £150,000 p.a. There are 2 (2019/20: 1) senior managers currently employed by the Trust who were paid more than £150,000 p.a. (the Chief Executive and the Chief Medical Officer). The salaries for these posts have been benchmarked and are commensurate with national, regional and local comparator roles within the NHS, reflecting the very high levels of responsibility associated with the posts.

Employment Conditions of Other Employees

The Trust applies national pay rates, terms and conditions for other staff, both medical and non-medical and has not implemented any local conditions reflecting market forces or other factors.

All other employees' remuneration is based on the national terms and conditions appropriate to their contract of employment. While the Trust does not consult with staff on remuneration for directors, it is always mindful of the remuneration of staff when making decisions. When reviewing salary, the Nomination and Remuneration Committee considers what is happening to staff pay across the sector, the comparison to the median ratio of the workforce and ensuring that the Committee continues to be financially prudent. NHS Providers produce an annual remuneration survey for benchmarking.

The future focus of activity for people services will relate to the Wellbeing Strategy and primarily involve, delivering a range of resilience, stress management and health

promotion initiatives placing the emphasis on prevention rather than the management of sickness absence. This will occur within the framework of an overarching Wellbeing Strategy which is being informed by work being undertaken with partner organisations directly and as part of wider ICS activity.

Council of Governors remuneration

As Somerset NHS FT is a foundation trust, the Council of Governors is required to approve the remuneration and terms of service of the Chair and Non-Executive Directors. The Council of Governors has established a Remuneration and Nominations Committee in accordance with the Trust's constitution.

There was no remuneration paid to governors. During 2020/21 a total of £1,000 (2019/20: £5,200) of travel expenses were reimbursed to four governors. Details of the governors are shown on page 88.

Contracts of Employment

The Trust reviewed and updated the standard contracts of employment to ensure a consistent approach in line with current national terms and conditions and best practice on contracts.

Executive Directors allowed to work elsewhere as a Non-Executive

In the case of executive directors serving as a non-executive, earnings will not be retained by the relevant director. The board does not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.

Pensions and retirement benefits

Accounting policies for pensions and other retirement benefits are set out in note 1.8 to the accounts and details of senior employees' remuneration can be found on page 42 of this report.

Salaries and Pensions Entitlements of Senior Managers

The following sections provide details of the remuneration and pensions of the Directors for the period ended 31 March 2021 and have been audited.

Total remuneration 2020/21	Note	**Salary**	**Taxable benefits ***	**Pension related benefits ****	**Total Remuneration**	**Recharges Salary**	**Recharges Pension**	**Remuneration Net of recharges *****
Name and Title		**(Bands of £5,000)**	**(To nearest £100)**	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**(Bands of £2,500)**	**(Bands of £5,000)**
		£000		**£000**	**£000**	**£000**	**£000**	**£000**
Peter Lewis, Chief Executive		190-195	0	55 – 57.5	245 – 250	n/a	n/a	245-250
Andy Heron, Deputy Chief Executive & Chief Operating Officer (Mental Health & Community Services)		130 – 135	100	32.5 – 35	160 – 165	n/a	n/a	160 – 165
Phil Brice, Director of Governance and Corporate Development		110 – 115	0	65 – 67.5	175 – 180	n/a	n/a	175 – 180
Pippa Moger, Director of Finance		135 – 140	0	25 – 27.5	160 – 165	n/a	n/a	160 – 165
Hayley Peters, Chief Nurse	4	95 – 100	0	50 – 52.5	145 – 150	n/a	n/a	145 - 150
Matthew Bryant, Chief Operating Officer (Acute Hospital Services)	1	125 – 130	0	35 – 37.5	165 – 170	(5 – 10)	(7.5 – 10)	150 – 155
David Shannon, Director of Strategic Development & Improvement		125 – 130	0	30 – 32.5	155 – 160	n/a	n/a	155 – 160
Isobel Clements, Director of People and Organisational Development		120 – 125	0	30 – 32.5	150 – 155	n/a	n/a	150 – 155

Total remuneration 2020/21 (continued)	Note	**Salary**	**Taxable benefits ***	**Pension related benefits ****	**Total Remuneration**	**Recharges Salary**	**Recharges pension related benefits**	**Remuneration Net of recharges**
Name and Title		**(Bands of £5,000)**	**(To nearest £100)**	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**(Bands of £2,500)**	**(Bands of £5,000)**
		£000		**£000**	**£000**	**£000**	**£000**	**£000**
Daniel Meron, Chief Medical Care Officer	2	200 – 205	0	175 – 177.5	375 – 380	n/a	n/a	375 – 380
Alison Wootton, Acting Chief Nurse	3	25 – 30	100	25 – 27.5	50 – 55	n/a	n/a	50 – 55
Colin Drummond, Chairman		50 – 55	0	n/a	50 – 55	n/a	n/a	50 – 55
Barbara Clift, Non-Executive Director		10 – 15	0	n/a	10 – 15	n/a	n/a	10 – 15
David Allen, Non-Executive Director		10 – 15	0	n/a	10 – 15	n/a	n/a	10 – 15
Jan Hull, Non-Executive Director		15 – 20	100	n/a	15 – 20	n/a	n/a	15 – 20
Barbara Gregory, Non-Executive Director		15 – 20	0	n/a	15 – 20	n/a	n/a	15 – 20
Kate Fallon, Non-Executive Director		15 – 20	0	n/a	15 – 20	n/a	n/a	15 – 20
Stephen Harrison, Non-Executive Director		10 – 15	0	n/a	10 – 15	n/a	n/a	10 – 15
Alexander Priest, Non-Executive Director		5 – 10	0	n/a	5 – 10	n/a	n/a	5 – 10

Notes

1. Part of Yeovil District Hospital Board as Chief Operating Officer from 1 Jan 2021.
2. £96k of the salary for the Medical Director relates to their clinical role.
3. From 5 Apr to 10 Jul 2020.
4. From 1 Apr to 4 Apr and from 11 Jul to 31 Mar 2021.

*Taxable benefits are costs associated with travel expenses allowances that are subject to income tax.

**The value of pension related benefits is determined in accordance with the HMRC method, which incorporates pensions payable for a 20 year period.

The equivalent disclosures for 2019/20 were as follows:

Total remuneration 2019/20	Note	**Salary**	**Taxable benefits ***	**Pension related benefits ****	**Total Remuneration**	**Recharges Salary**	**Recharges Pension**	**Recharges Taxable benefits ***	**Remuneration Net of recharges *****
Name and Title		**(Bands of £5,000)**	**(To nearest £100)**	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**(Bands of £2,500)**	**(To nearest £100)**	**(Bands of £5,000)**
		£000		**£000**	**£000**	**£000**	**£000**		**£000**
Peter Lewis, Chief Executive		n/a	n/a	n/a	n/a	90 – 95	22.5 – 25.0	0	115 - 120
Andy Heron, Deputy Chief Executive & Chief Operating Officer (Mental Health & Community Services)		130 – 135	400	32.5 – 35	162.5 – 165	(65 – 70)	(15 – 17.5)	(200)	80 - 85
Phil Brice, Director of Governance and Corporate Development		100 – 105	100	17.5 – 20	117.5 – 120	(50 – 55)	(7.5 – 10)	0	55 – 60
Pippa Moger, Director of Finance		135 – 140	100	15 – 17.5	150 – 152.5	(65 – 70)	(7.5 – 10)	0	75 – 80
Stuart Walker, Chief Medical Care Officer	1&2	n/a	n/a	n/a	n/a	30 – 35	0	0	30 – 35
Hayley Peters, Chief Nurse		n/a	n/a	n/a	n/a	60 – 65	10 – 12.5	0	75 – 80
Matthew Bryant, Chief Operating Officer (Acute Hospital Services)		n/a	n/a	n/a	n/a	60 – 65	20 – 22.5	0	80 – 85

Total remuneration 2019/20 (continued)	Note	**Salary**	**Taxable benefits ***	**Pension related benefits ****	**Total Remuneration**	**Recharges Salary**	**Recharges pension related benefits**	**Recharges Taxable benefits ***	**Remuneration Net of recharges *****
Name and Title		**(Bands of £5,000)**	**(To nearest £100)**	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**(Bands of £2,500)**	**(To nearest £100)**	**(Bands of £5,000)**
		£000		**£000**	**£000**	**£000**	**£000**		**£000**
David Shannon, Director of Strategic Development & Improvement		n/a	n/a	n/a	n/a	60 – 65	10 –12.5	0	75 – 80
Isobel Clements, Director of People and Organisational Development		n/a	n/a	n/a	n/a	60 – 65	55 – 57.5	0	115 – 120
Daniel Meron Chief Medical Care Officer	2&3	n/a	n/a	n/a	n/a	30 – 35	0	0	30 – 35
Andrea Trill Interim Medical Director Integrated and Community Care	4	n/a	n/a	n/a	n/a	15 – 20	5 – 7.5	0	25 – 30
Matthew Hayman Interim Medical Director Integrated and Community Care	4	n/a	n/a	n/a	n/a	15 – 20	-	-	15 – 20
Stephen Ladyman, Chairman		45 – 50	300	n/a	45 – 50	n/a	n/a	n/a	45 – 50
Philip Dolan, Non-Executive Director		10 – 15	100	n/a	10 – 15	n/a	n/a	n/a	10 – 15
Barbara Clift, Non-Executive Director		10 – 15	400	n/a	10 – 15	n/a	n/a	n/a	10 – 15
David Allen, Non-Executive Director		10 – 15	100	n/a	10 – 15	n/a	n/a	n/a	10 – 15

Total remuneration 2019/20 (continued)	Note	**Salary**	**Taxable benefits ***	**Pension related benefits ****	**Total Remuneration**	**Recharges Salary**	**Recharges pension related benefits**	**Recharges Taxable benefits ***	**Remuneration Net of recharges *****
Name and Title		**(Bands of £5,000)**	**(To nearest £100)**	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**(Bands of £2,500)**	**(To nearest £100)**	**(Bands of £5,000)**
		£000		**£000**	**£000**	**£000**	**£000**		**£000**
Jan Hull, Joint Non-Executive Director		15 – 20	400	n/a	15 – 20	n/a	n/a	n/a	15 – 20
Barbara Gregory, Joint Non-Executive Director		15 – 20	400	n/a	15 – 20	n/a	n/a	n/a	15 – 20
Kate Fallon, Joint Non-Executive Director		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Stephen Harrison, Joint Non-Executive Director		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Notes

1. To 12 July 2019.
2. 100% of the salary for the Medical Director relates to their director role, there is no element relating to their clinical role
3. From 2nd December 2019.
4. Job Share from 13th July to 2nd December 2019.

*Taxable benefits are costs associated with travel expenses allowances that are subject to income tax.

**The value of pension related benefits is determined in accordance with the HMRC method, which incorporates pensions payable for a 20 year period.

*** The Trust entered into an Alliance with Taunton & Somerset NHS Foundation Trust during 2017/18. As a result, a single Executive/Management Team was formed. The table of Salary and Pension entitlements of senior managers for 2018/19 and 2017/18 includes the full entitlements paid to senior managers during the year. This is not the amount chargeable to the Trust. Recharges between the two organisations are shown separately in the table. On 1st April 2020, Somerset Partnership and Taunton and Somerset NHS Foundation Trusts merged forming Somerset NHS Foundation Trust.

Pension Benefits	Note	Real increase in pension at age 60	Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31 March 2021	Lump sum at age 60 related to accrued pension at 31 March 2021	Cash equivalent transfer value at 31 March 2021	Cash equivalent transfer value at 31 March 2020	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
Name and Title		**(Bands of £2,500) £000**	**(Bands of £2,500) £000**	**(Bands of £5,000) £000**	**(Bands of £5,000) £000**	**£000**	**£000**	**£000**	**£000**
Peter Lewis, Chief Executive		2.5 – 5	0 – 2.5	75 – 80	170 – 175	1369	1265	54	n/a
Andy Heron, Deputy Chief Executive & Chief Operating Officer (Mental Health & Community Services)		2.5 - 5	0	35 – 40	65 – 70	748	684	33	n/a
Matthew Bryant, Chief Operating Officer (Acute Hospital Services)	1	2.5 – 5	0 – 2.5	40 – 45	85 – 90	699	640	29	n/a
Phil Brice, Director of Governance and Corporate Development		2.5 – 5	5 – 7.5	30 – 35	65 – 70	629	539	66	n/a
Pippa Moger, Director of Finance		0 – 2.5	0	40 – 45	85 – 90	738	684	22	n/a
Alison Wootton, Acting Chief Nurse	2	0 – 2.5	0 – 2.5	35 – 40	115 – 120	834	766	11	n/a
Hayley Peters, Chief Nurse	3	2.5 – 5	0 – 2.5	45 – 50	95 – 100	802	728	32	n/a
David Shannon, Director of Strategic development & Improvement		2.5 – 5	0 – 2.5	40 – 45	75 – 80	617	567	22	n/a

Pension Benefits	Note	Real increase in pension at age 60	Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31 March 2021	Lump sum at age 60 related to accrued pension at 31 March 2021	Cash equivalent transfer value at 31 March 2021	Cash equivalent transfer value at 31 March 2020	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
Name and Title		**(Bands of £2,500) £000**	**(Bands of £2,500) £000**	**(Bands of £5,000) £000**	**(Bands of £5,000) £000**	**£000**	**£000**	**£000**	**£000**
Isobel Clements, Director of People and Organisational Development		0 – 2.5	0 – 2.5	45 – 50	110 – 115	902	839	31	n/a
Daniel Meron Chief Medical Care Officer		7.5 – 10	15 – 17.5	50 – 55	135 – 140	1192	966	181	n/a

Notes
1 Part of Yeovil District Hospital Board as Chief Operating Officer from 1 Jan 2021. Full pension figures attributed to the employee have been disclosed in the table above rather than the amount chargeable to the Trust.
2 From 5 Apr to 10 Jul 2020
3 From 1 Apr to 4 Apr and from 11 Jul to 31 Mar 2021

As Non-Executive Directors do not receive pensionable remuneration there are no entries in respect of pensions for Non-Executive Directors.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design.). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

Median pay

	2020/21	2019/20
Band of highest paid director's salary (£'000)	£200-205k	£65-70k
Median Total Remuneration	£18,047	£23,761
Ratio	11.10	2.84

The banded remuneration of the highest paid director in the financial year 2020-21 was £200-205k (2019-20, 65-70k net of recharges to Taunton and Somerset NHS Foundation Trust). This was 11.10 times (2019-20, 2.84) the median remuneration of the workforce, was £18,047 (2019-20, £23,761). The 2020-21 median includes substantive, bank and agency. The equivalent 2019-20 information only shows substantive staff as individual bank and agency was not available.

The calculation is based on full time equivalent staff at 31 March 2021 on an annualised basis. The median is a type of average, defined as the middle number in a sorted list of values.

In 2020-21, 3 (2019-20, 132) employees received remuneration in excess of the highest-paid director. During 2019/20, gross of recharges to Taunton and Somerset NHS Foundation Trust, 3 employees received remuneration in excess of the highest-paid director.

Remuneration ranged from £6 to £316,750 (2019-20 £1,520 to £135,000),

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

There was no pay freeze for staff in 2020/21.

Cash Equivalent Transfer Values

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

pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Staff costs

	Permanent	Other	2020/21 Total	2019/20 Total
	£000	**£000**	**£000**	**£000**
Salaries and wages	290,477	3,157	**293,634**	**95,412**
Social security costs	29,389	0	**29,389**	**8,480**
Apprenticeship levy	1,468	0	**1,468**	**478**
Employer's contributions to NHS Pensions	37,353	0	**37,353**	**12,492**
Additional contribution 6.3%, paid by NHSE	16,259	0	**16,259**	**5,430**
Redundancy	376	0	**376**	**0**
Temporary staff (including agency)	34,530	0	**34,530**	**11,532**
Total staff costs	409,851	3,157	**412,632**	**133,824**
Costs capitalised as part of assets	**(2,547)**	**0**	**(2,547)**	**(244)**

Average number of employees (WTE basis)

	Permanent Number	Other Number	2020/21 Total Number	2019/20 Total Number
Medical and dental	710	28	**738**	**113**
Ambulance Staff	3	0	**3**	**0**
Administration and estates	2,114	94	**2,208**	**518**
Healthcare assistants & other support staff	1,327	246	**1,573**	**949**
Nursing, midwifery and health visiting staff	2,290	177	**2,467**	**966**
Scientific, therapeutic and technical staff	1,275	17	**1,292**	**615**
Healthcare science staff	145	8	**153**	**0**
Other	0	28	**28**	**77**
Total of which	**7,864**	**598**	**8,462**	**3,238**
Number of employees (WTE) engaged on capital projects	**46**	**0**	**46**	**6**

Retirements due to ill-health

During 2020/21 there were 7 early retirements from the Trust agreed on the grounds of ill-health (2019/20: one early retirement). The estimated pension liabilities of this ill-health retirement was £364,997 (2019/20: £39,012).

The additional pension costs for individuals who retired early on ill-health grounds will be borne by the NHS Business Services Authority- Pensions Division.

Directors' remuneration and other benefits

		31 March 2021	31 March 2020
		£000	£000
Salary		**1,387**	670
Employer's National Insurance contributions		**179**	86
Employer pension contributions		**199**	91
		1,765	847
Number of executive directors to whom pension benefits are accruing		**9**	9

Benefits are accruing under the NHS defined benefit pension scheme to 9 of the directors; (2019/20: 9). No benefits are accruing under any money purchase schemes.

Reporting of compensation schemes - exit packages 2020/21

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
£10,001 - £25,000	**0**	**1**	**1**
£25,001 - £50,000	**0**	**2**	**2**
£50,001 - £100,000	**2**	**2**	**4**
	2	**5**	**7**
Total resource cost (£)	**154,597**	**221,734**	**376,331**

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally-agreed arrangements or local arrangements for which Treasury approval was required."

Reporting of compensation schemes - exit packages 2019/20

There were no compensation schemes-exit packages reported during 2019/20.

Trade Union Facility Time Disclosure

Rep Name	Union	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	TOTAL PAID HRS	Horuly rate with on-costs	Average Union Hours Per Week	Cost Per Week	Total Cost Per Year	FTE	Contracted Hours	% of Employers Cost	Percentage of time spent on facility timein bands of a) 0%, b) 1-50%, c) 51-99% and d) 100%	Unpaid time for Trade Union activities	Time spent on trade union activities as a % of total paid facility time
Ami Mackay	RCN	16	16	16	16	16	16	16	16	16	MAT LEAVE	MAT LEAVE	MAT leave	144	£21.17	2.77	£ 58.63	£ 3,048.72	0.40	15.00	18%	B	0	0.00%
Andrew Dodd	UNITE	0	0	0	0	0	0	0	0	0	0	0	0	0	£12.10	-	£ -	£ -	0.80	30.00	0%	A	0	0.00%
Benjamin Matthews	CSP						12	12	12	12	12	12	12	84	£21.57	1.62	£ 34.84	£ 1,811.62	0.76	28.50	6%	B	0	0.00%
Beverley Jones	RCN	65	65	65	65	65	65	65	65	65	65	65	65	780	£24.26	15.00	£ 363.93	£ 18,924.21	1.00	37.50	40%	B	96	12.31%
Carolyn Higgins	Society of Radiographers	0	0	0	0	0	0	0	0	0	0	0	0	0	£0.00	-	£ -	£ -	1.00	37.50	0%	A	0	0.00%
Claire Bodger	RCN	None due to ward pressures												0	£0.00	-	£ -	£ -	0.61	23.00	0%	A	0	0.00%
Danny Kungebeharry	RCN	16	16	16	16	16	16	16	16	16	16	16	16	192	£28.60	3.69	£ 105.59	£ 5,490.59	1.00	37.50	10%	B	0	0.00%
Debbie Russell	Unison	128	128	128	128	128	128	128	128	128	128	128	128	1536	£19.49	29.54	£ 575.79	£ 29,940.98	0.85	31.88	93%	C	0	0.00%
Deborah Quick	UNITE	0	0	0	0	0	0	0	0	0	0	0	0	0	£13.28	-	£ -	£ -	1.00	37.50	0%	A	0	0.00%
Denyze Harris	UNITE	65	65	65	65	65	65	65	65	65	65	65	65	780	£39.36	15.00	£ 590.40	£ 30,700.80	1.00	37.50	40%	B	90	11.54%
Eleanor Copp	RCM	0	0	0	0	0	0	0	0	0	0	0	0	0	£0.00	-	£ -	£ -	1.00	37.50	0%	A	0	0.00%
Frank Hicks	UNITE	6	6	6	6	6	6	6	6	6	6	6	6	72	£12.10	1.38	£ 16.75	£ 871.18	1.00	37.50	4%	B	0	0.00%
Gemma Reynalds	Unison	30	30	30	30	30	30	30	30					240	£13.77	4.62	£ 63.55	£ 3,304.80	0.80	30.00	15%	B	0	0.00%
Helen Doolan	Society of Radiographers	12	12	12	12	12	12	12	12	12	12	12	12	144	£24.26	2.77	£ 67.18	£ 3,493.44	0.59	22.00	13%	B	0	0.00%
Helen White	RCN	16	16	16	16	16	16	16	16	16	16	16	16	192	£21.57	3.69	£ 79.64	£ 4,141.44	1.00	37.50	10%	B	0	0.00%
Jackie Benham	UNITE	12	12	12	12	12	12	12	12	12	12	12	12	144	£19.49	2.77	£ 53.98	£ 2,806.97	1.00	37.50	7%	B	0	0.00%
James Knight	UNTIE	0	0	0	0	0	0	0	0	0	0	0	0	0	£0.00	-	£ -	£ -	0.80	30.00	0%	A	0	0.00%
Judith Barry	RCN	22	18.5	29.5	15.5	19	33.5	25	13	20.5	10	10	10	226.5	£26.23	4.36	£ 114.25	£ 5,941.10	1.00	37.50	12%	B	24	10.60%
Laura Collins	CSP	12	12	12	12	12	12	12	12	12	0	0	12	120	£19.98	2.31	£ 46.12	£ 2,398.14	1.00	37.50	6%	B	0	0.00%
Lawrence John	UNITE	0	0	0	0	0	0	0	0	0	0	0	0	0	£0.00	-	£ -	£ -	1.00	37.50	0%	A	0	0.00%
Lee Talbot	UNITE				9.42				3					12.42	£12.36	0.24	£ 2.95	£ 153.54	1.00	37.50	1%	B	0	0.00%
Lesley Harper	BDA	3.5	2	3.5	4	4	0	4.5	3.5	0	3.5	6.5	6.5	41.5	£26.77	0.80	£ 21.37	£ 1,111.14	1.00	37.50	2%	B	0	0.00%
Luisa Stephens	Unison	60	60	60	60	60								300	£15.26	5.77	£ 88.04	£ 4,578.00	1.00	37.50	15%	B	0	0.00%
Marcela Coe	Unison	0	2.5											2.5	£24.26	0.05	£ 1.17	£ 60.65	0.61	23.00	0%	A	0	0.00%
Mark Roughan	GMB	8	8	8	8	8	8	8	8	8	8	8	8	96	£28.60	1.85	£ 52.80	£ 2,745.60	1.00	37.50	5%	B	0	0.00%
Mike Slade	UNITE	0	0	0	0	0	0	0	0	0	0	0	0	0	£28.60	-	£ -	£ -	1.00	37.50	0%	A	0	0.00%
Neuza Nunes	UNITE	0	0	0	0	0	0	0	0	0	0	0	0	0	£13.28	-	£ -	£ -	0.80	30.00	0%	A	0	0.00%
Nikki Neville	Unison then RCN	10	8	11.5	11	16	10	10	11	10			10	107.5	£13.28	2.07	£ 27.45	£ 1,427.60	1.00	37.50	6%	B	0	0.00%
Nicola Farnham	RCN	12	12	12	12	12	12	12	12	12	12	12	12	144	£24.26	2.77	£ 67.18	£ 3,493.44	0.80	30.00	9%	B	0	0.00%
Patrick King	Unison	0	0	14	14	0	17.5	20	15	15	20	20	20	155.5	£19.49	2.99	£ 58.28	£ 3,030.70	1.00	37.50	8%	B	0	0.00%
Paul Pursey	GMB	16	16	16	16	16	16	16	16	16	16	16	16	192	£11.23	3.69	£ 41.46	£ 2,156.16	0.43	16.00	23%	B	0	0.00%
Dr Peter Park	BMA	16	16	16	16	16	16	16	16	16	16	16	16	192	£58.14	3.69	£ 214.67	£ 11,162.88	1.00	37.50	10%	B	0	0.00%
Scott Leitch	Unison	0	0	0	0	0	0	0	0	0	0	0	0	0	£0.00	-	£ -	£ -	0.80	30.00	0%	A	0	0.00%
Stephen Gill	RCN	9	9	9	9	9	9	9	9	9	9	9	9	108	£11.23	2.08	£ 23.32	£ 1,212.84	1.00	37.50	6%	B	0	0.00%
Steven Higgins	Society of Radiographers	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	8.5	102	£28.60	1.96	£ 56.10	£ 2,917.20	1.00	37.50	5%	B	0	0.00%
Tara Gonzales	Unison	0	0	0	0	0	0	0	0	0	0	0	0	0	£0.00	-	£ -	£ -	0.80	30.00	0%	A	0	0.00%
Zoe Buckland	RCN						27.5	32	33.5	37.5	26.5	37.5	37.5	232	£17.40	4.46	£ 77.53	£ 4,036.80	0.80	30.00	15%	B	0	0.00%
													Trust Wide Totals	6339.92		121.92	£ 2,903.09	£ 150,960.53		1,224.38	10%	B	210	3.31%

Total Pay Bill	£ 411,541,000	% of the total pay bill spent on facility time	0.04%

*The blacked out cells indicate times when those individuals would not have been available to perform/eligible for Trade Union facility time (left the Trust, started a TU role mid-year, moved Unions * M/L = maternity leave*

Signed

PETER LEWIS, Chief Executive **11 June 2021**

TRUST WORKFORCE REPORT

The Trust has a workforce of 11,414 employees working in a range of inpatient, outpatient, and community and mental health team settings across a wide range of geographical locations. The information provided is drawn from the national ESR (NHS Electronic Staff Record) system and provided in a way that will be recognisable to all, using national guidelines for Staff Group and using our known Trust Workforce Directorate naming convention.

Colleagues in post at 31 March 2021

Type	Headcount	FTE (Full Time Equivalent)
Contracted Employees	9,489	8,140
Bank/Zero Hours Employees	1,925	0
Grand Total	**11,414**	**8,140**

We also host Trainee clinical Psychologists. These figures do not count towards our profiles such as sickness and turnover figures.

Trainee Clinical Psychologist	Headcount	FTE
	199	198.1

Workforce Information by Directorate

Directorate	Headcount	FTE
Clinical Support & Specialist	972	838.5
Corporate Support Services	1,315	1,177.0
Families Care Directorate	966	766.1
Integrated and Urgent Care	2,165	1,803.6
Maternity Pay	116	99.8
Mental Health and LD	1,090	962.9
Operational Management	384	160.7
Primary Care & Neighbourhoods	961	768.1
Surgical Care	1,799	1,563.2
Grand Total	**11,414**	**8,140.0**

Contracted and Bank/Zero Hours by Directorate

Directorate	Headcount		FTE	
	Bank/ Zero Hours	Contracted	Bank/ Zero Hours	Contracted
Bank	1,646	0	0.0	0.0

Directorate	Headcount		FTE	
	Bank/ Zero Hours	Contracted	Bank/ Zero Hours	Contracted
Clinical Support & Specialist	6	966	0.0	838.5
Corporate Support Services	24	1,291	0.0	1,177.0
Families Care Directorate	24	942	0.0	766.1
Integrated and Urgent Care	8	2,157	0.0	1,803.6
Maternity Pay	1	115	0.0	99.8
Mental Health and LD	5	1,085	0.0	962.9
Operational Management	183	201	0.0	160.7
Primary Care & Neighbourhoods	12	949	0.0	768.1
Surgical Care	16	1,783	0.0	1,563.2
Grand Total	**1,925**	**9,489**	**0.0**	**8,140.0**

Workforce Information by Staff Group

Staff Group	Headcount	FTE
Add Prof Scientific and Technic	540	435.6
Additional Clinical Services	3,001	1,898.5
Administrative and Clerical	2,151	1,621.0
Allied Health Professionals	816	648.4
Estates and Ancillary	864	611.8
Healthcare Scientists	72	59.3
Medical and Dental	1,020	689.1
Nursing and Midwifery Registered	2,947	2,173.3
Students	3	2.9
Grand Total	**11,414**	**8,140.0**

Contracted and Bank/Zero Hours by Staff Group

Staff Group	Headcount		FTE	
	Bank/ Zero Hours	Contracted	Bank/ Zero Hours	Contracted
Bank	1,646	0	0.0	0.0
Add Prof Scientific and Technic	35	505	0.0	435.6
Additional Clinical Services	785	2,216	0.0	1,898.5
Administrative and Clerical	245	1,906	0.0	1,621.0
Allied Health Professionals	56	760	0.0	648.4
Estates and Ancillary	124	740	0.0	611.8
Healthcare Scientists	6	66	0.0	59.3
Medical and Dental	249	771	0.0	689.1
Nursing & Midwifery Registered	425	2,522	0.0	2,173.3
Students	0	3	0.0	2.9
Grand Total	**1,925**	**9,489**	**0.0**	**8,140.0**

Staff Group by Gender

Staff Group	Headcount		FTE	
	Female	Male	Female	Male
Add Prof Scientific and Technic	411	129	326.8	108.9
Additional Clinical Services	2,576	425	1,612.4	286.1
Administrative and Clerical	1,814	337	1,331.7	289.3
Allied Health Professionals	663	153	510.0	138.4
Estates and Ancillary	472	392	321.2	290.6
Healthcare Scientists	47	25	38.3	21.0
Medical and Dental	509	511	347.1	341.9
Nursing and Midwifery Registered	2,664	283	1,945.6	227.7
Students	3	0	2.9	0.0
Grand Total	**9,159**	**2,255**	**6,436.1**	**1,703.9**

Analysis of gender breakdown (based on headcount) – non-audited information Directors

	Male	Female
Executive	6	3
Non-executive	4	4
Total	10	7

Other senior managers (all employees (excluding directors) at band 8 and above)

	Male	Female
Medical consultants & GPs	302	241
Senior managers (all band 8+ staff)	170	332

Other employees

	Male	Female
Medical (training and career grade)	165	219
All other staff	1,644	8,528

Gender pay gap

The Trust's gender pay gap report for 2019/20 was split into two reports for the legacy organisations as the report is based on a snapshot of data as at 31 March 2019. The gender pay gap shows the median and mean pay gap and provides an

analysis of the difference between medical and nonmedical roles). The Women's Network created a gender pay gap sub-group to lead the work in understanding the gender pay gap and developing the associated action plan.

In line with national guidance, the data is published on the Trust's website at: https://www.somersetft.nhs.uk/about-us/about-us/mission-vision-statement-and-our-values/equality-and-diversity/

The information can also be found on the Cabinet Office website https://gender-pay-gap.service.gov.uk/

Staff Sickness Absence as 31 March 2021

The following figures are reported in the annual accounts and are based on the financial year and reflect the statistics reported on the website of the Health and Social Care Information Centre:

Total number of staff years	7,742
Total days lost through sickness	129,243
Absence % Rate	4.1%
Calculated absences per staff year	16.7

Sickness is shown as total actual days lost to sickness eg. Medical suspension would not be included as sickness. The Trust experienced monthly levels of sickness during 2020/21 ranging from (June 2020) 3.8% to a high of (January 2021) 5.8%.

Staff Turnover as at 31 March 2021

Turnover excludes all Training grade/Junior Doctors and students in a transient role. This is done as these members of staff are slated to leave as part of their role and therefore not a true leaver in a turnover sense.

Directorate	**March 2021**
Clinical Support and Specialist	11.3%
Corporate Support Services	7.7%
Families Care Directorate	8.8%
Integrated and Urgent Care	11.0%
Mental Health and Learning Disabilities	9.9%
Operational Management	4.9%
Primary Care & Neighbourhoods	9.3%
Surgical Care	8.3%
Grand Total including Maternity Pay	9.4%

Employees with disabilities

The Workforce Disability Equality Standard (WDES) is a set of specific measures designed to enable NHS organisations to compare the experiences of disabled and non-disabled colleagues. This information can then be used to develop a local action plan, and enable demonstration of progress against the indicators of disability equality. There is one report for the reporting year 2019/20, with the majority of the ten metrics separated into two sets of data: one from each legacy trust.

The data shows the workforce representation as a whole and the board representation against this alongside the experience of colleagues with a disability.

In line with national guidance, the data is published on the Trust's website at: https://www.somersetft.nhs.uk/about-us/about-us/mission-vision-statement-and-our-values/equality-and-diversity/

As part of the Trust's commitment to supporting colleagues with a disability or underlying health condition the Lived Experience Network was developed to enable colleagues with a disability to come together and share their experiences, barriers and challenges and to provide a forum for their voices to be heard in a safe environment. The Trust is committed to having a representative workforce and takes appropriate steps to support the attendance of colleagues with a disability, making reasonable adjustments as necessary to help colleagues with a disability remain in work.

Information on diversity and inclusion policies, initiatives and longer term ambitions

The Trust Vision is to be an organisation that gets it right for patients, carers, colleagues and communities through an inclusive culture. This is underpinned by the value "working together."

The Trust aims to get it right for the diverse communities of Somerset and beyond – and wants services to serve, reflect and celebrate that diversity. The Trust wants everyone to feel that they belong and services to be accessible to all who need them.

The Trust is signed up to the Somerset Equality Objectives which are shared with other health and social care organisations across Somerset. Alongside this the Trust has an Inclusion Strategy which sets out the following 7 key ambitions:

- Our colleagues, patients, carers and communities belong and are valued
- Colleagues are encouraged and enabled to speak up safely
- A representative workforce at all levels
- Working in partnership with and for our diverse communities
- An accessible organisation
- A networked organisation that works collaboratively
- An informed organisation that actively seeks out inequalities.

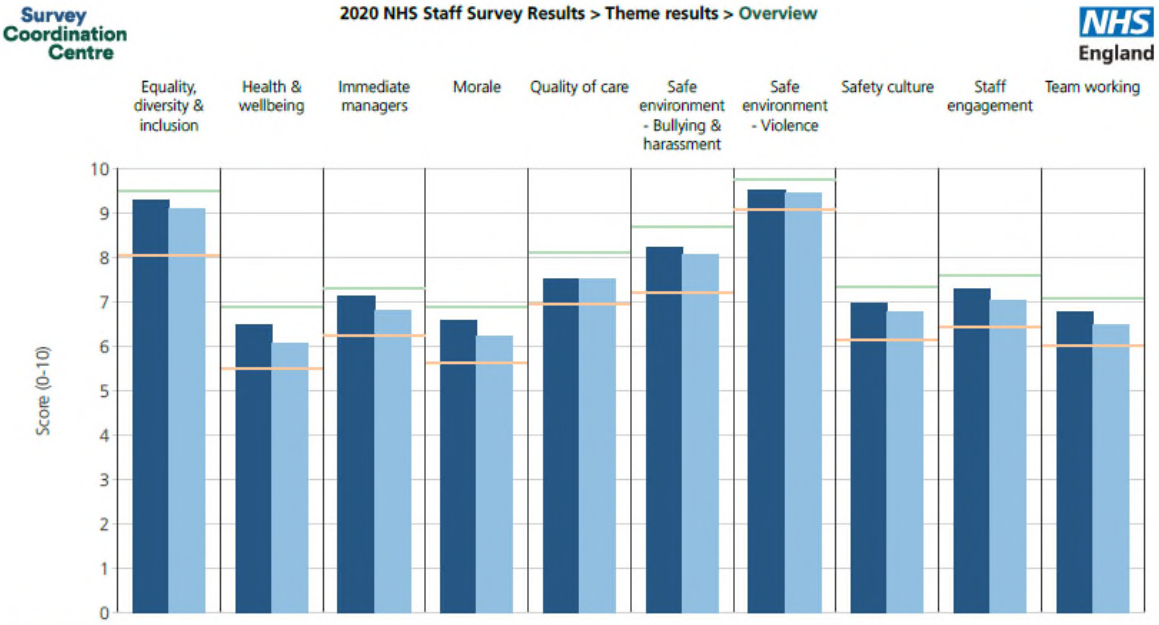
STAFF ENGAGEMENT

Staff Survey

The 2020 NHS Staff Survey was completed between September and December 2020 with a 49% response rate which is a 2% increase from the 2019 survey for both Somerset Partnership and Taunton & Somerset NHS Foundation Trusts.

This year was the first year that the staff survey was completed as Somerset NHS Foundation Trust and this is the reason, due to the establishment of Somerset Foundation Trust being 1 April 2020, there is no comparison data.

The 2020 survey was amended slightly with one of the eleven themes being removed for this year which is the Quality of Appraisal theme. The results of the other ten themes can be seen in the table below.



	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	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.3	6.5	7.1	6.6	7.5	8.2	9.5	7.0	7.3	6.8
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	4,366	4,383	4,385	4,378	3,854	4,370	4,377	4,385	4,390	4,341

The key points from the table are that in eight of the themes the Trust scored higher than the benchmark group average and for two of the themes the Trust remained the same as the benchmark group average.

In terms of Staff Engagement this remains in line with the score from both individual Trusts in the 2019 results.

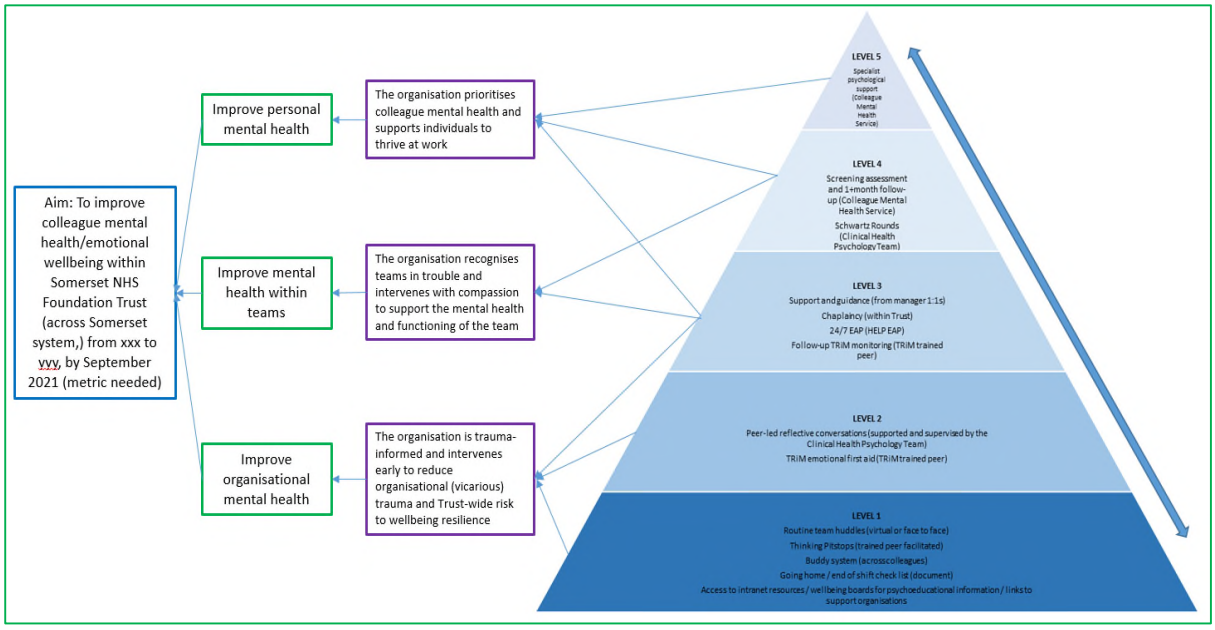
Overall Staff Engagement

Throughout 2020 the engagement focus for the Trust was colleague wellbeing with a more targeted focus on psychological and emotional wellbeing of our colleagues. Evidence and research from previous global pandemics suggested colleagues would experience emotional reactions to the situation around them and as an employer we wanted to ensure we were supporting colleagues through the pandemic. This in turn enabled our colleagues to provide the patient care required in these challenging times.

Wellbeing drop-in sessions were established both face to face and virtually to enable as many colleagues to attend as possible. Support for leaders across the Trust took the form of peer to peer review sessions and Action Learning Sets, enabling colleagues to share experiences and gain insight from other peers across the Trust.

An internal colleague support line was set up, utilising the skills within the Trust to support other colleagues who were struggling with the demands of both work and life at the time. This line continues to be in place and is ensuring that we can provide support to colleagues and keep them in work. A stepped care model which can be seen below was developed and used as the approach to colleague psychological wellbeing for Somerset NHS FT. This line worked alongside the Employee Assistance Programme already in place and delivered through our Occupational Health Service provider.

Stepped Care Model for SFT



Throughout 2020 it has been important to ensure our colleagues were kept well informed about the Trust and the changes being made in line with the national agenda. In order to achieve this the following channels were used:

Staff News - This a weekly news bulletin that is sent electronically to all colleagues within SFT to inform them of things that are taking place in the landscape of the NHS

and the impact of this on SFT and this comes through the message from the Chief Executive which is the front page of the Staff News. This bulletin also enables colleagues to send in and celebrate successes from across the Trust as well as inform colleagues about what the Trust is doing to meet our values of outstanding care and listening and leading through the getting it right sections.

Daily Briefing – This was sent throughout the peak of the pandemic and the purpose of this was to inform colleagues of the operational status of the Trust and also inform colleagues about the support available and to remind them that it was there. This message continued for 2020 and in the later part of 2020, early part of 2021 became the Winter Briefing and this was then sent out weekly

Live Virtual Team Brief – This was established part way through the year and offered a forum for colleagues to hear directly from the Executive Team about current focus as well as provide an opportunity for colleagues to ask questions and hear responses to these. The Team Briefs took place every fortnight and as they were virtual accessibility for colleagues increased.

Senior Managers continue to meet regularly with Executive Team members to discuss financial, performance, operational and other issues of importance at Senior Management Operational Team Meeting.

The Somerset Operational Partnership meeting takes place monthly which is a forum where Trade Union colleagues and Senior Managers from SFT meet.

Listening events also ran especially during the latter part of 2020 a forum enabling colleagues within teams to speak up and voice concerns and share what is working well. These were facilitated by members of the Leadership and OD Team and the People Business Partner Team working in conjunction with the senior management teams across the Trust. These were in addition to the Wellbeing drop-in sessions, Peer to Peer reviews and the Action Learning sets which all provided a forum for colleagues to have a voice.

Pulse Check Survey and Results

During 2020 the Pulse Check survey was paused and the time was used to pause, reflect and review on what Somerset NHS Foundation Trust wanted and needed from an engagement survey.

A small task and finish group was established to look at this piece of work and the membership of the group comprised of various stakeholders including; operational team members, clinical colleagues, medical colleagues and non-clinical colleagues. There was a mix of leadership within the group.

The group set about looking at the various ways we report colleague engagement data and the various meetings at which this data is presented. Some of the feedback from the previous pulse survey was that this felt like a duplication and colleagues were not always aware or sure of what feedback or action was taken as a result of them completing the survey.

The recommendation from the group was as follows:

- To continue with a Pulse survey for colleagues
- To change the delivery format and frequency of pulse from every six months to the whole Trust to 400 randomised colleagues every month. The system will enable us to do this so that every colleague will have the opportunity to complete the pulse survey.
- To review the question set and align this more to the Culture SFT wants to establish and this will then become the diagnostic tool we use to track our progress
- To involve and use improvement methodology in this process to ensure we can track progress to see if interventions used are making a difference.

HEALTH AND SAFETY

There continues to be a positive health and safety culture within the organisation and this is recognised by external regulators such as the Health and Safety Executive. The Trust's Health and Safety Committee and the Safety Environment and Advisors Group (SEAG) are effective meetings that ensure structures and processes are in place to manage health and safety successfully. Safety topic leads report to SEAG either directly or via specialist safety meetings such as the Fire Safety Committee. SEAG is chaired by the head of health, safety and risk who is responsible for ensuring that a structure is in place to manage the health and safety functions for the 24 topic leads who report into it. This includes policy consultation, development and approval, monitoring of policy implementation plans, policy monitoring and action plan updates. This work schedule aligns with the Integrated Quality Assurance Board (IQAB).

Incidents reported to the HSE under RIDDOR

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulation (RIDDOR) requires the Trust to report deaths, certain types of injury, some occupational diseases and dangerous occurrences that 'arise out of or in connection with work'. An annual RIDDOR report is prepared and shared widely for consideration / action. All RIDDORs are fully investigated and monitored. An overview of all RIDDORs is a standing agenda item on the safety committees. During 2020/21, the Trust reported 44 incidents to the Health and Safety Executive as detailed in the table below. This is similar to the combined total from the two legacy organisations in 2019/20 (41). Of the 44 incidents, three were classified in the major incident category due to the nature of injuries that were sustained (fractures).

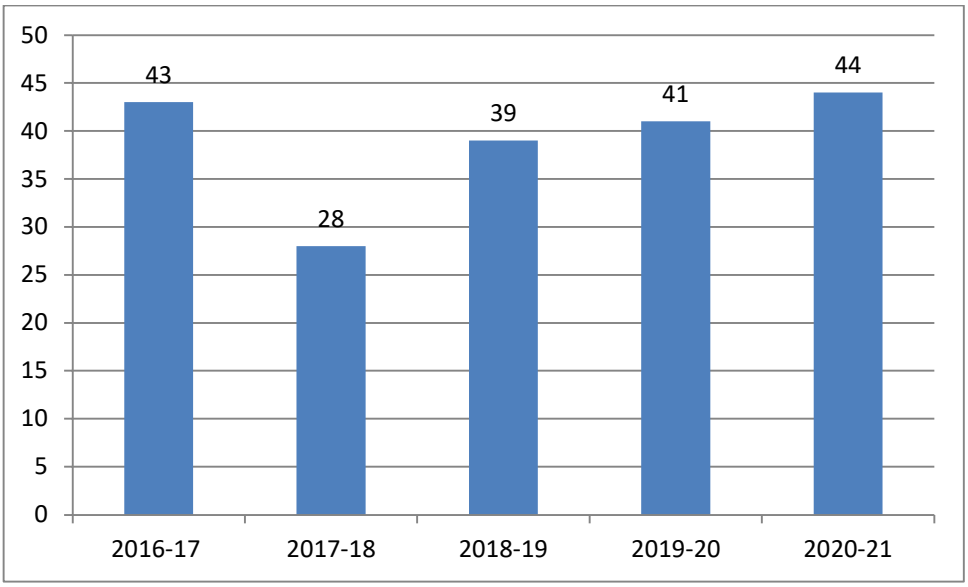
COVID-19 RIDDORs:

This period has seen additional HSE guidance in relation to the reporting under RIDDOR where an individual has either been exposed to or contracted COVID 19 as a direct result of their work. For an occupational exposure to be judged as the likely cause of the disease, it should be more likely than not that the person's work was the source of exposure to coronavirus as opposed to general societal

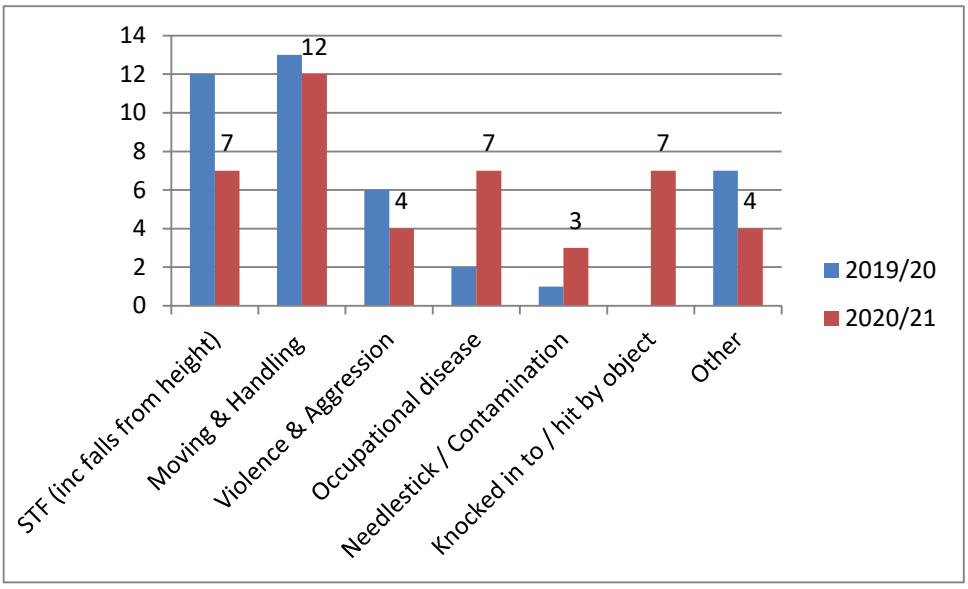
exposure. The HSE have recognised that this is likely to be in limited circumstances and have provided clarification / examples. A robust process has been in put in place with close links between Health and Safety, Infection Prevention and Control and the Track and Trace Teams. A total of five colleagues were reported in this category.

The following two tables are an extract from the annual report and give an indication of the total number of RIDDORs year on year and a breakdown by cause.
It is to be noted that any figures detailed in the following tables are a combined representation of the legacy TST and SomPar Trusts for 2016/17 to 2020/21.

Number of RIDDOR reports made to the Health and Safety Executive - 2016/17 to 2020/21



Number of RIDDOR reports by cause - 2019/20 – 2020/21



COUNTER FRAUD

Somerset NHS Foundation Trust values its reputation for top quality care and financial probity, and we conduct our business in a fair and ethical manner.

Somerset NHS Foundation Trust supports the NHS Counter Fraud Authority strategy that aims to reduce fraud, bribery and corruption within the NHS. We are committed to the prevention, detection and investigation of any such allegations and will seek to apply criminal, disciplinary, regulatory and civil sanctions where allegations are upheld. This includes the recovery of identified losses to ensure that NHS resources are used for their intended purpose - the delivery of patient care.

We expect all organisations / contractors instructed by our organisation to demonstrate a comparable commitment in order to do business with us. This enables us to reassure our patients, members and stakeholders that public funds are protected and safeguarded.

The Trust employs a Counter Fraud Manager who during 2020/21 has conducted both proactive and reactive work in line with the requirements of the NHS Counter Fraud Authorities Standards for Providers on Fraud, Bribery and Corruption.

To limit our exposure to the risks of fraud, bribery and corruption we also have a number of key policies and procedures which includes, but is not limited to anti-fraud, bribery and corruption policy/procedure, Raising Concerns policy and a Code of Conduct and Conflict of Interest policy. These policies apply to all colleagues and individuals who act on behalf of our organisation.

The success of our approach is dependent on colleagues, stakeholders, service users, visitors or anyone associated with the Trust to report suspicions of Fraud, Bribery and Corruption. We actively encourage reporting to the nominated Counter Fraud Manager or to the NHS Counter Fraud Authority.

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Somerset 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 Somerset 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 Somerset NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, 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 a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.
- 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

PETER LEWIS
Chief Executive **11 June 2021**

ACCOUNTABILITY REPORT

Directors' Report

Board of Directors

The Trust's Board of Directors reserve certain powers and decisions which may only be exercised or made by them in formal session. These powers and decisions are set out in the Scheme of Delegation (which may be obtained from the Secretary to the Trust) together with the decisions which are delegated to Executive Directors or to Board Committees.

The directors are required to prepare an annual report and accounts for each financial year. The directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

The Board should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.

The Board, and in particular Non-Executive Directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant advisor for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.

Membership of the Board as at 31 March 2021

A full list of directors who were in post on 31 March 2021 and details of changes during the year is set out below together with details of the number of meetings of the Board and Board Nomination and Remuneration Committee attended in-year.

* Indicates member of the Audit Committee
\+ Indicates member of the Board Nomination and Remuneration Committee

Non-Executive Directors

Colin Drummond OBE, DL+
Chairman
(Chair of the Nomination Committee)

Appointed: 1 April 2020
Term Expires: 31 March 2023

Board Attendance: 15/15
Board Nomination/Remuneration Committee Attendance: 2/2

Colin was appointed Chairman of Somerset NHS Foundation Trust on 1 April 2020 following the merger between Somerset Partnership NHS Foundation Trust and Taunton and Somerset NHS Foundation Trust.

He was chairman of Taunton and Somerset NHS Foundation Trust from 2014 and is also pro-chancellor and chair of governors of the University of Plymouth.

From 1992 to 2013 Colin was chief executive of Viridor, one of the UK's leading recycling, renewable energy and waste management companies, and an executive director of Pennon Group PLC. He was then chairman of Viridor until the end of 2014. Prior to joining Pennon, Colin was chief executive of Coats Viyella Yarns Division, an executive director of Renold PLC, a consultant with the Boston Consulting Group and an official with the Bank of England. Colin was chairman of the Government's 'Living with Environmental Change' Business Advisory Board from 2009 to 2015 and of the Environmental Sustainability Knowledge Transfer Network from 2007 to 2013. He was master of the Worshipful Company of Water Conservators for 2007/08 and chair of the 'WET 10' City Livery Companies from 2008 to 2013. From 1997 to 2015 he was a trustee, and is now honorary vice president, of the Calvert Trust Exmoor.

Colin holds an MA from Oxford University and an MBA from Harvard Business School where he held a Harkness Fellowship. He was appointed an OBE in the Queen's Birthday Honours 2012 for services to technology and innovation, and a Deputy Lieutenant (DL) of Somerset in 2016.

Jan Hull

Non-Executive Director
(Deputy Chairman from 1 March 2019)
Chair of the Quality and Governance Committee
Planning Meetings
Joint Chair of the People Committee

Appointed: 1 August 2017
Re-Appointed:1 August 2020
Term Expires: 31 July 2023

Board Attendance: 15/15
Board Nomination/Remuneration Committee Attendance: 2/2

Jan spent the early part of her career with Unilever, in an international perfumery business covering sales, marketing and general management roles, including two years in the USA. She has over 20 years' experience of the NHS in Somerset, initially in public health and later as deputy chief executive for NHS Somerset, until she became managing director of the South, Central and West Commissioning Support Unit.

Jan retired from this post in 2016. Jan has worked at senior level with all of the major health and social organisations in the county, including primary care, local authorities and the voluntary sector. She also has significant experience of structural change, having led the merger of three commissioning support units in 2015.

Dr Kate Fallon

Non-Executive Director
(Senior Independent Director from 1 April 2020)
Chair of the Finance Committee

Appointed: 29 May 2018
Re-Appointed: 29 May 2021
Term Expires: 28 May 2024

Board Attendance: 15/15
Board Nomination/Remuneration Committee Attendance: 1/2

Kate came to the Trust with great experience in the strategic direction and transformation of services within the NHS. She established a new NHS Trust in 2010, which trebled in size in 2011 and became the first community trust to be licensed by Monitor as a Foundation Trust in November 2014.

Previously, Kate transformed her own GP practice, taking it from a traditional reactive business to a forward-planning, innovative "beacon site", with a sustained Investors in People accolade. Kate is currently a trustee of the Board of Skills for

Health and a member of the Board of the National Skills Academy for Health. In 2015 she was included in the HSJ “Top 50 NHS Chief Executives” list, being recognised for her approach to service transformation and the integration of services across NHS boundaries.

David Allen

Non-Executive Director
Chair of the formal meetings of the Quality and Governance Committee

Appointed: 1 May 2016
Re-Appointed: 1 May 2019
Term Expires: 30 April 2022

Board Attendance: 14/15
Board Nomination/Remuneration Committee Attendance: 2/2

David undertook a number of managerial roles within the NHS and has solid experience in acute, mental health and community services, specialising in risk, governance and compliance.

Prior to his work in the NHS, David was a director and company secretary at a leading insurance company, with overall responsibility for information technology, human resources, facilities, compliance and governance.

David is a chartered engineer and holds a BSc (Hons) in Engineering and he is a member of the British Computing Society.

Barbara Clift

Non-Executive Director
Chair of the Mental Health Act Committee

Appointed: 1 November 2014
Re-Appointed: 1 November 2017
Re-Appointed: 1 November 2020
Term Expires: 1 November 2021

Board Attendance: 15/15
Board Nomination/Remuneration Committee Attendance: 2/2

Barbara brings a wealth of experience from the commercial and voluntary sectors and her own business. She worked for global technology company IBM for 22 years in several business areas at senior level and with many corporate clients from multiple industries in the UK and overseas.

She attended various executive development courses at INSEAD, Harvard, MIT and Oxford and was active in mentoring and female career development and retention. Her business development work in Africa was recognised with a Nelson Mandela New Women in Business award. In Europe she was nominated for the European Business Women of the Year Award for her work with strategic alliances.

On leaving IBM, Barbara worked as a consultant for a not-for-profit sector skills organisation working with schools to encourage girls into the IT industry. She was a volunteer for St Margaret's Hospice providing bereavement listening ear services and held trustee positions for charities supporting preventative health, adults with learning difficulties, and a listening ear service for parents who have lost a child.

Barbara is currently a trustee for the Somerset Eating Disorders Charity (SWEDA).

Barbara Gregory

Non-Executive Director
Chair of the Audit Committee

Appointed: 1 August 2017
Re-Appointed: 1 August 2020
Term Expires: 31 July 2023

Board Attendance: 13/15
Board Nomination/Remuneration Committee Attendance: 2/2

Barbara Gregory is a chartered accountant who has worked at senior management level in the NHS since 1993, including 15 years at Board level in many different parts of the health system.

She has an excellent working knowledge gained from first-hand experience of the health and social care system including working in strategic transformation programmes. Barbara has also worked closely with senior colleagues from local authorities on the integration of provision and commissioning and on the opportunities for the devolution of expenditure to providers as part of the potential development of accountable care organisations/systems.

Stephen Harrison

Non-Executive Director
Joint Chair of the People Committee

Appointed: 29 May 2018
Re-Appointed: 29 May 2021
Term Expires: at the date of a merger with Yeovil District Hospital NHS Foundation Trust or 28 May 2024 whichever date is first.

Board Attendance: 15/15
Board Nomination/Remuneration Committee Attendance: 2/2

Stephen has lived in Wookey for nearly 40 years after joining Clarks Shoes for his main career. On leaving Clarks, Stephen developed a portfolio of organisational development consultancy work and community activity, including being elected leader of Mendip District Council.

In the NHS he has undertaken non-executive director roles with Bath and West Community Trust, Mendip Primary Care Trust (PCT), North Somerset PCT and finally as chairman of a cluster of PCTs across Bristol, North Somerset and South Gloucestershire. Stephen was the chairman of YMCA Mendip and a trustee of a day care centre for older people.

Alexander Priest

Non-Executive Director
(Associate Non-Executive Director from 1 October 2019 to 31 March 2020)

Appointed: 1 April 2020
Term Expires: 31 March 2023

Board Attendance: 14/15
Board Nomination/Remuneration Committee Attendance: 2/2

Following a degree and PhD in chemistry at Oxford University (where he used A.I. to design anti-cancer drugs), Alex started his career promoting apprentice partnerships as chief executive of an educational charity in London.

In January 2016, he jumped from a successful career in intellectual property law to become chief executive of Mind (the mental health charity) in his home county of Somerset, where he now farms with his young family. Alex also holds various trusteeships and directorships in the property, education and third sectors.

Executive Directors

Peter Lewis

Chief Executive (Voting)

Appointed: 4 November 2017

Board Attendance: 13/15

Peter is the Chief Executive of Somerset NHS Foundation Trust. Peter joined Taunton and Somerset NHS Foundation Trust in 2005 as director of finance and performance. He then became deputy chief executive of the acute trust in 2008 and took on the responsibility of chief operating officer in 2010.

Following the alliance between Taunton and Somerset NHS Foundation Trust and Somerset Partnership Foundation Trust in May 2017, Peter became chief executive of both organisations in November 2017. Prior to joining Taunton and Somerset NHS Foundation Trust, Peter was director of performance at Dorset and Somerset Strategic Health Authority, and also worked in both commissioning and provider organisations prior to that.

Peter is also a fellow of the Chartered Institute of Management Accountants.

Andy Heron

Deputy Chief Executive and Chief Operating Officer (Mental Health and community Services). This title was changed to Chief Operating Officer (Mental Health, Families and Neighbourhoods) in 2020 (voting)

Joint SRO Somerset COVID-19 Vaccination Programme and Deputy Chief Executive (from 9 November 2020 to date) but Andy remained a voting member of the Board in view of hid Deputy Chief Executive role

Joint Chief Operating Officer at Yeovil District Hospital NHS Foundation Trust from 25 January 2021

Board Attendance: 14/15

Andy joined the NHS in Somerset in 2014 when he joined Somerset Partnership NHS Foundation Trust as chief operating officer. Having originally qualified as an occupational therapist, he worked in a number of clinical roles within mental health across the South West before moving into leadership roles during the 1990s.

Andy played a role in the establishment of a new specialist NHS mental health trust serving the Avon and Wiltshire areas and became the general manager of mental health services for a seven year period up to 2006. Following this Andy gained a broad range of experience in London and the South West in senior commissioning and provider roles in the NHS, and also in social care, with most of his work being focussed on service modernisation.

Prior to joining the Trust in 2014 he was working as director of projects for a successful mental health and community foundation NHS trust in East London where he held responsibility for service modernisation and business development. Andy maintains a strong interest in care pathway redesign and service transformation and in recent years has taken on a number of system leadership roles within Somerset, centred on improving patient flow and working with partners in the development successful community alternatives to hospital admission.

Matthew Bryant

Chief Operating Officer (Acute Services). This title was changed to Chief Operating Officer (Hospital Services) in 2020 (voting)

Joint Chief Operating Officer at Yeovil District Hospital NHS Foundation Trust from 25 January 2021

Appointed: 1 October 2017

Board Attendance: 12/15

Matthew joined Taunton and Somerset NHS Foundation Trust in 2014 as director of operations and was appointed as chief operating officer in 2015. He was appointed as chief operating officer (acute hospital services) on the joint executive team for Taunton & Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust in 2017 following the establishment of the alliance between the two trusts.

Matthew is responsible for the day-to-day running of the hospital and for its performance in meeting the required national standards. Matthew has worked in the NHS in the South West since 1998. Prior to coming to Taunton, he managed medical and surgical services at the Royal Devon and Exeter Hospital, and was part of the management team when that trust became one of the country's first foundation hospitals.

He led the trust's delivery of new models of care for older people, which included a strong focus on integration with services outside hospital. He helped establish the

Peninsula Medical School in Exeter, of which he became an honorary fellow, teaching undergraduate medical students about healthcare management. He was also involved in the commissioning of specialist services and the development of joint working for health authorities across Devon and Cornwall.

Matthew joined the NHS on the national general management training scheme, after graduating from Oxford University. He is a trustee of Hospiscare, the palliative care provider for Exeter, East and mid-Devon, and a visiting specialist at Plymouth University Medical School.

Pippa Moger

Director of Finance (voting)

Appointed: June 2013

Board Attendance: 14/15

Pippa has over 17 years of experience in NHS finance and over ten years at deputy and director level. She has worked across regulator, commissioning and providers sectors during this period and has a broad perspective on NHS finances.

Pippa joined Somerset Partnership NHS Foundation Trust in June 2013 as director of finance and business development. She was then appointed as director of finance for Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust in October 2017 before the two trusts merged to form Somerset NHS Foundation Trust in April 2020. Pippa believes NHS resources must be used in the most efficient and effective way while ensuring patient safety is not compromised.

Pippa is a fellow of the Association of Chartered Certified Accountants (ACCA).

Dr Daniel Meron

Chief Medical Officer (voting)

Appointed: 2 December 2019

Board Attendance: 13/15

Daniel joined us in December 2019 from his role of chief medical officer of Solent NHS Trust, which provides mental health, community and primary care services to people living in Southampton, Portsmouth and some parts of Hampshire and the Isle of Wight. He was also deputy medical director at University Hospital Southampton Foundation Trust, a large teaching hospital providing secondary and tertiary acute services in Wessex.

Daniel combined senior leadership roles with active front-line clinical work as a consultant in liaison psychiatry in Southampton General Hospital, as well as being actively engaged in research at the School of Medicine, University of Southampton.

Hayley Peters

Chief Nurse (voting)

Appointed: 2 October 2017

Board Attendance: 9/9

Hayley was seconded to the Nightingale Hospital in Bristol for the period 6 April 2020 to 10 July 2020 during which time Alison Wootton acted as Acting Chief Nurse).

Hayley became the executive director of patient care at Musgrove Park Hospital in September 2015, having joined the trust as deputy director of nursing in July 2013. Hayley went on to become the chief nurse for both Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust in November 2017 before the two trusts merged to form Somerset NHS Foundation Trust in April 2020.

Prior to becoming an executive, Hayley worked in senior clinical leadership roles in the South West, London and the South East. Hayley's early professional career

centred in critical care, first as an intensive care nurse and later, following a period of training at Birmingham Medical School, as one of the very first physician's assistants to practise in the UK. As part of Hayley's role at Somerset NHS Foundation Trust, she has executive responsibility for safeguarding, patient safety and quality (jointly with the chief medical officer) and patient experience. Hayley is board safety champion for children, maternity and neonates.

Alison Wootton

Acting Chief Nurse (voting)

Appointed: 6 April 2020 to 10 July 2020

Board attendance: 5/6

Phil Brice

Director of Governance and Corporate Development (voting)

Appointed: January 2012

Board Attendance: 15/15

Phil joined Somerset Partnership NHS Foundation Trust in 2012, having worked in the NHS since 2000. He went on to become the director of governance and corporate development for both Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust in October 2017 before the two trusts merged in April 2020 to form Somerset NHS Foundation Trust.

He worked for the Somerset Heath Authority before becoming director of corporate services for Taunton Deane Primary Care Trust and then director of corporate services and communications for NHS Somerset from 2006 – 2011.

He previously worked for the Treasury Solicitor's department, the Parliamentary and Health Service Ombudsman and AXA PPP healthcare.

Isobel Clements

Director of People and Organisational Development (non-voting)

Appointed: 1 November 2017

Board Attendance: 14/15

Isobel started her career at Musgrove Park Hospital in 1988 and held several senior human resources and organisational development management roles, including at associate and deputy level, until she was appointed director of people and organisational development in 2018 for both Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust before the two trusts merged to form Somerset NHS Foundation Trust in April 2020.

Isobel has played a key role in developing the Trust's system of distributed leadership, in ensuring that the organisation's values are brought to life in everyday behaviour. She has overseen a number of leadership development programmes that substantial numbers of our leaders have benefitted from. Isobel is a member of the Chartered Institute of Personnel and Development.

David Shannon

Director of Strategic Development and Improvement (non-voting)

Appointed: 24 October 2017

Board Attendance: 14/15

David joined Musgrove Park Hospital in 2016 as director of finance and went on to become the director of strategic development and improvement for both Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust in October 2017 before the two trusts merged to form Somerset NHS Foundation Trust in April 2020. David was previously director of operational finance at North Bristol NHS Trust from June 2014. Before that he spent six years at Nottingham University Hospitals NHS Trust, most of them as assistant director of finance. He originally joined the NHS in 1998 on its graduate financial management training scheme.

Board effectiveness

On the basis of the expertise and experience described above and the Board skills mix analysis carried out in 2019, the Trust is confident that the necessary range of knowledge and skills exists within the Board of Directors and that its balance, completeness and appropriateness to the requirements of the NHS Foundation Trust constitute a high performing and effective Board. No company directorships or other material interests in companies are held by any Board members where those companies or related parties are likely to do business, or are possibly seeking to do business, with the Trust. The Chairman has held no other significant commitments during 2020/21. A register of interests of Board members is available from the Secretary to the Trust and is also included in the Board papers published on the Trust's website. Declarations can also be accessed through the publicly available Conflict of Interest system.

The effectiveness of the Board of Directors meetings is reviewed at the end of each meeting. In addition, a review of the effectiveness of the Board has been undertaken by the Trust's internal auditors. Effectiveness of Board sub committees is monitored through the Board by quarterly reports and regular evaluation/review of the terms of reference.

Non-Executive Directors are subject to regular and annual appraisals by the Chairman; unsatisfactory appraisals could result in termination of their appointment. The decision to remove Non-Executive Directors rests with the Council of Governors. During 2020/21 an appraisal of the Chairman's performance has not been undertaken as the Chairman only took up his post on 1 April 2020. A 360 degree appraisal process will be undertaken in 2021/22 and feedback from the appraisal process will be presented to the Council of Governors. The Chairman's appraisal process is agreed with the Council of Governors on an annual basis.

The performance of Executive Directors is similarly reviewed through regular supervision and annual appraisals by the Chief Executive, whose performance is, in turn, reviewed and appraised by the Chairman, and reported to the Non-Executive Directors through the Nomination and Remuneration Committee.

The Board considers that all the Non-Executive Directors, including the Non-Executive Director who is currently in her seventh year as a Non-Executive Director, are independent in character and judgement and there are no known circumstances or relationships which are likely to affect, or could appear to affect, the directors' judgement. The Board also considers that all Board members meet the Fit and Proper persons test.

In assessing the Trust's performance, we take account of our delivery against the NHS Oversight framework and its five key themes of:

- Quality of Care
- Finance and Use of Resources
- Operational Performance
- Strategic Change

- Leadership and improvement capability

Our performance against these is set out in the Financial Overview and Review section of this report on pages 33 - 37. In 2020/21, Somerset NHS Foundation Trust was in segment 2.

Monitor (NHS Improvement) Foundation Trust Code of Governance

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

The Board can confirm that it is compliant with the Monitor Foundation Trust Code of Governance.

Managing Conflicts of Interest in the NHS

The Trust has complied with NHS England's guidance to publish the Trust's Conflicts of Interest register on its website.

Significant interests held by directors

Interests held by directors which may conflict with their management responsibilities are declared at each Board meeting. Board papers which include these disclosures are available on the Trust's website. Transactions related to those interests are shown in page 50, note 31 of the accounts.

Directors' disclosure to auditors' statement

For each individual who is a director at the time this annual report was approved, so far as the directors are aware there is no relevant audit information of which the auditors are unaware and the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Quality and Governance Committee

The Quality and Governance Committee is a Board-level committee responsible for providing assurance on issues of legal, regulatory and standards and compliance with our legal and statutory requirements, clinical and quality objectives, effectiveness of strategies and the quality standards required by NHS Improvement and the Care Quality Commission. The Chair of the Quality and Governance Committee provides a six-monthly assurance report to the Audit Committee in respect of its compliance and governance functions.

Membership of the Quality and Governance Committee comprises six Executive Directors and four Non-Executive Directors, two of whom also sit on the Audit Committee. The Quality and Governance Committee meets formally on a bi-monthly basis. In addition planning meetings take place in the intervening months. The

purpose of the planning meetings is to consider the standard business items and identify areas for detailed deep dives for discussion at the formal Quality and Governance Committee meetings.

Attendance at the formal Quality and Governance Committee meetings

Name	Formal Quality and Performance Committee meetings attended	
	Possible	Actual
David Allen (Chairman)	5	5
Stephen Harrison	5	4
Kate Fallon	5	5
Barbara Clift	5	4
Jan Hull	5	5
Phil Brice	5	5
Alison Wootton	1	1
Hayley Peters	4	4
Isobel Clements	5	4
Daniel Meron	4	4
Andy Heron	3	2
Matthew Bryant	5	4
Alexander Priest	5	4

Finance Committee

The Committee is a Board Committee and acts in an advisory capacity. The Finance Committee met 13 times during the year to focus on investigating the progress made in the delivery of financial plans and carry out an in-depth analysis of the financial performance of the Trust. The Chief Executive and other executive directors have a standing invitation to attend this committee.

Attendance at Finance Committee

Name	Finance Committee meetings attended	
	Possible	Actual
Kate Fallon (Chairman)	13	13
Barbara Clift	13	13
Barbara Gregory	13	12
Pippa Moger	13	12
David Shannon	13	10
Alexander Priest	13	11
Matthew Bryant	13	8
Stephen Harrison	10	8
Andy Heron	4	1

Finance and performance issues are regularly addressed by the Trust Board and the Finance Committee, comprising Non-Executive Directors, and also at the monthly Senior Management Team, which is chaired by the Chief Executive.

Audit Committee

Membership of the Audit Committee consists of four Non-Executive Directors. The Chairman of the Trust is not a member of the Audit Committee.

The role of the Audit Committee is:

- to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities;
- to review arrangements by which staff may raise in confidence, concerns about possible improprieties of financial reporting and control, clinical quality, patient safety or other matters;
- to review the annual accounts and make recommendations on the approval of the annual accounts to the Board;
- to ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance;
- to develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm;
- to make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor;
- to review the work and findings of the external auditor and consider the implications and management's responses to their work;
- to review the work and findings of the Counter Fraud Service and consider the implications and management's responses to their work; and
- to review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the integrated governance of the organisation.

Internal audit services are provided by independent auditors and the key role of this service is to develop an internal audit strategy and deliver an annual audit plan, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework.

Attendance at Audit Committee meetings

Name	Audit Committee meetings attended	
	Possible	Actual
Barbara Gregory (Chairman)	5	5
Stephen Harrison	5	5
Barbara Clift	5	5
David Allen	5	5

Directors' Responsibility for Trust Annual Report and Accounts

The directors have responsibility for preparing the annual report and accounts. They consider that 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 Somerset NHS Foundation Trust's performance, business model and strategy.

Significant Issues considered by the Audit Committee

After discussion with both management and the external auditor, the committee determined that the key risks of misstatement of the financial statements related to:

- Valuation of Land and Building Assets;
- Fraud risk from expenditure and revenue recognition;
- Management override of controls;
- Merger of systems and financial information

Modern Slavery and Human Trafficking Act 2015 Policy Statement

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps taken to ensure slavery and human trafficking is not taking place in any of its supply chains and in any part of its business.
This statement sets out actions taken by Somerset NHS Foundation Trust to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

We are committed to ensuring there is no modern slavery or human trafficking in any part of our business and, in addition require that our suppliers hold similar ethos.

We have robust multi agency safeguarding vulnerable adults and safeguarding children policies in place and all staff receive mandatory safeguarding training which includes guidance on how to identify and report any concerns relating to modern slavery and human trafficking.

We follow employment checks and standards which include the right to work and depend on receiving suitable references.

We are committed to social and environmental responsibility and have zero tolerance of modern slavery and human trafficking. Any identified concerns regarding modern slavery and human trafficking would be escalated as part of the organisational safeguarding processes in conjunction with partner agencies.

We will:

- comply with legislation and regulatory requirements;
- ensure suppliers and service providers are aware we promote the requirements of the legislation;
- develop awareness of modern slavery issues;
- include modern slavery conditions or criteria in specifications and tender documents within the supplementary terms and conditions;
- encourage suppliers and contractors to take their own action and understand their obligations about these new requirements;
- expect supply chain/framework providers to demonstrate compliance with their obligations in their processes.

Trust staff must contact and work with the procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

Procurement staff will:

- check draft specifications include a commitment from suppliers to support the requirements of the Act;
- not award contracts where suppliers do not demonstrate their commitment to ensuring slavery and human trafficking are not taking place in their own business or supply chains;

- communicate clear expectations to our suppliers through a supplier code of conduct;
- work with the procurement department to monitor compliance by suppliers with the requirements of the Act.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2020.

To the best of my knowledge, the information in this document is accurate.

Signed

PETER LEWIS **11 June 2021**
Chief Executive

COUNCIL OF GOVERNORS

The Council of Governors is made up of 33 elected governors, ten of whom are staff Governors. In addition to the Nominations and Remuneration Committee, the Council has the following working groups: People Group; Quality and Patient Experience Group; and Strategy and Planning Group.

The Council meets every quarter in public. Meetings are advertised on the Trust's website and at our headquarters. No business can be transacted at a meeting unless at least half of the governors are present, and of these, not less than half must be governors elected by the public or appointed by non-health service bodies. In view of the COVID-19 pandemic, meetings during 2020/21 have taken place virtually but the link to the meetings have been made publicly available.

The responsibilities of the Council of Governors are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;
- to represent the interests of the members of the Trust as a whole and the interests of the public;
- to assist the Board of Directors in setting the strategic direction of the Trust and targets for the Trust's performance;
- to monitor the Trust's performance in achieving strategic objectives and performance targets that have been set;
- to act as guardians to ensure that the Trust operates in a way that is consistent with NHS and Trust principles (as set out Annex 9 of the Constitution) and the terms of the Trust's Authorisation;
- to appoint the Trust's external auditors;
- to exercise such other powers and to discharge such other duties as may be conferred on the Council of Governors under the Constitution;
- to appoint the Chairman and other Non-Executive Directors of the Trust;
- with the approval of at least three quarters of the Governors, to remove the Chairman and other Non-Executive Directors of the Trust;
- to approve the appointment of the Chief Executive by the Non-Executive Directors of the Trust, at a general meeting;
- to approve significant transactions.

The Council of Governors is provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.

Led by the chairperson, the Council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.

All governors are required to disclose details of company directorships or other material interests in companies where those companies or related parties are likely to do business, or are possibly seeking to do business, with the Trust. No such company directorships or other material interests in companies are held by any governors. A register of the interests of governors is published and updated at each public meeting of the Council of Governors and is available on our website at www.somersetft.nhs.uk or can be obtained from the Secretary to the Trust.

Disagreements between Council of Governors and Trust Board

Where any disagreements between the Council of Governors and the Trust Board occur, the Trust policy "Policy and Procedure for Council of Governors: Raising Concerns" details the process by which these disagreements are resolved. This policy was last reviewed and approved in 2020. A copy of the policy can be found on the website.

Nominations and Remuneration Committee (Council of Governors)

The Council of Governors is required to approve the remuneration and terms of service of the Chairman and Non-Executive Directors and has established a Nominations and Remuneration Committee to do so, in accordance with the Trust's Constitution.

The role of the Committee is:

- to consider the Non-Executive Director or Chairman vacancies due in the next 12 months and make recommendations to the Council of Governors (Annex 9, para 3.1.1 of the Constitution); and
- to advise the Council of Governors as to the remuneration and allowances and of the Terms and Conditions of the office of the Chairman and other Non-Executive Directors (para 32.1 of the Constitution).

The Senior Independent Director, the Chairman and other Directors may be invited to attend meetings of this Committee.

The Committee met once during the year on 3 December 2020 to discuss:

- Non-Executive Director Succession Planning
- Re-appointment of two Non-Executive Directors
- Recruitment process for a new Non-Executive Director

Committee's attendance is set out below:

Nomination and Remuneration Committee – Attendance at meetings		
	Possible	**Actual**
Ian Hawkins (Chairman)	1	1
Philippa Hawks	1	1
Richard Brown	1	1
Jeanette Keech	1	1
Kate Butler	1	1

The success planning report set out the end dates of the Non-Executive Directors' Terms of Office as well as the proposed succession plan. As part of the succession plan, it was suggested to re-appoint Kate Fallon and Stephen Harrison and to appoint a new Non-Executive Director to replace one of the Non-Executive Directors who had handed in his resignation from July 2020.

The Committee carried out an internal process for the re-appointment of Kate Fallon and Stephen Harrison, whose first terms will come to an end on 29 May 2021 and agreed to recommend the re-appointment of these Non-Executive Directors (but on different terms) to the Council of Governors. The Council of Governors approved the recommendation from the Nominations and Remuneration Committee at its meeting held on 10 December 2020.

The Committee further discussed the recruitment process for a new Non-Executive Director and the process was approved at the Council of Governors meeting held on 10 December 2020. The process included the use of headhunters to be able to reach a wider diversity of candidates. The recruitment process was managed by headhunters but overseen by the Secretary to the Trust to ensure that the process was in line with the Trust's Constitution. The recommendation from the Appointment Panel was approved by Governors and the successful candidate will be taking up his role as an Associate Non-Executive Director from 1 May 2021 and as Non-Executive Director from 7 July 2021.

Council of Governors elections

During 2020/21 elections were held in the following constituencies: Taunton Deane, Mendip, Sedgemoor, South Somerset, West Somerset and staff. In view of a change in the name of the organisation following the merger from 1 April 2020 the election process could not commence prior to the merger. Staff elections took place during April and May 2020. In view of the COVID-19 pandemic, the public governor elections were delayed until May and June 2020.

All seats were contested and all public and staff governor seats were filled.

Governor	Constituency	Governor in place on 1 April 2020	Term of Office		Meetings	
			From	To	Possible	Actual
Erica Adams	Public – Somerset West and Taunton	New seat	1 April 2020	31 March 2023	4	4
Ian Aldridge	Public – Somerset West and Taunton	Ian Aldridge	1 May 2019	30 April 2022	4	1*
Margaret Worth	Public – Somerset West and Taunton	Margaret Worth	1 May 2019	30 April 2022	4	4
Kate Butler	Public – Somerset West and Taunton	Kate Butler	1 May 2019	30 April 2022	4	4

Governor	Constituency	Governor in place on 1 April 2020	Term of Office		Meetings	
			From	To	Possible	Actual
Helen (Judy) Cottrell	Public – Somerset West and Taunton	Helen (Judy) Cottrell	1 May 2019	30 April 2022	4	4
Sumitar Young	Public – Somerset West and Taunton	Sumitar Young	1 May 2020	30 April 2023	4	4
Jane Armstrong	Public – Somerset West and Taunton	Elaine Hodgson	1 May 2020	30 April 2023	4	4
Melanie Devine	Public – Somerset West and Taunton	Philippa Hawks	1 May 2020	30 April 2023	4	4
Jeanette Keech	Public – Somerset West and Taunton	Jeanette Keech	1 May 2019	30 April 2022	4	3
Timothy Slattery	Public – Somerset West and Taunton	New seat	1 April 2020	31 March 2023	4	4
Stephen Fowler	Public – Mendip	Cathy Hackett	1 May 2020	30 April 2023	4	1
Richard Brown	Public – Mendip	Richard Brown	1 May 2020	30 April 2023	4	4
Bob Champion	Public – Mendip	Bob Champion	1 May 2019	30 April 2022	4	4
Philip Jackson	Public – Mendip	**Vacancy**	1 May 2020	30 April 2023	4	4
Mike Hodgson	Public – Sedgemoor	Malcolm Turner	1 May 2020	30 April 2023	4	3*
Judith Goodchild	Public – Sedgemoor	Judith Goodchild	1 May 2019	30 April 2022	4	4
Eddie Nicholas	Public – Sedgemoor	Dave Gudge	1 May 2020	30 April 2023	4	4
Peter Reed	Public – Sedgemoor	New seat	1 April 2020	11 February 2021	3	3
Martin Davidson	Public – Sedgemoor		11 February 2021	31 March 2023	1	1
Gillian Waldron	Public – South Somerset	Gilliam Waldron	1 May 2019	30 April 2022	4	4
Paddy Ashe	Public – South Somerset	Paddy Ashe	1 May 2020	30 April 2023	4	4
Ian Hawkins	Public – South Somerset	Judi Morrison	1 May 2020	30 April 2023	4	4
Sue Steele	Public – South Somerset	Nick Beecham	1 May 2020	30 April 2023	4	4
Alan Peak	Public –Outside Somerset	Alan Peak	1 May 2019	30 April 2022	4	4
Julie Vale	Staff	Vacancy	1 April 2020	31 March 2023	4	4
Manuel Blanco-Guzman	Staff	Hannah Coleman	1 April 2020	31 March 2023	4	3
Paul Aldwinckle	Staff	Paul Aldwinckle	1 May 2019	30 April 2022	4	3

Governor	Constituency	Governor in place on 1 April 2020	Term of Office		Meetings	
			From	To	Possible	Actual
Polly Maguire	Staff	Polly Maguire	1 May 2019	30 April 2022	4	4
Phil Hodgson	Staff	Nicola Shergold	1 April 2020	31 March 2023	4	3
Owen Howell	Staff	Owen Howell	1 May 2020	30 April 2023	4	2
Julie Jones	Staff	New seat	1 April 2020	31 March 2023	4	2
Lynn Pearson	Staff	New seat	1 April 2020	31 March 2023	4	3
Phil Shelley	Staff	New seat	1 April 2020	31 March 2023	4	4
Neil Thomas	Staff	New seat	1 April 2020	31 March 2023	4	4
Cllr Heather Shearer	District Councils	Cllr Heather Shearer	All appointed organisations were appointed on 1 May 2008 for an unlimited period.		4	4
Vacancy	District Councils	Vacancy			-	-
Cllr Terry Napper (to 8 Sept 2020)	Somerset County Council	Cllr Terry Napper			1	1
Rod Williams (from 8 Sept 2020)	Somerset County Council	Cllr Terry Napper			3	3
Dr Jayne Chidgey-Clark	Somerset Clinical Commissioning Group	Dr Jayne Chidgey Clark			4	3
Robert Cornes	Taunton Samaritans (permanently appointed from 23 May 2017)	Ian Hawkins	1 May 2020	30 April 2023	4	4
Caroline Toll	Care UK (permanently appointed from 23 May 2017)	Caroline Toll	-	-	4	4
Jos Latour	Universities	New seat	18 May 2020	17 May 2023	4	4
Vacancy	Somerset GP Board	New seat	-	-	-	-

The process for removal from the Council of any Governor who consistently and unjustifiably fails to attend the meetings of the Council or has an actual or potential conflict of interest which prevents the proper exercise of their duties, is clearly set out in the Constitution which has been approved by the Council of Governors. Any incidence of consistent non-attendance by a governor is discussed at a Council of Governors meeting and individual circumstances are taken into account in deciding whether or not to remove a governor on the ground of consistent non-attendance.

Steps taken by Members of the Board in Understanding the Views of the Council of Governors and Membership

All Board members are encouraged to attend Council of Governors' meetings and routinely do so, with the Chief Executive leading on standing agenda items and other Directors presenting agenda items and responding to questions as required.

As the majority of Board members attend the Council of Governors' meetings, feedback from the meetings can be taken into account immediately. In addition, representatives from the Council of Governors also attend the public Board meetings and governors are invited to attend the joint Board/Council of Governors away day held in December each year to discuss strategic priorities. Membership of the Board Committees include a dedicated Governor.

The Chairman meets with the lead and deputy lead governor on a regular basis to discuss issues arising from Board meetings and governors' concerns. The Chairman and/or Chief Executive also meet with the Staff Governors on a regular basis. Governors also meet with Non-Executive Directors on a quarterly basis.

During the year five Governor Development sessions have been held. These development sessions covered: the Governors' Charter and what effectiveness looks like; integration of services; winter planning; healthcare chaplaincy; diversity and inclusion; counter fraud; Triangle of Care; neighbourhood networks; and update on the merger with Yeovil District Hospital NHS Foundation Trust.

Details are given below of the attendance at meetings of the Council of Governors by Trust Board members. Board members are not members of the Council but have a standing invitation to attend Council meetings.

Board Member Attendance at Council of Governors Meetings

		Meetings	
		Possible	**Actual**
Colin Drummond	Chairman	4	4
Barbara Clift	Non-Executive Director	4	4
David Allen	Non-Executive Director	4	4
Jan Hull	Non-Executive Director	4	3
Barbara Gregory	Non-Executive Director	4	4
Kate Fallon	Non-Executive Director	4	3
Stephen Harrison	Non-Executive Director	4	4
Alexander Priest	Non-Executive Director	4	3

		Meetings	
		Possible	Actual
Peter Lewis	Chief Executive	4	4
Daniel Meron	Chief Medical Officer	4	2
Pippa Moger	Director of Finance	4	3
Phil Brice	Director of Governance and Corporate Development	4	4
Hayley Peters	Chief Nurse	4	3
Andy Heron	Chief Operating Officer (Mental Health, Families and Neighbourhoods)/Joint SRO Somerset COVID-19 Vaccination Programme	4	2
Isobel Clements	Director of People and Organisational Development	4	4
David Shannon	Director of Strategic Development and Improvement	4	2
Matthew Bryant	Chief Operating Officer (Hospital Services)	4	4

Governor Involvement in Business Planning

Since becoming a foundation trust, we have encouraged governors and members to participate in the Trust's annual business planning process and the Governors were invited to and attended a joint Board/Council of Governors Away Day on 1 December 2021 to discuss the key priorities for 2021/22.

Governors have also been involved in setting the Quality Account priorities for 2021/22 in support of the NHS Improvement Annual Plan process and governors were invited to and attended a joint Board/governors away day held on 3 December 2020 to discuss the key priorities for 2021/22.

Progress made in implementing the annual plan action plan is monitored by the Strategy and Planning Group, which receives quarterly progress reports for discussion. The Group provides regular feedback on progress made in implementing the actions to the Council of Governors meeting.

Engagement with members

We recognise the importance of having a strong and engaged membership. With circa 18,900 members (public and staff combined), the Trust has access to the local population, interaction with which helps to improve services.

The membership strategy was reviewed in 2019/20 and came into effect from 1 April 2020. The focus of the Trust's membership strategy is on improving meaningful engagement with its members and a key form of engagement is through the annual members' meeting held in September each year. The membership and membership engagement is monitored by the People Group.

Engagement with members during 2020/21 has, in view of the COVID-19 pandemic, been through virtual means but regular Members' Briefings have been produced and emailed to Members for whom an email address is on their record.

The Trust's membership (which is reviewed by the People Group), is broadly representative of the population it serves. According to 2011 census data, the majority of Somerset residents are 'white British'. Somerset also has an increasingly older population, and the Trust's membership largely reflects this trend but there is an under representation of members in the 12-21 age group. There is also a slight under representation of male members.

An active membership drive was undertaken during 2019/20 prior to the merger to encourage as many members as possible to transfer to the merged organisation, where appropriate. Membership applications can be completed online, but the membership form is being revised and hard copies will be placed in strategic places to further improve membership.

Membership as at 31 March 2021

Public membership

Constituency	Number of Members 31.03.2020	Number of Members 31.03.2019	increase/ decrease over year
Public	7,692	6,576	+ 1,116

Staff membership

Constituency	Number of Members 31.03.20	Number of Members 31.03.2019	increase/ decrease over year
Staff	11,326	4,449	+ 6,877

How to Become a Member of the Trust

Anyone aged 12 years or over, living anywhere in England or Wales, can join us as a Member. You can sign up online https://secure.membra.co.uk/SomersetApplicationForm or write, phone or email the Membership Office to have a Freepost form sent to you. There is no charge to become a member.

We welcome suggestions from members for topics which they would find of interest, or other types of event they would like us to arrange.

There are also web pages for members on the Trust's website, and governors are happy to accept invitations to talk to community groups with an interest in local health services.

Details of meetings and events can be found on the Trust's website.

Membership Office Tel: **01278 432167**

Email: foundationtrust@somersetft.nhs.uk

Somerset NHS Foundation Trust
2nd Floor Mallard Court, Express Park, Bristol Road
Bridgwater, Somerset TA6 4RN

Tel: 01278 432000 Fax: 01278 432099

Email: foundationtrust@somersetft.nhs.uk **Website:** www.somersetft.nhs.uk

Trust Board Contact Details

All Board members can be contacted at the following address:

Somerset NHS Foundation House
Trust Management, Lydeard House
Musgrove Park Hospital
Taunton, TA1 5DA

Or via the following telephone numbers:

Chairman, Chief Executive and Non-Executive Directors	01823 - 342511
Chief Operating Officer (Mental Health and Community Services)	01278 - 432163
Chief Operating Officer (Acute Hospital Services)	01823 - 343411
Chief Nurse	01823 - 342498
Director of Finance	01823 - 342512
Chief Medical Officer	01823 - 342442
Director of Governance and Corporate Development	01278 - 432084
Director of People and Organisational Development	01823 - 342261
Director of Strategic Development and Improvement	01823 - 342527
Secretary to the Trust	01278 - 432073

A register of interests of the Trust Board and Council of Governors is available upon request from the Secretary to the Trust, who can also provide a copy of the Scheme of Delegation. The Registers of Interests are also available on the internet www.somersetft.nhs.uk as part of the Board and Council of Governors' meeting papers.

Council of Governors Contact Details

Governors can be contacted via the Governor and Membership Support Officer:

Tel: **01823 - 342511**
email: governors@somersetft.nhs.uk

or write care of the Musgrove Park Hospital address above.

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 Somerset 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 Somerset 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 Trust has identified an executive director with responsibility for progressing risk management in the organisation. The Director of Governance and Corporate Development has clearly defined risk management responsibilities and is supported by the Associate Director of Integrated Governance. The Chief Operating Officers have overall accountability for the day to day delivery of risk management activity within the clinical directorates. Responsibilities for risk management are clearly defined within job descriptions for all of these roles.

The Trust's governance support team is responsible for providing appropriate training, support and guidance to enable all managers to carry out their risk management responsibilities. Specific training courses on risk management for managers, risk assessment, incident management and investigation are supported by a corporate induction and mandatory update programme covering all regulatory requirements.

The Director of Governance and Corporate Development and Chief Operating Officers are key members of the Trust's Senior Operational Management Team (SOMT), where the risk register is reviewed monthly to ensure operational risks are being adequately controlled.

The Director of Governance and Corporate Development chairs the Trust's key operational management group for governance, the Integrated Quality Assurance

Board (IQAB). The Associate Director of Integrated Governance is also a key member of this committee. The IQAB meets monthly to monitor progress with corporate and operational plans and receive assurance reports and improvement plans from nominated leads on all regulatory requirements in accordance with its reporting schedule.

Bi-monthly Quality, Outcomes, Performance and Finance meetings are held with each of the directorates where risks above 12 are reviewed and monitored. The risk section of the meeting is chaired by the Associate Director of Integrated Governance.

The Trust's Serious Incident Review Group meets regularly to share issues raised following incidents, complaints, concerns and claims, along with information from other key sources, such as morbidity and mortality reviews. This enables sharing of good practice and lessons learned via directorate governance structures and allows for direct input into the Trust's improvement programme.

The Audit Committee has responsibility for monitoring the effectiveness of the Trust's risk management systems and for reviewing and challenging the organisation's risk appetite and maturity.

The risk and control framework

The idea of 'integrated governance' in the NHS combines the principles of corporate and financial accountability with clinical and management accountability and it moves towards a single risk management process which covers all the Trust's objectives, supported by a co-ordinated approach to collecting and analysing information about performance and risk.

The Trust has effective processes in place for the identification, reporting and management of clinical and non-clinical risks, supported by a Head of Health & Safety and Risk and a dedicated Risk Manager within the governance team. The risk management process is based on the Australian / New Zealand risk management standard (further developed by the National Patient Safety Agency in 2008) and applies to both clinical and non-clinical risks.

Risks are assessed and evaluated using a single form and rating system for all types of risk, allowing direct comparison. From this score, risks are categorised into one of three accountability levels, and responsibility for the control and monitoring of the risk is allocated to the appropriate department, Directorate or the Trust executive team, depending on the level identified. Responsibility for completing actions is allocated to an individual manager, with monitoring carried out by the relevant Directorate or Trust committee.

The corporate risk registers, which include all of the highest risks, are reviewed on a monthly basis at the SOMT and quarterly by the Board, with the overall process for management of risk being overseen by the Audit Committee.

The Board of Directors delegates key duties and functions to its sub-committees. There are five key committees within the structure that provide assurance to the Board of Directors. These are:

- Audit Committee
- Quality and Governance Committee
- Finance Committee
- Mental Health Act Committee
- People Committee

Through the majority of the financial year, in line with the national guidance *Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic*, the Board agreed to adopt a simple, supportive and streamlined approach to governance and assurance during the period of the COVID-19 emergency, focusing its attention on the impacts and response to the pandemic together with urgent business determined by national or regional directives. However, all Board sub–committees continued to function during the period and the Board has continued to meet virtually.

Alongside these arrangements and in line with the Trust's Major Incident Plan, the Trust stood up its Strategic, Tactical and Operational command and control structures to direct and oversee the Trust's response to the pandemic. The effectiveness of the arrangements is overseen by the Quality and Governance Committee and reported regularly to the Trust Board.

There are a range of mechanisms available to these committees to gain assurance that our systems are robust and effective. These include using internal and external audit, peer review, external inspection and review, management reporting and clinical audit.

The Board of Directors receives regular reports from its sub committees on business covered, risks identified and actions taken, based on the principle of exception reporting.

The **Audit Committee** provides objective assurance to the Board and management as to the adequacy and effectiveness of the organisation's risk management. The Committee is required to discharge a number of statutory duties and assists the Board with its responsibilities to strengthen and improve the risk management and controls framework. The Audit Committee considers the findings and recommendations of internal and external audit reports, counter fraud reports and monitors the Trust's Assurance Framework.

Membership of the Audit Committee comprises four Non-Executive Directors.

The Board's sub-committee for quality and patient safety is the **Quality and Governance Committee** (Q&GC).

The Q&GC receives reports covering three areas:

- risk, performance and quality assurance (including in its planning meetings the Corporate Risk Register and Assurance Framework and quality and performance dashboards);
- external reports and reviews (including CQC, PHSO and relevant national and regional reports);
- reports on topics covering all aspects of quality performance together with data security and protection, health safety, security and estates and patient and carer experience. In addition, each of the operational divisions within the Trust has their own devolved governance responsibilities and governance groups which report regularly to the IQAB.

The Q&GC also receives exception reporting in relation to quality performance, based on identified key performance indicators. The Q&GC triangulates performance information with clinical governance (patient safety, clinical effectiveness and patient experience) and workforce data to provide oversight of the quality of Trust services.

Membership of the Q&GC comprises four Non-Executive Directors, two of who are also members of the Audit Committee, together with the Chief Nurse, Chief Medical Officer, both Chief Operating Officers, the Director of People and Organisational Development and the Director of Governance and Corporate Development.

The Committee holds a bi-monthly planning meeting at which it regularly receives:

- Care Quality Commission Insight reports
- Quality and Performance exception reports and divisional dashboards
- Safer staffing dashboards
- Serious Incident Review Group tracker report and other key information (including details of inquests and incidents reported under the RIDDOR regulations)
- Mortality surveillance and learning from deaths reports
- Exception reports from the IQAB for any high risk themes or topics which are assessed as amber or below for compliance over the year
- Information on any data outliers

At its alternate bi-monthly meetings the Q&GC also receives in-depth reports on areas of risk identified from these reports, setting out areas of risk identified, actions being taken to address and mitigate the risks and determines areas for which further assurance is required.

Issues and risks may be referred to the Audit Committee to request additional external assurance. The Q&GC monitors all reports on Care Quality Commission (CQC) inspections of the Trust services and any action plans arising from them; and will consider relevant reports of investigations undertaken by the Parliamentary and Health Service Ombudsman, the Information Commissioner, HM Coroner and the Health and Safety Executive and all action plans arising from them.

The Q&GC will also refer to and receive matters for consideration from the other Board sub-committees, including the People Committee, the Mental Health Act Committee and the Finance Committee.

The **Finance Committee** comprises four Non-Executive Directors, the Director of Finance, the Deputy Director of Finance, the Director of Strategic Development and Improvement and Chief Operating Officers. The Committee focuses on the delivery by the Trust of its key financial targets, its management of capital and investment, including the IM&T and Estates strategies.

The **Mental Health Act Committee** focuses on compliance and monitoring of the Trust's approach to Mental Health legislation, including the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. The Committee comprises three Non-Executive Directors, the Medical Director (mental health), the Chief Operating Officer (Mental Health, Neighbourhoods and Families), the Director of Governance and Corporate Development, the Deputy Service Director for Mental Health and Learning Disabilities and the Mental Health Legislation Co-ordinator. Representatives from Somerset County Council and from the Care Quality Commission also attend the meetings.

The **People Committee** oversees the development and delivery of the People Strategy. The Committee monitors development and performance against the core objectives of the policy relating to colleague engagement; leadership; learning and development and workforce planning. The Committee comprises three non-executive directors; the Director of People and Organisational Development and other executive directors. Freedom to Speak Up Guardians; staff governors and staff side representatives also attend the meeting.

Representatives from the Council of Governors and their working committees attend all board sub-committees and report on their activities to the public meetings of the Council of Governors.

The Trust's Risk Management Policy sets out responsibilities for all colleagues in relation to risk identification, risk assessment, risk management and risk handling. The main methods for the identification of risk are:

- Review of compliance with key standards, for example the CQC registration requirements, and health and safety legislation.
- Executive review of annual and strategic objectives to identify potential risks to meeting those objectives.
- Local risk assessment at departmental level, feeding up to divisional risk registers.
- Facilitated risk identification sessions at various levels in the organisation.
- Information from reviews of incidents, complaints, claims, mortality, etc.
- Information from external sources such as CQC inspections, audits and patient and staff surveys.

All risks are assessed and evaluated using a standard form and scoring system, allowing direct comparison. From this evaluation, risks are categorised into one of three accountability levels, and responsibility for the control and monitoring of the risk is allocated to the department, the directorate or the Trust's executive team, depending on the level identified. Responsibility for completing actions is allocated to an individual manager, with monitoring carried out by the relevant directorate committee or Trust executive director. The three accountability levels are set based on the Trust's risk appetite, which is regularly reviewed by the Board.

Risk identification is linked to the setting of organisational objectives, as detailed in the Trust's board assurance framework. Capital planning includes an assessment of risk issues, and spending is prioritised on a risk basis. All papers considered by the Board are referenced to the risks they are aimed at addressing. The board assurance framework links to the significant risks that may affect the Trust achieving its objectives, how they are currently controlled and what sources of assurance the Board has that the risks are being managed appropriately. It also details action that is necessary to reduce the risks or improve sources of assurance, with prioritisation based on the standard Trust risk evaluation process. Information and data security risks are identified and managed through the Trust's risk assessment and incident reporting processes. The Trust has established and Data Security and Protection Group to monitor this process and provide assurance on the systems in place for managing information risks.

Assurance on compliance with CQC registration requirements, along with other key regulatory requirements, is provided to the Q&GC via the work of the IQAB. The IQAB reviews the assurances in place for all requirements in line with an annual plan, providing regular updates to the Q&GC.

Somerset NHS Foundation Trust is fully compliant with the registration requirements of the CQC. Somerset FT was formed in April 2020 by the merger of Somerset Partnership and Taunton & Somerset NHS FTs. The new integrated trust has not been subject to a full CQC inspection. Somerset Partnership was last subject to inspection in October 2018 (report published January 2019). Taunton & Somerset was last subject to inspection in January 2020 (report published in March 2020). Both inspections were subject to well-led reviews at a time when the trusts were working with a single executive team and aligned Board and Sub Committee structures. Both trusts were rated Good for the Well Led domain.

The Trust has had an Assurance Framework in place throughout 2020/21. The Assurance Framework is designed to provide the Trust with a method for the effective and focused management of the principal risks which may impact on the achievement of objectives.

The Assurance Framework is linked to the Trust's strategic aims and objectives.

The process for the Assurance Framework includes sub-Committee oversight, with specific sections requiring completion by the Committees. The Assurance Framework is reviewed at each Audit Committee and quarterly by the Board. The Trust's Assurance Framework is designed to provide the Trust with a method for the

effective and focused management of the principal risks which may impact on the achievement of objectives.

The highest risks to the Trust are available for detailed scrutiny to both internal and external auditors. Action plans for the management of risks have been developed and monitored through identified governance groups and overseen by the Audit Committee and the Board.
The Q&GC reviews quarterly the levels of risk identified and the controls in place to manage them.

A summary of significant risks (managed in year) is provided below:

- **COVID-19** - Throughout the reporting period, the impact of the coronavirus pandemic meant that the Trust, working with all partner agencies locally, regionally and nationally has had to make unprecedented changes in a very short period of time. Our acute, community, mental health and corporate services have responded to the coronavirus pandemic by refocusing services, standing some up and stepping others down, to ensure that we can care for the people who need our support.

- **Performance Targets** - The delivery of a number of performance targets has remained a significant challenge throughout the year, including RTT, cancer waits, A&E waiting times, diagnostic tests and dental general anaesthetics for children in Dorset. This has been significantly impacted by the reduction in elective activity and requirement for major changes to pathways due to the Covid pandemic. Each of these performance areas have been subject to detailed review and planning at a system level to address the issues of capacity and demand.

- **Finance** - Although the Trust achieved its control total this year, in line with arrangements put in place for the Covid pandemic, the system-wide risks in relation to the financial position have also been significant again during the year and the Trust has worked with the CCG, Somerset County Council and partner organisations to manage these risks during the year.

- **Sustainability and Transformation Partnership (STP)/Integrated Care System (ICS)** – the continued difficult progress of the development and implementation of the Somerset STP – and the Somerset Clinical Commissioning Group's Fit for My Future (FFMF) programme - has again presented a number of risks for the Trust in terms of its impact on existing strategic plans, capacity within the Trust to support the STP while maintaining focus on our core services, and the financial sustainability of the Trust within the wider Somerset health and social care system. In December 2020 Somerset STP was designated as an Integrated Care System (ICS). Senior members of the Trust, including the Chief Executive, continue to occupy central roles in the ICS Programme. An engagement programme was undertaken by the STP in 2019/20 relating to the future of community services and community hospitals but this was paused during 2020/21 due to the impact of COVID-19. The delay in development of plans has continued to have an impact on the Trust delivering some of its plans, although significant work was undertaken to

ensure that Trust aims and objectives align with those of the wider ICS and FFMF programme.

- **Staffing Pressures** - The Trust has continued to identify risks in a number of services around staffing pressures arising from vacancies, sickness absence and increasing levels of demand, all exacerbated by the Covid pandemic. This has led to the temporary closure or reduction of some services. In particular, the temporary closure of inpatient wards in some community hospitals. An extensive recruitment campaign was maintained during the year, including continued overseas recruitment, but was not sufficiently successful and significant pressures remain.

- **Aging Estate** - The condition of some of the estate and the extent of the backlog maintenance continues to be a challenge for the delivery of services at Musgrove Park Hospital. Priorities for investment are constantly kept under review, based on risk assessment, to ensure that risks are minimised.

NHS Resolution handles negligence claims made against the Trust and works to improve risk management practices in the NHS.

All colleagues are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust. There are structured processes in place for incident reporting, and the investigation of Serious Incidents. The Trust Board, through the risk management policy and incident reporting policy, promotes open and honest reporting of incidents, risks and hazards.

The Trust has a positive culture of reporting incidents enhanced by accessible online reporting systems available across the Trust. All patient related incidents which have resulted in harm as well as 'near miss' incidents are reported onto the National Reporting & Learning System (NRLS) to aid national trend analysis of incident data. The Trust receives regular summaries of incident reporting activity benchmarked against that of other, similar organisations. Significant issues are escalated to the Quality and Governance Committee. During the year the Trust has implemented a new risk and incident reporting system.

Developing Workforce Safeguards

In October 2018 NHSI released 'Developing workforce safeguards – supporting providers to deliver high quality care through effective staffing'. The report made many recommendations and highlighted good practice to support Trusts make evidenced decisions about safe staffing levels across all clinical areas, covering all staffing groups.

The Trust has reviewed the safeguards and recommendations during the year and put in place a series of measures to meet these requirements. Central to this is the resourcing principles, aims and plans set out in the Trust's People Strategy.
We have in place regular reviews of safe staffing for inpatient ward areas with key staffing data triangulated against outcomes such as incidents, red flag reports or any harm reported, professional opinion from clinical leaders about current risks or

mitigation in all areas. There is a six-monthly report to the Trust Board on safer staffing in inpatient wards.

The Trust does not as yet have a comprehensive workforce plan that extends to all clinical professionals but is working with colleagues and partner organisations through the Local Workforce Action Board to develop this.

Any service changes, skill mix reviews and new roles are subject to a Quality Impact Assessment process that it shared with organisations across the county. Escalation processes are documented at a local level and as part of system-wide escalation needs.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making colleagues (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 NHS22 guidance.

Public engagement with risk management

The Trust involves its key public stakeholders with managing the risks that affect them through the following mechanisms:

- Engagement with HealthWatch Somerset;
- The Council of Governors and Trust members are consulted on key issues and risks as part of the annual operating plan;
- Annual members' meeting;
- Engagement with patient and carer representative groups, including the voluntary sector and Leagues of Friends.

Due to the pandemic, some of this work has been reduced during 2020/21.

The Trust has an integrated Quality and Patient Experience (QPE) Group, which is chaired by a public governor and comprises governors, executive directors, operational colleagues, voluntary sector representatives and HealthWatch representatives. The QPE Group provides a quarterly report, including assessment of risks and issues, to the Council of Governors and escalates areas of risk to the Quality and Governance Committee.

During 2020/21 the Trust was not involved in any formal public consultations but did share with the Health Scrutiny Committee plans linked to the Musgrove 2030 development programme for consideration of any future consultation implications. No issues were raised by Committee members but it was agreed that further updates would be provided as the plans develop.

The Trust has further developed its risk management processes to ensure that relevant and up to date risk information is available at all key meetings, ensuring that decisions are based on robust assessments of risk. The Trust has an open and fair culture, encouraging incident reporting to enable all services to learn and improve as part of its core business.

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

The Trust has undertaken risk assessments and has a sustainable development management plan in place which is being developed to take 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.

Quality Governance is a key element of the overall governance arrangements of the Trust. At the heart of the Trust's commitment to quality is a clearly defined system of quality performance management, and a clear risk management process.

A Quality and Performance Report is presented to the Board at each meeting and highlights the key issues and trends, in relation to the provision of high quality care and patient experience.

The Chief Executive is ultimately accountable for the clinical governance processes in the Trust. During the year, this responsibility was delegated to the Chief Nurse, working closely with the Chief Medical Officer and the Director of Governance and Corporate Development.

The Executive Directors are experienced in NHS settings and the Non-Executive Directors provide independent challenge and bring a range of senior level experience from the commercial and public sectors. They receive independent appraisals conducted by the Chief Executive and Chairman.

The Trust has an integrated structure for monitoring quality and safety including a committee structure which has executive and non-executive representation.
The Board monitors quality through the following processes:

- the monthly quality and performance report;
- the reporting of serious incidents and learning;
- a monthly IQAB which focuses on compliance with statutory, regulatory and quality standards, reporting exceptions to the Quality and Governance Committee;

The Trust has a comprehensive clinical audit work plan covering both national and local audits. An annual review of clinical audits is reported to the Quality and Governance Committee and the outcomes of specific clinical audits considered as a key part of reporting to the IQAB.

A framework exists for the management and accountability of data quality.

The trust is fully compliant with the registration requirements of the Care Quality Commission. During 2020/21 the Trust has implemented its action plan to address areas for improvement identified by the Care Quality Commission arising from its inspection of some core services at Musgrove Park Hospital in 2019.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making colleagues (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.

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

The following key processes are in place to ensure that resources are used economically, efficiently and effectively:

- Scheme of Delegation and Reservation of Powers approved by the Board
- Standing Financial Instructions
- The monitoring of spend in year using budgets and variance analysis against actuals, with regular monthly financial monitoring reports produced for each operational unit or segment. An organisational report is produced monthly and reported to the Board, and discussed and reviewed in detail at the Finance Committee
- Robust competitive processes used for procuring non-staff expenditure items
- Cost improvement schemes, which are assessed for their impact on quality with local clinical ownership and accountability
- Strict controls on vacancy management and recruitment; and
- Contract monitoring arrangements with key commissioners which provide evidence that key requirements have been delivered.

Colleagues have a responsibility to identify and assess risk and to take action to ensure controls are in place to reduce and or mitigate risks whilst acknowledging need for economy, efficiency and effectiveness of the use of resources. All budget managers have a responsibility to manage their budgets and systems of internal control effectively and efficiently. These processes are not only reviewed on an ongoing basis by managers themselves but are also examined by internal and external audit as part on their annual plans.

A local counter fraud specialist and procedures are in place for work related to fraud and corruption as required by NHS Counter Fraud Authority.

The Trust Board gains assurance from the Finance Committee in respect of financial and budgetary management across the organisation and the Audit Committee, which receives reports regarding Losses and Special payments and the Write-Off of Bad Debts.

There are a range of internal and external audits that provide further assurance on economy, efficiency and effectiveness, including internal audit reports on key financial systems, data quality and performance management.

The Audit Committee receives reports from directors of the Trust as well as internal audit, external audit and the Counter Fraud specialist on the work undertaken to review the Trust's systems of control including economy, efficiency and effectiveness of the use of resources. Action plans are agreed from these reports to improve controls where necessary.

Information governance

Maintaining the security of the information that the Trust holds provides confidence to patients and employees. To ensure that security is maintained an Executive Director has been identified to undertake the role of Senior Information Risk Owner (SIRO). The SIRO has overseen the implementation of a wide range of measures to protect the data we hold and a review of information flows to underpin the Trust's information governance assurance statements and its assessment against the data security and protection toolkit. The review against the data security and protection toolkit provides assurance that these aspects are being managed and identified weaknesses addressed.

The Trust will submit its return for the data security and protection toolkit in June 2021, with an expected achievement level of 'exceeds standards'.

During 2020/21, the Trust reported three incidents to NHS Digital and the Information Commissioner. In all cases, the Information Commissioner was satisfied with the initial steps the Trust had taken and required no further actions.

Data quality and governance

The following steps were put in place during the year to assure the Board that there are appropriate controls in place to ensure the accuracy of data:

- The information provided is subject to robust checking and scrutiny through the Trust's governance groups and the Senior Operational Management Team meetings. The information is further integrated and tested by the Quality and Governance Committee and by the Board itself
- The Trust ensures key areas of performance are included within the annual internal audit programme
- Data quality and information governance are reviewed through regular quarterly reports to the Data Security and Protection Group and through Board monitoring of the data security and protection toolkit

The Trust's integrated governance model uses a full range of corporate, clinical, and information governance assurances to inform the Board in relation to operations and compliance. This includes formal 'topic-based reporting to the IQAB and specialist governance sub-groups for data security and protection, health safety, security and estates, equality and inclusion, and quality and patient experience. In addition, each of the operational directorates within the Trust has their own devolved governance responsibilities and governance groups which report to the IQAB.

Controls are in place to ensure that all the Trust's employees have the appropriate skills and expertise to perform their duties. This includes the provision of relevant training and helps to ensure the accuracy and reliability of data collected and prepared by employees and which is used to assess the quality of the Trust's performance.

The quality metrics relied on by the Board have been regularly reported through Trust governance structures, including the Quality and Governance Committee, Trust Board and Council of Governors where appropriate.

Data quality issues are addressed through the Trust's information governance systems in line with its relevant policies and through internal audit.

The metrics include key measures developed with the Trust's principal commissioners, the Somerset Clinical Commissioning Group, to provide them with assurance that the Trust is providing high quality care. Additional measures relating to patient experience are provided by the monthly assessments that the Trust has established, overseen by the Trust's Quality and Patient Experience Group.

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 trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and the Quality and Governance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- NHS Improvement Single Oversight Framework
- Care Quality Commission inspection reports
- Internal Audit reports
- External Audit reports
- CQC Insight Reports
- NHSR assessments
- Clinical audits
- Patient and staff surveys; and
- Benchmarking information

The Board is supported by the Quality and Governance Committee, Finance Committee, Mental Health Act Committee, People Committee and Audit Committee

who routinely review the Trust's system of internal control and governance framework, together with the Trust's integrated approach to achieving compliance with the Care Quality Commission essential safety and quality standards.

The Assurance Framework provides the Board with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. The Assurance Framework was subject to review and scrutiny at each meeting of the Quality and Performance Committee and Audit Committee, with a quarterly update provided to the Trust Board.

The Finance Committee focus on investigating the progress made in the delivery of financial plans and to undertake an in-depth analysis of financial information. Clinical Audit is given a high importance. The annual clinical audit plan reflects the priorities of the Board and national best practice, for example, NICE clinical guidelines, national confidential enquiries, NHS frameworks, high level enquiries and other nationally agreed guidance.

Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Audit Committee. This has included a specific review of risk maturity and the implementation of a new risk management system. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.

Two internal audits identified limited assurance as part of the review of trust services in year:

- Temporary Staffing
- Backlog Maintenance

Action plans were developed to address the issues identified. Completion of the actions will be overseen by the Trust's Audit Committee.

The Head of Internal Audit Opinion was issued for 2020/201 at a level of Moderate assurance. The Opinion states:

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:

- The majority of audits provided moderate or substantial assurance in the design of controls including the audit of key financial systems, data quality and performance management. Whilst two had limited assurance for operational effectiveness, we were specifically directed by management to review these areas to help them improve the control environments
- The Trust has a good record of implementing audit recommendations. We have closed all bar four prior year recommendations and management are proactive in discussing plans to address the risks identified in the 2019/20 audit.
- The Trust is expected to break-even against its agreed control total.

Conclusion

The Annual Governance review has identified no significant control issues.

Signed

Chief Executive Date: **11 June 2021**

Appendix 1

SOMERSET NHS FOUNDATION TRUST

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2021

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Foreword to the accounts

These accounts, for the year ended 31 March 2021 have been prepared by Somerset NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

On 1 April 2020, Somerset Partnership NHS Foundation Trust acquired (transfer by absorption) Taunton and Somerset NHS Foundation Trust and the combined organisation became known as Somerset NHS Foundation Trust.

Somerset Partnership NHS Foundation Trust provided community and mental health services to the population of Somerset, whilst Taunton and Somerset NHS Foundation Trust provided acute services to the population of North, West and Central Somerset.

These accounts cover 1 April 2020 to 31 March 2021 for services provided by Somerset NHS Foundation Trust. The comparator figures (2019/20) relate only to the services provided by Somerset Partnership NHS Foundation Trust.

Somerset NHS Foundation Trust

Signed 

Name **Peter Lewis**
Job title **Chief Executive**
Date **11 June 2021**

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SOMERSET NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Somerset NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of, the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

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

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

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

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

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk of incentive for revenue to be manipulated into the wrong period around the year end and the risk that Trust management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals. We consider this risk to be applicable to non-payroll and non-depreciation expenditure.

We did not identify any additional fraud risks.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included users who would not be expected to post journals, unusual postings to cash accounts, unusual pairings to/from fraud risk accounts and finally the final journals posted in the period.
- Assessing significant estimates for bias.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify expenditure had been recognised in the correct accounting period.
- Evaluating accruals posted as at 31 March 2021 and verifying accruals are appropriate and accurately recorded.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.

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

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

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

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

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

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

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

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

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

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

Other information in the Annual Report

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

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

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

Remuneration and Staff Reports

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

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 65, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

We have nothing to report in this respect.

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

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

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

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

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

Statutory reporting matters

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

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

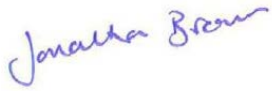
We have nothing to report in these respects.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Somerset NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.



Jonathan Brown
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

15 June 2021

Statement of Comprehensive Income

Note 1

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	521,463	175,402
Other operating income	4	89,534	11,293
Operating expenses	6	(617,500)	(181,129)
Operating (deficit)/surplus from continuing operations		**(6,503)**	**5,566**
Finance income	11	12	186
Finance expenses	12	(1,759)	(32)
PDC dividends payable		(5,666)	(2,473)
Net finance costs		**(7,413)**	**(2,319)**
Other (losses)/gains	13	(551)	7
Share of profit of associates / joint arrangements	16	8	-
Gains arising from transfers by absorption	32	132,484	-
Surplus for the year from continuing operations		**118,025**	**3,254**
Surplus for the year		**118,025**	**3,254**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(3,034)	558
Revaluations	15.1	6,696	-
Total comprehensive income for the period		**121,687**	**3,812**

Note 1
The comparator figures (2019/20) relate only to the services provided by Somerset Partnership NHS Foundation Trust.

The accompanying notes form part of the financial statements.

Statement of Financial Position

	Note	31 March 2021 £000	Note 1 31 March 2020 £000
Non-current assets			
Intangible assets	14	19,346	2,864
Property, plant and equipment	15	287,959	87,090
Receivables	18	1,505	-
Total non-current assets		**308,810**	**89,954**
Current assets			
Inventories	17	4,784	453
Receivables	18	25,425	11,462
Cash and cash equivalents	19	75,392	28,579
Total current assets		**105,601**	**40,494**
Current liabilities			
Trade and other payables	20	(86,629)	(21,346)
Borrowings	22	(3,685)	(249)
Provisions	24	(240)	(93)
Other liabilities	21	(14,472)	(482)
Total current liabilities		**(105,026)**	**(22,170)**
Total assets less current liabilities		**309,385**	**108,278**
Non-current liabilities			
Trade and other payables	20	-	-
Borrowings	22	(26,046)	(795)
Provisions	24	(2,140)	(78)
Other liabilities	21	(2,458)	-
Total non-current liabilities		**(30,644)**	**(873)**
Total assets employed		**278,742**	**107,405**
Financed by			
Public dividend capital		176,712	33,713
Revaluation reserve		69,221	8,659
Income and expenditure reserve		32,809	65,033
Total taxpayers' equity		**278,742**	**107,405**

Note 1
The comparator figures (2019/20) relate only to the services provided by Somerset Partnership NHS Foundation Trust.

The notes on pages 22 to 54 form part of these accounts.

Name **Peter Lewis**
Position **Chief Executive**
Date **11 June 2021**

The accompanying notes form part of the financial statements.

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**33,713**	**8,659**	**65,033**	**107,405**
Surplus for the year	-	-	118,025	**118,025**
Transfers by absorption: transfers between reserves	93,350	56,900	(150,250)	**-**
Impairments	-	(3,034)	-	**(3,034)**
Revaluations	-	6,696	-	**6,696**
Public dividend capital received	51,900	-	-	**51,900**
Public dividend capital repaid	(2,250)	-	-	**(2,250)**
Taxpayers' and others' equity at 31 March 2021	**176,713**	**69,221**	**32,808**	**278,742**

Statement of Changes in Equity for the year ended 31 March 2020

Note 1

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**33,593**	**8,101**	**61,779**	**103,473**
Surplus for the year	-	-	3,254	**3,254**
Impairments	-	558	-	**558**
Public dividend capital received	120	-	-	**120**
Taxpayers' and others' equity at 31 March 2020	**33,713**	**8,659**	**65,033**	**107,405**

Note 1
The comparator figures (2019/20) relate only to the services provided by Somerset Partnership NHS Foundation Trust.

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 and Social Care as the public dividend capital dividend.

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.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

The accompanying notes form part of the financial statements.

Statement of Cash Flows

	Note	2020/21 £000	Note 1 2019/20 £000
Cash flows from operating activities			
Operating (deficit)/surplus		(6,503)	5,566
Non-cash income and expense:			
Depreciation and amortisation	6	18,755	5,011
Net impairments	7	15,400	(144)
Income recognised in respect of capital donations	4	(1,779)	(171)
Amortisation of PFI deferred credit		(259)	-
Decrease in receivables and other assets		10,347	1,011
Decrease in inventories		51	32
Increase in payables and other liabilities		29,820	4,626
Increase in provisions		1,312	11
Net cash flows from operating activities		**67,144**	**15,942**
Cash flows from investing activities			
Interest received		12	186
Purchase of intangible assets		(5,737)	(550)
Purchase of PPE and investment property		(32,742)	(3,132)
Sales of PPE and investment property		22	7
Receipt of cash donations to purchase assets		300	-
Net cash flows (used in) investing activities		**(38,145)**	**(3,489)**
Cash flows from financing activities			
Public dividend capital received		51,900	120
Public dividend capital repaid		(2,250)	-
Movement on loans from DHSC		(25,765)	(200)
Capital element of finance lease rental payments		(755)	(84)
Capital element of PFI, LIFT and other service concession payments		(1,413)	-
Interest on loans		(258)	(21)
Interest paid on finance lease liabilities		(255)	(11)
Interest paid on PFI, LIFT and other service concession obligations		(1,219)	-
PDC dividend (paid)		(6,162)	(2,655)
Net cash flows from / (used in) financing activities		**13,823**	**(2,851)**
Increase in cash and cash equivalents		**42,822**	**9,603**
Cash and cash equivalents at 1 April - brought forward		**28,579**	**18,976**
Cash and cash equivalents transferred under absorption accounting	32	3,991	-
Cash and cash equivalents at 31 March	19.1	**75,391**	**28,579**

Note 1

The comparator figures (2019/20) relate only to the services provided by Somerset Partnership NHS Foundation Trust.

The accompanying notes form part of the financial statements.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Reporting Entity

Somerset NHS Foundation Trust ("The Trust") is a public benefit corporation authorised under the National Health Service Act 2006, on 1 May 2008. It is licensed by NHS Improvement as an NHS provider under the Health and Social Care Act 2012 (as amended).

The primary objective of the Trust is to provide acute, community and mental health services to the population of Somerset and increasingly to a wider community.

The financial statements of the Trust are for the year ended 31 March 2021 as approved by the Trust Board.

Note 1.2 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 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.

Note 1.3 Accounting convention

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

Note 1.4 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.

The Trust has prepared its financial plans and cash flow forecasts for the coming year on the assumption that funding will be received from the Department of Health and Social Care consistent with the revised funding arrangements in response to the COVID-19 pandemic. Discussions to date indicate this funding will be forthcoming. These funds are expected to be sufficient to enable the Trust to meet its obligations as they fall due; and will be accessed through the nationally agreed process published by NHS Improvement and the Department of Health and Social Care.
There has been no application to the Secretary of State for the dissolution of the Trust and following the preparation of detailed financial plans for 2021/22, no such application is planned.

The Board of Directors has therefore concluded that these financial statements should be prepared on a going concern basis as there is a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the next 12 months.

Note 1.5 Interests in other entities

Joint ventures
Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. IFRS 11 specifies that since the Trust does not have subsidiaries that are consolidated and does not therefore produce consolidated accounts, the Trust is required to prepare 'economic interest' accounts in which interests in joint ventures are accounted for using the equity method.

Note 1.6 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 a [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 was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

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

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when 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.

NHS injury cost recovery scheme

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

Note 1.7 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 grant 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 1.8 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. 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.

Note 1.9 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 1.10 Property, plant and equipment

Note 1.10.1 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 will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has 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, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

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.

Note 1.10.2 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 (ie operational assets used to deliver either front line services or corporate functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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.

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.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. During 2020/21, a desktop valuation exercise to update the latest carrying values as at 31 March 2021 was undertaken by Cushman & Wakefield DTZ.

The valuation exercise was carried out in March 2021 with a valuation date of 31 March 2021. The outbreak of COVID-19, declared by the World Health Organisation as a "Global Pandemic" on the 11 March 2020, has and continues to impact many aspects of daily life and the global economy – with some real estate markets having experienced lower levels of transactional activity and liquidity. Travel, movement and operational restrictions have been implemented by many countries. Although these may imply a new stage of the crisis, they are not unprecedented in the same way as the initial impact. The pandemic and the measures taken to tackle COVID-19 continue to affect economies and real estate markets globally. Nevertheless, as at the valuation date property markets are mostly functioning again, with transaction volumes and other relevant evidence at levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly, and for the avoidance of doubt, our valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards. For the avoidance of doubt this explanatory note has been included to ensure transparency and to provide further insight as to the market context under which the valuation opinion was prepared. In recognition of the potential for market conditions to move rapidly in response to changes in the control or future spread of COVID-19 we highlight the importance of the valuation date.

A 1% change in the valuation would have a £2 million impact on the Statement of Financial Position with a nil change on the PDC dividend due to be paid next year and accrued in these financial statement.

Of the £202 million net book value of land and buildings subject to valuation, £201 million relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

A full valuation (excluding assets under construction/work in progress) was undertaken during 31 March 2021. This value, together with indexation applied to buildings in line with the Valuers advice has been included in the closing Statement of Financial Position.

The component elements of each property asset are depreciated individually where the value of the component parts are judged to be material in relation to the overall value of that asset and where the useful economic lives of the components are significantly different from that of the overall property asset. The component parts that are individually depreciated by the Trust are building structures, engineering elements and external works.

The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value. Cushman & Wakefield has supplied amended estimates of the diminution in value relating to operational buildings scheduled for imminent closure and subsequent demolition. These buildings have been written down in the accounts to these values. Open market values have also been provided for land and residences.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 15.

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.

Accounting for revaluations:

Reductions in value are charged to an asset revaluation reserve for that class of asset; where no revaluation reserve exists the reduction in value is charged directly to the Statement of Comprehensive Income. Any subsequent increase on revaluation that off-sets a previous decrease in value recognised in the Statement of Comprehensive Income will be recognised first in the Statement of Comprehensive Income up to the amount previously expensed, and then credited to the revaluation reserve for that class of asset.

For impairments expensed directly to the Statement of Comprehensive Income, the balance on any revaluation reserve (up to the level of impairment) to which the impairment would have been charged under IAS 36 is transferred to the income and expenditure reserve.

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' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'non-current assets held for resale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until 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 expenditure.

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 income 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 IFRS5 are met:
- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

Note 1.10.3 Donated and grant funded assets

Donated and grant funded property, plant and 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.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Note 1.10.4
Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI transactions which meet the International Financial Reporting Interpretations Committee (IFRIC) 12 definition of a service concession, as interpreted in HM Treasury's Financial Reporting Manual (FReM), are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.10.5 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	Max life
	Years	Years
Buildings, excluding dwellings	1	50
Dwellings	19	41
Plant & machinery	5	30
Transport equipment	7	10
Information technology	2	10
Furniture & fittings	3	25

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 1.11 Intangible assets

Note 1.11.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Trust intends to complete the asset and sell or use it;
• the Trust has the ability to sell or use the asset;
• how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use
• the Trust can measure reliably the expenses attributable to the asset during development.

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

Note 1.11.2 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. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sales at the reporting date and where they do not meet the definitiions of investment properties (IAS 40) or assets held for sale (IFRS 5).

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

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.11.3 Useful economic life 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:

Development expenditure	2 to 10 years (10% - 50%)
Software licences	2 to 10 years (10% - 50%) or the terms of the licence, if shorter

Note 1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. Due to the high turnover of stocks within the Trust, current costs are used as a fair estimate of first in/ first out valuation.

Note 1.13 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 1.14 Financial assets and financial liabilities

Note 1.14.1 Recognition

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

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

Note 1.14.2 Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

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

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

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

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

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

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

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

Note 1.14.3 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 1.15 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.

Note 1.15.1 The trust as 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.

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.

Note 1.15.2 The trust as 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.

Note 1.16 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:

		Nominal rate
Short-term	Up to 5 years	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

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 24.2 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 1.17 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 25 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 25, 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 1.18 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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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 1.19 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 1.20 Corporation tax
The Trust is a Health Service Body within the meaning of s986 Corporation Taxes Act 2010. Accordingly it is not liable to corporation tax. The Trust is also exempt from tax on chargeable gains under s271(3) Taxation of Chargeable Gains Act 1992.

There is, however, a power for HM Treasury to submit an order to Parliament which will dis-apply the corporation tax exemption in relation to particular activities of an NHS Foundation Trust (s987 Corporation Taxes Act 2010). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities to be specified in the order which are not related to, or ancillary to, the provision of healthcare, and where the profits therefrom exceed £50,000 per annum. Until such an order is approved by Parliament, the Trust has no corporation tax liability.

Note 1.21 Foreign exchange
The functional and presentational currency of the Trust is sterling.

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

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.22 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 1.23 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.

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

Note 1.25 Transfers of functions from other NHS bodies
For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the net assets transferred is recognised within The Statement of Comprehensive Income, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

On 1st April 2020, Somerset Partnership and Taunton and Somerset NHS Foundation Trusts merged forming Somerset NHS Foundation Trust. Reporting for 2020/21 will show on this basis and the equivalent disclosure for 2019/20 will show the primary statements and accompanied notes for Somerset Partnership NHS Foundation Trust only.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.27 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 impact of applying IFRS 16 in 2022/23 will have a material impact on the Financial Statements.

Note 2 Operating Segments

Operating segments are reported in a manner consistent with the internal reporting provided to the Chief Operating Decision Maker. The Chief Operating Decision Maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Board that makes strategic decisions. The Somerset NHS Foundation Trust is managed by the Board of Directors, which is made up of both Executive and Non-Executive Directors. The Board is responsible for strategically and operationally leading the work of the Trust. The Non-Executive Directors bring external expertise to the organisation and provide advice and guidance to the Executive Directors. The Executive Directors take care of the day to day running of the Trust.

The Board is therefore considered to be the Chief Operating Decision Maker (CODM) of the Trust.

The monthly financial information presented to the Board includes a Trust level Statement of Comprehensive Income, a Statement of Financial Position, a Statement of Cash flows and a number of other financial indicators including Covid-19 spend, capital expenditure, performance against cost improvement plans, agency spend and debt analysis. The segmental expenditure data is included by way of a separate note reporting achievement against planned expenditure inclusive of any directorate specific income and highlighting any variances. It is acknowledged that the analysis of figures included below is different to that used for the remainder of the financial statements. The detail includes current budget and year to date data, in each case comparing actual data to plan. The commentary also includes the Directorates' contribution to Trust wide initiatives, such as cost improvement programmes. Other information reported to the Board is specifically analysed for its purpose, for example trust pay spend against budget analysed by employee groups and income stream expectations by type (NHS Clinical, non NHS etc) compared to actual achieved. Information such as delivery of the savings plan is a trust wide position paper but detailed into the areas tasked with implementing savings.

The Trust has used three key factors in its identification of its reportable operating segments. The key factors are that the reportable operating segment:

a) engages in activities from which it earns revenues and incurs expenses;

b) reports financial results which are regularly reviewed by the Trust's Board of Directors to make decisions about allocation of resources to the segment and to assess its performance; and

c) has discrete financial information.

The Trust's reportable segments and services provided are:

Integrated and Urgent Care
The services provided by this operating segment include A&E, MIU, Cardiology, Care of the Elderly, Endocrinology, Neurology, Rehabilitation, Respiratory and Stroke and Community Services.

Surgery
The services provided by this operating segment include Gastroenterology, Upper and Lower GI Surgery, Vascular, Breast Care Centre, Dermatology, Urology, Orthopaedics, Theatres, ITU/HDU, Anaesthetics, Sterile Services, Pre-op Assessment, Surgical Admissions, General Outpatients and Orthopaedic Services.

Clinical Support and Specialist Services
The services provided by this operating segment include the dedicated cancer centre, Haematology & Oncology, Pharmacy, Therapies, Pathology, Imaging, Speech and Language Therapy and other diagnostic testing.

Corporate and other services
This segment provides corporate management for the Trust and includes the administrative aspects of governance and professional management of all clinical staff, the Trust Board, Finance, Information and IT, People Services, Organisational Development, Performance Management, Operational Management, Education and Training, central clinical functions of operational managers, clinical site managers, discharge coordination, patient transport and winter response actions.

Families Care Directorate
The services provided by this operating segment include Reproductive Medicine, EPAC, Gynaecology, Maternity and Paediatrics (including Somerset Neo-Natal Intensive Care Unit, Child and Adolescent Mental Health Services, Primary Care Dental Service and Community Services.

Mental Health and LD

The services provided by the mental health and LD segment include inpatient services for adult acute including Paediatric Intensive Care Unit, Section 136 health based places of safety; rehabilitation and older peoples mental health inpatient, commissioned inpatient services of low secure and CAMHS Tier 4; Home Treatment/Crisis services; Perinatal; Psychiatric Liaison; Community mental health services including open mental health working in collaboration with voluntary VSC; forensic liaison services; Assertive Outreach; Talking Therapies, Pharmacy and Learning Disability services.

Primary Care and Neighbourhoods

The services provided by this operating segment include District Nursing & Rehab services, provision of dementia and older peoples mental health services and the newly created Intermediate Care Model.

The table below summarises details reported to the Board during 2020/21.

	Actual £'000
Income - Commissioner Block	483,991
Income - COVID block	27,328
Income - Top Up	26,796
Income - Passthrough	7,363
Total Corporate Income	**545,478**
Expenditure less sundry income	
Primary Care and Neighbourhoods	(32,125)
Families Care Directorate	(45,248)
Mental Health and LD	(55,186)
Integrated and Urgent Care	(98,502)
Surgery	(94,017)
Clinical Support and Specialist Services	(80,457)
TOTAL OPERATING DIRECTORATES	**(405,535)**
Corporate and other services	(146,445)
TOTAL OTHER SERVICES	**(146,445)**
Total Operating Expenditure	**(551,980)**
Trust EBITDA	**(6,502)**
Net Finance Costs	(7,957)
Remove Capital Donations/grants I&E impact	14,485
Performance on a control total basis	**26**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.6.

Note 3.1 Income from patient care activities (by nature)

	2020/21	2019/20
	£000	£000
Acute services		
Block contract / system envelope income*	296,593	-
High cost drugs income from commissioners (excluding pass-through costs)	31,677	-
Other NHS clinical income	2,740	-
Mental health services		
Block contract / system envelope income*	69,773	71,621
Clinical partnerships providing mandatory services (including S75 agreements)	609	333
Community services		
Block contract / system envelope income*	95,384	92,281
Income from other sources (e.g. local authorities)	2,760	5,677
All services		
Private patient income	858	-
Additional pension contribution central funding**	16,258	5,430
Other clinical income	4,811	60
Total income from activities	**521,463**	**175,402**

*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. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**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	101,911	18,728
Clinical commissioning groups	407,925	149,297
Department of Health and Social Care	20	162
Other NHS providers	2,740	2,102
NHS other	12	87
Local authorities	3,218	2,860
Non-NHS: private patients	858	-
Non-NHS: overseas patients (chargeable to patient)	190	1
Injury cost recovery scheme	336	312
Non NHS: other	4,253	1,853
Total income from activities	**521,463**	**175,402**
Of which:		
Related to continuing operations	521,463	175,402

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

	2020/21	2019/20
	£000	£000
Income recognised this year	190	1

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	2,282	-	**2,282**	179	-	**179**
Education and training	19,005	-	**19,005**	2,153	-	**2,153**
Non-patient care services to other bodies	9,659	-	**9,659**	1,102	-	**1,102**
Provider sustainability fund (2019/20 only)	-	-	**-**	2,308	-	**2,308**
Reimbursement and top up funding (2020/21 only)	47,241	-	**47,241**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	2,416	-	**2,416**	716	-	**716**
Receipt of capital grants and donations	-	1,779	**1,779**	-	171	**171**
Charitable and other contributions to expenditure	-	6,308	**6,308**	-	-	**-**
Rental revenue from operating leases	-	105	**105**	-	-	**-**
Amortisation of PFI deferred income / credits	-	259	**259**	-	-	**-**
Other income	480	-	**480**	4,664	-	**4,664**
Total other operating income	**81,083**	**8,451**	**89,534**	**11,122**	**171**	**11,293**
Of which:						
Related to continuing operations			89,534			11,293

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 in within contract liabilities at the previous period end	-	125

Note 5.2 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	509,836	175,090
Income from services not designated as commissioner requested services	101,161	312
Total	**610,997**	**175,402**

Note 6 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	177	3,186
Purchase of healthcare from non-NHS and non-DHSC bodies	21,414	6,616
Staff and executive directors costs	409,709	133,580
Remuneration of non-executive directors	183	140
Supplies and services - clinical (excluding drugs costs)	34,878	4,230
Supplies and services - general	8,351	2,422
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	37,071	3,998
Consultancy costs	374	225
Establishment	6,887	4,716
Premises	26,289	9,492
Transport (including patient travel)	1,486	824
Depreciation on property, plant and equipment	15,089	4,105
Amortisation on intangible assets	3,666	905
Net impairments	15,400	(144)
Movement in credit loss allowance: contract receivables / contract assets	(31)	8
Movement in credit loss allowance: all other receivables and investments	17	10
Increase/(decrease) in other provisions	1,359	-
Change in provisions discount rate(s)	85	(1)
Audit fees payable to the external auditor		
audit services- statutory audit	111	60
other auditor remuneration (external auditor only)	-	3
Internal audit costs	126	66
Clinical negligence	13,297	472
Legal fees	532	196
Insurance	580	92
Research and development	7	23
Education and training	1,724	313
Rentals under operating leases	2,762	2,986
Redundancy	376	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	3,619	-
Car parking & security	168	255
Losses, ex gratia & special payments	765	35
Subscriptions	565	503
Interpreting costs	294	245
Other*	10,170	1,568
Total	**617,500**	**181,129**
Of which:		
Related to continuing operations	617,500	181,129

*Other expenditure includes £2.2m Out of Area Named Patients, £1.8m of Surgical services for the Independent Sector, £0.8m HomeFirst/Packages of Care and £0.5m for International Recruitment Programme and Provider pharmacy Services.

Note 6.1 Other auditor remuneration

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
2. Audit-related assurance services	-	3
Total	**-**	**3**

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 / deficit resulting from:		
Changes in market price	14,993	(144)
Other	407	-
Total net impairments/(reversal of impairments) charged to operating surplus / deficit	**15,400**	**(144)**
Impairments charged to the revaluation reserve	3,034	(558)
Total net impairments	**18,434**	**(702)**

The Trust's land, buildings and dwellings were revalued by Cushman & Wakefield DTZ as at 31 March 2021. The Trust's specialised buildings and associated land have been valued using the depreciated replacement cost method, based upon provision of a modern equivalent asset (MEA). A fundamental principle of MEA valuations is that a hypothetical buyer would purchase the least expensive site that would be suitable and appropriate for the existing operations. The valuation of the Trust's specialised land and buildings has therefore been based upon the Trust hypothetically being located on a suitable alternative sites away from the town centre, where the cost of the land would be significantly lower, but where the Trust would still be able to provide the same level of service but the location of providing the service would be delivered from the model.

Applying these MEA revaluations has resulted in a net overall decrease of £11,741,000 in the value of the Trust's estate (2019/20: net increase of £702,000). This decrease in value of the Trust's estate is recorded in property, plant and equipment. £15,401,000 has been recognised as a net impairment charged to the Statement of Comprehensive Income. (2019/20: net reversal of impairment charge of (£144,000)) and the remaining £3,660,000 has been recognised as an impairment to the revaluation reserve (2019/20: £558,000).

Note 8 Employee benefits

	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	293,634	95,412
Social security costs	29,389	8,480
Apprenticeship levy	1,468	478
Employer's contributions to NHS pensions	53,611	17,922
Temporary staff (including agency)	34,530	11,532
Total gross staff costs	**412,632**	**133,824**
Total staff costs	**412,632**	**133,824**
Of which		
Costs capitalised as part of assets	2,547	244

Note 8.1 Retirements due to ill-health

During 2020/21 there were 7 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £365k (£39k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

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 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 at 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 at 20.6%, and the Scheme Regulations were amended accordingly.

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

Note 10 Operating leases

Note 10.1 Somerset NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Somerset NHS Foundation Trust is the lessor.

Income is generated from catering concessions.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Other	105	-
Total	**105**	**-**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	285	-
- later than one year and not later than five years;	333	-
Total	**618**	**-**

Note 10.2 Somerset NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Somerset NHS Foundation Trust is the lessee.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	2,762	2,986
Total	**2,762**	**2,986**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,639	2,998
- later than one year and not later than five years;	5,105	5,934
- later than five years.	2,114	1,650
Total	**9,858**	**10,582**
Future minimum sublease payments to be received	-	-

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	12	186
Total finance income	**12**	**186**

Note 12 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	184	21
Finance leases	227	11
Main finance costs on PFI and LIFT schemes obligations	1,219	-
Total interest expense	**1,630**	**32**
Unwinding of discount on provisions	43	-
Other finance costs	87	-
Total finance costs	**1,760**	**32**

Note 12.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

The Trust has not incurred any interest arising from claims made under this legislation or paid any compensation to cover debt recovery costs in 2020/21 or 2019/20.

Note 13 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	1	7
Losses on disposal of assets	(552)	-
Total (losses)/gains on disposal of assets	**(551)**	**7**
Total other (losses)/gains	**(551)**	**7**

The net loss on disposal arose from the disposal of Microsoft Software licences.(2019/20: gain on disposal arose from recycling IT assets which had no asset value).

Note 14.1 Intangible assets - 2020/21

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**5,855**	**-**	**5,855**
Transfers by absorption	18,484	3,775	**22,259**
Additions	2,825	2,912	**5,737**
Impairments	(407)	-	**(407)**
Reclassifications	2,713	(2,713)	**-**
Disposals / derecognition	(920)	-	**(920)**
Valuation / gross cost at 31 March 2021	**28,550**	**3,974**	**32,524**
Amortisation at 1 April 2020 - brought forward	**2,991**	**-**	**2,991**
Transfers by absorption	6,889	-	**6,889**
Provided during the year	3,666	-	**3,666**
Disposals / derecognition	(368)	-	**(368)**
Amortisation at 31 March 2021	**13,178**	**-**	**13,178**
Net book value at 31 March 2021	**15,372**	**3,974**	**19,346**
Net book value at 1 April 2020	**2,864**	**-**	**2,864**

Note 14.2 Intangible assets - 2019/20

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019	**5,305**	**-**	**5,305**
Additions	550	-	**550**
Valuation / gross cost at 31 March 2020	**5,855**	**-**	**5,855**
Amortisation at 1 April 2019	**2,086**	**-**	**2,086**
Provided during the year	905	-	**905**
Amortisation at 31 March 2020	**2,991**	**-**	**2,991**
Net book value at 31 March 2020	**2,864**	**-**	**2,864**
Net book value at 1 April 2019	**3,219**	**-**	**3,219**

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 - brought forward	**4,578**	**73,750**	**845**	**258**	**8,226**	**7**	**9,935**	**2,315**	**99,914**
Transfers by absorption	8,036	122,426	3,011	16,331	51,613	63	11,575	5,229	**218,284**
Additions	-	3,882	105	34,054	7,227	25	2,062	255	**47,610**
Impairments	(216)	(30,629)	(206)	-	-	-	-	-	**(31,051)**
Reversals of impairments	-	5,874	-	-	-	-	-	-	**5,874**
Revaluations	173	6,112	412	-	-	-	-	-	**6,697**
Reclassifications	-	3,563	(318)	(8,735)	4,495	19	932	44	**-**
Disposals / derecognition	-	-	-	-	(29)	-	-	-	**(29)**
Valuation/gross cost at 31 March 2021	**12,571**	**184,979**	**3,849**	**41,908**	**71,532**	**114**	**24,504**	**7,843**	**347,300**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**8**	**0**	**-**	**4,858**	**3**	**6,567**	**1,388**	**12,824**
Transfers by absorption	-	-	-	-	28,709	37	7,321	2,513	**38,580**
Provided during the year	-	7,066	146	-	4,710	10	2,595	562	**15,089**
Impairments	-	(4,449)	(31)	-	-	-	-	-	**(4,480)**
Reversals of impairments	-	(2,553)	(115)	-	-	-	-	-	**(2,668)**
Revaluations	-	1	-	-	-	-	-	-	**1**
Reclassifications	-	(64)	-	-	18	-	46	-	**-**
Disposals / derecognition	-	-	-	-	(6)	-	-	-	**(6)**
Accumulated depreciation at 31 March 2021	**-**	**9**	**0**	**-**	**38,289**	**50**	**16,529**	**4,463**	**59,341**
Net book value at 31 March 2021	**12,571**	**184,970**	**3,849**	**41,908**	**33,243**	**64**	**7,975**	**3,380**	**287,960**
Net book value at 1 April 2020	**4,578**	**73,742**	**845**	**258**	**3,368**	**4**	**3,368**	**927**	**87,090**

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	**4,367**	**73,022**	**908**	**0**	**7,493**	**7**	**8,694**	**2,295**	**96,786**
Additions	-	1,912	-	592	733	-	1,241	20	**4,498**
Impairments	(5)	(3,219)	(91)	-	-	-	-	-	**(3,315)**
Reversals of impairments	216	1,701	28	-	-	-	-	-	**1,945**
Reclassifications	-	334	-	(334)	-	-	-	-	**-**
Valuation/gross cost at 31 March 2020	**4,578**	**73,750**	**845**	**258**	**8,226**	**7**	**9,935**	**2,315**	**99,914**
Accumulated depreciation at 1 April 2019	**-**	**7**	**1**	**-**	**4,367**	**3**	**5,242**	**1,171**	**10,791**
Provided during the year	-	2,057	16	-	491	-	1,325	217	**4,106**
Impairments	-	(443)	(14)	-	-	-	-	-	**(457)**
Reversals of impairments	-	(1,613)	(3)	-	-	-	-	-	**(1,616)**
Accumulated depreciation at 31 March 2020	**-**	**8**	**0**	**-**	**4,858**	**3**	**6,567**	**1,388**	**12,824**
Net book value at 31 March 2020	**4,578**	**73,742**	**845**	**258**	**3,368**	**4**	**3,368**	**927**	**87,090**
Net book value at 1 April 2019	**4,367**	**73,015**	**907**	**(0)**	**3,126**	**4**	**3,452**	**1,124**	**85,995**

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	12,571	165,335	3,849	41,838	20,400	45	7,202	2,521	**253,761**
Finance leased	-	-	-	70	3,895	-	-	245	**4,210**
On-SoFP PFI contracts and other service concession arrangements	-	18,160	-	-	4,189	-	686	-	**23,035**
Owned - donated/granted	-	1,474	-	-	4,759	19	87	614	**6,953**
NBV total at 31 March 2021	**12,571**	**184,969**	**3,849**	**41,908**	**33,243**	**64**	**7,975**	**3,380**	**287,959**

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	4,578	71,060	845	258	2,682	4	3,352	730	**83,509**
Finance leased	-	-	-	-	145	-	-	-	**145**
Owned - donated/granted	-	2,682	-	-	541	-	16	197	**3,436**
NBV total at 31 March 2020	**4,578**	**73,742**	**845**	**258**	**3,368**	**4**	**3,368**	**927**	**87,090**

Note 15.5 Net book value of assets held under finance leases

The Trust held £4,210,000 (2019/20: £145,000) of assets under finance leases during the financial year. This relates to the provision and installation of energy infrastructure assets and dental equipment.

Note 15.6 Donated assets

During 2020/21, donations of £1,779,000 were donated to the Trust (2019/20: £171,000). £1,479,000 was equipment donated from Department of Health and Social Care and NHS England for the COVID response. There were no restrictions on the use of donated assets.

Note 15.7 Asset reclassification

During the year there was £8,735,000 (2019/20: £334,000) of reclassifications from assets under construction to other asset classes.

Note 16 Investments in associates and joint ventures

	2020/21	2019/20
	£000	£000
Carrying value at 1 April - brought forward	**-**	**-**
Share of profit / (loss)	-	-
Carrying value at 31 March	**-**	**-**

The Trust holds a 51.4% share in each of Southwest Pathology Services LLP (SPS LLP), Southwest Path Services LLP (services LLP) and SPS Facilities LLP (LLP) .The joint venture, Southwest Pathology Services LLP (SPS LLP), was established to deliver and develop laboratory based pathology services throughout the region. Laboratory processing of tests is carried out by SPS LLP, whilst responsibility for the interpretation of the test results remains with the Trust. The Trust has retained customer contracts for the provision of a complete pathology service with GPs, independent sector providers and other third parties and SPS LLP charges the Trust for the cost of processing those tests. During 2013/14 the trust entered into another Joint Venture partnership with Integrated Pathology Partnerships Ltd and Yeovil District Hospital NHS Foundation Trust. This 'sister' joint venture, Southwest Path Services LLP, was established to deliver a range of additional testing services to Trusts, including point of care testing of patients' glucose levels. These entities are jointly controlled by the Trust, Yeovil District Hospital NHS FT and Integrated Pathology Partnership Ltd. The arrangements are treated as a joint venture and are accounted for using equity accounting, such that 51.4% of the surplus / (deficit) made is included in the Trust's SOCI and 51.4% of the net assets of the Joint Venture are included in the SOFP of the Trust. In 2014/15 SPS LLP was restructured to form SPS LLP and SPS Facilities LLP.

	SPS LLP (Services)		SPS Facilities LLP		Combined	
	2020/21	2019/20	**2020/21**	2019/20	**2020/21**	2019/20
	£000	£000	**£000**	£000	**£000**	£000
Profit and loss account						
Turnover	**10,635**	8,625	**10,011**	8,295	**20,646**	16,920
Cost of sales	**(10,259)**	(8,138)	**(9,679)**	(7,861)	**(19,938)**	(15,999)
Gross Profit	376	487	332	434	708	921
Operating Expenditure	**(366)**	(350)	**(327)**	(325)	**(693)**	(675)
Profit before tax	**10**	137	**5**	109	**15**	246
Trust's share of profit in Statement of Comprehensive Income	**5**	70	**3**	56	**8**	126
Statement of Financial Position						
Non current assets						
Current assets	**540**	345	**657**	304	**1,197**	1,002
	540	345	**657**	**304**	**1,197**	1,002
Payables: amounts due within one year	**(512)**	(328)	**(698)**	(351)	**(1,210)**	(1,026)
Payables: amounts due in greater than one year	**0**	0			**0**	0
	(512)	(328)	**(698)**	(351)	**(1,210)**	(1,026)
Net Assets/(Liabilities)	**28**	17	**(41)**	(47)	**(14)**	(24)
Share of net assets recognised in the Statement Of Financial Position	**14**	9	**(14)**	(9)	**0**	(0)

Note 17 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	1,545	148
Consumables	21	275
Energy	172	30
Other	3,046	-
Total inventories	**4,784**	**453**

Inventories recognised in expenses for the year were £45,551k (2019/20: £2,752k). Write-down of inventories recognised as expenses for the year were £0k (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 £6,284k of items purchased by DHSC.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 18.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	19,812	8,867
Allowance for impaired contract receivables / assets	(79)	(154)
Allowance for other impaired receivables	(117)	(22)
Prepayments (non-PFI)	3,865	2,595
PDC dividend receivable	618	52
VAT receivable	1,285	124
Other receivables	41	-
Total current receivables	**25,425**	**11,462**
Non-current		
Contract receivables	1,940	-
Allowance for impaired contract receivables / assets	(435)	-
Total non-current receivables	**1,505**	**-**
Of which receivable from NHS and DHSC group bodies:		
Current	15,145	5964

Note 18.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**154**	**22**	**146**	**12**
Transfers by absorption	495	100	-	-
New allowances arising	213	117	8	12
Changes in existing allowances	16	(100)	-	-
Reversals of allowances	(260)	-	-	(2)
Utilisation of allowances (write offs)	(104)	(22)	-	-
Allowances as at 31 March 2021	**514**	**117**	**154**	**22**

Note 19.1 Cash and cash equivalents movements

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	**28,579**	**18,976**
Transfers by absorption	3,991	-
Net change in year	42,822	9,603
At 31 March	**75,392**	**28,579**
Broken down into:		
Cash at commercial banks and in hand	1,607	27
Cash with the Government Banking Service	73,785	28,552
Total cash and cash equivalents as in SoFP	**75,392**	**28,579**
Total cash and cash equivalents as in SoCF	**75,392**	**28,579**

Note 19.2 Third party assets held by the trust

Somerset 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	24	98
Total third party assets	**24**	**98**

Note 20 Trade and other payables

	2021	2020
	£000	£000
Current		
Trade payables	15,660	8,813
Capital payables	13,832	1,196
Accruals	45,720	8,817
Social security costs	7,732	2,294
Other payables	3,685	226
Total current trade and other payables	**86,629**	**21,346**
Non-current		
Capital payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	4,891	3,731

Note 21 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	14,214	482
Deferred PFI credits / income	258	-
Total other current liabilities	**14,472**	**482**
Non-current		
Deferred PFI credits / income	2,458	-
Total other non-current liabilities	**2,458**	**-**

Deferred PFI credits relate to a public private partnership project (PPP) for the building of a car park (completed in October 2006) and the provision of services for 25 years. The ownership of the building will pass to the Trust after the 25 year concession period. The residual value (assessed by professional valuation) is £4,468,000. Throughout this period, the operator pays an agreed proportion of the car parking fees to the Trust; no other financial transactions take place. Since 2009/10, this has been accounted for under International Financial Reporting Standards and the asset together with the outstanding liability is required to be accounted for in the Statement of Financial Position.

Note 22.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	895	205
Obligations under finance leases	929	44
Obligations under PFI, LIFT or other service concession contracts*	1,861	-
Total current borrowings	**3,685**	**249**
Non-current		
Loans from DHSC	6,668	700
Obligations under finance leases	1,813	95
Obligations under PFI, LIFT or other service concession contracts*	17,565	-
Total non-current borrowings	**26,046**	**795**

* Obligations under PFI, LIFT and other services are made up of 2 balances: Radiology Managed Equipment Service of £6,965,000 at an interest rate of 3.9% with final payment in June 2027 and The Beacon centre PFI of £12,460,000 at an interest rate of 8.5% with final payment in April 2040.

Note 22.2 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	**905**	**139**	**-**	**1,044**
Cash movements:				
Financing cash flows - payments and receipts of principal	(25,765)	(755)	(1,413)	**(27,933)**
Financing cash flows - payments of interest	(258)	(255)	(1,219)	**(1,732)**
Non-cash movements:				
Transfers by absorption	32,498	3,317	16,302	**52,117**
Additions	-	68	4,518	**4,586**
Application of effective interest rate	184	227	1,219	**1,630**
Other changes	-	-	19	**19**
Carrying value at 31 March 2021	**7,564**	**2,741**	**19,426**	**29,731**

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £24,981,000 (Interim loan principal £24,917,000 and interest accrual £64,000).

Note 22.3 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	**1,105**	**222**	**-**	**1,327**
Prior period adjustment	-	-	-	**-**
Carrying value at 1 April 2018 - restated	**1,105**	**222**	**-**	**1,327**
Cash movements:				
Financing cash flows - payments and receipts of principal	(200)	(84)	-	**(284)**
Financing cash flows - payments of interest	(21)	(10)	-	**(31)**
Non-cash movements:				
Application of effective interest rate	21	11	-	**32**
Carrying value at 31 March 2020	**905**	**139**	**-**	**1,044**

Note 23 Finance leases

As a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2021 £000	Restated * 31 March 2020 £000
Gross lease liabilities	**3,058**	**147**
of which liabilities are due:		
- not later than one year;	937	47
- later than one year and not later than five years;	2,121	100
Finance charges allocated to future periods	(317)	(8)
Net lease liabilities	**2,741**	**139**
of which payable:		
- not later than one year;	928	44
- later than one year and not later than five years;	1,813	95

* Restaed to allign gross and net lease liabilities.

Leases for energy infrastructure:
During 2011/12, the Trust entered into a contract with a private sector partner, Schneider Electric, for the provision and installation of energy infrastructure assets. The total value of the contract was £7,867,000 and the installation work commenced in June 2011 and was completed during the 2012/13 financial year. The overall leasing commitment for the contract amounts to £7,867,000 and repayments commenced in December 2012 and will be paid annually over the 12 year term of the lease. This is a standard lease paid in periodic fixed annual payments and there are no restrictions or renewable options.

The remaining low value leases relate to equipment leased over a five-year period.

Note 24.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Total
	£000	£000	£000	£000
At 1 April 2020	**133**	**-**	**38**	**171**
Transfers by absorption	240	571	43	**854**
Change in the discount rate	19	66	-	**85**
Arising during the year	485	904	31	**1,420**
Utilised during the year	(84)	(45)	(3)	**(132)**
Reversed unused	(29)	-	(32)	**(61)**
Unwinding of discount	12	31	-	**43**
At 31 March 2021	**776**	**1,527**	**77**	**2,380**
Expected timing of cash flows:				
- not later than one year;	80	83	77	**240**
- later than one year and not later than five years;	327	338	-	**665**
- later than five years.	369	1,106	0	**1,475**
Total	**776**	**1,527**	**77**	**2,380**

Pensions: early departure costs

Pensions - early departure costs relate to Pre1995 early retirements. These are calculated on figures supplied by the NHS Pensions Agency and a significant amount of the payments are expected to be greater than one year.

Pensions: injury benefits

Injury Benefit provisions are based on figures supplied by the NHS Pensions Agency. A significant amount of the payments are expected to be for a period greater than 1 year.

Legal claims

The provisions are based on the expected values and probabilities quantified by NHS Resolution. The outcome of these cases are inherently uncertain and the timing of payments is dependant on the progression of each case. The figures included in the summary are based purely on the Trust's excess reflecting the fact that the NHS Resolution makes the majority of payments direct. See also note 26.

Note 24.2 Clinical negligence liabilities

At 31 March 2021, £163,597k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Somerset NHS Foundation Trust (31 March 2020: £1,248k).

Note 25 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(33)	(15)
Gross value of contingent liabilities	**(33)**	**(15)**
Net value of contingent liabilities	**(33)**	**(15)**

Note 26 Contractual Capital Committments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	21,823	394
Intangible assets	81	-
Total	**21,904**	**394**

Note 26 On-SoFP PFI, LIFT or other service concession arrangements

Note 27 The Beacon Centre

The project agreement is with the Taunton Linac Company Limited (the operator) for the provision of an Oncology and Haematology Centre on the Musgrove Park Hospital site (The Beacon Centre) including the supply and maintenance of the building and major medical equipment within the facility. The facility opened in May 2009 and provides state of the art non-surgical cancer services to the residential population of Somerset, in a suitable location and setting at Somerset NHS Foundation Trust. The new Oncology and Haematology Centre provides:

- Two Linear Accelerators (a third has been purchased by the Trust)
- One simulation suite with processing and treatment planning facilities
- 18 bed Oncology Ward
- Chemotherapy suite for 22 day patients
- Outpatients suite with 4 consulting and 8 examination rooms

Key Features of the Scheme:

In return for an agreed monthly payment, the following facilities are provided to the Trust by the Operator plus associated hard Facilities Management and asset renewal services:

- Inpatient and Outpatient facilities
- Radiotherapy treatment area
- Administrative offices
- Public spaces

Under the Project Agreement, the above facilities are provided at a pre-determined level of quality for the 30 year term (excluding the construction period).

The operator has also procured, installed, and will maintain and replace major medical equipment for the full 30 years of the operating period. The major equipment requirements include two Linear Accelerators. However, soft Facilities Management services such as portering, catering and cleaning are provided by the Trust and are outside the scope of this PFI project.

Nature of Payment

The Operator provides the services in return for an annual service charge. In covering payment for facilities, other services and financing, the annual service charge is unitary in nature. The Trust has agreed a payment mechanism that incorporates the principles of the NHS Standard Form contract. This relates payment to the successful (or otherwise) achievement of the service and quality standards set out in the output specification. The unitary payment can be abated for instances of non-performance against the standards in the output specification up to a maximum of 100% of the unitary fee, which fall into three areas:

i) Failure events – where there is a failure to meet a specific service standard relating to a particular area of the hospital.

ii) Failure events – relating to the Radiotherapy Equipment.

iii) Quality failures – where there is a failure to supply a service across a wider range of parameters, which cannot be attributed to a specific area of the hospital.

The unitary payment relating to the Beacon Centre is set by the contract between the Trust and the operator and is subject to an inflationary uplift based on the Retail Price Index (RPI). The total unitary payment for 2020/21 amounted to £3,984,000 and for 2021/22 will be £3,984,000. The value of the liability at 31 March 2021 was £12,462,000 and the net book value of the assets was £11,463,000.

Property ownership

The site on which the new Oncology facilities have been built is in the freehold ownership of the Trust.

Expiry of contract

On expiry of the contract (May 2039), the facility will revert to the ownership of the Trust for no payment.

Note 27.1 Provision of Multi-Storey Car Park

This is a public private partnership project (PPP). It relates to the building of a car park (completed in October 2006) and the provision of services for 25 years. The ownership of the building will pass to the Trust after the 25 year concession period. The residual value (assessed by professional valuation) is £4,468,000. Throughout this period, the operator pays an agreed proportion of the car parking fees to the Trust; no other financial transactions take place. Since 2009/10, this has been accounted for under International Financial Reporting Standards and the asset together with the outstanding liability is required to be accounted for in the Statement of Financial Position. The asset and liability are summarised below:

	31 March 2021
	£000
Net Book Value of asset (included in property, plant and equipment, note 15)	6,642
Liability (see deferred PFI income, note 21)	2,716

Note 27.2 Managed Equipment Solution for Diagnostic Imaging

On 20 July 2017 the Trust entered into a contract for the provision of a managed service contract within diagnostic imaging. The contract is for the following services:

-A Facilities Infrastructure Replacement Programme (FIRP), which includes the replacement, installation and decommissioning of all assets within the department along with an increase of modalities for ultrasound, MRI and CT scanning;

-The provision of a fully inclusive “Gold Standard” maintenance cover for the department, that includes all parts, durables and labour;

-The provision of a guaranteed uptime availability of the facility to perform diagnostic testing and reporting;

-A consumables management service;

-A full inventory management service;

-Technical training for all modalities;

-Professional training availability for radiographer reporting courses;

-Data collection and analysis to allow for patient level costing within the department;

-Market, professional, technical and analytical intelligence to work in partnership with the Trust, for the purposes of delivering continual improvement in quality and practice across the diagnostic imaging department;

The service provider receives payment in two elements:-

-A managed facility service paid for through a unitary payment fixed for the duration of the contract apart from annual RPI indexation, paid quarterly in advance.

-A consumables management service paid for through a quarterly payment in advance based on an estimate of annual consumption. An assessment of actual consumables provided is made each quarter and either a balancing invoice or credit note raised as appropriate.

A set of performance parameters has been agreed with the managed service provider. Penalties will apply if performance failures are not corrected within the agreed remedial period.

The accountancy treatment is that ownership of the Trust’s existing asset portfolio within the scope of the managed service has been transferred to the managed service provider at fair market value. The assets have been recapitalised to the balance sheet under IFRIC 12. New equipment bought by the service provider has been capitalised under IFRIC 12 where their useful lives are fully utilised during the 10 years of the managed equipment solution agreement. Where new asset lives extend beyond the 10 years of the agreement equipment has been accounted for as operating leases.

The total unitary payment made to the managed equipment solution provider during the 2020/21 financial year for the managed facility service was £2,270,000 and consumables management service of £1,125,000. The values of payments due for 2021/22 for the managed facility service is £900,000.

Note 27.3 Imputed finance lease obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position. There is no comparative data as the Trust acquired Taunton and Somerset NHS FT on 1 April 2020 and the balance sheet is transfer through absorption at that date:

	PFI Schemes	Other Service Concessions	31 March 2021
	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**24,912**	**8,536**	**33,448**
Of which liabilities are due			
- not later than one year;	1,875	1,322	3,197
- later than one year and not later than five years;	5,950	5,130	11,080
- later than five years.	17,087	2,084	19,171
Finance charges allocated to future periods	(12,450)	(1,572)	(14,022)
Net PFI, LIFT or other service concession arrangement obligation	**12,462**	**6,964**	**19,426**
- not later than one year;	810	1,051	1,861
- later than one year and not later than five years;	2,253	4,081	6,334
- later than five years.	9,399	1,832	11,231

The obligations above relates to the Beacon Centre (PFI cancer facility) which opened in May 2009 and the radiology managed facility service (other service consessions) which commenced 1 August 2017.

Note 27.4 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	PFI Schemes	Other Service Concessions	31 March 2021
	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**67,961**	**16,065**	**84,026**
Of which payments are due:			
- not later than one year;	3,978	2,570	6,548
- later than one year and not later than five years;	15,910	10,280	26,190
- later than five years.	48,073	3,215	51,288

Note 27.5 Analysis of amounts payable to service concession operator

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

	PFI Schemes	Other Service Concessions	31 March 2021
	£000	£000	£000
Unitary payment payable to service concession operator	**3,981**	**2,271**	**6,252**
Consisting of:			
- Interest charge	1,026	193	1,219
- Repayment of balance sheet obligation	649	765	1,414
- Service element and other charges to operating expenditure	2,306	1,313	3,619
Total amount paid to service concession operator	**3,981**	**2,271**	**6,252**

Note 28 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT arrangements:

Staff Nursery

This is accounted for off the Statement of Financial Position. The operator is required to provide childcare facilities over the concession period, of 30 years from 2003, therefore the arrangement has 12 years to run. The services are provided to Trust employees in the first instance and to the public thereafter. The land was provided by the Trust on a 99 year lease. Other than this, there is no financial cost to the Trust. The land and building will revert to Trust ownership at the end of the 99 year lease.

Note 29 Financial instruments

Note 29.1 Financial risk management

IFRS 9, dealing with financial instruments, require disclosure of the role that financial instruments have had during the year in creating or changing the risks the Trust faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with local Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which these standards mainly apply.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest-rate risk

The Trust has the power to borrow for capital expenditure subject to affordability as confirmed by NHS Improvement, the independent regulator. Some of the financial instruments have a fixed interest rate which means the Trust is exposed to interest rate risk. If the interest rate moves interest paid could be higher than the market rates, and/or interest received could be lower than the market rates.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the trade and other receivables note (Note 19.1).

Cash deposited with financial institutions outside the Government Banking Service at 31 March 2021 was £1,530,000 (2019/20: £2,000). These balances relate to the Primary Care Practices bank accounts. The credit risk on this is negligible.

Liquidity risk

The Trust's net operating costs are incurred under contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from retained surpluses and funds obtained from the Independent Trust Financing Facility or central funding from the Department of Health and Social Care in the form of Public Dividend Capital. The Trust has undertaken a going concern review involving a year's future cash flow assessment. Following this review, the Trust has concluded that it is not exposed to significant liquidity risks.

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups and Specialist Commissioners, which are financed from resources voted annually by Parliament .

The Trust currently finances its capital expenditure from funds made available from cash surpluses generated by the Trust's activities. The PFI project relating to the Beacon Centre has created liabilities on the Statement of Financial Position that the Trust is committed to meeting for the duration of the service concession. This liability is subject to an annual inflationary uplift. Similarly, the Trust is committed to the Energy Project which added a leasing liability to the Trust's SOFP in 2011/12 and which increased in 2012/13. The Trust is committed to the payment of this leasing obligation for the duration of the 12 year lease term. The Trust has also entered into a radiology managed facility service for a period of 10 years and is committed to meeting the liabilities created on the statement of financial position for the duration of the agreement. In addition, the Trust completed the new surgical ward development (the Jubilee Building) during 2013/14 and supported existing cash reserves to fund this development by drawing against a £12 million loan facility from the Foundation Trust Financing Facility. The approval of major capital projects such as the Jubilee Building are subject to comprehensive project development processes involving the creation of separate project boards, continuous scrutiny by the Trust Board and also through the involvement of NHS partners including the Trust's principal CCG and NHS Improvement.

Investment risk

The Trust has the ability to invest surplus cash; the risks resulting from transactions of this nature are mitigated by the Trust's treasury and investment policies and protocols and by the reporting of performance against financial targets to NHS Improvement.

Note 29.2 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	21,162	**21,162**
Cash and cash equivalents	75,392	**75,392**
Total at 31 March 2021	**96,554**	**96,554**

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	8,687	**8,687**
Cash and cash equivalents	28,579	**28,579**
Total at 31 March 2020	**37,266**	**37,266**

Note 29.3 Carrying value of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	7,563	**7,563**
Obligations under finance leases	2,742	**2,742**
Obligations under PFI, LIFT and other service concession contracts	19,426	**19,426**
Trade and other payables excluding non financial liabilities	78,816	**78,816**
Total at 31 March 2021	**108,547**	**108,547**

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	905	**905**
Obligations under finance leases	139	**139**
Trade and other payables excluding non financial liabilities	17,295	**17,295**
Total at 31 March 2020	**18,339**	**18,339**

Note 29.4 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 Note 1
	£000	£000
In one year or less	84,774	17,591
In more than one year but not more than five years	18,106	344
In more than five years	22,747	551
Total	**125,627**	**18,486**

Note 1

The prior year comparator figures in this note were previously prepared on a discounted cash flow basis. In line with the recommendations of the Group Accounting Manual this has been updated to be shown on an undiscounted basis. This has no impact on the value of the liabilities within the Statement of Financial Position.

Fair values of financial assets and liabilities

There is no significant difference between the book values and fair values of the Trust's financial assets and liabilities at 31 March 2020.

Note 30 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				
Bad debts and claims abandoned	128	724	27	8
Stores losses and damage to property	-	-	1	-
Total losses	**128**	**724**	**28**	**8**
Special payments				
Ex-gratia payments	28	41	-	-
Total special payments	**28**	**41**	**6**	**26**
Total losses and special payments	**156**	**765**	**34**	**34**
Compensation payments received	-	-	-	5

Note 31 Related parties

Transactions between the Trust and its related parties are reviewed each year and declared below.

During the year, there were no related party transactions relating to board members or members of the key management staff or parties related to them.

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are summarised below:

These transactions represent income and expenditure from a range of services and supplies. Expenditure, for example, includes the purchase of an ambulance service. Income relates to the commissioning of patient care services, the provision of estates services and the sale of drugs.

		Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
		2020/21	2020/21	31/03/2021	31/03/2021
		£000	£000	£000	£000
Department of Health and Social Care		0	306	0	0
NHS England		16	135,520	6,689	6,742
Health Education England		1	20,000	0	212
NHS Bath and North East Somerset, Swindon and Wiltshire CCG		0	760	0	5
NHS Bristol, North Somerset and South Gloucestershire CCG		0	2,047	0	166
NHS Dorset CCG		0	1,371	0	0
NHS Kernow CCG		38	268	0	0
NHS Devon CCG		0	9,553	0	51
NHS Somerset CCG		0	394,336	1,547	5,769
Devon Partnership NHS Trust		31	890	132	0
North Bristol NHS Trust		203	108	131	12
Royal United Hospitals Bath NHS Foundation Trust		315	399	34	354
Dorset County Hospitals NHS Foundation Trust		485	17	8	0
Dorset Healthcare University NHS Foundation Trust		166	4	2	1
Gloucester Hospitals NHS Foundation Trust		2,141	0	360	0
Great Western Hospitals NHS Foundation Trust		1	61	0	0
Royal Devon & Exeter NHS Foundation Trust		319	1,591	74	29
Avon & Wiltshire Mental Health Partnership NHS Trust		5	750	0	0
University Hospitals Bristol and Weston NHS Foundation Trust (formerly University Hospital Bristol NHS Foundation Trust and Weston Area Health NHS Trust)		1,177	163	523	81
Yeovil District Hospital NHS Foundation Trust		4,013	2,086	768	576
	7	13,605	0	35	0
NHS Property Services		2,105	0	222	0
Other NHS bodies		1,484	3,783	746	530
Charitable Funds		82	480	40	0

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.

NHS Pension Scheme	53,611	0	5,223	0
Somerset County Council	181	3,512	88	696
Other central and local government bodies	32,302	81	9,358	1,368
Other related parties				
Wiveliscombe GP Surgery	0	820	0	0
North Petherton GP Surgery	0	551	0	0
Warwick House GP Surgery	0	943	0	94
Creech House GP Surgery	0	578	0	177
SPS Facilities Limited	7,812	190	0	32
Integrated Pathology Partnerships Limited	16	633	3	102
South West Pathology Services LLP	7,815	216	0	101

The equivalent disclosures made for 2019/20 were as follows:

	Payments to related party	**Receipts from related party**	**Amounts owed to related party**	**Amounts due from related party**
	2019/20	**2019/20**	**31/03/2020**	**31/03/2019**
	£000	**£000**	**£000**	**£000**
Department of Health and Social Care	0	162	0	0
NHS England	0	15,865	658	1,385
Health Education England	1	2153	0	136
NHS Bath and North East Somerset CCG (merged with NHS Wiltshire CCG on 1st April 20200	0	122	0	22
NHS Bristol, North Somerset and South Gloucestershire CCG	0	201	5	58
NHS Dorset CCG	0	183	0	59
NHS Kernow CCG	1	40	0	8
NHS Devon CCG	0	572	5	114
NHS Somerset CCG	0	147,470	0	1,344
NHS Wiltshire CCG (merged with NHS Bath and North East Somerset CCG on 1st April 2020)	0	423	0	129
Devon Partnership NHS Trust	30	432	0	251
North Bristol NHS Trust	0	22	0	7
Royal United Hospitals Bath NHS Foundation Trust	229	368	23	172
Weston Area Health NHS Trust (acquired by University Hospital Bristol NHS Foundation Trust on 1st April 2020)	0	13	0	13
Dorset County Hospitals NHS Foundation Trust	1,486	23	41	0
Dorset Healthcare University NHS Foundation Trust	174	1	2	0
Gloucester Hospitals NHS Foundation Trust	356	0	27	0
Great Western Hospitals NHS Foundation Trust	29	0	27	0
Royal Devon & Exeter NHS Foundation Trust	5	204	1	0
Avon & Wiltshire NHS Foundation Trust	51	756	12	1
University Hospital Bristol NHS Foundation Trust (acquired Weston Area Health NHS Trust on 1st April 2020)	42	13	5	0
Yeovil District Hospital NHS Foundation Trust	2,513	516	635	65
Taunton and Somerset NHS Foundation Trust	7,537	4,296	1,401	2,038
NHS Resolution	472	0	35	0
NHS Property Services	1,681	0	512	0
Other NHS bodies	504	1,247	355	109

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.

NHS Pension Scheme	17,922	0	1,754	0
Somerset County Council	0	3,318	0	647
Other central and local government bodies	3,531	109	2,294	151
Other related parties				
Wiveliscombe GP Surgery	0	783	0	133
North Petherton GP Surgery	0	317	0	46

Note 32 Transfers of functions from other NHS Bodies

On 1 April 2020, Somerset Partnership and Taunton and Somerset NHS Foundation Trusts merged forming Somerset NHS Foundation Trust. The transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain £132,484k corresponding to the net assets @ 31/03/2020 transferred is recognised within The Statement of Comprehensive Income, but not within operating activities. The audited financial statements for Taunton and Somerset NHS Foundation Trust can be found on the Trust website: https://www.somersetft.nhs.uk/publications/reports-plans-and-publications/annual-accounts/

Note 33 Events after the reporting period

On 4 May 2021; the Trust entered into a Strategic Research agreement with Sensyne Health Plc. As part of this agreement, the Trust were allocated 1,428,571 ordinary shares @ 10p each.

Note 34 Employee benefits

	Permanent £000	Other £000	2020/21 Total £000	2019/20 Total £000
Salaries and wages	290,477	3,157	**293,634**	95,412
Social security costs	29,389	-	**29,389**	8,480
Apprenticeship levy	1,468	-	**1,468**	478
Employer's contributions to NHS pension scheme	53,611	-	**53,611**	17,922
Temporary staff	-	34,530	**34,530**	11,532
Total gross staff costs	**374,945**	**37,687**	**412,632**	**133,824**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**374,945**	**37,687**	**412,632**	**133,824**
Of which				
Costs capitalised as part of assets	2,547	-	**2,547**	244

Note 34.1 Average number of employees (WTE basis)

	Permanent Number	Other Number	2020/21 Total Number	2019/20 Total Number
Medical and dental	710	28	**738**	113
Ambulance staff	3	-	**3**	-
Administration and estates	2,114	94	**2,208**	518
Healthcare assistants and other support staff	1,327	246	**1,573**	949
Nursing, midwifery and health visiting staff	2,290	177	**2,467**	966
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	1,275	17	**1,292**	615
Healthcare science staff	145	8	**153**	-
Other	-	28	**28**	77
Total average numbers	**7,864**	**598**	**8,462**	**3,238**
Of which:				
Number of employees (WTE) engaged on capital projects	46	-	**46**	6

Note 34.2 Reporting of Compensation Schemes - Exit Packages 2020/21

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
£10,000 - £25,000	-	1	**1**
£25,001 - 50,000	-	2	**2**
£50,001 - £100,000	2	2	**4**
Total number of exit packages by type	**2**	**5**	**7**
Total cost (£)	£155,000	£221,000	**£376,000**

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally-agreed arrangements or local arrangements for which Treasury approval was required.

Reporting of compensation schemes - exit packages 2019/20

There were no exit packages during 2019/20.

Exit packages: other (non-compulsory) departure payments

	2020/21		2019/20	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	5	221	-	-
Total	**5**	**221**	**-**	**-**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Note 34.3 Directors Remuneration

The aggregate amounts payable to directors were:

	2020/21 Total £000	2019/20 Total £000
Salary	1,387	670
Employer's National Insurance contributions	179	86
Employer's pension contributions	199	91
Total	1,765	847

Further details of directors' remuneration can be found in the remuneration report.

Benefits are accruing under the NHS defined benefit pension scheme to 9 of the Directors (2019/20: 9). No benefits are accruing under any money purchase schemes.

Year end report 2020/21

Somerset NHS Foundation Trust

June 2021

I confirm that this is the final version of our ISA 260 Audit Memorandum relating to our audit of the 2020/21 financial statements for Somerset NHS Foundation Trust. This document was discussed and approved by the Trust's Audit Committee on 20 May 2021 and subsequently re-issued to the Committee on 10 June 2021.

Jonathan Brown

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Jon Brown

Engagement Lead for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

11 June 2021

Our audit opinions and conclusions:	
Financial Statements: unqualified	Use of resources: no significant weaknesses identified

Key contacts

Your key contacts in connection with this report are:

Jon Brown
Engagement Lead
Tel: 07799 035341
Jonathan.brown@kpmg.co.uk

Duncan Laird
Senior Manager
Tel: 07776 476430
Duncan.laird@kpmg.co.uk

Alex Middleton
In-charge
Tel: 07769 671985
Alexander.middleton@kpmg.co.uk

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Introduction

To the Audit Committee of Somerset NHS Foundation Trust

We are pleased to have the opportunity to meet with you on 20 May 2021 to discuss the results of our audit of the financial statements of Somerset NHS Foundation Trust (the 'Trust'), as at and for the year ended 31 March 2021.

We are providing this report in advance of our meeting to enable you to consider our findings and hence enhance the quality of our discussions. This report should be read in conjunction with our audit plan and strategy report, presented on 19 January 2021. We will be pleased to elaborate on the matters covered in this report when we meet.

This is the first audit of the merged Trust and it has been a challenging audit. There were a number of transactions that were finalised close to the year end due to late central guidance from NHSE/I, for example accounting for central purchased PPE, funding for holiday pay accruals and guidance on the settlement of the Flowers legal claim. This, coupled with the additional complexity in agreeing balances back to the underlying general ledger as a result of the change in finance system and some sickness in the audit team has provided additional challenges.

In addition, the regulation of NHS FT audits has changed during the year and now all FTs with income or expenditure greater than £500m fall under the scope of the AQR, which results in additional work and more scrutiny.

However, our audit is progressing well and nearing completion. There have been no significant changes to our audit plan and strategy other than an update to our assessment of the significant risk over recognition of expenditure. Subject to your approval of the financial statements, we expect to be in a position to sign our audit opinion, provided that the outstanding matters noted on page 4 of this report are satisfactorily resolved.

We expect to issue an unmodified Auditor's Report on the financial statements and have not identified any significant weaknesses in your arrangements to secure value for money. In addition to this opinion we will prepare our Auditor's Annual Report which contains a narrative summary of our findings to be published on the Trust's website. This is planned to be completed by the time we sign our audit opinion.

We draw your attention to the important notice on page 4 of this report, which explains:

- The purpose of this report;
- Limitations on work performed; and
- Restrictions on distribution of this report.

Yours faithfully,

Jon Brown

20 May 2021

How we have delivered audit quality

Audit quality is at the core of everything we do at KPMG and we believe that it is not just about reaching the right opinion, but how we reach that opinion. We consider risks to the quality of our audit in our engagement risk assessment and planning discussions.

We define 'audit quality' as being the outcome when audits are:

– **Executed consistently**, in line with the requirements and intent of **applicable professional standards** within a strong **system of quality controls** and

– All of our related activities are undertaken in an environment of the utmost level of **objectivity**, **independence**, **ethics** and **integrity**.

The National Audit Office (NAO) has issued a document entitled Code of Audit Practice (the Code). This summarises where the responsibilities of auditors begin and end and what is expected from the Trust.

External auditors do not act as a substitute for the Trust's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

Important notice

This report is presented under the terms of our audit engagement letter.

— Circulation of this report is restricted.

— The content of this report is based solely on the procedures necessary for our audit.

This report has been prepared for the Audit Committee, in order to communicate matters of interest as required by ISAs (UK), and other matters coming to our attention during our audit work that we consider might be of interest, and for no other purpose.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone (beyond that which we may have as auditors) for this report, or for the opinions we have formed in respect of this report.

Purpose of this report

This report has been prepared in connection with our audit of the financial statements of Somerset NHS Foundation Trust (the 'Trust'), prepared in accordance with International Financial Reporting Standards ('IFRSs') as adapted by the Group Accounting Manual issued by the Department of Health and Social Care, as at and for the year ended 31 March 2021. This report summarises the key issues identified during our audit but does not repeat matters we have previously communicated to you.

Limitations on work performed

This report is separate from our audit report and does not provide an additional opinion on the Trust's financial statements, nor does it add to or extend or alter our duties and responsibilities as auditors. We have not designed or performed procedures outside those required of us as auditors for the purpose of identifying or communicating any of the matters covered by this report.

The matters reported are based on the knowledge gained as a result of being your auditors. We have not verified the accuracy or completeness of any such information other than in connection with and to the extent required for the purposes of our audit.

Status of our audit

Our audit is now complete. Once we have received copies of the signed annual report and financial statements and the management representations letter we will sign our audit opinion.

Restrictions on distribution

The report is provided on the basis that it is only for the information of the Audit Committee of the Trust; that it will not be quoted or referred to, in whole or in part, without our prior written consent; and that we accept no responsibility to any third party in relation to it.

Our audit findings

Significant audit risks

Page 8 – 12

Significant audit risk	Risk change	Our findings
Revenue Recognition	Decrease ▼	The results of our testing were satisfactory and we did not identify any significant issues. See page 8 for further details
Expenditure Recognition (updated from audit plan)	Stable -	The results of our testing overall were satisfactory. Our work identified errors in relation to accruals. See page 9 for further details
Valuation of land and buildings	Stable -	The results of our testing overall were satisfactory. Our work identified errors in relation to posting of revaluation movements. See pages 10 and 11 for further details

Key accounting estimates

Page 14

Valuation of land and buildings	We reviewed the calculations performed by the valuer, confirmed their accuracy, assessed the assumptions underpinning the valuation and compared the output to our own expectation based on external market data.

Value for money

Page 17 – 18

Under the Code of Audit Practice we are required to report to you if we have identified a significant weakness in the Trust's arrangements to securing economy, efficiency and effectiveness in its use of resources. We have nothing to report in this respect. Our Auditor's Annual Report contains our public commentary in regard to this work and will be issued at the same time as the audit opinion.

Whole of Government Accounts

Page 16

We intend to issue an unqualified Group Audit Assurance Certificate to the NAO regarding the Whole of Government Accounts submission, made through the submission of the summarisation schedules to Department of Health and Social Care

Audit misstatements

Page 27

We have identified five adjusted and two unadjusted audit differences in our work that are above our reporting threshold. Further details are in Appendix 5.

We have also identified six adjusted and two unadjusted audit differences in disclosures as a result of our work. Further details are in Appendix 5

Number of Control deficiencies

Page 24

Significant control deficiencies	6
Other control deficiencies	0
Prior year control deficiencies remediated	n/a

Other matters

In auditing the accounts of an NHS body auditors must consider whether, in the public interest, they should make a report on any matters coming to their notice in the course of the audit, in order for it to be considered by Trust members or bought to the attention of the public. There are no such matters we wish to bring to your attention. We intend to issue our certificate closing the audit alongside our audit opinion.

COVID-19: Audit implications

The table below identifies the specific areas of our audit that were expected to be affected by the COVID-19 pandemic, and how our audit differs from those prior to the pandemic.

Materiality	– Materiality was calculated on a normalised basis – one-off funding such as Covid-19 top-up funding was removed from the benchmark used to calculate materiality to allow materiality to not be artificially inflated by the non-recurrent funding received.
Subsequent events disclosures	– Due to the rapidly evolving situation, we considered the impact of events subsequent to the reporting date to determine whether subsequent events should be reflected (adjusting) vs. disclosed (non-adjusting) in the financial statements. At the time of writing our report we have not identified any issues which require reporting. – We will continue to monitor this through to the date of the auditor's report.
Audit effort and audit fees	– We have not charged additional fees due to the challenges of remote working as we consider that the extra costs incurred are offset by efficiencies inherent to home working.
Going concern	– The required enhanced procedures under the revised ISA (UK) 570 on your risk assessment process and fact that we need to perform procedures through to the date of the auditors' report, which is due to be later than in prior years, meant a different approach in this key area. – Practice Note 10 (and the Group Accounting Manual) have be[illegible]ated during the year to reiterate the continuation of services principal and therefore, despite the ongoing uncertainty of fun[illegible]e have concluded that it is appropriate to prepare your financial statements on a going concern basis.
Accounting estimates **See page 13**	– The risk of material misstatement relating to the valuation of property, plant and equipment has altered due to the higher degree of estimation uncertainty resulting from current economic conditions. However it is noted that RICS have issued guidance reiterating that an inherent uncertainty paragraph is not expected in every asset valuation issued (as was common at the height of the pandemic in the prior year). – We evaluated the methods, assumptions and data used to derive the estimates for asset valuations to obtain evidence that they are appropriate in the context of the financial reporting framework and are, when appropriate, based on conditions and events at the measurement date. We considered whether management has appropriately addressed the increased estimation uncertainty when selecting the point estimate. – We evaluated whether the Trust had included the required disclosures, including significant assumptions about the future and other major sources of estimation uncertainty, and whether they include the information necessary to achieve the fair presentation of the financial statements as a whole.

COVID-19: Audit implications (contd.)

Obtaining sufficient appropriate audit evidence	– There was an extension to the standard timetable (to 15th June 2021) for the completion of our audit to enable us to obtain sufficient appropriate audit evidence to support our audit opinion. This was made for all providers and was to allow auditors more time to:
	  – modify audit procedures when expected audit evidence was unavailable;
	  – collate external confirmations or perform alternative audit procedures; or
	  – allow further time for the settlement of invoices.
	– We adapted our testing methods to respond to challenges of remote working:
	  – Using a Trust laptop to have read-only access to the finance system to be able to retrieve audit evidence directly ourselves; and
	  – stratifying sample populations by risk for the different NHS financial regimes within the period given their differing control environments.

Audit risks

1 Revenue recognition

Fraud risk related to overstatement of revenue

Significant audit risk

The risk

Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk.

We recognise that the incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the requirement to meet regulatory and financial covenants, rather than broader share-based management concerns.

The system has been provided a set funding amount for periods 7-12. As the allocation for the Trust is unlikely to cover the level of expenditure in the period, this may create an incentive for revenue to be manipulated.

As much of the Trust's income for 2020-21 has been contracted on a block basis our risk will be focused on the variable elements of income the Trust has received during the year and recognition at year end.

Our response

- We evaluated the design of controls in place for the Trust to monitor and reconcile the amount of funding due to be received from CCGs;
- We inspected the claims made for additional funding for April to September 2020 to verify that the Trust has appropriately claimed income to a break-even position in line with issued guidance;
- CCG income: We agreed a sample of commissioner income per the agreed funding schedules to payments received in the bank accounts to confirm that the agreed cash had been received;
- Income recognition: We completed sample testing of invoices for material income in the period prior to and following 31 March 2021 to determine whether income is recognised in the correct accounting period, in accordance with the amounts billed to the corresponding parties;
- Agreement of Balances: We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers and confirm the values they are disclosing within their financial statements to the value of income captured in the financial statements. We sought explanations for any variances over £300,000, and all balances in dispute, and challenged the Trust's assessment of the level of income they are entitled to and receipts that can be collected;
- Other income: We tested material other income balances by agreeing a sample of income transactions through to supporting documentation and bank balances.
- We carried out sample testing of year end income accruals to assess whether the actual value of income billed and received following 31 March 2021 agree to the amounts accrued.

Our findings

We have not identified any significant issues. We have agreed over 93% of CCG income to cash receipts and have completed sample testing over the remaining funding streams. Our assessment of the design of process level controls identified that the Trust has a good process in place but that it would need to be further formalised in order for us to be able to place reliance on it. We have received the final Agreement of Balances mismatch reports and confirmed that all identified mismatches are errors with counterparties.

Audit risks

2 Expenditure recognition

Fraud risk related to misstatement of expenditure

Significant audit risk

The risk

As the Trust has agreed an outturn total with local NHS partners for its expected financial performance there is a risk that non-pay expenditure may be manipulated in order to report that the control total has been met.

The setting of a target can create an incentive for management to misstate the level of non-pay expenditure compared to that which has been incurred.

After these targets were set additional funding streams have been made available to cover specific costs, meaning that budgets may allow management to overstate accruals if performance against the system funding envelope allows, for example to bring forward expenditure from 2021-22 to mitigate financial pressures.

We consider this would be most likely to occur through manipulating accruals and prepayments at the end of the year to bring forward expenditure which should be deferred to the following year. Note this risk has been updated since we issued our audit plan.

Our response

We performed the following procedures in order to respond to the significant risk identified:

- We assessed the design of process level controls for the authorisation of the purchasing of goods and services;
- We assessed the design of controls for developing manual expenditure accruals at the end of the year to verify that they have been completely and accurately recorded;
- We inspected invoices for material expenditure, in the period following 31 March 2021, to determine whether expenditure has been recognised in the correct accounting period;
- We selected a sample of year end accruals and inspected evidence of the actual amount paid after year end in order to assess whether the accrual had been accurately recorded.
- We inspected journals posted as part of the year end close procedures that increase the level of expenditure recorded in order to critically assess whether there was an appropriate basis for posting the journal and the value could be agreed to supporting evidence;
- We performed a retrospective review of prior year accruals in order to assess the accuracy with which accruals had been recorded at 31 March 2020 and considered the impact on our assessment of the accruals at 31 March 2021. We also compared the items that were accrued at 31 March 2020 to those accrued at 31 March 2021 in order to assess whether any items of expenditure may not have been accrued for at the year end that required recording.

Our findings

We have not identified any significant issues but have identified a number of audit adjustments – see Appendix 5. We have identified a small number of reclassification errors in expenditure and payables that the Trust has amended. Our work in this area has been made more difficult by the loss of key identifier information during the data migration to the new finance system and has resulted in a number of mapping errors. Our assessment of the design of process level controls identified that the Trust has a good process in place but that it would need to be further formalised in order for us to be able to place reliance on it.

Audit risks

3 Valuation of land and buildings

Risk of error relating to misstatement of asset valuations

Significant audit risk

The risk

Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with a 'modern equivalent asset'.

The predecessor organisations - Somerset Partnership FT and Taunton & Somerset FT – both applied alternative site methodology in their valuations, where the valuation was based on a model of a theoretical, idealised estate.

The land and buildings for Somerset FT will be a consolidation of the estates of the predecessor organisations.

The Trust is due to undertake a desktop revaluation of its land and buildings in year. The last full revaluation took place on 31 March 2020.

Our response

We have performed the following procedures designed to specifically address the significant risk associated with the valuation:

- We critically assessed the independence, objectivity and expertise of Cushman & Wakefield, the valuers used in developing the valuation of the Trust's properties at 31 March 2020;
- We inspected the instructions issued to the valuers for the valuation of land and buildings to verify they were appropriate to produce a valuation consistent with the requirements of the Group Accounting Manual;
- We compared the accuracy of the data provided to the valuers for the development of the valuation to underlying information, such as floor plans, and to previous valuations, challenging management where variances are identified;
- We critically assessed the controls in place for management to review the valuation and the appropriateness of assumptions used;
- We considered the carrying value of the land and buildings; including any material movements from the previous revaluations. We challenged key assumptions within the valuation, including the use of relevant indices and assumptions of how a modern equivalent asset would be developed, as part of our judgement;
- We performed inquiries of the valuers in order to verify the methodology that was used in preparing the valuation and whether it was consistent with the requirements of the RICS Red Book and the GAM;

Audit risks

3 Valuation of land and buildings (continued)

Risk of error relating to misstatement of asset valuations

Significant audit risk

The risk

Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with a 'modern equivalent asset'.

The predecessor organisations - Somerset Partnership FT and Taunton & Somerset FT – both applied alternative site methodology in their valuations, where the valuation was based on a model of a theoretical, idealised estate.

The land and buildings for Somerset FT will be a consolidation of the estates of the predecessor organisations.

The Trust is due to undertake a desktop revaluation of its land and buildings in year. The last full revaluation took place on 31 March 2020.

Our response (continued)

- We agreed the calculations performed of the movements in value of land and buildings and verify that these have been accurately accounted for in line with the requirements of the GAM; and
- Disclosures: We considered the adequacy of the disclosures concerning the key judgements and degree of estimation involved in arriving at the valuation.

Our findings

We have not identified any significant issues but have identified audit adjustments in relation to the postings of revaluation movements on individual assets – see Appendix 5. We reviewed the calculations performed by the valuer, confirmed their accuracy, assessed the assumptions underpinning the valuation and compared the output to our own expectation based on external market data. No significant issues have been identified.

Audit risks

4 Management override of controls[a]

Fraud risk related to unpredictable way management override of controls may occur

Significant audit risk

The risk

- Professional standards require us to communicate the fraud risk from management override of controls as significant.
- Management is in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.
- We have not identified any specific additional risks of management override relating to this audit.

Our response

- Our audit methodology incorporates the risk of management override as a default significant risk.
- In line with our methodology, we evaluated the design and implementation of controls over journal entries and post-closing adjustments.
- Assessed the appropriateness of changes compared to the prior year to the methods and underlying assumptions used to prepare accounting estimates.
- Assessed the appropriateness of the accounting for significant transactions that are outside the component's normal course of business, or are otherwise unusual.
- Assessed the full population of relevant journal entries to identify journals displaying high risk characteristics. We followed up each of these journals in order to assess the appropriateness and accuracy of the transaction posted.

Our findings

- We identified journal entries and other adjustments that met our high-risk criteria for further testing. No issues have been identified.
- We evaluated the valuation of land and buildings, including the consideration of movements in building cost indices and location factors and did not identify any indicators of management bias. See slide 13 for further discussion.
- We considered the merger to be a significant unusual transaction and performed testing to agree the values of assets and liabilities transferred from Taunton & Somerset FT and confirm that the accounting treatment was in line with the requirements of the GAM.

Note: (a) Significant risk that professional standards require us to assess in all cases.

Mandated risks

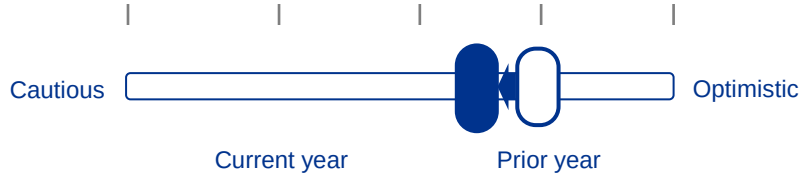
Risk	Why	Finding from the audit
Fraud risk from revenue recognition	Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk.	As much of the Trust's income for 2020-21 has been contracted on a block basis our risk has been focused on the variable elements of income the Trust has received during the year and recognition at year end. See page 8 for further details.
Fraud risk from management override of controls	Professional standards require us to communicate the fraud risk from management override of controls as significant because management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We have not identified any specific additional risks of management override relating to this audit.	Our procedures, including testing of journal entries, accounting estimates and significant transaction outside the normal course of business, no instances of fraud were identified.

Reconfirming materiality: We can confirm that we have completed all our audit work to the materiality that we proposed at the planning stage of the audit, which was a total materiality of £10m, performance materiality of £7.5m with an audit differences posting threshold of £0.3m.

Key accounting estimates - Overview

Our view of management judgement

Our views on management judgments with respect to accounting estimates are based solely on the work performed in the context of our audit of the financial statements as a whole. We express no assurance on individual financial statement captions.



Asset/liability class	Our view of management judgement	Balance (£m)	YoY change (£m)	Our view of disclosure of judgements & estimates	Further comments
Valuation of property, plant and equipment	Cautious / Neutral / Optimistic	201.2	122	Needs improvement / Neutral / Best practice	Although the land and buildings account balance has moved by £122m, this is mainly due to the transfer by absorption of £133m of assets relating to Taunton Somerset FT. We have reviewed the desktop valuation completed by Cushman & Wakefield and confirmed that it has been completed in line with RICS guidance and the requirements of the GAM. We have summarised our findings on pages 10 and 11.

Other matters

Annual report

We have read the contents of the Annual Report (including the Accountability Report, Directors Report, Performance Report and Annual Governance Statement (AGS)) and audited the relevant parts of the Remuneration Report. We have checked compliance with the NHS Group Accounting Manual (GAM) issued by Department of Health and Social Care and Foundation Trust Annual Reporting Manual (the ARM). Based on the work performed:

- We have not identified any inconsistencies between the contents of the Accountability, Performance and Director's Reports and the financial statements.
- We have not identified any material inconsistencies between the knowledge acquired during our audit and the director's statements. As Directors you confirm that you consider that 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 Trust's performance, business model and strategy.
- The part of the Remuneration Report that is required to be audited was found to contain a number of presentational errors, which have been corrected by management;
- The AGS is consistent with the financial statements and complies with relevant guidance; and
- The report of the Audit Committee included in the Annual Report includes the content expected to be disclosed as set out in the GAM and ARM and was consistent with our knowledge of the work of the Committee during the year.

Whole of Government Accounts

As required by the National Audit Office (NAO) we are required to provide a statement to the NAO on your consolidation schedule. We comply with this by checking that your summarisation schedule is consistent with your annual accounts. We have completed that work and found no matters to report.

Independence and Objectivity

ISA 260 also requires us to make an annual declaration that we are in a position of sufficient independence and objectivity to act as your auditors, which we completed at planning and no further work or matters have arisen since then.

Audit Fees

Our fee for the audit was £111,000. This fee has been updated since our audit plan agreed by the Audit Committee in January 2021 due the reduced audit requirements on the quality report. We have not completed any non-audit work at the Trust during the year.

Value for money

We are required under the Audit Code of Practice to confirm whether we have identified any significant weaknesses in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

In discharging these responsibilities we include a statement within the opinion on your accounts to confirm whether we have identified any significant weaknesses. We also prepare a commentary on your arrangements that is included within our Auditor's Annual Report, which is required to be published on your website alongside your annual report and accounts.

Commentary on arrangements

At the time of writing we have not yet finalised our commentary on the Trust's arrangements. However, we intend to issue the Auditor's Annual Report at the same time as we sign the audit opinion and will provide a copy to the Committee ahead of publication.

Response to risks of significant weaknesses in arrangements to secure value for money

As reported in our risk assessment we noted one risk of a significant weakness in the Trust's arrangements to secure value for money. Our response to this risk is set out on the following page. We have no recommendations to report.

Summary of findings

We have set out in the table below the outcomes from our procedures against each of the domains of value for money:

Domain	Risk assessment	Summary of arrangements
Financial sustainability	One significant risks identified	No significant weaknesses identified
Governance	No significant risks identified	No significant weaknesses identified
Improving economy, efficiency and effectiveness	No significant risks identified	No significant weaknesses identified

We confirm that we have not identified any significant weaknesses to be included within our value for money report.

Value for money - risk of significant weakness in arrangements

Domain - Financial sustainability	
Description of risk	**Our response**
Due to the current underlying deficit at both the Trust and Integrated Care System level there is a risk that the Trust does not have in place adequate arrangements to achieve financial sustainability in the medium term.	We will review the process followed to finalise the 2021-22 financial plan for both the Trust and the ICS together with arrangements in place to establish the required efficiency programme central to achievement of the 2021-22 plan.
	Our findings
	The Trust and its partners in the ICS have agreed and submitted plans for H1 2021/22 which deliver breakeven positions across the ICS. Discussions are underway to plan for H2 although further guidance is awaited on the funding regime that will be in place. The pre-Covid analysis identified a significant underlying deficit across the Somerset system and this will need to be revisited when further guidance is issued. However we consider the arrangements in place at the Trust to be appropriate and have not identified any significant weaknesses which would impact our value for money conclusion.

Appendix

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Appendix One

Revision to the Going Concern auditing standard

The revision of International Standard on Auditing (ISA) 570 relating to going concern applies for audits of the year ending 31 March 2021 and subsequent years. The revised standard introduces a requirement for all entities to complete a formal assessment of their status as a going concern and recommends that this is presented to the entity's Audit Committee.

Going concern is a fundamental concept to the preparation of the accounts for all entities, however it is interpreted separately in the public sector. While the risk associated with going concern is lower for NHS providers and commissioners care should be taken to ensure appropriate consideration is given to assessing whether there is a risk that the going concern status might not be appropriate.

Practice Note 10

The expectations for content to be included within a going concern assessment are set out in Audit Practice Note 10, which provides guidance for completing audits in the public sector in the UK. This sets out that a risk assessment for an entity in the public sector must at a minimum consider the following factors:

- What are the requirements of the reporting framework with regards to going concern; and
- Complete a risk assessment to consider whether there are any factors that would call into doubt the going concern status.

Requirements of the reporting framework

The definition of going concern is set out in the Financial Reporting Manual published by HM Treasury and supported by the DHSC Group Accounting Manual. These set out that:

"*For non-trading entities, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.*"

HM Treasury Financial Reporting Manual

The above therefore means that the assurance over the continued provision of services comes primarily from the publication of documents that set out that the services the organisation provides will continue to be provided. This means even if it is expected that the organisation will merge it is still considered to be a going concern.

In forming the going concern assessment providers and CCGs are required to consider whether there is a documented expectation for the services they provide to continue. This can consider factors such as:

- The requirement for health services to be provided is set out in legislation, such as the Health Act and Health and Social Care Act.
- The presence of published allocations, such as resource limits for CCGs, that confirm they will continue to receive funding.
- The presence of strategies, such as ICS long term plans, that plan for the continued provision of the services provided by the entity.

Appendix One

Revision to the Going Concern auditing standard

Risk assessment

The assessment of going concern should consider whether any risks have been identified that may mean the going concern assumption is not appropriate. As the key sources of assurance that services will provide are based on legislation and published strategies this should focus on whether there are any factors published that could lead to the services provided ending.

This assessment should consider the impact of the white paper that is currently being consulted on, particularly for the establishment of integrated care systems as legal entities.

Assessing financial performance

While the focus of the going concern assessment does not need to be on financial performance it is important that there is an understanding of the expected future financial performance, particularly if it is expected there may be deficits or gaps in funding available.

While deficits or gaps in funding may not lead to a modification of the going concern status they may still require disclosure within the going concern accounting policy so that users of the accounts can understand why the accounts are prepared on a going concern basis.

Demising entities

Where a CCG or provider is due to demise, for example due to merger with another entity, then they are still considered to be a going concern. The risk assessment will need to give the same consideration as set out above for the new merged entity to confirm that it is appropriate for it to be considered a going concern.

Conclusion

Following our consideration of the above we have concluded that management's decision, based on the continuation of services principle, to prepare the financial statements on a going concern basis is a reasonable one.

Appendix Two

Changes to our audit reports as a result of ISA (UK) changes

Going concern

Our conclusion on going concern has been updated to provide a positive confirmation that we have not identified any factors that would cause us to consider there is a material uncertainty over the Trust's status as a going concern.

Irregularities and fraud

In all audit reports, we are now required to **explain to what extent the audit was considered capable of detecting irregularities, including fraud.**

This is tailored to each audit. We include a summary of what risks we identified relating to fraud and what procedures we have performed in response to these.

Laws and Regulations

For audits of financial periods commencing on or after 15 December 2019, auditors are required to explain in the auditor's report to what extent the audit was considered capable of detecting irregularities, including fraud.

This was already a requirement for auditors of public interest entities (PIEs) in ISA (UK) 700 (Revised June 2016).

We also set out as part of the report the laws and regulations that we have identified that have a direct impact on the preparation of the Trust's accounts.

Appendix Three

Required communications with the Audit Committee

Type		Response
Our draft management representation letter		We have not requested any specific representations in addition to those areas normally covered by our standard representation letter for the year ended 31 March 2021.
Adjusted audit differences		There were adjusted audit differences above our reporting threshold. These had no impact on the reported financial performance of the Trust. See Appendix 5.
Unadjusted audit differences		There were a small number of unadjusted audit differences above our reporting threshold. See Appendix 5.
Related parties		There were no significant matters that arose during the audit in connection with the entity's related parties.
Other matters warranting attention by the Audit Committee		There were no matters to report arising from the audit that, in our professional judgment, are significant to the oversight of the financial reporting process.
Control deficiencies		We communicated to management in writing all deficiencies in internal control over financial reporting of a lesser magnitude than significant deficiencies identified during the audit that had not previously been communicated in writing.
Actual or suspected fraud, noncompliance with laws or regulations or illegal acts		No actual or suspected fraud involving management, employees with significant roles in internal control, or where fraud results in a material misstatement in the financial statements was identified during the audit.
Make a referral to the regulator		If we identify that potential unlawful expenditure might be incurred then we are required to make a referral to your regulator. We have not identified any such matters.
Issue a report in the public interest		We are required to consider if we should issue a public interest report on any matters which come to our attention during the audit. We have not identified any such matters.

Appendix Three

Required communications with the Audit Committee

Type		Response
Significant difficulties		No significant difficulties were encountered during the audit.
Modifications to auditor's report		None. We have complied with the new requirements of AGN07 which removes the need for Foundation Trusts to have audit findings reported via a long for audit report.
Disagreements with management or scope limitations		The engagement team had no disagreements with management and no scope limitations were imposed by management during the audit.
Other information		No material inconsistencies were identified related to other information in the annual report, Strategic and Directors' reports. The Annual report is fair, balanced and comprehensive, and complies with the revised guidance issued during March 2021.
Breaches of independence		No matters to report. The engagement have complied with relevant ethical requirements regarding independence.
Accounting practices		Over the course of our audit, we have evaluated the appropriateness of the Trust's accounting policies, accounting estimates and financial statement disclosures. In general, we believe these are appropriate.
Significant matters discussed or subject to correspondence with management		There were no significant matters arising from the audit that were discussed, or subject to correspondence, with management.
Certify the audit as complete		We are required to certify the audit as complete when we have fulfilled all of our responsibilities relating to the accounts and use of resources as well as those other matters highlighted above.
Standard representations requested		We have requested the standard letter of management representation.

Appendix Four

Recommendations raised and followed up

The recommendations raised as a result of our work in the current year are as follows:

Priority rating for recommendations					
1	Priority one: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	2	Priority two: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	3	Priority three: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
Financial Statements			
1	2	**Issue: Authorisation of New Starters** As part of our interim controls testing we selected a sample of new starters at the Trust, ensuring that they had been appropriately authorised to be added to the payroll system. As part of our sample we identified one new starter who's new starter form had not been appropriately authorised, but was however added to the payroll system. **Impact:** Without appropriate authorisation of new starters, new employees may be added to the payroll system without any form of review of the supporting details, leading to incorrect details being included within the payroll system. **Recommendation:** It is recommended that the Trust review their new starters controls in order to ensure they operate over all new categories of employees.	Accepted. This was an individual error and following a review the Trust has established a new process whereby a payroll colleague monitors the Payroll shared email inbox and the Payroll Officer will check that new starter forms are sent by the appropriate authorised signatory. In this particular instance, the payroll colleague was aware that the new starter had completed the recruitment process via the updates provided on the Payroll system and was ready to start.

Appendix Four

Recommendations raised and followed up

The recommendations raised as a result of our work in the current year are as follows:

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
Financial Statements			
2	2	**Issue: Authorisation of Leavers** During our interim audit we identified a leaver in our controls testing sample that had been deleted from the system without prior authorisation from a line manager. The background to this leaver was that they were a bank worker that had a duplicated employee profile within the payroll system. **Impact:** Payroll records that are deleted without relevant approval may lead to issues with the running of payroll runs. The further impact of this control recommendation is that a duplicate employee record existed within the system. **Recommendation:** All leavers prior to being deleted from the payroll system should be approved by a relevant line manager. The Trust should review their processes for checking for duplicate employee records to ensure no further records are present within the payroll system.	Accepted. The Trust supports the current approach and will action a deletion of a duplicate record if found to avoid any salary over payments. The Trust will continue to ensure processes are as effective possible to minimise this occurring.
3	3	**Issue: Authorisation of Payroll Run** We noted as part of our interim audit that the Payroll Team perform a number of checks over the monthly, mid-month and weekly payroll runs prior to the payment being made. Whilst a strong process has been identified, there is no formal signoff of the payroll run prior to the payment being issued. **Impact:** Without a formal signoff of the payroll run, it is difficult to evidence that all checks have been performed by the Payroll Team prior to the payment being made. Recommendation: It is recommended that a formal signoff be added to the final payroll run checks to evidence that all checks have been performed with any queries or issues rectified prior to the payment being made.	Accepted. The sign off process has now been amended so that 2 separate Payroll staff are required to check and sign the BACS report prior to sending the file for transfer.

Appendix Four

Recommendations raised and followed up

The recommendations raised as a result of our work in the current year are as follows:

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
Financial Statements			
4	3	**Issue: Asset Verification Exercise** As part of our interim audit, we identified that the Trust had not performed an asset verification exercise during the year in order to confirm the existence of assets. This was a control recommendation raised in the prior year audit of Taunton and Somerset NHS Foundation Trust. **Impact:** Without performing an annual verification exercise, the Trust risks holding assets within the Fixed Asset Register that no longer exist, or have been disposed of without the relevant information being sent to the Finance Team. We do note that the circumstances surrounding the Covid-19 pandemic have not made this exercise practical to complete during the year. **Recommendation:** The Trust should implement a formal annual verification exercise of all assets held within it's Fixed Assets Register to ensure any disposals or assets that are no longer suitable for use are identified	Accepted. During 2021/22; the Trust has plans in place to ensure the Fixed Asset Register is verified on a cyclical basis.
5	3	**Issue: Monthly Review of Accruals** As part of our final audit, we identified that whilst there was a process in place at the Trust to identify reasons for movements in accrual balances, this process was not consistent across all directorates and there was no set threshold for movement requiring investigation. **Impact:** Without having a formal review process in place, significant or unusual movements in accrual balances may not be investigated, leading to inaccurate accrual balances being recognised in the financial statements. **Recommendation:** We recommend that the Trust formalises their review of accruals on a monthly basis, implementing a set threshold for investigation and evidences the follow up of all variances above this, regardless of Directorate.	Accepted. The Trust will continue to review monthly control account reconciliations/detailed directorate reviews and monthly meetings with the team. In addition, the trust will put additional processes in place to ensure significant or unusual accrual movements would be recognised and reviewed in line with budget variances.

Appendix Four

Recommendations raised and followed up

The recommendations raised as a result of our work in the current year are as follows:

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
Financial Statements			
6	2	**Issue: Fixed asset system reports** In the prior year audit of Taunton & Somerset NHS Foundation Trust it was noted that the RAM (Real Asset Management) system had not been calibrated to correctly identify those assets which were true revaluations and those which were reversals of prior impairments. Following the merger, Somerset NHS FT engaged RAM to design a new asset register to resolve this issue. Our testing of the revaluation movements on an asset-by-asset basis identified that this issue has not been resolved. **Impact:** The RAM system cannot currently provide the reports and information required to accurately prepare the accounts. **Recommendation:** Management should go back to RAM to identify the issue with the new system and how this can be re-calibrated for next years audit.	Accepted. The Trust has spoken with Real Asset Management (RAM) and identified the technical migration issue which will be resolved in Q1 21-22.

Appendix Five

Audit Differences

Under UK auditing standards (ISA (UK) 260) we are required to provide the Audit Committee with a summary of unadjusted audit differences (including disclosure misstatements) identified during the course of our audit, other than those which are 'clearly trivial', which are not reflected in the financial statements. In line with ISA (UK) 450 we request that you correct uncorrected misstatements. However, they will have no effect on the opinion in our auditor's report, individually or in aggregate. As communicated previously with the Audit Committee, details of all adjustments greater than £300K are shown below:

Unadjusted audit differences (£m)				
No.	Detail	SOCI Dr/(cr)	SOFP Dr/(cr)	Comments
1	Dr Accruals Cr Non-pay expenditure	 (1.5)	£1.5	Our initial accruals testing identified a number of errors, such as accruals for expenditure relating to a government energy efficiency scheme which ended in March 2019 and accruals for which invoices had already been received and paid. The levels of errors in our initial sample meant that we were unable to conclude on the total population so we requested that management complete a full review of the year end accruals balance. This adjustment is to remove the accruals balances which management agree are incorrect.
2	Dr Trade receivables Cr Trade payables		£0.3 (£0.3)	From our reclassification test we have concluded that the negative debtor balance is overstated, and therefore 300k should be reclassified to creditors.
Total		(£1.5)	£1.5	

Under UK auditing standards (ISA (UK) 260) we are required to provide the Audit Committee with a summary of adjusted audit differences (including disclosures) identified during the course of our audit. The adjustments below have been included in the financial statements.

Adjusted audit differences (£m)				
No.	Detail	SOCI Dr/(cr)	SOFP Dr/(cr)	Comments
1	Dr Trade Debtors Cr Accruals		£2.66 (£2.66)	Misstatement was identified through initial conversations with the finance team regarding the reconciliation of accruals listings through to the draft financial statements. The misstatement had been caused by the incorrect posting of an accrued income journal to expenditure accruals due to the use of new account codes as a result of the systems migration that took place during the year.
Total		£0	£0	

Appendix Five

Audit Differences

Adjusted audit differences (£m)				
No.	Detail	SOCI Dr/(cr)	SOFP Dr/(cr)	Comments
2	Dr Agency Costs Cr Salaries and Wages	£2.17 (£2.17)		Misstatement was identified through initial conversations with the finance team regarding the reconciliation and mapping of agency costs to the employee benefits note in the financial statements. A portion of agency costs had been incorrectly included within salaries and wages and has since been updated.
3	Dr Trade Debtors Cr Trade payables		£0.35 (£0.35)	Misstatement relates to debit balances within the creditors ledger. Purpose of the misstatement is to therefore gross back up the balances to reflect the true position.
4	Dr Trade Debtors Cr Trade payables		£0.34 (£0.34)	Misstatement relates to credit balances within the debtors ledger. Purpose of the misstatement is to therefore gross back up the balances to reflect the true position.
5	Dr Impairments Cr Gain on revaluation	£6.7 (£6.7)		Through the review of the revaluation it was noted that the Trust had presented their revaluation net of impairments rather than calculating and disclosing revaluation movements on an asset-by-asset basis.
Total		£0	£0	

Appendix Five

Disclosure Misstatements

Under UK auditing standards (ISA (UK) 260) we are required to provide the Audit Committee with a summary of unadjusted audit differences (including disclosure misstatements) identified during the course of our audit, other than those which are 'clearly trivial', which are not reflected in the financial statements. In line with ISA (UK) 450 we request that you correct uncorrected misstatements. However, they will have no effect on the opinion in our auditor's report, individually or in aggregate.

Details of the adjusted disclosure misstatements are set out below. We also have one unadjusted disclosure misstatement.

Adjusted disclosure misstatements	
No.	**Detail**
1	**Audit Fee:** As part of our review of the audit fee disclosure in the draft financial statements, it was identified that the fee disclosed included irrecoverable VAT of £22k. In line with the GAM 2020/21 and the ICAEW Technical audit fees should be disclosed net of VAT. This has since been updated in the financial statements.
2	**Remuneration Report:** Our review of the Remuneration Report identified a number of errors, including incorrect categorisation of salary and the omission of employee contributions from the overall increase in CETV calculation. All such errors have since been updated.
3	**Annual Report Disclosures:** Our review of the Annual Report identified a number of key disclosures required by the Annual Report Manual to be missing. These included the future policy table for Senior Manager Remuneration and the Trade Union Facility Time publications. All disclosure omissions have since been updated.
4	**Headcount Disclosure:** We noted in our review of the Headcount disclosure calculation that the average whole time equivalent had been calculated over a six month period rather than the 12 months required by the GAM 2020/21. This misstatement remains uncorrected in the financial statement at this point, due to the data not being available to quantify the movement in the whole time equivalent disclosure.
5	**PFI note:** Updated the disclosure to show the correct number of years remaining in the concession period
6	**Intangibles note:** In our consistency check between the financial statements and the supporting PFR workbook, we noted that Software Development Costs had been double counted in the financial statements supporting note.

Appendix Five

Disclosure Misstatements

Under UK auditing standards (ISA (UK) 260) we are required to provide the Audit Committee with a summary of unadjusted audit differences (including disclosure misstatements) identified during the course of our audit, other than those which are 'clearly trivial', which are not reflected in the financial statements. In line with ISA (UK) 450 we request that you correct uncorrected misstatements. However, they will have no effect on the opinion in our auditor's report, individually or in aggregate.

Details of the unadjusted disclosure misstatements are set out below.

Unadjusted disclosure misstatements	
No.	Detail
1	**Median pay:** Our review identified a calculation error due to the inclusion of the highest paid director in the median pay ratio calculation. This then impacts both the median pay calculation and the multiple which is calculated. The reported ratio is 10.94 but should be reported as 11.10.
2	**Fixed asset disclosure note: accumulated depreciation** As a result of the issues identified with the system reports available from the RAM system, the Trust is unable to accurately calculate and disclose the impact of the revaluation movements on the accumulated depreciation reported in the fixed assets note.

Appendix Six

Confirmation of Independence

We confirm that, in our professional judgement, KPMG LLP is independent within the meaning of regulatory and professional requirements and that the objectivity of the Partner and audit staff is not impaired.

To the Audit Committee members

Assessment of our objectivity and independence as auditor of the Somerset NHS Foundation Trust

Professional ethical standards require us to provide to you at the planning stage of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequer discussion with you on audit independence and addresses:

- General procedures to safeguard independence and objectivity;
- Independence and objectivity considerations relating to the provision of non-audit services; and
- Independence and objectivity considerations relating to other matters.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP partners and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the FRC Ethical Standard.

As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values
- Communications
- Internal accountability
- Risk management
- Independent reviews.

We are satisfied that our general procedures support our independence and objectivity.

Independence and objectivity considerations relating to the provision of non-audit services

Summary of non-audit services

ʼe have not provided any non-audit services during the year.

We have considered the fees charged by us to the Trust and its affiliates for professional services provided by us during the reporting period. Total fees charged by us can be analysed as follows:

	2020/21
	£
Financial Statements	98,000
Whole of Government accounts/data transfer post merger	3,000
Value for money	10,000
Total audit fees	**111,000**
Charitable Funds audit	3,300
Total Fees	**114,300**

Appendix Six

Confirmation of Independence

Application of the FRC Ethical Standard 2019

We communicated to you previously the effect of the application of the FRC Ethical Standard 2019. That standard became effective for the first period commencing on or after 15 March 2020, except for the restrictions on non-audit and additional services that became effective immediately at that date, subject to grandfathering provisions.

We confirm that as at 15 March 2020 we were not providing any non-audit or additional services that required to be grandfathered.

Confirmation of audit independence

We confirm that as of the date of this letter, in our professional judgement, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the partner and audit staff is not impaired.

This report is intended solely for the information of the Audit and Compliance Committee and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so.

Yours faithfully

KPMG LLP