NHS
Avon and Wiltshire
Mental Health Partnership
NHS Trust

ANNUAL REPORT

2017/18

Avon and Wiltshire Mental
Health Partnership NHS Trust

CONTENTS

GLOSSARY

The following glossary is provided to help those unfamiliar with the abbreviations used within Avon and Wiltshire Mental Health Partnership NHS Trust. A list of abbreviations in use in the wider NHS can be found here:

www.nhsconfed.org/acronym-buster

A

A&E Accident and Emergency

APSTT Additional Professional, Scientific Therapeutic & Technical

AWP Avon and Wiltshire Mental Health Partnership NHS Trust

B

BASS Bristol Autism Specialised Service

BNSSG Bristol, North Somerset, South Gloucestershire

BSW Bath, Swindon and Wiltshire

C

CAMHS Child and Adolescent Mental Health Service

CCG Clinical Commissioning Group

CEO Chief Executive Officer

CIP Cost improvement plan

CPA Care programme approach

CQC Care Quality Commission

CQGG Clinical quality and governance group

CQUIN Commissioning for quality and innovation

D

DHSC Department of Health and Social Care

DTOC Delayed transfer of care

E

EiDA Equality in Diversity Awards

ESR Electronic staff record

F

FFT Friends and Family Test

FIP Financial improvement plan

FTC Fixed-term contract

H

HBPoS Health-based places of safety

I

I&E Income and expenditure

IAPT Improving Access to Psychological Therapies

ICD International classification of diseases

IG	Information governance
IGMS	Information governance management system
IQD	Improving quality delivery system
IM&T	Information management and technology
IT	Information technology

L

LCFS	Local Counter Fraud Service
LDU	Local Delivery Unit
LiA	Listening into Action

M

MH	Mental health
MaPSaF	Manchester Patient Safety Framework

N

NED	Non-Executive Director
NIHR	National Institute for Health Research
NHSE	NHS England
NHSI	NHS Improvement

P

PCLS	Primary Care Liaison Service
PFI	Private Finance Initiative
PMO	Programme Management Office

Q

QIP	Quality improvement plan

S

SFI	Standing financial instruction
SO	Standing order
STEPS	Specialised treatment for eating disorders
STP	Sustainability and Transformation Partnerships

T

TCSL	Transforming Change through System Leadership

W

WTE	Whole time equivalent

PERFORMANCE REPORT

OVERVIEW

The purpose of the overview section is to provide readers with a short summary of our activity in 2017/18. It includes a statement from our Chair and Chief Executive, information about our Trust and some key facts and figures.

Welcome to our Annual Report for 2017-18

Before we get into the detail of what we've achieved and learnt over the past 12 months, we would like to take this opportunity to thank our very dedicated and hard-working staff, as well as all our Sustainability and Transformation Partnership (STP) partners and commissioners, for their ongoing support in helping us develop and deliver our vision for mental health provision in Avon and Wiltshire. We also hugely value the important insight of our service users and carers. They, along with input from our Board, help us to learn and make the changes we need to continually improve and enhance our services.

Everything we do is focused on giving the best possible care in the right place, at the right time, to help our service users and their families to recover and live their best life. This annual report is our opportunity to look back at the last year and celebrate our successes, acknowledge the challenges and think ahead to the ambitions we want to realise.

Statement from our Chair

2017/18 has been a pivotal year for the Trust with the launch of our new strategy. Our five year plan sets out how we intend to design and provide sustainable services to deliver real change in mental health care that meets the needs of the communities we serve. The strategy reflects our ambition for excellent care that supports individuals and their families to recover and live their best lives.

It was also a year of considerable challenge, during which we responded to continued workforce shortages, financial pressure and increasing demand for our services. Despite delivering a significant level of savings, the Trust is reporting a financial deficit for the year. We are committed to delivering services and supporting growth in a way that is compatible with the financial environment we operate in and with the resources available to us. Our transformation strategy is fundamental to achieving this through new models of care that allow us to provide accessible, safe and effective care as close to home as possible. I am optimistic that with the support of our staff we will be in a position to deliver an improved financial outturn in the coming year and a plan for long-term sustainability.

Achieving true parity for mental health requires us to maintain our dual focus on strengthening core services as well as delivering improvements set out in the Five Year Forward View for Mental Health. Working with our commissioners and partners in the two Sustainability and Transformation Partnerships will help us to meet the demand pressures on services. We also welcome a continued focus at national level on investing in mental health. It was encouraging to see the national focus and investment last year which allowed us to invest resources in developing perinatal care and services for children and young people as well as for military personnel and veterans.

Partnership working was a priority for 2017/18 and will remain a priority going forward. Our strategy is rooted in the principles of supporting and involving our service users and carers and engaging our staff. I am particularly pleased to acknowledge the input of service users in the development of our Service User and Carer Engagement and Involvement Strategy that describes how they will be involved in designing and improving services. There is much more to do in this area but it does signal a new way of working which we will build on. I also want to mention our Family, Friends and Carers' Charter which recognises the critical role of carers as part of the 'Triangle of Care'. The Bath-based KS2 Carers Group also wrote a great booklet about what the Charter means for carers in real terms which added real weight, credibility and support to what we're doing.

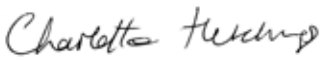
One of my highlights this year has been meeting and hearing from staff on my visits around the Trust. I continue to be struck by people's passion and dedication and the potential for service improvement that will come from creating a culture and opportunities for staff at all levels to innovate and contribute to the delivery of our transformation. The Board made a commitment to adopt 'Listening into Action' which has brought a much needed shift in focus and changed the way we engage with our staff, listen to their ideas and support them to create the changes that will improve care. It's very encouraging to see people be part of, drive and have a stake in finding solutions to the issues we want to solve. Listening into Action has been led from the front by our Chief Executive Officer (CEO), Hayley Richards. I'd like to thank Hayley for her championing of a change in culture and commitment to making it happen.

Building an open, transparent and effective Board is part of ensuring the Trust is well led and can deliver its strategy and I would like to thank Board colleagues for their support for this endeavour. In recognition of the improvements in governance we have made this year the Care Quality commission (CQC) rated the Trust 'good' in the Well Led domain in its 2017 focused re-inspection.

Another high point has been the transformation of our Charitable Fund into a proactive and rapidly growing charity - now called Headlight. Thanks to the generosity of our supporters, we have been able to go above and beyond what is possible from NHS funding, making a positive impact in enhancing patients' experiences, supporting their recovery and raising awareness of mental health across our communities.

In summary, we now have clarity of purpose and a well-developed plan to deliver the changes required for us to consistently meet the changing needs of our service users, engage our staff and be sustainable. I look forward to supporting Hayley and the Executive team in the year ahead in meeting the complex challenges we face and achieving the Trust's ambitions.

I hope you enjoy reading this report.



Charlotte Hitchings
Chair

Statement from our Chief Executive

Our Annual Report provides us with an opportunity to look back on what we have achieved during 2017/18. It has been a challenging 12 months but we have, made life better for many thousands of people. We can only continue to do so due to the significant contribution of our staff, as well as our Board, service users, carers, volunteers, commissioners, partners and communities.

The main purpose of our work is to deliver care that empowers people to take control and stay in control of their life despite having a health problem. It is founded on the principle of partnership and a commitment to living well. The last 12 months has seen a major shift in our approach to make this happen.

In June 2017, the CQC returned to inspect our services and noted significant improvement and recognised the quality of care provided by our staff. The report concluded that our rating of 'requires improvement' remains unchanged and identified specific actions to help us improve further. Since the publication of the report we have actively worked on the recommendations and are confident we have made improvements and will continue to do so.

The first phase of our new strategy saw the launch of an ambitious plan to transform the Trust over an 18 month period. Last year we focused time and energy on laying the foundations and building our programme of projects, which are all rooted in quality improvement, our number one priority.

We also committed to actively listening to staff and welcoming their ideas for how we can improve. I'm incredibly proud of what we've achieved since we made the decision to become a 'Listening into Action' Trust. By empowering staff to make positive changes we are already seeing care being modernised through redesigned services and facilities in a financially sustainable way.

At the end of our journey, our services and the experience of those who need them will be transformed. Care pathways will be clearly defined and easy to access; there will be early help from multidisciplinary teams to ensure the physical, mental and social needs of individuals are understood and a greater range of community care options provided by partners with shared expertise and resource. These all support individuals to manage their health and remain at home. When necessary, individuals who need brief intensive support will be cared for in inpatient centres of excellence. Our Specialised Services will provide wrap around expertise ensuring those in our care have access to first-class support when they need it.

Even at this early stage we are starting to see how the future will look with significant operational improvements already being delivered in reduced delayed transfers of care and out of trust placements which are already positively, and significantly, impacting the quality of care, safety and patient outcomes.

An important back drop to our work in 2017/18 has been the support we have had through NHS Improvement and their Financial Improvement Programme (FIP). We have also been able to benefit from innovative approaches, tools and lessons learnt from elsewhere in the NHS. Financial stability and sustainability is a crucial part of how we will protect patient care and services going forward.

As the NHS and social care respond to the challenge of improving health and wellbeing and providing sustainable care we have valued the opportunity to work with partners. We have been active members of two Sustainability and Transformation Partnerships and welcome their prioritisation of mental health. We value the knowledge, expertise and insight from all our partners and recognise that collective action is the key to sustainable solutions to shared challenges.

In terms of the next 12 months our focus will be on how we can make our services the safest they can possibly be, how we can recruit great people to work with us and retain the fantastic people we already have and finally how we do better with what resources we have to provide excellent mental health care that is sustainable. The progress we have made over the last year shows that we are ready for the year ahead and as Chief Executive I am proud of each and every one of my colleagues and look forward to working with them, as well as our communities in everything we do during 2018/19.

Hayley Richards
Chief Executive

About the Trust

Avon and Wiltshire Mental Health Partnership NHS Trust ('the Trust') provides community and inpatient mental health services for the people of Bristol, North Somerset, South Gloucestershire, Bath and North East Somerset, Swindon and Wiltshire for people with disabling mental health problems such as:

- severe anxiety
- severe depression
- obsessive compulsive disorders
- phobias
- borderline personality disorder
- schizophrenia
- psychosis

We also provide some specialist services across the South West. These include:

Specialist Services	Secure Services	CAMHS
For people with mental health problems relating to eating disorders, pregnancy and childbirth, drug or alcohol dependency, dementia and memory services and mental health services for deaf people and people with learning disabilities.	For people with mental health problems who have been through the criminal justice system or who are in prison.	Children and Adolescent Mental Health Services. For children and young people who have difficulties with their emotional or behavioural wellbeing.

Figure 1 - Trust specialist services in 2017/18.

Increasingly, we provide treatment and care in people's own homes and other community settings, reflecting the preferences of our service users. Our community services are supported by high-quality inpatient services that provide short-term assessment, treatment and care.

The Trust is a partner in, and the expert mental health advisor to, two sustainability and transformation partnerships (STPs): Healthier Together (Bristol, North Somerset, South Gloucestershire); and Bath and North East Somerset, Swindon and Wiltshire (BSW).

The year in numbers

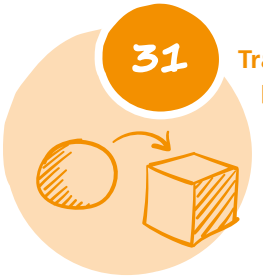
88 research studies we participated in

Patients received a total of **170,811** days in-patient care

Serving a population of **1.8 million**

Covering a geographic region of **2,200 miles** including Dorset

31 Transformation projects got underway



715,280 contacts with people in the community

Quality CQC Rating is Good in well-led caring and responsive areas

All of our premises are now smoke free

90% of service users would recommend us to their friends and family

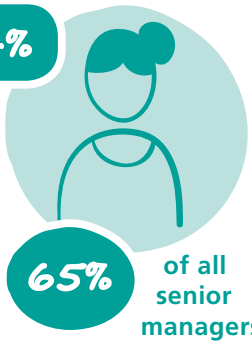
8,000 service users have told us about their care through the friends and family test

565 Recruited people

1,233 people like us on Facebook

Became a Listening into Action Trust and have **357** champions and **5** response teams

74% of staff are women and they represent **65%** of all senior managers



2,677 people follow us on Twitter and LinkedIn

We work with **4,172** dedicated staff

97 premises we operate

PERFORMANCE ANALYSIS

We monitor our performance using a large number of quality, operational and financial measures. These measures are reported and scrutinised through the governance processes described in our Annual Governance Statement (Page 53). We have also adopted measures to test the accuracy of the data that we rely on to assess our performance. The steps that we take to ensure the quality of our data are described on page 62.

As part of our annual planning cycle, we seek to identify the risks and uncertainties that may impact upon our key performance indicators and objectives in the future; these are laid out in our annual operating plan. For example, our planning processes take account of uncertainty from the introduction of new standards or changes to the regulatory framework.

Once identified, the risks to our objectives are set out in our Board Assurance Framework. This describes how we will seek to control or mitigate these risks throughout the year, and how we take assurances on whether these controls remain effective. Our risk management and assurance processes, including the role of internal and external audit, are also outlined in detail in our Annual Governance Statement (starting on page 53).

This section outlines how well we did against our key measures of performance, including:

- How well we did against our **2017/18 objectives** (page 16) ;
- How well we did on key **national and local indicators** (page 19);
- What our quality regulator, the **Care Quality Commission**, says about our services (page 20);
- What our service users tell us through the F**riends and Family Test** and **Annual Community Mental Health Survey** (page 21);
- What our staff tell us through the **Annual Staff Survey** (page 26);
- How well we are managing our **finances** (page 30);
- Our efforts towards achieving **environmental sustainability** (page 34); and,
- Whether we are **transforming our services** to meet the challenges of the future (page 34)

How well did we do against our 2017/18 objectives?

	What we said…	What we achieved…
Supporting service users and carers	We will improve patient safety	• Focused on reducing avoidable patient falls. Achieved a 57% reduction on our older adult inpatient wards. • Introduced two initiatives to improve standard and completeness of record keeping. • Developed an audit to support improvements in the number of service users with a completed risk management plan. • Reduced the use of restrictive practices and seclusion across the Trust.
	We will improve clinical outcomes	• Introduced training and improvement projects to increase the % of service users receiving cardio-metabolic assessment and treatment. • Increased the number of service users whose smoking status was recorded and given advice or referred to stop smoking services. • Increased the number of service users who have alcohol screening recorded and receive advice or referral to an appropriate service. • Developed a 'Patients as Leaders' programme to enable direct service user participation in the work of Board committees.
	We will improve statutory compliance	• Focussed improvement works on ensuring compliance with all Fundamental Standards Regulations set out in the Health and Social Care Act 2008. • Following the regulatory re-inspection in 2017, the CQC lifted the warning notices previously in place.
Engaging our staff	We will develop our culture to address issues described in staff survey results	• Successfully implemented Listening into Action and 'crowd fixing' programmes across all parts of the Trust and established response teams to tackle key issues. • Link Directors are in place across all parts of the Trust. • Increased the number and quality of nominations from across the Trust for our staff and team awards which culminated in an award ceremony at the end of the year.
	We will improve the experience and wellbeing of staff working in AWP	• Introduced staff experience groups to have real-time conversations to tackle key issues. • Established the Staff Health and Wellbeing Taskforce. • More staff vaccinated against flu than ever before. • Restructured the Trust communications team who have a greater focus on employee engagement and supporting better internal communication.
	We will improve workforce resilience	• Developed and implemented a range of initiatives to improve wellbeing and reduce staff turnover. • Continued work to increase the number of apprentices recruited to work across the Trust

	What we said…	What we achieved…
Being sustainable	We will bring the organisation back into financial balance	• Some early progress made in turning around a deteriorating financial position, but more progress needed. • Reviewed the Trust Strategy and sought feedback internally and externally which will be incorporated into the next phase of strategy development. • Engaged with our commissioners on service change plans and the implementation of the Estates Strategy in 2018. • Participated at all levels across both STP footprints, providing expert mental health advice and other inputs as required. This entitles the Trust to receive an STP CQUIN payment for 2017/18.
	We will invest wisely in our capital programme to support service transformation	• Investment in IT led to successful roll out of Skype across the Trust and the introduction of specialist technology to protect the Trust against cyber and ransomware risks. • Successfully invested in estates projects including: - Improvements to Wiltshire Health Based Place of Safety (HBPoS) in Devizes. - Co-location of South Gloucestershire services at Kingswood Civic Centre. - Relocation of Child and Adolescent Mental Health Services (CAMHS) community services to Woodside. - Improvements to the physical environment at the CAMHS inpatient unit at Riverside. - Consolidation of Central Bristol community estate to support local services.

Table 1 - Achievements against our objectives in 2017/18.

Risks to our objectives

We identified and managed the following risks to our objectives, through our Board Assurance Framework.

Key Risks 2017/18

We will support service users and carers

- Risk of poor patient experience of our services due to inadequate involvement and communication with users and carers.

  Mitigations include: Involvement and Engagement strategy developed, service users and carer forums and participation in the patient leader course

- Risk of lost opportunities to improve the physical healthcare of our population, if we do not maximise the opportunities to work with our partners in public health, voluntary, and third sector partners within the system, who specialise in preventative aspects of healthcare.

  Mitigations include: CQUIN on physical health, Smoke free hospital

- Service users will receive compromised care or care in inappropriate places which could lead to deterioration in symptoms or increased clinical risk due to Delayed Transfer of Care (DTOC).

  Mitigations include: A review of systems and process which reduced DTOC.

We will engage our staff

- If we do not maximise engagement with our workforce and improve the organisational culture, then we will not retain staff and deliver our strategic objectives.

  Mitigations include: Listening into Action culture change programme. Revised communications team structure and focus.

We will be sustainable

- Risk to financial sustainability if the Cost Improvement Plan (CIP) for 17/18 is not delivered as the trust will not be able to deliver objectives. The Trust will need to agree cash loans with the Department of Health and Social Care (DHSC) to support cash flow.

  Mitigations include: Participated in the Financial Improvement Programme. Delivered a CIP programme of £9.1m.

Key Risks 2018/19

We will support service users and carers

- If we do not learn from, and embed change as a result of, incidents, internal governance processes, issues raised by CQC, NHSI and other regulatory bodies then we will not continuously improve clinical care

  Mitigations: CQC action plan, Well Led Framework assessment, Sign up to safety programme.

- If we are unable to improve our estate to ensure it is fit for purpose then clinical care may be compromised.

  Mitigations: STP Estates Programme, BNSSG proposed consultation process, BSW engagement on estate strategy.

- If demand and capacity are not aligned and funded then waiting times will increase and outcomes for patients will worsen.

  Mitigations: Transformation programme, re-negotiated contracts, STP engagement.

We will engage our staff

- If we cannot change culture and engage staff then we will not be able to transform our services to improve care.

  Mitigations: Listening into Action, Link Directors, new communications team to lead and maintain a revised communications and engagement programme.

- If we are unable to recruit and retain an appropriately skilled workforce and manage in accordance with a workforce plan then effective service delivery may be compromised and agency costs increased.

  Mitigations: Recruitment and Retention Strategy, implementation of local recruitment plans.

- If we do not have an effective senior leadership team with the capacity and redesign capability to deliver change then we will not deliver the transformational change programmes and ensure continuous improvement.

  Mitigation: Review of executive team and senior leadership team, appointment of Interim Programme Director, Transformation.

We will be sustainable

- If STPs transform services to meet the system financial deficit then this may reduce funding for mental health core services and the impact on the sustainability of the Trust.

  Mitigation: STP engagement, re-negotiated contracts.

- If we fail to engage with external stakeholders then there will be insufficient support from the public and stakeholders during public consultations which will impede our transformation.

  Mitigation: Engagement with STPs and stakeholders in developing transformational plans

Supporting our service users and carers

National standards

Quality measure	Target	2016/17	2017/18
7 day follow-up to inpatient discharge	95%	95%	98%
Service users with a review (CPA)	95%	97%	96%
Early intervention in psychosis – referral to treatment	50%	85%	83%
IAPT – referral to treatment to treatment (% within 6 weeks)*	75%	96%	95%
IAPT – referral to treatment to treatment (% within 18 weeks)*	95%	100%	99%
Gate-keeping admissions by the Crisis service	95%	99%	97%
Delayed transfers of care (DTOC)	7.5%	12%	10%
Data quality: outcomes	50%	86%	84%
Data quality: identifiers	97%	99.9%	99.9%

Table 2 - Performance against national standards in 2017/18.

Local indicators

Quality measure	Target	2016/17	2017/18
% of service users in employment	10%	12%	13%
% of service users in settled accommodation	70%	72%	72%
Crisis assessment within 4 hours of referral	95%	99.6%	99%
Referral to assessment within 4 weeks	95%	96%	94%
Referral to treatment within 18 weeks	95%	96%	97%
% of service users with a risk assessment (CPA)	95%	99.9%	99.8%
% of service users with a Crisis plan (CPA)	90%	99%	99%
% of service users with a care coordinator (CPA)	95%	100%	100%
Supervision rates	97%	86%	84%

Table 3 - Performance against local indicators in 2017/18.

What the CQC told us

The CQC carried out a planned inspection of the Trust in 2017. Following the inspection, the Trust was commended for the improvements we made since our inspection in 2016 and, as a result, a Section 29A improvement notice that had been in place since 2016 was lifted.

The Trust was rated 'Good' in the caring, responsive and well-led domains, and 'Requires Improvement' in the safe and effective domains, resulting in an overall rating of 'Requires Improvement'. Whilst a number of our individual services were rated good, further work is required to bring all of our services up to the required standard.

More details on our CQC inspection and the steps the Trust is taking in response can be found on page 58.

Are services...	Inadequate	Requires Improvement	Good	Outstanding
Safe?		Requires Improvement		
Effective?		Requires Improvement		
Caring?			Good	
Responsive?			Good	
Well led?			Good	
Overall rating		**Requires Improvement**		

Figure 2 - CQC Rating

What our service users and carers tell us

Friends and Family Test (FTT)

The national Friends and Family Test is an important way for us to hear what people think of our services and whether they would recommend the services they have used to their friends and family. It is designed to highlight areas of good practice as well as areas for improvement. This year we were in the top three of mental health trusts for the number of Friends and Family Test responses received with over 8,000 of our service users providing feedback. Since 2013, a total of 38,579 people have told us about their care.

Over the year, 90% of service users in the community said they would recommend our services to friends and family and 3% would not. In the same period, 81% of inpatients would recommend our services and 6% would not.

Of the comments received, 87% were positive and 13% were negative, compared to 89% and 11% in 2016/17. Of that praise, the professionalism of staff was often singled out with service users telling us that staff cared, communicated effectively and treated them with dignity and respect.

FTT Community 2017/18

Theme	Positive	%	Negative	%
Responsive	182	3%	216	20%
Effective	3,453	49%	422	39%
Caring	2,967	42%	321	30%
Safe	119	2%	54	5%
Well Led	317	5%	57	5%
Total	**7,035**		**1,070**	

Figure 3 - FTT (Community), April 2017 - March 2018

Theme	Positive	%	Negative	%
Responsive	2	<1%	6	3%
Effective	555	39%	107	50%
Caring	774	55%	67	31%
Safe	41	3%	11	5%
Well Led	48	3%	23	11%
Total	**1,420**		**214**	

Figure 4 - FTT (Ward), April 2017 - March 2018

N.B. percentage figures are rounded to the nearest 1%, so the percentages as a whole may not add up exactly to 100%.

Annual Community Mental Health Survey

A range of positive service user feedback was received through the annual Community Mental Health Survey. We scored 67.3% for people's overall rating, compared to the highest mental health and learning disability trust which scored 74.6%.

Our highest scores were in the following areas:

Domain	Results
Meeting individual needs	80.7% of service users said that the person they saw listened carefully to them. 71% felt that the people they saw understood how their mental health needs affected other areas of life. 75.3% said they were given enough time to discuss their needs and treatment.
Planning care	73.6% reported being involved as much as they wanted to be in agreeing their care with someone. 77.1% say that their care takes into account their personal circumstances.
Crisis care	76.3% knew who to contact out of office hours if they have a crisis. This places the Trust in the top 20% of all Trusts.
Physical health	56.9% reported receiving support for physical health needs, an increase from 51.2% in 2016/17.
Involvement and information about treatment	69.1% said that they were involved in decisions about which medicines they should receive. 73% said that when they were given new medicines they were also given understandable information. 80% of service users had an NHS mental health worker check with them about how they were getting on with their medicines in the last 12 months. 74.5% said that treatments and therapies were explained to them.

Table 4 - Highlights from the Community Mental Health Survey, CQC, 2017.

Although we achieved some high standalone scores, we were in the lowest 20% of mental health and learning disability trusts for care planning. For example, a below average number of respondents felt they were involved enough in discussing how their care was working (73.5% compared with a range of 61-84%) and fewer service users felt that decisions were made together during the review of their care (72.7%, range 64-83%).

Some improvements have already been made to written care plans and further improvements are planned including improved training of staff through our Care Plan Approach.

Service user and carer involvement

Our service users and carers are at the heart of everything we do. These are some of the ways we have involved our service users in shaping our services in 2017/18:

- More service users are attending our **Service User Group and Carers Forum** than ever before. We are increasing the number of opportunities for service users and carers to get involved in interviewing and training staff, reviewing our patient leaflets and having a say on our strategy, transformation work and quality improvement programme.

- Our Specialised Services **peer mentoring training programme** continues to be run across our prison services and in the Liaison and Diversion Service (covering courts and police stations across our area) as well as in Bristol Autism Specialised Service (BASS) and Pathfinders, a multi-disciplinary team that works with individuals who have been diagnosed or are suspected of having a personality disorder.

- In 2017/18 we recruited new **Service user and Carer Engagement Leads** who began to plan key activities including a new recruitment campaign and improved publicity to attract more service users and carers to help shape our work.

- We were also delighted to have secured funding to run a **Patient Leaders programme** from March 2017- July 2018. Run by the Kings Fund, this course supports staff, service users and carers to build collaborative relationships and to lead and influence changes in NHS services.

Peer mentoring

Service users share their lived experiences to help promote recovery in others

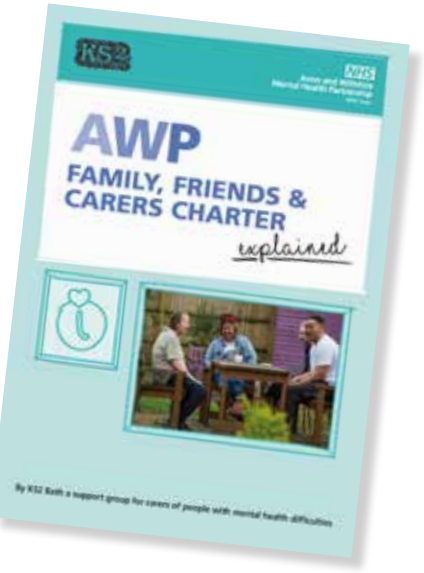
Peer mentors support and advise service users by sharing their lived experiences and first-hand knowledge to promote recovery. The peer mentor initiative also gives mentors a purpose and an aim, as well as building skills and self-esteem and has led to employment for many people, either within AWP or third sector organisations.

Working in partnership with our carers

We have 2 star **Triangle of Care** membership and our action plans are actively monitored as part of the commitment to on-going improvement and good practice. We have carer leads and carer champions in clinical teams across the Trust to develop relationships and to improve carer awareness of the work we do. This includes a Trust-wide carer group which meets every six weeks to share local issues and escalate concerns.

This year also saw the relaunch of the Trust's Family, Friends and Carers' Charter along with a new booklet written by carers explaining the charter. It sets out what people can expect when supporting someone receiving our mental health services. The accompanying booklet written by KS2 Bath (a peer support group for carers) explains exactly what kind of involvement, information and support carers can expect and what to do if these things don't happen.

This year has also seen the Trust's first **Carer Wellbeing Programme**. This offered an activity group for service users to engage in meaningful activities such as life story, cognitive stimulation therapy and games and music therapy.



Healthwatch

A joint working agreement is in place with Healthwatch, the independent body who champion the rights of health and social care service users. Our Healthwatch leads share information about our services and listen and respond to public feedback. As well as commenting on our Quality Account, our six local Healthwatch organisations were invited to suggest quality priorities for the Trust; based on their local engagement work and regular visits to Wour inpatient wards.

Voluntary Services

Volunteers play an important role in the Trust, complementing the work of our staff and improving service user experience through the skills and enthusiasm they bring to their roles. Our volunteers are a diverse group of people that includes students, service users, carers, former members of staff and members of our local communities who have a desire to make a difference to the lives of others. We are also increasing the number of peer mentors in specialist services and volunteers from partner organisations such as St. Mungo's, the homeless charity. These inspiring peer mentors, who are current or recent service users, are able to support fellow service users in their recovery journey.

We have also appointed a new Volunteer Co-ordinator and we are now in the process of developing a new fit-for-purpose database to manage our volunteers and allow for the expansion of the service in the coming year.

Engaging our staff

Our dedicated staff hugely influence the quality of every experience a service user or carer has with us. In 2017/18 the second of our annual objectives was to support and develop our staff who work in challenging situations every day. Given the complex and sometimes challenging nature of their work we made engaging with our staff a Trust priority.

Our Workforce

As of 31 March 2018 the Trust employs a skilled and diverse workforce of almost 3,600 people (whole time equivalent) making for a total headcount of 4,172. Around half of our staff hold a professional clinical registration. The breakdown of our staff by professional group is as follows:

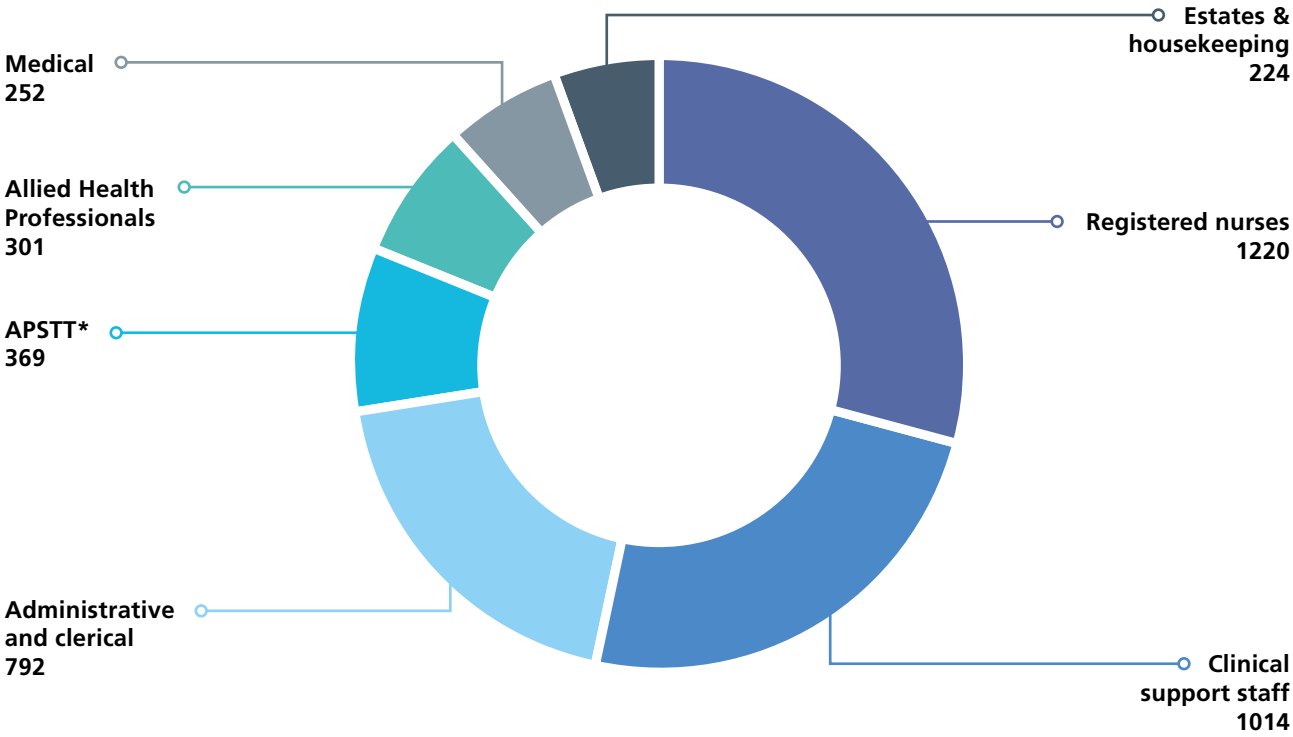


Figure 5 - Workforce headcount (by profession) 2017/18

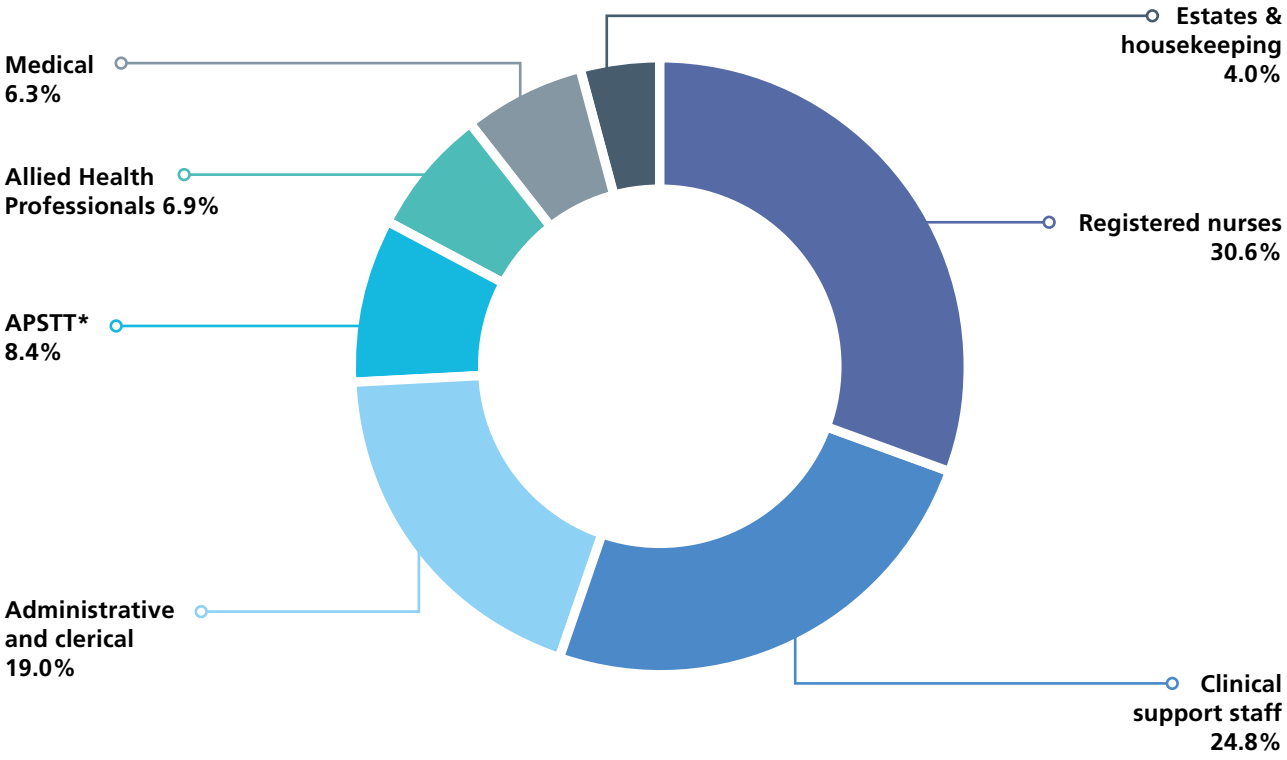


Figure 6- Workforce WTE (by profession) 2016/17

*APSTT – Additional Professional, Scientific Therapeutic & Technical which includes Clinical Psychologists and Social Workers.

Supervision and appraisal

To ensure staff receive the necessary support, feedback and development they need we prioritise regular supervision and appraisal. All staff have monthly supervision with their manager to support them in carrying out their role. In addition, the Trust is committed to every member of staff having an annual appraisal (as a minimum). During 2017/18 we achieved our target for supervision. We will continue to work towards achieving our appraisal target and ensuring that appraisals help staff to develop and do their job well.

Indicator	Target	2015/16	2016/17	2017/18
Supervision	85%	84.8%	86.1%	86.4%
Appraisal	95%	90.6%	90.5%	89.7%

Table 5 - No. of staff supervised and appraised during 2017/18.

Sickness

Our average rate of sickness absence over the last 12 months was 4.37% which is a slight improvement on the previous year's rate of 4.46% in both 2016/17 and 2015/16.

Engaging and supporting our staff

We appointed a Director of Human Resources, Julian Feasby, who joined us in July 2017. Having a board-level director responsible for our staff has helped us ensure that their experience stays front of mind in the decisions we make. Our line managers also receive wide ranging support from the Executive Team, Employee Relations, Organisational Development and Learning and Development teams.

Through Listening into Action, our CEO has spearheaded our approach to staff engagement which provides a great way to enable front-line staff to find solutions to the day-to-day issues that get in the way of providing great care.

What our staff tell us about working for AWP

We receive feedback on the experience of our staff through a number of sources. These include:

- Local and Trust-wide consulting groups with trade union representatives;
- Local and Trust-wide staff experience groups;
- Listening into Action 'crowd fixing' conversation events;
- Walk around visits by executive and non-executive directors with identified Link Directors in each area; and,
- Surveys, notably the annual NHS Staff Survey

Staff Survey Results

Every year, all of our substantively employed members of staff are invited to complete the NHS Staff Survey. This year, 2,056 staff responded, giving the Trust a response rate of 51.9% compared to an average 50.9% for mental health and learning disability trusts.

As in previous years the Trust commissioned Picker to administer its staff survey, which enables us to compare our performance with previous years and to compare our results with 14 other mental health and learning disability trusts that also commissioned Picker.

Compared with 2016, the Trust did significantly better on three questions and significantly worse on five questions, with no significant difference reported on 80 questions.

Staff Survey 2017 – Key themes

High scores	Improving scores	Declining scores
• Trusted to do my job • Don't feel pressured to come to work when unwell • Incident reporting • Reporting unsafe clinical practice • Not experiencing discrimination from colleagues	• Manager support • Mandatory training • Appraisals and reviews	• Adequate materials, supplies and equipment • Pay satisfaction • Errors/near misses/incidents that could hurt staff • Identification of training, learning or development needs

Figure 7 - Staff survey highlights, Picker, 2017.

In response to the 2017 staff survey results, the Trust will focus on supporting teams and managers to improve staff experience in three key areas:

- Engaging and communicating with our teams
- Having the resources to do the job
- Continuing to tackle concerns around bullying and harassment

The survey also told us about levels of motivation, how much staff feel able to suggest and implement improvements and how prepared they are to speak positively about the organisation. Our engagement score has remained slightly below the average for mental health and learning disability trusts for the past five years.

Improving staff experience

Our Staff Experience Groups provide an open channel of communication for frontline staff to describe issues that impact day-to-day experience of working in their local areas. We also run a Trust-wide Staff Experience Group chaired by the Chief Executive. These groups provide real-time feedback and corroborate our survey results which helps us prioritise improvements and ensure progress is made.

Celebrating Staff Achievement

Internally, AWProud is our way of celebrating the great things our staff do every single day and last year more than 1,600 AWProud messages were sent. Whether saving a life, delivering a great project or being the person whose engaging ways help us feel motivated, it is a quick, easy and fun way for colleagues to make someone's day by sending them a personalised message to say 'thank you' or 'well done'.

In addition, each month staff can nominate a team of the month which colleagues then vote on. The 12 winners go forward for Team of the Year and all the winning teams attend our annual Staff Awards event where we recognise excellence and long service.

AWP Staff Awards 2017

Clockwise from left: Figure 8 - Team of the Year: Elizabeth Casson House, Bristol. Figure 9 - Lifetime Achievement: Angela Marcellino. Figure 10 - Everyday Excellence: Emma Donnelly and Annabel Trowbridge.

Public Recognition for staff

This year we have also had cause for celebration with national and local recognition for our teams and staff.

The Daisy Unit, our bespoke care unit for people with complex learning disabilities, was shortlisted for the 2017 Kate Granger Awards for Compassionate Care.

In December 2017, the Bristol Community Rehabilitation Service (a partnership between the Trust, Second Step, Missing Link and Bristol Mental Health) won a national award at the Third Sector Care Awards. The award recognised the team's innovative ways of working and how better outcomes are achieved when teams work together.

At the National Dementia Care Awards 2017 a team comprising Psychiatrist Dr Maria-Paloma Sequeiros, community psychiatric nurse Cheryl Buckley from South Gloucestershire Later Life Mental Health Services and Day Services Manager Beth Tovey from South Gloucestershire Council won the Best Dementia Training Initiative award for their 'Real Life with Dementia – Practical Training Course for Carers'.

STEPS, our eating disorder service, was shortlisted for the Bristol Post Health and Care Award Healthcare Team of the Year which honours local 'heroes of healthcare'.

We are incredibly proud of these accolades and all the other unsung innovative ideas that were achieved and delivered by our staff in 2017/18.

Employer 'Kite' Marks

In the past year we have continued to focus on treating people as individuals, respecting and valuing their diversity and we are proud to continue to be one of the **Top 50 Inclusive UK Employers**.

We recognise that our work is challenging for staff particularly when coupled with both organisational changes and local health and social care infrastructure changes. Last year, managers, employee relations, occupational health and health and well-being teams worked hard to support staff in building their resilience, to stay well and to be able to return to work after a leave of absence. We have achieved accreditation in six of the eight domains of the **Workplace Wellbeing Charter**, a nationally recognised standard for employers committed to supporting staff health and wellbeing.

We are a **Disability Confident** employer, supporting those with disabilities to both join the workforce and remain in work where their health situation changes. We are participating in discussions around the proposed national Workforce Disability Equality Standard which seeks to identify gaps between the experience of staff with and without a disability.

Research and Development

The Trust is committed to research being part of everything we do. We support high quality research into the prevention, treatment and management of mental health problems, addictions and dementia and aim to put research findings into clinical practice. The Trust ensures that we give everyone who uses our services, their carer's and families (as well as our staff) the chance to find out about research they could take part in. This forms our pledge to make us a 'Research for All' and 'Everyone Included' Trust.

This financial year, we have participated in 88 studies; 50 National Institute for Health Research (NIHR) adopted studies (10 sponsored by commercial companies) and 38 student and non-NIHR research. We continue to act as a Participant Identification Centre on NIHR studies with the Research Institute for the Care of the Elderly and North Bristol NHS Trust. For our last full year of data (April 2016 to March 2017), comparable figures were: 78 active studies in AWP, 43 NIHR studies (13 sponsored by commercial companies) and 35 student and non-NIHR research. We recruited a total of 650 patients into NIHR studies during this period.

Being sustainable

Along with the wider NHS, we have had a challenging year from a financial perspective. For the financial year 2017/18, we reported a net deficit of £10.4m which is a significant movement away from the £2.6m surplus position agreed by the Trust Board with NHS Improvement in December 2016.

The significant deterioration of the position against the plan is mainly due to the cost of employing agency staff, the use of beds in the third sector as we have had to treat more inpatients than our current bed capacity could accommodate and costs associated with making sure our buildings are fit for purpose and enable safe and quality services to be provided.

Given the financial deficit that we have experienced in 2017/18 we have drawn down a loan from the Department of Health of £11.3m. This has enabled us to continue paying staff and suppliers on a timely basis which has been borne out by the improvement in the better payment performance target for invoices paid with 30 days.

The reported deficit excludes impairments which are technical in nature and are exceptional items.
The Financial Risk Rating is reported as a 4 which is in line with the plan and this is made up of a liquidity ratio of 2, an I&E margin metric of 4 and an agency rating of 4.

2017/18 has proved a financially challenging year due primarily to the requirements of safer staffing and on-going recruitment difficulties for both medical and nursing staff.

Key financial performance indicators

Under the metric framework, the weighting of the liquidity ratio and capital servicing capacity have been reduced from 50% to 25% and two new measures both weighted.

Measure	Planned rating	Actual rating
Liquidity ratio metric	3	2
Capital servicing capacity	2	4
I&E margin	1	4
Agency rating	1	4

Figure 7 - Staff survey highlights, Picker, 2017.

Income

Operating income received in 2017/18 by the Trust was £220.6m, with £209.5m (95%) coming from the delivery of patient care services. The largest proportion of our clinical income comes from our main six CCGs. Non-clinical income for the period is £11.0m with the majority of this income received to fund education, training and research. A breakdown of total income by source is shown in the graph below:

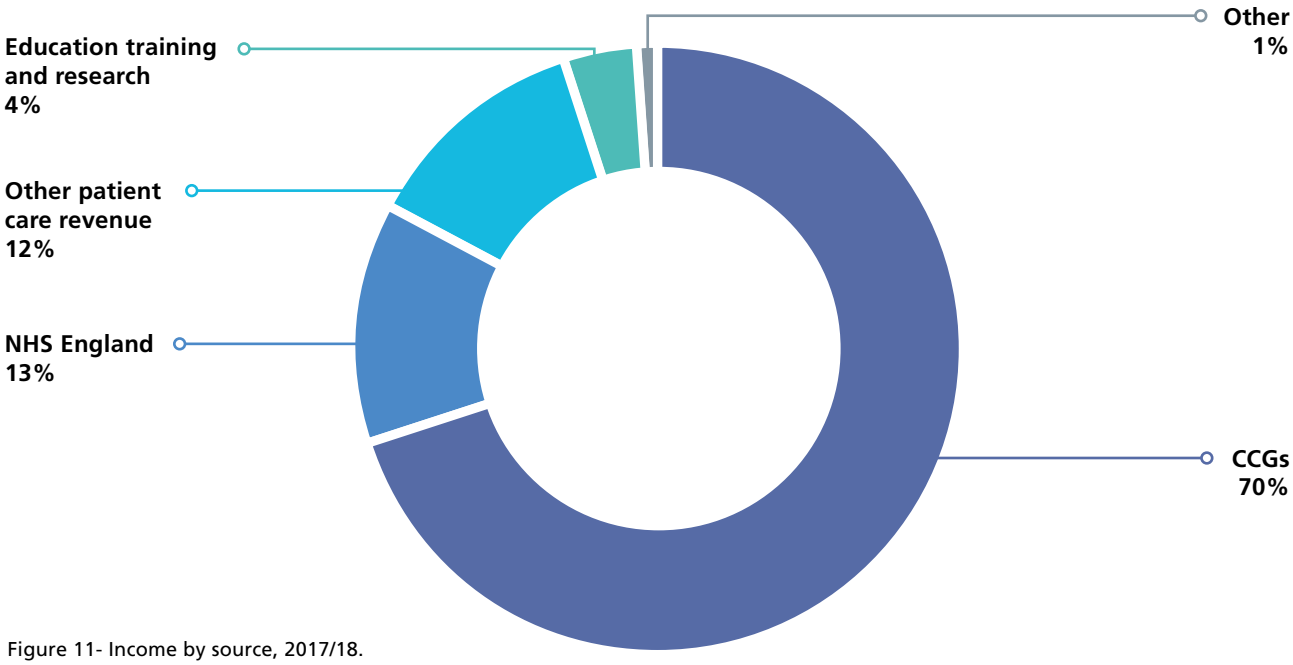


Figure 11- Income by source, 2017/18.

Expenditure

Operating expenses totalled £224.1m for the year and, as in previous years, staff costs account for the largest use of resources at 76% of the total expenditure.

An analysis of operating expenditure by type is shown in the graph below:

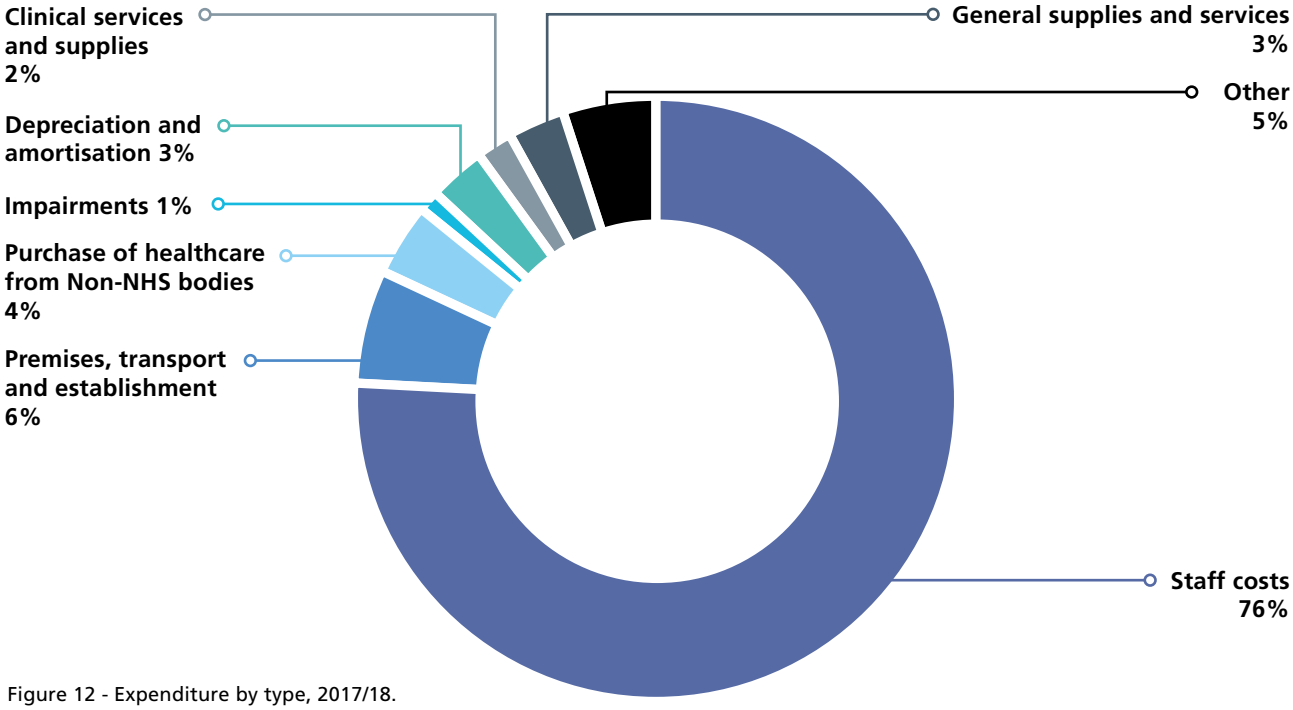


Figure 12 - Expenditure by type, 2017/18.

Capital programme

Capital Expenditure for the year is £5.2m (plus £0.4m of lifecycle expenditure on the PFI classified under IFRIC 12). The capital plan and specific schemes has changed quite significantly throughout the course of the year, though the value of the plan has changed very little.

In addition to Trust funded capital there has also been 2 receipts in the form of Public Dividend Capital:

- Riverside development £0.5m
- WiFi development £0.35m

The chart below sets out the capital split of projects:

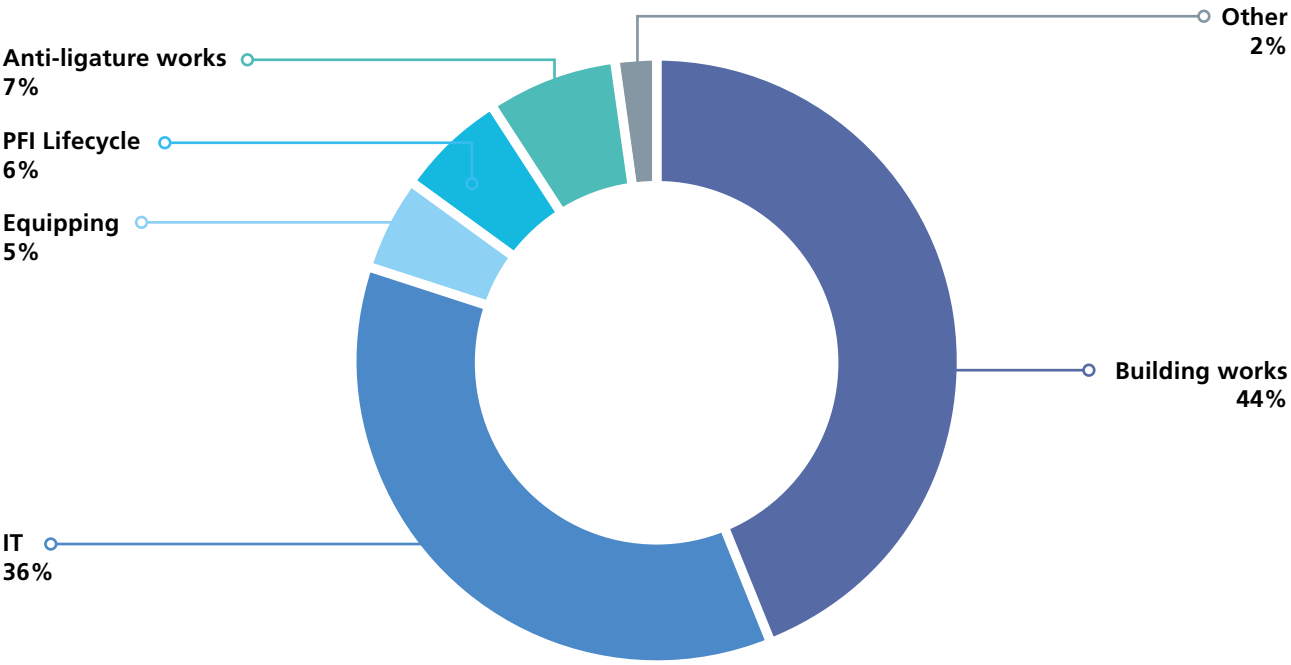


Figure 13 - Capital spending by type, 2017/18

Better payment practice code

We are committed to dealing fairly and professionally with all of our supplier partners. One way that we do this is by working to the Better Payment Practice Code. In short, this means that we aim to pay at least 95% of invoices within the agreed terms, unless there is a dispute. For most of our partners, this would be within 30 days of the date of invoice.

In the case of the 2017/18 position, it should be noted that this was a relatively stable year with loan facilities being available all year. Whereas in the 2016/17 position, it should be noted that the position improved significantly in the second half of the year, once we were in receipt of the Revolving Working Capital Facility from the Department of Health.

Better payment practice code compliance	NHS	Non-NHS
2016/17	27.38%	51.42%
2017/18	80.87%	90.65%

Table 7 - Better Payment Practice Code performance.

Balance sheet events

There are no post balance sheet events reported during the period 2017/18.

Going Concern

After submission of the latest operating plan and forecasts, and after making enquiries, the Directors have a reasonable expectation that the Trust does not have adequate resources to continue in operational existence for the foreseeable future, without a requirement to draw further cash. We currently anticipate that we will require cash loans from the Department of Health of £6.4m during the year ended 2018/19. It is not anticipated that there will be any issues at this point in drawing down the required cash resources from the Department of Health. For this reason the Trust will continue to adopt the going concern basis in preparing the accounts.

We are required to report that on 15 February 2018 the auditors referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to the Trust forecasting a breach of its break-even duty for the three year period ending 31 March 2019. There is reason to believe that the Trust, or an officer of the Trust, has made a decision which would involve the body incurring unlawful expenditure and has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

Financial position 2018/19 and beyond

Given the financial performance for 2017/18 the financial plan for 2018/19 will be just as challenging. Having undertaken a detailed budget setting process for 2018/19 our Trust Board agreed a budget that required us to achieve savings of £9.65m in order to deliver a deficit position of £6.35m. It is also noted that we will not be eligible to receive any sustainability funding from NHS Improvement.

This level of savings represents approximately 4.4% of our funding and reflects the huge financial challenge that we currently face. Savings plans for £9.65m have been developed with £6.89m that have been either implemented or are in progress towards implementation. The budgets have been agreed by our Trust Board for 2018/19 with work continuing on the delivery of the required savings.

The reason for the continued financial pressure relates to the workforce challenges that we face and the continued usage of high cost agency staff across many of our staff groups. In addition, we have had to spend significant money on maintaining suboptimal clinical accommodation and ensuring that clinical services can operate out of safe premises.

We are also experiencing continually increasing levels of demand particularly in the urban centres where we provide services in. This is being compounded by the complexity of some clients health needs when presenting to our services which in turn is creating further cost pressures. We will continue to develop new models of care in order to cope with these levels of demand as well as trying to close the financial gap.

Our Trust Board has agreed a capital plan that continues to focus on patient care and safety, heightened utilisation of the estate as well as focusing on the enhancement of the Information Technology platform that we currently use as a way of promoting new working practices and increasing productivity.

Environmental sustainability

In support of our Transforming Care agenda we are revising our strategic estate plan. The impact on this plan has been to initiate a shift away from leased sites to concentrate service delivery in buildings that are in more suitable condition for future service delivery (moving to remove backlog maintenance and improved energy profiles by removing underutilised fixed assets), to coordinating care to reduce staff travel and to identify better locations to improve community team co-ordination and efficiency.

We continue to invest in upgrades to our heating system and during the year we replaced the existing equipment with condensing boilers at Sandalwood Court. We continued with the policy of targeting transport footprint by reducing business travel through greater use of virtual meetings including teleconferencing and investing in and rolling out skype facilities.

Improved working relationships with our partner organisations within healthcare (via One Public Estate and STPs) has resulted in greater co-location of staff, many of whom are actively sharing common work spaces which has created difficulties in defining our carbon footprint. As a result, we have delayed calculation of our footprint until building usage data is more reliable. A combined estate planning approach across our STPs will also incorporate carbon reduction plans by accounting for sites located at higher risk, for example sites located in flood plains, within the wider sustainability agenda.

In 2018/19 and beyond, we are looking to manage a greater percentage of sites which we 'own', thus allowing limited resources to be more effectively targeted and achieve greater returns. To support this, we will appoint an Energy Manager in 2018/19 to allow more targeted energy saving programs to be delivered.

Improved partnership working with Private Finance Initiative (PFI) providers and others, to implement plans and install new, more effective (environmentally proven) technologies and equipment, will ensure we are able to provide 'the right services, in the right buildings, on the right sites' into the future.

Transformation

This year we have commenced an operational transformation programme driven by the ambitions set out in our Clinical Strategy.

We have been working to:

- Transform our community services so more people can be cared for close to home, making it easier for people to access our services, to receive support early and to provide a variety of supportive alternatives to inpatient admission.
- Focus on getting the right person to the right service at the right time. This involves preventing acute inpatient admission wherever possible by offering community-based alternatives that support people to stay at home.
- Addressing efficiencies, reducing waste and duplication to release time for clinical care, sharing expertise and resources wisely.
- Support our specialised services to increase partnership working to provide better care across a wider footprint.

An example of one of our projects has been the development of Acute Community Units with the first unit opening its doors in Bristol in March.

Acute Community Units are:

- A unit where a service user may go during the day to access services which have been identified in their care plan to support them and to return home at the end of the day.
- An alternative to hospital admission and to support home treatment.
- A service for individuals who are on the caseloads of the Intensive Teams across the Trust.
- An enabler to allow Intensive Teams to work in different ways to manage more service users in the community.
- A facility to support discharge and help to reduce re-admission rates.

Another project has been focussed on improving access by strengthening our Primary Care Liaison Services (PCLS). PCLS is the opportunity for individuals to receive advice and guidance from a mental health specialist. Mental health issues can bring poor motivation, allied physical health problems, and social and financial problems. If access to support is not straightforward, individuals may not be able to access the service they require.

The project aims to streamline the PCLS model based on best practice, benefiting referrers, staff and individuals requiring access to a mental health specialist. The new model offers a one stop point of access and triage process where questions can be answered, with the following benefits:

- Referrers need to spend less time navigating complicated systems.
- Individuals will feel confident that they are receiving a service from a professional, organised team.
- Staff are better supported to deliver high quality, clinically sound mental health services.

New service developments

Over the last year we have successfully developed a range of new and existing services, often working in partnership with colleagues from across our wider network – reflecting the national direction of travel for provision now and in the future. A summary of some of this work is provided below:

Drug and Alcohol Treatment Services

In early 2017/18, we successfully bid to continue to provide Drug and Alcohol Services in Dorset – taking on responsibility for delivering services to those people with more complex needs across Bournemouth, Christchurch and Poole. We are now also working with the Exeter Drugs Project (EDP) to support them in providing the full range of drug and alcohol addiction support services across Dorset. We know from our experience in providing similar services in Bristol that service users achieve the best outcomes when treatment providers work effectively together, and we are excited to be working with EDP to deliver these services.

Drug and Alcohol Treatment Services are changing nationally and locally. Over the last year we have been working closely with colleagues in Bristol Council to look at different ways in which we can meet the needs of some of our most complex and vulnerable service users. We have changed the services we provide in order that we can focus on those with the highest level of need, and we will continue to work with partners across the city to identify other ways in which we can deliver services differently.

Veterans Mental Health Services

Over the course of the last year we have continued to develop our Veterans Mental Health Services, taking on responsibility for providing training and development to other health care providers across the South West, as well as developing our partnership with Berkshire Healthcare NHS Foundation Trust to support veterans in our regional community. As increasing numbers of serving personnel are repatriated back to Wiltshire, we know that demand for our specialist mental health service is likely to increase and we are pleased to be supporting our wider health care system and community to increase their understanding of the specific needs of veterans.

Offender health

We have continued to work with colleagues in both Bristol Community Health and Hanham Health to provide a fully integrated prison health service. The national increase in demand for services from the prison population is replicated across our local prison services, and we continue to develop and refine our services to respond to this.

We were successful in our application to continue providing mental health service support to Vinney Green Secure Children's Home, again working in partnership with colleagues at Hanham Health. We are focusing on implementing new models of treatment within Vinney Green to support children and young people, working collaboratively with colleagues from not only health services but also social care and education to provide the best interventions and treatment for children and young people.

Identifying those people with learning disabilities, substance misuse and or mental health needs who have come into contact with the criminal justice system quickly and effectively is a core component of Liaison and Diversion services across the country. In achieving this, individuals are more effectively supported and referred to the right service for their needs, whether as part of treatment within criminal justice settings or through diverting them to specialist mental health services. Over the last year, we were successful in our application to run Avon and Somerset Liaison and Diversion services, in partnership with Somerset Partnership NHS Foundation Trust. We already work with colleagues in Somerset through the South West Regional Partnership for Secure Services, and this development builds on those existing relationships.

Secure Services

The South West Regional Partnership for Secure Services, of which we are a member, has developed significantly over the last year. Partners from across the South West, including NHS and independent sector providers, have successfully repatriated over 65 service users from out of area placements back into the region and have started work to develop proposals for new community based forensic teams. Bringing service users closer to home enables better outcomes for them, and enables them to interact with their families and local communities, reducing the risk of readmission. Through closer working across a large network of providers, we have been able to share expertise and learning, and drive real change in service delivery both within the Trust and regionally.

Investment in our estate

As part of the national programme to improve old and outdated estate across the NHS, we submitted two applications for additional capital investment – one to support improvements in Bristol, North Somerset and South Gloucestershire (BNSSG) and one to expand our Child and Adolescent Mental Health Service (CAMHS) inpatient unit at the Riverside. We were delighted to hear at the end of the year that these had been successful, and we are now working with colleagues across our Sustainability and Transformation Partnership (STP) to refine and develop our plans. This investment will enable us to improve our services – enabling us to provide treatment in more modern environments, and providing better access to vital provision for service users from across our region. We are excited about the changes that this money will enable, and we are grateful to colleagues in our STP and at NHS England for their continued support in this project.

Improving our services – 2018/19 and beyond

Over the last year we have made significant progress in developing and refining our operational and strategic plans. A new Trust Strategy has been developed, setting out our vision for the future of mental health services across our organisational footprint. This reflects the Five Year Forward View for Mental Health priorities and our ambitions for the next five years. Our revised purpose: 'Working together, living our best lives' is central to everything we do, and is underpinned by our vision for service delivery:

"We aspire to give you the best possible care in the right place, at the right time, to help you recover and live your best life"

To deliver that vision, and in response to feedback from our staff, service users, commissioners and regulators, we have set ourselves three key objectives for 2018/19:

Objective 1: We will improve the quality of our care by focusing on patient safety

We will do this by delivering our CQC action plan, building on our Safe Wards programme, implementing our Suicide Prevention Strategy and delivering our commitments to Sign Up to Safety. We will involve Experts by Experience to challenge and inform our improvement work.

Objective 2: We will attract and retain great staff to support and provide safe and effective care

We will do this by enabling staff to lead improvements to our services, acting on staff feedback and improving manager communication and increasing the visibility of senior staff. Listening into Action will thread through everything we do.

Objective 3: We will transform our services to meet increased demand safely and sustainably

We will do this by transforming our clinical care model, working with partners to implement new models of care in line with the Five Year Forward View for Mental Health, improving management of beds to ensure service users receive care when and where they need it. Managers will remain within budget and we will continually look for opportunities to be more efficient.

Sign Up to Safety

One initiative to help ensure that our services are safe

An example of how we aim to improve the safety of our services is through our Sign Up to Safety campaign. An NHS England initiative, the Sign Up to Safety campaign aims to bring together NHS organisations to help create the conditions for making care safer. Each of our clinical leads has made a specific pledge to improve safety. A dedicated work plan is then developed to deliver the improvements needed. A series of Sign Up to Safety events will be held during 2018/19 to which staff, service users and carers will be invited to contribute.

For more information, [LINK – available 30 April]

We will deliver these objectives through a robust two-year transformation programme, supported by NHS Improvement, and building on our financial improvement plan. The transformation programme will include the following specific pieces of work:

- Service user flow programme
- Clinical quality improvement programme
- Infrastructure programme
- Workforce programme
- Productivity programme; and,
- Cost reduction programme

These programmes have been endorsed by our local CCG partners, contributing to the delivery of the STP ambitions and priorities in Bristol, North Somerset and South Gloucestershire (BNSSG) and B&NES, Swindon and Wiltshire (BSW).

What might stop us achieving our objectives?

Challenge	Risk
Continued reduction in income for core mental health service provision, combined with increasing demand and acuity of service users.	Ongoing financial deficit, driven by high levels of bank and agency staff above the agency cap in order to support those with the greatest need. Challenges in maintaining quality and access standards for all service users.
Significant estates transformation required across our geographical footprint to ensure that environments are fit for purpose and reflect service user needs.	Continued use of disparate estate, meaning that we are unable to consolidate skills and expertise, or share staff across units. This in turn drives increasing agency and bank use at times of pressure.
Staff working under significant pressure across all services, impacting on overall morale.	Continued high turnover amongst existing staff and failure to attract new staff to work in the organisation.
Level of system wide of transformation required in order to meet the financial deficit whilst maintaining existing levels of provision.	Sustainability of some core mental health services may be impacted if the system cannot achieve transformation aims.
Level of cultural change required internally and externally to support mental health service provision.	Failure to deliver transformed models of care will impact clinical, operational and financial sustainability.

These risks will be managed in accordance with our risk management strategy and policy and given oversight through the Board Assurance Framework at Trust Board. External risks will be managed through partnership working enabled by the Sustainability and Transformation Partnerships.

To the best of my knowledge this performance report presents a fair and balanced view of the performance of the Trust in 2017/18.

Hayley Richards
Chief Executive

ACCOUNTABILITY REPORT

CORPORATE GOVERNANCE REPORT

Directors report

The Board

Avon and Wiltshire Mental Health Trust is governed by a Board which provides strategic leadership to the organisation. Our Board is comprised of five executive directors and seven non-executive directors (including the Chair). This complies with the requirements of the NHS Act 2006 (as amended) which requires that the Board consist of at least five non-executive directors not including the Chair and that there are more non-executive directors than executive directors. Non-voting directors also regularly attend Board.

To support the Board, the Trust has two statutory and three designated committees which provide assurances on specific functions within the organisation. The Trust's committee structure is set out in detail on page 55.

Board membership during 2017/18

Non-Executive Directors

Charlotte Hitchings
Chair

Prior to joining the Trust, Charlotte was Deputy Chair and Senior Independent Director of 2gether NHS Foundation Trust, which provides specialist social and mental healthcare services across Gloucestershire and Herefordshire. She has also served as Independent Chair of Health Education West Midlands Local Education and Training Board. Charlotte has held senior positions at British Telecom and O2 and has her own executive coaching consultancy.

Appointed to the Board: November 2016
Committees: Nomination and Remuneration (Chair)

Neil Auty

Non-Executive Director

Neil has had a 20-year corporate board career in the food industry, both in the UK and Europe, focusing on turnarounds, acquisitions and divestitures for national and international corporations.

14 years ago he took early retirement, but quickly became bored and set up a staff rostering software company which is now being prepared for sale through the AIM market (a sub-market of the London Stock Exchange). During this time Neil also founded a not-for-profit company providing a free on-line library of pre-vetted self-help videos for the over 60s and he mentors a group of care homes in Dorset.

Appointed to the Board: October 2016 as Associate Non-Executive Director
Appointed to the Board: January 2018 as a Non-Executive Director
Committees: Quality and Standards

Sarah Elliot

Non-Executive Director

Sarah has a background in the NHS, working as a nurse, health visitor and in a variety of senior clinical leadership roles including Chief Nurse for NHS England (southern area).

Since retiring from working full time in the NHS, Sarah has developed a portfolio of roles including chairing two Local Safeguarding Children Boards and mentoring and acting as a Special Advisor to the Care Quality Commission.

Sarah places a high value on service user involvement, prevention and the wellbeing agenda and has worked with local and national voluntary sector groups to facilitate person-centered care and independence. Over the years, Sarah has undertaken a range of volunteering roles including as a lay panel member of a youth offending service, as a school governor and in a dementia café.

Appointed to the Board: February 2017
Committees: Quality and Standards (Chair), Audit and Risk

Ernie Messer

Non-Executive Director and Vice Chair

Ernie has a broad general management career starting in the commercial sector, with senior roles in retail financial services, human resources, IT and large scale strategic change. Eight years ago he switched to the not-for-profit and charity sector specialising in governance, creating high performing leadership teams and successful collaboration between organisations. He is a consultant at Cass Business School's Centre for Charity Effectiveness in London where his work includes helping clients who deliver mental health services and social care services. He also teaches on their MSc programme on the 'Managing People and Quality' module.

Appointed to the Board: 1 February 2016 as an as Associate Non-Executive Director
Appointed to the Board: September 2016 as a Non-Executive Director and Vice Chair/Senior Independent Director from December 2017
Committees: Charitable Funds (Chair), Finance and Planning

Charlotte Moar

Non-Executive Director

Charlotte is a qualified accountant with wide experience in finance, business planning, performance management and informatics.

She is currently Programme Director Efficiency and Transformation for NHS England. Prior to this, Charlotte held finance Director/Deputy Chief Executive posts with Cardiff & Vale University Health Board, South Central Strategic Health Authority, NHS Wiltshire, Great Western Hospitals Foundation Trust and Avon & Wiltshire NHS Partnership Trust. Prior to joining the NHS, Charlotte worked in industry, in the theatre and in publishing.

Charlotte is also the Chair of Bristol Zoological Society, a Non-Executive Director of NHS Resolution and a member of the audit and risk committees of the Medical Research Council and the Big Lottery Fund.

Appointed to the Board: 1 February 2016
Committees: Audit and Risk (Chair)

Mark Outhwaite

Non-Executive Director

Mark runs his own consulting business specialising in coaching, change management and organisational development support, mainly to public sector organisations. He also has a long term interest in the challenges of technology implementation and provides advice and support to tech start-ups in the healthcare sector. At the core of all his approaches is user engagement in co-design and co-production from inception to implementation and beyond.

Mark started his career as an army officer and subsequently became a NHS Chief Executive firstly in a Family Health Services Authority and subsequently in Health Authorities. He left the NHS to set up his own business after a final stint as a Director of the NHS Modernisation Agency.

Appointed to the Board: 1 February 2016
Committees: Finance and Planning (Chair)

Malcolm Shepherd

Non-Executive Director

Malcolm's early career was in industry where he held financial and commercial director posts with several large companies, but for the last 25 years he has worked within the voluntary sector as a consultant, employee, trustee and volunteer. In April 2016 Malcolm retired as Chief Executive of Sustrans, the charity behind the National Cycle Network and other projects which encourage people to travel in ways that benefit their health and the environment. Malcolm was Chief Executive for nine years.

Malcolm also held numerous other positions in the sector including being on the Council of the National Trust, a Director of Friends of the Earth (15 years in total, 3 years as Chairman) and in advisory roles to the Department of Transport.

Since retiring Malcolm has also become a trustee of Avon Wildlife Trust and Life Cycle UK, continuing his passion for the environment and public health.

Appointed to the Board: November 2016
Committees: Audit and Risk, Finance and Planning, Charitable Funds

Executive Directors

Hayley Richards

Chief Executive Officer

Hayley qualified in medicine from the University of Bristol in 1986. She became a member of the Royal College of General Practitioners in 1990 and a member of the Royal College of Psychiatrists in 1993, achieving dual accreditation in General and Old Age Psychiatry.

Hayley joined the Trust as a Consultant Psychiatrist in 2006, and has since undertaken a variety of leadership roles, including Director of Medical Education and Clinical Tutor. In 2013 Hayley became Medical Director where she played a key role in developing our clinically led structure and clinical involvement in decision making. She became Deputy Chief Executive in 2014 and was appointed Chief Executive in February 2016.

Rebecca Eastley

Medical Director

Rebecca trained in London and qualified as a doctor in 1986. Specialising in psychiatry, she was awarded MRCPsych 1991, and achieved dual accreditation in General Adult and Old Age Psychiatry.

Rebecca has broad experience as a Consultant Psychiatrist, taking up her first substantive post in 1999, and has over 12 years' experience in medical management and clinical leadership roles.

Committees: Quality and Standards, Audit and Risk (attendee)

Simon Truelove

Director of Finance

Simon has spent the whole of his working career in the NHS having started as a trainee accountant with Bristol and Weston Health Authority in 1989. He qualified as a Chartered Accountant in 1995 and secured his first finance director post in 2002. He has worked in a range of organisations including commissioning organisations, ambulance trusts and integrated health and social care providers.

He joined the Trust at the end of September 2016 having been the Chief Financial Officer and Deputy Accountable Officer for Wiltshire CCG since 2013. Simon is passionate about the NHS and particularly supports the empowerment of his teams to deliver the best they can in order to transform the services that they support.

Committees: Audit and Risk (attendee), Finance and Planning, Charitable Funds

Sue McKenna

Chief Operating Officer

Sue McKenna has a wealth of experience delivering mental and physical health services within public sector and voluntary organisations, with a number of years at director level. She is fully committed to improving outcomes and experiences for service users, their carers and staff.

Recent roles have included a range of leadership and management positions across physical and mental health, predominantly across adult mental health, forensics, including personality disorder and health and justice. Sue has also led on a number of multi-agency transformational projects across intricate services and wide geographies. Personal growth and learning through academic study has been a life long journey supporting Sue's professional career development.

Sue also remains a registered nurse, in both physical and mental health.

Committees: Quality and Standards, Finance and Planning, Audit and Risk (attendee)

Rachel Clark

Director of Strategy

Following an early career in health research and research management, Rachel joined the NHS where she has worked for more than 17 years.

During this time Rachel has supported and enabled research, innovation and improvement, and enterprise development in an acute setting. Rachel joined AWP in 2010 as Head of Innovation before moving to the role of Director of Organisational Development.

She recently took up the post of Director of Strategy and is enjoying the opportunity to champion the importance of mental health and work with partners to transform services to meet the needs of local communities.

Rachel is strongly committed to the values and aims of the NHS and is proud to work in AWP.

Committees: Charitable Funds (attendee), Finance & Planning (attendee)

Julian Feasby

Director of Human Resources

Julian's career encompasses a range of sectors, focusing on sustainability and people leadership.

During his early career in the private sector, Julian ran a range of functions from large contact centres in the UK and US to water distribution and sustainability teams.

During eleven years with the Environment Agency, Julian fulfilled key roles in the senior human resources team, pursuing particular interests in staff engagement and the development of effective and motivational line management.

Throughout his career, Julian's interests have remained in working with organisations that provide services people really need – an interest that led to him joining AWP, an organisation he describes as meaningful and inspiring.

Julie Kerry

Director of Nursing and Quality

Julie spent her early career was in and around the Thames Valley working with young people with psychosis. As well as spending time in housing and for a charity, she has also held senior clinical and operations roles before moving to the Strategic Health Authority and then NHS England. Before joining AWP Julie was Director of Nursing in the Independent Sector.

Julie joined AWP at the beginning of April 2018. She is passionate about ensuring our patients are at the heart of all we do and wants to increase co-production at every level of the organisation alongside empowering our front line staff to drive quality improvements will help to reduce suicide, reduce restrictive practice, and improve our physical health care offer.

Committees: Quality and Standards, Audit and Risk (attendee)

Appointments to the Board

The skill mix and experience of the Board is kept under continual review and is taken into account when new directors are appointed. One new Non-Executive Director, Neil Auty, was appointed in January 2018, replacing Ruth Brunt, who left the organisation at the end of her term in November 2017. Neil had previously sat on the Board as an Associate Non-Executive Director. Andrew Dean, Director of Nursing and Quality went on assignment to NHSI for twelve months from November 2017. A new Director of Nursing, Julie Kerry, joined the Trust in April 2018. Triss Horwood joined the Trust as a NExT Non-Executive Director in March 2018 and finally, Sarah Knight, who had previously occupied the role of interim company secretary, was appointed into the substantive position this year.

Board diversity

As of 31 March 2018, the Board was composed of four executive directors, three of whom are female, one male, and a female Director of Nursing joined the Board on 9 April 2018. Of the seven non-executive directors (including the Chair), three are female, four are male.

Board Development

To continually improve the capacity and capability of the Board of Directors, the Trust provides a comprehensive programme of Board development days throughout the year. In 2017/18, Board seminars covered the following areas:

- Equality and diversity
- Risk and assurance
- Strategy and planning
- Service transformation
- Leadership and organisational cultural
- Strategic finance

Register of Interests

Each Non-Executive Director is considered to be independent, with no financial or business interest in the Trust. No director has close family ties with any of the Trust's advisors, directors or senior employees. None of the Non-Executive Directors have previously been employed by the Trust in the last 10 years.

In the reporting period no Board director declared any significant interest in a commercial company that the Trust is either currently doing business with or seeking to do business with in the future. One director is married to the Deputy Accountable Officer/Chief Financial Officer of the Bristol, North Somerset and South Gloucestershire CCG. These interests have been declared and to date no conflict of interest has arisen. Were a conflict to arise this would be handled in accordance with the Trust standing orders and NHS guidance.

A Directors' Register of Interest is maintained by the Company Secretary and is available on the Trust website **www.awp.nhs.uk/news-publications/freedom-of-information/lists-and-registers/**

Board meeting attendance

This table sets out the number of meetings directors attended, against the total number they could have been expected to attend. For example, Ruth Brunt, who left the organisation in November 2017, could have attended seven meetings before her departure

	Member	Number of eligible meetings attended in 2017/18	Comments
Non-Executive Directors	Charlotte Hitchings (Chair)	10(10)	
	Neil Auty	7(10)	Associate Non-Executive Director (April-December 2017) Non-Executive Director (January 2018 -)
	Ruth Brunt	7(7)	Left end November 2017
	Sarah Elliot	7(10)	
	Ernie Messer	8(10)	
	Charlotte Moar	9(10)	
	Mark Outhwaite	8(10)	
	Malcolm Shepherd	9(10)	
Executive Directors	Hayley Richards (CEO)	9(10)	
	Andrew Dean	5(6)	Assignment to NHSI 1 November 2017
	Rebecca Eastley	9(10)	
	Sue McKenna	8(10)	
	Simon Truelove	9(10)	
Directors (non-voting)	Rachel Clark	9(10)	
	Julian Feasby	7(7)	

Extraordinary Board meetings

In addition to the ten ordinary Board meetings held this year, three extraordinary Board meetings were held. Extraordinary board meetings are called to address specific, time-critical issues, where decisions are required outside of the normal Board schedule.

Whilst a quorum of members is required for decisions to be approved, due to the short notice of the meetings, it is not expected that all Board members will be able to attend extraordinary board meetings.

	Member	Meetings attended (meetings held)	Comments
Non-Executive Directors	Charlotte Hitchings (Chair)	2(3)	
	Neil Auty	2(3)	Associate Non-Executive Director (April-December 2017) Non-Executive Director (January 2018 -)
	Ruth Brunt	2(2)	Left end November 2017
	Sarah Elliot	2(3)	
	Ernie Messer	3(3)	
	Charlotte Moar	2(3)	
	Mark Outhwaite	3(3)	
	Malcolm Shepherd	3(3)	
Executive Directors	Hayley Richards (CEO)	2(3)	
	Andrew Dean	1(2)	Assignment to NHSI 1 November 2017
	Rebecca Eastley	2(3)	
	Sue McKenna	3(3)	
	Simon Truelove	3(3)	
Directors (non-voting)	Rachel Clark	2(3)	
	Julian Feasby	3(3)	

Declaration

Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Personal data related incidents

The Trust has made a full declaration of all personal data related incidents that were reported to the Information Commission in the Annual Governance Statement, page 62.

Board committees

Audit and Risk Committee (statutory)

Role of the committee

This Committee provides the Board with assurance that the Trust has an effective system of integrated governance, risk management and internal control in place across the Trust's activities (both clinical and non-clinical) to support achievement of the Trust's objectives. The Committee meets at least six times a year.

Principal activities in 2017/18

- Reviewing risk management arrangements of the Trust to provide assurance that risks are being systematically identified and mitigated.
- Reviewing the Board Assurance Framework and strategic and corporate risk registers with deep dives into individual Directorate risk registers.
- Planning and delivering work programmes for external audit, internal audit, clinical audit and counter fraud to ensure that these provide assurance that the Trust is managing risks.
- Reviewing the Trust's arrangements around internal control including policies and exceptions to policies.
- Scrutiny of governance statements including annual report and accounts.

Committee members

Member	Number of eligible meetings attended in 2017/18	Comments
Charlotte Moar (Chair)	7(7)	
Sarah Elliot	5(7)	
Malcolm Shepherd	7(7)	

Committee attendees

In 2017/18, the following are regular attendees of the meeting:

- Director of Finance
- Director of Nursing and Quality
- Internal Audit
- External Audit
- Local Counter Fraud Specialists
- Company Secretary

Nomination and Remuneration Committee (statutory)

Role of the committee

The Committee must ensure a formal, rigorous and transparent procedure for the appointment of Executive Directors to the Trust Board and executive directors (non-voting) who attend the Board. It also develops, maintains and implements a remuneration policy that will enable the Trust to attract and retain the best candidates for executive directors (voting and non-voting) who attend Trust Board meetings.

Principal activities in 2017/18

- Industry benchmarking of very senior managers pay.
- Remuneration for directors.
- Annual performance evaluation of directors.
- Oversight of redundancy and severance pay.

Committee members

Member	Number of eligible meetings attended in 2017/18	Comments
Charlotte Hitchings (Chair)	11(11)	
Neil Auty	5(5)	
Ruth Brunt	5(6)	Left end November 2018
Sarah Elliot	9(11)	
Ernie Messer	9 (11)	
Charlotte Moar	8(11)	
Mark Outhwaite	8(11)	
Malcolm Shepherd	10(11)	

Committee attendees

In 2017/18, the following have also attended committee meetings:

- Chief Executive
- Director of Human Resources
- Company Secretary

Quality and Standards Committee (designated)

Role of the committee

The purpose of the Committee is to provide assurance to the Board that the Trust has in place the necessary structures and processes for the effective provision of safe, high quality patient care that complies with all legislation, regulations and guidance relevant to the Trust.

Principal activities in 2017/18

- Oversight of the preparation of the Quality Accounts.
- Providing assurance of learning from serious untoward incidents.
- Oversight of CQC preparation and action plan.
- Scrutiny of the Trust's clinical audit programme.
- Review of Trust performance indicators.
- Quality impact assessment of transformation projects.
- Oversight of medicines safety.

Committee members

Member	Number of eligible meetings attended in 2017/18	Comments
Ruth Brunt (Chair)	6(8)	Left end November 2017
Neil Auty	7(10)	
Sarah Elliot	9(10)	
Andrew Dean (Director of Nursing)	4(7)	Assignment to NHSI November 2017
Sue McKenna (Chief Operating Officer)	6(10)	
Rebecca Eastley (Medical Director)	9(10)	

Committee attendees

In 2017/18, the following have also attended committee meetings:

- Director of Human Resources
- Associate Director, Governance, Improvement and Quality
- Company Secretary

Finance and Planning Committee (designated)

Role of the committee

The Committee provides assurance to the Board that the Trust's financial performance and business development arrangements are sufficient and effectively managed and controlled.

Principal activities in 2017/18

- Oversight of progress against the Trust's Financial Improvement Plan (FIP).
- Review of the estate transformation programme.
- Budget setting and contract negotiations.
- Overview of commercial activities.
- Monitoring the finance risk register.
- Scrutiny of business planning processes.
- Benchmarking information.

Committee members

Member	Number of eligible meetings attended in 2017/18	Comments
Mark Outhwaite (Chair)	9(11)	
Ernie Messer	10(11)	
Malcom Shepherd	10(11)	
Simon Truelove (Director of Finance)	9 (11)	
Sue McKenna (Chief Operating Officer)	8(11)	

Committee attendees

In 2017/18, the following have also attended committee meetings:

- Director of Strategy
- Divisional Associate Directors
- Head of Planning and Business Development

Charitable Funds Committee (designated)

Role of the committee

The purpose of this Committee is to oversee the management of charitable funds, supporting the delivery of the Trust's vision and strategic objectives through the enhancement of the work of staff and service users.

The Committee reports to the Trust Board as Corporate Trustee.

Principal activities in 2017/18

- Oversight of the charitable fund account balance.
- Review of income generating activities.
- Approval of bids for funds greater than £5,000.
- Ensuring organisational compliance with charity regulations.

Committee members

Member	Number of eligible meetings attended in 2017/18	Comments
Ernie Messer (Chair)	4(4)	
Malcolm Shepherd	3(4)	
Simon Truelove	3(4)	

Committee attendees

In 2017/18, the following have also attended committee meetings:

- Director of Strategy
- Fundraising Manager
- Head of Financial Accounting and Treasury

Annual governance statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable 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 Avon and Wiltshire Mental Health Partnership NHS 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 Avon and Wiltshire Mental Health Partnership NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accountable Officer, I recognise that risk management is a critical component in providing high quality services. I understand that I am the Executive Director with overall accountability for risk management. Our approach is both proactive – staff are encouraged to identify risks through risk assessment and raising concerns; and reactive – through systematic learning from incident, complaints and claims.

To affect my responsibilities for managing risk, I have designated the Director of Nursing and Quality as the lead Executive Director for risk. In addition, the remaining Executive Directors are responsible for managing risk within their areas of responsibility.

How we support our staff to manage risk

The Trust has in place a policy framework to guide staff in the identification, management and reporting of risk to managers. A combined Risk Strategy and Policy was updated in September 2017. Further guidance is available to staff in our Incident, Risk Assessment, Being Open and Whistleblowing policies. In May 2017, we held a board seminar which included risk management to develop the capacity of our leadership team on risk issues.

Our Health, Safety and Risk Management Team also provides six training sessions a year on risk management. In 2017/18, senior staff from each of our divisions (and previously our Local Delivery Units) received dedicated training, either as a group or in one-to-one sessions. In addition, the Health, Safety and Risk Management Team provide 'as required' training on the use of our electronic risk management system, RiskWeb (by Ulysses). Compliance with training requirements is monitored by our Learning and Development department.

The risk and control framework

Corporate Governance

The Trust's corporate governance framework includes its Standing Orders (SOs), Standing Financial Instructions (SFIs), scheme of delegation, assurance framework, risk management strategy and, finally, its policy framework. In respect of corporate governance, the Trust seeks to follow best practice as described in the UK Corporate Governance Code (2016).

The Trust has taken the following steps to strengthen its governance processes in 2017/18:

- Reviewed governance processes and revised the terms of reference for board committees.
- Introduced 'deep dives' into Trust Board sub-committees on issues which present a risk to the strategic objectives to provide further assurance to the Trust Board on the controls in place to mitigate those risks.
- Introduced an Executive Committee, chaired by the Chief Executive and reporting to the Trust Board with responsibility for performance.
- Introduced quarterly performance review meetings with divisions.
- Undertaken an internal Well Led Framework assessment

The Board

In October 2017 the Care Quality Commission (CQC) rated the Trust as 'good' in the Well-Led domain. This was an improvement from 'requires improvement' in 2016. In their report, the CQC commended the Trust on better risk awareness and management at Board level, focus on Board development and on the accessibility of the executive team.

Trust Board formally reviewed our internal process for self-assessment against NHS Improvement's Well-Led Framework in December 2017. Following the Board review, and as part of undertakings agreed with NHS Improvement, we will commission an external review of our leadership against the Well-Led Framework in September 2018.

Throughout 2017/18 the Board sought feedback about its effectiveness at the end of Board meeting. Each attendee is asking to rate specific areas of Board business and indicate what went well and what could be improved in the future. Each attendee is invited to give the meeting a score out of four, with the Chair responsible for acting on the feedback. In November 2017, the Board participated in an externally facilitated Board seminar, focussing on the feature of a high performing board and reflecting on the current Board. This led to a number of actions including developing an agreed set of behaviours and values. This reflective practice is a requirement of all our Board committees. In addition, all Board Committees prepare an end of year review.

Board committees

The Trust's committee structure consists of three statutory and two designated committees. The Nomination and Remuneration Committees were combined in 2017. Each committee is chaired by a non-executive. The Chair of each committee reports on its activity directly to Trust Board as part of the Trust's vertical reporting process. In addition, reports are received between committees as part of the Trust's horizontal reporting processes.

In March 2018, an Executive Committee was established. This committee is chaired by the Chief Executive and reports to the Trust Board, although it is not a formal sub-board committee.

Committee structure

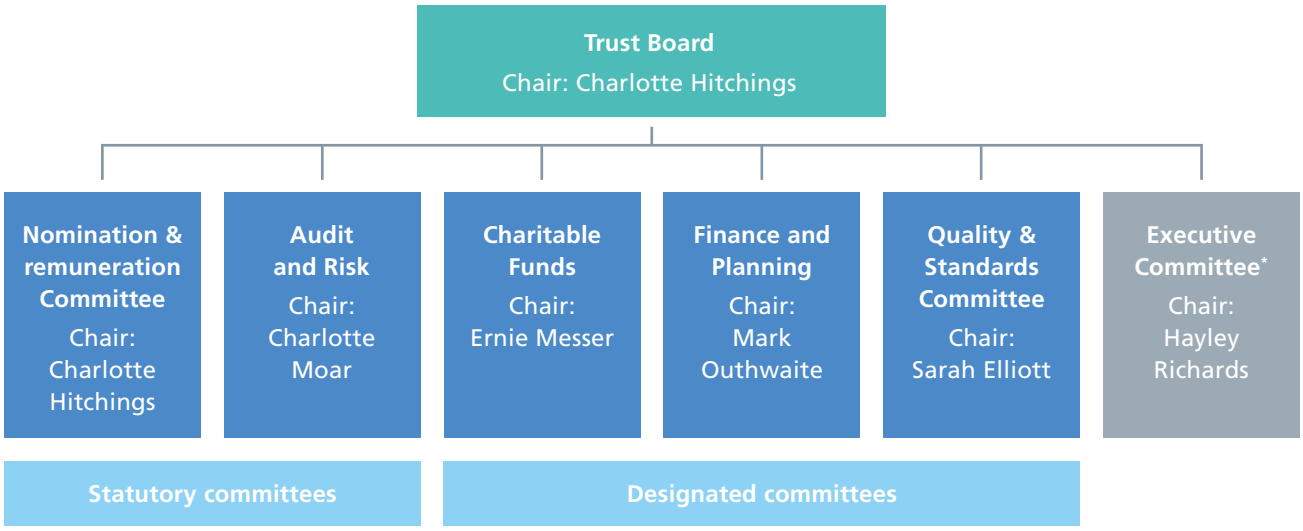


Figure 14 - Trust committee structure, as of 31 March 2018.

*A new Executive Committee was established in March 2018 to provide oversight of the Trust's performance. Executive Committee is not a formal sub-committee of Trust Board, but reports into Board through the Chief Executive.

The Audit and Risk Committee

Responsibility for the oversight and scrutiny of our risk management systems has been delegated to the Audit and Risk Committee. The Audit and Risk Committee seeks assurances as to the effectiveness of management through the provision of reports, risk registers and the board assurance framework. It also takes assurances from internal audit, through our internal audit programme and from our external auditors. The Chair of the Audit and Risk Committee provides a regular report to Trust Board on the work of the committee including any concerns or issues that require reporting to the Board.

In addition, the Finance and Planning and Quality and Standards Committees have oversight of significant business and clinical risk respectively. In addition to the Trust horizontal reporting processes, our Non-Executive directors are members of more than one committee, helping them to triangulate sources of information and assurance. A Chairs call/meeting has been introduced to plan the year going forward and to monitor progress.

Board Assurance Framework

The Board Assurance Framework sets out the Trust's principal risks to our strategic and annual objectives, how we would seek to control those risks in year and the mechanisms for reporting whether those controls remain effective (assurances). Throughout the reporting period, the Executive Directors were individually accountable for the corporate risks within their area of responsibility. The Board reviewed the Board Assurance Framework three times in 2017/18.

Risks featured on the Board Assurance Framework (BAF) in 2017/18 were aligned to the strategic and annual objectives. A lead Director and a lead sub-committee were identified for oversight of the risks.

The 2018/19 Board Assurance Framework is being updated and will include a number of risks from 2017/18 Board Assurance Framework.

Key Risks 2017/18

We will support service users and carers

- Risk of poor patient experience of our services due to inadequate involvement and communication with users and carers.

  Mitigations include: Involvement and Engagement strategy developed, service users and carer forums and participation in the patient leader course

- Risk of lost opportunities to improve the physical healthcare of our population, if we do not maximise the opportunities to work with our partners in public health, voluntary, and third sector partners within the system, who specialise in preventative aspects of healthcare.

  Mitigations include: CQUIN on physical health, Smoke free hospital

- Service users will receive compromised care or care in inappropriate places which could lead to deterioration in symptoms or increased clinical risk due to Delayed Transfer of Care (DTOC).

  Mitigations include: A review of systems and process which reduced DTOC.

We will engage our staff

- If we do not maximise engagement with our workforce and improve the organisational culture, then we will not retain staff and deliver our strategic objectives.

  Mitigations include: Listening into Action culture change programme. Revised communications team structure and focus.

- Risk to financial sustainability if the CIP plan for 17/18 is not delivered as the trust will not be able to deliver objectives. The Trust will need to agree cash loans with the DHSC to support cash flow.

  Mitigations include: Participated in the Financial Improvement Programme. Delivered a CIP programme of £9.1m.

Key risks 2018/19

We will support service users and carers

- If we do not learn from, and embed change as a result of, incidents, internal governance processes, issues raised by CQC, NHSI and other regulatory bodies then we will not continuously improve clinical care

  Mitigations: CQC action plan, Undertakings, Well Led Framework assessment, Sign up to safety programme.

- If we are unable to improve our estate to ensure it is fit for purpose then clinical care may be compromised.

  Mitigations: STP Estates Programme, BNSSG proposed consultation process, BSW engagement on estate strategy.

- If demand and capacity are not aligned and funded then waiting times will increase and outcomes for patients will worsen.

  Mitigations: Transformation programme, re-negotiated contracts, STP engagement.

We will engage our staff

- If we cannot change culture and engage staff then we will not be able to transform our services to improve care.

  Mitigations: Listening into Action, Link Directors, new communications team to lead a revised communications and engagement activities.

- If we are unable to recruit and retain an appropriately skilled workforce and manage in accordance with a workforce plan then effective service delivery may be compromised and agency costs increased.

  Mitigations: Recruitment and Retention Strategy, implementation of local recruitment plans.

- If we do not have an effective senior leadership team with the capacity and redesign capability to deliver change then we will not deliver the transformational change programmes and ensure continuous improvement.

  Mitigation: Review of executive team and senior leadership team, appointment of Interim Programme Director, Transformation.

We will be sustainable

- If STPs transform services to meet the system financial deficit then this may reduce funding for mental health core services and the impact on the sustainability of the Trust.

  Mitigation: STP engagement, re-negotiated contracts.

- If we fail to engage with external stakeholders then there will be insufficient support from the public and stakeholders during public consultations which will impede our transformation.

  Mitigation: Engagement with STPs and stakeholders in developing transformational plans

15 - Table of risks featured on the Board Assurance Framework as of 31 March 2018.

The Trust has not been able to fully self-certify 'confirmed' compliance with the NHS provider licence Condition 4 due to the deficit in 2016/17, 2017/18 and planned deficit for 2018/19. This prompted the external auditors to issue a section 30 referral to the Secretary of State. The Trust is developing a long term financial plan to ensure we return to a financially sustainable position. Bank and agency cost has been one of the significant drivers of the deficit and so recruitment and retention of staff is key to its success in the future; this has been identified as a key future risk above.

Risk management

The Trust approved a new combined risk management strategy and policy in September 2017 which describes our approach to managing risk. All divisions and departments are required to identify and manage risks within their areas, and to record risks via an electronic risk register system. This enables the Trust to report on risks thematically, or by risk score or the date the risk was identified, amongst other criteria. The Trust has formally adopted the 'identify / assess / act / monitor / review' cycle for the management of risks.

The Clinical Director and Associate Director of Operations for each of our three divisions are accountable for managing the day-to-day operational risks within their area. The divisional directors are held to account for the management of their risks at the Operational Delivery Group (Risk) meeting. Divisions present their risks to the Audit and Risk Committee on a rotational basis. This provides the committee with assurance on how the top risks are being managed.

Divisional Risk Registers are reviewed by the Chief Operating Officer to identify any risks that require escalation to the Corporate Risk Register. The Corporate Risk Register is reviewed on a quarterly basis at the Trust Board. A named Executive Director is made responsible for each of our corporate risks and accountable to the Trust Board for demonstrating what actions have been taken to either eliminate or mitigate the risk.

Quality Governance

A Quality and Standards Committee, chaired by a Non-Executive Director oversees the Trust's quality agenda on behalf of the Board. The role of the Committee is to provide assurance to the Board that the structures and processes in place for the provision of safe, high quality patient care are effective and comply with legislation, regulation and guidance. This includes areas such as strategy and planning, capability and culture, processes and structures, and measurement. The Director of Nursing and Quality has executive responsibility for maintaining the system of quality governance.

In order to deliver and maintain its system of quality governance we are developing a Quality Strategy and Quality Improvement Plan (QIP).

The Trust made further improvements to its quality governance processes in 2017/18, establishing a new Clinical Quality Governance Group (CQGG) which was later combined with an the Operational Delivery Group to ensure that quality was central to our business as usual. The Trust implemented a new electronic Improving Quality Delivery (IQD) system to analyse and monitor quality issues and actions.

AWP is committed to continuing to improve the quality of incident investigations and recommendations to enable Trust wide learning and improvement. Considerable work has been undertaken to improve our governance and quality processes in relation to investigations and we are working collaboratively with commissioners to make further improvements. The quality of the investigations is governed by a robust internal governance process; this process was reviewed and further developed in July 2017. As a result of improving our governance processes we are declaring an increased number of serious incidents; we have reviewed our data and are confident that this increase reflects developments in our governance which better enable the identification of serious incidents rather than there being an increase in the number of serious incidents occurring.

All investigation reports are reviewed by a multidisciplinary team, including executive level staff to ensure that reports are honest and transparent and reflect organisational learning when things go wrong. All investigation reports undergo further scrutiny by our commissioners and we are working collaboratively with commissioners to further improve the quality of investigations. We are currently developing our specially trained patient safety review team to further support this work. The most commonly reported serious untoward incidents are suspected suicide. We have developed a suicide prevention strategy which will lead the organisation through a framework aimed at reducing the number of service users whose lives are ended following suspected suicide. This work is being led by our specialist Suicide Prevention Lead. More information about this can be found in the Trust's Quality Account for 2017/18.

In addition, we have taken steps to ensure risk management is embedded as part of business as usual. Quality Impact Assessments (QIAs) are undertaken when any change to clinical services is planned. The QIA occurs at various points during the change process to ensure any potential impact is known and can be monitored and any potential risks adequately mitigated. The QIAs are overseen and ratified at the Quality and Standards Committee.

The Care Quality Commission (CQC)

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust had a formal re-inspection by the Care Quality Commission in June 2017. In an improved position from our 2016 assessment, the Trust was rated 'good' in the caring, responsive and well-led domains, and 'requires improvement' in the safe and effective domains. However, the overall rating remained 'requires improvement'.

The CQC recognised that the Trust had made many of the improvements that they recommended in 2016 including changes to older adult services and the way in which the organisation was led. Both of these specific ratings improved to 'Good'. They also acknowledged the significant changes to the Board and in particular the Executive team. As a result of the improvements that had been made the CQC removed the Sec. 29 Warning Notice that was put in place in 2016.

However, the CQC highlighted two key areas where significant improvement was required: Health Based Places of Safety (HBPoS) and Children and Adolescent Mental Health Services (CAMHS). It is acknowledged by the Trust, as highlighted by the CQC, that there is still work required to improve the service provision and effectiveness of working practices across the HBPoS and CAMHS service provision of the organisation to enable the Trust to realise and sustain a 'Good' CQC rating. Work is already underway to improve these services, including:

Steps taken following the CQC assessment
Significant multi-agency programme to ensure that service users receive a prompt and thorough assessment in our Places of Safety. This has included collaborative work with the Local Authorities, CCGs, Police, Ambulance Service, service users and carers.
Temporarily reducing the number of Places of Safety in Wiltshire and Swindon.
Working with the medical staffing group to ensure that there is an effective and responsive approach to Section 12 medical rostering.
Improved management of waiting lists with our CAMHS services.
A significant improvement to the Riverside Inpatient unit for children and young people.

Figure 16 - Actions taken following the CQC assessment in 2017.

We were pleased that the inspection team found that, without exception, service users and carers spoke positively about the care they received and service users said they feel safe in our care. We are proud that our hard-working and committed staff were described by the inspection team as caring, enthusiastic and delivered high quality care, treating service users and carers with dignity and respect.

Deterrents to fraud

BDO were appointed to work with the Trust on deterring fraud and provided 100 days of service provision in 2017/18 which consisted of 75 days of prevention work, and 25 days of investigation. Assurances were given to the Audit and Risk Committee that the work of the Local Counter Fraud Specialists (LCFS) was compliant with NHS Protect's Standards for Providers, as required by the NHS Standard Contract, and aligned with our internal audit plan to ensure all significant risks are addressed. LCFS provided a report on progress against the Trust's LCFS plan at each Audit and Risk Committee.

Highlights of key deterrents:

- Issuing 8 fraud alerts and circulars
- Liaising with internal audit process/team?
- Delivering bespoke fraud risk management workshops
- Providing briefing notes to the Committee

At the end of each financial year, the LCFS undertakes a Standards Self-Review which focusses on:

- Demonstrating a risk-based approach to anti-fraud, bribery and corruption work;
- Identifying objectives to mitigate risk, the conduct of tasks, and the production of outputs to address identified risks; and
- The successful measurement of effective outcomes.

In 2017/18, the LCFS determined that the Trust had achieved 17 Green and 4 Amber ratings, with an overall rating of Green.

Elective waiting time data

The Trust has in place a Data Quality Management Strategy that sets out the approach to ensuring the quality of all Trust data, including the data that underpins waiting list management and measurement. This approach sees:

- Clinical teams actively managing their waiting lists using daily reports; ensuring that patients are seen quickly following prioritisation based on clinical need.
- Performance against all waiting time standards is reported monthly to Committee and Board, and externally to the Commissioners of our services. Importantly, this includes both nationally defined standards such as those for Early Intervention and IAPT services, but also those standards that have been agreed locally, such as waiting times for emergency assessment.
- The Trust uses validation reports provided by NHS Digital, checking that performance reported locally matches data published nationally.

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

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

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that our obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust's Business Plan and Annual Operating Plan are approved by the Trust Board and submitted to NHS Improvement (NHSI). Delivery against the Annual Operating Plan via the Trust's annual objectives is monitored in detail by the Trust Board on a quarterly basis using the Board Assurance Framework and specific quarterly reports to Board updating on progress against objectives.

The Finance Director and Chief Operating Officer provide detailed monthly financial, activity and performance reports to the Finance and Planning Committee who review and challenge on the delivery of the statutory financial targets including the delivery of the income and expenditure target, capital target, cash targets and the

better practice payment code. The reports are also made available to the members of the Trust Board, the Trust's External Auditors and NHS Improvement. The Chair of the Finance and Planning Committee also provides a report to the Trust Board after each meeting of the Committee describing the level of assurance that has been gained.

The Trust's resources are managed within the framework defined in its Standing Financial Instructions. Financial governance arrangements are reviewed by internal and external audit to ensure economic, efficient and effective use of resources. The processes by which expenditure is committed are continually being reviewed and are audited by internal audit on an annual basis. Budget responsibility has been significantly improved in 2017/18 which has included the review of all budget holders, improved budget sign off processes and greater performance management on delivery against budgets. As part of the enhancement of the performance management framework, performance against budget is more robustly reviewed by the Executive Team and actions agreed for the recovery of budgetary overspends. These new processes continue to be developed and will be enhanced going forward into 2018/19. The Trust has also undertaken a lessons learned review on the budget setting and budget monitoring process in 2017/18, the outcomes having been used to improve the budget setting process for 2018/19.

The financial performance of the Trust in 2017/18 has again been challenging given that the Board had accepted the NHSI control total which required the Trust to deliver savings of £20.5m (9.8% of turnover). The Board's acceptance of the control total was partly informed by the internal savings programme and the Trust volunteering for the NHSI Financial Improvement Programme (FIP). However, early into the financial year it was soon evident that some of the internal savings targets were not going to be delivered and the impact of the FIP was not going to have an impact in the current financial year. The improved rigour in budgetary management in 2017/18 saw a number of areas significantly improve their financial position by enhancing the control on expenditure. Through the support of the FIP provider, greater control has been placed on roster management and the development of greater controls on specific expenditure items such as IT equipment and learning and development expenditure.

As well as increased financial control the Trust focussed on the transformation of its services. The Operations Directorate and Clinical Executive have been supported by the FIP provider to establish new service models that aim to deliver a standardised approach to service delivery across the Trust, while increasing the productivity of community based services. A new monthly Transformation Board was setup in 2017. This monitors the programmes of work that will support the transformation of services and changes to frontline service as they start to happen. It is envisaged that these changes will have an impact on service provision going forward into 2018/19 and beyond.

Throughout 2017/18 the Trust has enhanced its reporting of its financial, workforce and operational performance. This information is used to support the monitoring and delivery of departmental financial objectives and to provide assurance to the Board via the Finance and Planning Committee. Particular attention has been placed on the workforce reporting through the newly established workforce committee.

Given the Financial Improvement Programme and Cost Improvement Programme did not deliver the savings to achieve financial balance, the Trust management team have established a much more rigorous process for the development of savings for 2018/19. Accountability and responsibility is being monitored through the Transformation Board and it is expected that this will support a further improvement in the Trust's financial position. However, it is clear that the Trust will still be in deficit in 2018/19 given that the savings identified at the end of March do not cover the planned difference between income and expenditure. This has been discussed at length within the Board who have decided to not to accept the 2018/19 control total.

The continued deficit has prompted the Trust's external auditors to issue a section 30 referral to the Secretary of State given that the Trust has not achieved its breakeven duty over the last 3 years. We have taken this referral very serious and will be working hard to reduce the deficit in 2018/19

Information governance

The Trust has put in place a comprehensive Information Governance Management System (IGMS) to ensure the security of data under its control. This is based on high level information governance and information security policies which are designed to ensure the integrity, confidentially and availably of information in compliance with the NHS Information Governance Guidance on Legal and Professional Obligations. Additionally the Trust implements technical and operational controls to ensure compliance with the cyber security standards defined in the NHS Digital's Information Governance Toolkit and guidance issued by NHS Digital, CareCERT and the National Cyber Security Centre.

Information Governance Toolkit

The Information Governance Toolkit is a Department of Health Policy (DH) delivery vehicle that NHS Digital has commissioned to develop and maintain. It draws together the legal rules and central guidance set out by DH policy and presents them in a single standard as a set of information governance requirements to protect information held by NHS Trusts.

Each year the Trust is required to carry out a self-assessment of its compliance, against the Information Governance Toolkit requirements.

The Trust achieved Level 2 compliance with an overall score of 67% and was rated satisfactory (green) for 2017/18. This is an improvement over the 2016/17 un-satisfactory rating.

This is the last year that the Trust will be using this assessment methodology and the IG toolkit will be replaced in 2018/19 with the new Data Security and Protection toolkit (DSP Toolkit). The new DSP toolkit has major changes in both scope and requirements and will need a significant review of how the Trust manages its information and IT systems. Plans are already underway regarding this work.

Information governance incidents

The Trust has established an Information Governance Steering Group, a sub-group of the Audit, Risk and Assurance Committee, to provide assurance that information governance incidents are identified, reported and that appropriate action is taken. In 2017/18 the Trust reported 11 information governance incidents to the Information Commissioner.

Category and description	No.	Action taken
Confidentiality Breach Staff members used existing letter as a template and failed to update all information	7	Editable letter templates are being designed to be trailed in the Trust's electronic patient records system.
Confidentiality Breach Information sent to wrong recipient	2	A second letter included in the envelope. Teams involved instructed to document procedure that envelopes must be checked before being sealed.
Lost historic health and social care record Tracked and traced to location 10 years ago from record library. Not tracked back to record library. Search of location failed to find the record.	1	Track and trace reminder sent out.
Lost staff disciplinary file Arrived and signed for at location but subsequently lost. Search of location failed to find the file.	1	Disciplinary files must be delivered by hand.

Table 8 - Incidents reported to the Information Commissioner in 2017/18.

Annual quality account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Trust has followed the NHS Improvement guidance on the required form and content of the Quality Account, to ensure it meets these legal requirements. To ensure that proper arrangements are in place, the Trust has established a system of internal control for the preparation of the Quality Accounts. Through the system of internal control, the Directors of the Trust have satisfied themselves that the Quality Account for 2017/18 is fairly stated.

On behalf of Board, the Chair and Chief Executive have signed a statement to confirm the Directors have taken steps to satisfy themselves that:

- The Quality Account represents a fair and balanced picture of the quality of our services in 2017/18.
- There is adequate internal control over the collection and reporting of performance measures in the Quality Account; and these controls are subject to review to confirm they are effective.
- The data underpinning the performance measures in the Quality Account is accurate and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate review and scrutiny.
- The Quality Account has been prepared in accordance with Department of Health guidance, subject to external audit and is to be submitted by the agreed deadline of 30 June 2018.

The Trust's Quality Account 2017/18 was developed in partnership with our service users, carers, our staff, commissioners, Healthwatch and the Local Authority overview and scrutiny committees.

Following publication, a copy of the Trust's Quality Account 2017/18 will be available on the Trust's website: **www.awp.nhs.uk/news-publications/publications/quality-account/.**

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other 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 and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

A further key source of assurance is our internal audit programme. The Trust agreed an internal audit plan at the beginning of the year, which focussed on key areas of risk for the organisation. The Audit and Risk Committee has had oversight of the internal audit plan, receipt of internal audit reports and has monitored compliance with recommendations. The majority of internal audit reports in 2017/18 gave either reasonable or substantial assurance. Partial assurance was granted in five audit reports, as follows:

Audit title	Key actions taken, or to be taken
Workforce systems and data	• Improve automation of data sharing between ESR and the finance system • Improve budget sign off processes
Stakeholder engagement	• Improve the way we engage with stakeholders on our strategy
Cost improvement plans (CIPs)	• Improve robustness of CIP plans • Review CIP planning process • Ensure CIP plans are approved through a consistent process
Training – Apprenticeship Levy	• Workforce plans (including the role of apprentices) developed for individual service areas
Incident management follow up (lessons learnt)	• Improve the time that it takes to add actions to our Improving Quality Delivery (IQD) system

Table 9 - Internal Audit report granting partial assurance in 2017/18.

Whilst the Trust has a number of workforce initiatives in progress, we recognise the need for more credible workforce plans to tackle the recruitment and retention challenges that we are likely to continue to face in the future.

The Head of Internal Audit has provided me with the following opinion:

The organisation has an adequate and effective framework for risk management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

In the preparation of these accounts, the Audit and Risk Committee, Internal Audit and External Audit have had the opportunity to review the Annual Governance Statement and provide any comments they may have.

Conclusion

The Board has concluded that no significant internal control issues have been identified.

Chief Executive

Senior managers

The Trust employs a skilled and diverse workforce of 4,172 people. 2,100 (50.3%) of these staff hold a professional clinical registration.

Senior managers by grade (at 31 March 2018)

Pay grade	Number
Band 8d	19
Band 9	1
Clinical Director (not on AfC)	2
Senior Manager	1
Director	6
Total	**29**

Table 10 - Senior managers by grade as of 31 March 2018.

All staff

Number and cost of staff employed by staff group

Average number of employees (WTE basis)

	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	270	10	**280**	217
Ambulance staff	-	-	**-**	-
Administration and estates	353	16	**369**	532
Healthcare assistants and other support staff	595	-	**595**	559
Nursing, midwifery and health visiting staff	1,138	71	**1,209**	1,163
Nursing, midwifery and health visiting learners	847	66	**913**	884
Scientific, therapeutic and technical staff	561	1	**562**	495
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	156	-	**156**	-
Total average numbers	**3,920**	**164**	**4,084**	**3,850**
Of which: Number of employees (WTE) engaged on capital projects	-	-	**-**	5

Staff costs

	Permanent £000	Other £000	2017/18 Total £000	2016/17 Total £000
Salaries and wages	130,464	-	**130,464**	127,052
Social security costs	11,391	-	**11,391**	10,905
Apprenticeship levy	620	-	**620**	-
Employer's contributions to NHS pensions	16,247	-	**16,247**	15,523
Pension cost - other	14	-	**14**	12
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	1,666	-	**1,666**	67
Temporary staff		10,927	**10,927**	9,145
Total gross staff costs	**160,402**	**10,927**	**171,329**	**162,704**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**160,402**	**10,927**	**171,329**	**162,704**
Of which				
Costs capitalised as part of assets	-	-	**-**	59

Staff composition

Traditionally, health and care services have attracted a higher proportion of females than many other professions. The majority of the Trust workforce is female (74%). There has been no change in gender balance since 2016/17.

As of 31 March 2018, the split between directors and other posts by sex is:

Sex	Directors	Other posts
Female	4 (80%)	3,097 (74.6%)
Male	2 (20%)	1,053 (25.4%)

Table 11 - Board directors by sex, as of 31 March 2018.

Gender gap

From 1 April 2017, the Equality Act 2010 requires that all trusts formally report their gender pay gap. The 'Gender Pay Gap' is a measure of the difference in the average earnings between males and females across an organisation (or the labour market). It is expressed as a percentage of males' earnings.

Overall, the Trust has very strong female representation in the organisation, and across the Agenda for Change pay bands and Consultant grades. At 31 January 2018, 74.7% of our workforce was female.

Amongst other requirements, the Trust is required to publish the following:

- The mean and median gender pay gap based on hourly rates of ordinary pay.
- The difference between the mean and median hourly rate of ordinary pay of male and female employees.
- The mean and median bonus gender pay gap based on the bonus paid during the period.

Gender	Mean hourly rate	Median hourly rate
Male	£18.03	£15.16
Female	£15.34	£13.45
Difference	£2.69	£1.71
Pay gap %	**14.91%**	**11.28%**

Figure 17 - Gender pay gap.

The data shows that the mean gender pay gap is 14.91%, which is comparable with similar Trusts. This indicates that even though females are better represented in numbers at every level in the organisation, the average hourly pay is not the same.

Gender differences in staff turnover and length of employment may be contributing to the gender pay gap; however, the Trust will need to undertake further analysis in 2018/19 to fully understand the causes of the gender pay gap and identify actions to close the gap.

The Trust's 2017/18 gender pay gap report can be read in full on the Trust's website at: **www.awp.nhs.uk**

Sickness absence

At 31 March 2018, our sickness rate (for the previous 12 months) was 4.37%. This compares to 4.49% in 2016/17. This continues a slight downward trend from 4.51% in 2015/16.

Staffing policies

The Trust is committed to treating our workforce and volunteers fairly, regardless of their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex and their sexual orientation, mental health needs, domestic circumstances, ex-offender status, political allegiance or trades union membership. The means by which we seek to safeguard against such discrimination is set out Workforce Diversity and Equal Opportunities policy.

To further challenge attitudes towards the disabled and to remove barriers to employment, the Trust has signed up to the 'Disability Confident' scheme. This means that any disabled applicant meeting the minimum requirements of a job specification will be guaranteed an interview. The Trust is also committed to making reasonable adjustments during the selection process where required.

In 2017/18, more of our staff declared a disability than in previous years. Staff who become disabled during employment are also supported. Under our Managing Attendance and Absence Policy we commit to making reasonable adjustments both to an employee's role and to their workplace so that, wherever possible, disabled staff are enabled to make best use of their skills and abilities and to ensure the Trust retains the skills and talent of the workforce. This includes providing appropriate and relevant training to enable staff to take up alternative roles if, due to health reasons, they are unable to continue in their substantive post.

All staff, regardless of protected characteristics including disability, have equal access to training and career development and promotion opportunities. Managers are supported through training and coaching by the Employee Relations team to ensure that staff are treated fairly during their employment. The Trust is continuing to develop a career development framework to support all employees to achieve their full potential.

Other issues

The Trust's HR directorate supports employee matters through a range of engagement structures, management coaching and work with staffside representatives as well as maintaining and developing a formal policy structure that enables the organisation to carry out its work effectively. The HR team provides support and advice on informal and formal concerns relating to employment matters to staff and managers.

We employ an Equality and Diversity Advisor whose role is to provide coaching, development, advice and support to executives, managers and staff and also to ensure that the Trust meets its obligations in relation to the publication of relevant data.

Engagement with employees is carried out through a range of measures. The senior management of the Trust actively engages with the trades unions via regular meetings. Policies are developed in conjunction with elected representatives and agreed via the General Negotiating Group. Alongside these formal structures the Trust has local staff engagement and consultative groups which meet regularly. These groups also address matters of health and safety to promote safe working. This is supported by statutory and mandatory training.

In advance of organisational change there is formal engagement with staffside representatives and feedback from staff and staffside is gathered during consultation processes. Organisational change is undertaken in line with Trust policy.

The Trust is continuing to build succession planning to ensure career development opportunities for staff, supported through acting up and secondment arrangements.

The Trust pays staff in line with nationally agreed Terms and Conditions, and makes use of recruitment and retention premia where appropriate to attract and retain staff.

Expenditure on consultancy

The Trust spent £210,484 on consultancy in 2017/18 compared to £1,570,505 in 2016/17.

Off-payroll arrangements

Off-payroll engagements

It is Trust policy that all substantive staff should be paid through the payroll wherever possible. The Trust has not needed to engage contractors on an off-payroll basis that have not been employed through an agency and therefore fulfilling all tax and national insurance requirements.

Reporting of off-payroll engagements earning more than £220 per day.

For all off-payroll engagements as of 31 March 2018, for more than £220 per day and that last longer than six months	
Number of existing engagements as of 31 March 2018	0
Of which, the number that have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

For all new off-payroll engagements between 1 April 2017 and 31 March 2018, for more than £220 per day and that last longer than six months	
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for which assurance has been requested	0
Of which:	
Assurance has been received	0
Assurance has not been received	0
Engagements terminated as a result of assurance not being received	0

Off-payroll engagements of board members with significant financial responsibility between 1st April 2017 and 31st March 2018

Off-payroll engagements of board members	
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements.	0

External Auditor's remuneration

The remuneration paid to the External Auditor in respect of the audit of the accounts for 2017/18 was approximately £52,000 (Trust and Charitable Fund) and £12,000 (Quality Accounts) inclusive of VAT.

Exit packages and severance payments

Exit packages in 2017/18 (to 31 March 2018)

The Trust did not pay any exit packages to its Directors during the 2017/18 financial year. Exit packages for all other Trust staff can be found in the table below:-

Reporting of compensation schemes - exit packages 2017/18						
	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages	
	16/17	17/18	16/17	17/18	16/17	17/18
Exit package cost band (including any special payment element)						
<£10,000	5	9	-	-	5	**9**
£10,001 - £25,000	3	5	-	-	3	**5**
£25,001 - 50,000	-	9	-	-		**9**
£50,001 - £100,000	-	9	-	-		**9**
£100,001 - £150,000	-	4	-	-		**4**
£150,001 - £200,000	-	-	-	-		**-**
>£200,000	-	-	-	-		**-**
Total number of exit packages by type	**8**	**36**	**-**	**-**	**8**	**36**
Total resource cost (£)	£67,522	£1,666,000	£0	£0	**£67,522**	**£1,666,000**

Table 12 - Exit packages by band and total cost, 2017/18.

There were no exit packages: other(non-compulsory) departure payments

Nominations and Remuneration Committee

On behalf of the Trust Board, the Committee is responsible for all decisions concerning the appointment, remuneration and terms of service of Executive Directors and other very senior appointments.

Director's salaries (excluding Non-Executive Directors) are determined by the Trust's Nomination & Remuneration Committee, the membership consisting of the Chair and all the Non-Executive Directors. The policy of the Committee is to reward Executive Directors and very senior managers fairly, individually and collectively to recruit and retain high quality people, ensuring a clear link between pay increases and Trust performance.

The purpose of the Committee is to consider the remuneration and terms of service, including any performance-related elements and the provision of other benefits, for members of the Trust Board and senior managers where national terms and conditions do not apply. The Committee uses benchmarking information provided by NHSI and nationally agreed terms and conditions to inform its decision making.

During 2017/18 there was one contractual redundancy payment made to a previous senior manager who was on secondment to an external health sector organisation from 1 January 2017 and who left on 2 August 2017. This is shown in the Remuneration report.

There were no other compensation payments made to former senior managers, nor any amounts payable to third parties for the services of a senior manager with Board level authority.

Should a current Director/senior manager retire early they would be eligible only for the benefits associated with their membership of the NHS Pension scheme.

Independence of Non-Executive Directors is established in accordance with good governance principles, defined for the NHS within the Healthy NHS Board: principles for good governance and the NHS Foundation Trust Code of Governance. Interests of Non-Executive Directors are reported on **<link to be inserted>**

Directors' expenses paid in 2017/18

Expenses paid to Directors from 1st April 2016 to 31 March 2018		
Directors	**2017-18**	**2016-17**
Number of paid Directors in office	16	15
Number Directors receiving expenses	15	11
Total sum of expenses paid to Directors	£37,493	£27,260

Table 13 - Directors' expenses 2017/18.

Hutton review of fair pay – pay multiple

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. In this context the median is defined as the total remuneration of the staff member who lies in the middle of the linear distribution of staff, excluding the highest paid Director. The median is based on the annualised, full time equivalent remuneration for the year excluding employers' costs.

The banded remuneration of the highest paid Director of the Trust in the financial year 2017/18 was £170k to £175k (2017/18 £170k to £175k). This was 6.9 times (2016/17 7.2 times) the median remuneration of the workforce, which was £24,879 (2016/17 £24,304).

There was no pay award or pay freeze implemented for any group or the entire workforce during 2017/18 that had an impact on the ratio. The Chief Executive did not accept a pay award during 2017/18.

In 2017-18, 0 (2016-17, 0) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £15,404 to £165,000 (2016-17 £15,251-£165,000).

Total remuneration includes salary, non-consolidated performance-related pay, if applicable, and benefits–in-kind. It does not include severance payments, employer pension contributions or the cash equivalent transfer value of pensions. The highest paid Director's salary increase was the most significant factor affecting the ratio.

SALARIES AND ALLOWANCES	2017-18						2016-17					
Name and Title	Salary (bands of £5000)	Expense payments[1] (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5000)	Expense payments[1] (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Anthony Gallagher - Chair (until 11/07/2016)	-	-	-	-	-	-	5-10	0	0-5	0-5	0-2.5	5-10
Susan Thompson - Acting Chair (from 12/07/2016 until 30/11/2016)	-	-	-	-	-	-	10-15	0	0-5	0-5	0-2.5	10-15
Charlotte Hitchings (from 07/11/2016)	35-40	0	0-5	0-5	0-5	35-40	15-20	0	0-5	0-5	0-2.5	15-20
Hayley Richards - Chief Executive	165-170	56	0-5	0-5	62.5-65	230-235	165-170	58	0-5	0-5	210-212.5	385-390
Simon Truelove - Director of Finance (from 26/09/2016)	120-125	36	0-5	0-5	42.5-45	165-170	55-60	18	0-5	0-5	115-117.5	175-180
Andrew Dean - Deputy Chief Executive & Director of Nursing (until 31/10/2017)	130-135	36	0-5	0-5	0-5	130-135	135-140	36	0-5	0-5	0-2.5	135-140
Sue McKenna - Director of Operations (from 08/07/2016)	105-110	36	0-5	0-5	155-157.5	265-270	80-85	27	0-5	0-5	105-107.5	190-195
Rachel Clark - Director of Strategy	85-90	36	0-5	0-5	20-22.5	110-115	80-85	36	0-5	0-5	20-22.5	105-110
Rebecca Eastley - Medical Director (from 31/10/2016)	150-155	36	0-5	0-5	407.5-410	560-565	60-65	15	0-5	0-5	217.5-220	275-280
Julian Feasby - Director of Human Resources (from 03/07/2017)	75-80	0	0-5	0-5	17.5-20	95-100	-	-	-	-	-	-
Sarah Knight - Company Secretary (from 17/01/2017)	60-65	0	0-5	0-5	2.5-5	65-70	10-15	0	0-5	0-5	15-17.5	25-30
Sue Hall - Director of Resources 9 (until 29/06/2016)	-	-	-	-	-	-	30-35	9	0-5	0-5	5-7.5	35-40
Gary Bryant - Director of Finance (from 01/06/2016 until 26/09/2016)	-	-	-	-	-	-	50-55	0	0-5	0-5	0-2.5	50-55
Emma Roberts - Director of Corporate Affairs and Company Secretary (until 31/12/2016)	-	-	-	-	-	-	60-65	3	0-5	0-5	0-2.5	65-70
Matthew Page - Acting Director of Operations (until 07/07/2016)	-	-	-	-	-	-	20-25	6	0-5	0-5	0-2.5	20-25
Timothy Williams - Acting Medical Director (until 31/10/2016)	-	-	-	-	-	-	115-120	0	0-5	0-5	87.5-90	200-205
Non Executive Directors												
Ruth Brunt (Until 10/11/2017)	0-5	0	0-5	0-5	0-2.5	0-5	5-10	0	0-5	0-5	0-2.5	5-10
Malcom Shepherd (from 28/11/2016)	5-10	0	0-5	0-5	0-2.5	5-10	0-5	0	0-5	0-5	0-2.5	0-5
Ernest Messer (From 01/09/2016)	5-10	0	0-5	0-5	0-2.5	5-10	5-10	0	0-5	0-5	0-2.5	5-10
Charlotte Moar (From 1/02/2016)	5-10	0	0-5	0-5	0-2.5	5-10	5-10	0	0-5	0-5	0-2.5	5-10
Mark Outhwaite (From 1/02/2016)	5-10	0	0-5	0-5	0-2.5	5-10	5-10	0	0-5	0-5	0-2.5	5-10
Sarah Elliot (from 6/02/2017)	5-10	0	0-5	0-5	0-2.5	5-10	0-5	0	0-5	0-5	0-2.5	0-5
Barry Dennington (until 30/09/2016)	-	-	-	-	-	-	0-5	0	0-5	0-5	0-2.5	0-5
Peaches Golding (until 31/08/2016)	-	-	-	-	-	-	0-5	0	0-5	0-5	0-2.5	0-5
Neil Auty (from 1/01/2018) - Associate Non-Executive Director (until 31/12/2017)	5-10	0	0-5	0-5	0-2.5	5-10	0-5	0	0-5	0-5	0-2.5	0-5

Notes:

1. The expense payments relate to car allowances
2. Emma Roberts was on assignment to West of England Academic Health Science Network between 01/01/2017 – 02/08/17.
3. Emma Roberts received a contractual payment of £42k for loss of office as her post was removed from the structure whilst she was on assignment.
4. The expense payments which are taxable relate to individual car allowances

All of the above Directors were in post for the 12 month period to 31st March 2018 except where indicated.
No annual performance or long term performance related bonuses were paid during the period.
Salary amounts include all salary paid and payable to the Directors by the Trust; this may include payments in arrears made during the year.

Band of Highest Paid Directors Total Annualised Remuneration (£'000)	170-175	170-175
Median Total Remuneration	24,879	24,304
Ratio	6.9	7.2

PENSION BENEFITS Name and title	Real increase in pension at pension age (bands of £2500) £000	Real increase in pension lump sum at pension age (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2018 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2017 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Employers Contribution to Stakeholder Pension £000
Hayley Richards - Chief Executive	2.5-5	2.5-5	70-75	210-215	1,367	141	1,521	*
Rachel Clark - Director of Strategy	0-2.5	0-2.5	20-25	45-50	287	32	323	*
Andrew Dean - Director of Nursing[2]	*	*	*	*	*	*	*	*
Rebecca Eastley - Medical Director (from 31/10/2016)	10-12.5	30-32.5	50-55	205-210	961	425	1,395	*
Julian Feasby - Director of Human Resources (from 03/07/2017)	0-2.5	0-2.5	0-5	0-5	0	10	14	*
Sarah Knight - Company Secretary (from 17/01/2017)	0-5	0-2.5	10-15	35-40	220	8	231	*
Sue McKenna - Director of Operations (from 08/07/2016)	5-7.5	15-17.5	40-45	140-145	727	179	913	*
Simon Truelove - Director of Finance (from 26/09/2016)	2.5-5	2.5-5	30-35	75-80	473	59	538	*

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

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 (or other allowable beneficiary'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 in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in

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

All the figures in the above table, together with the pay multiples have been subjected to external audit

PARLIAMENTARY ACCOUNTABILITY AND AUDIT REPORT

Independent auditor's report to the directors of Avon and Wiltshire Mental Health Partnership NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Avon and Wiltshire Mental Health Partnership NHS Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that the Trust incurred a deficit of £11.9 million (adjusted retained deficit £10.7 million) during the year ended 31 March 2018 and, at that date, had net current liabilities of £0.9 million. The Trust is seeking additional support from NHS Improvement for 2018/19 of £6.4 million. As stated in note 1.1.2, NHS Improvement has not, at the date of our report, confirmed this support. These events or conditions, along with the other matters explained in note 1.1.2, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report set out on pages 1 - 76, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 15 February 2018 we referred a matter to the Secretary of State under section 30(b) of the Local and Audit Accountability Act 2014 because the Trust had accumulated a significant overspend in 2017-18 and we had reason to believe that the Trust had taken a course of action which, if followed to its conclusion, would lead to a breach of the Trust's break-even duty for the three year rolling period ended 31 March 2020.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit and Risk Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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

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

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matters described in the basis for qualified conclusion section of our report we are satisfied that, in all significant respects Avon and Wiltshire Mental Health Partnership NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- During the course of 2017/18 the Trust's financial position deteriorated significantly and the Trust incurred a deficit of £11.9 million, compared to a planned surplus of £2.6 million. Total staff costs have increased by £8.6 million since 2016-17 and this has significantly contributed to the operational deficit.
- For 2018-19, whilst some £9.65 million of savings plans have been identified by the Trust, there remains a gap of over £10 million where robust savings plans have yet to be identified to deliver the control total set by NHS Improvement. The Trust has yet to agree to the control total surplus of £2.992 million set by NHS Improvement. This level of unidentified savings represents a significant risk that the control total is not achievable.

Each Local Delivery Unit is required to produce a workforce plan, but the Trust does not have a robust trust-wide workforce plan in place. The significant overspend on the budget for staff costs has contributed to the unplanned operational deficit.

These matters identify weaknesses in the Trust's arrangements for:

- setting a sustainable budget with sufficient capacity to absorb emerging cost pressures; and
- planning, organising and developing the workforce effectively.

These matters are evidence of weaknesses in proper arrangements for:

- sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions; and
- planning, organising and developing the workforce effectively to deliver strategic priorities.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Avon and Wiltshire Mental Health Partnership NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Barrie Morris

Barrie Morris
Appointed Auditor
for and on behalf of Grant Thornton UK LLP

2 Glass Wharf
Bristol
BS2 0EL

22 May 2018

Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

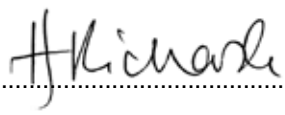
The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, as far as I am aware, there is no relevant audit information of which the 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 trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed.....  .....Chief Executive

22 May 2018

Statement of Directors' responsibilities in respect of the accounts

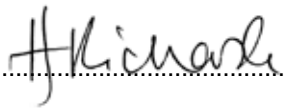
The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

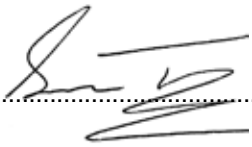
The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Signed.....  .....Chief Executive

22 May 2018

Signed.....  .....Finance Director

22 May 2018

Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for Avon and Wiltshire Mental Health Partnership NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2017/18 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:

- the financial records maintained by the NHS trust
- accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
- the template accounting policies for NHS trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.

2. I certify that the TAC schedules are internally consistent and that there are no validation errors.

3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.

Simon Truelove, Director of Finance
22 May 2018

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Trust is required to submit to NHS Improvement.

2. I have reviewed the schedules and agree the statements made by the Director of Finance above.

Hayley Richards, Chief Executive
22 May 2018

FINANCIAL STATEMENTS

Avon and Wiltshire Mental Health Partnership NHS Trust

Annual accounts for the year ended 31 March 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	209,909	203,282
Other operating income	4	10,646	11,075
Operating expenses	5, 7	(224,100)	(223,850)
Operating surplus/(deficit) from continuing operations		**(3,545)**	**(9,493)**
Finance income	10	20	16
Finance expenses	11	(6,569)	(6,241)
PDC dividends payable		(1,844)	(2,444)
Net finance costs		**(8,393)**	**(8,669)**
Other gains / (losses)	12	-	462
Surplus / (deficit) for the year from continuing operations		**(11,938)**	**(17,700)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(133)	-
Revaluations		-	(5,242)
Other reserve movements		-	33
Total comprehensive income / (expense) for the period		**(12,071)**	**(22,909)**

The notes 7 to 47 on the following pages form part of this account.

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	710	1,084
Property, plant and equipment	14	113,750	116,329
Total non-current assets		**114,460**	**117,413**
Current assets			
Inventories	15	292	373
Trade and other receivables	16	13,627	14,067
Cash and cash equivalents	18	1,056	1,056
Total current assets		**14,975**	**15,496**
Current liabilities			
Trade and other payables	19	(13,233)	(16,386)
Borrowings	21	(1,275)	(1,470)
Provisions	22	(1,097)	(200)
Other liabilities	20	(291)	(143)
Total current liabilities		**(15,896)**	**(18,199)**
Total assets less current liabilities		**113,539**	**114,710**
Non-current liabilities			
Borrowings	21	(58,023)	(47,948)
Provisions	22	(1,738)	(1,763)
Total non-current liabilities		**(59,761)**	**(49,711)**
Total assets employed		**53,778**	**64,999**
Financed by			
Public dividend capital		101,018	100,168
Revaluation reserve		13,583	14,019
Income and expenditure reserve		(60,823)	(49,188)
Total taxpayers' equity		**53,778**	**64,999**

The notes on pages 7 to 47 form part of these accounts.

The financial statements on pages 2 to 6 were approved by the Audit and Risk Committee, on behalf of the Board on 18th May 2018 and signed on its behalf by

Name Hayley Richards
Position Chief Executive
Date **22 May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**100,168**	**14,019**	**(49,188)**	**64,999**
Surplus/(deficit) for the year	-	-	(11,938)	**(11,938)**
Other transfers between reserves	-	(303)	303	**-**
Impairments	-	(133)	-	**(133)**
Public dividend capital received	850	-	-	**850**
Taxpayers' equity at 31 March 2018	**101,018**	**13,583**	**(60,823)**	**53,778**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**99,621**	**20,846**	**(33,106)**	**87,361**
Prior period adjustment	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**99,621**	**20,846**	**(33,106)**	**87,361**
Surplus/(deficit) for the year	-	-	(17,700)	**(17,700)**
Other transfers between reserves	-	(1,612)	1,612	**-**
Revaluations	-	(5,242)	-	**(5,242)**
Public dividend capital received	547	-	-	**547**
Other reserve movements	-	27	6	**33**
Taxpayers' equity at 31 March 2017	**100,168**	**14,019**	**(49,188)**	**64,999**

Information on reserves

1 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

2 Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS trust.

3 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.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(3,545)	(9,493)
Non-cash income and expense:			
Depreciation and amortisation	5	6,211	6,040
Net impairments	6	2,197	8,422
(Increase) / decrease in receivables and other assets		318	879
(Increase) / decrease in inventories		81	(105)
Increase / (decrease) in payables and other liabilties		(3,322)	(2,598)
Increase / (decrease) in provisions		872	425
Other movements in operating cash flows		92	-
Net cash generated from / (used in) operating activities		**2,904**	**3,570**
Cash flows from investing activities			
Interest received	10	20	16
Purchase of intangible assets	13	-	(692)
Purchase of property, plant, equipment and investment property	14	(5,288)	(5,759)
Sales of property, plant, equipment and investment property		-	1,991
Net cash generated from / (used in) investing activities		**(5,268)**	**(4,444)**
Cash flows from financing activities			
Public dividend capital received		850	547
Movement on loans from the Department of Health and Social Care		11,349	5,899
Capital element of PFI, LIFT and other service concession payments		(1,470)	(1,357)
Interest paid on PFI, LIFT and other service concession obligations		(6,216)	(6,124)
Other interest paid	11.1	(353)	(55)
PDC dividend (paid) / refunded		(1,796)	(2,580)
Net cash generated from / (used in) financing activities		**2,364**	**(3,670)**
Increase / (decrease) in cash and cash equivalents		**-**	**(4,544)**
Cash and cash equivalents at 1 April - brought forward		**1,056**	**5,600**
Prior period adjustments		**-**	**-**
Cash and cash equivalents at 1 April - restated		**1,056**	**5,600**
Cash and cash equivalents at 31 March	18.1	**1,056**	**1,056**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

Note 1.1.1 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 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

The Trust incurred a retained deficit of £11,938,000 (an adjusted retained deficit £10,380,000) during the year ended 31 March 2018 and, at that date had net current liabilities of £921,000.

The Trust is assuming an additional cash loan of £6.35m in 2018/19 to maintain current payment performance assuming that the Trust delivers its savings plan. This is in addition to the current cash loan of £17.25m. Although the Trust has not received formal notification of future financing, this has always been available in accordance with the need of the Trust to meet all essential liabilities and there is no indication that this will not continue. If the Trust fails to deliver in full the savings plan in 2018/19 then a further cash loan will be required. As the Trust's continuing operational stability depends on finance that has not yet been approved, in line with the NHS Group Accounting Manual, this represents a material uncertainty for the going concern basis. The savings identified within the current Trust plan for 2018/19 are £9.65m.

Although these factors represent a material uncertainty that may cast significant doubt over the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the 2017/18 Department of Health Group Accounting Manual, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

The Trust is required to report that on 15 February 2018 the auditors referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to the Trust forecasting a breach of its break-even duty for the three year period ending 31 March 2020. There is reason to believe that the Trust, or an officer of the Trust, has made a decision which would involve the body incurring unlawful expenditure and has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

Note 1.2 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.2.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Private Finance Initiative (PFI)

The Trust applies judgement to the impact on future years of its PFI scheme i.e inflationary uplifts.

Gross and Net Accounting Treatment

The Trust has recorded revenue and expenditure as gross and not netted them off e.g. the Trust seconds staff to another body, the Trust has included staff costs as expenditure and the reimbursement from the other body as revenue.

Review of Lease arrangements

The Trust has applied the rules of IAS17 and IFRIC4 in determining the accounting of its lease arrangements. An assessment of these leases has been undertaken in 2017/18 and all were ascertained to be operating leases under IAS17.

Note 1.2.2 Key sources of estimation uncertainty

Existing Use Valuation

The Trust has considered the appropriate valuations in assessing a true and fair value of its property and equipment, and its intangible assets at the Statement of Financial Position date. All property has been valued using MEA (Modern Equivalent Asset) and RICS (Royal Institute of Chartered Surveyors)

The Trust received a full valuation from the District Valuer as at 31 March 2017, with a desktop exercise completed during 2017-18 for known material changes. This has led to an impairment in year of £2,197k

The carrying amount of the Trust land and building assets at 31 March 2018 is £105,710k.

Economic Lives of Non-Current Assets

The Trust has applied useful economic lives to its assets as provided by the District Valuer and has depreciated on that basis.

Non Property Assets

The Trust has applied the depreciated historic cost method in valuing its non property assets so that the valuation is not materially different from fair value. The net book value (NBV) of all non property assets (equipment) is £7,989k at 31 March 2018. Intangible assets have a carrying value of £710k and Assets Under Construction have a carrying value of £49k

Note 1.2.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Note 1.3.1 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.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.4.1 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 1.5.1 Property, plant and equipment

Note 1.5.2 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control. This is generally only applicable to items of IT equipment, due to them being attached to the Trust network.

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

Note 1.5.3 Measurement
All property, plant and equipment are measured initially at cost, representing the cost 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 that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts 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, modern equivalent asset basis.

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, borrowing costs. Assets are revalued and depreciation commences when they 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 economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

The estimated useful lives applied are as follows:

Buildings - 12-54 years, dependant on District Valuer valuation
Furniture - up to 10 years
Information Technology - 5-10 years
Plant and equipment short life - 5 years
Plant and equipment medium life - 10 years
Plant and equipment long life - 15 years

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

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

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the *GAM*, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.5.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Note 1.6.1 Intangible assets

Note 1.6.2 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, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Note 1.6.3 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Note 1.6.4 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset, which is generally between 1-5 years.

Note 1.7.1 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.8.1 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 NHS Trust's cash management.

Note 1.9.1 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 1.9.2 The trust as lessee
The Trust holds only its PFI asset as a finance lease, which was initially valued, at the inception of the lease, at fair value, with a matching liability for the lease obligation. Finance charges of the PFI obligation are recognised in calculating the Trust's surplus.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

Note 1.9.3 The trust as lessor

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 on a straight-line basis over the lease term.

Note 1.9.4 Private Finance Initiative (PFI) transactions
HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The NHS Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS Trust's Statement of Financial Position.

Other assets contributed by the NHS Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the NHS Trust through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

Note 1.10.1 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 the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 22.1 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 1.11.1 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Note 1.12.1 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.

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.13.1 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 1.14.1 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However 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.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the NHS Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

Note 1.15.1 Research & Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Income on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

Note 1.16.1 Accounting Standards that have been issued but have not yet been adopted

• IFRS 9 Financial Instruments – Application required for accounting periods from 1 April 2018, no material impact is expected.

• IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods from 1 April 2018, no material impact is expected.

• IFRS 16 Leases – Application required for accounting periods from 1 April 2019, no material impact is expected.

Note 2 Operating Segments

The Trust Board receives regular reports on the financial position of the Trust, that is also reviewed by the Finance and Planning Committee. These reports include a Statement of Comprehensive Income and a Statement of Financial Position, which are provided on a 'whole Trust' basis. It is therefore considered that the Trust has just one reportable segment, that being a healthcare segment.

The total income in the Trust position from external customers is £220.6m, and this has been classified between block contracts, cost and volume contracts and clinical income from mandatory services.

The total income from CCGs under common control amounts to 10% or more of total income and is £153.2m. This excludes direct income from NHS England which is £29.4m

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Mental health services		
Cost and volume contract income	1,293	1,762
Block contract income	166,151	164,076
Clinical partnerships providing mandatory services (including S75 agreements)	-	-
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	42,465	37,444
Total income from activities	**209,909**	**203,282**

Note 3.2 Income from patient care activities (by source)		
Income from patient care activities received from:	**2017/18 £000**	**2016/17 £000**
NHS England	29,381	30,671
Clinical commissioning groups	153,578	148,439
Department of Health and Social Care	-	-
Other NHS providers	685	596
NHS other	102	101
Local authorities	7,280	7,523
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	-	-
NHS injury scheme	-	-
Non NHS: other	18,883	15,952
Total income from activities	**209,909**	**203,282**
Of which:		
Related to continuing operations	209,909	203,282
Related to discontinued operations	-	-

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	1,605	1,915
Education and training	6,793	6,235
Non-patient care services to other bodies	77	676
Sustainability and transformation fund income	344	315
Rental revenue from operating leases	646	1,429
Income in respect of staff costs where accounted on gross basis	633	249
Other income	548	256
Total other operating income	**10,646**	**11,075**
Of which:		
Related to continuing operations	10,646	11,075
Related to discontinued operations	-	-

Note 5 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	947	866
Purchase of healthcare from non-NHS and non-DHSC bodies	9,168	9,903
Staff and executive directors costs	169,663	162,645
Remuneration of non-executive directors	80	71
Supplies and services - clinical (excluding drugs costs)	1,618	1,575
Supplies and services - general	6,374	4,410
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	3,985	3,573
Consultancy costs	210	1,571
Establishment	2,554	2,393
Premises	7,830	10,644
Transport (including patient travel)	3,514	3,139
Depreciation on property, plant and equipment	5,837	5,770
Amortisation on intangible assets	374	270
Net impairments	2,197	8,422
Increase/(decrease) in other provisions	113	-
Change in provisions discount rate(s)	22	62
Audit fees payable to the external auditor		
audit services- statutory audit	50	50
other auditor remuneration (external auditor only)	12	24
Internal audit costs	68	82
Clinical negligence	438	313
Legal fees	358	230
Insurance	216	259
Research and development	455	752
Education and training	580	775
Rentals under operating leases	3,266	3,202
Redundancy	1,666	-
on IFRS basis	1,242	1,357
Car parking & security	486	514
Hospitality	27	37
Losses, ex gratia & special payments	10	-
Other	740	941
Total	**224,100**	**223,850**
Of which:		
Related to continuing operations	224,100	223,850
Related to discontinued operations	-	-

The majority of the redundancy costs noted in year are related to corporate restructuring and a scheme on the Trust Cost Improvement Programme

The reduction in net impairments in the year is due to the District Valuer completing a full valuation in 2016/17 that was not felt necessary in 2017/18. A desktop review was instead conducted on material changes within the year.

The significant reduction in premises costs in year is due to the premises costs for the CAMHS service are being charged directly to the main service provider.

The audit fees shown above are recorded inclusive of VAT as this is the actual cost to the organisation, with the VAT not being recoverable for these services.

Note 5.1 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
Other non-audit services	12	24
Total	**12**	**24**

Note 5.2 Limitation on auditor's liability

The auditor's liability for external audit work carried out for the financial year 2017/18 is limited to £2,000,000.

Note 6 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	3,006
Changes in market price	2,197	5,416
Total net impairments charged to operating surplus / deficit	**2,197**	**8,422**
Impairments charged to the revaluation reserve	133	-
Total net impairments	**2,330**	**8,422**

The impairments shown in the table above are as a result of the District Valuer desktop exercise that took place during 2017/18. The exercise focused on material changes and significant projects within the year and considered added value or bringing back into full operational use of particular assets.

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	130,464	127,052
Social security costs	11,391	10,905
Apprenticeship levy	620	-
Employer's contributions to NHS pensions	16,247	15,523
Pension cost - other	14	12
Termination benefits	1,666	67
Temporary staff (including agency)	10,927	9,145
Total gross staff costs	**171,329**	**162,704**
Recoveries in respect of seconded staff	-	-
Total staff costs	**171,329**	**162,704**
Of which		
Costs capitalised as part of assets	-	59

Note 7.1 Retirements due to ill-health

During 2017/18 there was 1 early retirement from the trust agreed on the grounds of ill-health (8 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £62k (£460k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Note 9 Operating leases

Note 9.1 Avon and Wiltshire Mental Health Partnership NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Avon and Wiltshire Mental Health Partnership NHS Trust is the lessor.

It should be noted that the significant change between years is due to the leases for the CAMHS service passing to the main service provider, rather than through AWP as in the prior year.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	646	1,429
Contingent rent	-	-
Other	-	-
Total	**646**	**1,429**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	451	357
- later than one year and not later than five years;	381	178
- later than five years.	184	-
Total	**1,016**	**535**

Note 9.2 Avon and Wiltshire Mental Health Partnership NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Avon and Wiltshire Mental Health Partnership NHS Trust is the lessee.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	3,266	3,202
Contingent rents	-	-
Less sublease payments received	-	-
Total	**3,266**	**3,202**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	2,073	1,482
- later than one year and not later than five years;	6,803	3,190
- later than five years.	24,393	15,787
Total	**33,269**	**20,459**
Future minimum sublease payments to be received	-	(129)

Note 10 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	20	16
Total	**20**	**16**

Note 11.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	353	54
Interest on late payment of commercial debt	-	1
Main finance costs on PFI and LIFT schemes obligations	3,401	3,507
Contingent finance costs on PFI and LIFT scheme obligations	2,815	2,617
Total interest expense	**6,569**	**6,179**
Unwinding of discount on provisions	-	62
Total finance costs	**6,569**	**6,241**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	1

Note 12 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	-	570
Losses on disposal of assets	-	(108)
Total other gains / (losses)	**-**	**462**

No properties or other assets were sold in the year 2017/18

Note 13.1 Intangible assets - 2017/18

	Software licences	Internally generated information technology	Websites	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**1,430**	**669**	**14**	**2,113**
Additions	-	-	-	**-**
Gross cost at 31 March 2018	**1,430**	**669**	**14**	**2,113**
Amortisation at 1 April 2017 - brought forward	**524**	**498**	**7**	**1,029**
Provided during the year	272	95	7	**374**
Amortisation at 31 March 2018	**796**	**593**	**14**	**1,403**
Net book value at 31 March 2018	**634**	**76**	**-**	**710**
Net book value at 1 April 2017	**906**	**171**	**7**	**1,084**

Note 13.2 Intangible assets - 2016/17

	Software licences	Internally generated information technology	Websites	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**738**	**669**	**14**	**1,421**
Valuation / gross cost at 1 April 2016 - restated	**738**	**669**	**14**	**1,421**
Additions	692	-	-	**692**
Valuation / gross cost at 31 March 2017	**1,430**	**669**	**14**	**2,113**
Amortisation at 1 April 2016 - as previously stated	**397**	**362**	**-**	**759**
Prior period adjustments	**-**	**-**	**-**	**-**
Amortisation at 1 April 2016 - restated	**397**	**362**	**-**	**759**
Provided during the year	**127**	**136**	**7**	**270**
Amortisation at 31 March 2017	**524**	**498**	**7**	**1,029**
Net book value at 31 March 2017	**906**	**171**	**7**	**1,084**
Net book value at 1 April 2016	**341**	**307**	**14**	**662**

Note 14.1 Property, plant and equipment - 2017/18

	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 2017 - brought forward	**19,470**	**100,160**	**297**	**1,161**	**1,080**	**605**	**20,842**	**12,210**	**155,825**
Additions	-	3,143	-	87	296	-	2,062	-	**5,588**
Impairments	(369)	252	-	-	-	-	(16)	-	**(133)**
Reclassifications	-	1,199	-	(1,199)	-	-	-	-	**-**
Valuation/gross cost at 31 March 2018	**19,101**	**104,754**	**297**	**49**	**1,376**	**605**	**22,888**	**12,210**	**161,280**
Accumulated depreciation at 1 April 2017 - brought forward	**88**	**13,263**	**297**	**-**	**981**	**360**	**13,906**	**10,601**	**39,496**
Provided during the year	**-**	**2,594**	**-**	**-**	**88**	**54**	**2,515**	**586**	**5,837**
Impairments	-	2,197	-	-	-	-	-	-	**2,197**
Accumulated depreciation at 31 March 2018	**88**	**18,054**	**297**	**-**	**1,069**	**414**	**16,421**	**11,187**	**47,530**
Net book value at 31 March 2018	**19,013**	**86,700**	**-**	**49**	**307**	**191**	**6,467**	**1,023**	**113,750**
Net book value at 1 April 2017	**19,382**	**86,897**	**-**	**1,161**	**99**	**245**	**6,936**	**1,609**	**116,329**

Note 14.2 Property, plant and equipment - 2016/17

	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 2016 - as previously stated	**20,612**	**95,296**	**297**	**4,751**	**1,025**	**605**	**19,927**	**12,098**	**154,611**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016 - restated	**20,612**	**95,296**	**297**	**4,751**	**1,025**	**605**	**19,927**	**12,098**	**154,611**
Additions	-	4,181	-	1,193	55	-	915	112	**6,456**
Revaluations	(1,142)	(4,100)	-	-	-	-	-	-	**(5,242)**
Reclassifications	-	4,783	-	(4,783)	-	-	-	-	**-**
Valuation/gross cost at 31 March 2017	**19,470**	**100,160**	**297**	**1,161**	**1,080**	**605**	**20,842**	**12,210**	**155,825**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**2,199**	**297**	**-**	**905**	**306**	**11,748**	**9,849**	**25,304**
Accumulated depreciation at 1 April 2016 - restated	**-**	**2,199**	**297**	**-**	**905**	**306**	**11,748**	**9,849**	**25,304**
Provided during the year	**-**	**2,730**	**-**	**-**	**76**	**54**	**2,158**	**752**	**5,770**
Impairments	88	8,334	-	-	-	-	-	-	**8,422**
Accumulated depreciation at 31 March 2017	**88**	**13,263**	**297**	**-**	**981**	**360**	**13,906**	**10,601**	**39,496**
Net book value at 31 March 2017	**19,382**	**86,897**	**-**	**1,161**	**99**	**245**	**6,936**	**1,609**	**116,329**
Net book value at 1 April 2016	**20,612**	**93,097**	**-**	**4,751**	**120**	**299**	**8,179**	**2,249**	**129,307**

Note 14.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	19,013	44,650	49	307	191	6,467	1,023	**71,700**
On-SoFP PFI contracts and other service concession arrangements	-	42,050	-	-	-	-	-	**42,050**
NBV total at 31 March 2018	**19,013**	**86,700**	**49**	**307**	**191**	**6,467**	**1,023**	**113,750**

Note 14.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	19,382	43,378	1,161	99	245	6,936	1,609	**72,810**
On-SoFP PFI contracts and other service concession arrangements	-	43,519	-	-	-	-	-	**43,519**
NBV total at 31 March 2017	**19,382**	**86,897**	**1,161**	**99**	**245**	**6,936**	**1,609**	**116,329**

Note 15 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	114	132
Other	178	241
Total inventories	**292**	**373**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £2,174k (2016/17: £2,090k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 16.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	7,093	6,980
Accrued income	961	919
Prepayments (non-PFI)	1,595	1,792
PFI prepayments - capital contributions	3,102	3,176
PDC dividend receivable	74	122
VAT receivable	690	802
Other receivables	112	276
Total current trade and other receivables	**13,627**	**14,067**
Total non-current trade and other receivables	**-**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	5,044	6,148
Non-current	-	-

Note 16.2 Credit quality of financial assets

Ageing of non-impaired financial assets past their due date

Ageing of non-impaired financial assets	31 March 2018 Trade and other receivables £000	31 March 2017 Trade and other receivables £000
0 - 30 days	-	-
30-60 Days	2,029	584
60-90 days	266	29
90- 180 days	673	415
Over 180 days	1,124	217
Total	**4,092**	**1,245**

Note 17 Non-current assets held for sale and assets in disposal groups

	2017/18 £000	2016/17 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**1,529**
Prior period adjustment		**-**
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**-**	**1,529**
Assets sold in year	-	**(1,529)**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

Note 18.1 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.

	2017/18	2016/17
	£000	£000
At 1 April	**1,056**	**5,600**
Prior period adjustments	-	-
At 1 April (restated)	**1,056**	**5,600**
Net change in year	-	(4,544)
At 31 March	**1,056**	**1,056**
Broken down into:		
Cash at commercial banks and in hand	86	90
Cash with the Government Banking Service	970	966
Total cash and cash equivalents as in SoFP	**1,056**	**1,056**
Total cash and cash equivalents as in SoCF	**1,056**	**1,056**

Note 18.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the the trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	2018	2017
	£000	£000
Bank balances	123	153
Total third party assets	**123**	**153**

Note 19.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	2,540	5,351
Capital payables	1,470	1,170
Accruals	9,117	7,723
Receipts in advance (including payments on account)	70	-
VAT payables	16	9
Accrued interest on loans	17	-
Other payables	3	2,133
Total current trade and other payables	**13,233**	**16,386**
Of which payables from NHS and DHSC group bodies:		
Current	1,682	3,002
Non-current	-	-

The significant reduction in the other payables in year is due to the early payment of the pension contributions in March to support the cash position

Note 19.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-		460	
- number of cases involved		-		8
- outstanding pension contributions	-		2,095	

Note 20 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	291	143
Total other current liabilities	**291**	**143**

Note 21 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,275	1,470
Total current borrowings	**1,275**	**1,470**
Non-current		
Loans from the Department of Health and Scoial Care	17,248	5,899
Obligations under PFI, LIFT or other service concession contracts	40,775	42,049
Total non-current borrowings	**58,023**	**47,948**

Note 22 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**863**	**204**	**5**	**891**	**1,963**
Change in the discount rate	6	-	-	16	**22**
Arising during the year	48	109	917	26	**1,100**
Utilised during the year	(92)	(43)	(5)	(40)	**(180)**
Reversed unused	-	(69)	-	(1)	**(70)**
At 31 March 2018	**825**	**201**	**917**	**892**	**2,835**
Expected timing of cash flows:					
- not later than one year;	91	48	917	41	**1,097**
- later than one year and not later than five years;	362	153	-	164	**679**
- later than five years.	372	-	-	687	**1,059**
Total	**825**	**201**	**917**	**892**	**2,835**

Early Departure Costs:

Early departure costs all relate to pre 1995 early retirements.

Legal Claims:

This provision includes employment tribunals where the Trust has made a provision for the costs of legal fees and/or settlement costs, and employers and public liability claims paid by the NHS Litigation Authority which are limited to an excess.

Other Provisions

Injury benefits are payable through the NHS Pensions Agency.

Redundancy

redundancy.

Change in Discount Rate

The discount rate used has been changed within the year from 0.24% to 0.10% in line with Treasury guidance.

Note 22.1 Clinical negligence liabilities

At 31 March 2018, £2,587k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Avon and Wiltshire Mental Health Partnership NHS Trust (31 March 2017: £1,745k).

Note 23 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	1,470	492
Total	**1,470**	**492**

Note 24 On-SoFP PFI, LIFT or other service concession arrangements

Note 24.1 Imputed finance lease obligations

Avon and Wiltshire Mental Health Partnership NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**81,683**	**86,554**
Of which liabilities are due		
- not later than one year;	4,562	4,872
- later than one year and not later than five years;	17,089	17,065
- later than five years.	60,032	64,617
Finance charges allocated to future periods	(39,633)	(43,035)
Net PFI, LIFT or other service concession arrangement obligation	**42,050**	**43,519**
- not later than one year;	1,275	1,470
- later than one year and not later than five years;	4,834	6,109
- later than five years.	35,941	35,940

Note 24.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	203,850	212,520
Of which liabilities are due:		
- not later than one year;	8,868	8,671
- later than one year and not later than five years;	37,526	36,696
- later than five years.	157,456	167,153

Note 24.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	9,269	8,468
Consisting of:		
- Interest charge	3,401	3,507
- Repayment of finance lease liability	1,470	717
- Service element and other charges to operating expenditure	1,242	1,357
- Capital lifecycle maintenance	341	270
- Contingent rent	2,815	2,617
Total amount paid to service concession operator	**9,269**	**8,468**

Under IFRIC12, the asset is treated as an asset of the Trust; the substance of the contract is that the Trust has a finance lease and payments comprise of two elements - imputed finance lease charges and service charges and can provide details of the imputed finance lease charges in the table above.

The PFI Operator is expected under the Schedule 14 Hard Services Agreement to maintain the assets to a condition at the end of the project term that is consistent with when the assets were first brought into use. The PFI contract is currently with the PFI Operator and there are termination options in place with this provider.

Financial Close was achieved for the PFI scheme in March 2004 to modernise Mental Health Services in Avon and expand Secure Services. Construction was completed for all units by the 2006/07 financial year.

The Project will expire its term in November 2036 at which time the entire PFI asset will revert to being owned by the Trust.

The Trust will own the assets at the end of the finance lease arrangement and this consists of the following Trust buildings:

- Callington Road - all blocks
- Blackberry Hill - Fromeside
- Blackberry Hill - Acer
- Blackberry Hill - Wickham
- Hanham Whittucks Road
- Weston-Super-Mare Long Fox Unit
- Weston-Super-Mare Elmham Way
- Weston-Super-Mare Coast Resource Centre

There has been no re-negotiation or re-financing within the accounting year of the PFI scheme. The indices used to inflate the unitary charge within the financial year are those agreed with the PFI operator contract.

Note 25 Carrying values of financial assets

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	8,164	**8,164**
Cash and cash equivalents at bank and in hand	1,056	**1,056**
Total at 31 March 2018	**9,220**	**9,220**

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	7,900	**7,900**
Cash and cash equivalents at bank and in hand	1,056	**1,056**
Total at 31 March 2017	**8,956**	**8,956**

Note 25.1 Carrying value of financial liabilities

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	17,248	**17,248**
Obligations under PFI, LIFT and other service concession contracts	42,050	**42,050**
Trade and other payables excluding non financial liabilities	13,222	**13,222**
Total at 31 March 2018	**72,520**	**72,520**

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	5,899	**5,899**
Obligations under PFI, LIFT and other service concession contracts	43,519	**43,519**
Trade and other payables excluding non financial liabilities	14,244	**14,244**
Total at 31 March 2017	**63,662**	**63,662**

Note 25.2 Fair values of financial assets and liabilities

Note 25.3 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	14,497	15,713
In more than one year but not more than two years	1,997	2,405
In more than two years but not more than five years	21,735	9,603
In more than five years	34,291	35,941
Total	**72,520**	**63,662**

Note 26 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	5	3	18	13
Total losses	**5**	**3**	**18**	**13**
Special payments				
Ex-gratia payments	33	6	41	10
Total special payments	**33**	**6**	**41**	**10**
Total losses and special payments	**38**	**9**	**59**	**23**

Note 27 Gifts

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Total gifts	-	-	-	-

Note 28 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Avon and Wiltshire Mental Health Partnership NHS Trust.

Whilst no material transactions take place between parties, it should be noted that the Trust has the Headlight Charitable fund that is directly linked to it with the Trust Board acting as the Trustee of the charity

The Department of Health and Social Care is regarded as a related party. During the year 2017/18 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. As below :

- CCGs
- NHS England
- NHS Foundation Trusts
- NHS Trusts
- NHS Litigation Authority
- NHS Business Services Authority
- Local authorities

Note 29 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	50,690	78,657	48,374	78,328
Total non-NHS trade invoices paid within target	46,414	71,301	25,442	40,274
target	91.56%	90.65%	52.59%	51.42%
NHS Payables				
Total NHS trade invoices paid in the year	1,612	8,396	1,871	10,944
Total NHS trade invoices paid within target	1,459	6,790	421	3,010
Percentage of NHS trade invoices paid within target	90.51%	80.87%	22.50%	27.50%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later. It should be noted that the significant improvement in 2017/18 is due to being in receipt of loan financing during the entire period, whereas in 2016/17, this was only in place for half of the year.

Note 30 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	10,729	9,633
Finance leases taken out in year	-	-
Other capital receipts	-	-
External financing requirement	**10,729**	**9,633**
External financing limit (EFL)	10,729	9,633
Under / (over) spend against EFL	-	-

Note 31 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	5,588	7,151
Less: Disposals	-	(1,530)
Charge against Capital Resource Limit	5,588	5,621
Capital Resource Limit	5,910	6,047
Under / (over) spend against CRL	322	426

Note that the above figures represent the Capital Resource Limit, whereas the Trust is monitored on the Capital Departmental Expenditure Limit which shows total Capital Cash financing of £5,250k with gross capital expenditure (less IFRS) of £5,247k.

Note 32 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(10,380)
IFRIC 12 breakeven adjustment	655
Breakeven duty financial performance surplus / (deficit)	(9,725)

Note 33 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,113	3,219	3,541	2,936	2,784	2,810	90	(8,918)	(9,707)
Breakeven duty cumulative position	86	1,199	4,418	7,959	10,895	13,679	16,489	16,579	7,661	(2,046)
Operating income		198,752	195,955	192,190	194,609	197,437	198,530	197,394	214,357	220,555
Cumulative breakeven position as a percentage of operating income		0.60%	2.25%	4.14%	5.60%	6.93%	8.31%	8.40%	3.57%	-0.93%

Avon and Wiltshire
Mental Health Partnership
NHS Trust

CONTACT US

For further information please visit:

www.awp.nhs.uk

Or contact us on:

T. 01225 731731

E. awp.communications@nhs.net