NHS
Avon and Wiltshire
Mental Health Partnership
NHS Trust

Annual Report

2018 / 19

Avon and Wiltshire Mental Health Partnership NHS Trust

Annual Report 2018 / 19

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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

BAF	Board Assurance Framework
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
FRF	Financial recovery funding
FT	Foundation Trust
FTC	Fixed-term contract

H

HBPoS	Health-based places of safety
HR	Human Resources

I

I&E	Income and expenditure
IAPT	Improving Access to Psychological Therapies

ICD	International classification of diseases
ICO	Information Commissioners Office
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
NPSA	National Patient Safety Agency

P

PCLS	Primary Care Liaison Service
PFI	Private Finance Initiative
PMO	Programme Management Office
PRIDE	Passion, Respect, Integrity, Diversity and Excellence - AWP values
PSF	Provider Sustainability Fund

Q

QI	Quality Improvement
QIA	Quality Impact Assessment
QIP	Quality improvement plan

R

RMN	Registered Mental Health Nurse
RTT	Referral to Treatment

S

SFI	Standing financial instruction
SO	Standing orders
STEPS	Specialised treatment for eating disorders
STP	Sustainability and Transformation Partnership

T

TCSL	Transforming Change through System Leadership

W

WTE	Whole time equivalent

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Performance Report

Overview

The purpose of the overview section is to provide readers with a short summary of our activity in 2018/19. 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 2018/19

Our vision is *...to provide the best care in the right place at the right time to help you recover and live your best life.*

Care quality is our first priority. We are proud of the comprehensive range of services we offer and the compassionate care our staff provide. We remain committed to working in partnership with health, care, police, criminal justice and a wide range of voluntary sector organisations to ensure we can be responsive to individual needs.

This annual report allows us to look back at the last year, celebrate our successes, acknowledge the challenges and think ahead to the ambitions we want to realise in the coming year.

Statement from our Chair and Chief Executive

Welcome to our Annual Report for 2018/19, which describes our achievements and the challenges we have faced.

Last year we sustained or improved our performance and made progress towards being financially sustainable, in a context of workforce shortages, financial pressure and increasing demand for mental health services. We are pleased to report that our financial position was much improved, with our deficit reduced from £10.4m to £1.0m. Increasing demand for services and workforce gaps continue to present challenges to our future sustainability; we are committed to continue to work with our partners to address these as a whole system delivering health care to our communities.

The Care Quality Commission (CQC) undertook an inspection of our Trust in September and October 2018. It is pleasing that the CQC recognised our staff as committed to providing safe, compassionate care, and noted an improved staff culture, with staff describing that they feel supported and valued by the Trust. Overall, whilst the improvements the Trust has made were noted, in particular to our Health Based Places of Safety, the Trust was rated as 'Requires Improvement'. We have plans in place to deliver the improvements required in order to fulfil the Board of Directors' ambition to provide outstanding care.

This year saw the development of several services, including a new service model for our Primary Care Liaison Services, improvements to our Crisis Care services and the extension of our Community Perinatal and Liaison and Diversion services. We continued to receive positive feedback about service user experience, with the majority surveyed confident to recommend our care to friends and family. We are particularly pleased to have seen our community mental health survey results improve.

An integral part of our care approach is that care is a joint endeavour between professionals and service users, and involving families. In addition to partnering in care, we want to embed co-production, with Experts by Experience working as equal partners alongside professionals to shape and improve services. An example this year was a service user and carer led project which explored the importance of effective communication. This provided insights into what matters to those using services, resulting in a video which forms part of our induction for new staff and 'Top Tips' to provide practical support to staff. In the past year we have worked with the King's Fund to run a Patient Leaders programme to equip service users with confidence and skills to lead alongside clinical experts so we can extend this approach. We are also delighted to have established a partnership with the charity 'Making Families Count' to learn how we can make our services safer and more responsive.

Our staff continue to demonstrate extraordinary commitment, living our AWP PRIDE values and providing person-centred, compassionate care. This report highlights some of their achievements but cannot fully reflect the transformative impact they have on a day to day basis. We are enormously proud of our colleagues and extend our personal thanks to them.

We welcome the ambition set out in the NHS Long Term Plan to improve mental health. We continue to be active members of two Sustainability and Transformation Partnerships, both of which are prioritising mental health. If we are to realise our shared ambition, ongoing investment in mental health is essential, as are opportunities to transform and join up care and ensure that physical and mental health are treated with equal importance. We will continue to advocate the equitable use of resources to achieve true parity of esteem and meet the needs of our communities.

During the course of the year we said goodbye to several Board members; Rebecca Eastley, Medical Director, Sue McKenna, Chief Operating Officer and non-executive directors Charlotte Moar, Sarah Elliott and Triss Horwood. Triss joined us as a NeXT

non-executive director for a year as part of NHS Improvement's programme to increase diversity on Boards. I would like to acknowledge their contribution and thank them for the role they played in our improvement journey. We also welcomed new colleagues to our Board including Julie Kerry, Director of Nursing and Quality, Mathew Page, Chief Operating Officer, and Sarah Constantine, Medical Director. We appointed three new non-executive directors, Marie-Noelle Orzel, Shelley Whitehead and Brian Stables. The experience and knowledge of our non-executive directors is varied and considerable and we are grateful for their commitment and contribution to improving AWP.

This year Hayley made the decision to retire from the NHS after 33 years of service. The majority of these years were spent as a doctor, and more recently as Medical Director and then Chief Executive at the Trust.

Hayley hands the leadership baton to Dominic Hardisty, joining us from his previous role as Chief Operating Officer and Deputy Chief Executive at Oxford Health NHS Foundation Trust. Dominic has an exciting vision for AWP and shares the ambition of the Board and Senior Leadership Team for excellence. We wish him every success.

Thank you for reading our annual report and for continuing to partner with and support us as we strive to continually improve.

Charlotte Hitchings
Chair

Hayley Richards
Chief Executive

> **"Thanks to Hayley's leadership we are well placed to face the challenges that lie ahead and build on productive relationships with partners to deliver excellent mental healthcare. I would like to express my personal appreciation and thanks to Hayley for her commitment, passion and drive to develop the Trust and champion mental health. On behalf of the Trust Board, I wish her a fulfilling retirement."**

> **"Throughout my career it has been a privilege to work with dedicated colleagues committed to upholding the values set out in the NHS Constitution and providing care that transforms lives. I am deeply thankful for colleagues, patients, service users and carers, and partners who have been part of my journey."**

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, B&NES, Swindon and Wiltshire. We treat people with a wide range of disabling mental health problems such as:

- Severe anxiety
- Severe depression
- Obsessive Compulsive Disorders
- Phobias
- Borderline Personality Disorder
- Schizophrenia
- Psychosis

Our service users increasingly want to be treated in or as near to their home as possible, and we are responding to this through providing more care in our local communities. When service users require inpatient care, we continue to focus on keeping them in hospital for as short a time as possible, making sure that we provide timely and effective assessment and treatment so that they can go home and continue their recovery with the support of their families, carers and our community teams.

We also provide specialist care and treatment for people with more specific needs, including:

- Secure services – for people with a mental health disorder who pose or who have posed risks to others, and where that risk is usually related to their mental disorder
- Eating disorders – for people who have an eating disorder and may require specialist inpatient or community based treatment
- Drug and alcohol services – for people who have a drug or alcohol dependency and who may need inpatient detoxification and treatment or community based care, which is often delivered in partnership with third sector colleagues
- Perinatal services – for women who have mental health needs arising from pregnancy and childbirth, provided both in the community and also in our inpatient Mother and Baby Unit
- Specialist services for people with learning disabilities
- Child and Adolescent Mental Health Services (CAMHS) – for children and young people requiring community services in Bristol and South Gloucestershire, and for children and young people requiring inpatient treatment from across the South West region
- Veterans Mental Health Services – for armed forces personnel who have been or who are about to be discharged from service and who have a mental health need
- Specialist services for deaf people with mental health needs

Our more specialised services are increasingly delivered in partnership with a much wider group of providers. We are an active member of the South West Regional Partnership which has responsibility for overseeing the provision of our Secure Services through the NHS England New Care Models Programme. Working with partner organisations across the South West, we have increased the number of beds available for people requiring these services and enabled more people to be cared for in the region.

The New Care Models Programme will be developed in the coming year to incorporate inpatient Child and Adolescent Mental Health Services and inpatient Eating Disorders services, with the same focus on treating more service users closer to home.

We provide expert mental health input as partners in two Sustainability and Transformation Partnerships (STPs) – Healthier Together covering Bristol, North Somerset and South Gloucestershire and BSW covering B&NES, Swindon and Wiltshire. Over the last 12 months both STPs have further developed their plans for the future, with improving the mental health and wellbeing of both populations a priority for the next five years.

Living our Values

P Passion
doing our best all of the time

Care judged as good for 'caring' and 'effective' by CQC

We participated in
96 research studies
64 National Institute for Health Research studies (NIHR) – this is a 10% increase

Achieved our **end of year control total**

675,395 community contacts

857 participants in studies

NHS 70 celebrations hosted 7 'big 7-Tea' parties across the Trust

172,450 days of inpatient care

R Respect
listening, understanding and valuing what you tell me

We held 3 **co-production workshops** with service users and carers

We have 2 star **Triangle of Care membership**

Making Families Count partnership

3,357 people follow us on Twitter

Listening into Action

Safe Wards

1,458 people like us on Facebook

I Integrity
being open, honest and straightforward

Freedom to Speak Up Guardian

36 Anti-bullying Champions

Received **1098** compliments

D Diversity
relating to everyone as an individual

disability confident EMPLOYER

Total headcount of **4243** dedicated staff

Patients as Leaders Programme

89.6% 9546 (see page 19) said they would recommend our services

E Excellence
striving to provide the highest quality support

Community MH Survey results: The Trust received **225** responses (27%) compared to the national response rate of 28%

72.5% ...of people reported that they received good care, compared to 67.3% last year

We recorded many scores in the top 20% of Trusts with none in the lowest 20%. This is an improvement on last year where we saw a number of scores in the lowest 20% category

10,000 service users told us about their care through the friends and family test

Reduction in DTOC **from 10% to 5.6%**

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 57). 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 57.

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 strategic risks to our objectives are set out in our Board Assurance Framework. Our corporate risk register 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 63).

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

- How well we did against our **2018/19 objectives** (page 14);
- How well we did on key **national and local indicators** (page 16);
- What our quality regulator, the **Care Quality Commission**, says about our services (page 17);
- What our service users tell us through the **Friends and Family Test, Annual Community Mental Health Survey and Inpatient Mental Health Survey** (page 19);
- What our staff tell us through the **Annual Staff Survey** (page 27);
- How well we are managing our **finances** (page 31);
- Our efforts towards achieving **environmental sustainability** (page 35); and,
- How we plan to continue our **improvement journey** in the coming year and what might stop us achieving our plans (page 39)

How well did we do against our 2018/19 objectives

	What we said...	What we achieved...
Supporting service users and carers	We will improve the quality of our care by focussing on patient safety	• We focussed on reducing violent incidents on inpatient wards. Using a targeted improvement approach we have seen a reduction in violent incidents in one ward. We will spread this learning in the coming year to achieve greater impact • We have fully implemented the Safewards programme across the Trust and established a Safewards Forum • We have increased the uptake of staff flu vaccination; vaccinating 216 more staff than last year, a 10% increase in the vaccinations given • We have trained 87% of the workforce in suicide prevention. • We have established a new follow up model - 94.1% of service users received follow up within three days of discharge • We continue to embed a 'Preventing Suicide' Risk Assessment. 83% of service users had a documented NPSA compliant risk assessment • We have improved our recording of physical health • We have increased the number of initial pressure ulcer risk assessments carried out on our Older Adult wards • New and improved services
Engaging our staff	We will attract and retain great staff to support and provide safe and effective care	• Staff Turnover has reduced by 1% • We have made positive progress to reduce the total number of vacancies across the Trust by 1.5% • We invested in training Learning Disability nurses to ensure we can meet individual needs • We introduced a new Managers Toolkit to ensure staff are positively supported in their roles • We maintained our staff survey completion rate • We have seen an improvement in staff feeling supported by their manager and having the resources they need to do the job
Being sustainable	We will transform our services to meet increased demand safely and sustainably	• We improved our financial position and achieved our end of year target • We secured new investment to improve our Children and Young People's Mental Health Service and Perinatal Mental Health Care • We secured investment to improve our IT infrastructure and buildings • We continued working with our STP partners to develop a Mental Health Strategy that focuses on prevention of ill health

Table1 - Achievement against annual objectives

Supporting our service users and carers

National standards

Quality Measure	Target	2017/18	2018/19
7 day follow up to inpatient discharge	95%	98%	96.8%
Service users with a review (Care Programme Approach, CPA)	95%	96%	98.1%
Early Intervention – Referral to treatment (RTT)	53%	83%	80.1%
Talking Therapies (IAPT) – RTT (6 weeks)	75%	95%	94.4%
Talking Therapies (IAPT) – RTT (18 weeks)	95%	99%	99.0%
Gate keeping admissions by the Crisis Team	95%	97%	95.8%
Delayed transfers of care (DTOC)	3.5%*	10%	5.6%
Data Quality – Outcomes	50%	84%	87.5%
Data Quality – Identifiers	97%	99.9%	100%

Table 2 – Performance against national standards in 2018/19
*This was 7.5% in 2017/18

The Trust has consistently achieved compliance against indicators on the NHSI Dashboard. The Trust has worked very closely with CCGs and Local Authority partners to reduce delayed transfers of care (DTOC) levels wherever possible. This partnership working led to a reduction in our DTOC from 10% in 2017/18 to 5.6% in 2018/19.

Local indicators

Quality Measure	Target	2017/18	2018/19
% of service users in employment	n/a	13%	17.3%
% of service users in settled accommodation	n/a	72%	79.9%
Crisis assessment within 4 hours of referral	95%	99%	99.5%
Referral To Assessment within 4 weeks	95%	94%	94.2%
Referral To Treatment within 18 weeks	95%	97%	97.2%
% of service users with a risk assessment	95%	99.8%	99.9%
% of service users with a crisis plan	90%	99%	98.4%
% of service users with a care co-ordinator	95%	100%	100%
Supervision rates	85%	84%	98.6%

Table 3 - Performance against local indicators in 2018/19

The Trust has consistently achieved in its performance against the majority of local indicators and in some areas exceeded its performance targets in 2018/19. The Trust is committed to continually improving against these indicators to ensure that service users referred to the service access assessment and treatment as quickly as possible to enable recovery.

What the CQC told us

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

We were inspected by the CQC in September and October 2018. The overall rating for the Trust remained as 'Requires Improvement'. We were rated 'Good' in the effective and caring domains and 'Requires Improvement' in the safe, responsive and well-led domains. The CQC recognised the significant improvements made to the Mental Health Crisis Services and Health Based Places of Safety.

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.

The ward for people with a learning disability or autism (Daisy Unit) was rated as 'Inadequate' and the CAMHS service was rated as 'Requires Improvement'. In relation to inpatient care, the CQC found that improvements were still required relating to ligature management, environment risks and seclusion practices.

No warning notices were issued in 2018.

We are committed to ensuring that all areas of improvement identified in the 2018 CQC inspection are addressed and are embedded through underlying cultural change. We have identified the following quality priorities:

- CQC and Regulatory Improvement
- Embedding a culture of Quality Improvement (QI) - including embedding a culture of co-production
- Getting the basics right – improvement in safeguarding practice, care planning, risk planning and physical healthcare

Our CQC Progress

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ►◄ Sept 2018	Good ►◄ Sept 2018	Good ►◄ Sept 2018	Good ►◄ Sept 2018	Requires improvement ▼ Sept 2018	Requires improvement ▼ Sept 2018
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Forensic inpatient or secure wards	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Child and adolescent mental health wards	Requires improvement ►◄ Sept 2018	Requires improvement ▼ Sept 2018	Requires improvement ▼ Sept 2018	Requires improvement ▼ Sept 2018	Requires improvement ►◄ Sept 2018	Requires improvement ►◄ Sept 2018
Wards for older people with mental health problems	Requires improvement Oct 2017	Good Sept 2017	Good Oct 2017	Good Oct 2017	Good Oct 2016	Good Oct 2017
Wards for people with a learning disability or autism	Requires improvement ▼ Sept 2018	Inadequate ▼ Aug 2018	Requires improvement ▼ Sept 2018	Inadequate ▼▼ Sept 2018	Inadequate ▼▼ Sept 2018	Inadequate ▼▼ Sept 2018
Community-based mental health services for adults of working age	Requires improvement Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Mental health crisis services and health-based places of safety	Good ▲▲ Sept 2018	Good ▲ Sept 2018	Good ►◄ Sept 2018	Good ▲▲ Sept 2018	Good ▲ Sept 2018	Good ▲▲ Sept 2018
Specialist community mental health services for children and young people	Requires improvement ►◄ Sept 2018	Good ▲ Sept 2018	Good ►◄ Sept 2018	Requires improvement ►◄ Sept 2018	Good ▲ Sept 2018	Requires improvement ►◄ Sept 2018
Community-based mental health services for older people	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Community mental health services for people with a learning disability or autism	Requires improvement Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Substance misuse services	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016

Table 4 – CQC Rating

What our service users and carers tell us

Friends and Family Test (FFT)

The national Friends and Family Test is an important way for us to hear what people think of our services. At its heart, the test asks whether people 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, the Trust received feedback from over 10,000 service users through the Friends and Family Test, compared with 8,000 responses in 2017/18.

Since 2013, 51,695 people have told us about their care.

Of those who completed the FFT survey this year, 89.6% (9546) said they would recommend our services and 2.6% (273) said they would not. The remaining responses were recorded as neither of don't know 7.9% (839). Of the comments received, 87% of the responses (8360) were positive and 13% (1203) were negative, compared to 87% and 13% in 2017/18.

Of the praise received, the care provided by staff was often singled out, with service users telling us staff are understanding, friendly and caring.

Examples include:

> "I would like to thank nursing staff, which helped get me well again as nothing was much trouble. Even though I was really poorly, without their encouragement, I think I would have given up. So thank you all for looking after me."

> "The team of staff were always polite and very helpful."

> "I feel the staff have been brilliant with me as they supported me and cared for me and got me well."

> "Staff have been friendly, welcoming and professional. I really enjoyed my time here. Staff constantly go above and beyond their job description to make people feel safe and secure and foster their recovery."

Theme	Positive	%	Negative	%
Responsive	824	9.86%	349	29.01%
Effective	3587	42.91%	412	34.25%
Caring	3649	43.65%	269	22.36%
Safe	127	1.52%	67	5.57%
Well Led	173	2.07%	106	8.81%
Total	**8360**	**100%**	**1203**	**100%**

Table 5 – FFT (Community) April 2018 – March 2019
Please note not all respondents provided comments

Theme	Positive	%	Negative	%
Responsive	9	0.85%	11	7%
Effective	230	21.84%	42	27%
Caring	706	67.05%	64	42%
Safe	76	7.22%	20	13%
Well Led	32	3.04%	17	11%
Total	**1053**	**100%**	**154**	**100%**

Table 6 – FFT (Ward), April 2018 – March 2019

Annual Community Mental Health Survey

This year the Trust again invited feedback from our service users through the national community mental health survey.

The Trust received 225 responses, which equates to a response rate of 27%, compared to the national response rate of 28%. We recorded many scores in the top 20% of Trusts with none being in the lowest 20%. This is an improvement on last year where we saw a number of scores in the lowest 20% category. Our overall score for people reporting that they received good care was 72.5%, compared to 67.3% last year. This year the highest Trust scored 75.3%.

Domain	What people told us
Meeting individual needs	65.5% of people told us that they were seen often enough 78.8% of people told us they had enough time to discuss their needs with the team
Planning Care	79.2% of people told us they knew who was in charge of organising their care 77.9% of people told us that they were involved in agreeing their care plan
Crisis Care	71.6% of people told us they knew who to contact in a crisis
Physical Health	83.8% of people told us that they had received a review of their medication in the last 12 months 52.2% of people told us that mental health staff had helped them to take part in a group or activities

Table 7 – Highlights from the Community Mental Health Survey, 2018

This is very positive feedback for the Trust, however, we are committed to improving scores that fall within the middle range or are below average, including:

- Out of Hours contact
- Involving people in decisions about their medication
- Signposting people to support for their physical health needs

Inpatient Mental Health Survey

This year the Trust commissioned an inpatient survey. We had over 130 responses from people who had recently been under the care of our inpatient wards. Overall the feedback was mixed with some areas scoring highly, such as 81% of service users reporting that staff made them feel welcomed when they arrived on the ward. Other areas have clearly demonstrated room to improve the experience of people, for example, providing enough activities on the ward to support people's recovery.

Along with other sources of feedback we have used this to form our Quality Priorities for 2019/20. This is demonstrated for example with activity provision being a key area of focus through our Reducing Restrictive Practice improvement programme.

We will continue to monitor feedback from service users who stay on our inpatient wards and are confident we will see an improvement in 2020/21.

Service Improvement highlights in 2018/2019

Service User and Carer Involvement

We want service users and carers to be at the heart of what we do. These are some of the ways we have engaged our service users to help shape our services in 2018/19:

- Review of the Trust wide service user and carer meetings and structure, ensuring that we co-produce a system that is effective for all
- Ran a Patient Leaders programme from March 2017 to July 2018 facilitated by the King's Fund
- Ran co-production workshops, supported by the King's Fund, to build the foundations to support effective partnership working
- 'Making Families Count' training day for our staff
- Reducing Restrictive Practice training day with Expert by Experience input
- Communication project led by service users and carers. The units have been operating as pilots and we have been closely monitoring their activity to understand how we can shape our service provision to provide the best possible care in the most cost effective way for our service users.

Improving Primary Care Liaison Services

We have successfully developed and implemented a new service model for our Primary Care Liaison Services (PCLS) using a standardised approach to ensure that service users receive the same service regardless of where they live in our geographical area.

The improved PCLS model delivers a service that ensures service users and carers receive efficient and timely access to mental health services, brief interventions or support and signposting to advice.

Piloting Acute Community Units

Over the past year we have piloted two Acute Community Units (ACU) that aim to provide:

- A place where service users may go during the day to access services which have been identified in their care plan and return to their own home at the end of the day
- An alternative to hospital admission for service users in the community who are on the caseloads of our intensive and crisis teams
- A facility to support discharge and prevent re-admission to our inpatient units
- A facility to enable our intensive and crisis teams to work more effectively to manage more service users in the community

The first ACU in Bristol opened its doors to service users in March 2018 and a second unit followed in Swindon in June 2018.

The units have been operating as pilots and we have been closely monitoring their activity to understand how we can shape our service provision to provide the best possible care in the most cost effective way for our service users.

Service Developments

Over the last year we have developed a number of our services to respond to demand and population needs. A number are described below:

Community Perinatal Services

Community Perinatal teams provide vital care for women with mental health needs arising from their pregnancy and post birth, supporting them to recover and live their best lives with their baby and wider family. Our first Community Perinatal team was established in Bristol, North Somerset and South Gloucestershire in 2017, and we received further funding from NHS England in 2018 to set up a similar team in B&NES, Swindon and Wiltshire. Both teams work alongside local maternity services and third sector organisations, delivering a seamless and integrated service for women and their families.

Liaison and Diversion Services

Early intervention to support people with mental health needs who have been identified through the criminal justice system is an important part of our work. Following our successful bid to provide these services in Avon and Somerset in 2018/19 (in partnership with Somerset Partnership NHS FT) we were awarded the contract to run the same service covering the Wiltshire Police area. There is a strong link between these services, our prison mental health services and our secure service provision. As a result we are able to provide a more joined up and effective service for these often vulnerable service users.

Expansion of the New Care Models programme

Over the last year we have continued to develop and expand our role within the South West collaboration (New Care Model) which currently covers Secure Services.

A key focus of our New Care Model is to bring back service users currently receiving care far from home. We know that if people are looked after closer to home, they typically have a shorter length of stay and achieve long term recovery. Since the inception of the Secure Services New Care Model we have successfully repatriated 104 service users, with over 80% of male and over 50% of women service users treated in the region.

Work is underway to develop similar collaborations to focus on CAMHS and Eating Disorders.

Crisis Care Improvements

Our service developments are not limited to specialised care, and we are pleased to have made positive progress in improving our crisis services across both Bristol, North Somerset and South Gloucestershire (BNSSG) and B&NES, Swindon and Wiltshire (BSW). We have successfully piloted a new model of street and control room triage and introduced Core 24 in BNSSG. Core 24 is a new model of hospital based liaison, with the aim being for service users to be treated more quickly by mental health experts in A&E departments.

In BSW we have piloted the relocation of the Health Based Place of Safety and are working with Commissioners to evaluate this in 2019/20. Feedback from the CQC at their most recent inspection was that this was now a 'Good' service, providing safe, effective and responsive care for our service users.

Supporting our Service Users and Carers in 2019/20

Our plans for 2019/20 are informed by feedback from service users, carers, regulators and ambitions set out in our strategy. Our priorities for improving care in 2019/20 are described below:

Our objective for 2019/20 is:

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

We want to achieve:

1. CQC rating of 'Good'
2. Service users co-producing their care plan and risk assessment
3. A reduction in restrictive practice
4. Safeguarding as everyone's business
5. Physical and mental health treated with equal importance
6. Improved learning from incidents
7. A Trust wide Quality Improvement programme

Engaging our Staff

Our dedicated staff directly influence the quality of care and experience a service user or carer receives. We are proud that the CQC provided positive feedback on the caring and responsive attitude of our staff when they inspected us in 2018.

Our Workforce

As of 31 March 2019 the Trust employs a skilled and diverse workforce of 3,620 people (whole time equivalent) making for a total headcount of 4,243. Around half of our staff hold a professional clinical registration. The breakdown of our staff by professional group is as follows:

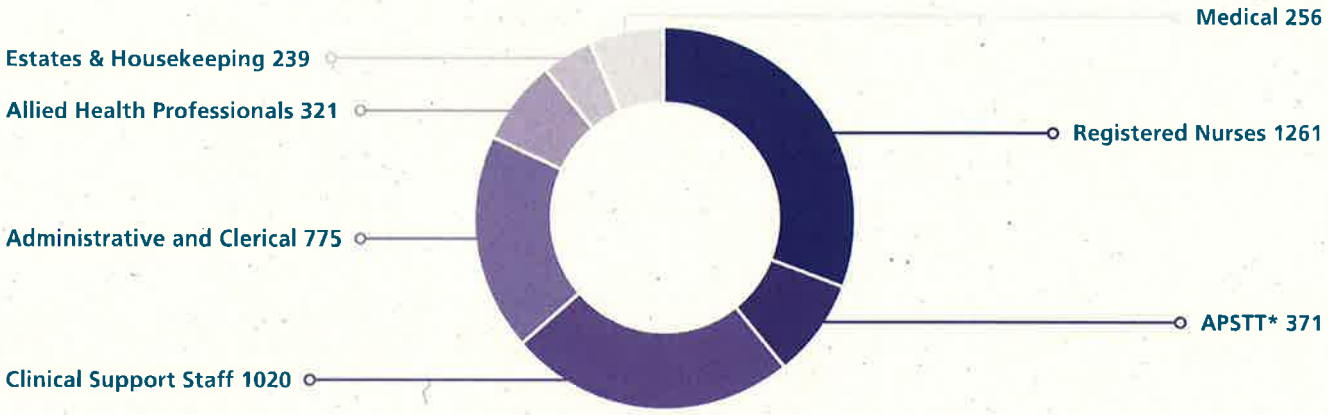

Figure 1 - Workforce headcount (by profession) 2018/19

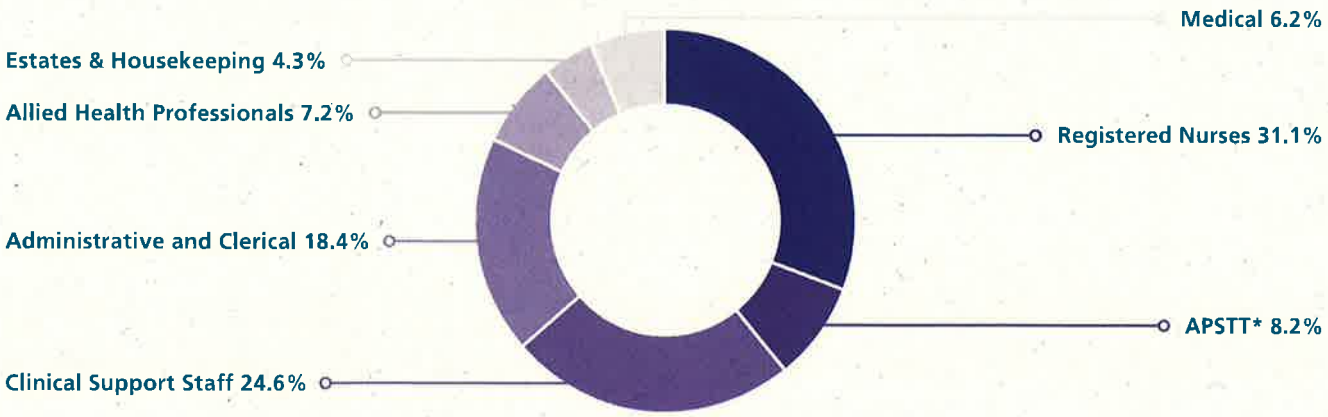

Figure 2 - Percentage of workforce WTE (by profession) 2018/19

These charts show staff grouped in line with the NHS staff groups used in the national Electronic Staff Record.

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

Supervision and appraisal

To ensure staff receive support, feedback and development we prioritise regular supervision and appraisal. All staff have monthly meetings with their manager to support them in carrying out their role. In addition, we are committed to every member of staff having an annual appraisal with clear objectives set for the forthcoming year that align with our Trust wide priorities.

During 2018/19 we have exceeded 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	2016/17 Performance	2017/18 Performance	2018/19 Performance
Supervision	85%	85%	85%	87%
Appraisal	95%	84%	87%	87%

Table 8 – No. of staff supervised and appraised during 2018/19

Sickness and attendance

Our average rate of sickness absence over the last 12 months was 4.44% which is slightly higher than 2017/18 (4.37%). We continue to work to develop managers to be able to support staff back to work as appropriately as possible, and to better understand the drivers of sickness absence

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 representative
- Local and Trust wide staff experience groups
- Listening in Action 'crowd fixing' conversation events and annual Pulse Check survey
- Visits by Executive and Non-Executive Directors with identified Link Directors in each area
- 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, 2,087 staff responded, giving the Trust a response rate of 51.8%. This is comparable to last year where 2,056 staff responded. We are slightly below the national average for Trusts of our type.

One of the key areas for improvement identified in the 2017/18 survey was the need to ensure that staff had adequate resources to do their work. The work we carried out included the introduction and roll out of Skype for Business; upgrading 98% of PC's and 85% of laptops to Windows 10 system and installing new multifunction printers across all of our sites. As a result of this work we saw an improvement of 3% in this measure in our 2018/19 staff survey.

Topics where staff rated their experience better in 2018 than in 2017 included:

- Satisfaction with level of pay
- Support from manager to receive training, learning or development identified in appraisal
- Satisfaction with recognition for good work
- Having adequate materials, supplies and equipment to do my work
- Organisation treats staff involved in errors fairly

In response to the 2018 staff survey results, we will focus on three key priorities described below. These reflect our strategic intentions and recognise where we need to make the greatest progress.

- Care of Service Users is the organisation's top priority
- The health and wellbeing of our staff
- Improving communication with senior staff

Each locality and corporate team also receive survey results that reflect in detail the experience of their own staff in that area. Managers use these results to discuss with staff where we can improve and, as a team, jointly develop department-specific responses that reflect their situation and experiences.

Staff wellbeing

During 2018/19 we continued the work to embed our approach to staff wellbeing, as described in our Staff Wellbeing strategy. The work encompasses welfare, physical health, mental health and the promotion of staff benefits.

The refresh of our management development programme also allowed us to properly incorporate wellbeing awareness and management into the content. This is important as line managers are crucial to supporting staff in their day to day work, and signposting the many support mechanisms in place relating to staff well-being.

Occupational Health provision is provided by an external expert organisation and take up of their services has continued to develop.

Celebrating our staff - highlights from 2018/19











Engaging our staff in 2019/20

Our plans for 2019/20 are informed by feedback from staff, regulators and ambitions set out in our workforce strategy. Our priorities for improving staff experience in 2019/20 are described below:

Annual Objective for 2019/20:

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

We want to achieve:

- Improved staff wellbeing and experience
- Clear career pathways
- Increased staff development opportunities, including Apprenticeships
- Increased retention of staff, especially in their first year

Being Sustainable

Along with the wider NHS, we have had a challenging year from a financial perspective. For the financial year 2018/19, we reported a net deficit of £2.2m (adjusted to £1.0m net of impairments) which is a significant improvement on the 2017/18 performance of £12.1m (adjusted to £10.4m net of impairments) and ahead of the position agreed by the Trust Board with NHS Improvement in June 2018 of a £2.6m deficit. The achievement of the agreed position led to the Trust being able to receive £2.9m (2017/18 £0.3m) of additional funding from NHS Improvement in the form of Provider Sustainability Funding.

Given the financial deficit that we have experienced in 2018/19 we have drawn down a loan from the Department of Health of £1.8m (2017/18 £11.3m). This has enabled us to continue paying staff and suppliers on a timely basis which has been borne out by the constant achievement shown 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 3 and consists of a liquidity ratio of 3, capital servicing of 4 an I&E margin metric of 4, I&E distance from plan of 1 and an agency rating of 4. The 2017/18 comparators are shown in the table overleaf.

2018/19 has proved a financially challenging year primarily due to the on-going recruitment difficulties for both medical and nursing staff as well as a continued dependency on out of Trust placements.

Key financial performance indicators

Financial metrics and risk ratings 1 March 2018 and 31 March 2019				
	31 March 2019		31 March 2018	
Measure	Planned Rating	Actual Rating	Planned Rating	Actual Rating
Liquidity Ratio Metric	1	3	2	4
Capital Servicing	4	4	3	2
I&E Margin	4	4	1	4
I&E Distance from Plan	-	1	-	4
Agency Rating	4	4	1	4

Table 9 - Financial metrics and risk ratings at 31 March 2019

A risk rating of 1 is the highest rating and 4 is the lowest rating

Income

Operating income received in 2018/19 by the Trust was £236.7m, with £223.9m (95%) coming from the delivery of patient care services (2017/18 £220.6m, £209.9m (95%). The largest proportion of our clinical income comes from our main four CCGs. Non-clinical income for the period is £12.7m, 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:

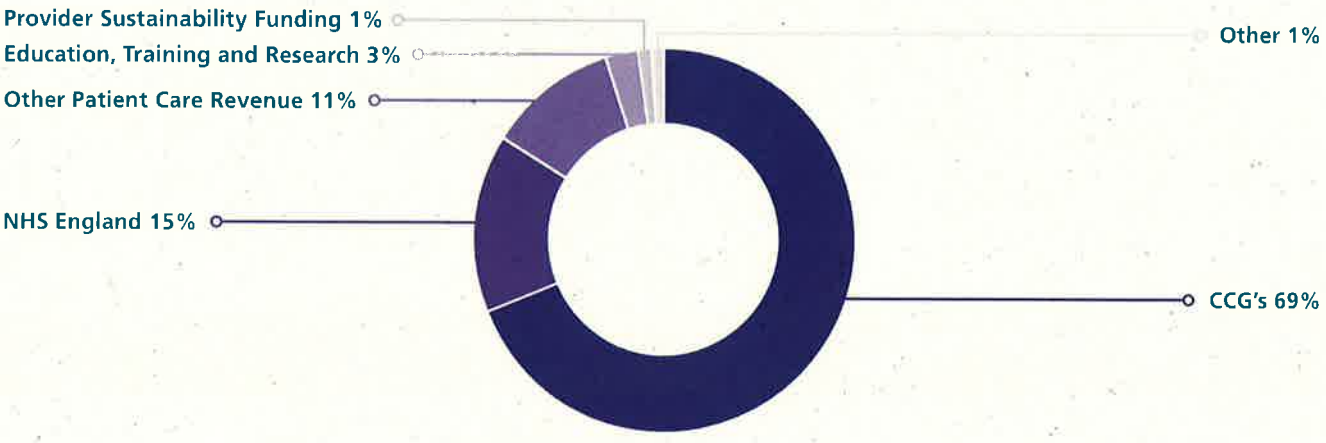

Figure 3 - Income by source, 2018/19

Expenditure

Operating expenses totalled £230.5m for the year and, as in previous years, staff costs account for the largest use of resources at 78% of the total expenditure (2017/18 £224.1m, 76%).

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

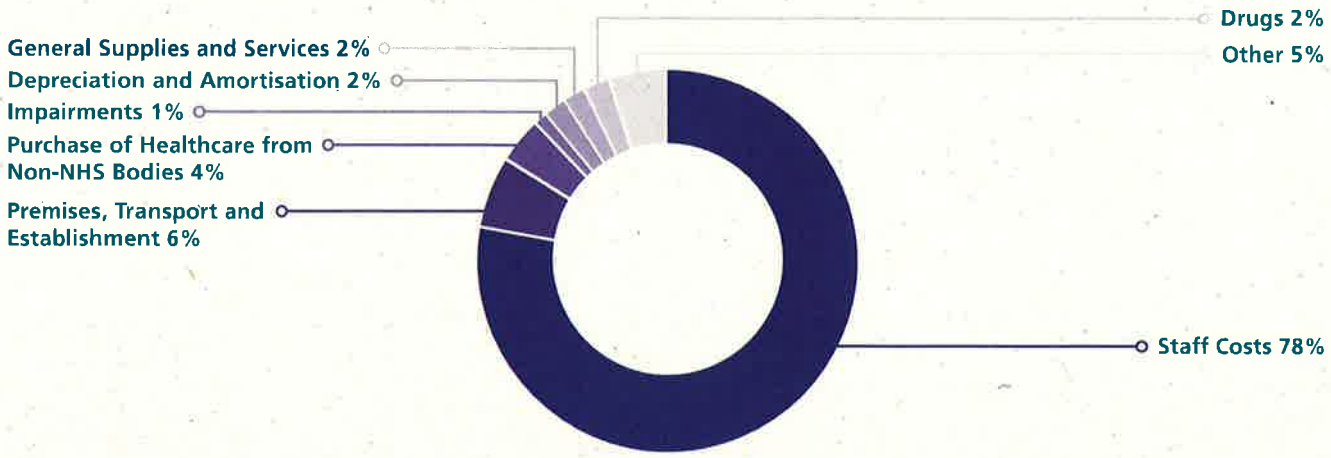

Figure 4 - Expenditure by type, 2018/19

Capital programme

Capital Expenditure for the year is £4.0m (plus £0.5m of lifecycle expenditure on the PFI). 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 a significant receipt for IT developments totalling £0.5m in the form of Public Dividend Capital.

Capital expenditure in 2017/18 was £5.2m (plus £0.4m of lifecycle expenditure on the PFI), also receiving £0.9m of Public Dividend Capital.

The chart below sets out the capital split of projects.

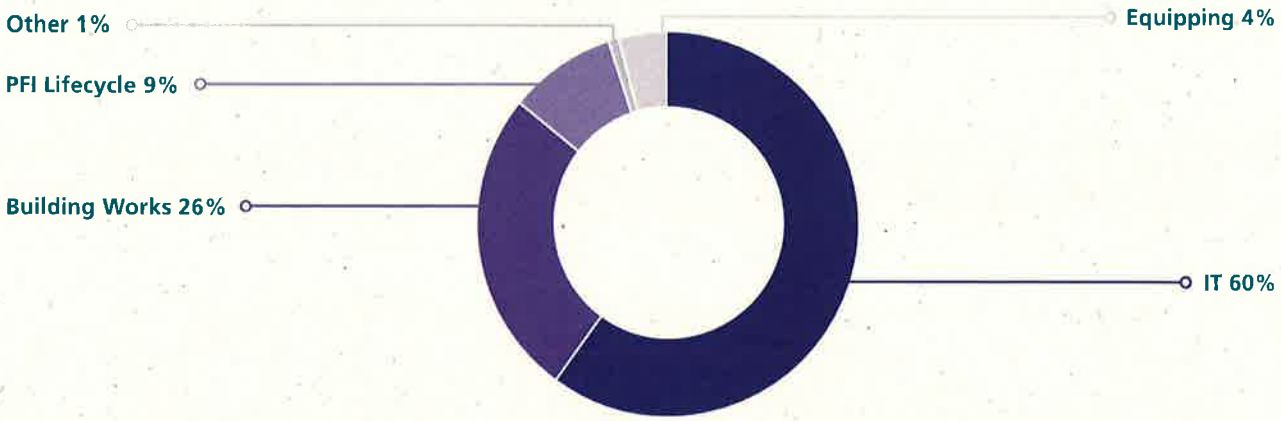

Figure 5 - Income by source, 2018/19

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 2018/19 position, it should be noted that this was a relatively stable year in terms of cash availability, though the Trust faced significant challenges in processing the volume of agency invoices that were received which impacted upon overall invoice turnaround time.

Better Payment Practice Code Compliance	NHS	Non-NHS
2017/18 by number of invoices	90.51%	91.56%
2017/18 by value of invoices	80.87%	90.65%
2018/19 by number of invoices	81.30%	79.60%
2018/19 by value of invoices	74.50%	87.70%

Table 10 - Better Payment Practice Code performance

Balance sheet events

There are no post balance sheet events reported during the period 2018/19.

Going Concern

The Trust incurred a retained deficit of £2.2m (adjusted of £1.0m) during the year ended 31 March 2019 and, at that date had net current liabilities of £0.042m.

The Trust is assuming no additional cash support in 2019/20 to maintain current payment performance assuming that the Trust delivers its savings plan. The Trust is however anticipating the achievement of Provider Sustainability Funding (PSF) of £1.9m and Financial Recovery Funding (FRF) of £3.2m. This will maintain the current cash loan position of £19.0m. If the Trust fails to deliver in full the savings plan in 2019/20 then PSF and FRF will not be achieved in full and a further cash loan will be required. The savings identified within the current Trust plan for 2019/20 are £7.1m.

As directed by the 2018/19 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.

These circumstances constitute a material uncertainty that may cast significant doubt as to the Trust's ability to continue as a going concern and therefore it may be unable to realise its assets and discharge its liabilities in the normal course of business.

Whilst the Trust does not consider itself to be significantly exposed to any significant risks arising from Brexit, the ongoing uncertainty of a final agreed outcome means that this cannot be fully assessed. The potential areas of exposure relate to anti-psychotic drugs and food supply, and the impact of any fuel costs and supply issues.

Financial position 2019/20 and beyond

Given the financial performance for 2018/19 the financial plan for 2019/20 will be just as challenging. Having undertaken a detailed budget setting process for 2019/20 our Trust Board agreed a budget that will require us to achieve savings of £7.1m (compared to £9.65m last year) in order to deliver the planned deficit control total of £5.0m. If this control total is delivered, we will be eligible to receive both provider sustainability funding (£1.9m) and financial recovery funding (£3.1m) from NHS Improvement to deliver a breakeven position. In 2018/19, the level of savings achieved was £12.1m, which equated to 5.5%.

This level of savings represents approximately 2.9% of our funding and reflects the significant financial challenge that we currently face. Savings plans for £5.6m have been developed with £4.5m that have been either implemented or are in progress towards implementation. The budgets have been agreed by our Trust Board for 2019/20 with work continuing on the delivery of the required savings.

A significant contributory factor to the continued financial pressure relates to the workforce challenges that we face and the continued high levels of agency staff used across many of our staff groups. In addition, continued high demand for inpatient beds above available capacity leads to out of area placements. This puts financial pressure on us, despite a risk share arrangement being in place with Commissioners.

We also continue to experience increasing levels of demand, particularly in the urban centres where we provide services. 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

We recognise that the healthcare service we provide to our local community and the resources we use to deliver care, produce carbon emissions. These emissions make up our total carbon footprint. In order to identify opportunities to reduce our footprint and record progress, we have been actively monitoring our carbon emissions since 2007/08. This baseline measurement acts as a benchmark to evaluate the success of subsequent efforts to reduce emissions.

Our carbon footprint for 2017/18 was 7,157 tonnes CO2e1. This consists of emissions arising from: the use of gas (45.1%), electricity (41.3%), transport (11.6%), water (1.1%) and waste (0.8%). 7,157 tonnes of CO2 is equivalent to the annual carbon emissions of 883 UK homes2. (Data for 2018/19 is not currently available due to reporting timelines. Data for 2018/19 will be available in July 2019).

Source	Tonnes CO2e	% Share
Electricity	2956	41.3
Gas	3231	45.1
Water	82	1.1
Transport	828	11.6
Waste	60	0.8
Total	**7157**	

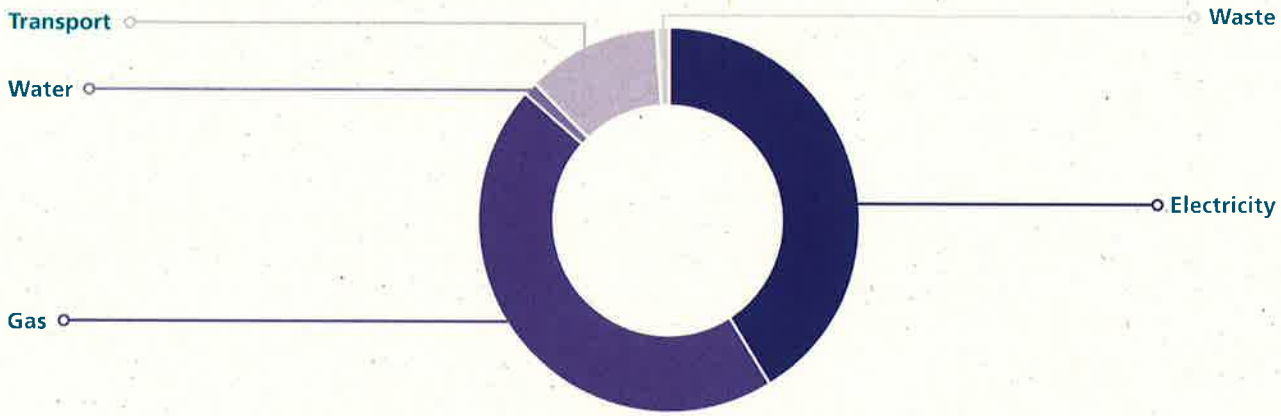

Figure 6 – AWP Carbon Footprint 2017/18

National NHS carbon reduction targets against a 2007/08 baseline

The NHS has aligned its national carbon reduction targets with the Climate Change Act 2008. This sets national reduction targets for 2020, 2030 and 2050 against a 1990 baseline (see below). However, the majority of NHS Trusts did not actively monitor their emissions until sometime after 1990; we have used 2007/08 as our baseline year:

National NHS carbon reduction targets:

- **2020:** 34% reduction
- **2025:** 50% reduction
- 2030: 64% reduction
- **2050:** 80% reduction

Trust annual carbon footprint

Source (tonnes CO_2e)	2007-8	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Electricity	3076	3240	3128	2906	3046	2972	3063	2906	2969	2945	2956
Gas	4433	4179	4126	4065	3771	4231	3800	3608	3704	4046	3231
Water	71	87	87	87	79	81	87	74	96	81	82
Transport	1451	1449	1462	1373	792	1088	922	854	902	872	828
Waste	79	91	85	88	75	55	64	51	47	52	60
TOTAL footprint	**9111**	**9047**	**8887**	**8519**	**7762**	**8427**	**7936**	**7493**	**7718**	**7995**	**7157**

Table 11 – AWP annual carbon footprint from 2007/08 – 2017/18

Up to 2017/18 our carbon footprint reduced by 21.4% compared to the 2007/08 baseline year. We have significant work to do to achieve the target reductions described above.

Existing carbon reduction projects:

- New Building Management System (BMS) being fitted to Hillview Lodge which will reduce our gas usage and improve the environment for service users and staff
- Improved ventilation for clinic rooms and kitchens in order to adapt to warmer summer temperatures
- Creating a grant funding bid to provide more cycle parking at our sites and an additional bid for installing electric vehicle charge points at selected sites
- Replacement of old boilers and hot water cylinders
- Feasibility studies for replacing old fluorescent lighting with LED
- Developing an energy and waste awareness campaign to encourage our staff to be more sustainable with energy usage, transport and waste management
- Continue the use of Skype as an alternative to attending long distance meetings

We have recently recruited an Energy and Sustainability Officer to support us to reduce energy consumption and improve the Trust's sustainability credentials. Our Sustainable Development Action Plan includes a climate change risk assessment and adaptation plan. This action plan focuses on the three largest emission sources: electricity, gas and transport.

We can further reduce emissions by positively engaging staff to use energy more efficiently and use sustainable means of transport, as well as encouraging greater use of "Skype for Business".

In 2017/18 we achieved a 24.6% carbon emissions reduction compared to our baseline year. However, due to recent variations we are cautious to draw definitive conclusions from this result until we have obtained the 2018/19 carbon emissions data.

Sustainability and Transformation Partnerships (STPs)

The Trust is a member of two Sustainability and Transformation Partnerships (STPs), "Healthier Together" covering Bristol, North Somerset, and South Gloucestershire (BNSSG), and "BSW" covering B&NES, Swindon and Wiltshire. Both STPs have dedicated Mental Health workstreams, each of which are focusing on developing a Mental Health Strategy for their respective areas. Themes emerging from early engagement with service users and carers across both BNSSG and BSW that need to be included in the Mental Health Strategies are:

- Improving crisis support for service users and carers, enabling earlier intervention and treatment
- Supporting people to look after their own mental health and wellbeing and creating more resilient communities
- Providing more care in the community, closer to people's homes
- Intervening earlier in children and young people's mental health, to reduce deterioration and support recovery
- Supporting the further development of services for women with perinatal mental health needs

Over the next 12 months we will be working with partners across our STPs to develop new approaches that enable us to address existing needs more effectively and create sustainable services that respond to increased demand and future needs. Our plans for the future will be incorporated into each STP Five Year Plan, which will be developed in the latter part of 2019/20.

Being sustainable in 2019/20

Our plans for 2019/20 are informed by the need to utilise technology to best effect, improve the environment in which care is provided and provide greater consistency to the delivery of community based care. Our priorities for improving our sustainability in 2019/20 are described below:

Our objective for 2019/20:

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

We want to achieve:

1. Standard care packages for people experiencing psychosis
2. Service improvements in Children and Young Peoples Mental Health Services
3. Better use of technology to free up clinical time
4. Essential technology improvements
5. Planned Estates changes across the Trust
6. Less reliance on agency staff

Improving our services, 2019 and beyond

Our plans for the coming year align with our strategic principles and aim to improve both the safety and experience for our service users, carers and staff:

Our vision: to give you the best possible care in the right place, at the right time to help you recover and live your best life

NHS
Avon and Wiltshire Mental Health Partnership
NHS Trust

Our top priorities for 2019/20

Supporting service users and carers

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

WE WANT TO ACHIEVE

1. CQC rating of 'Good'
2. Service users co-producing their care plan and risk assessment
3. A reduction in restrictive practice
4. Safeguarding as everyone's business
5. Physical and mental health treated with equal importance
6. Improved learning from incidents
7. A Trust wide Quality Improvement programme

Engaging our staff

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

WE WANT TO ACHIEVE

1. Improved staff wellbeing and experience
2. Clear career pathways
3. Increased staff development opportunities, including Apprenticeships
4. Increased retention of staff, especially in their first year

Being sustainable

We will transform our services to meet increased demand, safely and sustainably

WE WANT TO ACHIEVE

1. Standard care packages for people experiencing psychosis
2. Service improvement in Children and Young Peoples Mental Health Services
3. Better use of technology to free up clinical time
4. Essential technology improvements
5. Planned Estates changes across the Trust
6. Less reliance on agency staff

PASSION RESPECT INTEGRITY DIVERSITY EXCELLENCE

Delivery of these priorities is monitored through our governance processes and associated Performance Management Framework.

What might stop us achieving our strategic objectives?

Risks to our strategic objectives are managed through the BAF, they tend to be future risks.

We identified and managed the following risks to our objectives, through our Board Assurance Framework (BAF):

	Key risks	Mitigations
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.	CQC Action Plan, Undertakings, Well Led Framework assessment and Action Plan, Sign up to Safety programme, an external review of serious incidents, using an appreciative enquiry mode of root cause analysis.
	If we are unable to improve our estate to ensure it is fit for purpose then clinical care may be compromised.	STP Estates Programme, BNSSG proposed consultation process, BSW engagement on estate strategy, water management programme and a ligature reduction programme, contract negotiations.
	If the Trust does not involve service users and carers effectively then there is a risk of poor patient experience of our services.	Review of the service user and carers forum, strengthening co-production in the Trust and introducing an expert by experience post.
	If demand and capacity are not aligned and funded then waiting times will increase and outcomes for patients will worsen.	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.	Listening into Action, Link Directors, new communications team to lead revised communications and engagement activities, revised Leadership Forum.
	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.	Recruitment and Retention Strategy, implementation of local recruitment plans, participation in the NHSI Recruitment and Retention programme and increased engagement with universities.
	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.	Review of Executive Team and Senior Leadership Team, new appointments to Director posts and a review of the Leadership Forum.

	Key risks	Mitigations
We will be sustainable	If STPs transform services to meet the system financial deficit, this may reduce funding for mental health core services and the impact on the sustainability of the Trust.	STP engagement, re-negotiated contracts, estates strategic review.
	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.	Engagement with STPs and stakeholders in developing transformational plans.
	If the Trust does not meet its financial control total and develop a long term financial model (LTFM) that includes the impact of any savings associated with the transformation programme in order to achieve financial sustainability, then the Trust will continue to be in deficit which in turn will require the Trust's cash borrowing to increase, increase the level of scrutiny by the regulator and potentially restrict the level of available cash to improve patient care.	Cost Improvement Plan (CIP) plan, transformation plan, re-negotiated contracts, improved budget responsibility and performance management.

Table 11 - Table of risks featured on the Board Assurance Framework as of 31 March 2019

We are on a journey of improvement and this report provides an overview of our achievements and challenges during 2018/19. Our Trust Board and staff continue to strive to provide excellent care for individuals and their families in accordance with our shared values.

We know there is more to do and this report summarises what we will focus on in 2019/20 to make measurable improvements in the year. We have developed an ambitious programme that requires shared commitment, focus and effective partnerships. We remain fully committed to system working to ensure our services respond to and meet the changing needs of our communities.

To the best of my knowledge this performance report presents a fair and balanced view of the performance of the Trust in 2018/19.

Hayley Richards

Signed

Hayley Richards, Chief Executive

23 May 2019

Annual Report 2018 / 19

Accountability Report

Corporate Governance Report

Directors Report

The Board

Avon and Wiltshire Mental Health Partnership Trust (AWP) 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 59.

Board membership during 2018/19

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, Audit & Risk

Ernie Messer

Non-executive Director, Vice Chair, Senior Independent Director

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: 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 (Chair from September 2018)

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 an 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: February 2016
Committees: Finance and Planning (Chair until August 2018)
Quality & Standards (Chair from August 2018 until January 2019)

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 (Chair from September 2018), Finance and Planning, Charitable Funds

Marie-Noelle Orzel

Non-executive Director

Marie-Noelle has worked for the NHS for over 30 years in a variety of clinical, academic, managerial and executive roles at local, regional and national levels. Her last NHS role was as Improvement Director for NHS Improvement.

Appointed to the Board: December 2018, a Director Designate from 1 October 2018
Committees: Quality & Standards (Chair), Audit & Risk

Shelley Whitehead

Associate Non-executive Director

Shelley has supported a number of local and national organisations such as Young Minds and her local chapter of the Carers Support service in raising awareness and challenging to achieve improvements in mental health systems and services for children and young people.

Shelley specialises in strategic change projects, partnership development, governance and stakeholder management within both public sector and commercial organisations.

Appointed to the Board: December 2018
Committees: Audit & Risk (attendee), Finance & Planning

Sarah Elliott

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.

Appointed to the Board: February 2017. Left July 2018
Committees: Quality and Standards (Chair until July 2018), Audit and Risk

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.

Appointed to the Board: February 2016. Left 31 August 2018
Committees: Audit and Risk (Chair)

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. Hayley will retire in May 2019.

Committees: Executive Committee Chair

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), Executive Committee. Left the Trust February 2019

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.

Simon was made Deputy Chief Executive in February 2019

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

Sue McKenna

Chief Operating Officer

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

Committees: Quality and Standards, Finance and Planning, Audit and Risk (attendee), Executive Committee. Left the Trust May 2018

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 19 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 and 2017 Rachel became the Director of Strategy.

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), Executive Committee

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.

Committees: Executive Committee

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 an independent sector provider.

Julie joined AWP at the beginning of April 2018. She is passionate about ensuring our service users 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), Executive Committee

Mathew Page

Chief Operating Officer

Mathew trained as a mental health nurse at the University of the West of England, qualified in 1999 and joined the trust in 2014 as Deputy Director of Operations. He became Chief Operating Officer in July 2018.

Before joining AWP, Mathew specialised in Psychiatric Intensive Care Unit (PICU) and acute care and set up and ran the Montpellier Secure Recovery Service in Gloucester for seven years. He was instrumental in securing the contract for Child and Adolescent Mental Health Services (CAMHS) in Gloucestershire before going on to lead the transformation and expansion of the service, helping to develop several system-wide solutions for vulnerable children and their families, such as the Family Drug and Alcohol Court and a Functional Family Therapy Team. Mathew also developed the National Minimum Standards for CAMHS PICU.

Committees: Quality and Standards, Finance and Planning, Executive Committee

New Board members from April 2019

Brian Stables

Non-executive Director (from April 2019)

Brian has 17 years of experience in acute and primary care, most recently holding a nine year position as Chairman of the Royal United Hospitals NHS Foundation Trust (RUH), in Bath. Prior to his appointment at the RUH, he was a Foundation Trust Network Board Member and Trustee, before which he worked in the position of Non-executive Director and Vice Chairman of NHS Wiltshire.

Brian is a Fellow of the Chartered Institute of Management Accountants (FCMA), having an extensive career in the global automotive component industry.

Appointed to the Board April 2019
Committees: Audit & Risk (Chair from June 2019)

Sarah Constantine

Medical Director (from April 2019)

Sarah, who joined AWP in April 2019, was brought up in Chippenham in Wiltshire and studied at Southampton University Medical School.

She gained dual accreditation in older people and adult mental health and after 10 years as a consultant moved into more leadership roles, including lead for the Mental Health Act, appraisal/ revalidation and Electroconvulsive Therapy (ECT). She completed a Masters in Healthcare Leadership and has Quality Improvement experience; she strives to shape services and provide high quality care in partnership with service users and carers locally and at population level.

Committees: Quality and Standards, Executive Committee.

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, Marie-Noelle Orzel was appointed in December 2018, replacing Sarah Elliott, who left the organisation in July 2018. A new Director of Nursing, Julie Kerry, joined the Trust in April 2018. Mathew Page become Chief Operating Officer in June 2018, replacing Sue McKenna. A new Medical Director, Sarah Constantine, joined the Trust in April 2019 replacing Rebecca Eastley who left in February 2019. Dr Pete Wood became Acting Medical Director in the intervening period.

Triss Horwood joined the Trust as a NExT Non-executive Director in March 2018 and left in March 2019. Triss joined us as part of a scheme established by NHS Improvement to improve diversity on Trust Boards. Shelley Whitehead was appointed as an Associate Non-executive Director in December 2018. Brian Stables has been appointed as a Non-executive Director with a financial background and joined the Board on 1 April 2019.

Board diversity

As of 31 March 2019, the Board was composed of five executive directors, three of whom are male, two female. Of the seven non-executive directors (including the Chair and Associate Non-executive Director), 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 throughout the year. In 2018/19, Board seminars covered the following areas:

- Leadership and organisational culture
- Strategic finance
- Unitary Board
- Risk and assurance
- Strategy and planning
- Service transformation
- Sustainable Transformation Partnerships
- Well Led assessment

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

http://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.

	Member	Number of meetings attended in 2018/19	Comments
Non-executive Directors	Charlotte Hitchings (Chair)	11(12)	
	Neil Auty	10(12)	
	Sarah Elliott	3(3)	Left July 2018
	Ernie Messer	11(12)	
	Charlotte Moar	3(4)	Left August 2018
	Mark Outhwaite	11(12)	
	Malcolm Shepherd	11(12)	
	Marie-Noelle Orzel	4(4)	Started December 2018
	Shelley Whitehead (Associate NED)	4(4)	Started December 2018
Executive Directors	Hayley Richards (CEO)	10(12)	
	Julie Kerry	11(12)	
	Rebecca Eastley	6(10)	Left February 2019
	Sue McKenna	1(2)	Left May 2018
	Simon Truelove	11(12)	
	Mathew Page	7(9)	From June 2018
	Pete Wood (Acting Medical Director	2(2)	February – April 2019
Directors (non-voting)	Rachel Clark	11(12)	
	Julian Feasby	9(12)	

The number in brackets is the number of Board meetings where the director was a member

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.

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 2018/19

- 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.
- Oversight of the Well Led action plans
- Appointment of the internal and external auditors

Committee members

Member	Number of meetings attended in 2018/19	Comments
Charlotte Moar (Chair)	2(2)	Left August 2018
Sarah Elliott	2(2)	Left July 2018
Malcolm Shepherd (Interim Chair)	6(6)	
Neil Auty	4(4)	From September 2018
Mark Outhwaite	3(3)	From September 2018 to January 2019
Marie-Noelle Orzel	1(2)	From December 2018
Shelley Whitehead	2(2)	From December 2018 (attendee)

The number in brackets is the number of committee meetings where the director was a member

Committee attendees

In 2018/19, 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 2018/19

- Remuneration for directors.
- Annual performance evaluation of directors.
- Oversight of recruitment process for directors
- Oversight of redundancy and severance pay.

Committee members

Member	Number of eligible meetings attended in 2018/19	Comments
Charlotte Hitchings (Chair)	9 (9)	
Neil Auty	5(9)	
Marie-Noelle Orzel	4 (4)	
Sarah Elliott	2(2)	Left July 2018
Ernie Messer	8 (9)	
Charlotte Moar	1(3)	Left August 2018
Mark Outhwaite	8(9)	
Malcolm Shepherd	9 (9)	

The number in brackets is the number of committee meetings where the director was a member

Committee attendees

In 2018/19, 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 2018/19

- 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 2018/19	Comments
Neil Auty	8(9)	
Sarah Elliott (Chair)	2(2)	Left July 2018
Mark Outhwaite (Interim Chair)	6(6)	August 2018 – January 2019
Julie Kerry (Director of Nursing)	9(9)	
Sue McKenna (Chief Operating Officer)	0(1)	Left May 2018
Mathew Page (Chief Operating Officer)	6(7)	From June 2018
Rebecca Eastley (Medical Director)	5(8)	Left February 2019
Pete Wood (Acting Medical Director)	2(2)	February – April 2019
Marie–Noelle Orzel	3(3)	From December 2018

The number in brackets is the number of committee meetings where the director was a member

Committee attendees

In 2018/19, the following have also attended committee meetings:

- Director of Human Resources
- Associate Director, Governance, Improvement and Quality
- Company Secretary
- Service user/carer

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 2018/19

- 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 2018/19	Comments
Mark Outhwaite (Chair until August 2018)	8(10)	
Ernie Messer (Chair from September 2018)	10(10)	
Malcom Shepherd	10(10)	
Simon Truelove (Director of Finance)	10(10)	
Sue McKenna (Chief Operating Officer)	0(2)	Left May 2018
Mathew Page (Chief Operating Officer from June 2018)	5(8)	
Neil Auty	3(3)	
Shelley Whitehead	2(3)	From December 2018

The number in brackets is the number of committee meetings where the director was a member

Committee attendees

In 2018/19, the following have also attended committee meetings:

- Director of Strategy
- Divisional Associate Directors
- Associate Director 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 2018/19

- 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.
- Review of the Fundraising Strategy.
- Review of Charitable Funds policy.

Committee members

Member	Number of eligible meetings attended in 2018/19	Comments
Ernie Messer (Chair)	3(4)	
Malcolm Shepherd	4(4)	
Simon Truelove	3(4)	

The number in brackets is the number of committee meetings where the director was a member

Committee attendees

In 2018/19, the following have also attended committee meetings:

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

Annual Governance Statements 2018/19

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 2019 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 have 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 incidents, 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.

This policy was reviewed again in March 2019 by the new Head of Risk and Legal Services with minimal changes recommended, providing assurance to the Board that the policy is fit for purpose. Further guidance is available to staff in our Incident, Risk Assessment, Being Open and Freedom to Speak Up policies.

In June 2018, we held a Board seminar which included risk management where the Board reviewed and agreed the Board Assurance Framework risks, reviewed the current corporate risks and risk process. At that seminar, the Board confirmed the risk appetite for the Trust as being cautious. The Board reviews the Board Assurance Framework and Corporate Risk Register, on two additional occasions throughout the year.

Our Risk Management Team also provides six training sessions a year on risk management. In 2018/19, senior staff from each of our divisions received dedicated training, either as a group or in one-to-one sessions. In addition, the 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.

A significant amount of work was undertaken regarding the risk register in 2018/19, building on the work undertaken in 2017/18. The Board recognised that although risk management processes had improved in 2017/18 and internal audit had provided a reasonable assurance view of our risk processes, they still need to be strengthened. As a result the following actions were undertaken in 2018/19

- A new Head of Risk and Legal Services role was introduced in December 2018, following previous work undertaken by a management consultant in the summer of 2018
- The Head of Risk and Legal services visited three high performing NHS Trusts to identify best practice and review risk procedures and policies
- The Risk Management Strategy and Policy was reviewed with only minor changes recommended
- All corporate risks were reviewed and re-worded to ensure that they accurately reflected the current risks. These risks were mapped against the Board Assurance Framework risks
- An action plan was developed to embed risk processes throughout the Trust, this will build capacity to equip staff to better understand and manage risk
- New risks added to the risk register are reviewed by the Risk Management Team to check their wording and quality control the risks
- The reporting structure to discuss operational risks was reviewed in 2019. The risk manager now attends Operational Delivery Group on a monthly basis, to discuss operational and divisional risks to ensure they align with the corporate risk register. Risks are also reviewed at the Quality, Safety and Risk Assurance Group (QSRAG)
- Risk training is included in the managers toolkit, a training course for new managers
- Improved communication to all staff about the risk management process
- The risk register audits, conducted by the risk manager, are now shared with the Audit and Risk Committee for oversight and assurance

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, Board Assurance Framework, Risk Management Strategy and, finally, the Policy Framework. In respect of corporate governance, the Trust seeks to follow best practice as described in the UK Corporate Governance Code (2019).

The Trust has taken the following steps to strengthen its governance processes in 2018/19:

- Commissioned an external Well Led review (PricewaterhouseCoopers) which included a review of risk management processes and developed a clear action plan for improvement
- 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. These provide further assurance to the Trust Board on the controls in place to mitigate those risks
- Introduced an Executive Committee (February 2018), chaired by the Chief Executive and reporting to the Trust Board, with responsibility for operational performance and workforce
- Introduced quarterly performance review meetings with divisions
- Reviewed the quality governance structure to strengthen quality governance
- Reviewed the structure of the Nursing and Quality Directorate, to ensure we have the correct staff to support the quality agenda

Board and Committee structure

The Board committee structure is summarised below. The Chair of each committee provides an assurance report to the Board on the work of the committee.

**Executive Committee reports into Board this will be replaced by the Delivery Committee from May 2019 which will provide assurance to the Board on workforce and operational issues and be chaired by a Non-executive Director*

Figure 7 - Trust committee structure, as of 31 March 2019

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 assurance as to the effectiveness of management through the provision of reports, risk registers and the Board Assurance Framework. It also takes assurance 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 escalating to the Board. There is cross membership between the other Board committees and the Audit and Risk Committee to triangulate the sources of information and assurance.

Finance and Planning Committee and Quality and Standards Committee

The Finance and Planning and Quality and Standards Committees have oversight of significant business and clinical risks respectively. The Committees review financial and quality metrics, prior to submission to the Board. A Chairs of Committees' meeting was introduced to plan the year going forward and to monitor progress of the work of committees.

*Executive Committee

The Executive Committee was established in February 2018 to provide oversight of the Trust's operational and workforce performance. The Committee reviews operational performance and corporate risks along with mitigating actions. The Executive Committee is not a formal sub-committee of the Trust Board, but reports into Board through the Chief Executive. Following the external Well Led review, the structure was reviewed again and a Delivery Committee, chaired by a Non-executive Director, will be introduced in 2019/20. This assurance committee will scrutinise operations and workforce performance, prior to presentation to the Board.

Nominations and Remuneration Committee and Charitable Funds Committee

The Board has a Nominations and Remuneration Committee which reviews matters relating to executive pay and appointments. The Board, as corporate trustee of charitable funds, has established a Charitable Funds Committee for oversight of the Trust's charitable funds.

Board and Committee evaluation

Throughout 2018/19 the Board sought feedback about its effectiveness at the end of every Board meeting. Each attendee is asked to score the meeting and identify 'what went well' and 'what could be improved' in the future. The Chair is responsible for acting on the feedback. This reflective practice is a requirement of all our Board committees.

All Board committees prepare an end of year review which summarises the work undertaken, reviews the terms of reference and agrees a work plan for the following year.

In November 2018, the Board participated in an externally facilitated Board seminar, focussing on the feature of a high performing board and reflecting on the current Board and ways to improve performance.

External Well Led Review and CQC Well Led review

Between July and October 2018, PricewaterhouseCoopers (PWC) undertook a Well Led review, this was agreed as part of the enforcement undertakings the Trust agreed with NHS Improvement to improve financial governance. In October 2018 the Care Quality Commission (CQC) rated the Trust as 'Requires Improvement' overall and for the Well-Led domain.

Both the external Well Led review and the CQC, reviewed the Trust governance structures and were consistent in their findings.

"Governance structures and processes at Board and sub-committee level broadly operate in line with our expectations of a mental health trust. Reporting lines are clear, as is the split of business between the committees. However, we noted a gap in governance with reports on workforce going to the Board via the Executive Committee rather than via a formal assurance sub-committee.

"The Board meeting we observed was effectively chaired, with strong engagement around the table and robust challenge from both NEDs and between Executives.

"We found the Finance and Planning, and Audit and Risk Committees to be operating effectively but noted an opportunity to strengthen the information presented to the Quality and Standards Committee, as well as the level of debate and challenge." Well Led review PWC 2018

The CQC 2018 report stated that:

"The trust had structures, systems and processes in place to support the delivery of its strategy including committees, subcommittees and team meetings. In 2018, the trust underwent an external review of its committees and their terms of reference. The review identified the need for more robust quality governance reporting systems."

The Board agreed with the findings and has taken action to address the identified gaps.

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 2018/19. In addition, the Audit and Risk Committee reviewed it twice.

Risks featured on the Board Assurance Framework (BAF) in 2018/19 were aligned to the strategic and annual objectives. A lead Director and a lead sub-committee were identified for oversight of the risks.

Risks to our strategic objectives are managed through the BAF, they tend to be future risks.

	Key risks 2018/19	Mitigations
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	CQC action plan, Undertakings, Well Led Framework assessment and action plan, participation in the Sign Up to Safety Programme, an external review of serious untoward incidents using an appreciative enquiry mode of root cause analyses.
	If we are unable to improve our estate to ensure it is fit for purpose then clinical care may be compromised.	STP Estates Programme, BNSSG proposed consultation process, BSW engagement on estate strategy, water management programme and a ligature reduction programme, contract negotiations.
	If the Trust does not involve service users and carers effectively then there is a risk of poor patient experience of our services.	Review of the service user and carers fora, strengthening co-production in the Trust and introducing an expert by experience post.
	If demand and capacity are not aligned and funded then waiting times will increase and outcomes for patients will worsen.	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.	Listening into Action, Link Directors, new communications team to lead a revised communications and engagement activities, revised Leadership Forum.
	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.	Recruitment and Retention Strategy, implementation of local recruitment plans, participation in the NHSI Recruitment and retention programme and increased engagement with universities.
	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.	Review of executive team and senior leadership team, new appointments to director posts and a review of the Leadership Forum.
We will be sustainable	If STPs transform services to meet the system financial deficit, this may reduce funding for mental health core services and the impact on the sustainability of the Trust.	STP engagement, re-negotiated contracts, estates strategic review
	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.	Engagement with STPs and stakeholders in developing transformational plans
	If the Trust does not meet its financial control total and develop a long term financial model (LTFM) that includes the impact of any savings associated with the transformation programme in order to achieve financial sustainability, then the Trust will continue to be in deficit which in turn will require the Trust's cash borrowing to increase, increase the level of scrutiny by the regulator and potentially restrict the level of available cash to improve patient care.	CIP plan, transformation plan, re-negotiated contracts, improved budget responsibility and performance management.

Table 12 - Table of risks featured on the Board Assurance Framework as of 31 March 2019

The key corporate risks in year scored at 12 and above (using a 5 x 5 likelihood x severity risk matrix) in March 2019 were as follows:

Risk	Entry number	Directorate	Score
1. Health and Safety Executive breaches	1074	Nursing	16
2. Brexit/EU Exit could lead to high levels of inflation, and unfunded increase in operating costs	1113	Operations	16
3. CQC prosecution (Non-compliance with regulations)	1091	Nursing	16
4. Brexit/EU Exit could lead to civil unrest which would significantly affect emergency services partner organisations	1114	Operations	15
5. Health and Safety ligature management	989	Nursing	15
6. Brexit/EU Exit impact on supply of medication may be limited	1107	Operations	15
7. Staffing levels (Recruitment and retention of medical staff)	1134	Medical	12
8. Human Resources (Staff Engagement)	193	Human Resources	12
9. Human Resources (Executive Director capacity)	1007	Chief Executive	12
10. Human Resources (Staff Health and Well-being)	742	Human Resources	12
11. Human Resources (Trust wide Staffing Recruitment)	922	Human Resources	12
12. Information Governance (Non-compliance with Standards)	612	Finance	12
13. Information Governance (Cyber-Security and Training)	882	Finance	12
14. Brexit/EU Exit the supply of goods and services including building work and maintenance	1109	Operations	12

Table 13 - Table of risks featured on the Corporate Risk Register as of 15 March 2019

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 and 2017/18.

The Trust achieved its control total in 2018/19, however, it does not have a long term financial plan with clearly identified recurrent saving programmes costed. The Trust is developing a long term financial plan as part of its 5 year plan to ensure we return to a financially sustainable position. The key challenges include the shortfall in the substantive workforce which results in agency staff usage, use of out of trust beds when the Trust's internal bed capacity is exceeded and the demand that is being placed upon community services. All of these contribute to the overall financial sustainability of the Trust.

Risk management

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 Directors and Associate Directors for each of our three divisions are accountable for managing the day-to-day operational risks within their area. The divisions are held to account for the management of their risks at the Operational Delivery Group meeting. Divisions and localities 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 twice yearly basis at the Trust Board and at every Audit and Risk Committee meeting. A named Executive Director is 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.

Workforce

During 2018/19, the Trust has particularly focused on the recruitment and retention of its workforce, which the Board identified as one of its top strategic risks. The Director of Human Resources (HR) has addressed these risks from both a strategic and operational perspective. A new workforce strategy and workforce plan was approved by the Trust Board in September 2018. A cohort of "retention champions" has been established, which ensures that staff perspectives towards improvements are embedded at all times.

In line with the "developing workforce safeguard" recommendations, we are making continuous improvements in our approaches to workforce planning. Our HR Director is the executive sponsor for workforce issues, supported actively by all Board members. Developments are happening collaboratively between our nursing professionals, as far as safe staffing is concerned, operations, medical, finance and human resources to develop safe staffing initiatives.

We have a comprehensive approach to tackling an ever increasing pressure to use agency staff. The approach has been externally audited and found to be robust, although the multi-faceted pressures have meant an increased usage this year. We actively manage our internal bank of staff through e-rostering, to maximise their deployment where gaps in staffing occur, or service user issues require a short-term staffing enhancement.

We are developing new roles across our Trust to reduce the reliance on hard-to-recruit roles in challenging geographical situations. We are also establishing ways to make increasing use of our apprenticeship levy, notably a mental health nursing apprenticeship in due course.

Engagement with staff is one of the strategic priorities of the Trust. We are participating in a Listening into Action programme. We hold crowd fixing events where staff are invited to work through an identified issue and to find creative solutions. This, combined with other initiatives, aims to empower staff to solve issues they face.

There is a national and local shortage of nursing staff. We have been proactively working with universities to encourage students to join AWP after graduation. We have also sponsored nurses to study in areas of particular staff shortages, such as learning disabilities.

We complete Equality Impact Assessments (EIA) in relation to development of services, service changes, key policies and transformation programmes. The Equality and Diversity Advisor works with the Programme Management Office colleagues to prioritise EIAs to be completed. Additionally, an Impact Assessment Group has been set up where EIAs and Quality Impact Assessments are discussed on key strands of work currently taking place.

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 are in place for the provision of safe, high quality patient care and that we comply with legislation, regulation and guidance. The Director of Nursing and Quality has executive responsibility for maintaining the system of quality governance.

Both the external Well Led review and the CQC 2018 report highlighted areas for improvement in quality governance.

"We found a self-aware organisation and a leadership team which has a desire to continuously improve and develop. The Trust's historic financial challenges have led the Trust to previously focus more strongly on the finance agenda and there is now a need to ensure more balanced focus across quality, finance and performance." Well Led review (PWC 2018)

We made further improvements to quality governance processes in 2018/19. The Nursing and Quality Directorate (NQD) was re-structured, although this led to gaps in personnel and short-term capacity issues. Areas for improvement were identified by the new Director of Nursing and Quality relating to risk, safeguarding, serious untoward incidents and health and safety. A revised quality governance structure was implemented with clearer lines of accountability and reporting structures. A significant amount of time and resource was dedicated to improve these areas and by the end of 2018/2019 the NQD structure was strengthened. This quality governance structure will need to be embedded in 2019/2020.

We are committed to continuing to improve the quality of incident investigations to enable Trust wide learning and improvement. Considerable work has been undertaken to improve governance and quality processes in relation to investigations. We commissioned an external review of the root cause analyses of serious untoward incidents, using an appreciative enquiry approach. This work was undertaken jointly with the Clinical Commissioning Groups.

All investigation reports are reviewed by a multidisciplinary team, including executive level staff to ensure that reports are honest, transparent and reflect organisational learning when things go wrong. All investigation reports undergo further scrutiny by our commissioners and we are working collaboratively with them 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.

Quality Account for 2018/19

In order to deliver and maintain its system of quality governance we are developing a Quality Strategy and Quality Improvement Plan. The Board, as part of its Board development programme, received training on Quality Improvement (QI) methodologies in February 2019. In March 2019, the Quality and Standards Committee received a draft QI plan detailing an approach to QI. We recognise the importance of a coherent QI strategy supported by an achievable plan; this will be a priority in 2019/20.

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, can be monitored and any potential risks adequately mitigated. The QIAs are approved by the Director of Nursing and Quality and QIAs for significant projects are reviewed by the Quality and Standards Committee. During 2018/19, the Trust implemented a strengthened approach to QIA assessments following an internal audit, which includes a dedicated clinical quality sub group, multi-disciplinary decision making and clearer escalation to the Quality and Standards Committee.

The Care Quality Commission (CQC)

The Trust is fully compliant with the registration requirements of the CQC.

We were inspected by the CQC in September and October 2018 and were rated 'good' in the effective and caring domains and 'requires improvement' in the safe, responsive and well-led domains. However, the overall rating remained 'requires improvement'. The CQC recognised that the Trust had made many of the improvements from previous inspections but had not made all the improvements relating to acute wards and psychiatric intensive care units.

The ward for people with a learning disability or autism (Daisy Unit) was rated as 'inadequate' and the CAMHs service was rated as 'requires improvement'. The CQC

found that improvements were still required relating to ligature management environment risks and seclusion practices. The CQC did not issue any warning notices in 2018.

Detailed action plans have been developed for both the CAMHs service and the Daisy Unit and are being managed through the Programme Management Office.

The CQC recognised the significant improvements made to the mental health crisis services and health based places of safety.

We are committed to ensuring that all of the areas of improvement identified in the 2018 CQC inspection are addressed and are embedded. We are also committed to ensuring that underlying cultural changes are commenced through the following priorities:

- CQC and Regulatory Improvement
- Embedding a culture of Quality Improvement (QI) - including embedding a culture of co-production
- Getting the basics right – improvement in safeguarding practice, care planning, risk planning and physical healthcare

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 in 2018/19 as the Local Counter Fraud Service (LCFS). A risk-based plan was developed and agreed by the Audit and Risk Committee.

The LCFS undertook a fraud risk assessment in 2018/19, covering key risk areas including HR, payroll, finance and procurement. No significant control weaknesses were identified. The Trust has re-procured the Counter Fraud service and RSM have become the new provider of a joint internal audit and counter fraud service from 2019/20.

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.

Register of Interest

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

Pension scheme

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.

Equality and Diversity

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

Carbon Reduction Delivery Plans

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

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

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 Board on a quarterly basis using the Board Assurance Framework and specific quarterly reports to Board updating on progress against objectives.

The Director of Finance and Chief Operating Officer provide detailed monthly financial, activity and performance reports to the Finance and Planning and Executive Committees. The Finance and Planning Committee review and challenge on the delivery of the statutory financial targets including the delivery of the income and expenditure target, capital target, cash target and the better payment practice code. The reports are 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 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. All budgets are delegated to budget managers at the start of the financial year and each budget manager is required to sign the Declaration of Budgetary Responsibility. Areas where budgetary performance are not adequate, result in services being put into internal financial recovery. In 2018/19 they included the Bristol and Secure services local delivery units. The improved rigour in budgetary management in 2018/19 saw a number of areas significantly improve their financial position by enhancing the control on expenditure. These new processes continue to be developed and will be enhanced going forward into 2019/20.

The financial performance of the Trust in 2018/19 has again been challenging given that the Board accepted the NHSI control total which required the Trust to deliver savings of £12.1m.

As well as increased financial control the Trust focussed on the transformation of its services. The Trust established a Transformation Board in 2017, which focussed on agreed change programmes in 2018/19. The Trust piloted an Acute Care Unit and a Primary Care Liaison Service. The associated financial savings from the transformation project pilots were not realised, although there were some non-financial benefits. The Trust did not meet the target set by NHS Improvement to cap agency spend in 2018/19, which reflects the challenging workforce environment. The Trust has not delivered all of its savings recurrently in 2018/19 but has received some non-recurrent financial benefits, which have supported the delivery of the 2018/19 control total. For 2019/20 the Trust has a financial plan that requires savings of £7.1m to be delivered in order to deliver a breakeven position after the financial support from NHSI.

The Trust is working closely with commissioners and operational services to develop a local sustainable financial plan for the Trust, along with a sustainable system wide plan.

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 Data Security and Protection Toolkit and guidance issued by NHS Digital, CareCERT and the National Cyber Security Centre.

Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSP) is the new set of NHS standards requirement for information governance and cyber security which NHS Digital has been appointed to develop and maintain on behalf of NHS England. It draws together the legal requirements, central guidance set out by NHS policy and best practice and presents them in a single standards processes to improve the handling and protection of IT systems and information held by NHS providers.

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

The 18/19 DSP consist of 100 mandatory targets and additional non mandatory targets. Compliance requires all 100 mandatory targets to be met. While significant progress has been made this year the Trust only achieved compliance on 92 of the required targets.

This has required the Trust to submit an action plan to NHS Digital to address the remaining 8 targets. This is currently being assessed by NHS Digital and, if agreed, will require us to complete the compliance work no later than September 2019.

We have been advised by NHS Digital that the DSP toolkit will be further updated for 2019/20 with additional requirements around cyber security and IT systems management. This will require the Trust to address the continuing issue of the shortfall in suitable staff to manage the operation of the Trust's IT systems to the required level.

Information governance incidents

In 2018/19 there were 371 information governance incidents reported via the Safeguard system, of those 12 met the criteria to be reported to the Information Commissioner.

Category and description	No.	Feedback from ICO	Action taken By AWP
Confidentiality Breach Staff members used existing letter as a template and failed to update all information	111105	ICO confirmed not reportable	Internal investigation completed by manager and a new process will be followed in the department
Confidentiality Breach Information sent to wrong recipient	105110	ICO confirmed not reportable	None, as recipient was also AWP staff and so covered by NHS confidentiality policy (Mangers action form not completed)
Confidentiality Breach A previous staff member looked up the medical records for a family member	100191	Awaiting response form ICO	Investigated by Bank team, no feedback provided.
Disclosure of confidential information Service user found documents containing all access codes and other service user information	105750	ICO will keep the information provided on file, but will record that the report has been withdrawn.	Contacted ICO on 3 October to withdraw your report, explaining that the staff member's manager had advised that no such disclosure took place, and that the staff member discussed the incident in general terms only.
Confidentiality Breach Staff emailed multiple service user details to another staff member (not intended staff member) – only one service user details were required	106345	ICO closed with no further action.	Staff reminded of correct process, using email as a method of communication has been reviewed and stopped in all but exceptional cases.

Category and description	No.	Feedback from ICO	Action taken By AWP
Confidentiality Breach Fax sent to unknown wrong number	106498	ICO Reported that this was not required to be reported	Staff reminded to check fax details and only fax if necessary
Confidentiality Breach Service user details found offsite in a college room	106722	ICO confirmed not reportable	Staff to review process
Confidentiality Breach A letter did not reach its destination	106739	Awaiting response form ICO	Service user informed
Confidentiality Breach A doctor applied for registration but the portfolio contained several service user details from multiple trusts	107450	Awaiting response form ICO	AWP contacted the other trusts involved and the doctor resigned.
Security Breach Talking therapies Website Hacked	107611	Not required to report to ICO	Reported to NCCU and CareCERT
Confidentiality Breach Royal mail returned a care plan in a see through bag as the envelope got destroyed	109522	ICO confirmed not reportable	Complaint raised with Royal Mail however this is there process for damaged post.
Confidentiality Breach A complaint made the IG Team aware of a breach which occurred in 2015 of letters being sent to wrong addresses on multiple occasions	111022	ICO confirmed not reportable	IG/PALS investigated and discovered only one incorrect letter.
Confidentiality Breach An agency RMN did not record any entries from 19/2/19-22/2/19 then emailed the documentation to upload to their personal and their wife's personal email.	111125	ICO closed with no further action.	Advised agency and will not be using this RMN again.

Table 14 - Incidents reported to the Information Commissioner in 2018/19

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 2018/19 is fairly stated.

On behalf of the 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 2018/19.
- 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 2019.

The Trust's Quality Account 2018/19 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 2018/19 will be available on the Trust's website: **http://www.awp.nhs.uk/news-publications/publications/quality-account/.**

The Trust ensures that there are controls in place to ensure the accuracy of data through the following processes:

- Internal validation of data taken from the Trust IQ system
- Nationally validated data sets such as clinical audit and national confidential enquiry
- External audit by Deloitte including data accuracy checking
- Patient safety data submitted via National Reporting and Learning system (NRLS)

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, Quality and Standards Committee, Finance and Planning Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board and its Committees have a substantial role in reviewing effectiveness of the system on internal control.

Trust Board

I provide an update on the significant events or matters that affect the Trust at each Board meeting. The Board also receive the Board Assurance Framework (BAF) and risk register twice yearly and review the significant risks and mitigations. Each committee regularly reviews the BAF and corporate risks assigned to that Committee. Chairs of the Board sub-committees provide reports to the Board on the work of the committee and the assurance received regarding the items presented for assurance or approval. Items are escalated to the Board as required.

Audit and Risk Committee

The effectiveness of the system of internal control has been reviewed by the Audit and Risk Committee which receives the Board Assurance Framework as well as other reports including those from Internal Audit, External Audit and Counter fraud. The Committee receives all internal audit reports on both financial and non-financial areas and has monitored the implementation of all the recommendation via the use of a tracker system

The Trust had a clinical audit programme in place for 2018/19 which is agreed by the Quality and Standards Committee, prior to presentation to the Audit and Risk Committee

Internal audit

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 Trust. 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 (seven) of internal audit reports in 2018/19 gave a reasonable assurance opinion. Partial assurance was granted in four audit reports, as follows:

- Records Management
- Quality Impact Assessments
- Medical Staffing and Job Planning
- Agency Nurses

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.

Weaknesses in control

The Board identified weaknesses in the system of internal controls relating to quality governance following a review of systems undertaken by the new Director of Nursing and other issues. Detailed action plans were put in place to manage the identified risks and improve the issue relating to these areas:

- Governance weaknesses relating to quality governance structures, risk, safeguarding, health and safety and serious incident management reporting
- Likely prosecution by CQC regarding low roofs in 2019/20 relating to an incident in 2016 and the subsequent mitigation of low roof risk.
- Health and Safety Executive inspection in December 2018 identified gaps in our compliance with health and safety legislation including training for new starters, competence assistance, incident investigations, governance, policy changes and reviews. The Trust was required to pay a Fee for Intervention (FFI) for the time it took the Health and Safety to identify the breach.
- A locum doctor who was employed through an agency to work in the community was then transferred to inpatient services without Approved Clinician status. Once the issue was identified the Trust notified the agency and removed the doctor from duties.
- A lack of Quality Improvement (QI) capability as identified in the internal Well led assessment undertaken in 2017
- The Trust agreed enforcement undertakings with NHS Improvement in 2017. Although significant progress has been made regarding financial governance these remain in place.

Work has been ongoing in 2018/19 to strengthen the above areas including a revised quality governance structure, an agreed schedule of works to mitigate low roof risk, a detailed health and safety improvement plan and an improved QI capability. NHS Improvement commissioned a quality investigation in 2019 following the identification of the quality governance weaknesses, the findings of which are due to be fed back to the Board in June 2019.

In addition, to support the Trust's development, I commissioned a review of decision implementation in the Trust. This review aimed to understand the cultural and underlying causes as to why decisions taken at a senior level were not always effectively implemented. This work will result in a co-produced action plan being developed with the Board and senior leadership team. This plan will include improving accountability and responsibility structures.

The Board, via sub-committees, is monitoring the progress of all of the above weaknesses in internal control systems.

The findings and recommendations of the above reviews will be used to strengthen governance in the future.

Board turnover

During 2018/19 there have been a number of changes to the Board, including a new Director of Nursing, a new Chief Operating Officer, a new Non-executive Director with quality expertise and an Associate Non-executive Director with governance expertise. On 1 April 2019 a new Non-executive Director with a financial background started who will chair the Audit and Risk Committee. The Medical Director left in February 2019 and a new Medical Director started in April 2019. The interim period was covered by the Deputy Medical Director as Acting Medical Director. The Chief Executive will retire at the end May 2019 and a new Chief Executive will start on 1 August 2019. The Deputy Chief Executive will be the Acting Chief Executive during the two month gap. Whilst this provides an opportunity for new leadership, it is recognised that further support will be required to develop together as an effective unitary board. A board development programme is being established in 2019/20 to ensure board members have a clear understanding of operational, financial and quality improvement areas which are aligned to the Trust strategy.

Conclusion

There are no significant control issues identified, in addition to the internal control weaknesses identified in this statement.

Signed Chief Executive

23 May 2019

Remuneration and staff report

The following tables provide a breakdown of the workforce including senior managers by grade (band 8d and above), the numbers and costs of staff by whole time equivalent (wte) rather than head count.

Senior managers by grade (at 31 March 2019)

Pay grade	Number
Band 8d	17
Band 9	1
Clinical Director (not on AfC)	2
Director	7
Total	27

Table 15 – Senior managers by grade as of 31 March 2019

Number and cost of staff employed by staff group

Staff costs

	Permanent £000	Other £000	2018/19 Total £000	2017/18 Total £000
Salaries and wages	132,544	3,279	**135,823**	130,464
Social security costs	12,001	-	**12,001**	11,391
Apprenticeship levy	640	-	**640**	620
Employer's contributions to NHS pensions	16,565	-	**16,565**	16,247
Pension cost - other	52	-	**52**	14
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	380	-	**380**	1,666
Temporary staff	-	14,534	**14,534**	10,927
Total gross staff costs	**162,182**	**17,813**	**179,995**	**171,329**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**162,182**	**17,813**	**179,995**	**171,329**
Of which				
Costs capitalised as part of assets	-	-	-	-

Average number of employees (WTE basis)

	Permanent Number	Other Number	2018/19 Total Number	2017/18 Total Number
Medical and dental	278	16	**294**	280
Ambulance staff	-	-	-	-
Administration and estates	348	22	**370**	369
Healthcare assistants and other support staff	1,436	95	**1,531**	1,551
Nursing, midwifery and health visiting staff	1,165	87	**1,252**	1,166
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	580	1	**581**	562
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Other	160	-	**160**	156
Total average numbers	**3,967**	**221**	**4,188**	**4,084**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	-	-

Note: these figures are an average number of wte over the year including bank workers

Gender pay gap

The 'Gender Pay Gap' is a measure of the difference in the average earnings between males and females across an organisation. The data is expressed as a percentage of males' earnings on the snapshot date of 31 March each year, which must then be published on the government and organisation websites by 31 March of the following year.

AWP, in line with all NHS organisations has a predominantly female workforce in almost all disciplines and professions. At 31 March 2018, 74.6% of our workforce was female.

At 31 March 2018 our executive directors consisted of 3 women and 4 men. Our workforce consisted of 3164 women and 1081 men.

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.

As of 31 March 2018, our mean gender pay gap was 16.03% and our median was 11.54%. Despite females being well-represented at every level in the organisation, their average hourly pay is not equal. There has been a slight increase since the 2017 figures were reported.

Our analysis shows that our mean and median gender pay gap was most significantly affected by the nationally-defined medical salary arrangements. This is consistent with the results published by other NHS organisations.

The overall pay gap for staff on Agenda for Change pay bandings shows a significantly smaller pay gap at 5.08%

For Very Senior Manager pay, the average hourly base wage percentage gap favours females who earn 2.72% more than males.

The Trust's 2018 gender pay gap report can be read in full on the Trust's website at: Gender Pay Gap

	2017		2018	
Gender	Mean hourly rate	Median hourly rate	Mean hourly rate	Median hourly rate
Male	£18.03	£15.16	£18.57	£15.40
Female	£15.34	£13.45	£15.60	£13.62
Difference	£2.69	£1.71	£2.98	£1.78
Pay gap %	14.91%	11.28%	16.03%	11.54%

Sickness and attendance

Our average rate of sickness absence over the last 12 months was 4.44% which is slightly higher than 2017/18 (4.37%). We continue to work to develop managers to be able to support staff back to work as appropriately as possible, and to better understand the drivers of sickness absence.

Trade Union Facility Time

In line with Trade Union (Facility Time Publication Requirements) Regulations 2017 the following statements are included. The purpose of the regulation is to promote transparency and public scrutiny of facility time.

i) Relevant Union Officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
22	18.7

ii) Percentage of time spent on facility time

How many employees who were relevant union officials during the relevant period spent a) 0%, b) 1 – 50%, c) 51-99% or, d) 100% of their working hours on facility time?

Percentage of time spent on facility time	Number of employees
0%	0
1-50%	22
50-99%	0
100%	0

iii) Percentage of pay bill spent on facility time:

What percentage of your total pay bill was spent on paying employees who were relevant union officials for facility time during the relevant period?

Total cost of facility time	£11,410
Total pay bill	£179,995,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x100	0.01%

iv) Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours	8.6%

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.

We continue to support the national 'Disability Confident' scheme. This means that any disabled applicant meeting the minimum requirements of a job specification will be guaranteed an interview. We are committed to making reasonable adjustments during the selection process where required.

We have seen a continuing increased trend in 2018/19 of more of our staff declaring a disability than in previous years which reflects our work to ensure we recruit and retain staff who are disabled. 5.5% of staff declared themselves to be disabled in 2019, compared with 5.1% in 2018 and 4.5% in 2017. 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. We have been working to develop career pathways 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 staff side representatives. We also maintain and develop 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 initiatives. The senior management of the Trust actively engages with the trades unions via regular meetings.

All staff are welcome to participate in online policy development workshops which are held regularly. These are finalised in conjunction with elected staff-side 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 staff-side representatives and feedback from staff and staff-side is gathered during consultation processes. Organisational change is undertaken in line with Trust policy.

The Trust is continuing to develop succession planning to ensure career development opportunities for staff, supported through acting up and secondment arrangements. It also reduces the risk of critical role being unfilled for extended periods of time.

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.

Exit packages and severance payments

The Trust did not pay any exit packages to its directors during the 2018/19 financial year.

Exit packages for all other Trust staff can be found in the table below:

Reporting of compensation schemes - exit packages 2018/19						
	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages	
	17/18	18/19	17/18	18/19	17/18	18/19
Exit package cost band (including any special payment element)						
<£10,000	9	2	-	-	**9**	**2**
£10,000 - £25,000	5	1	-	1	**5**	**2**
£25,001 - 50,000	9	-	-	-	**9**	**-**
£50,001 - £100,000	9	2	-	-	**9**	**2**
£100,001 - £150,000	4	-	-	-	**4**	**-**
£150,001 - £200,000	-	1	-	-	**-**	**1**
>£200,000	-	-	-	-	**-**	**-**
Total number of exit packages by type	**36**	**6**	**-**	**1**	**36**	**7**
Total cost (£)	£1,666,000	£360,000	£0	£20,000	**£1,666,000**	**£380,000**

Table 16 – Exit packages and severance payments

There was one other (non-compulsory) departure payment.

The exit packages in both 2017/18 and 2018/19 related to restructuring of services to meet organisational need, following formal consultation.

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.

The purpose of the Committee is to consider the remuneration and terms of service, including 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 NHS Improvement and nationally agreed terms and conditions to inform its decision making.

The Trust remuneration policy is to appoint Executive Directors to at least the lower quartile rate for similar roles in similar-sized Trusts. This is based on comparable information provided NHS Improvement.

There were no 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.

Directors' expenses

Expenses paid to Directors from 1 April 2017 to 31 March 2019		
Directors	**2018-19**	**2017-18**
Number of paid Directors in office	18	16
Number of Directors receiving expenses	13	15
Total sum of expenses paid to Directors	34,456	37,493

Table 17 – Directors' expenses

Pay multiples

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 2018/19 was £165k to £170k (2017/18 £170k to £175k). This was 6.1 times (2017/18 6.9 times) the median remuneration of the workforce, which was £27,528 (2017/18 £24,879).

In 2018/19, 0 (2017/18, 0) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £17,460 to £167,075 (2017/18, £17,460 to £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.

A reduction in the highest-paid director's remuneration, in combination with an increase in median remuneration for workforce (as a result of the national pay award for staff) resulted in the reduction of the pay multiple from 6.9 in 2017/18 to 6.1 in 2018/19.

External Auditor's remuneration

The remuneration paid to the External Auditor in respect of the audit of the accounts for 2018/19 was approximately £47,000 (Trust and Charitable Fund) and £12,000 (Quality Accounts) inclusive of VAT.

Expenditure on consultancy

The Trust spent £365,890 on consultancy in 2018/19 compared to £210,484 in 2017/18.

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 2019, for more than £220 per day and that last longer than six months	
Number of existing engagements as of 31 March 2019	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 2018 and 31 March 2019, 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 2018 and 31 March 2019	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 2018 and 31st March 2019

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

SALARIES AND ALLOWANCES	2018-19						2017-18					
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
Charlotte Hitchings	35-40	0	0-5	0-5	0-5	35-40	35-40	0	0-5	0-5	0-5	35-40
Hayley Richards - Chief Executive	165-170	56	0-5	0-5	7.5-10	180-185	165-170	56	0-5	0-5	62.5-65	230-235
Mathew Page - Chief Operating Officer (from 01/06/2019)	110-115	33	0-5	0-5	155-157.5	270-275	-	-	-	-	-	-
Simon Truelove - Director of Finance	125-130	36	0-5	0-5	45-47.5	175-180	120-125	36	0-5	0-5	42.5-45	165-170
Sue McKenna - Director of Operations (until 31/05/2018)	15-20	6	0-5	0-5	-	-	105-110	36	0-5	0-5	155-157.5	265-270
Rachel Clark - Director of Strategy	95-100	36	0-5	0-5	50-52.5	145-150	85-90	36	0-5	0-5	20-22.5	110-115
Rebecca Eastley - Medical Director (until 15/02/2019)	135-140	32	0-5	0-5	80-82.5	220-225	150-155	36	0-5	0-5	407.5-410	560-565
Peter Wood - Medical Director (from 16/02/2019)	20-25	-	0-5	0-5	47.5-50	70-75	-	-	-	-	-	-
Julian Feasby - Director of Human Resources (from 03/07/2017)	105-110	-	0-5	0-5	25-27.5	130-135	75-80	0	0-5	0-5	17.5-20	95-100
Sarah Knight - Company Secretary	70-75	-	0-5	0-5	140-142.5	210-215	60-65	0	0-5	0-5	2.5-5	65-70
Julie Kerry - Director of Nursing (from 09/04/2018)	115-120	35	0-5	0-5	222.5-225	345-350	-	-	-	-	-	-
Andrew Dean - Director of Nursing (until 31/10/2018)	80-85	21	0-5	0-5	0-2.5	85-90	130-135	36	0-5	0-5	0-5	130-135
Non Executive Directors												
Ruth Brunt (Until 10/11/2017)	-	-	-	-	-	-	0-5	0	0-5	0-5	0-2.5	0-5
Malcom Shepherd	5-10		0-5	0-5	0-2.5	5-10	5-10	0	0-5	0-5	0-2.5	5-10
Ernest Messer	5-10		0-5	0-5	0-2.5	5-10	5-10	0	0-5	0-5	0-2.5	5-10
Charlotte Moar (until 21/08/2018)	0-5		0-5	0-5	0-2.5	0-5	5-10	0	0-5	0-5	0-2.5	5-10
Mark Outhwaite	5-10		0-5	0-5	0-2.5	5-10	5-10	0	0-5	0-5	0-2.5	5-10
Sarah Elliot (until 31/07/2018)	0-5		0-5	0-5	0-2.5	0-5	5-10	0	0-5	0-5	0-2.5	5-10
Marie Noel-Orzel (from 01/12/2018)	0-5		0-5	0-5	0-2.5	0-5	-	-	-	-	-	-
Shelley Whitehead (from 1/12/2018)	0-5		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		0-5	0-5	0-2.5	5-10	5-10	0	0-5	0-5	0-2.5	5-10

Notes:

1. The expense payments which are taxable relate to individual car allowances
2. Andrew Dean was on assignment at NHSI from 01/04/2018 to 31/10/2018

All of the above Directors were in post for the 12 month period to 31st March 2019 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)	165-170	170-175
Median Total Remuneration	27,528	24,879
Ratio	6.1	6.9

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 2019 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2018 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Employers Contribution to Stakeholder Pension £000
Hayley Richards - Chief Executive	0-2.5	2.5-5	70-75	215-220	1,479	175	1,690	*
Rachel Clark - Director of Strategy	2.5-5	2.5-5	20-25	50-55	323	91	421	*
Andrew Dean - Director of Nursing (until 31/10/2018)	*	*	*	*	*	*	*	*
Rebecca Eastley - Medical Director (until 15/02/2019)	2.5-5	10-12.5	70-75	220-225	1,395	0	0	*
Julian Feasby - Director of Human Resources	0-2.5	0-2.5	0-5	0-5	14	26	40	*
Sarah Knight - Company Secretary	5-7.5	5-7.5	20-25	40-45	231	134	371	*
Sue McKenna - Director of Operations (until 31/05/2018)	0	0	35-40	115-120	913	0	834	*
Simon Truelove - Director of Finance	2.5-5	0-2.5	35-40	80-85	538	117	667	*
Julie Kerry - Director of Nursing (from 09/04/2018)	10-12.5	25-27.5	30-35	85-90	369	244	627	*
Mathew Page - Chief Operating Officer (from 01/06/2019)	5-7.5	12.5-15	25-30	65-70	269	75	365	*
Peter Wood - Medical Director (from 16/02/2019)	0-2.5	0-2.5	50-55	155-160	946	21	1,141	*

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

Accountability Report Declaration

Hayley Richards

Signed Chief Executive

23 May 2019

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

In our opinion the financial statements of Avon and Wiltshire Mental Health Partnership NHS Trust (the 'trust'):

- Give a true and fair view of the financial position of the trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- Have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of HM Treasury as relevant to the National Health Service in England (the 'Accounts Direction').

We have audited the financial statements of the trust which comprise:

- The statement of comprehensive income;
- The statement of financial position;
- The statement of changes in equity;
- The statement of cash flows; and
- The related notes 1 to 33.

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- The table of salaries and allowances of senior managers and related narrative notes on page 81;
- The table of pension benefits of senior managers and related narrative notes on page 82; and
- The table of pay multiples on page 79.

The financial reporting framework that has been applied in their preparation is applicable law and the 'Accounts Direction'.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Local Audit and Accountability Act 2014 (the 'Act') 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 Financial Reporting Council's (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.

Material uncertainty relating to going concern

We draw attention to note 1.2 in the financial statements, which indicates that the trust incurred a net deficit of £2.2m during the year ended 31 March 2019 (31 March 2018: deficit of £11.9m) and has net current liabilities at 31 March 2019 of £0.042m (31 March 2018: £0.9m). The operational plan for 2019/20 forecasts a break even position however this position is only achieved after recognition of £5.1m income from Provider Sustainability Fund ("PSF") and the Financial Recoverability Fund ("FRF"). In addition, the trust has existing working capital loans of £19.1m (31 March 2018: £18.5m).

The trust has identified that no additional loan funding is required before the end of 2019/20 to support the trust in meeting its liabilities if it delivers in full the savings plan for 2019/20. The savings identified within the current Trust plan for 2019/20 are £7.1m (2018/19: £12.1m). If it fails to deliver in full the savings plan, then a further working capital cash loan will be required.

In addition, the receipt of the Provider Sustainability Fund ("PSF") income is dependent on the trust achieving its efficiency savings plan. If the trust did not receive the full amount of the PSF and FRF income forecast, it would have to apply for alternative funding from the Department of Health and Social Care ("DHSC").

As stated in note 1.2, these events or conditions, along with the other matters as set forth in note 1.2 to the financial statements, indicate that a material uncertainty exists that may cast significant doubt on 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, 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 audit 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 respect of these matters.

Responsibilities of directors

As explained more fully in the directors' responsibilities statement, the directors are responsible for the preparation of the financial statements and 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 directors either intend to liquidate the trust or to cease operations, or have no realistic alternative but to do so.

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

Opinions on other matters

In our opinion:

- the parts of the Remuneration Report subject to audit has been prepared properly in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Conclusion on the trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required to report to you if, in our opinion the trust has not made proper 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, with the exception of the matters reported in the basis for qualified conclusion section below, we are satisfied that, in all significant respects, Avon and Wiltshire Mental Health Partnership NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

In November 2018, the Trust received a report on the external Well Led Review undertaken during 2018/19. Some positive steps were noted but the report identified the need for further Board development to ensure team cohesion and effectiveness and noted that the cultural change programme to ensure high quality of care is foremost still had a significant amount more to achieve.

On 21 December 2018 the Care Quality Commission (CQC) issued an inspection report on the findings from its inspection visit from 4 September 2018 to 4 October 2018. The conclusion of the report was the Trust did not use a systematic approach to continually improve the quality of its services or safeguard standards of care, and there was a lack of quality governance systems in place. The overall rating was, "Requires improvement" with the following areas assessed individually as "Requires improvement":

- Are Services safe;
- Are services responsive; and
- Are services well led.

Wards for people with a learning disability or autism were assessed as inadequate in four of the six dimensions of care.

On 6 February 2019, NHS Improvement issued a notification of a decision to open a formal investigation into the Trust's arrangements for ensuring high quality care and its associated quality governance and oversight arrangements.

NHS Improvement stated that it had opened the investigation due to the growing number of quality concerns highlighted by recent external reviews including the December 2018 CQC comprehensive inspection report, the findings detailed in the HSE's letter of 20 December 2018 in respect of manual handling, violence and aggression management and reduction, the Coroner's September 2018 Regulation 28 report, the CQC's draft December 2018 findings from its investigation into low roofs, and most recently the absence of appropriate qualification checks for a locum doctor.

- These issues are evidence of weaknesses in proper arrangements for planning and deploying workforce to deliver the Trust's priorities effectively.

On 15 February 2018 the Trust's former auditor made a referral to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014. The referral stated that the auditor had reason to believe that Avon and Wiltshire Mental Health Partnership NHS Trust had

taken a course of action that, if followed to its conclusion, would lead to a breach of the Trust's break even duty for the three year rolling period ending 31 March 2020.

The financial statements of the Trust for 2018/19 noted that over the three year period ending 31 March 2019 the Trust had a cumulative deficit of £3.046m and it was therefore continuing on a path which is likely to lead to a breach of its breakeven duty set out in Paragraph 2(1) of Schedule 5 of the National Health Service Act 2006.

During 2018/19 the Trust spent £14.9m on agency staff breaching both its agency spend cap of £6.49m and internal budget of £9.76m for agency staff costs.

- These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Respective responsibilities of the accounting officer and auditor relating to the trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the trust's resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a) of the Local Audit and Accountability Act to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the trust's arrangements for securing economy, efficiency and effectiveness in 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, published by the Comptroller & Auditor General in November 2017, as to whether the trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

The Comptroller & Auditor General determined this overall evaluation criterion as that necessary for us to consider under its 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 2019.

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 form a view on whether, in all significant respects, the trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Matters on which we are required to report by exception

We have a duty under the Act to refer the matter to the Secretary of State without delay if we have reason to believe that the trust, or an officer of the trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 15 February 2018 the Trust's previous auditors referred a matter to the Secretary of State under section 30 of the Act in relation breaching the Trust's break-even duty for the three year rolling period ending 31 March 2020.

We are required to report in respect of the following matters if:

- In our opinion the governance statement does not comply with the NHS Trust Development Authority's (NHS Improvement) guidance; or
- We issue a report in the public interest under section 24 of the Act.

We have nothing to report in respect of these matters.

Certificate

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

Use of our report

This report is made solely to the Board of Directors of Avon and Wiltshire Mental Health Partnership NHS Trust in accordance with Part 5 of the Act and for no other purpose, as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the trust 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, as a body, for our audit work, for this report, or for the opinions we have formed.

Signed

Ian C Howse (Engagement Lead) CPFA, CA

For and on behalf of Deloitte LLP
Appointed Auditor
Cardiff, Wales

Date 28 May 2019

Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

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

23 May 2019

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 the 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, 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

23 May 2019

Signed  Director of Finance

23 May 2019

Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for Avon and Wiltshire Partner-ship NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2018/19 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.

Signed

Simon Truelove, Director of Finance

23 May 2019

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.

Signed Hayley Richards

Hayley Richards Chief Executive

23 May 2019

Annual Report 2018 / 19

Financial Statements

Avon and Wiltshire Mental Health Partnership NHS Trust

Annual accounts for the year ended 31 March 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	223,926	209,909
Other operating income	4	12,692	10,646
Operating expenses	6, 8	(230,478)	(224,100)
Operating surplus/(deficit) from continuing operations		**6,140**	**(3,545)**
Finance income	11	78	20
Finance expenses	12	(6,980)	(6,569)
PDC dividends payable		(1,452)	(1,844)
Net finance costs		**(8,354)**	**(8,393)**
Surplus / (deficit) for the year from continuing operations		**(2,214)**	**(11,938)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	(133)
Other reserve movements		(3)	-
Total comprehensive income / (expense) for the period		**(2,217)**	**(12,071)**

The notes 99 to 139 on the following pages form part of this account.

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	13	965	710
Property, plant and equipment	14	111,322	113,750
Total non-current assets		**112,287**	**114,460**
Current assets			
Inventories	15	289	292
Receivables	16	13,458	13,627
Cash and cash equivalents	17	3,572	1,056
Total current assets		**17,319**	**14,975**
Current liabilities			
Trade and other payables	18	(15,537)	(13,233)
Borrowings	20	(1,157)	(1,275)
Provisions	21	(570)	(1,097)
Other liabilities	19	(97)	(291)
Total current liabilities		**(17,361)**	**(15,896)**
Total assets less current liabilities		**112,245**	**113,539**
Non-current liabilities			
Borrowings	20	(58,693)	(58,023)
Provisions	21	(1,510)	(1,738)
Total non-current liabilities		**(60,203)**	**(59,761)**
Total assets employed		**52,042**	**53,778**
Financed by			
Public dividend capital		101,499	101,018
Revaluation reserve		13,235	13,583
Income and expenditure reserve		(62,692)	(60,823)
Total taxpayers' equity		**52,042**	**53,778**

The notes on pages 99 to 139 form part of these accounts.

The financial statements on pages 93 to 98 were approved by the Audit and Risk Committee, on behalf of the Board on 23 May 2019 and signed on its behalf by

Name H RICHARDS
Position Chief Executive
Date **23 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**101,018**	**13,583**	**(60,823)**	**53,778**
Surplus/(deficit) for the year	-	-	(2,214)	**(2,214)**
Other transfers between reserves	-	(348)	348	-
Public dividend capital received	481	-	-	**481**
Other reserve movements	-	-	(3)	**(3)**
Taxpayers' equity at 31 March 2019	**101,499**	**13,235**	**(62,692)**	**52,042**

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**
Prior period adjustment	-	-	-	-
Taxpayers' equity at 1 April 2017 - restated	**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**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		6,140	(3,545)
Non-cash income and expense:			
Depreciation and amortisation	6.1	5,343	6,211
Net impairments	7	1,198	2,197
(Increase) / decrease in receivables and other assets		438	318
(Increase) / decrease in inventories		3	81
Increase / (decrease) in payables and other liabilties		2,598	(3,322)
Increase / (decrease) in provisions		(755)	872
Other movements in operating cash flows		(3)	92
Net cash generated from / (used in) operating activities		**14,962**	**2,904**
Cash flows from investing activities			
Interest received		78	20
Purchase of intangible assets		(474)	-
Purchase of property, plant, equipment and investment property		(4,546)	(5,288)
Net cash generated from / (used in) investing activities		**(4,942)**	**(5,268)**
Cash flows from financing activities			
Public dividend capital received		481	850
Movement on loans from the Department of Health and Social Care		1,800	11,349
Capital element of PFI, LIFT and other service concession payments		(1,275)	(1,470)
Interest on loans		(519)	(353)
Other interest		(3)	-
Interest paid on PFI, LIFT and other service concession obligations		(6,448)	(6,216)
PDC dividend (paid) / refunded		(1,540)	(1,796)
Net cash generated from / (used in) financing activities		**(7,504)**	**2,364**
Increase / (decrease) in cash and cash equivalents		**2,516**	**-**
Cash and cash equivalents at 1 April - brought forward		**1,056**	**1,056**
Prior period adjustments		-	-
Cash and cash equivalents at 1 April - restated		**1,056**	**1,056**
Cash and cash equivalents at 31 March	17.1	**3,572**	**1,056**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 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 1.2 Going concern

These accounts have been prepared on a going concern basis.

The Trust incurred a retained deficit of £2.2m (adjusted of £1.0m) during the year ended 31 March 2019 and, at that date had net current liabilities of £0.042m.

The Trust is assuming no additional cash support in 2019/20 to maintain current payment performance assuming that the Trust delivers its savings plan. The Trust is however anticipating the achievement of Provider Sustainability Funding (PSF) of £1.9m and Financial Recovery Funding (FRF) of £3.2m. This will maintain the current cash loan position of £19.0m. If the Trust fails to deliver in full the savings plan in 2019/20 then PSF and FRF will not be achieved in full and a further cash loan will be required. The savings identified within the current Trust plan for 2019/20 are £7.1m.

As directed by the 2018/19 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.

These circumstances constitute a material uncertainty that may cast significant doubt as to the Trust's ability to continue as a going concern and therefore it may be unable to realise its assets and discharge its liabilities in the normal course of business.

Whilst the Trust does not consider itself to be significantly exposed to any significant risks arising from Brexit, the ongoing uncertainty of a final agreed outcome means that this cannot be fully assessed. The potential areas of exposure relate to anti-psychotic drugs and food supply, and the impact of any fuel costs and supply issues.

Note 1.3.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Note 1.3.1 Revenue from contracts with customers cont.
Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year. The Trust does not have any partially completed spells as all material contracts are on a block contract arrangement.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income. No material challenges are expected.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. It should also be noted that this is not a material income stream for the Trust.

Provider Sustainability Funding (PSF)

PSF is income earned by the Trust that is linked to the achievement of financial controls. It is earned on a quarterly basis throughout the financial year, with a final allocation statement for the year being provided by NHS Improvement once national outturn positions are known.

Note 1.3.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.3.3 Other income
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.4 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. Therefore, the scheme is accounted for as though it is a defined contribution scheme.
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 1.5 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 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential 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 1.6.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

Revaluations of property, plant and equipment are performed with sufficient regularity (once every three years, and last completed in March 2017) to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

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

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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 1.6.3 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 1.6.4 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

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

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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

Note 1.6.5 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	11	53
Plant & machinery	1	15
Transport equipment	1	7
Information technology	1	10
Furniture & fittings	1	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets

Note 1.7.1 Recognition

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

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, 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.

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

Note 1.7.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. 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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.7.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	1	5
Software licences	1	5

Note 1.8 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities

Note 1.10.1 Recognition

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

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

Note 1.10.2 Classification and measurement

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

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust would recognise an allowance for expected credit losses expected, though none are expected at this stage.

Note 1.10.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.11 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 1.11.1 The Trust as lessee

Finance leases

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.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.11.2 The Trust as lessor

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.11.3 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 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 1.12 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 21.2 but is not recognised in the Trust's accounts.

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

Note 1.13 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 22 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 22, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 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 1.15 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 1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.17 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 1.18 Critical judgements in applying accounting policies

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

Private Finance Initiative (PFI)

The Trust's PFI contracts have been assessed against the requirements for IFRIC 12 and have determined that the underlying assets and liabilities should be treated as on Statement of Financial Principles (SoFP). This was principally due to the degree of control exercised by the Trust over the assets and the fact that the residual assets revert to the Trust at the end of the agreement in 2037. The Trust has used the cost model provided by the PFI operator since it became operational in 2006, updating the values as necessary for inflationary uplifts and underlying asset values and economic lives. Asset values and remaining lives were last determined by the Trust District Valuer in March 2017 in line with other Trust buildings.

Note 1.18.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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 the next full valuation due during 2019/20. The Trust uses desktop exercises with the District Valuer where significant changes in expenditure or usage occur in year. There have been no such instances during 2018/19.

The carrying amount of the Trust land and building assets at 31 March 2019 is £103,305k.

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 £7,766k at 31 March 2019. Intangible assets have a carrying value of £965k and Assets Under Construction have a carrying value of £251k

Note 1.19.1 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.20.1 Standards, amendments and interpretations in issue but not yet effective or adopted

- IFRS 16 Leases – Application required for accounting periods from 1 April 2020, no material impact is expected, though no official guidance yet provided by the FReM (Financial Reporting Manual)
- IFRS 17 Insurance contracts – Application required for accounting periods from 1 April 2021, not adopted yet by the FReM, early adoption in not permitted

- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods from 1 April 2019

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 £236.6m, 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 £162.5m. This excludes direct income from NHS England which is £34.3m

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Mental health services		
Cost and volume contract income	1,333	1,293
Block contract income	179,399	166,151
Other clinical income from mandatory services	40,734	42,465
All services		
Agenda for Change pay award central funding	2,460	-
Total income from activities	**223,926**	**209,909**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	34,334	29,381
Clinical commissioning groups	162,527	153,578
Department of Health and Social Care	2,543	-
Other NHS providers	1,010	685
NHS other	-	102
Local authorities	5,665	7,280
Non NHS: other	17,847	18,883
Total income from activities	**223,926**	**209,909**
Of which:		
Related to continuing operations	223,926	209,909
Related to discontinued operations	-	-

Note 4 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	1,271	1,605
Education and training (excluding notional apprenticeship levy income)	6,760	6,793
Non-patient care services to other bodies	-	77
Provider sustainability / sustainability and transformation fund income (PSF / STF)	2,875	344
Income in respect of employee benefits accounted on a gross basis	491	633
Other contract income	727	548
Other non-contract operating income		
Rental revenue from operating leases	568	646
Total other operating income	**12,692**	**10,646**
Of which:		
Related to continuing operations	12,692	10,646
Related to discontinued operations	-	-

Note 5 Additional information on revenue from contracts with customers recognised in the period

	2018/19 £000	2017/18 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	291	-

Note 6.1 Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	1,127	947
Purchase of healthcare from non-NHS and non-DHSC bodies	8,520	9,168
Staff and executive directors costs	179,615	169,663
Remuneration of non-executive directors	73	80
Supplies and services - clinical (excluding drugs costs)	1,798	1,618
Supplies and services - general	5,552	6,157
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	3,962	3,985
Consultancy costs	366	210
Establishment	2,837	2,554
Premises	8,025	7,830
Transport (including patient travel)	4,045	3,514
Depreciation on property, plant and equipment	5,124	5,837
Amortisation on intangible assets	219	374
Net impairments	1,198	2,197
Increase/(decrease) in other provisions	70	113
Change in provisions discount rate(s)	(36)	22
Audit fees payable to the external auditor		
audit services- statutory audit	47	50
other auditor remuneration (external auditor only)	12	12
Internal audit costs	69	68
Clinical negligence	570	438
Legal fees	380	358
Insurance	241	216
Research and development	222	455
Education and training	790	580
Rentals under operating leases	2,561	3,266
Redundancy	380	1,666
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,265	1,242
Car parking & security	538	486
Hospitality	30	27
Losses, ex gratia & special payments	53	10
Other services, eg external payroll	225	217
Other	600	740
Total	**230,478**	**224,100**
Of which:		
Related to continuing operations	230,478	224,100
Related to discontinued operations	-	-

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.

Rentals under operating leases has reduced significantly in year due to a realignment of payments to NHS Property Services and the vacation of the Chippenham site by the Trust Headquarters in December 2017.

Note 6.2 Other auditor remuneration

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
Other non-audit services	12	12
Total	**12**	**12**

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial year 2018/19 (2017/18 was limited to £2,000,000)

Note 7 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-	2,197
Other	1,198	-
Total net impairments charged to operating surplus / deficit	**1,198**	**2,197**
Impairments charged to the revaluation reserve	-	133
Total net impairments	**1,198**	**2,330**

The impairments shown in the table above for 2018/19 are related to safety and quality works that were capital in nature though not adding value to the building. In addition to this, there are PFI capital works, paid as part of the unitary payment that are also not felt to have added building value.

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	135,823	130,464
Social security costs	12,001	11,391
Apprenticeship levy	640	620
Employer's contributions to NHS pensions	16,565	16,247
Pension cost - other	52	14
Termination benefits	380	1,666
Temporary staff (including agency)	14,534	10,927
Total gross staff costs	**179,995**	**171,329**
Recoveries in respect of seconded staff	-	-
Total staff costs	**179,995**	**171,329**
Of which		
Costs capitalised as part of assets	-	-

Employee benefits have risen significantly in year and included the following factors;

- Agenda for Change pay award cost and funding of £2,464k
- increase in agency staffing of £3,607k

Note 8.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £112k (£62k in 2017/18).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

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

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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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

Note 10 Operating leases

Note 10.1 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.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	568	646
Total	**568**	**646**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	473	451
- later than one year and not later than five years;	390	381
- later than five years.	188	184
Total	**1,051**	**1,016**

Note 10.2 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.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	2,561	3,266
Total	**2,561**	**3,266**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	2,664	2,073
- later than one year and not later than five years;	6,729	6,803
- later than five years.	23,948	24,393
Total	**33,341**	**33,269**

Note 11 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	78	20
Total finance income	**78**	**20**

Note 12.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	529	353
Interest on late payment of commercial debt	3	-
Main finance costs on PFI and LIFT schemes obligations	3,287	3,401
Contingent finance costs on PFI and LIFT scheme obligations	3,161	2,815
Total interest expense	**6,980**	**6,569**
Total finance costs	**6,980**	**6,569**

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

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims under this legislation	3	-

Note 13.1 Intangible assets - 2018/19

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**1,430**	**669**	**14**	**2,113**
Additions	474	-	-	**474**
Valuation / gross cost at 31 March 2019	**1,904**	**669**	**14**	**2,587**
Amortisation at 1 April 2018 - brought forward	**796**	**593**	**14**	**1,403**
Provided during the year	143	76	-	**219**
Amortisation at 31 March 2019	**939**	**669**	**14**	**1,622**
Net book value at 31 March 2019	**965**	**-**	**-**	**965**
Net book value at 1 April 2018	**634**	**76**	**-**	**710**

Note 13.2 Intangible assets - 2017/18

	Software licences £000	Internally generated information technology £000	Websites £000	Total £000
Valuation / gross cost at 1 April 2017 - restated	**1,430**	**669**	**14**	**2,113**
Valuation / gross cost at 31 March 2018	**1,430**	**669**	**14**	**2,113**
Amortisation at 1 April 2017 - restated	**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 14.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**19,101**	**104,754**	**297**	**49**	**1,376**	**605**	**22,888**	**12,210**	**161,280**
Additions	-	1,477	-	202	190	-	2,025	-	**3,894**
Valuation/gross cost at 31 March 2019	**19,101**	**106,231**	**297**	**251**	**1,566**	**605**	**24,913**	**12,210**	**165,174**
Accumulated depreciation at 1 April 2018 - brought forward	**88**	**18,054**	**297**	**-**	**1,069**	**414**	**16,421**	**11,187**	**47,530**
Provided during the year	-	2,687	-	-	98	17	2,018	304	**5,124**
Impairments	-	1,198	-	-	-	-	-	-	**1,198**
Accumulated depreciation at 31 March 2019	**88**	**21,939**	**297**	**-**	**1,167**	**431**	**18,439**	**11,491**	**53,852**
Net book value at 31 March 2019	**19,013**	**84,292**	**-**	**251**	**399**	**174**	**6,474**	**719**	**111,322**
Net book value at 1 April 2018	**19,013**	**86,700**	**-**	**49**	**307**	**191**	**6,467**	**1,023**	**113,750**

Note 14.2 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 - as previously stated	**19,470**	**100,160**	**297**	**1,161**	**1,080**	**605**	**20,842**	**12,210**	**155,825**
Valuation / gross cost at 1 April 2017 - restated	**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 - as previously stated	**88**	**13,263**	**297**	**-**	**981**	**360**	**13,906**	**10,601**	**39,496**
Accumulated depreciation at 1 April 2017 - restated	**88**	**13,263**	**297**	**-**	**981**	**360**	**13,906**	**10,601**	**39,496**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
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 14.3 Property, plant and equipment financing - 2018/19

	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 2019								
Owned - purchased	19,013	43,518	251	399	174	6,474	719	**70,548**
On-SoFP PFI contracts and other service concession arrangements	-	40,774	-	-	-	-	-	**40,774**
NBV total at 31 March 2019	**19,013**	**84,292**	**251**	**399**	**174**	**6,474**	**719**	**111,322**

Note 14.4 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**

The land and buildings of the Trust underwent a full revaluation exercise in March 2017. At March 2018, desktop valuation took place on those assets that were considered to have had a material change in use or significant expenditure in year. At March 2019, no such changes in usage or significant expenditure were deemed to have taken place. The Trust will be completing a full revaluation exercise during 2019/20.

Note 15 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	108	114
Other	181	178
Total inventories	**289**	**292**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £1,441k (2017/18: £2,174k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 16.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	7,344	
Trade receivables*		7,093
Accrued income*		961
Prepayments (non-PFI)	1,817	1,595
PFI lifecycle prepayments	3,283	3,102
PDC dividend receivable	162	74
VAT receivable	815	690
Other receivables	37	112
Total current trade and other receivables	**13,458**	**13,627**
Non-current		
Total non-current trade and other receivables	-	-
Of which receivables from NHS and DHSC group bodies:		
Current	5,715	5,044
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 17.1 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.

	2018/19	2017/18
	£000	£000
At 1 April	**1,056**	**1,056**
Prior period adjustments	-	-
At 1 April (restated)	**1,056**	**1,056**
Net change in year	2,516	-
At 31 March	**3,572**	**1,056**
Broken down into:		
Cash at commercial banks and in hand	84	86
Cash with the Government Banking Service	3,488	970
Total cash and cash equivalents as in SoFP	**3,572**	**1,056**
Total cash and cash equivalents as in SoCF	**3,572**	**1,056**

Note 17.2 Third party assets held by the Trust

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

	31 March 2019	31 March 2018
	£000	£000
Bank balances	117	123
Total third party assets	**117**	**123**

Note 18.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	4,384	2,540
Capital payables	999	1,470
Accruals	10,074	9,117
Receipts in advance (including payments on account)	-	70
VAT payables	17	16
Accrued interest on loans*		17
Other payables	63	3
Total current trade and other payables	**15,537**	**13,233**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	1,656	1,682
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 19 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	97	291
Total other current liabilities	**97**	**291**
Non-current		
Total other non-current liabilities	**-**	**-**

Note 20 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	27	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,130	1,275
Total current borrowings	**1,157**	**1,275**
Non-current		
Loans from the Department of Health and Social Care	19,048	17,248
Obligations under PFI, LIFT or other service concession contracts	39,645	40,775
Total non-current borrowings	**58,693**	**58,023**

Note 20.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2018	**17,248**	**42,050**	**59,298**
Cash movements:			
Financing cash flows - payments and receipts of principal	1,800	(1,275)	**525**
Financing cash flows - payments of interest	(519)	(3,287)	**(3,806)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	17	-	**17**
Application of effective interest rate	529	3,287	**3,816**
Carrying value at 31 March 2019	**19,075**	**40,775**	**59,850**

Note 21.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Redundancy	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**825**	**892**	**201**	**917**	**2,835**
Change in the discount rate	(8)	(28)	-	-	**(36)**
Arising during the year	53	42	134	360	**589**
Utilised during the year	(91)	(42)	(99)	(840)	**(1,072)**
Reversed unused	-	-	(159)	(77)	**(236)**
At 31 March 2019	**779**	**864**	**77**	**360**	**2,080**
Expected timing of cash flows:					
- not later than one year;	91	42	77	360	**570**
- later than one year and not later than five years;	360	167	-	-	**527**
- later than five years.	328	655	-	-	**983**
Total	**779**	**864**	**77**	**360**	**2,080**

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 NHS Resolution which are limited to an excess.

Other Provisions

Injury benefits are payable through the NHS Pensions Agency.

Redundancy

The Trust has notified a number of individuals for redundancy as at 31 March 2019, and therefore redundancy payments are likely within the next 12 months

Change in Discount Rate

The discount rate used has been changed within the year from 0.10% to 0.29% in line with Treasury guidance.

Note 21.2 Clinical negligence liabilities

At 31 March 2019, £2,629k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Avon and Wiltshire Mental Health Partnership NHS Trust (31 March 2018: £2,587k).

Note 22 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	30	56
Gross value of contingent liabilities	**30**	**56**
Net value of contingent liabilities	**30**	**56**
Net value of contingent assets	-	-

Note 23 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	337	1,470
Total	**337**	**1,470**

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 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**77,120**	**81,683**
Of which liabilities are due		
- not later than one year;	4,317	4,562
- later than one year and not later than five years;	17,231	17,089
- later than five years.	55,572	60,032
Finance charges allocated to future periods	(36,345)	(39,633)
Net PFI, LIFT or other service concession arrangement obligation	**40,775**	**42,050**
- not later than one year;	1,130	1,275
- later than one year and not later than five years;	5,354	4,834
- later than five years.	34,291	35,941

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 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**198,069**	**203,850**
Of which liabilities are due:		
- not later than one year;	9,211	8,868
- later than one year and not later than five years;	38,973	37,526
- later than five years.	149,885	157,456

Note 24.3 Analysis of amounts payable to service concession operator

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

	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	**9,568**	**9,269**
Consisting of:		
- Interest charge	3,287	3,401
- Repayment of finance lease liability	1,275	1,470
- Service element and other charges to operating expenditure	1,265	1,242
- Capital lifecycle maintenance	400	341
- Revenue lifecycle maintenance	-	-
- Contingent rent	3,161	2,815
- Addition to lifecycle prepayment	180	-
Total amount paid to service concession operator	**9,568**	**9,269**

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

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non financial assets	7,338	**7,338**
Cash and cash equivalents at bank and in hand	3,572	**3,572**
Total at 31 March 2019	**10,910**	**10,910**

	Loans and receivables	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**
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**

Note 25.1 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	19,075	**19,075**
Obligations under PFI, LIFT and other service concession contracts	40,775	**40,775**
Trade and other payables excluding non financial liabilities	15,461	**15,461**
Total at 31 March 2019	**75,311**	**75,311**

	Other financial liabilities £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	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**

Note 25.2 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	16,591	14,497
In more than one year but not more than two years	867	1,997
In more than two years but not more than five years	23,562	21,735
In more than five years	34,291	34,291
Total	**75,311**	**72,520**

Note 26 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	28	9	5	3
Total losses	**28**	**9**	**5**	**3**
Special payments				
Ex-gratia payments	45	43	33	6
Total special payments	**45**	**43**	**33**	**6**
Total losses and special payments	**73**	**52**	**38**	**9**

Note 27.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £17k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has not led to the classifiction of any receivables as a financial asset measured at amortised cost.

Note 27.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

There have been no material impacts to the Trust as part of the implementation of IFRS 15

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 2018/19 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 Resolution
- NHS Business Services Authority
- Local authorities

Note 29 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	56,850	79,590	50,690	78,657
Total non-NHS trade invoices paid within target	45,257	69,832	46,414	71,301
Percentage of non-NHS trade invoices paid within target	79.6%	87.7%	91.6%	90.6%
NHS Payables				
Total NHS trade invoices paid in the year	990	9,283	1,612	8,396
Total NHS trade invoices paid within target	805	6,913	1,459	6,790
Percentage of NHS trade invoices paid within target	81.3%	74.5%	90.5%	80.9%

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.

Note 30 External financing

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

	2018/19 £000	2017/18 £000
Cash flow financing	(1,510)	10,729
Finance leases taken out in year		
Other capital receipts		
External financing requirement	**(1,510)**	**10,729**
External financing limit (EFL)	1,029	10,729
Under / (over) spend against EFL	**2,539**	**-**

Note 31 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	4,368	5,588
Less: Disposals	-	-
Less: Donated and granted capital additions	-	-
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**4,368**	**5,588**
Capital Resource Limit	4,587	5,910
Under / (over) spend against CRL	**219**	**322**

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 £4.0m with gross capital expenditure (less IFRS) of £4.0m.

Note 32 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(1,000)
Breakeven duty financial performance surplus / (deficit)	**(1,000)**

Note 33 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£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)	(1,000)
Breakeven duty cumulative position	86	1,199	4,418	7,959	10,895	13,679	16,489	16,579	7,661	(2,046)	(3,046)
Operating income		198,752	195,955	192,190	194,609	197,437	198,530	197,394	214,357	220,555	236,618
Cumulative breakeven position as a percentage of operating income		0.6%	2.3%	4.1%	5.6%	6.9%	8.3%	8.4%	3.6%	(0.9%)	(1.3%)