Avon and Wiltshire Mental Health Partnership NHS Trust Annual Report 2020-2021

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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
- ADHD: Attention Deficit Hyperactivity Disorder
- APSTT: Additional Professional, Scientific Therapeutic & Technical
- AWP: Avon and Wiltshire Mental Health Partnership NHS Trust

B

- BAF: Board Assurance Framework
- BAME: Black, Asian and Minority Ethnic
- BANES: Bath and North East Somerset
- BASS: Bristol Autism Specialised Service
- BNSSG: Bristol, North Somerset, South Gloucestershire
- BSW: Bath and North East Somerset, Swindon and Wiltshire

C

- CAMHS: Child and Adolescent Mental Health Service
- CCG: Clinical Commissioning Group
- CEO: Chief Executive Officer
- CIP: Cost Improvement Plan
- CL: Control Line
- 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
- DSP: Data Security Protection
- DTOC: Delayed Transfer of Care

E

- ECT: Electroconvulsive Therapy
- EDI: Equality, Diversity and Inclusion
- EiDA: Equality in Diversity Awards
- EIA: Equality Impact Assessments
- ESR: Electronic Staff Record

F

- FCMA: Fellow of the Chartered Institute of Management Accounts
- FFT: Friends and Family Test
- FIP: Financial improvement plan
- FRF: Financial Recovery Funding
- FT: Foundation Trust
- FTC: Fixed-term Contract

G

- GDPR: General Data Protection Regulation

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
- ICS: Integrated Care Systems
- 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
- NEWS2 National Early Warning Score
- NIHR: National Institute for Health Research
- NHSE: NHS England
- NHSI: NHS Improvement
- NHSI/E: NHS Improvement/England
- NICE: National Institute for Health and Care Excellence
- NPSA: National Patient Safety Agency
- NUS: National Union of Students

P

- PCLS: Primary Care Liaison Service
- PDC: Public Dividend Capital
- PFI: Private Finance Initiative
- PICU: Psychiatric Intensive Care Unit
- PMO: Project Management Office
- PPE: Personal Protective Equipment
- PWC: PriceWaterhouseCoopers

Q

- QI: Quality Improvement
- QIA: Quality Impact Assessment
- QIP: Quality improvement plan

R

- RMN: Registered Mental Health Nurse
- ROPA: Records of Processing Activities
- RTT: Referral to Treatment

S

- SFI: Standing Financial Instruction
- SO: Standing Orders
- SOF: Single Oversight Framework
- STEPS: Specialised Treatment for Eating Disorders
- STP: Sustainability and Transformation Partnership

T

- TAC: Trust Accounts Consolidation

W

- WDES: Workforce Disability Equality Standard
- WGA: Whole Government Accounts
- WRES: Workforce Race Equality Standard
- WTE: Whole Time Equivalent

Overview

Our aim is to be recognised as Outstanding AWP, provider of specialist mental health and learning disability services. We are committed to providing outstanding care, through our outstanding people, ensuring our services are sustainable and delivered in partnership.

Outstanding Care is our first priority, so our service users receive the best possible treatment. 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 service users, carers, healthcare system partners, other healthcare providers, the police, criminal justice system, local authorities 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. The COVID-19 pandemic has rapidly changed how we deliver care and we want to take the best of those changes into our practice for 2021/22 as we return to 'business as usual'.

The Accountability Report on page 41 explains how the Trust is governed and provides detail on staff and pay.

Our strategic objectives are:

Welcome to our Annual Report for 2020/21

Message from our Chair and Chief Executive

We are delighted to welcome you to this Annual Report for Avon and Wiltshire Mental Health Partnership NHS Trust. The report covers the period 1st April 2020 to 31st March 2021. As we look back on what has been another challenging year, both for the Trust and within the local and national health and social care system, we will reflect on the developments we have seen.

Our aim is to be recognised as Outstanding AWP, provider of specialist mental health and learning disability services. We are committed to providing outstanding care, through outstanding people, ensuring our services are sustainable and delivered in partnership.

In this report we aim to provide a balanced view of the Trust's performance during the year, as well as celebrating the dedication and commitment of our staff to provide outstanding, safe and caring services for our patients, service users, carers and volunteers.

As we write this report, we find ourselves coming out of one of the most difficult years in the history of the NHS with the outbreak of the COVID-19 virus. Firstly, we want to pay tribute to all our NHS colleagues and their families who have lost their lives or loved ones across the country to this terrible disease. All of our staff, carers and volunteers have worked tirelessly since the outbreak and their dedication, commitment and resolve has made sure that we keep everyone as safe as possible whilst maintaining the care of all our patients and service users. The unprecedented challenges posed by COVID-19 at the latter end of this financial year saw gigantic efforts made by all of us. Across the health economy, we saw amazing collaboration with all our partners in the early stages of the most significant challenge faced by the NHS. We have included further information on our response on page 8 of this report.

The health and wellbeing of our staff is hugely important to us and the rest of the Board. We were delighted that the Trust was commended for our work around Trauma Informed Compassionate Leadership in response to COVID-19. One small way to show our thanks to our staff has been to give everyone a 'thank you day' to take off. It was encouraging to see that our staff survey results showed a significant improvement in staff believing that AWP is "definitely taking positive action on health and wellbeing". Further information on our staff health and wellbeing response and priorities are included on page 27 of this report.

Some of our amazing staff and their work have been recognised in national awards, including our Daisy Unit which was highly commended in the category of Learning Disability Initiative of the year at the Health Service Journal Patient Safety Awards. AWP was also a finalist in the category of Patient Safety Collaborative Mental Health Initiative of the Year for its work to reduce restrictive practice on Bradley Brook.

We will continue to work closely with our regulators to ensure AWP remains viable and spends public money in the most effective way whilst maintaining and improving standards of care and quality of services for our communities, patients and service users. We are keen to be able to evidence the improvements we have made since our last CQC inspection.

We would like to express our thanks to our wonderful staff for their continued hard work and dedication; everything they do is aimed at delivering and improving care for people with serious mental illness and everything that we accomplish is because of our staff.

We commend our Annual Report to you and ask that you continue with us on our journey to become Outstanding AWP.

Charlotte Hitchings

Chair

Dominic Hardisty

Chief Executive

About the Trust

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP or the Trust) provides community and inpatient mental health and learning disability services for the people of Bristol, North Somerset, South Gloucestershire, Bath and North East Somerset, Swindon and Wiltshire. We treat people with a wide range of mental health problems suchas:

- 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 by providing more care in our 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, providedboth 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, North Somerset 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 and commissioning the provision of our Secure Services, CAMHS inpatient care and Eating Disorder inpatient carethrough the NHS England Provider Collaboratives. The aim of Provider Collaboratives is to make best use of highly specialist resources across a larger geography whilst also providing care closer to home to support individual recovery.

We provide expert mental health input as partners in two Integrated Care Systems (ICS) – Healthier Together, covering Bristol, North Somerset and South Gloucestershire (BNSSG), and Bath, Swindon and Wiltshire (BSW) covering Bath and North East Somerset (BANES), Swindon and Wiltshire. We manage our services through three divisions, BNSSG and BSW are aligned with the ICSs and Specialised Services which include Provider Collaboratives.

Performance Analysis

We monitor our performance using a large number of quality, operational, workforce and financial measures. These measures are reported and scrutinised through the governance processes described in our Annual Governance Statement (page 57). We also have measures to test the accuracy of the data that we rely on to assess our performance.

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 risks throughout the year, and how we take assuranceson 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 57).

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

- Our COVID response (page 8)
- How well we did against our **2020/21 objectives** (page 11)
- How well we did on key **national and local indicators** (page 15)
- What our quality regulator, the **Care Quality Commission**, says about our services (page 18)
- 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 26)
- How well we are managing our **finances** (page 28)
- Our efforts towards achieving **environmental sustainability** (page 34)
- How we work with our partners (page 37)
- How we plan to continue our **improvement journey** in the coming year and what might stop us achieving our plans (page 39)

Our COVID response:

AWP, like all other NHS Trusts and indeed the country, spent the year trying to keep our service users, staff and the public safe from COVID-19. We re-designed services, changed how we worked, worked from home if possible and introduced new technology to minimise the risk of harm for our service users. We had to balance carefully the safety and effectiveness of our services to ensure the immediate safety of patients and staff, whilst recognising that there may be longer term consequences of these changes. To manage this process we used our emergency protocolsand set up an incident control centre; decisions had to be made at pace and so we established a specific clinical group to take quality decisions and an ethics group to review difficult decisions. The entire healthcare system worked hard to tackle the virus and we worked closely with our partners to ensure a co-ordinated response.

We changed and improved our infection control procedures in keeping with national advice. We had to use Personal Protective Equipment (PPE) in clinical situations where it would not have been necessary pre the COVID-19 pandemic.

In February 2021 we became a vaccination site and so we were able to keep our staff and patients safe by protecting them from the effects of the virus, if they were to catch it. 4155 members of staff had been vaccinated against COVID-19 by end of April 2021. We also managed to increase the uptake of the flu vaccine by 29%; 3630 staff were vaccinated against flu including 71% of frontline staff.

Some of the key decisions and actions we took included:

- Staying open for crisis and urgent referrals
- Opening a new 24/7 crisis line in record time
- Reducing inpatient capacity materially to minimise risks of cross-infection on the wards
- Moving to a 'streamed' inpatient model with differentiated wards for assessment, treatment, enhanced physical care and rehabilitation
- Embracing digital technology whenever possible to avoid the need for unnecessary face-to-face contact
- Providing a programme of wellbeing support to staff
- Working from home where possible
- Assessing all staff for their individual level of risk for COVID
- Introducing a Black, Asian and Minority Ethnic (BAME) group to specifically address the increased risk for people from a BAME background

The infographic below highlights some of the key changes we made to keep our service users and staff safe:

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How well did we do against our 2020/21 objectives

We developed plans with our local health community for 2020/21, which the Board agreed. However, on 11 March 2020, the Trust instigated its emergency plans to manage and respond to the COVID-19 pandemic. As a result we reduced our priorities for 2021/22, with a dual focus on responding to the pandemic as an individual organisation and as part of our wider system pandemic responses.

As a result of the pandemic, we have been able to accelerate some positive changes in practice particularly in the adoption and spread of digital technology. We will build on this and other learning from our COVID-19 response to ensure that we embed the changes we have made for the benefit of our service users.

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

	What we said…	What we achieved…
Outstanding Care	Develop COVID-19 adapted service model	Implemented a COVID-19 service model ensuring that we responded to those with most acute needs whilst protecting front line staff and service capacity This included operating a dynamic referral management process, based on risk stratification of our service users and operating a new model of assessment in our inpatient units to ensure we met Infection Prevention and Control standards
	Maintain focus on physical health of patients with Severe Mental Illness	Developed an outline Physical Health Strategy with associated investment proposals for future years, focusing on immediate improvements to our systems and working in collaboration with partners to identify new roles to support people with co-morbid physical and mental health needs
	Making sure that we deliver CQC quality improvements	The Trust has completed all 'must do' actions. The Trust estate has been improved including a refurbishment of female Psychiatric Intensive Care Unit at Callington Road and the planned relocation of Ward 4 to Hillview Lodge (August 2021) to eliminate dormitory ward accommodation

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

	What we said…	What we achieved…
Outstanding People	Creating a new approach to inclusive and compassionate leadership model	Launched trauma informed training, supported by nationally recognised trauma informed practice booklet for all staff Maintained and developed our Leadership Forum throughout the pandemic and established an Extended Executive Team Continued to run our leadership development programmes remotely through distance learning
	Retaining our staff including through wellbeing support	Developed our response to the NHS People Plan and established deliverables for 2021/22 Implemented a range of wellbeing initiatives resourced through NHS Charities Together funding, including wellbeing packs and investing in staff break room equipment Undertook robust risk analysis of all staff during the pandemic period and established BAME Staff Group to address known needs of staff from BAME communities

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

	What we said…	What we achieved…
Sustainable Services	Delivering planned estates changes for the benefit of our service users and carers (CQC actions)	Opened Cherry Ward an adult acute admission ward Reconfigured and improved our female PICU with additional capital investment from NHSE, ensuring that we provide a safe and effective environment in which to treat women with acute needs Improved our estate including the removal our last dormitory ward in the Trust (due to be completed by August 2021) Developed our inpatient CAMHS unit to address known quality and safety issues and to increase capacity to treat children and young people
	Digital transformation (e.g. Attend Anywhere)	Increased capital funding to secure additional IT equipment to support remote working Successfully bid for additional investment through the Salix decarbonisation scheme, which is planned to go live in 2021/22 Implemented a new digital system to support remote working (Attend Anywhere) and created 24/7 helplines for people with urgent mental health needs
	Workforce Resourcing/AWP staff every time	Developed new roles and use of Apprenticeship Levy to improve our future workforce pipeline

"We will plan and deliver care in partnership"

	What we said…	What we achieved…
Delivered in Partnership	Transfer North Somerset CAMHS into AWP	Successfully integrated North Somerset CAMHS service into our portfolio in April 2020 Secured additional investment for service developments in BNSSG enabling us to respond to surges in mental health demand arising from the pandemic
	Integrated care system development	Established our position as the expert secondary mental health provider in our Integrated Care Systems (ICSs) and actively contributed to the creation and development of Integrated Care Partnerships to improve local care for our populations Successfully secured additional investment to support rough sleepers in Bristol, working in partnership with voluntary care partners Established an Individual Placement and Support (IPS) service in BNSSG to enable people with Serious Mental Illness gain employment, in line with Long Term Plan priorities Supported both ICSs in designing a future model of community service provision that will deliver the priorities set out in the Community Mental Health Framework Secured additional investment from NHS England to support improved crisis response, including mental health as part of NHS 111 First

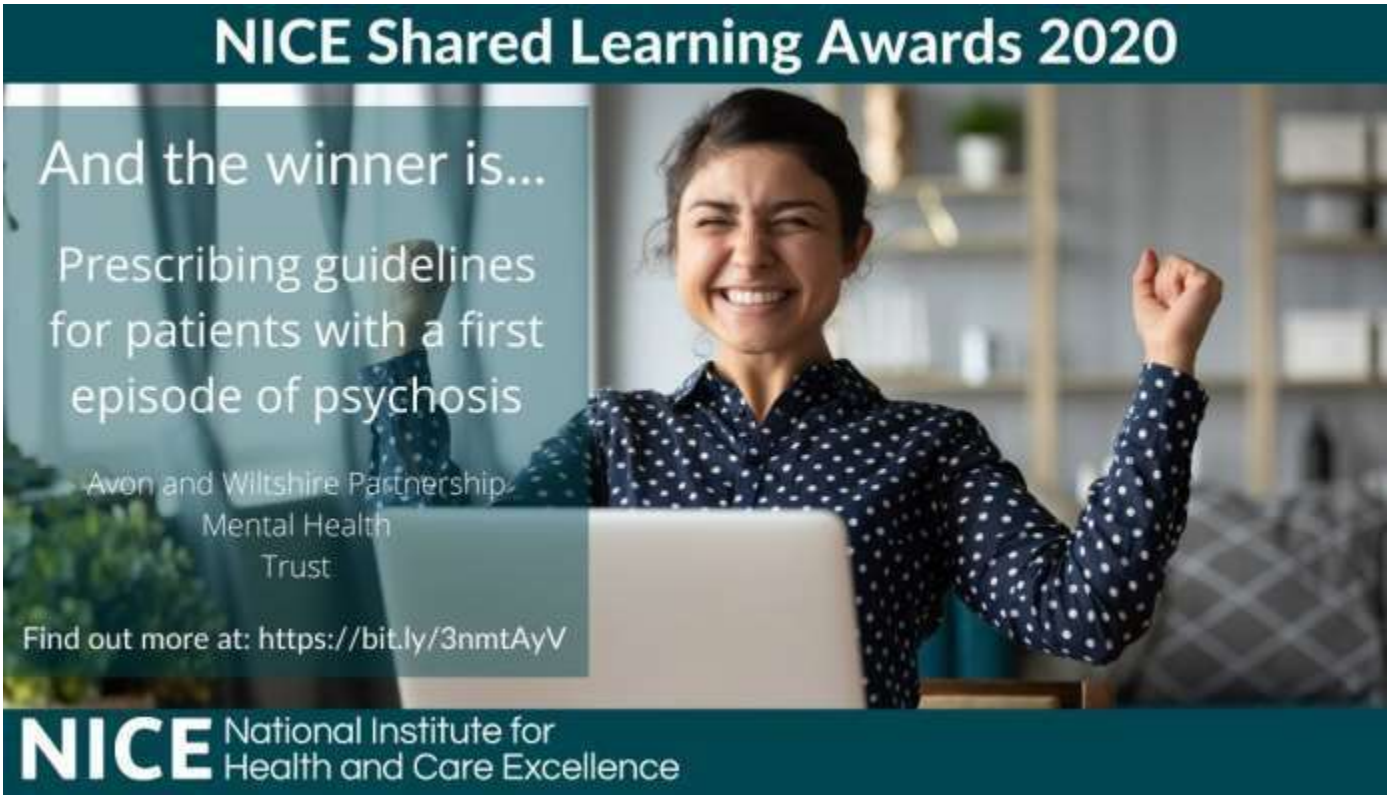
Outstanding Care

Awards

We were delighted that the Daisy Unit received a Highly Commended in the category of Learning Disability Initiative of the Year at the Health Service Journal Patient Safety Awards. This was in recognition of the work they have carried out to reduce restrictive practices on the unit. They took a Quality Improvement approach to supporting and caring for patients, which included meaningful and fun activities, community meetings and improved communications. As a result of this work, incidents of restrictive practice on the unit have fallen by 80%. The Daisy Unit was also shortlisted in the category of Quality Improvement Initiative of the Year at the same awards.

AWP was also a finalist in the category of Patient Safety Collaborative Mental Health Initiative of the Year for its work to Reduce Restrictive Practice on Bradley Brook, a medium secure ward at Fromeside. Over 18 months theteam on Bradley Brook ward worked to reduce restrictive practices. Since the introduction of the programme, the ward has seen an 82% reduction in restrictive practices, a reduction in the time patients spend in seclusion, improved staff retention and greater patient and carer satisfaction. The programme has resulted in reduced aggression and agitation amongst patients, better staff relationships, more engagement with patients and a more relaxed environment. The project has been so successful that other wards are also developing their own programmes to emulate the positive outcomes.

We were delighted that Dr Liz Ewins and the Bath and North East Somerset Early Intervention in Psychosis team won the National Institute for Health and Care Excellence (NICE) Shared Learning Award 2020 for their development of prescribing guidelines for patients with a first episode of psychosis. Dr Liz Ewins also won Audit Hero Clinical Practitioner of the Year 2020 awarded by the Healthcare Quality Improvement Partnership.



Our Contractual Performance

National standards:

Quality Measure	Target	2018/19	2019-20	2020-21
72 hour follow-up to inpatient discharge	80%	n/a	90%	84.5%
Admissions of patients <16 onto adult acute wards	0	0	0	0
Mixed sex accommodation breaches	0	2	5	7
% of service users in employment	n/a	17%	13%	12.2%
% of service users in settled accommodation	n/a	80%	73%	68%
Early Intervention - Referral to treatment (RTT)	60%	80%	74%	71%
Talking Therapies (IAPT) - RTT (6 weeks)	75%	94%	95%	90%
Talking Therapies (IAPT) - RTT (18 weeks)	95%	99%	99%	100%
Talking Therapies (IAPT) - % moving to recovery	50%	53.8%	52.3%	51.7%
Data Quality Maturity Index (DQMI)	95%	n/a	93%	92%
Out of Area Placement (OAP) bed days	National target to achieve 0 by 2021	6849	8406	9953

Table 1 - Performance against national standards in 2020/2021

AWP has continued in its commitment to achieving compliance against the indicators in the NHS Oversight Framework, though operational delivery was significantly disrupted during most of 2020/21 as the pandemic struck. We followed national guidance and continued to monitor services against key standards (such as the waiting time forassessment and treatment) however; compliance against many targets was not rigorously applied. This approach was agreed within the Trust and with both CCGs within our geography.

Despite this shift in focus, the Trust was able to maintain strong performance against many of the key national standards set for Mental Health Trusts. Key exceptions would firstly be our continued usage of Out of AreaPlacements, with an increase from 2019-20 driven largely by a planned closure (for refurbishment) of one of ourPICU units, plus changes to inpatient configuration due to the pandemic, which resulted in the temporary closure of some Trust operated beds. Secondly, the Trust has made limited progress towards improvement in our Data Quality Maturity Index score, due to temporary suspension of our internal Data Quality Group to allow key operational managers on that group to focus on service delivery during the pandemic.

Local indicators:

Quality Measure	Target	2018/19	2019/20	2020/21
Crisis assessment within four hours of referral (adult mental health service)	95%	99%	99%	97%
Referral to Assessment within four weeks (adult mental health service)	95%	94%	96%	96%
Referral to Treatment within 18 weeks (adult mental health service)	95%	97%	96%	98%
Referral to Treatment within 18 weeks (children's mental health service)	83%	63%	33%	90%
% of service users with a risk assessment	95%	99%	99%	99%
% of service users with a crisis plan	90%	98%	99%	99%
% of service users with a care coordinator	95%	100%	100%	100%
% of service users with an annual review (CPA only)	95%	97%	96%	96%

Table 2 - Performance against key local indicators in 2020/21

The Trust continued to monitor performance against a series of key local metrics during 2020/21, with full year results presented above. In most cases, the Trust has been able to maintain levels of performance seen in previous years and ensured that we delivered against the standards we set ourselves. Of particular note however is the performance against the 'Referral to Treatment' standard in our CAMHS service, which saw 90% of service users accessing treatment within 18 weeks (against a target of 83%), which was the first time we have achieved this target since taking over the service in 2017.

Equality of service delivery

We set up a Trustwide Equality and Diversity Inclusion (EDI) Group in 2020/21. Under this Trustwide EDI Group is a Service User/Carer EDI group which is focusing on access to services and the service user experience. There are a number of Quality Improvement Projects taking place at local levels, led by this group, which include:

- Access to CAMHS services by children with a BAME background
- Setting up a Mental Health Legislation Committee as a sub-committee of the Board to review data by ethnicity for service users detained under the Mental Health Act
- Reviewing the use of restrictive practice by ethnicity and working with staff on how to address this

Our Trust wide action plan includes the following actions for 2021/2022:

- Thematic review of race equality and service user / carer experience
- Trust wide review of access to services by those with specific communication needs (e.g. deaf service users)
- Training – care planning and improved therapeutic conversations with disabled service users
- Increase service user diversity in Experts by Experience Group

Our Service Quality: What the Care Quality Commission told us in 2020

The Trust is fully compliant with the registration requirements of the CQC.
We were inspected by the CQC in September and October 2018 and three services were inspected in February 2020. We were delighted that the inspection team found that the Child and Adolescent Mental Health Community Services were rated as 'Good' across all domains (rated as 'Requires Improvement' in 2018). The wards for Learning Disability and Autism were also rated 'Good' across all domains (rated as 'Inadequate' in 2018). This improvement was due to the sustained focus of our staff to improve services for patients and we thank them for this dedication. Our acute PICU wards were also inspected and the rating remained the same 'Requires Improvement'. This reflects the operational pressures experienced by the services.

The Well-Led inspection did not take place due to COVID-19 and the Trust was not issued with an updated overall 2020 rating. The overall rating for the Trust in 2018 was 'Requires Improvement'. We were rated 'Good' in the effective and caring domains, and 'Requires Improvement' in the safe, responsive and well-led domains. 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.

In December 2020 the CQC completed a focussed inspection process. The inspection covered Wiltshire and Swindon Community and Intensive Teams, Wiltshire Perinatal Teams and Secure Forensic Wards. The CQC made no changes to ratings, as the inspections were not considered comprehensive. Both Community services and Forensic services are currently rated as Good. The CQC made a number of recommendations known as 'Must' and 'Should do's', whichhave now been transferred across the Trust's CQC improvement plan, overseen by the CQC oversight group and then reported to the Safe Sub-group.

Our CQC Progress 2020

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← May 2020	Good →← May 2020	Good →← May 2020	Requires improvement ↓ May 2020	Good ↑ May 2020	Requires improvement →← May 2020
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
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 Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Wards for people with a learning disability or autism	Good ↑ May 2020	Good ↑↑ May 2020	Good ↑ May 2020	Good ↑↑ May 2020	Good ↑↑ May 2020	Good ↑↑ May 2020
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	Good ↑ May 2020	Good →← May 2020	Good →← May 2020	Good ↑ May 2020	Good →← May 2020	Good ↑ May 2020
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 Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016	Good Sept 2016
Overall	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Requires improvement Dec 2018	Requires improvement Dec 2018	Requires improvement Dec 2018

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Table 3 - Our CQC progress 2020

Please note: CQC rating changes in the services inspected in 2020 are indicated by arrows

Our ambition remains to provide outstanding care across all services.

Improvements to our Estate

The CQC identified a number of environmental issues that required improvement. Despite the COVID-19 pandemic, AWP has managed to maintain a programme of major changes and developments. Whilst some of these projects had an impact on our response to the latest CQC report received by the Trust, other projects occurred because the Trust has been able to bid for additional capital funding within the system.

The estate improvement programme in 2020/21 included:

Cherry Ward:

This project was the re-design and refurbishment of Laurel Ward (older adult beds) at Callington Road Hospital. The Cherry Ward is an adult acute admission ward. It is also the first acute ward to have a de-escalation suite fitted to the new higher Trust standard. The capital cost was £1.2M and despite COVID19 issues at the start of the project the ward opened on the 5th October 2020.

Elizabeth Casson House Environment Redevelopment:

This project is a substantial redesign and refurbishment of the female PICU at Callington Road Hospital. A number of our CQC "must dos" relate to this project with a budget of £1.4M. The design and room data sheets were completed by the first week of October 2020 and we remain on track to meet the deadline for finishing in August 2021.

Riverside Expansion – CAMHS Tier 4 Service:

This project is a substantial refurbishment and expansion of the existing building with a capital cost of £2.7M. The bed base will increase from 10 to 12 and will provide single rooms with on-suite accommodation. The site opened on 8 June 2021.

Ward 4 relocation to Hillview Lodge:

This project is part of the Department of Health's policy to eradicate dormitory accommodation in mental health services. Ward 4, currently located at St. Martins Hospital in Bath, is the Trust's only remaining ward with dormitory accommodation and is highlighted in CQC inspections. The project is a £3.0m redesign and rebuild of an area at Hillview Lodge Mental Health Unit on the RUH hospital site. This project is on track to complete in August 2021.

Hazel Unit – Seclusion Suite:

This project relates to the upgrade of the seclusion suite and a de-escalation suite at a capital cost of £250K. This work was completed in October 2020 and it is the first area in the Trust to have a seclusion suite installed at the new higher Trust standard.

What our service users and carers told us

Friends and Family Assessment of care

We take part in the national Friends and Family Test (FFT), which 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.

The FFT data reporting was paused by NHS England in response to COVID-19 to allow staff to redirect their efforts into essential clinical care, as can be seen by the charts below. The Trust's response rate has not recovered since restarting in December 2020. In December 2019 there was around **13%** response rate and this has decreased since then to **2.9%** response rate. We are working to improve the responses, including different methods of data collection, including via SMS text messaging.

Response rate 2017-2021

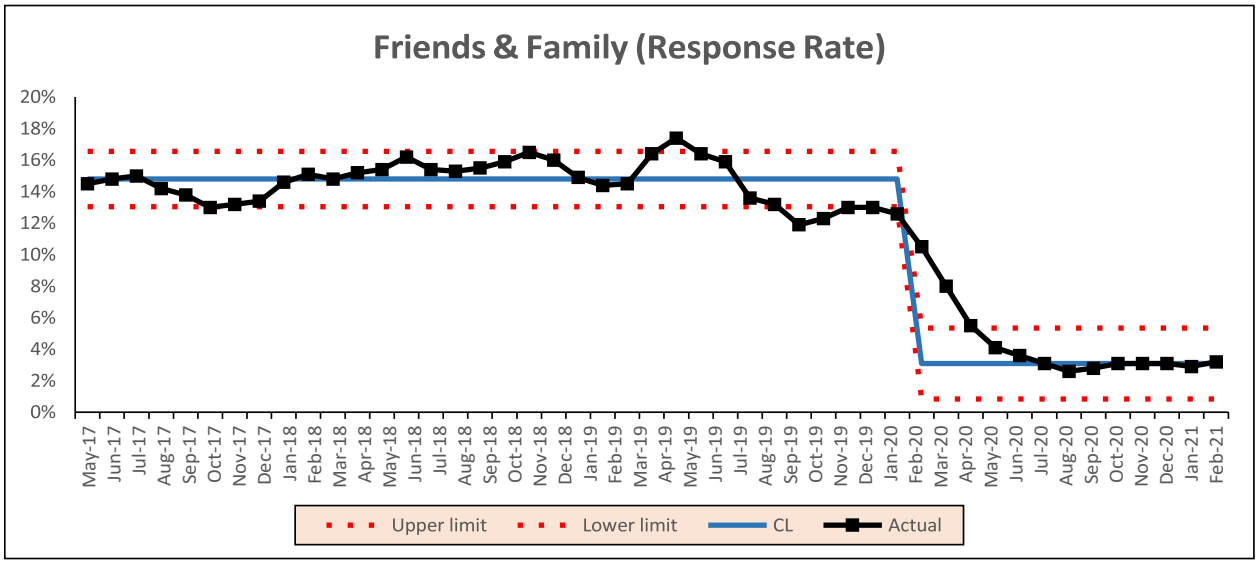


Figure 1 - Friends & Family response rate 2017-2021

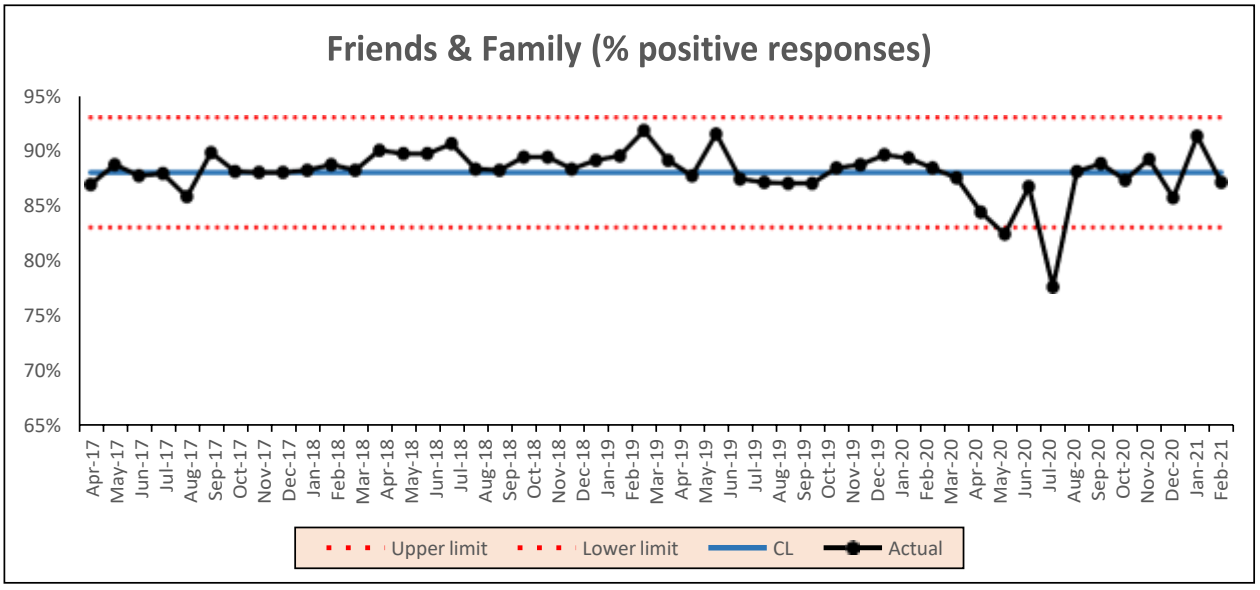


Figure 2 - Friends & Family positive response rate 2017-21

We will work with service users to understand the drop in positive responses, especially during the first three months of the year and during the first wave of the pandemic.

Patient Surveys

The Trust participated in the Annual Community Mental Health Survey commissioned by the CQC. The survey was undertaken between February and June 2020. 1250 community mental health service users were asked to comment on the care they had received. 351 surveys were returned giving a response rate of 29%.

We were in the top 20% of Trusts for 3 questions and people felt that they both understood and were involved in deciding what NHS therapies to use. The survey identified a number of areas where we need to improve, in particular we saw a reduction in people saying 'they were given enough time to discuss their needs and treatment' and in 'ensuring care needs take into account needs in other areas of the service user's life'. We were in the lowest 20% of Trust for 5 out of 37 questions. We will be working with service users and their families to understand what we can do to improve services and taking action to do so.

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2020		
					Number of Respondents	Score	RAG Rating
7. Have you been told who is in charge of organising your care and services?	63%	69.4%	79%	84%	286	82.5%	●
14. In the last 12 months, have you had a specific meeting with someone from NHS mental health services to discuss how your care is working?	66%	72.5%	79%	86%	261	79.3%	●
27. Were you involved as much as you wanted to be in deciding what NHS therapies to use?	62%	68.1%	73%	81%	131	74.6%	●

Table 4 - Responses in the top 20% of mental health trust responses

	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2020		
					Number of Respondents	Score	RAG Rating
5. Did the person or people you saw understand how your mental health needs affect other areas of your life?	62%	68.3%	74%	78%	320	67.6%	●
10. How well does this person organise the care and services you need?	76%	81.4%	86%	89%	200	80.5%	●
12. Were you involved as much as you wanted to be in agreeing what care you will receive?	63%	71.5%	75%	79%	254	69.6%	●
17. In the last 12 months, did you get the help you needed when you tried contacting this person or team?	60%	66.1%	72%	78%	158	62.6%	●
35. Overall...	62%	68.5%	72%	78%	311	68.4%	●

Table 5 - Responses in the lowest 20% of mental health trust responses

Category	2020 summary (% of positive responses)
Your care and treatment	--
Your health and social care workers	70%
Organising your care	86%
Planning your care	65%
Reviewing your care	78%
Crisis care	66%
Medicines	72%
NHS Therapies	78%
Support and Wellbeing	--

Table 6 - Patient Survey Results

The CQC decided that direct comparisons with the 2019 Community Mental Health Survey were not to be included in their official report, and that the 2020 Community Mental Health Survey is not directly comparable to previous iterations due to the survey taking place during the COVID-19 pandemic.

The score of service users' overall experience has seen a slight decrease in score whilst other Trusts' scores have improved.

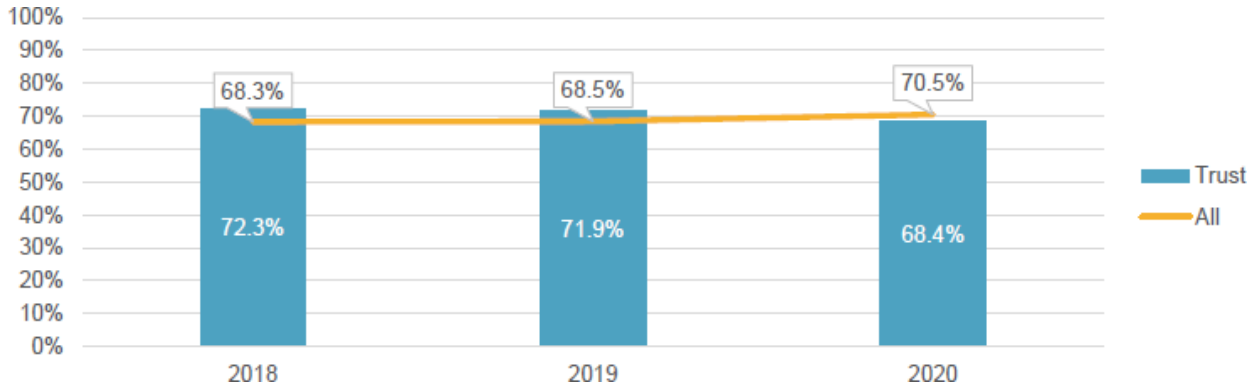


Figure 3 - Overall experience (Scale score from 0-10. 0 = "I had a very poor experience", 10 = "I had a very good experience").

We need to understand why the feedback is less positive and improve the experience of service users. To continue improving there are a number of things we have identified that we should make 'Always' events, for example, always ensuring we have told the service user who is in charge of organising their care and who to contact in a crisis.
Just 25.4% of service users said that they had been asked to give their views on the quality of their care. If we prompted staff to communicate that we want service users' views on their care when sharing the FFT to every person we could improve this quickly.

Service Users and Carers engagement and involvement

We have been working to ensure we engage, involve and move towards meaningful co-production where service users, carers and communities are involved in planning and delivering care, as reflected in the strategic priorities outlined in 2019. Due to COVID-19, we have not been able to hold the same number of engagement events as previous years with these groups.

The majority of the efforts this year from engagement and involvement staff has focused on maintaining existing links with service users and carers throughout the reduced contact periods during the global pandemic. Some staff were redeployed to support clinical services while others worked to maintain relationships.
Due to lockdowns, shielding and other physical travel restrictions some face to face events moved to virtual events, for example the partnership event with Medical Education was able to run for a fourth year by utilising Microsoft Teams. The Involvement Teams and Patient Experience Team worked hard to ensure that involvement continued via these virtual platforms.

The Strategic Expert by Experience Group (SEG) meetings were placed on hold for three months, following this they also moved to virtual meetings. Since moving to a virtual platform, they have continued to champion the service user voice within corporate services. The SEG have now moved into the Quality Improvement structure and report directly to the Director of Nursing and Quality.

To further value and bolster the carer voice within the organisation Carer Experts by Experience have been appointed to the Carer Lead meeting and subsequent subgroup. The group focuses on the Triangle of Care, Carer Awareness Training and Carer Champion Training, aiming to further embed active involvement and inclusion ofcarers and families in our everyday working.

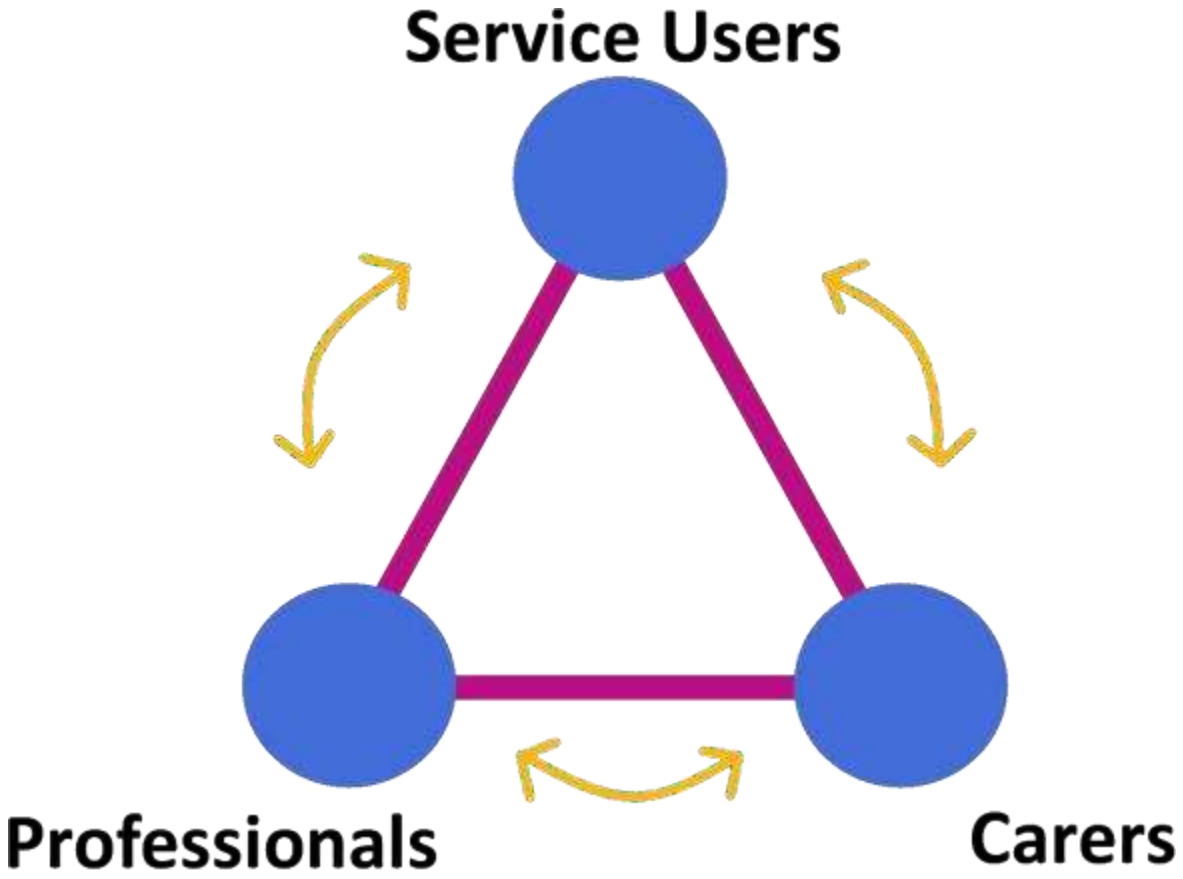
Although work was reduced due to COVID-19 restrictions the Local Involvement Co-ordinators (LICs), continued to champion the voice of service users and carers in as many projects as possible, including:

- The Community Mental Health Frameworks across BNSSG and BSW
- The Recovery Outreach Support and Engagement Team (ROSE)
- The BNSSG wide lived experience practitioners project on Personality Disorder

Triangle of Care

The Triangle of Care is the way service users, carers and healthcare professional's work together to provide care. We currently hold a 2-star Triangle of Care membership and are actively engaged in the Regional Collaborative Network, which focuses on improvement for carers.

Locally there are carer champions meetings which are held to discuss local teams and locality requirements as well as the preparation, assessment and subsequent action plans from the Triangle of Care. We also hold monthly Carers Lead meetings to ensure delivery of the Triangle of Care against the standards as well as co-ordinating Trust wide improvement work. The monthly Carer Lead meeting is attended by the Carers Lead for each LDU.



Outstanding People

Development of our staff through apprenticeships

All apprenticeship elements of the AWP clinical career ladder from education levels 2 – 7 are now active including Registered Nurse Degree apprentices and the Trust's first Advanced Clinical Practitioner apprentices. New-to-role Healthcare Support Worker apprentices have been integrated within Trust wide recruitment processes enabling new starters without relevant qualifications and with little or no experience within the sector to progress towards nationally recognised vocational diplomas:

The Trust's first groups of Clinical Associate Psychology (CAP) and Occupational Therapy apprentices are due to commence programmes in Q1 and Q2 of the new financial year. Overall, clinical and corporate apprenticeship activity within the financial year has doubled compared to last year, as planned.

Apprenticeship levy spend rose from 41% of total AWP contributions in 2019/20 to 70% during 2020/21 with 90% of spend for 2021/22 already committed to apprentices 'live' on programme as at March 2021. The significant increase in overall activity is anticipated to achieve a public sector target figure of around 3% against the national compliance target of 2.3%.

Recruitment and Resourcing

AWP wants to be an outstanding organisation. To achieve this we need to attract, support, develop and retain outstanding people. During a year of unprecedented challenges for the NHS, we focused on filling our vacancies, ensuring we were able to maintain and improve our services. We rapidly streamlined our recruitment processes, ensuring they were COVID safe and still met the NHS standards. Our centralised Healthcare Support Worker (HCSW) recruitment campaign was a great success and we were able to fill many of our vacancies across the Trust. Our close working relationship with local universities enabled us to offer around 60 students paid work placements over a number of months during the height of the pandemic, helping us manage the demand for our services. Our Recruitment and Resourcing Business Partner continues to work on broader AWP-wide campaigns and our strategic approach to reduce our overall number of vacancies.

We have a new On-boarding process whereby the Trust's On-boarding Co-ordinator, a new role for the organisation, acts as a focal point of contact for new employees from the time they receive an unconditional employment offer, through to the end of their first year in post. The On-boarding Co-ordinator liaises with new starters, line managers and the Human Resources and Learning and Development teams to ensure that new staff have a positive experience during their first 12 months at AWP.

On-boarding is a process of helping a new member of staff to acquire the necessary knowledge, skills and behaviours in order to become an effective member of the team as quickly as possible. It helps staff to get to know one another and learn how to communicate effectively. A good on-boarding experience results in happier employees who feel welcomed and valued and want to continue working for us. Since introducing the role, we have seen a substantial reduction in the number of people leaving the Trust within their first 12 months.

Our Workforce Performance Metrics

Supervision and appraisal

To ensure staff receive regular support, feedback and development we prioritise regular supervision, mid-year and yearly appraisals. All staff members have monthly meetings with their manager to support them in carrying out their role. Every member of staff also has an annual appraisal in which clear objectives are set for the forthcoming year that align with our Trust wide priorities.

During 2020/21 we have not met our target for supervision or appraisal, in part, due to a focus on the COVID-19 response. 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	2019/20 Performance	2020/21 Performance
Supervision	85%	85%	85%	87%	85%	77%
Appraisal	95%	84%	87%	87%	91%	85%

Table 7 - Number of staff supervised and appraised during 2020/21

Sickness and attendance

Our average rate of sickness absence over the last 12 months was 4.55% which is slightly lower than 2019/20 (4.91%). We continue to work to develop managers to be able to support staff to return to work as quickly as possible, and to better understand the drivers of sickness absence, including the impact of COVID-19.

What our staff told us about working for AWP

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

- Local and Trust wide consulting groups with trade union representatives
- Local and Trust wide staff experience groups
- Visits by Executives and Non-Executive Directors to our services, with identified Link Directors in each area
- Surveys, notably the annual NHS Staff Survey
- Frequent and constructive discussions with our various Trade Unions

Staff Survey Results

Every year, all of our substantively employed members of staff are invited to complete the NHS Staff Survey. This year, 45% of our staff completed the survey. This has decreased 9% in comparison to last year and it is felt that this isdue to the pressures and challenges of the pandemic. The average response rate for similar organisations who used the same contractor, Picker, to carry out the staff survey, was 52%.

Some changes were made nationally to the survey this year, which included the addition of questions on COVID-19 measures, safety at work and speaking up and caring responsibilities as well as the exclusion of personal development, working as a team and patient/service user feedback.

Our largest improvement last year was staff not coming into work when not feeling well enough to perform their duties (a 12% increase from the previous year). In addition to this, one of our chosen priorities from our 2019/20 survey was the view on the organisation definitely taking positive action on health and wellbeing. Over the course of the year, we have put in place a number of measures to address this. Examples include:

- Adoption of health and wellbeing locality and central hubs
- Items for recharge rooms/staff spaces, pre-paid cards for community and corporate teams to use to support health and wellbeing, hampers and weekly fruit boxes to our inpatient wards
- The launch of “a looking after your health and wellbeing” booklet
- Redesign of intranet health and wellbeing pages
- Promotion of staff trauma service, trauma informed training
- British Dietetics Association webinars, and running of an activity challenge

There were 14 measures which showed a statistically significant improvement. Examples include:

- Would recommend the organisation as a place to work
- Satisfied with opportunities for flexible working
- Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public

In response to the 2020 staff survey results, we will focus on four key priorities described below. These reflect our strategic intentions and recognise where we need to make the greatest progress, these are:

- Effective communication between managers and staff
- Line manager giving feedback on work
- Reducing bullying and harassment from service users and the public
- Improving our response rate in the 2021 NHS Staff Survey

Each team receives survey results that reflect in detail the experience of their own staff. Managers use these results to discuss areas of improvement with staff and, as a team, jointly develop department specific responses to the survey.

Staff wellbeing

During this last year we have all faced the global pandemic and as such it was even more important to continue to develop the Staff Wellbeing strategy. We have focused on keeping staff safe and well both physically and psychologically during COVID-19.

Many initiatives were developed to support staff wellbeing at work, the first of which was a vulnerable person's risk assessment. This was used to identify those colleagues who could be more impacted byeffects of COVID-19 and the results used to provide additional support in the form of a programme called 'Your Health and Wellbeing'. This programme included offering wellbeing conversations to all staff and physical health checks for those identified as vulnerable. We developed a suite of resources for managers and staff to access to support their individual and team wellbeing. This included providing COVID-19 secure rest areas away from service users, trauma training for managers, virtual common rooms for shielding staff, activity and nutrition advice and a Thank You Day off gifted to all staff in recognition of their outstanding efforts.

For those staff who may be suffering from the effects of long COVID, or who are taking a little longer to recover, we are following our Attendance and Health at work Policy, which takes a supportive approach to sickness management. This includes the use of wellbeing plans, Occupational Health (OH) referrals and phased returns to work.

In our staff survey published in January 2021 there was an 8% improvement in the response to "definitely taking positive action on health and wellbeing."

A new structure for health and wellbeing has been set up to ensure we listen to and deliver on the wellbeing needs of staff. Each locality team now has a Health and Wellbeing Hub that monitors and engages with local issues and implements local and AWP wide wellbeing initiatives. There is also a Central Health and Wellbeing Group that drives our Wellbeing Strategy and engages with all 10 hubs to ensure alignment.

We have also worked across the BNSSG and BSW systems and with national organisations to ensure our staff have access to the many wellbeing initiatives on offer.

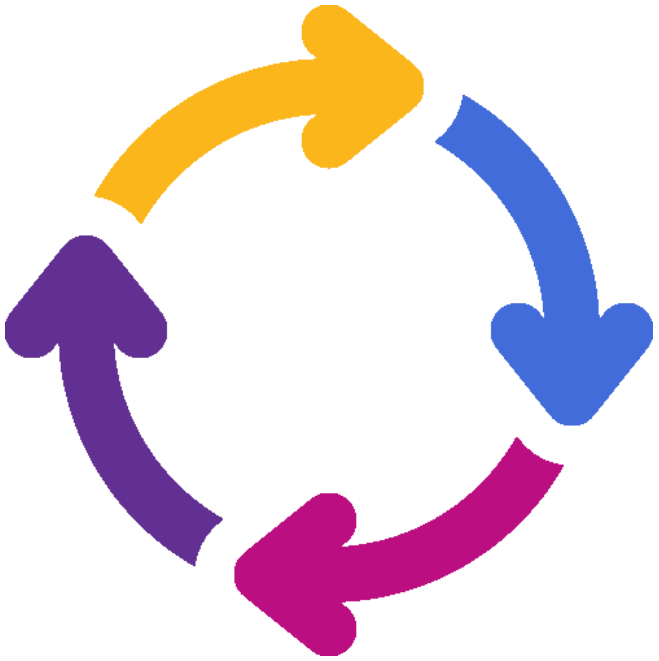
As thoughts turn to the 'recovery phase' we have reflected not only about how hard our working lives and personal lives may have been, but also about how much positive change has been achieved so quickly. We are evaluating the impact of our wellbeing initiatives and forecasting future trends to address how we will support the recovery of staff and harness this momentum for positive change.

Equality and Diversity

AWP 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 trade union membership.

We employ an Equality, Diversity and Inclusion Manager whose role is to provide coaching, strategic development, advice and support to executives, managers and staff. They also ensure that the Trust meets its obligations in relation to the publication of relevant data. Data gathered through the NHS Workforce Race Equality Standard (WRES) analysis showed that a disproportionate number of staff from Black, Asian and Minority Ethnic groups enter into formal disciplinary processes, compared to white staff. This disproportionality occurs across the NHS and we are committed to changing this situation. As part of our efforts to address this issue we are currently piloting an initiativeto introduce and train Independent Equality Advisors across the organisation.

We have more detail on our EDI work and gender pay gap in the remuneration report on page 76.



Sustainable Services

Our financial performance, including the performance by Local Delivery Unit (LDU), capital expenditure, cash holding and statement of financial position is reported on a monthly basis to the Finance and Planning Committee. This Committee is responsible for the detailed scrutiny of the financial performance and provides assurance to the Trust Board, including highlighting any issues.

Along with the wider NHS, we have seen a significantly different financial picture this year as the full extent of the pandemic unfolded along with an unprecedented funding regime. The flow of income into the Trust on a block contract basis with additional system funding arrangements have been closely monitored to ensure the Trust adhered to the required breakeven outturn position. For the financial year 2020/21, we reported a net surplus of £0.007m after technical adjustments (adjusted from a deficit of £6.6m when including impairments, grant income and DHSC stock). This is a significant improvement on the 2019/20 performance of a £7.2m deficit (adjusted to £9.2m when including impairments) and ahead of the deficit position of £9.5m agreed by the Trust Board with NHS Improvement in March 2020. It should be noted that this has only been possible with additional income provided to all NHS bodies in year, in response to the COVID-19 pandemic and ensuring that no NHS provider had cash issues as a result of a deficit financial position. The reported surplus to NHS Improvement excludes impairments that are technical in nature and are exceptional items.

Savings have not been a key focus in 2020/21 due to COVID-19, with the majority of identified efficiency schemes being put on hold allowing the Trust to focus on delivering its services within the COVID-19 situation. The financial planning and monitoring for COVID-19 evolved over the first quarter and has remained consistent from that point. 2020/21 has proved a financially challenging year in terms of ensuring appropriate controls remained in place for thesignificant amount of COVID-19 related expenditure (£12.0m) experienced. Further difficulties experienced in previous years were heightened during the significant pressure points of the pandemic, including ongoing recruitment difficulties for both medical and nursing staff as well as a continued dependency on Out of Area (OoA) placements. The majority of our business is commissioned by our two local Clinical Commissioning Groups (CCGs), NHS England, and local authorities (as commissioners for NHS patient care services and preventative services). Since CCGs, NHS England and local authorities are funded by Government to buy NHS patient care and preventative services, the Trust is not exposed to the degree of financial risk faced by business entities, apart from the normal contract negotiation/renewal that is expected in any organisation.

Given the funding position that we have experienced in 2020/21 we have not been required to draw down the anticipated loans from the Department of Health of £9.5m (2019/20 £3.0m). In addition to this, the existing Department of Health and Social Care (DHSC) interim revenue and capital loans as at 30 September 2020 were replaced with an issue of £23.4m Public Dividend Capital (PDC) to allow the repayment of the temporary loans.

Income

The following chart shows the split of our total income by source; the majority of income is received from NHS commissioners, mainly CCGs, for the delivery of patient care and from local authorities for public health provision.
Operating income received in 2020/21 by the Trust was £322.3m, with £287.0m (89%) from the delivery of patient care services compared to £257.6m, £245.1m (95%) respectively in 2019/20. The largest proportion of our clinical income comes from our two local CCGs. The employer contribution rate for NHS pensions remained centrally funded for the increase from 14.3% to 20.6% (excluding administration charge) for a second year. For 2020/21, NHSproviders continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on the Trust's behalf. The full cost and related funding have been recognised in these accounts.

Non-clinical income for the period is £35.3m, with the majority of this income received to fund education, training, research, as well as Top Up and Government grant funding. A breakdown of total income by source is shown in the graph below:

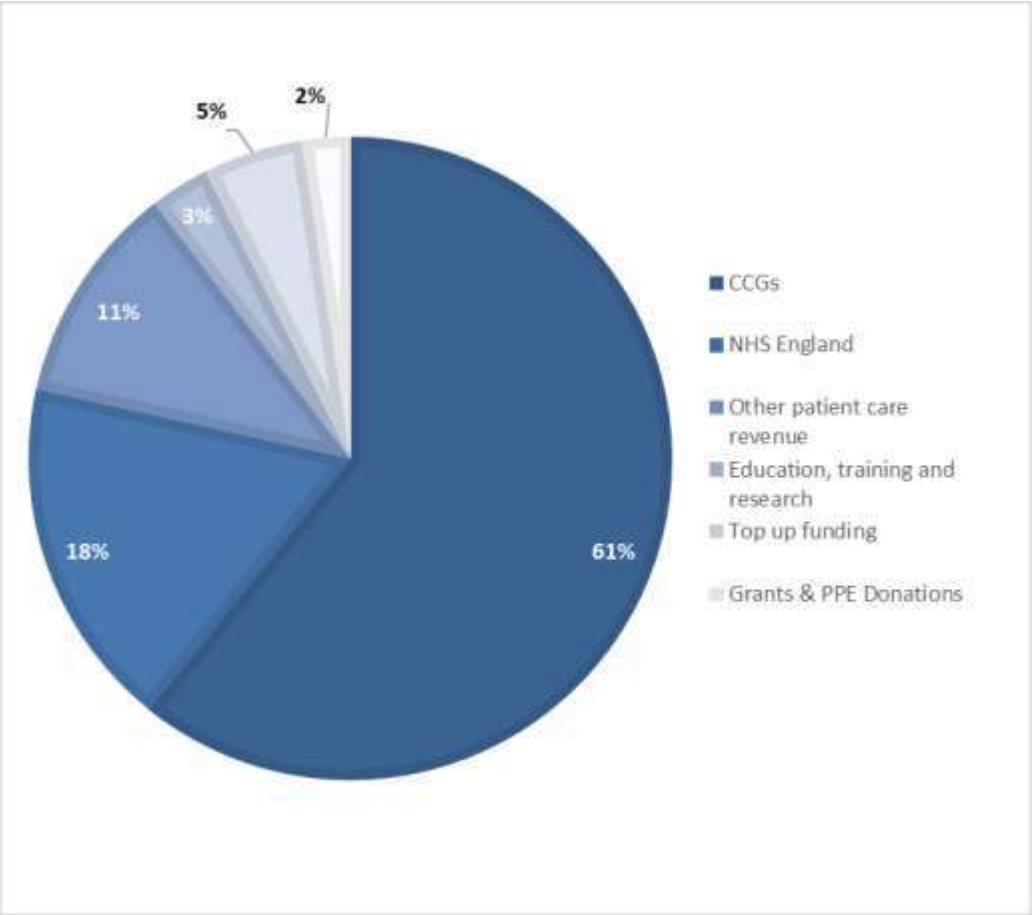


Figure 5 - Income by source, 2020/21

Expenditure

Operating expenses including finance costs totalled £328.9m for the year and, as in previous years, staff costs account for the largest use of resources at 69% of the total expenditure (2019/20 £258.2m, 76%). Of the expenditureon staff costs in 2020/21, £8.5m of this relates to a notional income amount that is related to a 6.3% increase in employers' pension that was funded ata national level (2019/20 £7.6m).

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

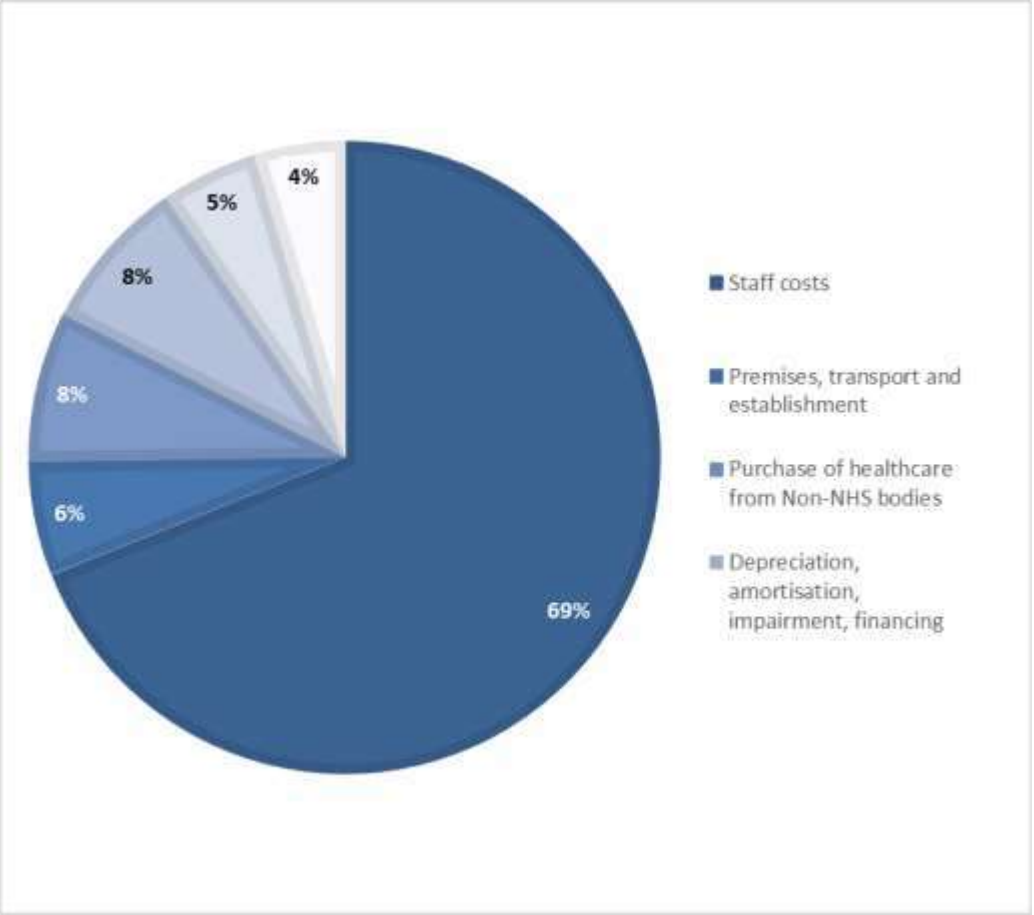


Figure 6 - Expenditure by source, 2020/21

Capital programme

Capital Expenditure for the year was £19.2m (including £0.9m of lifecycle expenditure on the Private Finance Initiative (PFI). The capital plan and specific schemes has changed quite significantly throughout the course of the year, with the value of the plan increasing significantly due to the addition of a number of schemes being funded from Public Dividend Capital (PDC) and a Salix government grant.

In addition to Trust funded capital there has also been additional funding provided from the Department for Health and Social Care of £3.7m for IT schemes, £6.0m for building-related schemes in the form of PDC. In order to support our sustainability agenda, we were also successful in being awarded £4.5m of Salix grant funding to support low carbon schemes such as LED lighting, heat pumps and solar initiatives.

Capital expenditure in 2019/20 was £9.6m (including £1.1m of lifecycle expenditure on the PFI), also receiving £0.5m of PDC for IT schemes. Within the £9.6m, was £5.1m of PDC funding, with £0.5m for IT related schemes and £3.6m for building related schemes.

The chart below sets out the capital split of projects.

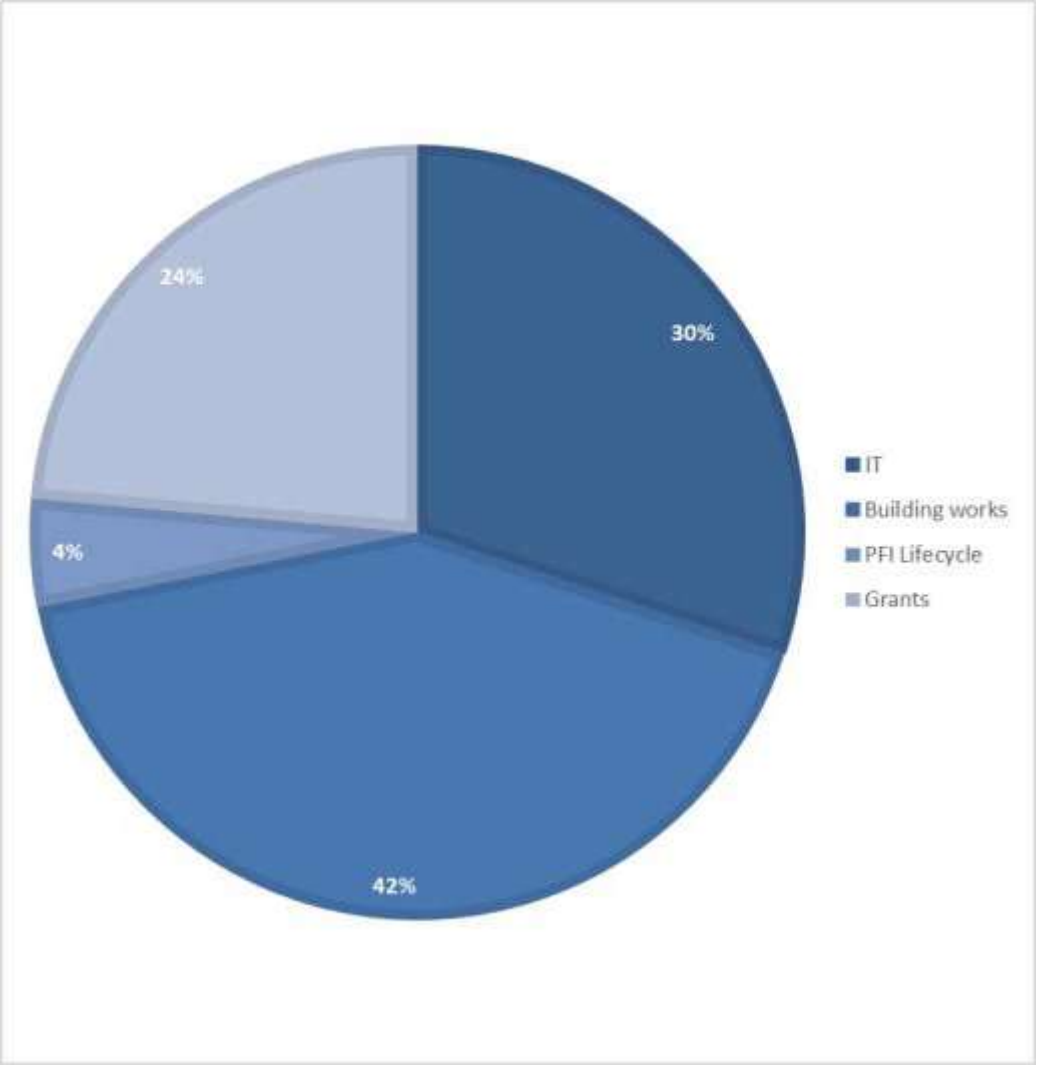


Figure 7 - Capital spending by type, 2020/21

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 2020/21 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 both agency and COVID related invoices that were being received. This did not however impact upon overall invoice turnaround time. Despite havingan increase of almost 10,000 non-NHS supplier invoices in-year, the Trust significantly improved the payment againsttarget in terms of both the value and number of invoices paid.

Better payment practice code compliance	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Non-NHS				
Total invoices paid in year	77,341	127,776	67,789	94,853
Total invoices paid within target	63,972	120,511	45,463	84,421
Percentage paid within target	**83%**	**94%**	**67%**	**89%**
NHS				
Total invoices paid in year	734	11,188	957	10,773
Total invoices paid within target	662	10,954	833	10,216
Percentage paid within target	**90%**	**98%**	**87%**	**95%**

Table 8 - Better Payment Practice Code performance

Going Concern

The Trust returned a retained surplus of £0.007m (adjusted technical deficit of £6.6m) during the year ended 31 March 2021 and, at that date, had net current liabilities of £3.9m.
The Trust is assuming cash support of £10.0m in 2021/22 to maintain current payment performance assuming that the Trust delivers its savings plan and continues with the current national plan to receive funding to support a breakeven position for the first half of the year. If the Trust fails to deliver, in full, the savings plan in 2021/22 then a further cash loan will be required.

With the unprecedented measures in place due to COVID-19, funding arrangements for 2021/22 are continually changing, with the Trust closely monitoring all interim funding arrangements.

As directed by the 2020/21 Department of Health and Social Care 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. As such, the Trust has adopted the going concern basis forpreparing the financial statements and has not included the adjustments that would result if it was unableto continue as a going concern.

We are required to report that in September 2020 the auditor 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 2021. The auditor's referral said "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."

As presented in Note 33 to the financial statements, despite breaching the break-even duty for the previous three years, The Trust achieved a small reported surplus in 2020/21.

Whilst the Trust does not consider itself to be significantly exposed to any significant risks arising from EU exit or COVID, the ongoing uncertainty means that this cannot be fully assessed. The Trust does not consider itself to be financially exposed due the additional costs from COVID-19 as all material costs are being funded directly through regular returns to NHS Improvement.

Financial position 2021/22 and beyond

Considerable work has been undertaken across the organisation to understand the recurrent financial position of the Trust, however the second wave of the pandemic that hit the UK in January and February has resulted in NHS England / Improvement making the decision to continue with the COVID-19 Finance regime for the first 6 months of the financial year 2021/22. As with 2020/21 the Trust's underlying deficit will be covered by additional funding in order for the Trust to support on its recovery of its service provision. COVID-19 costs will continue to be covered by aspecific system allocation for this period. The Trust will also be developing its productivity improvement programme over the first 3 to 4 months of the new financial year so that it can respond to the financial regime that will be applied to the last 6 months of the financial year, which is assumed to require the Trust to restart its long term financial plan in order to achieve financial sustainability.

As well as developing its productivity improvement plan the Trust will be embarking on a significant transformation of its community services in line with the system wide community mental health framework. This will bring more investment into mental health over the next three years in order to support people with serious mental illness.

Although the revenue budgets for 2021/22 are being heavily influenced by a COVID-19 financial regime, especially for the first 6 months of the financial year, the Trust's capital programme is to continue as normal. To this end the Trust's Board has agreed a capital plan of £3.8m which will support the continued development of its IT infrastructure, enhance patient safety further including the mitigation of health and safety risks and the continued redevelopment of the Trust's estate. The Trust will be continuing to complete business cases in order to secure additional funding to support the continued transformation of our estate.

Environmental Sustainability

We have continued to invest in various measures to reduce our carbon emissions during 2020-2021. We are fully aware that our consumption of resources to deliver services to the communities we serve all produce carbon emissions which negatively impact these communities and the wider environment.

Our carbon footprint for 2019-2020 was 7,807 tonnes CO2e. This is an increase of 306 tonnes from 2018-2019 mainly due to increased gas usage and increased business mileage.

7,807 tonnes of CO^{2e} is equivalent to the annual carbon emissions of 964 UK homes. [1]

Source	Tonnes CO^{2e}	% share
Electricity	2846	36.5
Gas	3595	46.0
Water	79	1.0
Business transport	1191	15.3
Patient transport	79.50	1.0
Waste	16.00	0.2
Total	**7807**	

Table 9 - Carbon footprint 2019-2020

Carbon emissions 2007 to 2019

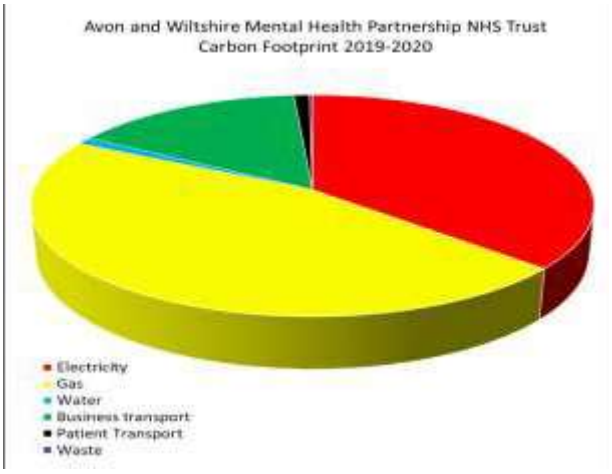


Figure 8 - Carbon emissions 2007 to 2019

[1] **Source:** The Committee on Climate Change – Fifth Carbon Budget "How every household can help reduce the UK's carbon footprint". The measure is based on an average UK home emitting 8.1 tonnes annually.

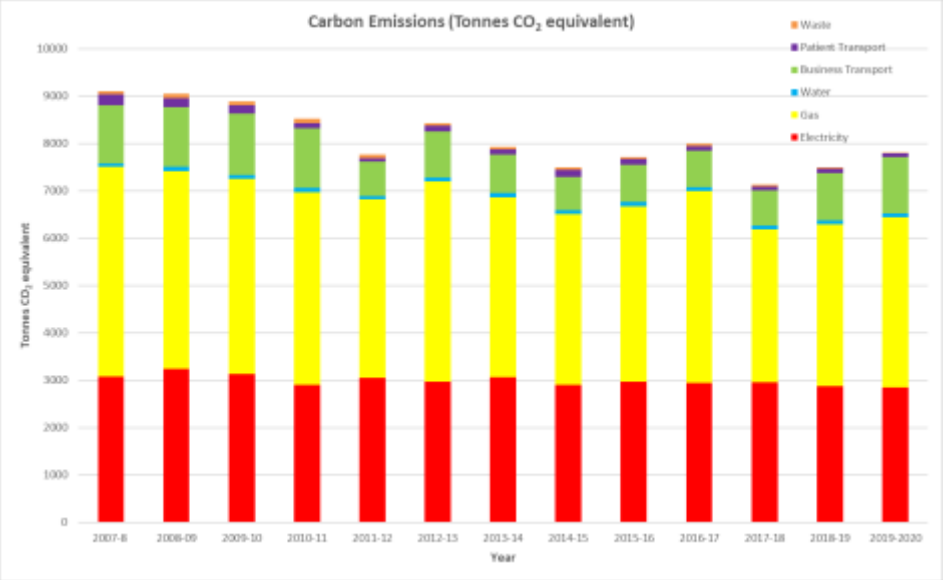


Figure 9 - Carbon emissions (tonnes CO^2 equivalent)

Sustainability achievements in 2020/2021

Renewable electricity tariff

In July 2020, the Trust moved the majority of its sites on to a renewable electricity tariff with EDF Energy. This means that we can certify approximately 65% of our electricity supply is now supplied from renewable sources (hydro, solar, wind, biomass and landfill gas). The remaining 35% of our electricity will also be from renewable sources from 1st April 2021.

Once all our electricity is on a renewable tariff, this will result in at least 2,800 tonnes carbon reduction, which is a 36% reduction.

Achieved £4.5 million grant funding for decarbonisation projects

In January 2021, a grant funding bid was produced by the Trust Energy and Sustainability Manager. This bid was successful and we have received £4.5 million from Salix, a non-profit company that delivers funding for public sector carbon reduction projects, for investing in various carbon reduction projects including:

- Solar photovoltaic systems
- LED lighting replacements
- Air Source Heat Pumps
- Various other projects including electric radiators, air conditioning controls, Building management system (BMS) installations, upgrading boiler room pipework insulation

Work is currently progressing across the Trust to complete these projects. Assuming all the proposed projects are delivered, this will result in approximately 1,500 tonnes carbon emissions reduction. This equates to an impressive 19% reduction in our total carbon footprint. Annual financial savings are estimated to be approximately £225,000. AWP is fully committed to continue its carbon reduction drive in order to meet its target of carbon neutrality by 2030.

Delivered in Partnership

Integrated Care Systems

We are members of two Integrated Care Systems (ICS) developed following the *White Paper for NHS Reform* published by the government. The NHS has published its parallel guidance *Integrating Care, Next Steps to Building Strong and Effective Integrated Care Systems Across England* which is guiding the development of ICSs.

We are members of the BSW and Healthier Together (BNSSG) ICSs, and a Provider Collaborative for specialised services. We will work closely with our partners to shape the two ICSs so that the best care is provided to the populations we serve and decisions are taken at a local level.

We will also continue to work with our partners to develop the Community Mental Health Framework in 2021/22. This will provide a great opportunity to change how we provide services in the community and to deliver care closer to home.

Regional Mental Health Transformation Board

We are working with all mental health providers in the South West to undertake a stock-take of mental health services. This will give us a good baseline position against which to assess priorities for change and improvements over the coming year.

What were the risks to us achieving our strategic objectives in 2019/2020?

We identified and managed the following risks to our objectives, through our Board Assurance Framework (BAF). We agree the BAF at the beginning of the year and review it regularly throughout the year. The overall risk appetite for the Trust was agreed as 'cautious', a preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward. In July 2020, we added a new risk (risk 13) relating to the impact our COVID response may have on our other priorities. We have closely monitored this and all risks throughout the year.

All Board subcommittee review the BAF risks and the highest scoring corporate risks regularly, and provide assurance through to the Trust Board. More detail on our risk management process is included in the Accountability report on page 41.

BAF ID	Board Assurance Framework Risk	Assurance Committee	Risk Level	Target
01	If we do not learn from, and embed change as a result of incidents, internal governance processes, issues raised by CQC and other regulatory bodies, then we will not improve clinical care	Quality & Standards Committee	**16**	**8**
02	If we are unable to improve our estate to ensure it is fit for purpose then clinical care may be compromised	Delivery Committee	**8**	**12**
03	If the Trust does not involve service users and carers effectively then there is a risk of poor patient experience of our services	Quality & Standards Committee	**12**	**12**

BAF ID	Board Assurance Framework Risk	Assurance Committee	Risk Level	Target
04	If we do not embed a culture of quality and safety in line with our values, then patient experience will not improve	Delivery Committee	**12**	**8**
05	If we are unable to attract and retain excellent staff, then our ability to provide sustainable high quality care will be compromised	Delivery Committee	**16**	**8**
06	If we do not address the issues affecting staff experience and wellbeing then there is a risk of increased staff turnover and sickness affecting the quality of care provided	Delivery Committee	**16**	**8**
07	If there is a lack of appropriate system response to meet the mental health needs across STPs (or future ICSs), then this may result in the failure to deliver sustainable quality services for the population	Finance and Planning	**16**	**12**
08	If the Trust continues to operate with a recurrent deficit between income and expenditure due to historical underfunding and an inefficient service model, then the Trust will need to either secure additional income for underfunded services or re-engineer services so that they fit within the funding envelope provided by commissioners. (**Re-worded risk)**	Finance and Planning	**15**	**8**
09	If we do not maintain and develop confidence in AWP as a provider of high quality mental health services, then we will not be successful in the retention or development of services	Finance and Planning	**12**	**9**
10	If we do not have the capacity and capability to utilise new technologies, then there is a risk we cannot provide high quality services through digital transformation	Finance and Planning	**8**	**8**
11	If the Trust does not adapt its clinical model to minimise the impact of COVID-19 on patient and staff health, then there is a risk that it may negatively impact on the health and safety of patients, staff and visitors, as well as causing widespread service disruption	Delivery Committee	**12**	**8**
12	If we are unable to work with commissioners to build new facilities or to re-develop current locations, then we will not be able to provide efficient high quality care, in keeping with national standards **(new risk 20/21)**	Finance and Planning	**12**	**8**
13	If the COVID-19 emergency continues and we reduce the effectiveness of our organisational controls then we risk achieving our strategic objectives and system working in the long term	Audit Committee	**16**	**12**

Table 11 - Summary BAF risk scores presented to the Trust Board in January 2021

Priorities for 2021/22

2021/22 will be a challenging year for all health services and the population as a whole, as we grapple with creating a new 'normal' following the COVID-19 pandemic.

Our approach is to:

- **Recover.** First and foremost we need to be proactive in supporting individuals, teams and leaders to rest and recover. Time will be needed to make sense of what has happened, talk about distressing experiences, mourn for what has been lost and reflect upon what has been learned
- **Reconnect.** We need to re-connect – with one another, with colleagues from across the organisation and broader system, and of course with our patients who have themselves each had different COVID experiences, some of which will have been very hard
- **Recreate.** Finally we need to focus on recreating our future – taking the essence of what we wanted to do before the pandemic and adapting it for a post-pandemic world. Many stakeholders have different expectations and timelines for what they will expect us to focus on. We need to find the right path through, remaining true to our vision/values and adapting to our changed environment, and competing pressures

Service Developments 2021/22

As we emerge from the COVID-19 pandemic, our focus will necessarily be on establishing a new way of working building on our learning from changes made as a result of the pandemic. This will include:

- Supporting our staff to continue to work differently, reducing our reliance on costly estate and providing more digitally enabled services
- Focusing on reducing waiting times and continuing to support service users in a more responsive way, including offering telephone, video or face to face contacts where appropriate
- Improving the physical health of our service users, making sure that we support them to stay well and mitigate the impact of any possible future waves of COVID
- Continuing to develop our partnerships so that we deliver care in a joined up way, making best use of clinical and non-clinical expertise in our systems

There will be a significant change in service delivery and oversight across our systems in 2021/22 through the Integrated Care System (ICS). Both ICSs have identified improving the mental health and wellbeing of their populations as a priority, and over the coming year we will be working with partners in the voluntary sector, GPs and other healthcare providers to design and implement new models and ensure that people move safely in and out of services across all ages.

This will include:

- Redesigning services for people who have complex emotional needs so that they are able to access earlier support and treatment and avoid crisis admissions
- Establishing a new model for community service provision that wraps around service users in their local area, using the combined expertise of secondary services, primary care and the voluntary sector. This will include appointing new peer support workers, mental health professionals working in primary care and investing in new roles in our community mental health teams
- Reducing the number of people who experience a mental health crisis, with earlier intervention and support from trained staff working 24/7

In our more specialised services, we will also see a shift in oversight away from NHS England Specialised Commissioning to our South West Regional Provider Collaborative. This was established in 2016 and will, in 2021/22, take over the commissioning of CAMHS and Eating Disorders services. This regional collaborative is focused on reducing the number of people in out of region beds by improving access to more local services and accelerating discharge to community based teams.

Performance Report Declaration

Dominic Hardisty
Chief Executive

11 June 2021

Corporate Governance Report

The Corporate Governance report explains the composition of the Trust's governance structures and how they achieve the Trust's objectives, this includes the Directors' Report (p41), statement of Accountable Officer responsibilities (p87) and the annual governance statement (P57). The Remuneration and Staff Report (p76) sets out the policy on remuneration for directors and senior managers. The Parliamentary Accountability section includes the independent audit report (p90).

Directors' Report

The Board

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is governed by a Board that provides strategic leadership to the organisation. Our Board comprises 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 consists 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 the Board.

To support the Board, the Trust has two statutory and five designated committees which provide assurances on specific functions within the organisation. The Trust's committee structure is set out in detail on page 61.

AWP complies Corporate Governance Code, updated in 2019. We work closely with our stakeholders to reduce the risk posed to our patients by the pandemic and to promote a compassionate culture throughout the system.

Board membership during 2020/21

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. In May 2020 Charlotte was appointed as a Council Member on the Higher Education Funding Council for Wales.

Charlotte has held senior positions at British Telecom and O2 and has her own executive coaching consultancy.

Appointed as Chair November 2016

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. 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: Audit and Risk, Finance and Planning

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. Twelve years ago he switched to the not-for-profit and charity sector providing management consultancy services at The Business School's Centre for Charity Effectiveness in respect of governance, building high performing leadership teams and helping successful collaboration between organisations. He also teaches on their MSc programme, coaches senior leaders and provides "turnaround" organisational services.

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 until July 2020), Finance and Planning (Chair), Mental Health Legislation Committee (Chair)

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 (NHSI).

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

Mark Outhwaite
Non-Executive Director

Mark runs his own consulting business specialising in coaching, change management and organisational development support, mainly to public sector organisations. He also has a long-term interest in the challenges of technology implementation and provides advice and support to tech start-ups in the healthcare sector. At the core of his approach 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: Quality and Standards, Delivery (Chair), Audit and Risk

Brian Stables
Non-Executive Director

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 and Risk, Charitable Funds (Chair from July 2020), Finance and Planning

Paul Olomolaiye

Non-Executive Director

Paul Olomolaiye is a Professor of Construction Engineering, with over 200 publications to his credit and currently the Pro Vice-Chancellor for Environment and Technology at UWE-Bristol. Paul lays a huge emphasis on world-class education and cross-functional collaborations and the academic space under his wing is a testimony to this philosophy. A Fellow of the Royal Society of Arts and Manufacturing, Paul is committed to every cause he takes up. He is a gifted creative thinker and strategic policy developer, with a passion for vision and excellence. He is renowned among his colleagues and team members as an inspirational leader.

Appointed to the Board: April 2020
Committees: Delivery, Mental Health Legislation

Samantha Budd

Associate Non-Executive Director

Sam was Chief Executive of the University of Bristol Students' Union and has over 30 years of senior experience within the recruitment, training and education sectors. She has held several non- executive and trustee roles.

Sam has a particular interest in equality, diversity and inclusion. She has worked in an advisory capacity with National Union of Students' (NUS) to shape the Race Matters agenda and has been involved in the development and implementation of Careers in Students' Unions, the new employer brand created to improve the diversity of the sector's workforce.

Sam is also a passionate advocate for mental health issues and was a member of the 2018 Bristol Leadership Challenge, an ambitious programme convened by the Mayor's City Office, aimed at addressing the systemic difficulties faced in Bristol by those citizens experiencing complex mental health problems.

Appointed to the Board: April 2020
Committees: Charitable Funds, Delivery

Jan Baptiste-Grant

Non-Executive Director Designate (Associate Non-Executive Director from May 2020- February2021)

Jan has worked in the NHS for the last 40 years. Holding executive and sub board positions since 2001, she has worked locally as a Chief Nurse/ Director of Nursing & Quality in Hospitals, CCG's and Primary Care Trusts, regionally, as the Director of Nursing across Thames Valley Strategic Health Authority, and nationally at the Department of Health as the Clinical Advisor in the development of NHS Professionals. Passionate about patientand service user outcomes and experiences, Jan previously held Trustee positions for the Terence Higgins Trust and the National Sickle Cell Society.

Appointed to the Board: May 2020
Committees: Finance and Planning, Mental Health Legislation, Quality and Standards

Shelley Whitehead (until November 2020)
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 – November 2020
Committees: Audit and Risk, Finance and Planning, Quality and Standards, Mental Health Legislation

Executive Directors

Dominic Hardisty
Chief Executive

Previously the Chief Operating Officer and Deputy Chief Executive at Oxford Health NHS Foundation Trust, Dominic commenced his role at AWP in August 2019.
Dominic has 20 years' experience as a leader, with the last 10 in the NHS, where he has worked across acute and community trusts. He has led teams to transform services across acute, community, mental health and children's/young people's pathways, as well as leading on responses to CQC inspections and the formation of partnerships across primary, acute, community and social care.

Simon Truelove
Director of Finance and Deputy Chief Executive

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, Delivery

Rachel Clark (until 30 April 2021)
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 in 2017 she 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, Finance and Planning

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 the 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: Delivery Committee, Nomination and Remuneration Committee (attendee)

Julie Kerry
Director of Nursing and Quality

Julie spent her early career 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 that will help to reduce suicide, reduce restrictive practice, and improve our physical health care offer.

Committees: Mental Health Legislation, Quality and Standards

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: Delivery, Finance and Planning, Quality and Standards.

Sarah Constantine
Medical Director

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 (QI) 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, Mental Health Legislation

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.

Paul Olomolaiye joined the Board from 1 April 2020 as a Non-Executive Director. Paul has an academic background and is a professor at UWE with strategic policy experience.

Samantha Budd joined the Board from 1 April 2020 as an Associate Non-Executive Director and has experience in recruitment training and education.

Jan Baptiste-Grant joined Board from May 2020 as an Associate Non-Executive Director and became a Non-Executive Director Designate from 1 February 2021. Jan has a clinical background.

Board Diversity

As of 31 March 2021, the Board was composed of five voting executive directors and two non-voting executives, four of whom are male, three female. Of the nine non-executive directors (including the Chair and Associate Non-executive Directors), four are female and five are male. Three of the nine non-executive directors come from a Black and Minority Ethnic Background and six from a white background. All executive directors are from a white background. One Board member has declared a disability.

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 2020/21, Board seminars covered the following areas:

- Leadership and organisational culture
- Strategic finance
- Risk and assurance
- Strategy and planning
- Mental Health Act training
- COVID-19 response
- Quality governance
- Environmental sustainability
- Safeguarding training
- Integrated Care Systems
- Trauma Training
- Resilience

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 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's 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. Deputies attend Board and Committee meetings in place of absent Directors whenever possible.

Attendance

Non-Executive Directors/Associate Non-Executive Directors/ Non-Executive Director Designate	Number of meetings attended in 2020/2021
Charlotte Hitchings	11 of 11
Ernie Messer	10 of 11
Brian Stables	11 of 11
Jan Baptiste-Grant (from May 2020)	9 of 10
Marie-Noelle Orzel (on secondment March-September 2020)	6 of 6
Mark Outhwaite	10 of 11
Neil Auty	9 of 11
Paul Olomolaiye	11 of 11
Samantha Budd	9 of 10
Shelley Whitehead (until December 2020)	7 of 7
Executive Directors	
Dominic Hardisty, Chief Executive	11 of 11
Julian Feasby, Director of Human Resources (non-voting)	11 of 11
Julie Kerry, Director of Nursing and Quality	11 of 11
Rachel Clark, Director of Strategy (non-voting) (until February 2021)	1 of 9
Sarah Constantine, Medical Director	11 of 11
Simon Truelove, Director of Finance	10 of 11

Table 12 - Board meeting attendance

Declaration

Each director knows of no information that 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 the achievement of the Trust's objectives.

The Committee meets at least six times a year.

Principal activities in 2020/21

- Review of risk management arrangements of the Trust to provide assurance that risks are being systematically identified and mitigated
- Review of 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
- Review of the Trust's arrangements around internal control including policies and exceptions to policies
- Scrutiny of governance statements including annual report and accounts

Committee attendees

Non-Executive Directors	Number of meetings attended in 2020/2021
Brian Stables	6 of 6
Marie-Noelle Orzel (on secondment March-September 2020)	3 of 3
Mark Outhwaite	5 of 6
Neil Auty	6 of 6
Charlotte Hitchings (not a regular member)	1 of 6
Paul Olomolaiye (not a regular member)	1 of 6
Associate Non-Executive Directors (attendees)	
Jan Baptiste-Grant (induction programme)	1 of 6
Samantha Budd (induction programme)	1 of 6

Table 13 - Audit and Risk Committee attendance

In 2020/21, 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
- Head of Financial Accounting, Treasury management and Finance Systems

Nomination and Remuneration Committee (statutory)

Role of the committee

The Committee ensures 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 2020/21

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

Committee attendees

Non-Executive Directors	Number of meetings attended in 2020/2021
Brian Stables	11 of 12
Charlotte Hitchings	11 of 12
Ernie Messer	12 of 12
Marie-Noelle Orzel (on secondment March-September 2020)	8 of 9
Mark Outhwaite	11 of 12
Neil Auty	11 of 12
Paul Olomolaiye	11 of 12

Table 14 - Nomination and Remuneration Committee attendance

In 2020/21, the following have also attended committee meetings:

- Company Secretary
- Chief Executive
- Director of Human Resources
- Deputy Chief Executive and Director of Finance

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 quality patient care that complies with all legislation, regulations and guidance relevant to the Trust.

Principal activities in 2020/21

- 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 attendees

Non-Executive Directors	Number of meetings attended 2020/2021
Marie-Noelle Orzel (on secondment March-September 2020)	7 of 7
Mark Outhwaite (inc. combined Delivery/Quality Committee)	9 of 9
Executive Directors	
Mathew Page Chief Operating officer	6 of 9
Sarah Constantine Medical Director	7 of 9
Julie Kerry Director of Nursing	8 of 9
Associate Non-Executive Directors/Non-Executive Director Designate	
Jan Baptiste-Grant (from May 2020)	9 of 9
Shelley Whitehead (until December 2020)	5 of 5

Table 15 - Quality and Standards Committee attendance

In 2020/21, the following have also attended committee meetings:

- Associate Director, Governance, Improvement and Quality
- Chair
- Chief Executive
- Company Secretary
- Director of Finance
- Director of Human Resources
- Interim Director of Transformation

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 2020/21

- Oversight of progress against the Trust's Financial Sustainability Plan
- 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
- Oversight of strategy

Committee attendees

Non-Executive Directors	Number of meetings attended 2020/2021
Brian Stables (from October 2020)	7 of 11
Ernie Messer	11 of 11
Neil Auty	10 of 11
Associate Non-Executive Directors/Non-Executive Director Designate (attendees)	
Jan Baptiste-Grant (from December 2020)	3 of 10
Samantha Budd (until December 2020)	5 of 10
Shelley Whitehead (until April 2020)	1 of 7
Executive Directors	
Mathew Page, Chief Operating Officer (member)	8 of 11
Simon Truelove, Director of Finance (member)	9 of 11

Table 16 - Finance and Planning Committee attendance

In 2020/21, the following have also attended committee meetings:

- Associate Director of Planning and Business Development
- Chair
- Chief Executive
- Company Secretary
- Director of Human Resources
- Director of Strategy
- Divisional Associate Directors
- Medical Director

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 2020/21

- 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 attendees

Non-Executive Directors	Number of meetings attended 2020/2021
Brian Stables	4 of 4
Neil Auty	4 of 4
Associate Non-Executive Directors	
Samantha Budd (member)	4 of 4
Executive Directors	
Simon Truelove, Director of Finance (member)	3 of 4

Table 17 - Charitable Funds Committee attendance

In 2020/21, the following have also attended committee meetings:

- Head of Communications
- Head of Financial Accounting and Treasury
- Company Secretary

Delivery Committee

Role of the committee

The Delivery Committee (the Committee) is established by the Board of Directors (Trust Board) as the senior operational assurance committee of Avon and Wiltshire Mental Health Partnership NHS Trust. The role of the Committee is to seek assurance in respect of the Trust's capability and capacity to deliver its:

- Operational performance targets and ambitions
- Change programmes
- Workforce strategy and implementation
- Estates programme
- Health and Safety obligations
- Emergency preparedness and resilience planning

Principal activities in 2020/21

- The Committee reviews the Integrated Performance Report
- The Committee has oversight of estates plans
- The Committee has oversight of the COVID-19 response and emergency planning
- The Committee has oversight of workforce issues
- The Committee received of equality and diversity issues

Committee attendees

Non-Executive Directors	Number of meetings attended in 2020/2021
Mark Outhwaite	7 of 8
Paul Olomolaiye	6 of 7
Associate Non-Executive Directors/Non-Executive Director Designate	
Jan Baptiste-Grant (from May 2020)	5 of 6
Samantha Budd (from May 2020)	2 of 6
Shelley Whitehead (until December 2020)	4 of 5
Executive Directors	
Julian Feasby, Director of Human Resources (member)	7 of 8
Mathew Page, Chief Operating Officer (member)	5 of 8
Simon Truelove, Director of Finance (member)	4 of 8

- Includes 2 x Combined Delivery Committee and Quality and Standards Committee

Table 18 - Delivery Committee attendance

In 2020/21, the following have also attended committee meetings:

- Chair
- Chief Executive
- Clinical Directors
- Company Secretary
- Director of Nursing and Quality
- Medical Director

Mental Health Legislation Committee

Role of the committee

The Mental Health Act Committee is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005, and with reference to guiding principles as set out in the Code of Practice and associated legislation as it applies to the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty.

Committee attendees

Non-Executive Director	Number of meetings attended in 2020/2021
Ernie Messer	3 of 3
Paul Olomolaiye	3 of 3
Associate Non-Executive Directors/Non-Executive Director Designate	
Jan Baptiste-Grant	3 of 3
Shelley Whitehead (until December 2020*)	1 of 1
Executive Directors	
Julie Kerry, Director of Nursing and Quality (member)	3 of 3
Sarah Constantine, Medical Director (member)	3 of 3

Table 19 - Mental Health Legislation Committee attendance

In 2020/21, the following have also attended committee meetings:

- Associate Director of Governance
- Chair
- Chief Executive
- Company Secretary
- Deputy Chief Operating Officer
- Head of Statutory Delivery Social Care and Social Work
- Mental Health Legislation Manager

Annual Governance Statement 2020/2021

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of 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 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accountable Officer, I recognise that risk is inherent in the provision of health care and that effective 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 where staff are encouraged to identify risks through risk assessment and raising concerns; and reactive through systematic learning from incidents, complaints and claims.

To help execute my responsibilities for managing risk, the Director of Finance and Deputy Chief Executive has delegated responsibility for the overall co-ordination of risk management. The other Executive Directors have collective responsibility for the appropriate operational application of the risk management process and lead for specific areas of risk within their individual areas of responsibility.

- The Director of Nursing leads on quality, clinical governance, safeguarding, patient safety and compliance with Care Quality Commission standards
- The Medical Director leads on medicines management and safe standards of medical practice
- The Director of Finance leads on financial risk, informatics, information governance risks and matters relating to Health and Safety
- The Director of Operations leads on risk across all clinical and operational services and manages risk in relation to the development, management and maintenance of the Trust estate
- The Director of Human Resources leads on risks associated with workforce capacity, retention of staff, absence management and staff wellbeing
- The Director of Strategy leads on risks associated with the health community and reputational risks

Our revised governance structure introduced in 2020 ensures that risk is discussed throughout the organisation, from a locality level feeding through to divisions. Corporate risks are reviewed by the Executive Team and Board Committees seek assurance that robust systems of governance, risk management and internal control are in place to support safe, patient-centred care.

The global pandemic declared in March 2020 has been a challenge for all organisations and one that has tested our risk processes and business continuity plans. The structures we had in place to manage risk had to flex and adapt to manage this rapidly evolving and highly challenging situation. In April 2020, the Board reviewed its governance processes and streamlined them where possible, to ensure the focus of management time was on addressing the pandemic and as many staff as possible were released to provide patient care. Nationally, reporting arrangements were streamlined to help manage the pandemic.

How we support our staff to manage risk

The Risk Management Policy defines the roles and responsibilities for managing risk to support risk management as an integral part of all our activities including all aspects of business planning and decision-making.

Responsibility for risk management is assigned throughout the organisation with most team or department managers responsible for a risk register. Further guidance is available to staff in our Incident, Risk Assessment, Being Open and Freedom to Speak Up policies. Each member of staff holds a responsibility for risk management integral to their role and included as part of the job description. Staff are expected to identify and report issues, risks and incidents.

All Trust employees have a responsibility for the delivery of high quality, safe care. To support this, our Risk Management Team co-ordinates and delivers a variety of risk management training packages. All staff are required to attend a corporate induction on joining the Trust with risk management refresher training available on request. The training was supplied online in 2020/21 to minimise the risk of infection.

The Board Assurance Framework (BAF) is regularly updated throughout the year; this supports the oversight and management of the principal risks to the achievement of the Trust's objectives. This included adding the significant risk that the COVID-19 pandemic presented for AWP services, staff and patients.
The following actions were undertaken in 2020/21:

- The BAF and corporate risk registers were reviewed and updated to reflect the risks relating to COVID-19
- As the first wave of COVID-19 receded in June 2020, the Board spent time to identify risks arising from our response to COVID-19, with particular focus on risks to service user/patient safety and experience. The Executive Team provided a summary of the actions taken to mitigate risks identified by the Board
- A new risk was added to the Board Assurance Framework relating to COVID-19
- All corporate risks were reviewed and re-worded to ensure they accurately reflect the current risks. These risks were mapped against the Board Assurance Framework
- New risks added to the risk register are reviewed by the Risk Management Coordinator for quality control with support and guidance given to risk owners to improve performance
- Improved communication to all staff about the risk management process

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.

The Trust has taken the following steps to strengthen its governance processes in 2020/21:

- The Trust revised its management structure and introduced an Incident Control Centre, and other meetings, such as a Clinical Oversight and Leadership Group, to manage the response to the pandemic. A Clinical Ethics Group was established to check and challenge any decisions made at pace which may have a negative impact of patients or staff. The Deputy Chief Executive managed business as usual and chaired a Restore, Recover and Learning group
- Reviewed governance processes and revised the terms of reference for board committees, during the first wave of COVID-19, the Delivery and Quality and Standards Committees combined, to balance gaining assurance whilst enabling management focus on the COVID-19 response
- Introduced a Mental Health Legislation Committee, an assurance committee, chaired by a Non-Executive Director to mental health act compliance issues
- Increased support to the structure of the Nursing and Quality Directorate, to ensure we have the correct staff to support the quality agenda
- Introduced the new Governance Structure which focusses on the five CQC domains, although the pace was slowed to respond to COVID-19
- Further developed the assurance map with internal auditors

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.

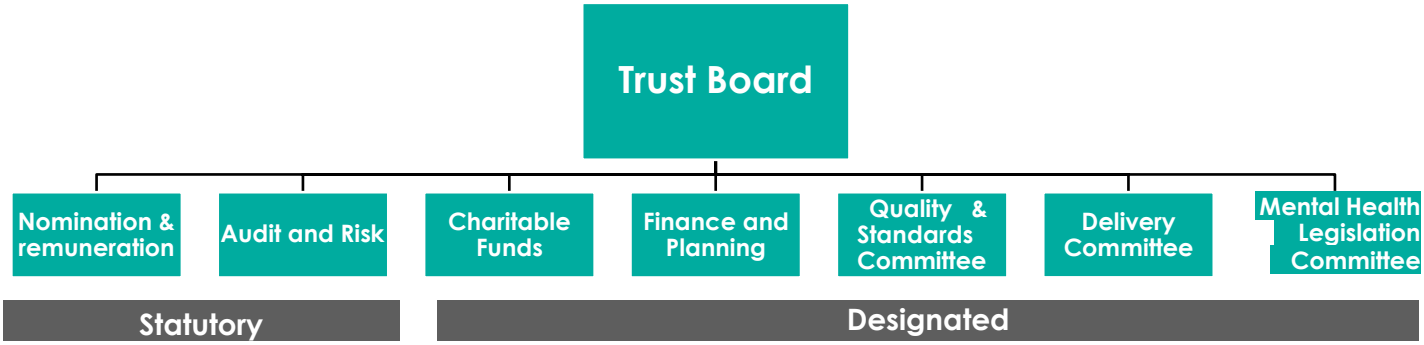


Figure 10 - Trust committee structure, as of 31 March 2021

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 Commie 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 the 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 Board committees and the Audit and Risk Committee to triangulate the sources of information and assurance.

Finance and Planning Committee

The Finance and Planning Committee has responsibility for reviewing and proposing the annual financial budget for the year and monitoring the in-year financial position. It has oversight of significant business transactions, financial risks and reviews financial metrics, prior to submission at the Board.

Quality and Standards Committee

The Quality and Standards Committee provides assurance to the Board on quality governance, has oversight of clinical risks and reviews quality metrics, prior to submission at the Board.

Delivery Committee

The Delivery Committee scrutinises operations and workforce performance, health and safety and the delivery of the estates strategy prior to presentation to the Board.

The Committee Chairs meet regularly to plan the year going forward, to co-ordinate work and to monitor progress of the work of committees.

Mental Health Legislation Committee

The Mental Health Act Committee is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005, and with reference to guiding principles as set out in the Code of Practice.

Nomination and Remuneration Committee and Charitable Funds Committee

The Board has a Nomination 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 2020/21 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. 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.

Executive Team

The Executive Team meet on a weekly basis and where required items are reported to Board via Board sub-committees or directly to Board through the Chief Executive's report. Each Executive Director has responsibility for a CQC Domain and reports into the Executive Team via the Quality Executive. The updated Governance structure implemented in 2020 is below in Figure 11.

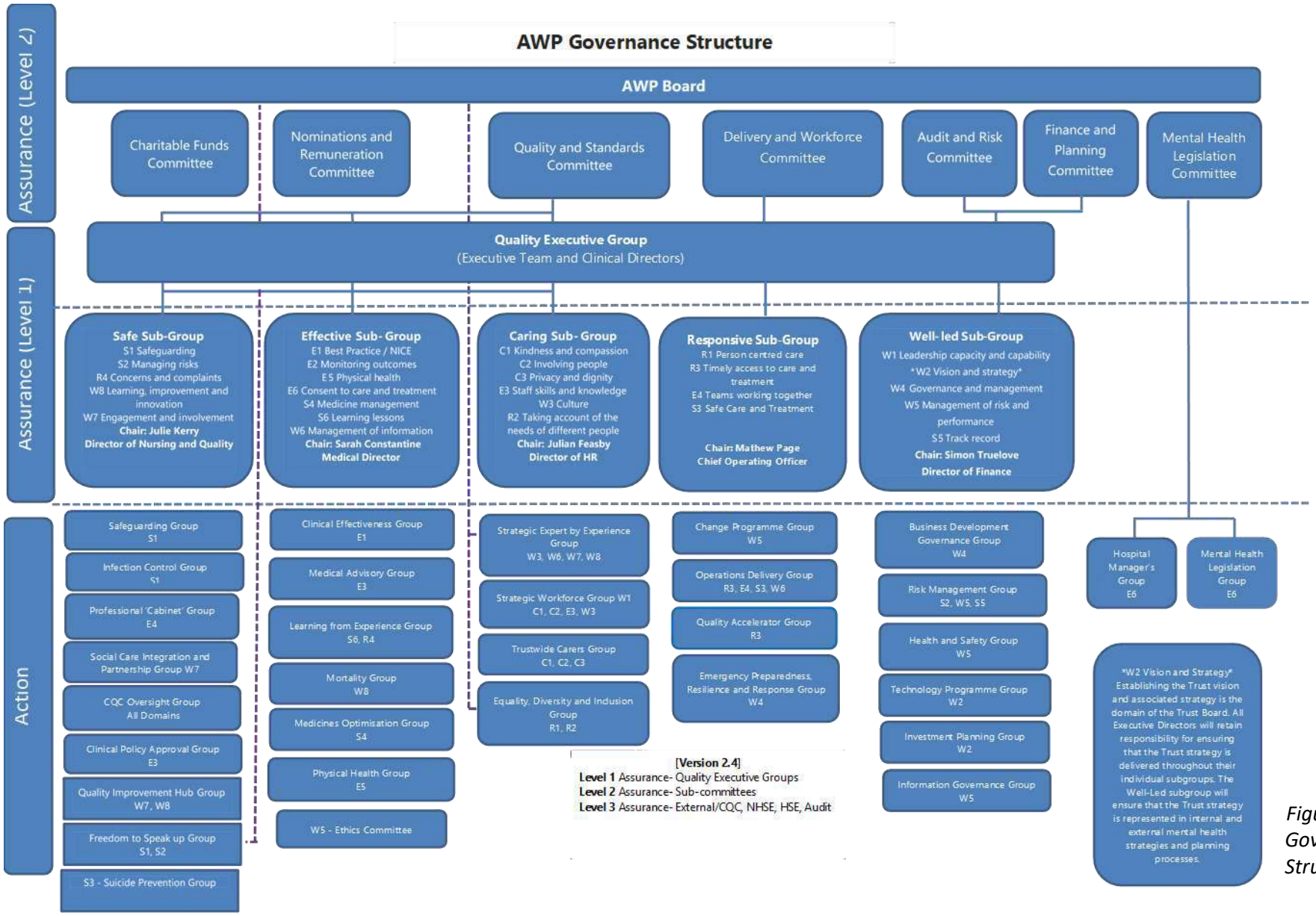


Figure 11 - Governance Structure

External Well-Led Review and CQC Well-Led Review

Between July and October 2018, Pricewaterhouse Coopers (PWC) undertook a Well-Led review. 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.

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 introduced a new quality governance structure in 2020 to improved quality assurance, based on the Care Quality Commission domains. Although in the early stages, this has improved quality reporting.

The CQC Well-Led review for 2020 was stood down, in response to the COVID-19 pandemic. The Trust had self-assessed itself as 'good' in its own internal assessment. The CQC rated the three core services in 2020, two of the three services had their overall rating increased from 'requires improvement' and 'inadequate' to 'good'. One service remained rated as 'requires improvement'.

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. The Board reviewed the Board Assurance Framework (BAF) three times in 2020/21. In addition, the Audit and Risk Committee reviewed the BAF at every meeting, and subcommittees review the risks allocated to them on the BAF.

BAF No.	Board Assurance Framework
01	If we do not learn from, and embed change as a result of incidents, internal governance processes, issues raised by CQC and other regulatory bodies, then we will not improve clinical care.
02	If we are unable to improve our estate to ensure it is fit for purpose then clinical care may be compromised
03	If the Trust does not involve service users and carers effectively then there is a risk of poor patient experience of our services.
04	BAF: 04 If we do not embed a culture of quality and safety in line with our values, then patient experience will not improve.
05	If we are unable to attract and retain excellent staff, then our ability to provide sustainable high quality care will be compromised.
06	If we do not address the issues affecting staff experience and wellbeing then there is a risk of increased staff turnover and sickness affecting the quality of care provided.
07	If there is a lack of appropriate system response to meet the mental health needs across STPs (or future ICSs), then this may result in the failure to deliver sustainable quality services for the population.
08	If the Trust continues to operate with a recurrent deficit between income and expenditure due to historical underfunding and an inefficient service model, then the Trust will need to either secure additional income for underfunded services or re-engineer services so that they fit within the funding envelope provided by commissioners.
09	If we do not maintain and develop confidence in AWP as a provider of high quality mental health services, then we will not be successful in the retention or development of services.
10	If the Trust cannot fund the deployment of future technology across the Trust and/or the culture of the Trust hinders innovation or delays the implementation of new ways of working, then the Trust will not benefit from technological advances that other mental health providers have deployed or be able to meet changing societal needs.
11	If the Trust does not adapt its clinical model to minimise the impact of COVID-19 on patient and staff health, then there is a risk that it may negatively impact on the health and safety of patients, staff and visitors, as well as causing widespread service disruption.
12	If we are unable to work with commissioners to build new facilities or to re-develop current locations, then we will not be able to provide efficient high quality care, in keeping with national standards.
13	If the COVID-19 emergency continues and we reduce the effectiveness of our organisational controls then we risk achieving our strategic objectives and system working in the long term.

Table 20 - Summary of BAF risk scores presented to the Trust Board in January 2021

	Risk ID	Risk Description	Executive Risk Owner	Current Score	Target Score	Review Due	Oversight Committee	CQC Domain
1	1722	CAMHS NS service provision	Mathew Page	16	4	18/03	Delivery Committee	RESPONSIVE
2	1936	Complex Patient and impact on staff	Julie Kerry	16	4	29/04	Quality & Standards Committee	SAFE
3	922	Trust wide staffing	Julian Feasby	16	6	14/04	Delivery Committee	CARING
4	1570	Staff Safety – Assaults	Julian Feasby	15	6	14/05	Delivery Committee	CARING
5	1185	Impact of CMH Framework and PCNs on staffing	Simon Truelove	15	3	02/05	Finance & Planning	WELL LED
6	2057	Ward evacuation assurance – fire door audit	Julie Kerry	15	10	29/04	Delivery Committee	SAFE
7	1316	Recruitment and retention of adequate clinical staff.	Mathew Page	12	2	16/05	Delivery Committee	RESPONSIVE
8	1248	Insufficient inpatient bed capacity & management.	Mathew Page	12	4	11/04	Delivery Committee	RESPONSIVE
9	1399	Bed management (demand exceeding availability)	Mathew Page	12	4	11/04	Delivery Committee	RESPONSIVE
10	989	Management and reduction of ligature risks – Health and Safety	Simon Truelove	12	4	16/05	Quality & Standards Committee	WELL LED
11	1735	Scale of demand for Mental Health services	Mathew Page	12	4	16/05	Delivery Committee	RESPONSIVE
12	1066	Modernisation of the Trust's inpatient and community estate	Simon Truelove	12	4	02/04	Finance & Planning Committee	WELL LED
13	1251	Fire Management and Fire safety	Simon Truelove	12	8	04/03	Delivery Committee	WELL LED

	Risk ID	Risk Description	Executive Risk Owner	Current Score	Target Score	Review Due	Oversight Committee	CQC Domain
14	499	Managing Challenging behaviours/ Seclusion Rooms	Julie Kerry	12	4	29/05	Quality & Standards Committee	SAFE
15	1134	Medical staffing levels – recruitment & retention	Sarah Constantine	12	3	04/05	Delivery Committee	EFFECTIVE
16	612	Compliance with new 2020/21 IG Standards, GDPR, cyber-security & managers' engagement.	Simon Truelove	12	3	03/04	Audit Committee	WELL LED
17	1937	Increase in referrals to Safeguarding team, impact on improvements	Julie Kerry	12	2	29/04	Quality & Standards Committee	SAFE
18	225	Delivery of in-year financial position	Simon Truelove	12	8	02/05	Finance & Planning Committee	WELL LED
19	1955	Data supply – for evidence based assurance	Julie Kerry	12	6	29/04	Quality & Standards Committee	SAFE
20	882	Cyber Security Breach	Simon Truelove	12	6	03/04	Audit & Risk	WELL LED
21	1970	Digital Culture	Simon Truelove	12	3	03/04	Audit & Risk	WELL LED
22	193	Staff Engagement – HR	Julian Feasby	12	9	14/05	Delivery Committee	CARING
23	2013	Evidence of good quality care planning	Julie Kerry	12	4	04/04	Quality & Standards	SAFE
24	2024	Scale and urgent nature of ad-hoc requests for new systems and developments	Simon Truelove	12	2	02/04	Audit & Risk	WELL LED
25	1958	Patient Safety capacity	Julie Kerry	12	6	29/04	Quality & Standards	SAFE

	Risk ID	Risk Description	Executive Risk Owner	Current Score	Target Score	Review Due	Oversight Committee	CQC Domain
26	1954	COVID-19 impact – Governance Review	Julie Kerry	12	8	08/05	Quality & Standards	SAFE
27	742	Staff Health Well-being	Julian Feasby	12	6	16/05	Delivery Committee	CARING
28	2058	Effectively resourced QI	Julie Kerry	12	6	29/05	Quality & Standards	RESPONSIVE
29	2059	Duty of Candour requirements.	Julie Kerry	12	6	29/05	Quality & Standards	EFFECTIVE

Table 21 - BAF Risks

The Trust has not been able to fully self-certify 'confirmed' compliance with the NHS provider licence Condition 4 due to the deficit in 2016/17, 2017/18, 2019/20 and 2020/21. The Trust did not achieve its control total in 2020/21, however the financial regime was changed in response to the pandemic and a 'true up' process was introduced. All NHS Trusts were funded so they all broke even.

The Trust has a financial recovery plan, approved by the Trust Board and Region; however, it does not achieve financial balance. The lack of a balanced financial plan, combined with the NHSI quality investigation led to the Board decision not to certify 'comply' against Condition 4 of the licence. The key challenges remain 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 challenge of the Trust.

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.

The Trust quality priority areas will continue into 2021/22:

1. **Getting the basics right** – Improvement to care planning, safeguarding practice, physicalhealthcare, clinical governance and serious incident management
2. **CQC and regulatory improvement** – CQC regulatory improvement and reducing restrictive practice and NHSI/E reducing restrictive practice
3. **Embedding and culture of Quality Improvement** (QI) -– Building QI capacity andmethodology and driving co-production.

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 including the appointment of the Trusts Patient Safety Specialist who will lead on the new patient safety strategy.

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 for 2020/21.

In order to deliver and maintain its system of quality governance we are developing a Quality Strategy and Quality Improvement Plan, however, this work was slowed in relation to the pandemic. We recognise the importance of a coherent QI strategy supported by an achievable plan; this will be a priority in 2021/22.

Quality Impact Assessments (QIAs) are undertaken when a significant change to 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.

In response to the pandemic the Trust successfully implemented a full infection, prevention and control command function deploying staff across the organisation in order to respond to the constant demands of COVID-19. The Trust made changes to the ward configuration to ensure that COVID-19 suspected patients were isolated and that core treatment continued separately reducing the risk of potential spread of infection. The Trust also adopted the Attend Anywhere programme to ensure that, in the first instance, community staff and service users remained in treatment, but also isolated. The Trust also developed a Clinical Leadership Overview Group (CLOG) with a purpose of ensuring that all the Trusts decisions related to COVID-19, often made at pace were reviewed and agreed by Senior Clinician Leaders, keeping quality and safety at the heart of all decision making.

The Trust developed a new approach toward Board assurance following the 2018 CQC inspection. The new approach uses quality data metric that flows through our localities and divisions triangulating information to Trust level through to committee and our Board.

Each locality and division is required to show clear mitigation and actions against all quality data and relevant metrics, providing assurance for mitigation, action planning for improvement or escalation. This work continued during the pandemic and key quality metrics were developed. This work will be further developed in 2021/22.

The Audit and Risk Committee made significant changes to the oversight and scrutiny of risks and the levels of assurance to Board. The Committee aligned the internal audit days to focus more closely on the Board Assurance Framework risks, populated and reviewed an assurance map for the Trust and improved the flow between the corporate, divisional and locality risk registers. Clinical leaders are invited to present their local risk register at Committee meetings where the linkages between the different levels of risk are discussed.

The Trust has a Link Director role where each locality has a linked executive and non-executive director. The purpose of the Link Director role is to build a deeper relationship with the senior leaders and staff in a given locality or service delivery unit and increase visibility of the executive team. It was introduced as a response to staff survey feedback. In 2020/21 services visits were reduced to manage the risk of infection, however, where possible virtual visits have taken place.

The Trust started implementing changes to the quality governance structure, based around the CQC domains, in June 2020. This has continued, albeit at a slower pace than planned, to enable us to focus on the COVID-19 challenge. The Trust has completed a 9 month review of the Governance changes which will be reviewed by the Quality and Standards Committee and the Board.

Care Quality Commission (CQC)

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

We were inspected by the Care Quality Commission in September and October 2018 and 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 or 2020. Detailed action plans were implemented in 2019 developed for both the CAMHs service and the Daisy Unit. An inspection in 2020 of CAMHs community services and the Daisy reassessed the services and both services were rated as 'good'. The acute psychiatric inpatient unit rating remained unchanged at requires improvement.

In December 2020, the CQC completed a focussed inspection process. The inspection covered, Wiltshire and Swindon Community and Intensive Teams, Wiltshire Perinatal Teams and Secure Forensic Wards. The CQC made no changes to ratings, as the inspections were not considered comprehensive. Both Community services and Forensic services are currently rated as Good. The CQC made a number of recommendations known as MUST and Should dos, which have now been transferred across the Trusts CQC improvement plan, overseen by the CQC oversight group and then to the Safe Sub-group.

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

RSM work with the Trust on deterring fraud as the Local Counter Fraud Service (LCFS). A risk-based plan was developed and agreed by the Audit and Risk Committee and a self-assessment undertaken by RSM rated the AWP as fully compliant with the Standards.

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 Improving Access to Psychological Therapies (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.

Risk management

The Trust uses the 5 x 5 matrix (likelihood and consequence) to identify the rating for each individual risk. All divisions and departments are required to identify, assess and manage risks within their areas, and to record risks via an electronic risk register. This enables the Trust to report on risks thematically, by risk score or the date of identification, amongst other indicators. The Trust seeks to proactively identify risks through a variety of sources, including:

- Health and Safety Assessments
- Fire Assessments
- Non-Executive Director Visits
- Business Continuity and Major Incident plans
- Incidents

- Serious Incident Investigations and Root Cause Analysis Reports
- Coroner's Reports
- Staff and Patient Surveys
- Audits
- Services Reviews
- National Guidance

The Trust has formally adopted the 'identify/assess/act/monitor/review' cycle for the management of these 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 areas. The divisions are held to account for the management of their risks at the Operational Delivery Group meeting, which is chaired by the Chief Operating Officer. The Chief Executive Officer holds the Chief Operating Officer to account for the performance of the organisation, including risk management.

Management teams at all levels review and manage risks related to their services. Divisions and localities present their risks to the Audit and Risk Committee on a rotational basis. This provides the Committee with assurance on how 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 three times a year at the Trust Board and at every Audit and Risk Committee meeting. The Audit and Risk Committee monitors the adequacy of the risk identification, monitoring and control of corporate risk within the Trust. A named Executive Director is responsible for each of our corporate risks and accountable to the Trust Board for demonstrating actions taken to eliminate or mitigate the risk.
In 2019, the Internal Audit Risk Management Report stated *"The policy on risk management has been informed by HM Treasury's Orange Book, NHS Resolution and The Healthy NHS Board: Principles for Good Governance."*

Workforce

During 2020/21, the Trust has continued to focus strongly on the recruitment and retention of its workforce, which the Board identified as one of its top strategic risks. Focus was particularly given to those within the first 12 months of their employment as this was where we identified a particular risk. We also further developed our support of line manager recruitment and development, as it is through good management that we are enacting the workforce strategies.

The Director of Human Resources (HR) has addressed these risks from both a strategic and operational perspective. The workforce strategy and workforce plans were refreshed during the year. During the COVID-19 pandemic, there has been specific centralised efforts to fill healthcare support worker vacancies, and to embrace our student nurse population in a more effective way. Apprenticeships were also identified for attention and investment, with a very substantial increase in nursing apprenticeships being supported.

Our comprehensive workforce report is scrutinised at both our bi-monthly Delivery Committee, chaired by a non-executive director, and also at the main Board. This ensures a particularly strong focus on assurance. We ensure that workforce matters are not only addressed by the one report - there are a number of reports which reflect on different aspects, including the Integrated Performance Report which blends clinical measures with workforce measures, the Public Sector Equality Duty, gender pay gap and occupational health management. This demonstrates that workforce is positively embedded throughout our organisation, not just the HR department.

In line with the national "developing workforce safeguards" 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, operations, medical, finance and human resources to develop safer and sustainable staffing initiatives. We are also working increasingly collaboratively with our two Integrated Care Systems (ICS).

We have a wide-ranging approach to tackling an ever-increasing pressure to use agency staff. The approach has been externally audited and found to be robust. We actively manage our internal bank of staff through e-rostering, to maximise their deployment where gaps in staffing occur, or patient issues require a short-term staffing enhancement.

It should be acknowledged that whilst these initiatives have helped to contain further agency use, they have not yet resulted in a sustained reduction in use.

We are developing new roles across our Trust to reduce the reliance on hard-to-recruit roles in challenging geographical situations. We have seen a substantial increase in our take-up of apprenticeships as a core part of our learning and development strategy. Leadership skills development has continued throughout the COVID-19 pandemic with a monthly development forum running for the top 100 leaders, based around the Healthcare Leadership Model. We are also engaged in system-leadership development in preparation for the future.

There is a national and local shortage of mental health 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 Project Management Office (PMO) colleagues to prioritise EIAs to be completed. Additionally, an Impact Assessment Group has been set up where EIA's and Quality Impact Assessments are discussed on key strands of work currently taking place. 2020-21 has seen a very substantial increase in activity in Equality, Diversity and Inclusion, with a wide range of action plans, staff networks and governance structures emerging and embedding into normal business.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months, Managing Conflicts of Interest in the NHS' guidance. Reporting was increased to the Audit and Risk Committee to reflect the increased gifts and donations received by staff during wave 1 of COVID-19.

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, employers' contributions and payments to the scheme are all in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The Trust has undertaken risk assessments and has a sustainable development management plan in place which 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

Due to the impact of COVID-19 on the NHS, the draft operational and financial plans that were being developed in quarter 4 of the previous financial year were put on hold. These were temporarily replaced by an operational and financial framework that mitigated many of the risks that the Trust has been dealing with over the last few years.
This meant that there was no formal Business Plan and Annual Operating Plan that was approved by the Trust Board and submitted to NHS Improvement (NHSI). Instead, the focus was on delivering the core service requirements while responding to the escalating impact of the COVID-19 pandemic. Monitoring of the key priorities established in the draft Annual Operating Plan were continued through the Board and sub-committees where appropriate, however the majority of the operational and financial focus was on dealing with the pandemic impact on Trust services.

In order to maintain financial control and ensure that value for money continued to be achieved, the financial procedures and processes have continued to be applied in line with previous years. Assurance has been provided by the Finance Director and Chief Operating Officer providing detailed monthly financial, activity and performance reports to the Finance and Planning and Delivery Committees. The Finance and Planning Committee has reviewed and challenged

on the delivery of the statutory financial targets including the delivery of the income and expenditure target, capital target, cash target and the better practice payment code in line with the revised national NHS Financial regime. The reports have been made available to the members of the Trust Board, the Trust's external auditors and NHSI. 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. Single tender waivers were reported to audit and risk committee, the number increased in 2020/21 due to purchasing COVID-19 related items, such as Personal Protective Equipment (PPE) for staff.

Financial governance arrangements are reviewed by internal and external auditors 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. These processes will need to be continued and further enhanced going forward into 2021/22.

The rapid introduction of a national COVID-19 financial regime by NHSE/I, in response to the impact on providers has meant that the financial performance of the Trust in 2020/21 has significantly improved. Through this framework funding has been received that has covered the structural deficit of the Trust, along with the shortfall in cost improvement targets not delivered in year resulting in the Trust breaking even. In addition, the additional costs associated with dealing with impact of COVID-19 on the Trust have been fully reimbursed by NHSE/I. Within this position the Trust has continued to experience operational challenges from increased demand, significant levels of vacancies that result in high usage of temporary staffing and underutilisation of some inpatient facilities.

Going forward into the financial year 2021/22, the current financial regime is set to continue for at least six months. This will mean that ongoing operational and financial risks will be mitigated; however it is envisaged that from quarter 3 the NHS will need to start recovering its operational and financial position and be in a place by March 2022 which has recovered the recurrent shortfall in savings for 2020/21 and 2021/22.

The Trust is developing a financial recovery programme in line with this challenge and is working with the two systems of BSW and BNSSG to understand and support the extent of the financial challenge in mental health services. At the time of writing the annual governance statement, there is no formal plan that can be approved by the Board given that national planning guidance was issued in April 2021. In order to support the continuation of the existing financial governance processes, the finance committee on behalf of the Board has approved for current budgets and budget responsibilities to be rolled over to the first quarter of 2021/22. A formal plan for quarter 2 to quarter 4 2021/22 will be submitted to the Board in due course.

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 availability 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 NHSE. It draws together the legal requirements, central guidance set out by NHS policy and best practice and presents them in a single standards process to improve the handling and protection of IT systems and information held by NHS providers.

Due to increased pressure on the NHS due to COVID-19 the reporting period for the 2020/2021 DSP submission has been extended to 30th June 2021 along with a number of changes to the number of assertions and whether they are

mandatory. The Trust is currently on track to achieve compliance with the current standards and no significant issues have been identified.

Information Governance Incidents

In 2020/21 there were 420 information governance incidents reported via the Safeguard system; of those 3 met the criteria to be reported to the Information Commissioner's Office (ICO).

Category and description	No.	Feedback from ICO	Action taken By AWP
Notified that a number of letters have sent to a GP surgery address which moved at least 2 years ago. A total of 31 letters between 30/08/18 – 02/09/20 in relation to 13 patients.	21221	No Further Action	An internal incident form was raised as per procedure. The surgery has been removed from AWP database and all patients have been reassigned to the correct GP surgery address
Member of staff searched her Ex-husbands RiO record - this was discovered after an IG same name audit.	22014	No Further Action	An investigation was held into this incident. The member of staff went through a disciplinary with the trust. There are strict measures in place for auditing systems for inappropriate access to records
Associate Director informed IG that a member of staff emailed the CCG and other external bodies' personal identifiable information pertaining to 86 service users (prisoner's service) in relation to COVID-19 outbreak. All email were NHS bodies or CCGS.	23266	Not required to report	No further action taken. Reminder to check recipients before sending emails

Table 22 - Information governance incidents

Records of Processing Activities

To further enhance the control, visibility and to ensure we are following the obligations set out by the General Data Protection Regulation, we have imbedded a new Records of Processing Activities (ROPA).

This internal record contains the information of all personal data processing activities carried out by the Trust. The ROPAs main purpose is intended as an accountability measure for the Trust to show compliance with data protection laws.

The Information Governance (IG) team are extremely proud of work undertaken with the ROPA due to the large scale of data held by the Trust, but also the organising of obtaining and recording all the data accurately and correctly within one document.

FOI / SARS

Over the last year the Trust has reviewed and improved its approach to Subject Access and Freedom of Information requests.

Specialist Freedom of Information training has been undertaken by the corporate governance team and new processes were put in place for the HR team to process and handle subject access requests (SAR) from staff members. Previously the processes were not streamlined or documented appropriately, but with the correct processes and policies in place, the SAR process is now imbedded and compliant.

Information Flow Mapping

The IG Team have moved to a new process and have implemented a Records of Processing Activities (ROPA) under Article 30 of the General Data Protection Regulation (GDPR). This replaces the previous Information Flow Mapping system.

This is a far more robust process whereby it is broken down by operational area, compared to departments. We have

identified 21 operational areas and 19 have currently been reviewed and approved. The ROPA is a working document which will continue to be reviewed and updated.

Annual Quality Accounts

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.

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 Delivery 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 receives the Board Assurance Framework (BAF) and risk register and reviews the significant risks and mitigations. Each committee regularly reviews the BAF and corporate risks assigned to that Committee. Chairs of the Board subcommittees 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 recommendations via the use of a tracker system.
The Trust had a clinical audit programme in place for 2020/21 which is agreed by the Quality and Standards Committee, prior to presentation to the Internal Audit 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 focused 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. Three internal audit reports in 2020/21 gave a reasonable assurance opinion (workforce management /payments to staff, investigations into service user deaths, bed management), one was granted substantial assurance (financial governance), three reports were granted partial assurance (financial performance management, programme prioritisation and establishment controls).

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 in 2018. Detailed action plans were put in place to manage the identified risks and improve the issues relating to these areas and significant progress was made.

The issues were:

- Governance weaknesses relating to quality governance structures, risk, safeguarding, health and safety and serious incident management reporting. A revised quality governance structure was put in place based on the Care Quality Commission domains.
- A lack of Quality Improvement capability was identified in the internal Well-Led assessment undertaken in 2017. A comprehensive programme was introduced with 62 QI projects delivered in 2019/20. This work was delayed in 2020/21, however will be prioritised in 2021/22
- The Trust participated in a quality investigation in 2019, due to the issues noted above. The Trust has met all of the information requests from NHSI and quality oversight is now part of the usual oversight process

In 2020/21 the following weaknesses were identified or continue:

- The Trust agreed enforcement undertakings with NHSI in 2017. Although significant progress has been made regarding financial and quality governance, these remain in place.

The Board, via subcommittees, is monitoring the progress of all of the above weaknesses in internal control systems. I have received further assurance from the CQC with an improved rating for two out of three services and all services being rated as well-led.

Board turnover

During 2020/21 there have been a number of changes to the Board. In 2020 a new Non-Executive Director, Paul Olomolaiye was appointed, along with two additional Associate Non-executive Directors, Sam Budd and Jan Baptiste-Grant. A board development programme was established in 2020/21 to ensure Board members have a clear understanding of operational, financial and quality improvement areas which are aligned to the Trust strategy. The development programme included work with Integrated Care Systems and work to further develop the corporate strategy.

Conclusion

No significant control issues have been identified.

Signed

Chief Executive
11 June 2021

Remuneration report

Remuneration and staff report

The following tables provide a breakdown of the workforce including senior managers by grade (band8d and above), the numbers and costs of staff by whole-time equivalent (wte) rather than head count.

Senior managers by grade (at 31 March 2020)	
Pay grade	**Number**
Band 8d	22
Band 9	1
Clinical Director (not on AfC)	1
Director	7
Total	31

Table 23 - Senior managers by grade as of 31 March 2021

Number and cost of staff employed by staff group	Permanent £000	Other £000	2020/21 Total £000	2019/20 Total £000
Salaries and wages	158,391	3,097	**161,488**	141,948
Social security costs	14,172	-	**14,172**	12,502
Apprenticeship levy	774	-	**774**	681
Employer's contributions to NHS pension scheme	27,881	-	**27,881**	25,041
Pension cost - other	80	-	**80**	38
Termination benefits	87	-	**87**	-
Temporary staff	-	22,318	**22,318**	16,757
Total gross staff costs	**201,385**	**25,415**	**226,800**	**196,967**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**201,385**	**25,415**	**226,800**	**196,967**
Of which				
Costs capitalised as part of assets	-	-	**-**	89

Table 24 - Number and cost of staff employed by staff group

Average number of employees (WTE basis)	Permanent Number	Other Number	2020/21 Total Number	2019/20 Total Number
Medical and dental	278	24	**302**	303
Ambulance staff	-	-	**-**	-
Administration and estates	381	7	**388**	377
Healthcare assistants and other support staff	1,603	135	**1,738**	1,523
Nursing, midwifery and health visiting staff	1,261	118	**1,379**	1,305
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	633	1	**634**	573
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	173	-	**173**	170
Total average numbers	**4,329**	**285**	**4,614**	**4,251**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	**-**	3

Table 25 - Average number of employees (wte)

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 2020, 75% of our workforce was female.
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 2020, the mean hourly rate of pay is £16.57 for females, compared to £19.38 for males. This is a 14.49% pay gap in favour of males, which is a very slight increase from the previous reporting year.
The median hourly rate of pay is £15.40 for females compared to £16.63 for males. There is a 7.42% pay gap in favour of males. The percentage gap for the median hourly rate is at its narrowest since the previous three reporting years.
In relation to pay quartiles, the proportion of males increases from 21.30% in the lower pay quartile towards 33.82% in the upper pay quartile. In contrast, the proportion of females decreases from 78.70% in the lower pay quartile to 66.18% in the upper pay quartile.

The only significant change is in the upper middle pay quartile where the percentages for males has lowered by 2% from 25.63% in 2019 to 23.91% in 2020. In comparison, the percentages for females in the same pay quartile has increased by nearly 2% from 74.36% in 2019 to the 76.09% in 2020.

In the Trust, the pay that is classified as 'bonus' is through the Department of Health's Clinical Excellence Awards (CEA's) scheme for Consultants only.

The mean bonus pay gap is 57.57% in favour of males. This is nearly 27% higher than in the previous reporting year and it's the highest percentage since the gender pay gap reporting started in 2017.

The median bonus pay gap is 52.72% in favour of males which is a decrease of just over 12% from the previous reporting year.

The proportion of males and females receiving a CEA bonus as a percentage of their overall representation in the workforce are at their lowest since the previous three reporting years.

It is important to note the refreshed 'Local Clinical Excellence Awards Guidance 2018 -21 in England'. This states that awards granted before 1 April 2018 (known as 'Existing LCEAs) will continue to be paid monthly (included in monthly salaries) until a review in 2022. However 'New LCEAs', which are awards granted between 2018 and 2021 and which will be awards for one year only, will be paid in a lump sum on the 1st April until a review in 2022.

These arrangements will factor in the Gender Pay Gap reporting. Existing CEA's will feature in the reporting snap-shot date of 31st March until 2022 (as the annual award amount is paid monthly), but the New CEA's paid on 1st April will not feature in the reporting (as these are a lump sum payments).

Looking only at Agenda for Change average hourly rate of base wage, there is a pay gap of 6.6% in favour of men, which is slightly lower than the previous reporting year.

The gap in Executive / VSM pay has shifted from 10.42% in favour of females in the last reporting year, to 15.09% in favour of males for this reporting year.

Overall, both our mean and median hourly pay gap percentages are significantly affected by medical staffing high base wage pay structures which are nationally defined.

The Trust's 2020 Gender Pay Gap report can be read in full on the Trust's website at: Gender Pay Gap.

Equality and Diversity

AWP is positive about employing disabled people and maintaining the standards set by the Disability Confident scheme (formally known as the Two Ticks scheme). This means that all applicants who declare a disability and who meet the minimum criteria for the job will be invited for interview. All shortlisted applicants are asked whether they require any particular arrangements to be made in the selection process to enable ease of participation; for instance in the case of disability. We provide reasonable adjustments in the workplace to enable continuation of employment where ever possible. There is guidance for managers and staff to support the implementation of reasonable adjustments and additional support can also be given to employees by our HR colleagues, the Trust's EDI Lead and through our Staff Disability Network. Wherever possible, if redeployment from one post to another occurs, relevant training can be provided. We provide equality of opportunity for all staff in training and career development. Our 2020 staff survey data in relation to the question of equality opportunity and fairness in career development, of all the disabled staff respondents (457), 49% (224) said that the Trust provides fairness and equal opportunities. This is a 2% increase from the 2019 staff survey.

Our existing Workforce Diversity and Equal Opportunity Policy is currently being refreshed so that it reflects our reinvigorated commitments to diversity and inclusion, instigated through establishing a more robust Equality Governance Framework. There is a specific EDI plan as explicitly referenced in AWP's Workforce Strategy which includes actions strengthening the diversity of our workforce, and taking actions to remove barriers to inclusion and equality. The diverse composition of our workforce is highlighted in our Public Sector Equality Duty Annual Equality Data Report which is published. The Workforce Race Equality and Disability Equality Standards respectively provide outcomes to key metrics which help us to identify barriers to inclusion and, in consultation with the Trust's EDI Group, take action to address these.

More information on our EDI initiatives are included in the Annual Report on page 29.

Sickness and attendance

Our average rate of sickness absence over the last 12 months was 4.55% which is slightly lower than 2019/20 (4.91%). We continue to work to develop managers to be able to support staff to return to work as quickly as possible, and to better understand the drivers of sickness absence including the impact of COVID-19.

Staff Turnover

Our staff turnover for 2020/21 was 13.07% (16.9% in 2019/20). This has been calculated using Full Time Equivalent (FTE) as per the NHSI definition "Defined as total WTE leavers in the previous 12 month period as a proportion of WTE staff in post for the same period."

Trade Union Facility Time (information not subject to audit)

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 duringthe relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employeenumber
21	17.52

Table 26 - Relevant Union Officials

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%	20
50 – 99%	1
100%	0

Table 27 – Percentage of time spent on facility time

ii) 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	£59,891
Total pay bill	£226,800,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x100	0.26%

Table 28 - Percentage of pay bill spent on facility time

iii) 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	10.97%

Table 29 - Paid trade union activities

Staffing policies

Engagement and Partnership Working

Our 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 directorate provides support and advice on informal and formal concerns relating to employment matters to staff and managers.

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 and staff initially through weekly on-line briefings during the height of the pandemic and now fortnightly on-line briefings. We also supported the creation of a full time Chair role for the Joint Union Council, to further enhance employee relations and engagement.

Managers across the organisation are welcome to participate in online policy development workshops which are held regularly. Policies 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 and ACAS good practice guidelines.

The Trust has recently updated its secondment policy to support career development opportunities for staff. It also reduces the risk of critical roles being unfilled for extended periods of time.
The Trust pays staff in line with nationally agreed Terms and Conditions, and makes use of temporary recruitment and retention premia where appropriate to attract and retain staff.

Exit packages and severance payments (information subject to audit)

The Trust did not pay any exit packages to its directors during the 2020/21 financial year.
Exit packages for all other Trust staff can be found in the table below. Exit packages for all other Trust staff were 2 in 2020/21 (zero in 2019/20).

Reporting of compensation schemes - exit packages 2020/21	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,000 - £25,000	1	-	**1**
£25,001 - £50,000	-	-	**-**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**2**	**-**	**2**
Total cost (£)	£87,000	£0	**£87,000**

Table 30 - Compensation schemes – exit packages 2020/21

Nomination 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.
Directors' salaries (excluding Non-Executive Directors) are determined by the Trust's Nomination and 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 NHSI 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 by NHSI.
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.

Expenses paid to Directors from 1 April 2020 to 31 March 2021		
Directors	**2020 to 21**	**2019 to 20**
Number of paid Directors in office	18	20
Number of Directors receiving expenses	7	14
Total sum of expenses paid to Directors	**18,378**	**28,375**

Table 31 - Directors' expenses

Pay multiples (information subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. 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 was £175k - £180k (2019/20 £145k to £150k). This was 6.6 times (2019/20 5.2 times) the median remuneration of the workforce, which was £27,060 (2019/20 £28,276).

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.

External Auditor's remuneration

The remuneration paid to the External Auditor in respect of the audit of the accounts for 2020/21 was £59,400 inclusive of VAT. In addition, there was a fee of £3,120 to provide an opinion on the charitable funds accounts.

Expenditure on consultancy

The Trust spent £395,740 on consultancy in 2020/21 compared to £485,400 in 2019/20 In 2019.
The Trust engaged a Quality Advisor to the Board to help with the preparation for the CQC and the COVID-19 response.
The Trust also engaged consultants to support Digital Projects.

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 2020, for more than £220 per day and that last longer than six months	
Number of existing engagements as of 31 March 2021	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

Table 32 - Off-payroll engagements as of March 2021

For all new off-payroll engagements between 1 April 2019 and 31 March 2020, 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 2020 and 31 March 2021	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

Table 33 - New off-payroll engagements between 1 April 2020-31 March 2021

Off-payroll engagements of board members with significant financial responsibility between 1 April 2020 and 31 March 2021

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

Table 34 - Off-payroll engagement of board members

Remuneration and pension benefits of Senior Managers (Information subject to audit)

SALARIES AND ALLOWANCES	2020-21						2019-20					
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
Executive Directors												
Dominic Hardisty - Chief Executive	170-175	39	0-5	0-5	92.5-95	230-235	115-120	24	0-5	0-5	87.5-90	205-210
Mathew Page - Chief Operating Officer	135-140	36	0-5	0-5	97.5-100	235-240	115-120	36	0-5	0-5	55-60	180-185
Simon Truelove - Director of Finance	140-145	36	0-5	0-5	27.5-30	170-175	135-140	36	0-5	0-5	75-77.5	215-220
Rachel Clark - Director of Strategy	100-105	36	0-5	0-5	35-37.5	135-140	95-100	36	0-5	0-5	32.5-35	130-135
Julian Peasby - Director of Human Resources	110-115	-	0-5	0-5	27.5-30	135-140	105-110	-	0-5	0-5	25-27.5	130-135
Sarah Knight - Company Secretary	70-75	-	0-5	0-5	20-22.5	90-95	70-75	-	0-5	0-5	15-17.5	85-90
Julie Kerry - Director of Nursing	125-130	36	0-5	0-5	45-47.5	175-180	120-125	36	0-5	0-5	182.5-105	225-230
Sarah Constantine - Medical Director	155-160	-	0-5	0-5	287.5-290	445-450	145-150	-	0-5	0-5	0-2.5	135-140
Hayley Richards - Chief Executive	-	-	-	-	-	-	30-35	9	0-5	0-5	-	30-35
Peter Wood - Acting Medical Director	-	-	-	-	-	-	5-10	-	0-5	0-5	95-97.5	100-105
Peter Tilley - Acting Director of Finance	-	-	-	-	-	-	15-20	-	0-5	0-5	0-2.5	0-5
Non Executive Directors												
Charlotte Hitchings	30-35	-	0-5	0-5	0-2.5	30-35	30-35	-	0-5	0-5	0-2.5	35-40
Malcom Shepherd	-	-	-	-	-	-	5-10	-	0-5	0-5	0-2.5	5-10
Paul Olomolaiye	10-15	-	-	-	-	10-15	-	-	-	-	-	-
Ernest Messer	10-15	-	0-5	0-5	0-2.5	10-15	5-10	-	0-5	0-5	0-2.5	5-10
Brian Stables	10-15	-	0-5	0-5	0-2.5	10-15	5-10	-	0-5	0-5	0-2.5	5-10
Mark Outhwaite	10-15	-	0-5	0-5	0-2.5	10-15	5-10	-	0-5	0-5	0-2.5	5-10
Marie-Noelle Orzel	5-10	-	0-5	0-5	0-2.5	5-10	5-10	-	0-5	0-5	0-2.5	5-10
Neil Auty	10-15	-	0-5	0-5	0-2.5	10-15	5-10	-	0-5	0-5	0-2.5	5-10
Shelley Whitehead (until 30/11/2020)	5-10	-	0-5	0-5	0-2.5	5-10	5-10	-	0-5	0-5	0-2.5	5-10
Jan Baptiste-Grant	5-10	-	0-5	0-5	0-2.5	5-10	-	-	-	-	-	-
Samantha Budd	5-10	-	0-5	0-5	0-2.5	5-10	-	-	-	-	-	-

Notes:
1. The expense payments which are taxable relate to individual car allowances

All of the above Directors were in post for the 12-month period to 31 March 2021 except where indicated.
No annual performance or long-term performance related bonuses were paid during the period.
Salary amounts include all salary paid and payable to the Directors by the Trust; this may include payments in arrears made during the year.

Band of Highest Paid Directors Total Annualised Remuneration (£'000)	170-175	145-150
Median Total Remuneration	27,060	28,276
Ratio	6.6	5.2

Table 35 - Salaries and allowances of Senior Managers

Pension Benefits

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 2021 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2021 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2020 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Employers Contribution to Stakeholder Pension £000
Dominic Hardisty - Chief Executive	2.5-5	0-2.5	25-30	0	336	63	405	-
Rachel Clark - Director of Strategy	0-2.5	0-2.5	30-35	55-60	471	43	522	-
Sarah Constantine - Medical Director	12.5-15	32.5-35	70-75	195-200	1,122	295	1,436	-
Julian Feasby - Director of Human Resources	0-2.5	0	5-10	0	66	27	95	-
Sarah Knight - Company Secretary	0-2.5	0-2.5	20-25	45-50	386	29	422	-
Simon Truelove - Director of Finance	0-2.5	0	45-50	90-95	770	48	831	-
Julie Kerry - Director of Nursing	2.5-5	0-2.5	40-45	90-95	735	62	810	-
Mathew Page - Chief Operating Officer	5-7.5	7.5-10	35-40	80-85	502	90	600	-

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 benefits 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.

Following the government's announcement that all public sector pension schemes will be required to provide the same indexation on the Guaranteed Minimum Pension (GMP) as on the remainder of the pension, the NHSPS has revised its method to calculate the CETV values. The real increase in CETV will therefore be impacted as it will include any increase in CETV due to the change in GMP methodology. 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.

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

Table 36 - Pension benefits of Senior Managers

Accountability Report Declaration

Dominic Hardisty, Chief Executive

11 June 2021

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.*

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 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, other items of comprehensive income and cash flows for the year

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 entity's auditors are aware of that information.

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

Signed

Chief Executive
11 June 2021

Statement of directors' responsibilities in respect of the accounts

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

- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- Make judgements and estimates which are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern

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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

Date: 11 June 2021

Chief Executive

Date: 11 June 2021

Director of Finance

Certificate on summarisation schedules

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

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2020/21 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
4.

Date: 11 June 2021

Director of Finance

Chief Executive Certificate

1. I acknowledge the accompanying 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.

Date: 11 June 2021

Chief Executive

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 2021 and of its expenditure and income for the year then ended; and
- 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 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 on page 84;
- the table of pension benefits of senior managers and related narrative notes on page 85;
- the table of exit packages [and related narrative notes] on page 80.

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 Code of Audit Practice, 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 (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

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

The going concern basis of accounting for the trust is adopted in consideration of the requirements set out in the Accounts Direction, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information
The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report. 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.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of 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 this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

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 they have been informed by the relevant national body of the intention to dissolve the trust without the transfer of the trust's services to another public sector entity.

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 FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

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

We considered the nature of the trust and its control environment, and reviewed the trust's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit and the Audit & Risk Committee about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team, including real estate and information technology specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following area, and our specific procedures performed to address this are described below:

- Accruals recorded as at 31 March 2021 are subject to potential management bias: we tested a sample of accruals to supporting documentation to assess whether the liability had been incurred as at 31 March 2021.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, reviewing internal audit reports and reviewing correspondence with HMRC and the licensing authority.

Report on other legal and regulatory requirements

Opinions on other matters:
In our opinion:

- the parts of the Remuneration Report subject to audit have been prepared properly in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources
Under the Code of Audit Practice and the Act, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

On 9 June 2021 we reported to the trust significant weaknesses in the trust's arrangements, which were:

- *Weaknesses in the trust's governance arrangements in how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements*, reflected in the findings of the trust's most recent external Well-led review, the CQC inspection report of May 2020, and NHSI's formal enforcement actions which remain in place. Actions by the trust to address the key matters in all these areas remain ongoing. We recommended that the trust continue to progress its action plans in these outstanding areas.

- *Weaknesses in the trust's arrangements to secure financial sustainability in how the body plans to bridge its funding gaps and identifies achievable savings*. On 3 September 2020 we made a referral to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014, which stated that we had reason to believe that the trust had taken a course of action that, if followed to its conclusion, had led to a breach of the trust's break even duty for the three year rolling period ended 31 March 2020, and that this would not be resolved during the period ending 31 March 2021. In 2020/21 the trust broke even on an "in- year" basis. The trust remains in a cumulative deficit position and hence in breach of its legal duty to breakeven on a cumulative basis. We recommended that the trust focus upon the identification and delivery of cost improvements in order to develop a balanced plan.

These weaknesses have not yet been addressed.

Our work in respect of the trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

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 the Code of Audit Practice and section 21(3)(c), as amended by schedule 13 paragraph 10(a) of the 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 undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in April 2021, as to whether the trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021 by the time of the issue of our audit report. Other findings from our work, including our commentary on the trust's arrangements, willbe reported in our separate Auditor's Annual Report.

Governance statement and reports in the public interest or to the regulator

We are also required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS Trust Development Authority (NHS Improvement);

- we refer a matter to the Secretary of State under section 30 of the Act because 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; 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.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report). We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

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. 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.

Paul Thomas DPhil, MChem, ACA (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Reading, United Kingdom

11 June 2021

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2021 issued on 11 June 2021 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the financial position of the trust as at 31 March 2021 and of its expenditure and income for the year then ended; and
- had 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').

Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources
As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2021 on 11 June 2021, we had not completed our work on the trust's arrangements.

In our audit report for the year ended 31 March 2021 issued on 11 June 2021, we reported significant weaknesses in the trust's governance arrangements and arrangements to secure financial sustainability.

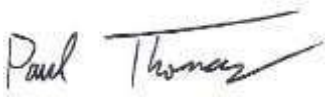
Certificate of completion of the audit
In our audit report for the year ended 31 March 2021 issued on 11 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources and the work necessary to issue our statement on consolidation schedules. We have now completed our work in these areas.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion or our exception reporting on the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

On 9 June 2021 we reported to the trust significant weaknesses in the trust's arrangements to secure financial sustainability and governance arrangements. The significant weaknesses reported were:

- Weaknesses in the trust's governance arrangements in how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements, reflected in the findings of the trust's most recent external Well-led review, the Care Quality Commission (CQC) inspection report of May 2020, and NHS Improvement's formal enforcement actions which remain in place. Actions by the trust to address the key matters in all these areas remain ongoing. We recommended that the trust continue to progress its action plans in these outstanding areas.
- Weaknesses in the trust's arrangements to secure financial sustainability in how the body plans to bridge its funding gaps and identifies achievable savings. On 3 September 2020 we made a referral to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014, which stated that we had reason to believe that the trust had taken a course of action that, if followed to its conclusion, had led to a breach of the trust's break even duty for the three year rolling period ended 31 March 2020, and that this would not be resolved during the period ending 31 March 2021. In 2020/21 the trust broke even on an "in- year" basis. The trust remains in a cumulative deficit position and hence in breach of its legal duty to breakeven on a cumulative basis. We recommended that the trust focus upon the identification and delivery of cost improvements in order to develop a balanced plan.

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



Paul Thomas DPhil, MChem, ACA (Key Audit Partner) For and on behalf of Deloitte LLP
Appointed Auditor Reading, United Kingdom
3 September 2021

Avon and Wiltshire Mental Health Partnership NHS Trust

Annual accounts for the year ended 31 March 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	287,048	245,147
Other operating income	4	35,248	12,456
Operating expenses	6, 8	(320,294)	(258,211)
Operating surplus/(deficit) from continuing operations		**2,002**	**(608)**
Finance income	11	-	96
Finance expenses	12	(6,664)	(7,106)
PDC dividends payable		(1,935)	(1,584)
Net finance costs		**(8,599)**	**(8,594)**
Deficit for the year from continuing operations		**(6,597)**	**(9,202)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	2,237	14,951
Other comprehensive income		**2,237**	**14,951**
Total comprehensive (expense) / income for the period		**(4,360)**	**5,749**

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

Statement of Financial Position as at 31 March 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	13	516	722
Property, plant and equipment	14	132,753	128,515
Receivables	16	39	33
Total non-current assets		**133,308**	**129,270**
Current assets			
Inventories	15	361	231
Receivables	16	15,786	13,938
Cash and cash equivalents	17	17,086	3,549
Total current assets		**33,233**	**17,718**
Current liabilities			
Trade and other payables	18	(32,231)	(20,253)
Borrowings	20	(1,189)	(24,295)
Provisions	21	(3,744)	(683)
Other liabilities	19	-	(55)
Total current liabilities		**(37,164)**	**(45,286)**
Total assets less current liabilities		**129,377**	**101,702**
Non-current liabilities			
Borrowings	20	(37,589)	(38,778)
Provisions	21	(1,437)	(1,391)
Total non-current liabilities		**(39,026)**	**(40,169)**
Total assets employed		**90,351**	**61,533**
Financed by			
Public dividend capital		138,419	105,241
Revaluation reserve		29,107	27,647
Income and expenditure reserve		(77,175)	(71,355)
Total taxpayers' equity		**90,351**	**61,533**

The notes on the following pages form part of these accounts.

Name : Dominic Hardisty 

Position Chief Executive

Date 11 June 2021

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**105,241**	**27,647**	**(71,355)**	**61,533**
Deficit for the year	-	-	(6,597)	**(6,597)**
Other transfers between reserves	-	(777)	777	**-**
Revaluations	-	2,237	-	**2,237**
Public dividend capital received	33,178	-	-	**33,178**
Taxpayers' and others' equity at 31 March 2021	**138,419**	**29,107**	**(77,175)**	**90,351**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**101,499**	**13,235**	**(62,692)**	**52,042**
Deficit for the year	-	-	(9,202)	**(9,202)**
Other transfers between reserves	-	(539)	539	**-**
Revaluations	-	14,951	-	**14,951**
Public dividend capital received	3,742	-	-	**3,742**
Taxpayers' and others' equity at 31 March 2020	**105,241**	**27,647**	**(71,355)**	**61,533**

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	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		2,002	(608)
Non-cash income and expense:			
Depreciation and amortisation	6	6,110	5,655
Net impairments	7	11,331	1,963
Income recognised in respect of capital donations	4	(4,538)	-
(Increase) / decrease in receivables and other assets		(1,299)	(880)
(Increase) / decrease in inventories		(130)	58
Increase in payables and other liabilities		7,495	2,337
Increase / (decrease) in provisions		3,115	(41)
Other movements in operating cash flows		(5)	-
Net cash flows from / (used in) operating activities		**24,081**	**8,484**
Cash flows from investing activities			
Interest received		-	96
Purchase of PPE and investment property		(15,132)	(7,049)
Receipt of cash grants to purchase assets		4,538	-
Net cash flows from / (used in) investing activities		**(10,594)**	**(6,953)**
Cash flows from financing activities			
Public dividend capital received		33,178	3,742
Movement on loans from DHSC		(23,398)	4,350
Capital element of PFI and other service concession payments		(867)	(1,130)
Interest on loans		(30)	(532)
Other interest		-	(2)
Interest paid on PFI and other service concession obligations		(6,672)	(6,534)
PDC dividend paid		(2,161)	(1,448)
Net cash flows from / (used in) financing activities		**50**	**(1,554)**
Increase / (decrease) in cash and cash equivalents		**13,537**	**(23)**
Cash and cash equivalents at 1 April - brought forward		**3,549**	**3,572**
Cash and cash equivalents at 1 April - restated		**3,549**	**3,572**
Cash and cash equivalents at 31 March	17	**17,086**	**3,549**

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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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 reported a net surplus of £0.007m after technical adjustments (adjusted from a deficit of £6.6m when including impairments, grant income and DHSC stock) during the year ended 31 March 2021 and, at that date had net current liabilities of £3.9m. The significant movement in this figure is due to the conversion of all interim loans during 2020/21 to Public Dividend Capital, which equated to £23.4m.

The Trust is assuming additional cash support of £10.0m in 2021/22 to maintain its current payment performance and assumes that the Trust delivers its savings plan. If the Trust fails to deliver in full the savings plan in 2021/22 then a further cash loan will be required. The future requirement will also be dependent on the financial guidance for the second half of the financial year.

With the unprecedented measures in place due to Covid, funding arrangements for 2021/22 may continue to change, with the Trust closely monitoring all interim funding arrangements, and any resulting amendments to the cash loan requirements within the year.

As directed by the 2020/21 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 in September 2020 the auditor 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 2021. 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.

The Trust does not consider itself to be financially exposed due the additional costs from the Covid outbreak as all material costs are being funded directly as part of the ongoing pandemic funding arrangements.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

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.

Note 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from Commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship levy income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Note 1.6 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 1.7 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:
• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has 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 lives.

Subsequent expenditure

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

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (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 as a minimum, and last completed in January 2021) to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

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

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

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

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

Depreciation

Items of property, plant and equipment are depreciated on a straight-line basis 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 are not depreciated until the asset is brought into use.

Revaluation gains and losses

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

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

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

Impairments

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

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.
Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated and grant funded assets

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

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

Private Finance Initiative (PFI) transactions

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

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

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

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	14	54
Plant & machinery	1	15
Transport equipment	1	10
Information technology	1	10
Furniture & fittings	1	7

Note 1.9 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, 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.

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 where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

Intangible assets are amortised over their expected useful lives on a straight line basis.

Useful lives of intangible assets

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

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

Note 1.10 Inventories

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

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

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS. This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

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

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

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.

Derecognition

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

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

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee

Finance leases
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.

The Trust as a lessor

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

Note 1.14 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 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates published and mandated by HM Treasury.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 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 1.16 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 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.
The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

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

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

Note 1.18 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 1.19 Third party assets

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

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.
The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

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

Note 1.22 Early adoption of standards, amendments and interpretations

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

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

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

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% for leases commencing in 2021 (leases commencing in 2020 have a rate of 1.27%) but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	14,132
Additional lease obligations recognised for existing operating leases	(14,132)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(1,618)
Additional finance costs on lease liabilities	(179)
Lease rentals no longer charged to operating expenditure	1,720
Estimated impact on surplus / deficit in 2022/23	**(77)**
Estimated increase in capital additions for lease assets in 2022/23	**330**

Note 1.24 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:

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 January 2021 in line with other Trust buildings.

Note 1.25 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 desktop valuation from the District Valuer as at 1 January 2021.

The carrying amount of the Trust land and building assets at 31 March 2021 is £115.4m.

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 £10.8m at 31 March 2021. Intangible assets have a carrying value of £0.5m and Assets Under Construction have a carrying value of £6.6m.

Note 1.26 Financial risk management

Interest rate risk

All of the Trust's financial liabilities carry a nil or fixed rate of interest, though these reduced to nil balances in year with the conversion of all loans to PDC.

Foreign currency risk

The Trust has negligible foreign currency expenditure - nil in year

Credit risk

The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations. This means that there is little risk that one party will fail to discharge its obligation with the other.

Note 2 Operating Segments

The Trust Board receives regular reports on the financial position of the Trust, which are 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 £276.7m, 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 £194.8m. This excludes direct income from NHS England which is £48.7m

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

Note 3.1 Income from patient care activities (by nature)	2020/21	2019/20
	£000	£000
Mental health services		
Block contract / system envelope income*	242,548	187,642
Other clinical income from mandatory services	34,133	49,470
All services		
Additional pension contribution central funding**	8,478	7,607
Other clinical income***	1,889	428
Total income from activities	**287,048**	**245,147**

*As part of the Covid pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

*** Other clinical income includes funding for the Trust annual leave accrual of £1,656k

Note 3.2 Income from patient care activities (by source)

	2020/21	2019/20
Income from patient care activities received from:	**£000**	**£000**
NHS England*	58,137	46,175
Clinical commissioning groups	194,778	173,272
Other NHS providers	13,252	2,416
NHS other	25	24
Local authorities	3,280	5,380
Non NHS: other	17,576	17,880
Total income from activities	**287,048**	**245,147**
Of which:		
Related to continuing operations	287,048	245,147
Related to discontinued operations	-	-

* Note that of the £58,137k of income from NHS England in 2020/21, £8,478k of this relates to a notional income amount that is related to a 6.3% increase in employer's pension that was funded at a national level (2019/20 £7,607k). There is a notional equal expenditure entry also noted within the accounts.

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,225	-	**1,225**	1,438	-	**1,438**
Education and training	8,037	456	**8,493**	6,840	280	**7,120**
Non-patient care services to other bodies	29		**29**	-		**-**
Provider sustainability fund (2019/20 only)			**-**	655		**655**
Financial recovery fund (2019/20 only)			**-**	1,105		**1,105**
Reimbursement and top up funding*	16,033		**16,033**			**-**
Income in respect of employee benefits accounted on a gross basis	85		**85**	233		**233**
Receipt of capital grants**		4,538	**4,538**		-	**-**
Donated inventories and equipment below capitalisation threshold - Covid response***		3,290	**3,290**		-	**-**
Rental revenue from operating leases		617	**617**		683	**683**
Other income	938	-	**938**	1,222	-	**1,222**
Total other operating income	**26,347**	**8,901**	**35,248**	**11,493**	**963**	**12,456**
Of which:						
Related to continuing operations			35,248			12,456
Related to discontinued operations			-			-

*As part of the Covid pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. As part of this funding regime, top up funding was provided of £16,033k.

** The Trust received £4,538k of Salix grant funding to enable an accelerated programme of decarbonisation works including LED lighting, heat pumps and solar panels

*** The Trust received personal protective equipment from national distributions of £3,287k with notional income and expenditure being shown in the accounts. In addition, £3k of equipment was also received as part of the national response to the pandemic.

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	-	97

Note 6 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,265	2,279
Purchase of healthcare from non-NHS and non-DHSC bodies***	25,393	15,896
Staff and executive directors costs*	226,713	196,878
Remuneration of non-executive directors	133	95
Supplies and services - clinical (excluding drugs costs)**	5,812	1,848
Supplies and services - general	5,151	4,458
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	5,307	4,334
Inventories written down	71	-
Consultancy costs	396	485
Establishment	1,383	2,070
Premises****	13,401	10,314
Transport (including patient travel)	4,346	4,036
Depreciation on property, plant and equipment	5,904	5,412
Amortisation on intangible assets	206	243
Net impairments*****	11,331	1,963
Increase/(decrease) in other provisions******	3,280	91
Change in provisions discount rate(s)	47	31
Audit fees payable to the external auditor		
audit services- statutory audit	59	52
other auditor remuneration (external auditor only)	-	4
Internal audit costs	107	66
Clinical negligence	1,037	741
Legal fees	532	472
Insurance	415	320
Research and development	423	435
Education and training	1,675	1,071
Rentals under operating leases	2,082	1,903
Redundancy	87	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (PFI)	1,359	1,329
Car parking & security	584	534
Hospitality	22	28
Losses, ex gratia & special payments	10	34
Other services, eg external payroll	334	262
Other	429	527
Total	**320,294**	**258,211**
Of which:		
Related to continuing operations	320,294	258,211
Related to discontinued operations	-	-

* Note that of the £226,800k of expenditure on staff costs in 2020/21, £8,478k of this relates to a notional income amount that is related to a 6.3% increase in employer's pension that was funded at a national level (2019/20 £7,607k). In addition, the Trust had new contracts in year for North Somerset CAMHS and Prisons direct services. There is a notional equal income entry also noted within the accounts

** In response to the Covid pandemic, the Trust was provided with £3,287k of national personal protective equipment - a notional income and expenditure amount has been included in the accounts

*** The increase in healthcare purchase from non-NHS bodies is largely driven by the Inspired Better Health contract of £7,221k

**** Premises costs have increased significantly due to the increase in data charges and other new ways of working in response to the Covid pandemic

***** The in year impairment rise is due to the large scale PDC funded capital schemes related to building works where the District Valuer has reviewed overall asset values as part of the desktop exercise including any large scale programmes

******The Trust has made a provision for a probable payment to HMRC in relation to a revised partial exemption calculation, £3,032k

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

Note 6.1 Other auditor remuneration

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit of the Trust Quality Account	-	4
Total	**-**	**4**

Note 6.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2020/21 or 2019/20.

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	1,884	(1,362)
Other	9,447	3,325
Total net impairments charged to operating surplus / deficit	**11,331**	**1,963**
Impairments charged to the revaluation reserve	(2,237)	(14,951)
Total net impairments	**9,094**	**(12,988)**

Of the impairments and reversals shown above for 2020/21, the changes in market price (charged to the operating deficit) and impairment reversals charged to the revaluation reserve are related to the District Valuers revaluation exercise that was undertaken on 1 January 2021. This gave a net gain on revaluation of £353k

The other impairments shown in the table above for 2020/21 are related to large scale PDC funded schemes that were capital in nature though not adding significant 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

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	161,488	141,948
Social security costs	14,172	12,502
Apprenticeship levy	774	681
Employer's contributions to NHS pensions	27,881	25,041
Pension cost - other	80	38
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	87	-
Temporary staff (including agency)	22,318	16,757
Total gross staff costs	**226,800**	**196,967**
Recoveries in respect of seconded staff	-	-
Total staff costs	**226,800**	**196,967**
Of which		
Costs capitalised as part of assets	-	89

Salaries and wages have increased significantly in year due to the Trust taking on the prison service contract.

Note 8.1 Retirements due to ill-health

During 2020/21 there was 1 early retirement from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £1k (£63k in 2019/20).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

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

Note 10 Operating leases

Note 10.1 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.

	2020/21	2019/20
	£000	£000
Operating lease income		
Minimum lease income	617	683
Total	**617**	**683**

	31 March 2021	31 March 2020 Restated
	£000	£000
Future minimum lease income due:		
- not later than one year;	526	681
- later than one year and not later than five years;	4	94
- later than five years.	-	-
Total	**530**	**775**

As part of the work in preparation for the introduction of IFRS 16 on 1st April 2022, a full review has taken place on all leases, including income for future years. The future lease receivables have been restated as the prior year disclosure had included lease obligations and income related to non-contracted amounts. Under IAS 17 these should have been excluded, and only the contractual future amounts under non-cancellable leases included.

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.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease expense	2,082	1,903
Total	**2,082**	**1,903**

	31 March 2021	31 March 2020 Restated
	£000	£000
Future minimum lease expense due:		
- not later than one year;	1,725	1,945
- later than one year and not later than five years;	3,166	3,488
- later than five years.	2,501	3,073
Total	**7,392**	**8,506**

As part of the work in preparation for the introduction of IFRS 16 on 1st April 2022, a full review has taken place on all leases, including expenditure for future years. The most significant leases that the Trust has, are with South Gloucestershire Council for use of Kingswood Civic Centre and North Bristol NHS Trust for the use of the Riverside Unit in Bristol. The Trust has also served notice on some significant leases such as St Martins and Riverside Bath. The future lease obligations have been restated as the prior year disclosure had included lease obligations and income related to non-contracted amounts. Under IAS 17 these should have been excluded, and only the contractual future amounts under non-cancellable leases included.

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	-	96
Total finance income	**-**	**96**

Note 12 Finance expenditure

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	-	535
Interest on late payment of commercial debt	-	2
Main finance costs on PFI and LIFT schemes obligations	3,099	3,187
Contingent finance costs on PFI and LIFT scheme obligations	3,573	3,347
Total interest expense	**6,672**	**7,071**
Unwinding of discount on provisions	(8)	35
Total finance costs	**6,664**	**7,106**

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

	2020/21	2019/20
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	2

Note 13 Intangible assets - 2020/21

	Software licences	Internally generated information technology	Websites	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	1,904	669	14	2,587
Additions	-	-	-	-
Valuation / gross cost at 31 March 2021	1,904	669	14	2,587
Amortisation at 1 April 2020 - brought forward	1,182	669	14	1,865
Provided during the year	206	-	-	206
Amortisation at 31 March 2021	1,388	669	14	2,071
Net book value at 31 March 2021	516	-	-	516
Net book value at 31 March 2020	722	-	-	722

Note 13.1 Intangible assets - 2019/20

	Software licences	Internally generated information technology	Websites	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	1,904	669	14	2,587
Additions	-	-	-	-
Valuation / gross cost at 31 March 2020	1,904	669	14	2,587
Amortisation at 1 April 2019 - as previously stated	939	669	14	1,622
Amortisation at 1 April 2019 - restated	939	669	14	1,622
Provided during the year	243	-	-	243
Amortisation at 31 March 2020	1,182	669	14	1,865
Net book value at 31 March 2020	722	-	-	722
Net book value at 31 March 2019	965	-	-	965

Note 14 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**19,346**	**124,866**	**297**	**3,766**	**1,794**	**546**	**26,901**	**12,226**	**189,742**
Additions	-	7,788	-	5,544	65	-	5,834	-	**19,231**
Impairments	(150)	(363)	-	-	-	-	-	-	**(513)**
Reversals of impairments	108	2,642	-	-	-	-	-	-	**2,750**
Revaluations	-	5	-	-	-	-	-	-	**5**
Reclassifications	1	2,283	-	(2,330)	-	1	45	-	**-**
Valuation/gross cost at 31 March 2021	**19,305**	**137,221**	**297**	**6,980**	**1,859**	**547**	**32,780**	**12,226**	**211,215**
Accumulated depreciation at 1 April 2020 - brought forward	**572**	**26,422**	**297**	**-**	**1,267**	**465**	**20,487**	**11,717**	**61,227**
Provided during the year	-	3,238	-	-	89	76	2,315	186	**5,904**
Impairments	-	12,289	-	-	-	-	-	-	**12,289**
Reversals of impairments	(562)	(396)	-	-	-	-	-	-	**(958)**
Accumulated depreciation at 31 March 2021	**10**	**41,553**	**297**	**-**	**1,356**	**541**	**22,802**	**11,903**	**78,462**
Net book value at 31 March 2021	**19,295**	**95,668**	**-**	**6,980**	**503**	**6**	**9,978**	**323**	**132,753**
Net book value at 31 March 2020	**18,774**	**98,444**	**-**	**3,766**	**527**	**81**	**6,414**	**509**	**128,515**

Note 14.1 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**19,101**	**106,231**	**297**	**251**	**1,566**	**605**	**24,913**	**12,210**	**165,174**
Additions	-	3,968	-	3,515	139	-	1,995	-	**9,617**
Impairments	(128)	(167)	-	-	-	-	-	-	**(295)**
Reversals of impairments	384	14,862	-	-	-	-	-	-	**15,246**
Reclassifications	(11)	(28)	-	-	89	(59)	(7)	16	**-**
Valuation/gross cost at 31 March 2020	**19,346**	**124,866**	**297**	**3,766**	**1,794**	**546**	**26,901**	**12,226**	**189,742**
Accumulated depreciation at 1 April 2019 - as previously stated	**88**	**21,939**	**297**	**-**	**1,167**	**431**	**18,439**	**11,491**	**53,852**
Accumulated depreciation at 1 April 2019 - restated	**88**	**21,939**	**297**	**-**	**1,167**	**431**	**18,439**	**11,491**	**53,852**
Provided during the year	-	3,004	-	-	100	34	2,048	226	**5,412**
Impairments	780	3,804	-	-	-	-	-	-	**4,584**
Reversals of impairments	(296)	(2,325)	-	-	-	-	-	-	**(2,621)**
Accumulated depreciation at 31 March 2020	**572**	**26,422**	**297**	**-**	**1,267**	**465**	**20,487**	**11,717**	**61,227**
Net book value at 31 March 2020	**18,774**	**98,444**	**-**	**3,766**	**527**	**81**	**6,414**	**509**	**128,515**
Net book value at 31 March 2019	**19,013**	**84,292**	**-**	**251**	**399**	**174**	**6,474**	**719**	**111,322**

Note 14.2 Property, plant and equipment financing - 2020/21

	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 2021								
Owned - purchased	19,295	56,890	6,980	503	6	9,978	323	**93,975**
On-SoFP PFI contracts and other service concession arrangements	-	38,778	-	-	-	-	-	**38,778**
NBV total at 31 March 2021	**19,295**	**95,668**	**6,980**	**503**	**6**	**9,978**	**323**	**132,753**

Note 14.3 Property, plant and equipment financing - 2019/20

	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 2020								
Owned - purchased	18,774	58,799	3,766	527	81	6,414	509	**88,870**
On-SoFP PFI contracts and other service concession arrangements	-	39,645	-	-	-	-	-	**39,645**
NBV total at 31 March 2020	**18,774**	**98,444**	**3,766**	**527**	**81**	**6,414**	**509**	**128,515**

The District Valuation Office has taken into account the market conditions to assess any asset values under Modern Equivalent Asset (MEA) valuation. In doing this the Trust has received the formal independent advice of the District Valuer to reflect the values of assets that are reflective of local market conditions. The valuation technique is referred to in Note 1.8 to Note 1.9 to the accounts.

The Trust underwent a full revaluation as at 1 January 2021 of Land and Buildings by the District Valuer using the appropriate valuation methodology for the class and status of the asset. At 31 March 2021, no further full site valuation amendments were made as there were not considered to be any material changes in usage.

Note 15 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	156	123
Consumables	205	-
Other	-	108
Total inventories	**361**	**231**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £4,564k (2019/20: £1,445k). Write-down of inventories recognised as expenses for the year were £71k (2019/20: £0k).

In response to the Covid pandemic, the Department of Health and Social Care (DHSC) centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £3,287k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above. Other inventories shown above were in relation to ward stocks that are no longer counted as they are not individually material in nature.

Note 16 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	5,533	5,795
Prepayments (non-PFI)	4,443	4,005
PFI lifecycle prepayments	3,381	3,052
PDC dividend receivable	252	26
VAT receivable	1,977	1,031
Other receivables	200	29
Total current receivables	**15,786**	**13,938**
Non-current		
Other receivables	39	33
Total non-current receivables	**39**	**33**
Of which receivable from NHS and DHSC group bodies:		
Current	2,636	3,916
Non-current	39	33

Contract receivables due as at 31 March 2021 are considerably reduced from the prior year due to the more efficient payment mechanisms introduced as part of the response to the Covid pandemic

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.

Note 17 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21	2019/20
	£000	£000
At 1 April	**3,549**	**3,572**
At 1 April (restated)	**3,549**	**3,572**
Net change in year	13,537	(23)
At 31 March	**17,086**	**3,549**
Broken down into:		
Cash at commercial banks and in hand	80	74
Cash with the Government Banking Service	17,006	3,475
Total cash and cash equivalents as in SoFP	**17,086**	**3,549**
Total cash and cash equivalents as in SoCF	**17,086**	**3,549**

Note 17.1 Third party assets held by the trust

Avon and Wiltshire Mental Health Partnership NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of service users and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2021	31 March 2020
	£000	£000
Bank balances	168	137
Total third party assets	**168**	**137**

Note 18 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	2,120	3,978
Capital payables	7,764	3,336
Accruals	21,132	12,306
VAT payables	1,169	568
Other payables	46	65
Total current trade and other payables	**32,231**	**20,253**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	2,158	722
Non-current	-	-

Note 19 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	-	55
Total other current liabilities	**-**	**55**
Non-current		
Total other non-current liabilities	**-**	**-**

Note 20 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	-	23,428
Obligations under PFI, LIFT or other service concession contracts	1,189	867
Total current borrowings	**1,189**	**24,295**
Non-current		
Obligations under PFI, LIFT or other service concession contracts	37,589	38,778
Total non-current borrowings	**37,589**	**38,778**

Due to the national requirement to extinguish all DHSC loans during 2020/21, all interim loans as at 31 March 2020 were moved from non-current to current borrowings. These loans were repaid in the year 2020/21 and replaced with a PDC draw of an equivalent value.

Note 20.1 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2020	**23,428**	**39,645**	**63,073**
Cash movements:			
Financing cash flows - payments and receipts of principal	(23,398)	(867)	**(24,265)**
Financing cash flows - payments of interest	(30)	(3,099)	**(3,129)**
Non-cash movements:			
Application of effective interest rate	-	3,099	**3,099**
Carrying value at 31 March 2021	**-**	**38,778**	**38,778**

Note 20.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2019	**19,075**	**40,775**	**59,850**
Cash movements:			
Financing cash flows - payments and receipts of principal	4,350	(1,130)	**3,220**
Financing cash flows - payments of interest	(532)	(3,187)	**(3,719)**
Non-cash movements:			
Application of effective interest rate	535	3,187	**3,722**
Carrying value at 31 March 2020	**23,428**	**39,645**	**63,073**

Note 21 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2020	**677**	**844**	**84**	**436**	**33**	**2,074**
Transfers by absorption	-	-	-	-	-	**-**
Change in the discount rate	10	37	-	-	-	**47**
Arising during the year	62	40	30	251	3,038	**3,421**
Utilised during the year	(87)	(43)	(2)	(86)	-	**(218)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	**-**
Reversed unused	-	-	-	(135)	-	**(135)**
Unwinding of discount	(2)	(6)	-	-	-	**(8)**
At 31 March 2021	**660**	**872**	**112**	**466**	**3,071**	**5,181**
Expected timing of cash flows:						
- not later than one year;	90	44	112	466	**3,032**	**3,744**
- later than one year and not later than five years;	364	181	-	-	**39**	**584**
- later than five years.	206	647	-	-	**-**	**853**
Total	**660**	**872**	**112**	**466**	**3,071**	**5,181**

Early Departure Costs:

Early departure costs all relate to pre 1995 early retirements.

Pensions Injury benefits

Injury benefits are payable through the NHS Pensions Agency.

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.

Redundancy:

The Trust has notified a number of individuals for redundancy as at 31 March 2021, and therefore redundancy payments are likely within the next 12 months

Other:

The Trust has made a provision for a probable payment to HMRC in relation to a revised partial exemption calculation, £3,032k. In addition to this, a notional estimate for provision required for the national 'Scheme Pays' consolidation in relation to clinicians pension tax. This figure is for national consolidation purposes and not a cost to the Trust

Change in Discount Rate:

The discount rate used has been changed within the year from 0.29% to -0.5% in line with Treasury guidance.

Note 21.1 Clinical negligence liabilities

At 31 March 2021, £4,660k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Avon and Wiltshire Mental Health Partnership NHS Trust (31 March 2020: £2,783k).

Note 22 Contingent assets and liabilities

	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	16	24
Gross value of contingent liabilities	**16**	**24**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**16**	**24**
Net value of contingent assets	**-**	**-**

Note 23 Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	677	1,258
Total	**677**	**1,258**

Note 24 On-SoFP PFI arrangements

Note 24.1 On-SoFP PFI arrangement obligations

The following obligations in respect of the PFI arrangements are recognised in the statement of financial position:

	31 March 2021 £000	31 March 2020 £000
Gross PFI liabilities	**68,838**	**72,804**
Of which liabilities are due		
- not later than one year;	4,220	3,966
- later than one year and not later than five years;	17,476	17,644
- later than five years.	47,142	51,194
Finance charges allocated to future periods	(30,060)	(33,159)
Net PFI obligation	**38,778**	**39,645**
- not later than one year;	1,189	867
- later than one year and not later than five years;	6,500	6,185
- later than five years.	31,089	32,593

Note 24.2 Total on-SoFP PFI arrangement commitments

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

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI arrangements	**189,667**	**189,353**
Of which payments are due:		
- not later than one year;	9,744	9,427
- later than one year and not later than five years;	41,798	39,904
- later than five years.	138,125	140,022

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:

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**10,092**	**10,056**
Consisting of:		
- Interest charge	3,099	3,187
- Repayment of balance sheet obligation	867	1,130
- Service element and other charges to operating expenditure	1,359	1,329
- Capital lifecycle maintenance	865	1,063
- Revenue lifecycle maintenance	-	-
- Contingent rent	3,573	3,347
- Addition to lifecycle prepayment	329	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	**10,092**	**10,056**

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.

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

- 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

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	5,571	**5,571**
Cash and cash equivalents	17,086	**17,086**
Total at 31 March 2021	**22,657**	**22,657**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	5,832	**5,832**
Cash and cash equivalents	3,549	**3,549**
Total at 31 March 2020	**9,381**	**9,381**

Note 25.1 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Obligations under PFI, LIFT and other service concession contracts	38,778	**38,778**
Trade and other payables excluding non financial liabilities	31,011	**31,011**
Total at 31 March 2021	**69,789**	**69,789**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	23,428	**23,428**
Obligations under PFI, LIFT and other service concession contracts	39,645	**39,645**
Trade and other payables excluding non financial liabilities	19,521	**19,521**
Total at 31 March 2020	**82,594**	**82,594**

Note 25.2 Maturity of financial liabilities

	2021	2020 Restated
	£000	£000
In one year or less	35,231	46,915
In more than one year but not more than five years	17,476	17,644
In more than five years	47,142	51,194
Total	**99,849**	**115,753**

The maturity analysis of the financial liabilities disclosure has been restated as the prior year disclosure had excluded the impact of finance charges allocated to future periods for PFI liabilities. Under IFRS 7, the contractual amounts disclosed in the maturity analyses as required by paragraph 39(a) and (b) are the contractual undiscounted cash flows i.e. including the impact of finance charges allocated to future periods for PFI liabilities.

Note 26 Losses and special payments

	2020/21		2019/20	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	12	3	19	7
Bad debts and claims abandoned	-	-	1	1
Total losses	**12**	**3**	**20**	**8**
Special payments				
Ex-gratia payments	41	7	44	26
Total special payments	**41**	**7**	**44**	**26**
Total losses and special payments	**53**	**10**	**64**	**34**
Compensation payments received		-		-

Note 27 Gifts

	2020/21		2019/20	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Gifts made	36	-	14	3

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.

During the year, there were two declarations of a material interest between parties. One being between a Trust Board member of Bristol, North Somerset & South Gloucestershire CCG and a Trust Board member of Avon and Wiltshire Mental Health Partnership NHS Trust and one between a Non-Executive Director of Avon and Wiltshire Mental Health Partnership NHS Trust and the University of the West of England.

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 2020/21 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

Non-NHS Payables	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Total non-NHS trade invoices paid in the year	77,341	127,776	67,789	94,853
Total non-NHS trade invoices paid within target	63,972	120,511	45,463	84,421
Percentage of non-NHS trade invoices paid within target	82.7%	94.3%	67.1%	89.0%
NHS Payables				
Total NHS trade invoices paid in the year	734	11,188	957	10,773
Total NHS trade invoices paid within target	662	10,954	833	10,216
Percentage of NHS trade invoices paid within target	90.2%	97.9%	87.0%	94.8%

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 limit

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

	2020/21 £000	2019/20 £000
Cash flow financing	(4,624)	6,985
External financing requirement	**(4,624)**	**6,985**
External financing limit (EFL)	8,961	7,034
Underspend against EFL	**13,585**	**49**

Note 31 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	19,231	9,617
Less: Granted capital additions	(4,538)	-
Charge against Capital Resource Limit	**14,693**	**9,617**
Capital Resource Limit	14,693	9,981
Under / (over) spend against CRL	**-**	**364**

Note 32 Breakeven duty financial performance

	2020/21 £000
Adjusted financial performance surplus / (deficit) (control total basis)	7
IFRIC 12 breakeven adjustment	77
Breakeven duty financial performance surplus / (deficit)	**84**

Note 33 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£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
Breakeven duty cumulative position	86	1,199	4,418	7,959	10,895	13,679	16,489
Operating income		198,752	195,955	192,190	194,609	197,437	198,530
Cumulative breakeven position as a percentage of operating income		0.6%	2.3%	4.1%	5.6%	6.9%	8.3%

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	90	(8,918)	(9,707)	(1,000)	(7,223)	84
Breakeven duty cumulative position	16,579	7,661	(2,046)	(3,046)	(10,269)	(10,185)
Operating income	197,394	214,357	220,555	236,618	257,603	322,296
Cumulative breakeven position as a percentage of operating income	8.4%	3.6%	(0.9%)	(1.3%)	(4.0%)	(3.2%)