Weston Area Health
NHS Trust

Weston Area Health NHS Trust Annual Report and Accounts 2016/17

We are Weston Area Health NHS Trust

Our strategic aim

Work in partnership to provide outstanding healthcare for every patient.

Our values of PRIDE

People and Partnership – working together with colleagues, other organisations and agencies to achieve high care standards or specifically helping a service user, visitor or colleague

Reputation –actions which build and maintain the Trust's good name in the community

Innovation – demonstrating a fresh approach or finding new solutions to problems

Dignity – Contributing to the Trust's Dignity in Care priorities (Care and Commitment, Communication, Compassion, Competence).

Excellence and equality – demonstrating excellence in and equality of service provision

Our vision

To work in partnership to provide outstanding healthcare for every patient

- Deliver *your* local NHS with PRIDE.
- Deliver joined up care which feels integrated for patients and their families.
- Enable patients from Weston-super-Mare, North Somerset and North Sedgemoor to access a full range of services.
- Deliver services which are valued and respected by patients, carers, commissioning CCGs and referring GPs.

Our business model

The strategic plan describes a business model for the Trust with two key elements:

- moving from a sole focus on the "treatment of ill-health" service model to one which embeds proactive "ill-health prevention" and "improving health and well-being";
- moving from an "independent" service provider model to one of "formal partnership" allowing a range of service provision partnership arrangements

- maximise the widest appropriate range of local services on site;
- support the delivery of care in alternative settings wherever safe;
- improve clinical sustainability;
- deliver high quality care within the Trust and across the region;
- meet targets within the Trust and support delivery across the region;
- deliver economies of scale;
- support achievement of whole system stability.

The Trust's purpose is to improve the health and wellbeing of our local community by providing excellent services to meet their healthcare needs, as close to home as possible, through innovation and collaboration with professional health and social care partners. The Trust's strategy is founded on one overarching principle: Putting Patients First; ensuring that we give them the best experience we can, doing so safely and using the evidence of best practice to inform what we do.

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Part 1 – Performance report

Overview from Chief Executive James Rimmer

Our Annual Report is an important publication for the Trust. It sets out the steps we have taken to improve services for our patients and how we are performing against national standards and benchmarks. The Report also gives the opportunity to showcase the excellent services and improvements that our staff deliver to provide care to our patients.

2016/17 has been a full and challenging year for the Trust. During the year there have been sustained periods of high demand for care through our Emergency Department. We have struggled to meet the accepted quality standards in the Department. The long term difficulties in recruitment of doctors in some specialties has proved a real test of our resilience.

We have performed well with our treatment times targets – with the exception of the 62 day target for patients with cancer. We continue to work with our partners to improve this.

Six out of twelve of our improvement priorities in our Quality Account have either been achieved or achieved in part. In particular we have seen a reduction in falls causing harm and improvement in the way we manage complaints. We recognise that there is further work to do, particularly to reduce pressure ulcers and to introduce new guidance on learning from deaths.

Our staff survey shows that whilst the Trust has improved in some areas, other acute trusts have also improved their results which mean that our results in comparison still remain poor in many areas.

Between 28 February and 15 March 2017 the Trust underwent a CQC follow up inspection of services at the Trust. A team of twenty two inspectors were on site for the first three days with a smaller team returning the following week for the unannounced part of the inspection.

The inspection focused on the services rated as ‘requires improvement’ or ‘inadequate’ following the inspections in May and August 2015. As such, the following services were reviewed:

- Urgent and emergency care
- Medical
- Surgery
- Critical care

The report from the inspection is likely to be available during June 2017. However, initial informal feedback to the Executive Team noted improvements – particularly in the surgical directorate – but also to some degree in the medical directorate. The timeliness of the flow of patients through the Emergency Department was raised as an area of concern. The Trust subsequently received a warning notice from the CQC on the 24 March 2017 regarding the flow of patients through the hospital and senior doctor leadership to the Emergency Department.

In support of this and other opportunities, we have announced that we will work in closer partnership local hospitals and with University Hospitals Bristol in particular. By so doing we will build on our existing clinical networks and establish the future services of the Trust.

In February our Commissioners sought the views of local people on a number of their ideas for the hospital. During an eight week engagement process opportunities for increasing planned surgical operations, reducing services overnight in the Emergency Department and reducing the complexity of patients in Intensive Care were all debated. The feedback from this is expected in June following independent analysis by Healthwatch North Somerset.

The Trust's auditors have given an unqualified audit opinion in respect of the financial statements but included an Emphasis of matter paragraph concerning the Trust's ability to continue as a going concern, see Accounting Policies page 70 for full disclosure.

I hope you find this report an enjoyable read and take assurance from the steps the Trust continues to take to improve services for our patients.

James Rimmer, Chief Executive
May 2017

Addendum - 20 June 2017
On 14 June (after the draft of this Quality Account was finalised) the CQC published the result of their follow up inspection in March 2017. This showed that the Trust was assessed as;

- Overall rating for this hospital - 'Requires Improvement'
- Urgent and emergency services – 'Inadequate'
- Medical care (including older people's care) – 'Requires Improvement'
- Surgery – 'Good'
- Critical care – 'Good'

Please find the full report on the Trust website – or the CQC website.

Whilst it is pleasing to note that the CQC rating for both Surgery and Critical Care have improved to 'Good' – and that we have been assessed as 'Good' for Caring across all services - Urgent and Emergency Services were rated 'Inadequate' – particularly as there aren't enough doctors to safely staff overnight rotas. Responsiveness (patient flow) was also rated 'Inadequate'.

The Trust is working closely with partners on actions designed to improve patient flow throughout the hospital and on the safety of care in the Emergency Department.

What we do

Weston Area Health NHS Trust was established in April 1991 being one of the first wave of 57 NHS Trusts created following the enactment of the NHS and Community Care Act 1990. The Trust is based at Weston General Hospital, built in 1986 near Uphill in the south of Weston-super-Mare.

The Trust provides a wide range of acute and rehabilitation hospital services, as well as some community health services primarily to residents of the North Somerset area. Services are provided on a contractual basis to local health bodies that are responsible for purchasing health care for the resident population.

The Trust serves a resident population of circa 208,154 people (source: Mid-2014 population estimate: ONS). A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year. The Trust also provides services to North Sedgemoor which has an estimated population 48,400 (Mid 2014 GP registered population). The largest town is Bridgwater, followed by Burnham-on-Sea and Highbridge.

The Trust's largest commissioner is North Somerset CCG, accountable for circa £280 million of NHS spending, over 55% of which is acute services spending. Most of the acute services spending is with local providers with Weston accounting for circa £70 million of the expenditure. In addition, the Trust receives other non-patient related income including education and training monies.

Key Socio-demographic factors

- Population growth of 24% over the past 30 years, which is substantially faster than the national average growth rate of just 13%. Over the next 10 years the population is projected to increase by a further 10% compared to a national average of 7%.
- Population has a higher proportion of people over the age of 65 (23%) compared to the national average (18%). During the next ten years the elderly (75+) population is expected to grow by 45-50%, compared to a national average of 35-42%. The numbers of children under the age of 14 are expected to grow by 12% over the same timeframe. Typically these population groups are high users of health and social care services.
- The expansion plans of Weston College and the designation of the College as a University Centre will further expand the local young adult population;
- Plans to develop 6,200 new houses in Weston-super-Mare, to be completed by 2026. Based on the Public Health projections this would equate to 14,260 people, many of whom would be younger families, with implications for local primary care, maternity and paediatric services.
- Household composition changing with increase in households in North Somerset occupied by one person or single parent with dependent children (faster rise than in England and Wales);
- Standardised Mortality Ratio for North Somerset is 94%, indicating a lower rate of mortality than the national average, but life expectancy varies significantly across the County, indicating some extremes of deprivation (and hence greater healthcare needs).
- High levels of deprivation in North Somerset with the 7th widest inequalities gap in the Country and levels of relative deprivation increasing;
- Lower levels of deprivation in North Sedgemoor but 3% of the area's population live within one of the 20% most deprived areas within England, below the regional average.
- Weston-super-Mare Central Ward has the lowest life expectancy (67.5 years for males and 76 years for females). Clevedon Yeo has the highest life expectancy for both males and females, at 86.1 years and 92.5 years respectively. There is therefore a gap in male life expectancy between these wards of 18.6 years.

Weston Area Health NHS Trust provides clinical services from three sites. The General Hospital is located in the south west of the main town of Weston-super-Mare and there are two children's centres providing community children's services which are located in Weston-super-Mare and Clevedon.

The Trust provides a wide range of acute health services to the population of North Somerset and

Sedgemoor and works closely with other hospitals in Bristol as part of ‘clinical networks’ including, for example, cancer, pathology and cardiology.

The Trust owns its fixed assets, including the land and buildings at Weston General Hospital. The Trust’s asset base is valued at £68.8m (31 March 2017)

The Trust is registered without conditions with the Care Quality Commission (CQC) the independent regulator of health and social care in England. However, In March 2017, the Trust received a warning notice requiring significant improvement to systems or processes to manage patient flow through the hospital which were found not to be operating effectively and did not ensure care and treatment was being provided in a safe way for service users.

Our vision and values

The vision of Weston Area Health NHS Trust has recently been redefined to better reflect the ambitions of the Trust. Our vision is to:

Work in partnership to provide outstanding healthcare for every patient

By achieving this vision we will:

- Deliver *your* local NHS with Pride
- Deliver joined up care which feels integrated for patients and their families
- Enable patients from Weston-super-Mare, North Somerset and North Sedgemoor to access a full range of services.
- Deliver services which are valued and respected by patients, carers, commissioning CCGs and referring GPs.

Our key strategic aim is to:

Deliver safe, caring and responsive services

This vision and strategic aims are supported by a series of local values which guide actions, behaviors and decision making within the organisation and which are consistent with the NHS Constitution. These values are:

People and Partnership – working together with colleagues, other organisations and agencies to achieve high care standards or specifically helping a service user, visitor or colleague.

Reputation – actions which help to build and maintain the Trust's good name in the community.

Innovation – demonstrating a fresh approach or finding a new solution to a problem.

Dignity – contributing to the Trust's Dignity in Care priorities (Care and Commitment, Communication, Compassion, Competence).

Excellence and equality – demonstrating excellence in and equality of service provision.

Performance analysis

Development and performance of the Trust during 2016/2017 and in the future

The business plan for the Trust in 2016/17 detailed a range of strategic and operational objectives that support the realisation of the Trust's vision. These objectives were aligned with the key Care Quality Commission and NHS Trust Development Authority themes of ensuring that services are Safe, Caring, Well Led, Responsive and Effective.

Strategic Focus

CQC Domains	Strategic Focus
SAFE	Ensuring people have a positive experience of care, and are protected from harm
CARING	Developing the Trust as a health promoting organisation
RESPONSIVE	Providing efficient and effective services
WELL LED	Providing a flexible workforce with capacity and capability to deliver high standards
	Developing and enabling strong partnerships and demonstrate leaders ship and engagement in localities
EFFECTIVE	Delivering affordable, value for money services and financial sustainability
	Delivering an estates strategy which ensures a safe environment for staff, patients and visitors
	Delivering an innovation strategy which harnesses opportunities to deliver care in an innovative way

The strategic objectives were supported by six key enabling strategies relating to:

- Finance
- Estates
- Information Management and Technology
- Workforce Development
- Communications and Engagement
- Governance

The strategic objectives were also supported by a range of operational objectives, which were in turn supported by departmental and Directorate work plans.

Operational Objectives – Priority areas of delivery 2016 - 2017

Priority area of delivery	Key supporting programmes of work to deliver	Key Success criteria	Governance
Patient Safety First	• Sign up to safety work programme • Mortality Improvement programme • CQC compliance programme	• Reduction in avoidable mortality • Reduction of hospital acquired pressure ulcers; • CQUIN targets delivered • CQC compliance	• Monthly directorate performance delivery • Senior Management Group • Clinical Advisory Group • Quality and Governance • Trust Board
Ensuring consistent delivery of constitutional standards	• ECIP and ED 4hr performance programme • Cancer Survivorship programme	• Delivery of constitutional standards	• Monthly directorate performance delivery Senior Management Group • Trust Board

Priority area of delivery	Key supporting programmes of work to deliver	Key Success criteria	Governance
	• Acute Medical Model programme		
Cultural Change including clinical engagement	• Developing clinical workforce resilience through partnership working; • Workforce re-design programme • Professional standards, clinical leadership and team working programme • Improving staff survey results programme	• Improvement in workforce stability measures • Improved staff survey results	• Trust Board • Clinical Advisory Group
Maintain/improve junior doctor training environment	• Great Start programme • Safety First programme	• Feedback from junior doctors and GMC	• Senior Management Group • Trust Board
Embedding strong board assurance, models of delegation and clinical governance throughout the Trust	• Implementation of external review recommendations with particular focus on ward to board processes	• Number of staff reporting incidents and feedback from incidents • Transparent ward to board processes	• Directorates • Senior Management Group • Trust Board and committees
System alignment, planning and delivery - partnership working to improve care pathways for patients and deliver sustainable clinical and staffing solutions	• North Somerset Transformation Programme • Sustainability Board • Developing strategic opportunities programme/BNSSG programme	• Clear strategic future described • Capacity and demand modelling for new portfolio • STP documented	• Senior Management Group • Trust Board
Delivery of the Financial Plan	• CIP delivery programme • Capital Investment Programme	• Delivery of financial plan • Delivery of 4.2% CIP	• Monthly directorate performance delivery • Senior Management Group • Finance Committee • Audit and Assurance Committee
IM&T improvements	• Upgrade delivery programme	• Deliver the Millennium 2015 code upgrade	• Information Governance Board

Performance delivery overview

Priority area of delivery	Summary of delivery achievement
Patient Safety First	The Trust has continued to focus on patient safety over the last 12 months. The Trust has established robust Ward to Board governance processes in relation to mortality with a consequent stabilisation of the Trust's Standardised Hospital Mortality Index (although 1.17 reduced to 1.15) remains outside of expected norms and a significant concern. The number of hospital acquired pressure ulcers has reduced in year and a new pressure damage prevention e-learning package has been introduced alongside regular review and learning from incidents being undertaken by a Pressure Ulcer Steering Group. The SHINE safety checklist has been introduced with audits being undertaken to ensure that its requirements are embedded within practice. The Trust has made good progress against delivery of CQUIN targets although not all targets have been achieved in full. In March 2017, the Trust received a warning notice requiring significant improvement to systems or processes to manage patient flow through the hospital which were found not to be operating effectively and did not ensure care and treatment was being provided in a safe way for service users.

Priority area of delivery	Summary of delivery achievement
Ensuring consistent delivery of constitutional standards	Performance in relation to the ED 4 hr target has proved extremely challenging over the last 12 months. Working with partners we have struggled to achieve our 62 day cancer treatment target. Remedial action plans and trajectories are in place to deliver improved performance. The Trust has continued to perform well in relation to Referral to Treatment Time including diagnostics with performance at or above national targets with the exception of some specialty two week cancer waits, particularly colorectal.
Cultural Change including clinical engagement	Staff survey results are disappointing and a programme of work is underway with staff to better understand their concerns and identify actions required. An OD diagnostics has been completed and results are being triangulated with the Staff survey results to design an OD programme. Clinical lead appointments have been made with an Associate Medical Director for surgery and medicine appointed and the existing clinical lead for Clinical Support Services becoming an Associate Medical Director for Clinical Support Services. Staff turnover has reduced during the last 12 months.
Maintain/improve junior doctor training environment	The Trust position has improved during the last 12 months in relation to the General Medical Council survey of junior doctors experiences of working at the Trust and no adverse comments were received during the last survey undertaken. The Trust has created a Junior Doctor Forum which meets regularly and has also appointed a Guardian of Safe Working and New Director of Medical Education during the last 12 months.
Embedding strong board assurance, models of delegation and clinical governance throughout the Trust	The Trust has commenced implementation of the key recommendations from the external governance review. In particular the Trust has appointed to new infrastructure roles, introduced a new performance reporting system improving transparency of ward to board reporting processes. Improvements have also been made to the committee structures including the introduction of a new workforce-related board committee and sub-committees focused on workforce, violence and crime reduction and environmental sustainability.
System alignment, planning and delivery - partnership working to improve care pathways for patients and deliver sustainable clinical and staffing solutions	The Trust has participated actively as a member of the BNSSG Sustainability and Transformation Plan (STP) development and as part of the Weston Sustainability Programme, a spotlight project within the BNSSG STP Acute Care Collaboration Workstream. The Trust has also entered into a partnership arrangement with University Hospitals Bristol NHS Foundation Trust to further develop joint working and service delivery arrangements. Partnership working with other parts of the NHS and external key stakeholders including Primary Care, Avon and Somerset Constabulary, North Somerset Council and Weston College have been significantly strengthened during the last 12 months delivering improvements in staff safety, multiagency joint working, more efficient use of resources and to ensure robust future planning around new workforce opportunities.
Delivery of the Financial Plan	Delivery of the financial plan has proved challenging this year, with significant costs incurred as a consequence of the need to employ locum and agency Clinician and nursing staff to ensure patient safety. A difficult winter period necessitating the opening of escalation capacity for a prolonged period has also driven up cost and reduced the opportunity to deliver planned savings.
IM&T improvements	The Cerner Millennium Patient Administration System code upgrade was delivered to time.

The environment in which health and social care services are operating nationally and within North Somerset and Sedgemoor is becoming increasingly complex. Analysis of national and local drivers for change clearly demonstrates that existing single organisation-focussed responses will be insufficient to meet the challenges facing health and social care services and that instead there needs to be a fundamental redesign of the way in which these services are delivered.

In recognition of these challenges, increasingly, operational planning and commissioning is being conducted within a “single commissioning voice” with a single set of commissioning intentions for all BNSSG CCGs and providers with ongoing alignment of commissioning intentions with STP programmes to ensure no duplication or omissions. Providers and commissioners will be required to work for a single set of activity and financial assumptions in order to avoid the risk that operational/operating plans do not add up to the whole.

Planning for service delivery is also increasingly being undertaken on a BNSSG-wide basis as part of the Sustainability and Transformation Plan. This approach is intended to overcome inefficiencies, duplication and variation and unnecessary boundaries and interfaces for patients and staff to navigate and ensure that care is provided in appropriate care settings for patients.

The key principles behind the work currently being undertaken are:

- We will deliver care consistently and at scale as part of a fundamental change in the way we respond to demand.

- We will remain responsive to individuals and local communities and ensure appropriate care and support in the right place at the right time.
- We will ensure equality of service provision for mental and physical ill health is a golden thread running through the whole of health and social care provision

Key drivers

The Trust's operational plan for the next 12 months clearly reflects the key principles developed by the STP, including strong joint working, developing financial viability across the whole system, delivering high-quality care and making the most efficient use of resources, for example, technology

The Trust's plan to ensure delivery of these imperatives and to address the evolving clinical service strategy are cognisant of the interdependency of the Trust with wider system partners to deliver short to medium term service sustainability, quality and safety and those of the wider system intended to transform pathways of care over a longer-time period.

In addition, during 2017/18 that the Trust will work more closely with University Hospitals Bristol NHS Foundation Trust through a formal partnership arrangement.

Following a joint Trust Board to Board meeting in January 2017, the Boards of Weston Area Health NHS Trust (WAHT)and University Hospitals Bristol NHS Foundation Trust (UHB) announced on 8 February 2017 that they had agreed to establish a formal partnership arrangement, increasing the level of joint working between the two Trusts.

This new collaboration is being created as part of the NHS vision of developing networks between smaller and larger Trusts and reflects the ongoing North Somerset Sustainability programme to build a strong future for Weston General Hospital.

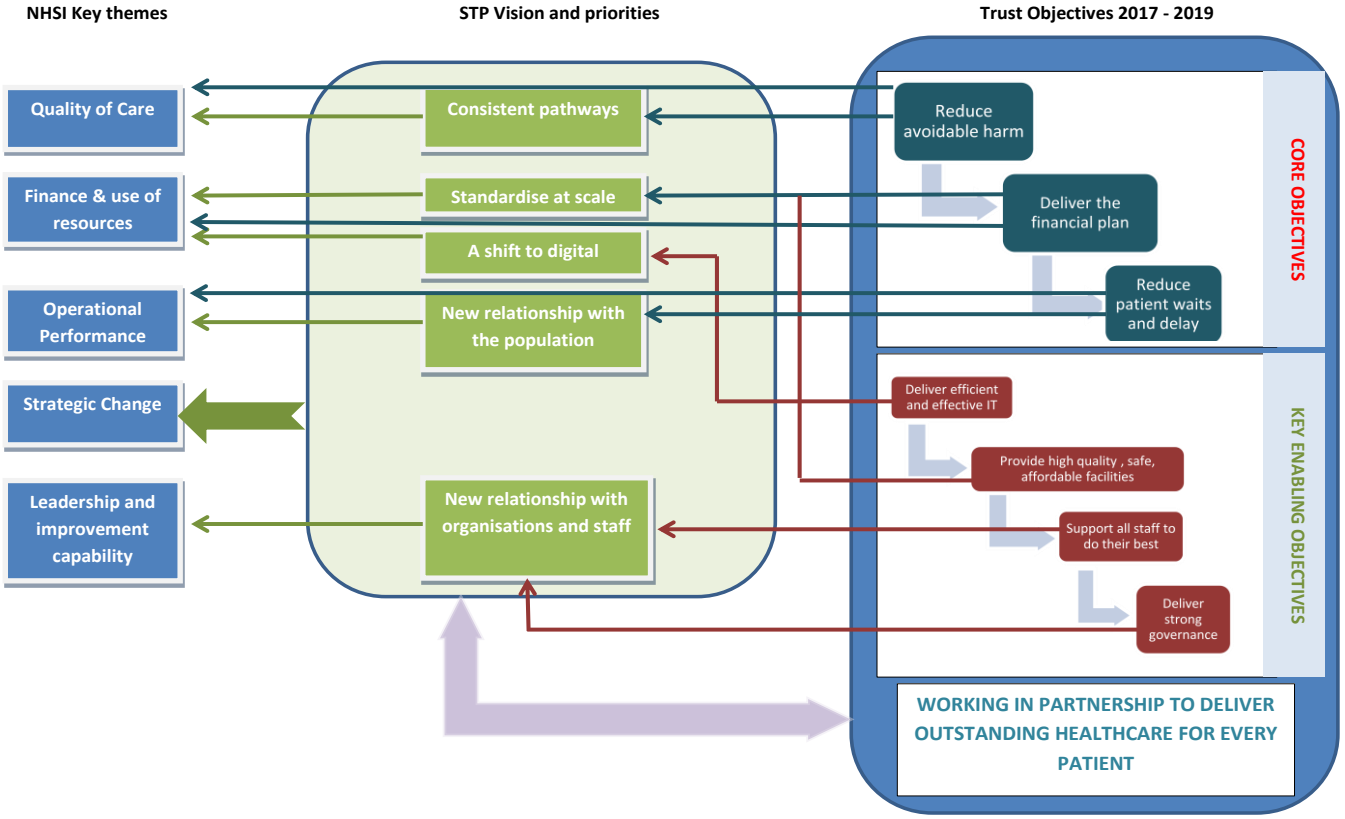
Building on long-standing, positive working relationships which give local people access to a range of services delivered or supported by Bristol and Weston clinicians, the two Trust Boards agreed to:

- Draw-up a formal partnership agreement, describing how the partnership will help address long-standing issues of clinical and financial sustainability at Weston General Hospital
- Develop a joint service strategy, setting out proposed areas for co-operation, which could include a greater range of shared clinical and management services
- Establish a joint management board to oversee delivery of this work.

Work establishing the full parameters of the new collaboration is intended to start by April 2017.

The Trust's focus during the next 12 months is described below:

Operational Plan 2017-19 Overview



Key risks to delivery of these objectives include:

- Risk of failure to deliver required length of stay improvements due to lack of internal and external partner capacity and capability
- Risk of failure to support improvements in quality of care and efficiency across the Trust through the delivery of an innovative, cyber secure and robust IT programme
- Risk of failure to deliver operational plan due to lack of internal capacity and capability
- Risk that medical staffing will not be at the required numbers/has over reliance on locums to deliver safe and dignified care
- Risk that mortality rates will not be ‘as expected ‘ compared to position across rest of England
- Risk that the Trust will not deliver clinical quality indicators, national performance targets and be a safe and suitable training environment
- Risk that people who use our services are not discharged in a safe and timely fashion
- Risk that the Trust is unable to secure partners to manage the future delivery of clinically and financially viable services
- Risk that the Trust will be unable to deliver a major savings plan

The operational plan describes mitigating actions to minimise these risks.

Meeting National Performance Objectives

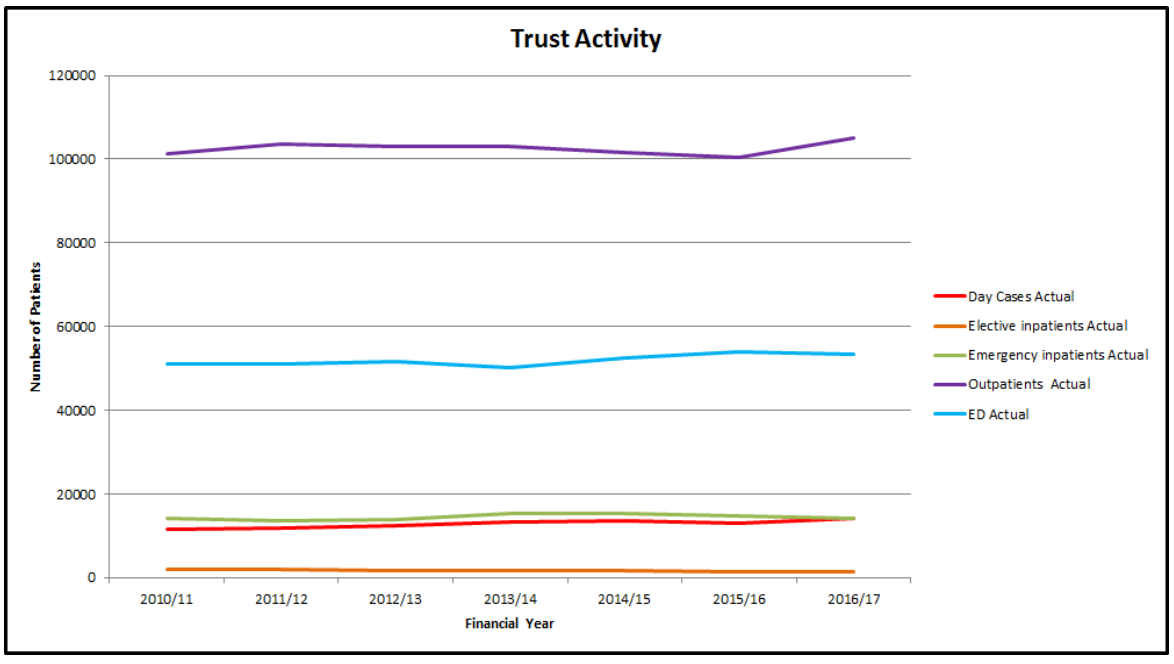
Our Performance

This section sets out the Trust performance for the financial year ending 31st March 2017. The first part describes patient admissions by type of patient. The second part shows the Trust's performance against some specific, nationally-set operational access and quality targets. Performance against each of these targets together with a wide range of clinical quality, patient safety, operational, human resource and financial targets are reported to the Trust Board in a public meeting, in the Trust's 'Integrated Performance Report'. Copies of these reports are available on the Trust website at www.waht.nhs.uk.

Patient Admissions

	2016/17	2015/16
Day cases	14,267	13,047
Elective inpatients	1,442	1,535
Emergency inpatients	14,179	14,789
Total admissions	29,888	29,371
Average length of Stay	3.2	2.9
Emergency Department Attendances	53,242	53,931
Outpatient attendances	105,036	100,531

'Elective' Inpatients are patients who come into the hospital for planned operations, procedures and treatment. 'Emergency' patients are admitted without an appointment and generally need urgent treatment.
The population the hospital cares for has a higher than average proportion of people who are elderly and frail, which means patients often are treated for more than one condition and, on occasions, their discharge is dependent on suitable care being available for them at home or in the community.
The average length of stay refers to the average number of days that patients spend in hospital. It is measured by dividing the total number of days stayed by all inpatients during a month by the number of admissions or discharges. Day cases are excluded. A lower length of stay demonstrates efficient, proactive planning of the whole process of care, as well as active discharge planning.



The graph above shows all of the hospital activity between 2010/11 and 2016/17. The following graphs describe the performance against plan for those six years. ('Plan' is the level of activity each year expected by the hospital in agreement with the Clinical Commissioning Group).

Outpatient Clinics

The Trust provides a wide range of specialist clinics, some of which are supported by visiting consultants from Bristol. These services reduce the need for local residents to travel long distances for specialist opinion and support.

18 Weeks Referral to Treatment Access Target

The Trust performed well against this national target which sets a maximum of 18 weeks from initial point of referral to the start of any treatment necessary for planned care. This demonstrates that the Trust continues to deliver efficient and effective pathways of care to our patients. The national target is 92%.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
18 Weeks Incomplete Pathway	90.12%	90.47%	92.99%	94.72%	97.20%	93.71%

Cancelled Operations

The Trust recognises that having to cancel operations is very distressing for patients and their families at a time that is already very worrying and stressful. The national target is to cancel no more than 0.8% of operations for the year. Unfortunately, due to the significant pressures the Trust experienced during the winter months there was a need to cancel elective operations during this period. Plans have since been developed to ensure that there is a reduction in the number of cancellations going forward.

	National Target	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
% Operations Cancelled	≤0.8%	0.60%	1.10%	0.18%	2.21%	1.81%	6.95%
% Cancelled Operations Rebooked Within 28 days	≥95%	100%	100%	100%	99.88%	100%	95.45%

Cancer Patients

The 2009 Cancer Reform Strategy sets out eight national cancer performance objectives for Trusts to deliver against. During 2016/17 the Trust met four of the national targets in full.

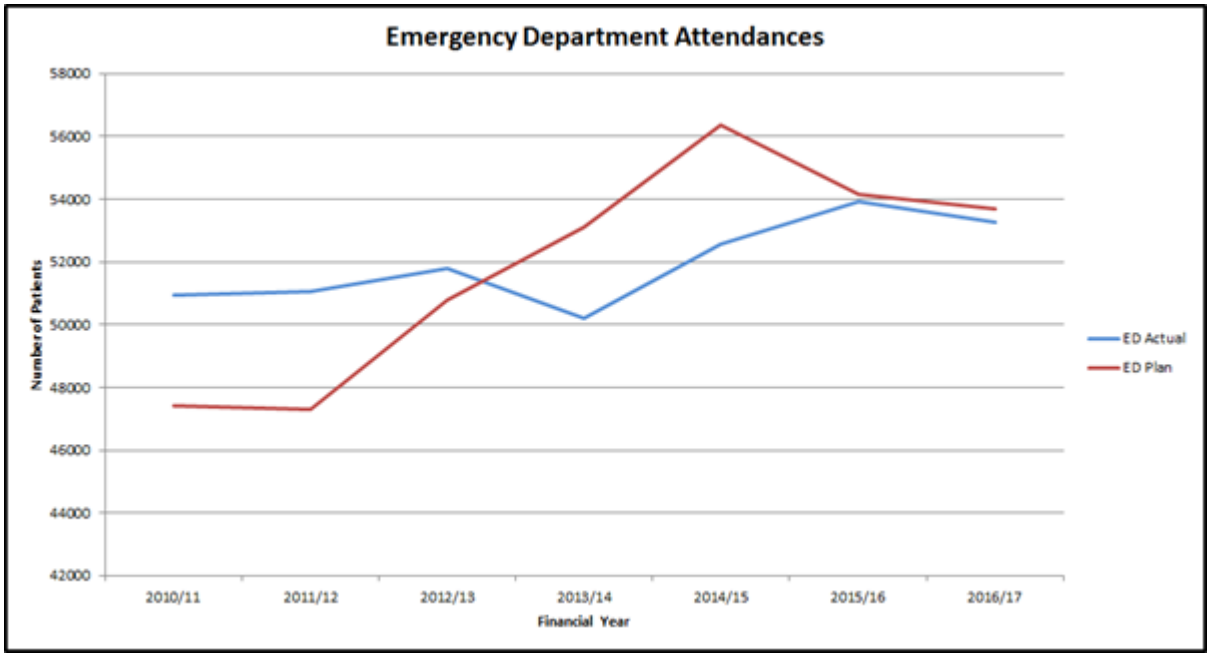
	National Target	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Breast Symptoms referred to a specialist who are seen within 2 weeks of referral	**≥93%**	97.20%	96.60%	93.50%	90.90%	88.68%	89.10%
31 days for second or subsequent cancer treatment- surgery	**≥94%**	100.00 %	98.60%	95.30%	99.30%	98.81%	99.46%
32 days for second or subsequent cancer treatment- drug treatment	**≥98%**	100.00 %	100.00 %	99.10%	99.97%	99.08%	96.36%

National screening programme who wait less than 62 days from referral to treatment	**≥90%**	95.80%	98.10%	86.40%	100.00 %	92.05%	100.00 %
Cancer reform strategy 62 upgrade standard	**≥90%**	94.20%	93.40%	86.10%	77.96%	94.73%	93.20%
2 week wait (urgent GP appointment to 1st outpatient appointment)	**≥93%**	96.50%	96.00%	95.30%	97.26%	96.30%	91.55%
NHS cancer plan 31 day standard	**≥96%**	99.80%	100.00 %	99.20%	99.65%	98.84%	100.00 %
NHS cancer plan 62 day standard	**≥85%**	92.30%	88.30%	81.40%	89.08%	77.50%	77.00%

The following table sets out the eight key targets and the Trust performance against each.

Four Hour Emergency Access Target

The Emergency Department is the department where many patients initially come for care. The following graph demonstrates that over the past six years, emergency department attendances have risen by 4.51%.



The Trust is required to meet the target of 95% of patients spending four hours or less from arrival to admission, transfer or discharge. The Trust did not achieve the target with a final position of 76.50%. The Trust has developed recovery plans to address this issue in 2017/18.

Stroke

All Trusts have been set a target to ensure 80% of stroke patients spend 90% or more of their stay in a specialised stroke unit. In 2016/17 the Trust achieved 85.64%.

Clostridium Difficile Infections

A Clostridium Difficile Infection (CDI) is a type of bacterial infection that can affect the digestive system. It more commonly affects people who are receiving health care either in the hospital or in a community residential setting. The two most commonly quoted risk factors for this infection are age (over 65 years) and receiving antibiotic treatment. Weston, therefore, has a large 'risk group' since a high proportion of patients admitted to the hospital fall into these categories.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Target (No More Than)	16	12	11	17	17	17
Cases Recorded	20	19	17	20	10	10

MRSA Blood Infections

The Trust was pleased to record zero cases of hospital apportioned MRSA blood stream infections for the second year running in 2016/17. Ongoing actions to maintain the zero rate include monitoring of practice (including hand washing), isolation practices and care of invasive devices.

Venous Thrombo Embolism

	National Target	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
% Patients VTE Assessed	≥90%	95.00%	96.10%	78.95%	97.16%	95.34%	63.02%

It is a national requirement that 95% of patients admitted to hospital should be assessed as to their risk of developing a venous thrombosis (blood clot). During the year staffing issues adversely affected our ability to record and audit our performance and we recognise that this requires significant improvement - although our review of hospital acquired thrombosis suggests patients are not at risk of harm. A Trust wide VTE action plan is being reviewed by our new Medical Director. This will be led in 2017.18 by our Deputy Director of Quality and Safety who will review the whole process of VTE assessment and audit of compliance.

Improving Service Quality and Patient Satisfaction

Learning from the Care Quality Commissions new inspection framework

Weston Area Health NHS Trust is required to register with the CQC and the Trust's current registration status is 'registered without conditions or restrictions'.

Following the CQC planned inspection in May and August 2015 the CQC gave an overall rating for the Trust of 'requires improvement'. The CQC report from the visit highlighted many areas of challenge but also many areas of excellence. The CQC described three areas of 'outstanding performance' – Children's Care in Hospital for Caring and Child & Adolescent Mental Health Services for Caring and Effectiveness. However, three areas were highlighted as 'inadequate' – the safety of the Emergency Department, Medical Care in ED and the Trust wide leadership of Medical Care.

The two individual 'inadequate for safety' scores have given the Trust an overall rating 'inadequate' for safety. The Trust sought to immediately address these issues - first with new triage processes in the Emergency Department, and secondly with new models of medical care, working with partners to support our medical services. Additional assistance was put in place to support our medical leadership.

The two 'outstanding' scores for Child & Adolescent Mental Health Services led to an overall rating of 'outstanding' for this service. Overall, 30 of the 49 areas reviewed were rated 'good' or 'outstanding'.

Following a Quality Summit with the Care Quality Commission in September 2015, the Trust developed action plans to address the 'must do' actions from the inspection, in conjunction with partners.

Of the 22 'must do' actions seven relate to the Emergency Department, four to operating theatres, two to staff attendance at mandatory training, two to patient flow, two to governance at Directorate and service level, one to medical cover out of hours, one to avoidable harm across the organisation (pressure ulcers, falls and medication incidents), one to acuity and staffing levels on the High Care Unit, one to IT systems and one to the security of medical records.

Progress with the delivery of plans to address these actions has been monitored monthly by the Senior Management Group and updates provided to the Quality and Governance Committee and Trust Board.

The Trust publicised the results of the inspection in line with CQC requirements and the complete reports are available on the Trust website.

The CQC undertook a follow up inspection of services at the Trust between 28 February and 2 March. A team of twenty two inspectors were on site with a smaller team returning the following week for the unannounced part of the inspection.
The inspection focused on the services rated as 'requires improvement' or 'inadequate' following the inspections in May and August 2015. As such, the following services were reviewed:

- Urgent and emergency care
- Medical
- Surgery
- Critical care

The report from the inspection is likely to be available during June 2017. However, initial informal feedback to the Executive Team noted improvements – particularly in the surgical directorate – but also to some degree in Urgent and Emergency Care and Medicine. The timeliness of the flow of patients through the Emergency Department and the effectiveness of the Trust's response to the national staff survey was raised as areas of concern.

Monitoring Patient Experience

Our ability to measure patient experience is critical to making positive changes and supporting staff in delivering the best care. Throughout 2016/17 there has been a significant focus on care delivery and the engagement of patients in informing how care and hospital services can and should be delivered.

The Trust has demonstrated a commitment to improving the experience of patients with the development and implementation of a service user council (the Patients' Council). They have the remit to challenge and hold the Trust to account on delivery and improvement of excellent patient experience.

During 2016/17, Council members have continued as members of the key committees in the Trust including the Trust Board, the Quality and Governance Committee and the Serious Incident Panel. The members have supported assessments of the care environment and hospital food.

The Patient Experience Review Group is key to demonstrating openness and accountability to patients and key stakeholders across the community. The Group includes membership from our Commissioners and Healthwatch and ensures that the Trust reviews and acts on the results of patient experience monitoring. This includes, but is not limited to:

- Patient or carer surveys
- Observations of care
- Service reviews that involve patients or their carers
- Patient stories
- Departmental audits that include measures of patient experience
- Direct approaches from patients via PALs, complaints, letters to the media, complements and social media feedback.

During 2016/17 both the Patients' Council and Patient Experience Review Group worked with us to agree our patient experience improvement priorities for 2017/18 described in our 2016/17 Quality Account. Both of these documents are available on the Trust's website.

National Inpatient Survey

The annual adult inpatient survey is carried out in all Trusts (www.cqc.org.uk). 83 out of the 156 Trusts use a company called Picker to manage this – and at the time of writing (24 May 2017) only the results from Picker Trusts are available. The survey is based on a sample of consecutively discharged inpatients who attended Weston in the summer of 2016. 1250 questionnaires were sent to patients of which 1158 were eligible to partake in the survey. The Trust received 538 completed responses giving a response rate of 46%, slightly lower than the previous year of 49%.

WAHT	2015		2016	
	Weston	National	Weston	National
Survey response rate	49%	45%	46%	41%

This data compares us with the 83 Picker Trusts – since at the time of writing this Account the nationwide comparative data was not available.

Of the 'Picker Trusts' the Trust was significantly better than average on five questions, significantly worse than average on seventeen questions and showed no significant differences on forty five questions.

The Trust has improved significantly the percentage of patients that rated care at 7+ out of 10.
None of the responses have worsened significantly.

The survey has highlighted many positive aspects of the patient experience.

- Overall: rated care 7+ out of 10 - increased to 86%
- Overall: treated with respect and dignity – increased to 85%.
- Doctors: always had confidence and trust – increased to 80%.
- Hospital: room or ward was very/fairly clean – unchanged at 98%.
- Hospital: toilets and bathrooms were very/fairly clean – unchanged at 97%.
- Care: always enough privacy when being examined or treated - increased to 92%.

Most patients are highly appreciative of the care they receive. There is however also room for improving the patient experience

Pleasingly the report indicates improved responses regarding;

- The experience of discharge from hospital
- Levels of confidence and trust in doctors
- Being asked regarding the quality of care whilst an inpatient
- Receiving information on how to complain

Areas of concern and ongoing improvement include;

- Feeling threatened by other patients or visitors
- Bothered by noise at night
- Doctors talking in front of patients as if they were not there
- Knowing which nurse was in charge of care
- Finding a member of staff to discuss concerns with
- Discharge; knowing what would happen next with care
- Discharge; understanding medications
- Discharge; knowing who to contact if worried

Detailed analysis of the 2016 survey results and our response will be published on www.waht.nhs.uk once received. A detailed action plan will be developed from this feedback and will be made available on the Trust's website.

During 2016/17 we also introduced external surveys of patients' experiences in the Emergency Department and in Outpatients Departments. The action plan from Outpatients was reviewed by Patient Experience Review Group in October 2016. We are currently developing the action plan from the Emergency Department survey report – which received by the Trust in April 2017.

Our Friends and Family Test results

The Friends and Family Test is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. As well as the standard six-point response for wards we have included additional questions to generate a richer data base to inform learning and change. The Trust introduced this survey tool in January 2013 for all acute wards and the Accident and Emergency Department. In October 2013 the survey was extended to include Maternity services. Each Division and ward receives a breakdown of the outcome of their survey results to allow them to take relevant action. In October 2014 the survey was extended to outpatients.

The Trust Friends and Family response rate and recommendation score is compared with the average scores for NHS acute services across England.

The results for 'Would Recommend' have been calculated using the formula:

$$\text{Recommend (\%)} = \frac{\text{(Extremely Likely + Likely)}}{\text{All responses x 100}}$$

The responses are divided into four categories; inpatients outpatients, maternity and A&E attendees. Our maternity, outpatients and results and A&E recommendation score has compared favourably with the national average.

The tables below give further detail.

Maternity question 1 = antenatal care
Maternity question 2 = care during birth
Maternity question 3 = care on the postnatal ward
Maternity question 4 = postnatal care in the community

			Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Would Recommend	In-Patient	Trust	94%	94%	97%	95%	95%	97%	94%	96%	95%	95%	97%	95%
		England	96%	96%	96%	96%	95%	96%	95%	96%	95%	95%	96%	96%
	A&E	Trust	88%	92%	93%	95%	81%	82%	79%	79%	90%	89%	94%	91%
		England	86%	85%	86%	85%	87%	86%	86%	86%	86%	87%	87%	87%
	Out patient	Trust	93%	89%	92%	95%	96%	95%	95%	97%	98%	95%	96%	94%
		England	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	94%
	Maternity	Trust 1	100%	96%	100%	96%	100%	96%	89%	100%	100%	93%	100%	100%
		England	96%	96%	95%	95%	95%	96%	95%	96%	96%	96%	96%	96%
		Trust 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		England	96%	97%	97%	97%	96%	96%	96%	97%	96%	97%	97%	97%
		Trust 3	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		England	94%	94%	94%	93%	93%	94%	94%	94%	94%	94%	94%	94%
		Trust 4	100%	100%	98%	100%	100%	100%	100%	97%	100%	100%	100%	98%
		England	97%	98%	98%	98%	97%	98%	98%	97%	98%	98%	98%	98%

Response Rate	In-Patient	Trust	40.4%	41.9%	42%	44%	33.4%	35.7%	31.5%	34.6%	31%	34%	38.10%	37.6%
		England	25.60%	25.90%	26.70%	27.60%	24.80%	26.70%	24.40%	24.40%	22.60%	24.3%	25.1%	26.1%
	A&E	Trust	4.9%	5.2%	4.5%	3.5%	5.2%	4.4%	2.9%	3.8%	1.6%	5.9%	5.70%	6.5%
		England	12.9%	12.9%	13.4%	12.9%	13.7%	13%	12.8%	12.7%	11%	12.3%	12.7%	12.9%
	Maternity (Births)	Trust	66.7%	73.7%	21.4%	81.3%	50%	38.1%	41.4%	100%	53.8%	40%	46.2%	23.1%
		England	23.8%	24%	35.4%	26.2%	22.9%	22.8%	21.9%	23.3%	21.5%	25.5%	23.1%	24.4%

Learning from PALs and complaints

The Trust has a well-established Patient Advice and Liaison Service (PALS) and a complaints-management system, supported and facilitated by a Senior Manager. Both services are used to ensure that patients and people using Trust services are supported in navigating the system and finding resolution to questions, concerns and complaints. The information from these questions, concerns and complaints is routinely analysed and used to inform service development and reported to the Trust Board through formal monthly reports.

The Senior Manager for complaints and PALS actively engages in supporting the development of staff to ensure they are able to respond appropriately and sensitively to complaints, whilst handling sensitive situations and data. A complaints investigation training programme was delivered in 2016. Staff training in complaints resolution is now available a part of the Trusts annual training programme and will remain high on the training agenda for the Trust.

The Trust received a total of 251 formal complaints which represents a 16.2% increase on the last year's total of 216 for 2015/2016.

The Trust looks for trends in complaints to see if there are any recurring or growing issues that may need special attention. The main subjects of complaint are around medical treatment and communication. The proportion of complaints linked to medical treatment and nursing care has risen slightly. The most significant increase however is the number of complaints linked to communication. To improve the standards of care the Trusts continue to deliver initiatives such as ward Wednesday which involves formal weekly ward visits by the Directorate Matrons, Director and Associate Director of Nursing and other senior nurses. The purpose is to monitor how care is delivered, specifically looking at the dignity, safety and the welfare of patients.

Throughout the year the themes of all complaints are reviewed. Directorates report on the learning that has been identified from the complaints resolved during the month. The Matrons and Departmental Managers ensure that any learning identified through complaints is shared across teams within the Directorates and that all improvements identified are fully implemented.

Complainants are always invited to come into the Hospital and discuss their concerns with the relevant staff, and this helps staff to get a better understanding of how things are from a patient's or family's perspective as well as helping patients and families to hear the staff view.

The table below shows the main types of complaints received during 2016/17 and the changes from last year.

Main types of complaints received during 2016/17:

	2014/15	2015/16	2016/17
Complaints about staff attitude - %	8%	6%	6%
Complaints about medical treatment - %	24%	23%	24.7%
Complaints about nursing care - %	11%	10%	12.9%

Complaints about communication - %	23%	23%	31.5%

Parliamentary and Health Service Ombudsman
The Parliamentary Ombudsman can investigate complaints when individuals feel they have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England. The Ombudsman can decide not to investigate, to agree with how the original complaint was dealt with, or to uphold a complaint and insist that the public organisation puts things right.

During 2016/17 five complaints were accepted by the Ombudsman for investigation. The Ombudsman confirmed that two of these complaints would be “not upheld”, and is still considering their decision on three cases.

Complying with the vision of good complaint handling
The Trust continues to cooperate with the Ombudsman when required. The framework introduced by the Parliamentary and Health Service Ombudsman in their report published in November 2014 was used in the complaints satisfaction survey for 2016/17.

Annual Quality Account

The Board of Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance to NHS trust boards on the form and content of this annual Quality Account.

Quality Accounts are public reports from providers of NHS healthcare about the quality of services they deliver. The primary purpose of Quality Accounts is for healthcare organisations to assess quality across all of the healthcare services they offer and to demonstrate publically a commitment to continuous, evidence-based quality improvement.

The content of the Trust's Quality Account for 2016/17 builds on the 2015/16 report. In it, we describe our progress against the priorities that we established for the year. We also identify a number of areas for focus during the next twelve months and we explain how we intend to improve quality during 2017/18.

Our improvement goals for 2017/18 were informed by:

- Feedback from Care Quality Commission inspections of the Trust.
- National requirements included in the NHS Constitution and Five Year Forward View.
- The needs of our population as described in the latest Joint Strategic Needs Assessment.
- The experiences of our patients – captured by the work of our Patients' Council, Patient Experience Review Group and Healthwatch North Somerset.
- Performance data about the Trust – including mortality, incidents, complaints/PALs and audit data.
- Our corporate risk register and Board Assurance Framework
- The views of our staff

The Trust uses the same systems and processes to collate, validate, analyse and report on data for the annual Quality Account as it does for other clinical quality and performance information. The Audit and Assurance Committee commission external auditors to undertake a review of the data assurance underpinning the Quality Account and through this process and other reviews of data, the Board are assured that the Quality Account represents a balanced view.

Ensuring Performance against our priorities

Managing effectively to ensure we have and can demonstrate that we are achieving our priorities is important for both staff and service users.

The Trust reviewed how it monitors performance through a revision of its Governance Framework. Governance is the term used to describe a systematic approach to planning, monitoring and improving the quality of care and services we deliver. It is a framework we use to ensure accountability for the continuing improvement of services we provide, whilst safeguarding high standards and creating an environment which provides excellence for those in our care.

Performance against our priorities is reviewed routinely at key committee meetings in the Trust, including the Trust Board.

Performance against priorities is also subject to scrutiny and review by our commissioners, and the NHS Improvement as well as the Care Quality Commission.

The resources, principal risks, uncertainties and relationships that may affect the Trust's long-term value

Six actual strategic risks remained consistently scored as 'red' (that is scored 15 or above with a likelihood assessment of 'likely' or 'almost certain') throughout the last year. All of these have reflected or created challenges in staffing and financial resource at the Trust. They were;

1. Risk that medical staffing in ED, histopathology, medicine will not be at the required numbers or skills to deliver safe and dignified care.
2. Risk that mortality rates will not be 'as expected' compared to the position across the rest of England.
3. Risk that the emergency department will not attain clinical quality indicators, performance targets and be a suitable training environment.
4. Risk that people who use our services are not discharged in a safe and timely fashion.
5. Risk that the Trust will be unable to deliver a major savings plan
6. Risk that we will fail to support the improvement in quality of care and efficiency across the Trust through the delivery of an innovative and robust IT programme.

Specific risk mitigation processes were utilised to manage these risks including:

- Action plans to address risks around the quality of supervision for junior doctors – overseen by the General Medical Council and Sustainability Board Clinical Oversight Group.
- Additional oversight of mortality review processes
- Participation in whole healthcare community groups to respond to emergency demand and expedite patient's discharge from the hospital.
- Daily monitoring, risk scoring and reporting of incidents, concerns, and staff risks.
- Increased Board monitoring of the patient's experience
- Active participation in Sustainability and Transformation Planning with partners.

These risks were managed through the Assurance Framework and risk management processes. In addition, the Board sought assurance that the Trust's objectives were being achieved and the risks controlled through a variety of assurance processes, including performance reports with high-level key performance indicators, audits (internal and external), assessments by regulatory and monitoring agencies (e.g. Royal Colleges, NHS Improvement).

The Risk Management Strategy defines the Trust's key external stakeholders and who is required to be kept informed of high level risks and, where appropriate, consulted in the management of risks faced by the Trust. Executive Directors have taken responsibility for assuring that external stakeholders are informed as necessary, particularly in the event of a serious untoward incident.

During the last 12 months, the Trust has continued its active involvement as required by the Civil Contingencies Act with the new Local Resilience Partnership Health which takes into account in terms of health emergency planning, risks identified on the Community Risk Register.

The Trust continues to work closely with the main commissioner of services, North Somerset Clinical Commissioning Group, to jointly plan and develop services.

The Trust will continue to work closely with other key partners during the coming months, notably the NHS Improvement, the North Somerset Clinical Commissioning Group, Somerset Clinical Commissioning Group, North Somerset Council, Weston College and the local Healthwatch. The Trust will also continue to take an active part in sector-wide networks in particular:

Regional meetings and forums

- Chairperson and Chief Executive meetings with NHS Improvement
- Specialist forums for Directors of Finance, Nursing & Human Resources

Bristol, North Somerset, Somerset & South Gloucestershire Area (BNSSSG) meetings and forums:

- Sustainability Board
- BNSSSG Quality Review Meetings
- North Somerset Infection Prevention and Control Forum
- West of England Academic Health Sciences Network

Clinical Networking:

- Care pathway networks including the Avon, Somerset, Gloucester and Wiltshire Cancer Network and Urgent Care Network
- North Somerset Safeguarding Adults Board
- North Somerset Safeguarding Children Board
- Avon and Somerset Local Health Resilience Partnership
- North Somerset Health Overview and Scrutiny Committee
- North Somerset Health and Wellbeing Board (People and Communities Board)

Participation in and strengthening of partnership arrangements for the Trust has continued to make a significant contribution to the achievements of the Trust and to the wider objectives of the health and social care economy including:

Emergency Preparedness

Weston Area Health NHS Trust recognises its statutory duties and responsibilities as a Category 1 responder under the Civil Contingencies Act (2004). Additionally the Trust is required to comply with the NHS England Core Standards for Emergency Preparedness, Resilience and Response. The Trust continually develops, maintains and tests its plans to manage Major Incidents or potential disruptions to the services we provide. The Trust works closely with our partner agencies in this process.

Preparedness

- Weston Area Health NHS Trust is represented in the Local Health Resilience Partnership (LHRP), a statutory planning body for health emergency planning.
- The Trust has had in place since September 2016 a new Resilience Manager, reviewing and redeveloping the Trusts emergency preparedness and business continuity documents and processes.
- The Trust has redeveloped its Incident Response Plan to include scalable arrangements for dealing with incidents ranging from critical incidents for managing serious operational pressures, to incidents involving mass casualties.
- The emergency preparedness and business continuity management arrangements have been reviewed in an internal audit in March 2017, with the Trust rated as satisfactory.
- The Trusts arrangements for CBRN (Chemical, Biological, Radioactive, Nuclear) were audited by South Western Ambulance NHS Trust in January 2017, with the Trust rated as fully compliant with the relevant standards.

Response

- Due to operational pressure in the winter of 2016 /17, The Trust declared a Critical Incident on 2 occasions. This enabled the implementation of command and control arrangements alongside necessary response arrangements from partner organisations. These response arrangements enabled safe services to be maintained during sustained periods of high operational pressure.
- The Pharmacy department activated their Business Continuity planning arrangements for the planned renovation of their facility and introduction of a new pharmacy robot. This disruptive

event went as planned with Pharmacy setting up safe operational capacity in an alternative temporary location.
- The Trust was required to place the Emergency Department into lockdown in November 2016, due to reports of a potentially armed patient planning to attend A&E. The incident required police support and was managed effectively and safely by all staff involved.

Training
A range of training activities that staff members have undertaken during 2016/17 have included the following:

- Strategic Leadership in a Crisis Course (November 2016)
- Emergencies on Trial Course (July 2016)
- Project Argus - Police led counter terrorism training event (March 2017)
- Business Continuity Desktop Exercise (December 2016)
- Certificate in Emergency Preparedness Resilience and Response (April 2016)
- Major Incident Awareness and Setting up the Incident Control Centre (October 2016)
- CBRN (Chemical, Biological, Radioactive, Nuclear) Training (Monthly)

Environmental Policy

Weston Area Health Trust is committed to encouraging and promoting Green Travel and carbon reduction in the Trust through a range of inter-dependent initiatives which are intended to improve the environment whilst also supporting staff health and wellbeing. This is managed by the Trust's Sustainability Management Group.

The group is committed to achieving best practice procedures through investment in training, guidance, and changes in the process of its business so that environmental management is an integral part of healthcare provision.

The Trust will continuously aim to improve its environmental performance against a series of objectives and targets in the following areas:

- To oversee the development, promotion and review of the Trust's sustainable Travel Plan.
- To review and where necessary, prioritise recommendations to encourage sustainable travel.
- To ensure that employees, patients and visitors are kept informed about the Trust's progress regarding the Travel Plan.
- To oversee key priorities, targets and reputational challenges on key sustainability issues
- To keep under review the Trust's sustainability plan;
- To consider and recommend Trust positioning and potential action on relevant emerging sustainability issues
- To share best practice throughout the organisation and engage with staff on how they can support sustainability plan delivery.

Carbon footprint

The Trust has calculated its Carbon Footprint for Year ending 31st March 2017, which enables the Trust to monitor performance against a Department of Health recognised assessment tool and to compare with other similar organisations.

	2015-16 Tonnes CO2e	2016-17 Tonnes CO2e	Change +/- Tonnes CO2e
SCOPE ONE EMISSIONS Fuel Combustion Gas Boilers	**1227.74**	**815.77**	**-411-97**
SCOPE TWO EMISSIONS Purchased Energy Consumption Electricity	**2389.40**	**1991.71**	**-397.69**
Water usage: 0.34kg per M3	**17.92**	**15.50**	**-2.42**
Non recycled waste Clinical Incinerated all types Clinical Alternative treatment General waste	**22.08** **18.80** **66.54**	**12.65** **19.42** **113.45**	**-9.43** **+0.62** **+46.91**
Recycled Waste Mixed municipal recycled : Glass	**1.34** **70.02**	**2.39** **54.20**	**+1.05** **-15.82**
TOTAL EMISSIONS	**3813.84**	**3025.86**	**-787.98**

Building Use

During 2016/17 the Trust invested £1.9m to improve its and upgrade its estate. Brief outlines of the main projects are highlighted below:

Endoscopy Refurbishment

This is the largest Capital investment this financial year (£1.4m). In order for this to be achieved a proportion of Ashcombe will be utilised. As part of the refurbishment Ashcombe will require some relocation of amenities such as office space and day assessment unit will be absorbed in the maternity unit. This is to ensure single sex compliance throughout the unit.

This refurbishment will also include:

- Replacement of the existing air handling units
- Replace surgeon's control panels
- Provide an uninterrupted power supply system linked to the day case theatres.
- Replacement of existing pressure stabilisers
- Updating all existing general lighting
- Rewire the department and alternations to the ventilation system.

In order to meet the service requirement the works will be phased to allow a continuous service throughout the refurbishment period. The plans have been shared with both departments, Infection Control, Fire Officer, Director of Operations, and Director of Nursing. An independent JAG accreditation will review and approve the design.

The planning, design, purchasing of equipment and tendering process has been completed this financial year and the works for phase one will commence in April 2017. The refurbishment will be staggered over three phases designed to reduce the amount of disruption to patients and staff during this period. This will be achieved by completing the works to Ashcombe ward first. This will enable a smoother transition from phase one (enabling works) into phase two. During this period Ashcombe Ward will lose Room 3 for the length of the project and it will become the main entrance to the site and a storage area during phase 3 of the project. A scaffold will be erected with hoist at the back of the hospital, so materials and labour can enter the work area without contaminating clinical areas. The third phase will incorporate the upgrade of scope rooms 1 & 2 and the male changing and recovery areas. These works will be near to completion, if not finished by the end of August 2017.

Berrow Ward Isolation Room

This work is to provide a negative pressure isolation facility to safely care for patients with specific airborne infections. The facility is required to protect all staff having contact with these patients and is a requirement in order to meet regulations within the Health and Social Care Act 2008. This work is commence in March 2017 and will be completed by the end of April 2017.

Pharmacy Robot

Yes, the Trust invested in a robot! This will provide the automation of storing, distribution and dispensing processes within the inpatient pharmacy. Additionally, it will supply an effective process for dispensing medication for patients to take home (TTOs), supports patient flow and will contribute to patient satisfaction. Automation will shorten dispensing times, reduce dispensing errors, and facilitate improved stock rotation and management, leading to a reduction in waste. It also has allowed a significant reconfiguration of the current pharmacy workforce, to provide a more comprehensive clinical pharmacy service, by increasing medicine reconciliation. During the installation phase a temporary pharmacy was set up in the rehab gym.

New Macmillan Centre

Macmillan has agreed to make a substantial contribution by way of a charitable grant ("the Macmillan Grant") towards the costs to improve services to people affected by cancer. A new suite with an enhanced interior will be built on the first floor. It will provide a welcoming and comfortable environment for those living with cancer, their carers and relatives. It will also improve the working environment for staff and provide a facility of which Weston General Hospital and Macmillan Cancer Support can be proud.

Lifts

A phased programme of work has commenced to renew the four main lifts in the Trust. This work will be completed across two financial year's. Phase one has been completed which included updating the two service lifts. Phase two which will start next financial year will see the refurbishment of the two passenger lifts.

Installation of New Heating System

The Trust installed a new heating system to increase the resilience of providing heating and hot water to the Trust. The new boilers fitted are more energy efficient. The new energy efficient boilers will help to reduce fuel consumption and improve the Trusts carbon emissions.

Waste & Recycling

The Trust will seek, wherever possible, to reduce the amount of waste produced across all of its properties. Where reduction is not an option, the Trust will aim to introduce reuse and recycling schemes, to minimise the amount of waste requiring final disposal by either incineration or landfill.

The Trust recycles:

- Paper
- Cardboard
- Glass/ Light Bulbs
- Metal
- Batteries
- Plastic
- Printer Cartridges

Protecting Information

The role of Senior Risk Information Owner is performed by the Director of Finance. Information risks are managed and controlled through the Trust's programme of compliance with the Information Governance Toolkit, the Health Informatics Committee and through the implementation of the Information Governance Assurance programme.

There was 1 Information Governance breach that was raised to the Information Commissioners Office. This was fully investigated and all affected parties were contacted. The Information Commissioners Office fed back to the trust that no further action would be taken by them as, 'although some of the information constituted sensitive personal data as defined under the DPA, it was relatively limited in nature. The incident was also the result of a one-off error. Consequently, the case, as reported to us, does not appear to meet the criteria set out in our Data Protection Regulatory Action Policy necessitating further action by the ICO'.

Compliance with Charges for Information

The Trust has complied with the Treasury's guidance on setting charges for information as required.

Part 2 – Accountability report

Corporate Governance report – Directors report

Details of the Directors

During 2016/17 the Weston Area Health NHS Trust Board was made up of thirteen members comprising Executive and Non-Executive Directors. The Chair, the Non-Executive Directors and five of the Executive Directors are voting members. The Board was led by the Chairman, Grahame Paine. The Chief Executive was James Rimmer.

In November 2016 Mr Graham Turner was appointed as Associate Non-Executive Director. He was subsequently appointed as Non-Executive Director in February 2017.
Caroline van Luttmer was appointed as Interim Director of Operations in November 2016 Phil Walmsley was appointed substantively to the role in March 2017.

The Trust Board met on eight occasions in public during 2016/17 and the agenda and papers for these meetings were sent out in advance of the meeting and are made available through the Trust's website. The Board reviewed its effectiveness in November 2016.

Members of the public are invited to attend board meetings and dates of meetings are published on the Trust's website. The Chair of the Patients' Council and a Director of Healthwatch North Somerset are invited members and frequent attendees.

The details of the Trust's Directors are included in the Remuneration Report.

Audit and Assurance Committee

The Trust Audit and Assurance Committee comprises four Non-Executive Directors of the Trust. Its primary role is to determine the adequacy and effective operation of the organisation's overall internal control system.

In performing that role the Committee's work is predominantly focused on the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives (the Assurance Framework).

As a result, the Committee has a pivotal role in reviewing the disclosure statements that flow from the organisation's assurance processes. Members of this Committee during 2016/17 were Ian Turner (Chairman), George Reah, (replaced by Graham Turner from November 2016) Grahame Paine, Rosalinde Wyke and Brigid Musselwhite.

Remuneration Committee

The Trust Remuneration Committee comprised the Chair and all of the Non-Executive Directors of the Trust.

The Committee reviews the salaries of the Executive Directors of the Trust. It also determines any annual performance bonuses in line with individual and corporate achievement of performance objectives, subject to the terms and conditions of the individual's contract of employment.

The remuneration of the Chair and the Non-Executive members of the Board is determined by the Secretary of State for Health. Details of the remuneration paid to Trust Board members are reported in the Remuneration Report.

Declaration of Interests

Directors are required to declare details of any business interests or employment relevant to the work of the Trust. They are also required to declare any gifts or hospitality offered or accepted and any criminal convictions obtained during the year. There were no interests disclosed in 2016/17 that would have resulted in significant conflict.

All the Directors have stated that:

- As far as they are aware there is no relevant audit information of which the Trust's auditors are unaware and,
- They have taken all the steps they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

Auditors

Grant Thornton are the auditors appointed to audit the Trust's statutory accounts. They provide audit and related services carried out in relation to the statutory audit e.g. reporting to the Department of Health.

The audit report gives the auditor's opinion stating whether the accounts give a 'true and fair' view of the Trust's financial position for the year. This opinion includes an assessment of whether the annual report is consistent with their knowledge of the Trust.

Only the following elements of the Accountability report are covered by the auditor's opinion:

- Single total figure of remuneration for each director
- CETV disclosures for each director
- 'Fair pay' (pay multiples) disclosures
- Exit packages, if relevant
- Analysis of staff numbers and costs

The audit opinion, for 2016/17 was that the accounts do give a 'true and fair' view and have been prepared in accordance with accounting policies. The audit report also comments on the Trust's arrangements for securing economy, efficiency and effectiveness. The opinion states that the auditor is satisfied that in all significant respects Weston Area Health NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2017, except for matters in relation to proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

The trust's outturn position for 2016/17 was a £7.185 million deficit, which is a significant deterioration compared to the trust's original forecast of a £3.2 million deficit. In addition, the trust's medium term financial plan shows a further substantial deterioration, with a forecast deficit of £6.035 million for 2017/18. The deterioration in the trust's financial outturn was primarily due to a significant shortfall in the planned savings of £4.1 million. Actual savings of £2.54 million were achieved which also led to the loss of £1.8m STF income in Quarters 3 and 4

In 2016/17, the Trust's external audit fees were £69,000 compared to £69,000 in 2015/16.

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

The Chief Executive of NHS Trust Development Improvement has designated that the Chief Executive should be the Accountable Officer to the Trust.

The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Improvement. 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.
- Annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

I confirm that, as far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

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

Signed; James Rimmer, Chief Executive

Date 26 May 2017

Statement of Directors' responsibilities in respect of the Accounts

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

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

By order of the Board

NB: sign and date in any colour ink except black

26-May-17 **Date** **Chief Executive**

26 MAY 17 **Date** **Finance Director**

Annual Governance Statement 2016/17

1. Scope of responsibility

As Accountable Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives whilst safeguarding the public funds and departmental assets for which I am personally responsible, as set out in the Accountable Officer Memorandum.

2. 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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Weston Area Health 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 at Weston Area Health NHS Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

3. The risk and control framework

The Trust has a governance system in place which has been developed and enhanced over a number of years and continues to be subject to regular review to ensure its continued fitness for purpose.

The **Trust Board** operates in accordance with the Trust Standing Orders and has overall responsibility for agreeing the risks, controls and assurances detailed in the Board Assurance Framework and for the frameworks maintenance and monitoring during the year. Board membership during 2016/17 was as follows:

Name	Title
Grahame Paine	Chairman (V)
George Reah	Vice Chair / Non-Executive Director (V)
Brigid Musselwhite	Non-Executive Director (V)
Ian Turner	Non-Executive Director (V)
Rosalind Wyke	Non-Executive Director (V)
Frank Powell	Non-Executive Director (V)
James Rimmer	Chief Executive (V)
Bronwen Bishop	Director of Strategic Development (V)
Karen Croker	Director of Operations (to Sept 2016)
Sheridan Flavin	Director of Human Resources
Rob Little	Director of Finance / Deputy CEO (V)
Nick Lyons	Medical Director (V)
Helen Richardson	Director of Nursing (V)

(V) Denotes Voting Member

Board attendance for the year (excluding an accounts and budget setting meeting) was as follows:

Name	03.05.16	05.07.16	06.09.16	01.11.16	20.12.16	10.01.17	07.03.17	10.03.17
Grahame Paine	Y	Y	Y	Y	Y	Y	Y	Y
George Reah/Grahame Turner	Y	Y	Y	N	Y	Y	Y	Y
Brigid Musselwhite	Y	Y	Y	Y	Y	Y	N	N
Ian Turner	Y	Y	Y	Y	N	Y	Y	Y
Rosalind Wyke	Y	Y	N	Y	Y	Y	Y	Y
Frank Powell	Y	Y	Y	Y	Y	Y	Y	Y
James Rimmer	Y	Y	Y	Y	Y	Y	Y	Y
Bronwen Bishop	Y	Y	Y	Y	Y	Y	N	N
Karen Croker	Y	Y	N					
Sheridan Flavin	Y	N	Y	Y	Y	Y	Y	Y
Rob Little	Y	Y	Y	Y	Y	Y	Y	N
Nick Lyons	Y	Y	Y	N	Y			
Helen Richardson	Y	Y	Y	Y	Y	Y	Y	Y

In 2016/17 the Board has reviewed and approved **Annual Reports** for:

1. Complaints
2. Safeguarding Adults and Children at Risk
3. Infection Prevention and Control
4. Health and Safety
5. Emergency Preparedness, Resilience and Response
6. Medical Revalidation and Appraisal
7. Nursing and Midwifery Revalidation
8. Medical Education

It has also considered and responded to;

- the Care Quality Commission review 'Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England'
- the Carter Procurement Transformation Plan
- quarterly reporting from the Trust's **Guardian of Safe Working** and
- quarterly reporting from the **Freedom to Speak Up Guardian**.

In November 2016 the Trust Chair led a review of the **effectiveness of the Board** whereby members were invited to score performance against fifteen key areas;

1. Enabling good corporate accountability and good social practice
2. Embedded board disciplines and appropriate delegations
3. Prioritise a people strategy
4. Building board capability and capacity
5. Exercising judgment
6. Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?
7. Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?
8. Does the board have the skills and capability to lead the organisation?

9. Does the board shape an open, transparent and quality-focused culture?
10. Does the board support continuous learning and development across the organisation?
11. Are there clear roles and accountabilities in relation to board governance (including quality governance?)
12. Are there clearly defined, well- understood processes for escalating and resolving issues and managing performance?
13. Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?
14. Is appropriate information on organisational and operational performance being analysed and challenged?
15. Is the board assured of the robustness of information?

Priorities for development were included in future planning and were agreed as;

- Oversight of a 'people strategy'
- Sustainability planning
- Strengthening Board capability and capacity
- Organisational development – in particular developing a 'learning organisation'
- Continued embedding good governance

The five committees established by the Board have met as planned and been quorate throughout the year. These committees are the:

- Audit and Assurance Committee
- Quality and Governance Committee
- Remuneration and Terms of Service Committee
- Finance and Performance (formerly Finance) Committee
- Trust and Charitable Funds Board
- People and Organisational Development Group

The **Board agendas** have reflected the main risks to the strategic objectives of the Trust and have been described in terms of the five **CQC domains** of:

- Are services safe?
- Are services effective?
- Are services caring?
- Are services responsive?
- Are services well led?

In September 2016 the Board approved an **annual review of the committee structure** at the Trust.

The changes:

- Sought to strengthen the remit and membership of the Clinical Advisory Group
- Clearly articulated the breadth of the Senior Management Group oversight of operational business;
- Enabled the Quality & Governance Committee agenda to be more strategic;

- Strengthened workforce assurance and reporting
- Proposed a collation of staff engagement via existing staff groups and the disbanding of the Staff Experience and Engagement Group
- Improved oversight and assurance of the quality of performance data via the Finance and Performance Committee
- Agreed the establishment of a people and Organisational Development Committee

The **Audit and Assurance Committee** is a committee of Non-Executive Directors. The committee monitors and oversees both internal control issues and the process for risk management. Audit Southwest (internal audit) and Grant Thornton (external auditors) attend all Audit and Assurance Committee meetings. The Audit Committee receives all reports of the Internal and External Auditors and reports regularly to the Board. The work of the Audit and Assurance Committee is supported by two key sub committees and their subgroups;

1. Risk Management
    - Infection Prevention and Control
    - Emergency Planning and Preparedness
    - Health & Safety & Security
    - Safeguarding Committee
    - Health Informatics Committee
2. Counter Fraud Steering

The Auditors have not raised any issues with the Trust accounts that would lead to a qualification and as at previous years we are not expecting any of our accounts to be qualified.

The **Quality and Governance Committee** is chaired by a Non-Executive Director. The Committee takes a comprehensive oversight of the quality and safety of care provided by the Trust and provides assurance to the Board. The work of the Quality and Governance Committee is supported by four key sub committees:

1. Risk Management
2. Clinical Advisory
    - Clinical Audit & Effectiveness
    - Mortality & Morbidity
    - Patient Experience
    - Research & Development
    - Radiation Protection
    - Resuscitation and Critical care
    - Organ Donation
    - Mental Health Operational
    - Medical Equipment
    - Drugs and Therapeutics
    - Transfusion
3. Workforce
4. Performance management

The **Finance and Performance (formerly Finance) Committee** is chaired by a Non-Executive Director. The Committee provides the Trust Board with assurance that there are robust and integrated mechanisms in place to ensure detailed consideration and oversight of the Trust's finance and performance, and associated clinical activity data and workforce metrics.

The Trust has a Board approved **Risk Management Strategy** which identifies that the Chief Executive has overall responsibility and accountability for having an effective risk management system in place for meeting all statutory requirements, and adhering to guidance issued by the Department of Health and NHS Improvement in respect of Governance.

The Board is committed to the continuous development of a framework to manage risks in a structured and focused way in order to protect patients, staff and the public from harm and to protect the Trust from losses or damage to its reputation.

At its Seminar on 4 October 2016, the Board mapped its **risk appetite** against its 2016.17 strategic objectives as follows;

Strategic focus	**Relative Willingness to Accept Risk – Risk Appetite**				
	Very Low	**Low**	**Moderate**	**High**	**Very High**
	1	**2**	**3**	**4**	**5**
Patient experience/safety					
Health promotion					
Efficient and effective					
Workforce					
Partnerships and leadership					
Finance					
Estates compliance					
Innovation					

And subsequently agreed the following risk appetite statement to guide senior managers;

> *The Trust operates within a high overall range of risks. The Trust's lowest risk appetite is for the safety and quality of patient care. This means that mitigating these risks so far as is reasonably practicable may take priority over meeting our other business and strategic objectives.*
>
> *Where business and strategic risks can be effectively mitigated, and within clearly defined limits of authority and escalation (as per the Trust's risk management policy and risk scoring matrix) positive risk taking will be encouraged where it may deliver innovation, service improvement or greater efficiency in our operations.*

The Director of Nursing has responsibility for managing the implementation of risk management, clinical governance and quality impact assessment. All managers and clinicians accept the management of risks as one of their fundamental duties.

These duties are defined in the **Risk Management Strategy**, which identifies the roles and responsibilities of Directors, managers and staff in relation to risk identification, analysis and control. Additionally, the strategy recognises that every member of staff must be committed to identifying and reducing risks.

To this end the Trust:

- Promotes an **environment of accountability** to encourage staff at all levels to report when things go wrong, allowing an open discussion to prevent their re-occurrence.

- Provides all staff with access to **risk management information, advice, instruction and training**. Risk management is included in the core Staff Induction Programme which covers incident reporting and complaints, information governance, manual handling, infection control. Risk management is also included in regular mandatory updates in line with the Statutory and Mandatory Training Policy. The level of training varies according to need and is assessed as part of the annual formal staff appraisal process. There is ongoing support from the **Governance Team** which includes Health and Safety expertise.

The **Risk Management Committee** leads the Trust's response to the management of all areas of risk and ensures that all elements of the Risk Management Strategy are addressed within available resources. This includes the management of risk in relation to the achievement of the Trust's corporate objectives and the Assurance Framework. The Risk Management Committee reports to both the Audit and Assurance Committee, the Quality and Governance Committee. It is chaired by the Lead Executive Director for Clinical Risk (the Director of Nursing).

Risk issues are reported to both the Audit and Assurance Committee and the Quality and Governance Committee via the Risk Management Committee, the Senior Management Group and the Trust's management structure. Management and ownership of risk is delegated to the appropriate level from executive director to local management through the directorate management teams. In April 2015 the two Directorates of Emergency and Planned Care were restructured to create a third Clinical Services Directorate.

Each Directorate has since established a **Directorate Governance Group** to manage risk and report and escalate concerns. Performance management of any governance/risk action plans are managed via the Directorate **Performance Assurance Framework** led by the Director of Operations.

The Performance Assurance Framework is also reviewed and discussed at the **Performance Management Review**, chaired by the Chief Executive and including all Executive Directors. This monthly meeting monitors the performance of the clinical Directorates and of Estates and Facilities against key performance indicators including risk.

Strategic risks are managed via the Board owned **Board Assurance Framework**. This document focuses on risks that could prevent the Trust from achieving its strategic objectives. Executive and Non-Executive Directors review this and the Corporate Risk Register document every two months via the Senior Management Group and Audit and Assurance Committee. The Board reviews this document at six

monthly intervals – paying particular attention to any material gaps in controls or assurance. The Audit and Assurance Committee considers the Board Assurance Framework and the Corporate Risk Register when setting the Internal Audit annual work plan.

The principal risks that have remained consistently risk scored red for a period of four months or longer as described on the 2016/17 Framework are:

AF Ref	Risk Title
1.1	Risk that **medical staffing** will not be at the required **numbers** to deliver safe and dignified care.
1.2	Risk that the safety of care will be compromised by **medical skills** shortages.
1.3	Risk that **mortality rates** will not be 'as expected 'compared to position across rest of England
1.4	Risk that the **emergency department** will not attain clinical quality indicators, national performance targets and be a safe and suitable training environment.
3.1	Risk that people who use our services are not **discharged** in a safe and timely fashion.
4.3	Risk that **mandatory training and induction** programmes will not be effective or appropriately attended by staff
5.1	Risk that the Trust is unable to secure partners to manage the future delivery of **clinically and financially viable services**.
6.1	Risk that the Trust will be unable to deliver a **major savings plan.**
8.1	Risk that we will fail to support the improvement in quality of care and efficiency across the Trust through the delivery of an innovative and **robust IT** programme

The Board agendas have reflected these main risks to the strategic objectives of the Trust and regular review of the effectiveness of mitigation has occurred by Executive Leads, by the Senior Management Group, by the Audit & Assurance Committee and Board.

An **electronic governance system,** which has the ability to record and monitor incidents, complaints and risks, has been operational since 2010. The system facilitates the reporting and management of incidents. It has been extended to include the complaints and risk register module to provide comprehensive reporting and to support greater **triangulation** of risk. Each weekday all incidents are risk scored by the Governance Team.

Integration with other assurance reporting streams (for example concerns raised via the Patient Advice & Liaison Services and agency staff usage), takes place each weekday and Executive and Operational leads are updated regarding any apparent trends.

The Head of Governance and team co-ordinate the identification of **Serious Incidents Requiring Investigation,** and other adverse incidents, which are reported and managed through the Directorate Governance Committees, Quality and Governance Committee and by the Trust Board.

The Serious Incident Review Panel ensures that serious incidents are adequately investigated and that lessons learned are identified. All SIRI investigation reports and action plans are shared with the Trust's lead commissioner, North Somerset Clinical Commissioning Group.

Following the publications of the Berwick, Francis and Keogh Reports in 2013 the Quality Improvement Hub was developed in October 2013. The aim of the Hub is to engage clinicians to focus on **quality improvement methodology**. The Hub is located in a central area in the hospital, enabling clinical staff to gain more direct support and guidance to undertake quality improvement projects. Clinical staff receive coaching and support to undertake baseline audits, to collect and organise data and to build improvement projects. Priority areas for improvement during 2016/17 have been identified via mortality review.

There is an established **Information Governance Framework** within the Trust, with the role of Caldicott Guardian being held by the Medical Director and the SIRO (Senior Information Risk Officer) role being held by the Director of Finance. Operational management of data protection is the responsibility of the Trust's in-house solicitor.

The Trust has monitored and implemented the Information Governance toolkit plan in 2016/17. The final self-assessment submission achieved 73% compliance with the NHS Health and Social Care Information Centre requirements.

NHS England guidance and embedded legislation on the recording and monitoring of Elective Waiting Time data is complex and allows for local agreement and flexibility in how some rules are interpreted. To ensure that inherent risks and unintended consequences from local interpretation are monitored the Trust has a robust framework and meeting structure that supports and drives the Information Governance agenda. This provides the Trust Board via the Audit Committee and Health Informatics Committee with the assurance that effective Information Governance best practice mechanisms are in place within the organisation.

Assessment of **data quality** incorporating Referral to Treatment/Elective Waiting List Management is included in the Trust's annual Internal Audit work plan. The audit process provides independent assurance of the design and operation of controls in place.

The Board regularly discusses a wide range of data regarding quality and patient safety, operational performance, human resources and finance – which is detailed within an Integrated Performance Report. This helps to improve data quality and presentation through robust discussion, analysis and questioning by directors, patients' representatives and members of the general public.

In order to achieve further transparency the Trust continues to benchmark its data and performance against Hospital Episode Statistics (HES) via Caspe Healthcare Knowledge Systems (CHKS) statistics (an independent provider of healthcare intelligence and quality improvement services).

Risks to information are managed and controlled via the Health Informatics Service risk register, Directorate risk registers (if appropriate), the Trust's corporate risk register and incident reporting mechanism. Through these above processes, I am aware of the risk management systems in place for information governance at the Trust.

There was one Information Governance breach that was raised to the Information Commissioners Office during 2016/17. This was fully investigated and all affected parties were contacted. The Information Commissioners Office fed back to the Trust that no further action would be taken by them as;

> *'although some of the information constituted sensitive personal data as defined under the DPA, it was relatively limited in nature. The incident was also the result of a one-off error. Consequently, the case, as reported to us, does not appear to meet the criteria set out in our Data Protection Regulatory Action Policy necessitating further action by the ICO'*

During 2016, in response to the CQC inspection in May and August 2015 and an increasing trend in mortality rates reported at the Trust (noted as outside expected variability in March 2016), the Medical Director and Director of Patient Safety worked together to improve the frequency and quality of **mortality review.**

A revised reporting template and process – overseen by the Mortality Review Group has demonstrated improvements to this process – improvements which will be fully realised in the coming year.

4. Risk identification and evaluation

There are currently 28 risks scored 9 or above on the Corporate Risk Register. (We score risks using a matrix that measures the likelihood of a risk occurring against its impact should it occur. A risk can score up to a maximum of 25). All identified risks have mitigation plans in place.

Of the Trust's highest scoring risks, four relate to the **Emergency Department** – the risk of overnight closure, suboptimal levels of medical staffing, the timeliness of medical review and delay in sepsis treatment.

- Four relate to **governance** arrangements – the overview of standards of clinical effectiveness, immature governance arrangements at Directorate level (safety incidents and policy compliance), safety incidents involving medicines and compliance with Health & Safety Regulations
- Three relate to **medical staff vacancies**
- Three relate to the Trust's ability to deliver the end of year **financial balance** – achieving the required level of savings when the level of income is lower than expected
- Two relate to **I.T.** legacy systems
- Two relate to the timeliness of **discharge and patient flow**
- One relates to the higher than expected **mortality** and efficiency of the mortality review process
- One relates to the ability to achieve national **cancer** targets
- One relates to the Trust's ability to achieve **accreditation of its endoscopy** department
- One relates to the incidence of **hospital-acquired pressure ulcers**

- One relates to **pending list** management
- One relates to compliance with **EPRR standards**
- One relates to the results of the **national staff survey**

Actions are in place with risks assigned to an appropriate executive lead and manager who are responsible for ensuring that the risk is either eliminated or managed appropriately.

During 2016.17 the Trust has been in the “higher than expected” category for the Summary Hospital-level Mortality Indicator **(SHMI).** This indicator compares the actual number of deaths with the expected number of deaths during (and for 30 days after) a hospital admission over a period of 12 months. During the year the indicator rose to 1.16 in April 2016 and reduced to 1.15 in the following quarter. In the latest available data (September 2016) the indicator remains at 1.15 against an upper acceptable limit of 1.14.

In response, the **Mortality Review Group** (MRG) has significantly strengthened the focus on mortality review to ensure a robust process. The group has identified areas where more detailed review of clinical care should take place by reviewing 489 deaths out of 656 (75%) during 2016-7. Using **Quality Improvement** (QI) strategies based on the Institute for Healthcare improvement (IHI) methodologies we are changing practice in the following areas -

- Urinary tract infections
- Community acquired pneumonia
- Hospital acquired pneumonia
- Chronic Obstructive pulmonary Disease
- Sepsis
- Fracture of the neck of the femur
- Deteriorating patient

The Trust has **Directorate level risk registers** which feed into the Corporate Risk Register. At Directorate level, the risk registers contain lower level localised risks which can be managed by the relevant Directorate. The Corporate Risk Register contains the higher level risks and Trust-wide risks. This supports risks to be identified, managed and escalated appropriately at all levels of the organisation. **Risk assessments**, including Health and Safety and Infection Control, are undertaken throughout the Trust.

Other sources used to identify risks include:

- Complaints and Health Service Ombudsman reports and recommendations
- Inquest findings and reports from HM Coroner
- External/peer review

- Audit of standards
- Feedback from patients and carers
- Internal and external audit reports
- Performance Assurance Framework
- Feedback from staff
- Clinical audit

Risks to the achievement of the Trust's strategic objectives are considered, assessed and managed via the **Board Assurance Framework** which is discussed by the Board on a six monthly basis at its public meeting. The Board has identified that the **Emergency Department** not attaining clinical quality indicators, national performance targets and be a safe and suitable training environment as the most significant risk to the achievement of its strategic objectives.

5. Quality governance

In a review of governance in 2014, the Board agreed on the key elements of monitoring **Ward to**

Board assurance as:

- Risk identification and management
- Incident reporting and responsiveness
- Audit of standards
- Patient, carer and staff experience

These key assurance streams are in turn reinforced by our:

- Leadership/culture
- Committee structure
- Skill mix review
- Senior nurse & medical governance
- Quality Impact Assessment
- Policy governance
- Equality of access
- External/peer review
- Innovation & improvement
- NICE/National Audit
- PALS & complaints
- Operational Governance
- Health & Safety
- Patient Information
- Training/workforce development
- Multi-Disciplinary Team working

The Board uses these monitoring systems and processes to assure itself and report on the quality and safety of care at the Trust.

The Executive Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare **Quality Accounts** for each financial year. The content of the Trust's Quality Account for 2016/17 builds on the 2015/16 report. In it, we describe our progress against the priorities that we established for the year. We also identify a number of areas for focus during the next twelve months and explain how we intend to improve quality for 2017/18.

The 2016/17 Quality Account has been agreed by the Board – subject to any amendments required following completion of the external audit review. The Quality Account incorporates the views of our Patients' Council and experiences of patients. It reflects the performance and risk data about the Trust.

The development of the report is led by the Director of Nursing. The views of North Somerset CCG, as lead commissioner, Healthwatch North Somerset and North Somerset County Council Health Overview and Scrutiny Committee have been sought.

The Trust uses the same systems and processes to collate, validate, analyse and report on data for the annual Quality Account as it does for other clinical quality and performance information. The data is subject to regular review and challenge, in-line with the Trust's commitment to openness and transparency.

6. Clinical and financial sustainability of the Trust

Over the last four years, the Trust's strategy has fundamentally been about organisational form change to deliver clinical, service and financial sustainability. The Trust has focused on "business as usual" as it engages with partners on the BNSSG **Sustainability and Transformation Plan**.

Nationally, challenges to the delivery of care and service pressures are building. In particular:

- Quality of care remains variable
- Preventable illness remains widespread
- Health inequalities are deep-rooted and growing in many areas although new treatment options are emerging.
- Demographic pressures, particularly with regard to care and support for frail older patients, are growing.
- Financial pressures are building.

The key challenges facing the health economy in North Somerset replicate the national picture and can be summarised as:

- Delivering sustainable, high quality clinical services
- Delivering a financially viable health economy
- Recruitment of staff (capability and capacity)
- Delivery of seven-day non-elective services

- Effective management of non-elective patients and sustainable achievement of the emergency care standard.

The **NHS Five Year Forward View** focuses on models of care rather than organisational form. This has presented new opportunities for the Trust to address both internal and system-wide challenges.

In light of these new opportunities, the Trust has worked alongside the NHS Improvement to develop a **strategic plan** which describes the Trust's priorities for the next four years and how definable progress towards improving the sustainability and viability and safety of all services will be delivered. The plan also describes how the Trust will work collaboratively with partners locally and more widely to deliver change which supports the achievement of the national priorities.

In support of this and other opportunities the Trust has announced a closer **partnership with University Hospitals Bristol** – in order to will build on our existing clinical networks and establish the future services of the Trust.

In addition, our Commissioners have sought the views of local people on a number of their ideas for the hospital. During an eight week **public engagement process** opportunities for increasing planned surgical operations, reducing services overnight in the Emergency Department and reducing the complexity of patients in Intensive Care were all debated. The feedback from this is expected in May.

7. External reviews

In August 2016 an **external review of governance** systems at the Trust was led by the **NHS Improvement.** The review looked for opportunities for further streamlining and improving of the effectiveness of the Board and its governance processes.

Triggers for the review were significant in year changes in the Board membership requiring the appointment of a new Chair, Chief Executive Officer, Director of Nursing and Medical Director. This, plus the requirement to introduce Sustainability and Transformation Plans, presented an opportune platform to review, refresh and reinvigorate governance mechanisms.

Terms of reference for the review included a review of:

- Committee structure and effectiveness
- Risk appetite
- Board to Ward assurance
- Board development
- Board effectiveness
- Service level governance and,
- Clinical Governance in the Emergency Department.

Actions from the review were agreed by the Board and included in an action plan - the implementation of which has been led by the Director of Nursing.

Our staff survey shows that whilst the Trust has improved in some areas, other acute trusts have also improved their results which mean that our results in comparison still remain poor in many areas.

During the year the results of the National Audit of Bowel Cancer indicated that the Trust had a higher than expected two year mortality following surgery. In January 2017 the Trust invited the **Royal College of Surgeons** to review the colorectal surgical service at the Trust – in particular to review the patients who died within two years of bowel cancer surgery between 2012 and 2013.

The report from this review was received by the Trust on 2 May 2017. The surgical directorate are formulating an action plan for Board approval. This action plan will ensure that any concerns raised are addressed promptly and that ongoing mortality in this group is monitored for improvement.

During the year our submissions to the National Hip Fracture Database indicated an increase in mortality associated with this care pathway. In response, the Trust invited the **British Orthopaedic Association and British Geriatric Society** to jointly review the care provided. It is anticipated that the report from this review will be received in June 2017.

Between 28 February and 15 March 2017 the Trust underwent a **CQC follow up** inspection of services at the Trust. The inspection focused on the services rated as 'requires improvement' or 'inadequate' following the inspections in May and August 2015. As such, the following services were reviewed:

- Urgent and emergency care
- Medical
- Surgery
- Critical care

The report from the inspection is likely to be available during May 2017. However, initial informal feedback to the Executive Team noted improvements – particularly in the surgical directorate – but also to some degree in Urgent and Emergency Care and Medicine.

However, the timeliness of the flow of patients through the Emergency Department was raised as an area of concern in a warning notice received by the Trust on 24 March 2017. A six week improvement programme has been initiated by the Director of Operations in response to this.

8. Review of the effectiveness of risk management and internal control

In summary, as Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways:

- The Board Assurance Framework provides me with evidence of the effective controls that manage the risks to the organisation achieving its principal objectives.
- The work of the Audit and Assurance and Quality and Governance Committees provide me with assurance on key controls to assist in securing and delivering the Trust's business objectives, effective and reliable control systems and agreed and timely corrective action plans for any gaps in controls, systems or assurances.

- The Head of Internal Audit who provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework, and on the controls reviewed as part of the internal audit work. Within the annual opinion, the Head of Internal Audit has given Significant assurance for the year ended 31 March 2017.
- Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance on the performance of key performance indicators and delivery of operational plans.
- Reports and feedback from external agencies to the Trust provide me with independent evidence on quality and patient safety outcomes and learning.

My review is also informed by detailed major sources of assurance on which reliance has been placed during the year which includes:

External Assurance

- Care Quality Commission Warnings, Monitoring Reports and Inspections.
- Peer Reviews and re-accreditation of specific functions within the organisation (e.g. Royal College of Surgeons, British Orthopaedic Association and British Geriatric Society)
- Audits (clinical, financial, internal, external).
- Other external body assessments/reports (NHS Improvement's Emergency Care Improvement Programme, Healthwatch, NHS Protect).
- Benchmarking of key performance data where possible, including use of the CHKS benchmarking system.
- Financial Monitoring and Accounts (FMA) returns.
- Local public perception including feedback from regular meetings with the Patients' Council, key local stakeholders and media coverage reports.
- Hazard/safety notices – reports regarding compliance.
- External professional guidelines (NICE, NPSA) – reports regarding compliance.
- Reports on the effectiveness of work undertaken by the Local Counter Fraud Specialist.
- National reports and surveys – reports detailing organisational compliance relative to other organisations (e.g. Friends and Family Test, National Inpatient survey, National Staff Survey).

Internal Assurance

- Local Patient and Staff surveys/questionnaires.
- Quarterly incidents, inquests, complaints, Patient Advice and Liaison Service and claims – reports to committees and trend analysis.
- Training reports detailing feedback from training and compliance with attendance.
- Feedback from staff via individual contact, larger group listening events and exit interviews, including feedback from Trade Unions.
- Clinical audit and effectiveness reports from the Quality Improvement Hub.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit and Assurance Committee and the Quality and Governance Committee. The governance structures and systems of internal control described have been in place during 2016/17 and the effectiveness of committees monitored. Board and Committee minutes record attendance at each meeting.

The system of internal control has been in place at Weston Area Health NHS Trust during the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

9. Significant Issues

The significant issues reported during the year would include:

1. The Summary Hospital-level Mortality Indicator (SHMI) placing the Trust in the "higher than expected" category - comparing the actual number of deaths with the expected number of deaths during (and for 30 days after) a hospital admission over a period of 12 months.

2. The Section 29a Warning Notice received from the CQC following their follow up inspection in March 2017 with regards to the impact on patient safety of patient flow in the Emergency Department and across the Trust.

3. The Trust did not meet it's financial target deficit for the year, with an out-turn deficit of £7.185m, compared to a target deficit of £3.2m. The financial deficit remains a significant issue'

10. Concluding Statement

My review confirms that the system of internal control at Weston Area Health NHS Trust requires strengthening at Directorate and service level. Weaknesses are noted with regards to medical leadership and engagement – particularly in the Medical Directorate.

I have ensured that plans are in place to mitigate the risks identified and that deliverable improvement plans are in place.

Otherwise my review confirms that Weston Area Health NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Accountable Officer : James Rimmer, Chief Executive

Organisation: Weston Area Health NHS Trust

Signature: Date 26/05/2017

Remuneration and Staff Report 2016/17

The Chair and all Non-Executive Directors of the Trust form the Remuneration and Terms of Service Committee with the Chair of the Trust also being Chair of the Committee. The remuneration policy for Executive Directors is set by the Remuneration Committee.

The policy is to pay market rates whilst ensuring that the Trust makes proper use of public money. This is defined as being between the lower and upper quartile range of salaries as indicated in the in the most appropriate survey of boardroom pay in the NHS, and also reflective of the organisational and individual performance. Any recommendations would also take account of the national context as set by the Department of Health in relation to Agenda for Change provisions. The exact salary is determined by the Committee based on the Trust's performance and the individual's contribution. This is presented by the Chief Executive for the Executive Directors and the Chairman for the Chief Executive, using the annual performance review in any decision.

The Executive Directors of the Trust with voting rights on the Board were appointed on the following dates:

- J Rimmer, Interim Chief Executive (from 03/08/2015 to 31/12/2015) Chief Executive (from 01/01/2016)

- R Little, Director of Finance and IM&T (from 01/07/2010)

- N Lyons , Medical Director (from 08/01/2016 to 31/03/2017)

- H Richardson, Interim Director of Nursing (from 15/02/2016 to 30/06/2016), Director of Nursing (from 01/07/2016)

- B Bishop, Director of Strategic Development (from 01/10/2008)

The Executive Directors of the Trust without voting rights on the Board were appointed on the following dates:

- K Croker, Interim Director of Operations (from 02/04/2013 to 30/09/2013) Director of Operations (from 01/10/2013 to 30/09/2016)

- S Flavin, Interim Director of Human Resources (from 01/10/2012 to 30/09/2013) Director of Human Resources (from 01/10/2013)

Mrs K Croker resigned from the position of Director of Operations, effective from 04/07/2016.

Mr N Lyons resigned from the position of Medical Director, effective from 31/03/2017.

Executive Directors are employed on permanent contracts and are required to give six months notice of termination to the Trust with the Trust being required to give six months notice to individuals. No payments are awarded for the early termination of a contract.

NHS Improvement appoints the Chair and Non-Executive Directors whose remuneration is determined by the Secretary of State for Health. The Chair and Non-Executive positions are appointed for a fixed period as determined by the Secretary of State and with immediate notice of termination.

Mr G Paine was appointed to the post of Chair from 17/11/15 for a two year term, having previously been Interim in the role from 1/5/15 to 16/11/15 whilst holding a Non Executive position.

Other Non-Executive Directors were appointed, or reappointed on two year appointments (unless another term is specified below) from the following dates:

- Dr G Reah February 2016 (reappointment – 1 year)
- Mr I Turner August 2015 (reappointment- 3rd term)
- Mrs B Musselwhite October 2015 (reappointment- 2nd term)
- Mr F Powell January 2016 (reappointment- 2nd term)
- Mrs A Wyke December 2015 (1st term)
- Mr G Turner February 2017 (1st term- 4 year appointment)

Mr G Reah's term as a Non executive director ended on 31/01/2017.

No awards have been made to past Senior Managers of the Trust.

There were no termination or exit package payments made to Senior Managers of the Trust.

The salaries and allowances and pension benefits for the Trust's Senior Managers are detailed as below:

The single toal figure of remuneration for each director on page 53.

CETV disclosures for each director on page 54.

The analysis of staff numbers page 55 and costs on page 56.

The fair pay (pay multiples) disclosures on this page below.

have been audited by Grant Thornton.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Director and the median remuneration of the organisation's workforce. The median employee has been calculated based on staff directly contracted to the Trust and also agency and bank employees.

The banded remuneration of the highest paid Director in Weston Area Health NHS Trust in the financial year 2016/17 was £140k - £144.9k (2015/16 was £125k - £129.9k). This was 5.3 times (2015/16, 4.8 times) the median remuneration of the workforce, which was £26,841 (2015/16, £26,438).

The reason for the increase is that the Chief Executive post-holder has been in post for the full year in 2016/17, whereas in 2015/16 this post was held by 2 individuals due to the previous post-holder one leaving the Trust mid year. The Executive Medical Director was the highest paid Director in 2015/16 despite the Chief Executive post having the highest annualised salary.

In 2016/17, thirteen (2015/16, eighteen) Trust employees received remuneration in excess of the highest-paid Director. Trust employees remuneration ranged from £6k to £201k (2015/16 £6k to £191k).

Total remuneration includes salary, non-consolidated payments-related pay, benefits-in-kind but not severance payments. It takes account of the increase in accrued pension due to inflation on employer's pension contributions or the cash equivalent transfer value of pensions.

Signed by **Chief Executive**

Salaries and Allowances

Name and Title	2016-17						2015-16					
	Salary (bands of £5,000)	Expenses Payments (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 £5,000)	Expenses Payments (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
J Rimmer, Interim Chief Executive (from 03/08/15 to 31/12/15) Chief Executive (from 01/01/16) *	140-144	nil	nil	nil	142.5-144.9	285-289	105-109	nil	nil	nil	127.5-129.9	235-239
N Wood, Chief Executive (from 01/10/13 to 04/07/15)	Not in post						35-39	nil	nil	nil	10.0-12.4	45-49
R Little, Director of Finance and IM&T (from 01/07/10)	105-109	nil	nil	nil	67.5-69.9	175-179	105-109	nil	nil	nil	15.0-17.4	120-124
N Lyons, Executive Medical Director (from 08/01/16 to 31/03/17)	135-139	nil	nil	nil	100.0-102.4	235-239	20-24	nil	nil	nil	2.5-4.9	25-29
A Martin, Interim Executive Medical Director (from 01/05/14 to 30/04/15) Executive Medical Director (from 01/05/15 to 06/01/	Not in post						125-129	nil	nil	nil	25.0-27.4	150-154
H Richardson, Interim Director of Nursing (from 15/02/16 to 30/06/16) Director of Nursing (from 01/07/16) ***	100-104	nil	nil	nil	nil	100-104	15-19	nil	nil	nil	72.5-74.9	90-94
C Perry, Interim Director of Nursing (from 01/04/2013 to 30/09/13) Director of Nursing (from 01/10/13 to 02/12/15)	Not in post						60-64	nil	nil	nil	nil	60-64
J Stroud, Deputy Director of Nursing (from 01/12/15 to 14/02/16)	Not in post						10-14	nil	nil	nil	55.0-57.4	65-69
B Bishop, Director of Strategic Development (from 01/10/08)	90-94	1	nil	nil	25.0-27.4	115-119	90-94	nil	nil	nil	15.0-17.4	105-109
K Croker, Interim Director of Operations (from 02/04/13 to 30/09/13) Director of Operations (from 01/10/13 to 30/09/16) ****	45-49	2	nil	nil	32.5-34.9	75-79	85-89	1	nil	nil	25.0-27.4	110-114
S Flavin, Director of Human Resources (from 01/10/13)	85-89	3	nil	nil	30.0-32.4	115-119	80-84	2	nil	nil	30.0-32.4	115-119
P Carr, Chair (from 01/08/13 to 30/04/15)	Not in post						0-4	2	nil	nil	nil	0-4
G Paine, Non-Executive Director (from 01/03/08 to 29/02/15) Acting Chairman (from 01/05/15 to 16/11/15) Chairman (from 17/	15-19	1	nil	nil	nil	15-19	15-19	nil	nil	nil	nil	15-19
A Wyke, Non-Executive Director (from 18/12/15)	5-9	nil	nil	nil	nil	5-9	0-4	nil	nil	nil	nil	0-4
I Turner, Non-Executive Director (from 01/08/07)	5-9	nil	nil	nil	nil	5-9	5-9	nil	nil	nil	nil	5-9
G Reah, Non-Executive Director (from 01/02/08 to 31/01/17)	5-9	nil	nil	nil	nil	5-9	5-9	nil	nil	nil	nil	5-9
B Musselwhite, Non-Executive Director (from 10/10/13)	5-9	nil	nil	nil	nil	5-9	5-9	nil	nil	nil	nil	5-9
G Turner, Associate Non-Executive Director (from 11/11/16 to 31/01/17) Non-Executive Director (from 01/02/17)	0-4	nil	nil	nil	nil	0-4	Not in post					
F Powell, Non-Executive Director (from 29/06/15)	5-9	nil	nil	nil	nil	5-9	0-4	nil	nil	nil	nil	0-4

* J Rimmer was seconded from University Hospital Bristol NHS Foundation Trust before becoming an employee of WAHT on 1/1/16. Included within the amounts disclosed for 2015/16 were three invoices from UHB totalling £70.9k, which have been included in full within Mr Rimmer's salary.

** A Martin was contracted to carry out clinical duties as well as Director's duties during the 2015/16 financial year. Miss Martin is a Consultant Vascular Surgeon. The values above include payments made for clinical duties.

*** H Richardson was seconded from the Care Quality Commission for the entire period that she was in post in 15/16 and up to 30/06/16 in 16/17. There was one invoice from the CQC for £16.7k and one for £33.1k in 16/17, both of which have been included in full within Mrs Richardson's salary for the relevant financial year.

**** Following K Croker leaving the Trust a number of her senior responsibilities were distributed amongst existing Executive Directors whilst other duties were given to an individual who was not required to attend board meetings and did not have any financial accountabity and has therefore not been included in this disclosure.

The amounts shown in the Expense payment (taxable) column of the table all relate to travel expenses agreed paid to senior managers for work to home mileage.

The amounts shown in the All pension-related benefits column of the table are calculated according to the DOH Group accounting manual 2016/17: The annual pension increase, adjusted for inflation, is expressed over an expected 20 year payment period ie. An annual increase of £10k = £200k.

Pension Benefits

Name and title	A Real increase in pension at age 60 at 31 March 2017 (bands of £2,500)	B Real increase in lump sum at age 60 at 31 March 2017 (bands of £2,500)	C Total accrued pension at age 60 at 31 March 2017 (bands of £5,000)	D Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000)	E Cash Equivalent Transfer Value at 01 April 2016	F Cash Equivalent Transfer Value at 31 March 2017	G Real Increase in Cash Equivalent Transfer Value	H Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
J Rimmer, Interim Chief Executive (from 03/08/15 to 31/12/15) Chief Executive (from 01/01/16)	5-7.4	10-12.4	50-54.9	140-144.9	764	916	151	0
R Little, Director of Finance and IM&T (from 01/07/10) *	2.5-4.9	7.5-9.9	55-59.9	165-169.9	n/a	n/a	n/a	0
N Lyons, Executive Medical Director (from 08/01/16 to 31/03/17)	2.5-4.9	12.5-14.9	15-19.9	55-59.9	241	340	99	0
H Richardson, Interim Director of Nursing (from 15/02/16 to 30/06/17) Director of Nursing (from 01/07/16)	(2.4)-(4.9)	(10)-(12.4)	25-29.9	80-84.9	567	522	(45)	0
B Bishop, Director of Strategic Development (from 01/10/08)	0-2.4	2.5-4.9	35-39.9	115-119.9	786	834	48	0
K Croker, Interim Director of Operations (from 02/04/13 to 30/09/13) Director of Operations (from 01/10/13 to 30/09/16)	0-2.4	nil	30-34.9	85-89.9	467	497	15	0
S Flavin, Director of Human Resources (from 01/10/13)	0-2.4	nil	5-9.9	nil	60	78	18	0

Notes :

** As Mr Little is of pensionable age, CETV is no longer applicable.*

Figures are adjusted for the time in post where this has been less than the whole year.

Figures in (brackets) indicate a decrease

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

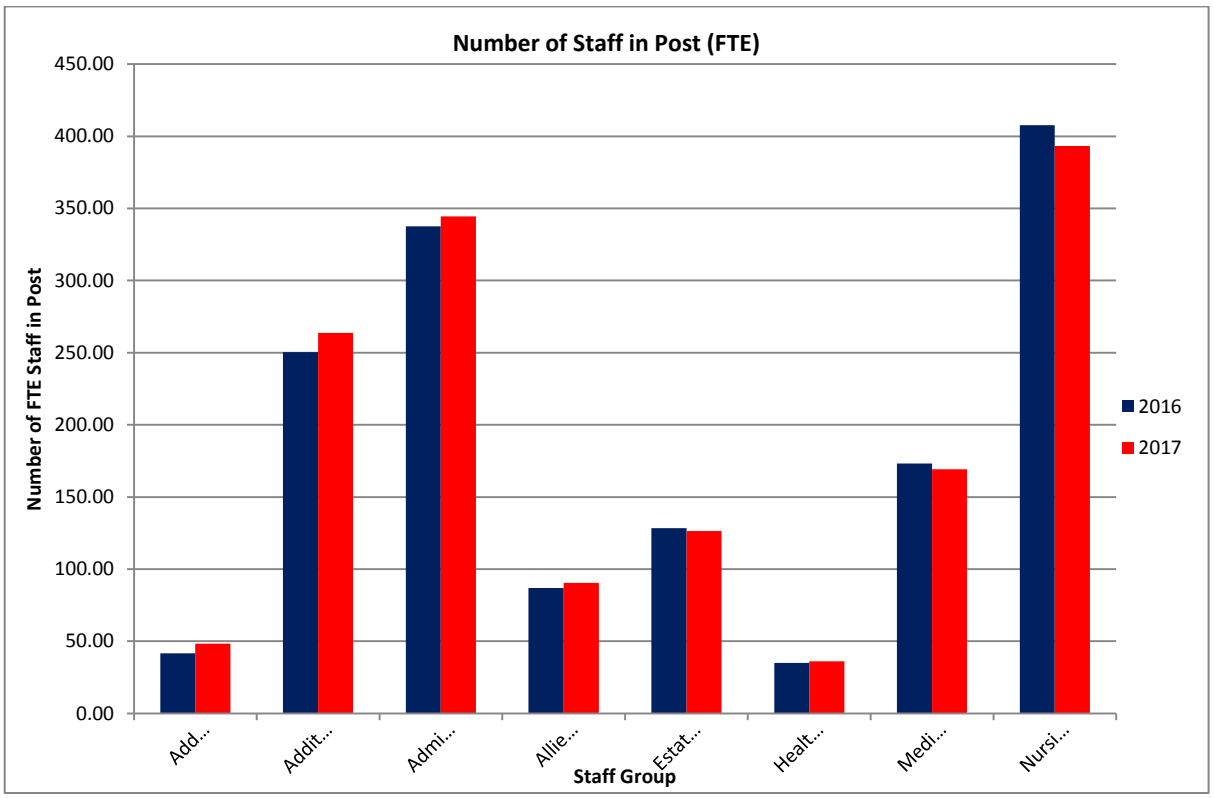
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made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

Staff report

Workforce profile

The graph presented below shows the workforce (permanent and fixed term) analysed using full time equivalents for staff in post, by occupational group for the last two years, highlighting changes in the workforce configuration.

The overall workforce has remained consistent from March 2016 to March 2017. There have however been fluctuations within staff groups, the most notable changes are within Nursing and Midwifery and Medical and Dental. The decrease in both of these staff groups relates to difficulties recruiting which has presented significant challenges.



Average Staff Numbers

The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The "contracted hours" method of calculating whole time equivalent number is dividing the contracted hours of each employee by the standard working hours.

	Total	Permanently	Other	Total	Permanently	Other
	31/03/2017	Employed		31/03/2016	Employed	
Employee category	**Number**	Number	Number	Number	Number	Number
Medical and dental	**245**	155	90	233	163	70
Administration and estates	**346**	336	10	335	331	4
Healthcare assistants and other support staff	**396**	352	44	387	357	30
Nursing, midwifery and health visiting staff	**471**	415	56	459	418	41
Allied Health Professionals	**177**	171	6	170	165	5
TOTAL	**1,635**	1,429	206	1,584	1,434	150

Total Gross Employee Benefits

The table below represents the total pay bill for 2016-17 the employee category analysis is as per the year end schedules including agency costs which is not comparable to the graph above.

Employee category	2016/17 £000
Administration and estates staff	10,553
Medical	24,915
Nursing	29,044
Allied Health Professionals	7,112
Other	4,088
Total Gross Employee Benefits	**75,712**

Staff Engagement

Staff engagement and wellbeing is a high priority for our organisation. Each year we develop an action plan to improve key areas of the national Staff Survey results and we share progress with our staff side colleagues through the monthly Joint Negotiating and Consultative Committee.

1. 2016 Staff Survey Results

Overall there has been a very disappointing set of staff survey results for 2016.

Staff recommendation of the organisation as a place to work or receive treatment

The scores for Q21a, Q21c and Q21d of the survey feed into Key Finding 1: *Staff recommendation of the organisation as a place to work or receive treatment*. Table 1 below illustrates how a deterioration in two of these questions which has slightly decreased the overall score for Key Finding 1. Possible scores range from 1 to 5 with 1 being the minimum score and 5 the maximum.

Table 1: Scores in Key Finding 1

	Question	2015	2016	Average for acute trusts
Q21a	Care of patients / service users is my organisation's top priority	72%	70%	76%
Q21c	I would recommend my organisation as a place to work	54%	52%	62%
Q21d	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	56%	58%	70%
KF1	**Staff recommendation of the organisation as a place to work or receive treatment**	**3.62**	**3.59**	**3.77**

Overall Staff Engagement

The overall indicator of staff engagement is calculated by using the questions that make up Key Findings 1, 4 and 7.

Table 2 below illustrates that the overall staff engagement score has declined slightly from the 2015 survey results, from 3.77 to 3.73 which is not statistically significant however it means the Trust's overall rankings *'Worse than average'.* The average score for acute Trusts in 2016 is 3.81and average for acute Trust in 2015 was 3.79.

Table 2: Scores in Overall Staff Engagement

	Key Finding	2015	2016	Change since 2015 survey (benchmark change)	Ranking against all acute trusts
KF1	Staff recommendation of the trust as a place to work or receive treatment	3.59	3.58	No change (-)	Worst 20%
KF4	Staff motivation at work	3.94	3.88	No change (Average)	Worse than Average
KF7	Percentage of staff able to contribute towards improvements at work	70%	71%	No change (Average)	Better than Average
	Overall staff engagement score	3.77	3.73	Decline	Worse than average

Highest and lowest ranking scores in 2016

Tables 3 and 4 below identify the areas where the Trust has scored most and least favourably.

In the highest ranking scores table below (Table 4), key finding 24 remains one of the highest scores for a second year running as indicated by the green shaded box.

Table 3: Key Findings with the highest scores

	Key Finding	Score 2015	Score 2016	Average for acute trusts
KF 7	Percentage of staff able to contribute towards improvements at work	70%	71%	70%
KF20*	Percentage of staff experiencing discrimination at work in the last 12 months	12%	11%	11%
KF24	Percentage of staff / colleagues reporting most recent experience of physical violence in the last 12 months	58%	72%	67%
KF27	Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse in the last 12 months	34%	48%	45%
KF29	Percentage of staff reporting errors, near misses or incidents witnessed in the last month	91%	91%	90%

*****The lower the score the better

In the worst ranking scores table below (Table 5), key findings 22 and 28 remain as two of the worst scores for a second year running as indicated by the red shaded box. However it is very disappointing to note

that key finding 3 has moved from being one of the highest ranking scores in 2015 (as shaded green) to one of the worst ranking scores in 2016.

Table 4: Key Findings with the worst scores

	Key Finding	Score 2015	Score 2016	Average for acute trusts
KF3	Percentage of staff agreeing that their role makes a difference to patients / service users	91%	88%	90%
KF14	Staff satisfaction with resourcing and support	3.21	3.14	3.33
KF22*	Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	19%	20%	15%
KF25*	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	33%	34%	27%
KF28*	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	37%	42%	31%

*****The lower the score the better

In order to try and triangulate the results in the entire survey the Director of Human Resources has reviewed the worst performing 'themes' and notes the following priorities for improvement;

Errors and incidents
Staff in the Trust often report that they witness potentially harmful errors, near misses or incidents (KF28)
Staff have medium confidence that the issue reported will be dealt with fairly or effectively (KF30)- and have a medium confidence in the security of reporting unsafe clinical practice (KF31)

Health and wellbeing
More staff than in 2015 have felt work related stress in the last 12 months (KF17)
Staff continue to feel pressure to come to work (KF18)- and don't feel that the Trust or their manager takes interest in or action to support their health and wellbeing (KF19)

Managers
The level of recognition and value felt by staff by manager and the organisation has decreased (KF5)
Staff have responded that communication between them and senior management has remained the same (KF6)
Staff report that they don't feel support from their immediate manager (KF10)

Patient care & experience
Staff have reported a decline in their staff satisfaction (KF2)
They report that their role makes less difference to patients / service users than it did 12 months ago (KF3)

Violence, harassment & bullying
Staff have reported continuing experience of physical violence from non – staff in the last 12 months (KF22)- and from staff (KF23)
Staff who experience violence will report it (KF24)
More staff have experienced harassment, bullying or abuse from non-staff in the last 12 months (KF25) - and less from staff (KF26)
Staff who experience harassment, bullying or abuse from staff will report it (KF27)

Further analysis of the results relating to the different staff groups will be undertaken, together with a review of the 2015 NHS Staff Survey Action Plan.

The Trust will review the actions that were completed in response to the 2015 staff survey as they appear to have had little or no impact as many of the key findings have deteriorated.

Our initial analysis of the survey results was described in a paper to our Board in March 2017. NHS Staff Surveys - 2016 Results. A detailed action plan will be made available on the Trust's website once approved.

2. Communicating with our Staff and Recognising their Achievements

The Trust is a small and friendly organisation but we recognise that communicating with our staff is something we will always aim to improve on. We encourage all of our managers to have regular team meetings because we recognize that electronic means of communication, although serving a purpose, do not provide the same opportunities as a 2-way conversation. The monthly team brief 'Ask James' led by our Chief Executive is open to all staff and is well attended. Staff have said that they appreciate an open and honest conversation with the leader of the organisation and the opportunity to raise any concerns they may have directly with him. Issues that are seen as considerable importance concerning all staff are given special prominence with special meetings arranged and briefing sheets issued through pay slips to make sure each member of staff receives the information.

Alongside, team briefs we continue to develop our traditional channels of communication through our weekly Staff e-Newsletter, updates to the staff Intranet, noticeboards and screen savers. A new initiative for this year has seen the launch of the Staff Discussion Forum available through the Intranet and providing the opportunity for staff to engage with particular topics regarding day to day business, work and values of the organization. During 2016 we developed our Nurse Assistant and Student Nurse forums, providing regular opportunities for these groups of staff to come together, share ideas and suggestions for improvement and to hear presentations from clinical specialists.

Last July once again, we ran our 'Celebration of Success' event at Batch Country House where those staff who had demonstrated outstanding work were recognised for their achievements. This is a popular and well attended event and serves to complement the monthly PRIDE awards where staff who have been nominated by their peers are recognized for going the extra mile for their patients or colleagues.

Equality and Diversity

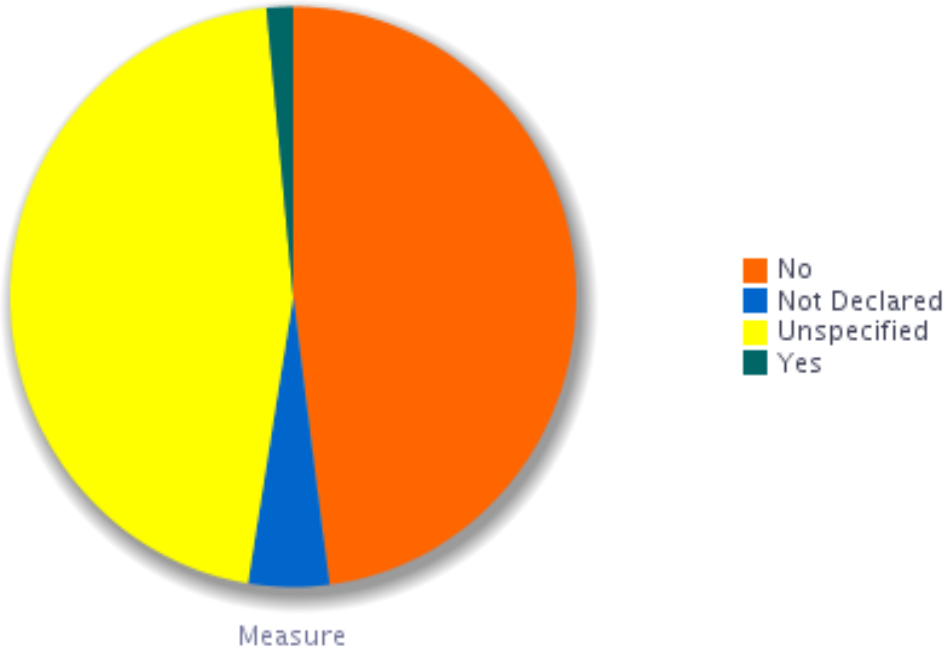
The Trust Equality and Diversity Policy sets out our commitment to promoting equality of opportunity for all and ensuring that staff and patients are free from discrimination. The policy sets out clear responsibilities for directors, managers, staff, patients and visitors.

All staff joining the Trust as part of the induction programme takes part in a dedicated Equality and Diversity session. During 2016/17 the equality and diversity induction programme has continued to been reviewed and reinvigorated to ensure that we continue to develop and improve the information provided to staff. The new programme has received positive feedback.

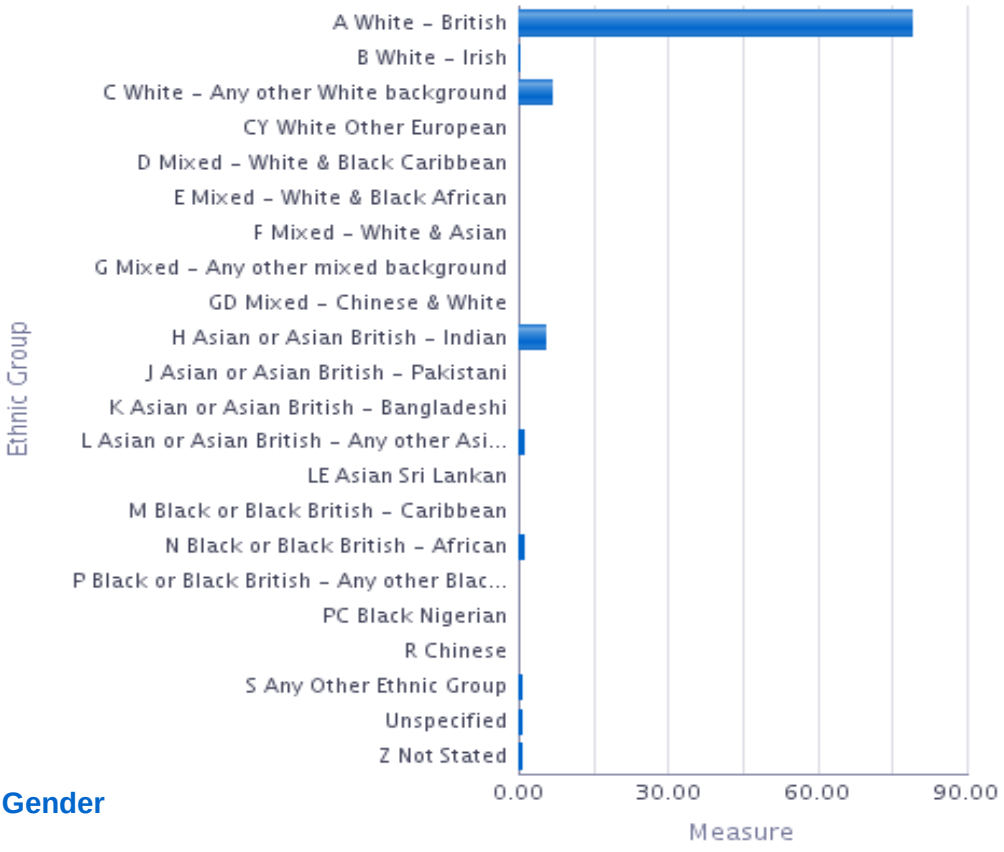
The Trust is accredited to the "positive about disability" initiative, which guarantees applicants an interview where they meet the minim essential criteria for the jobs description. Through the application and shortlisting process, details relating to protected characteristics are kept confidential from the recruiting manager to reduce potential for bias or prejudice.

The Trust has been enacting its responsibilities under the Workforce Race Equality Scheme (WRES) and will be developing a WRES action plan for the forthcoming year to bring about improvement against the nine indicators used within the Workforce Race Equality Scheme.

Disability



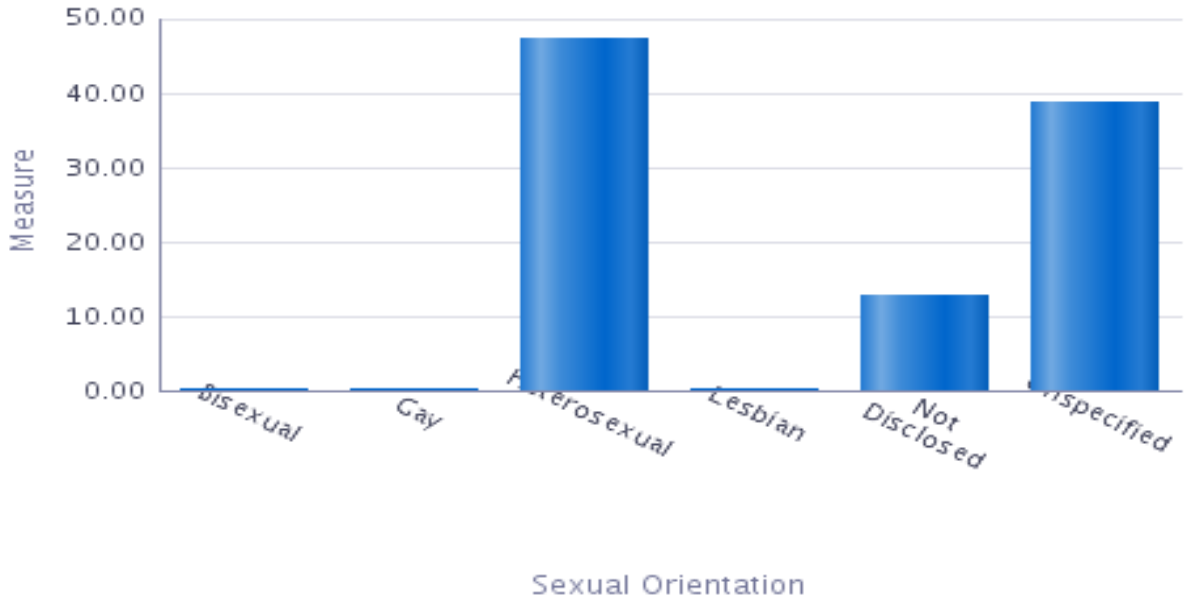
Ethnicity



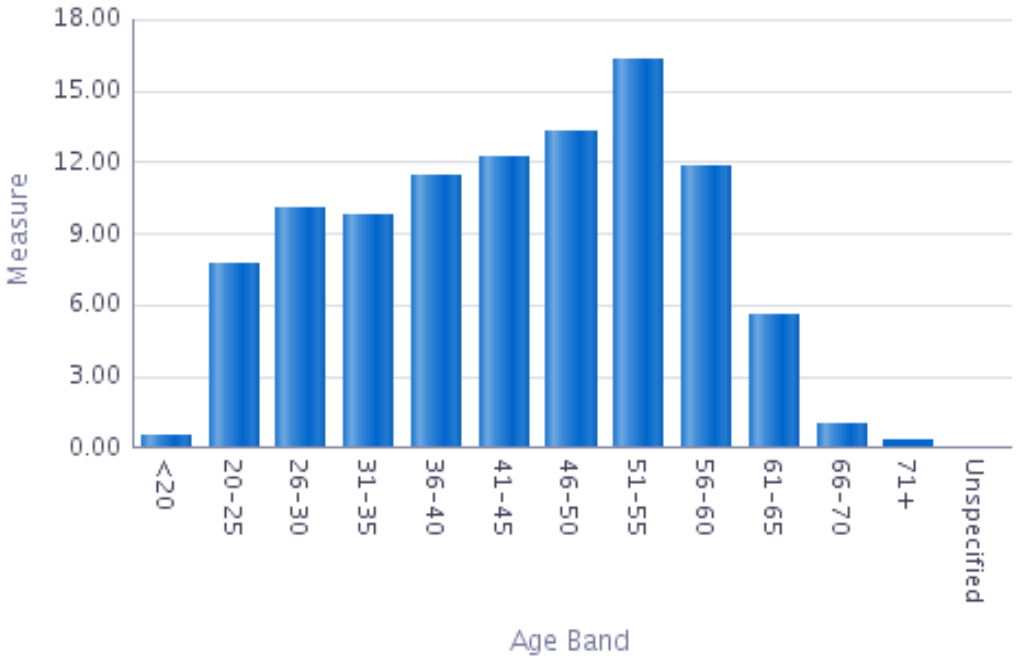
Gender

Seven of our Board members are male, six female.

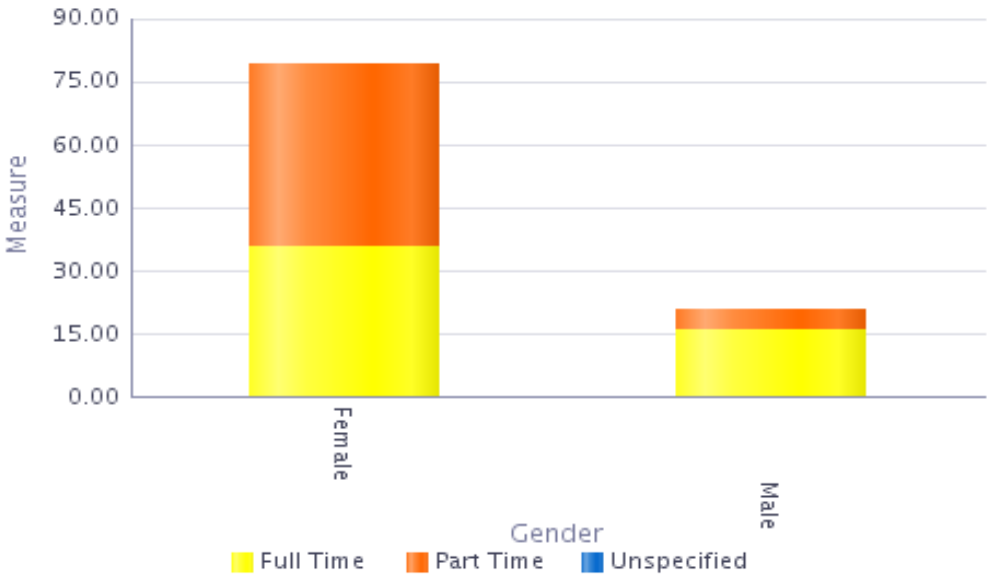
Sexual Orientation



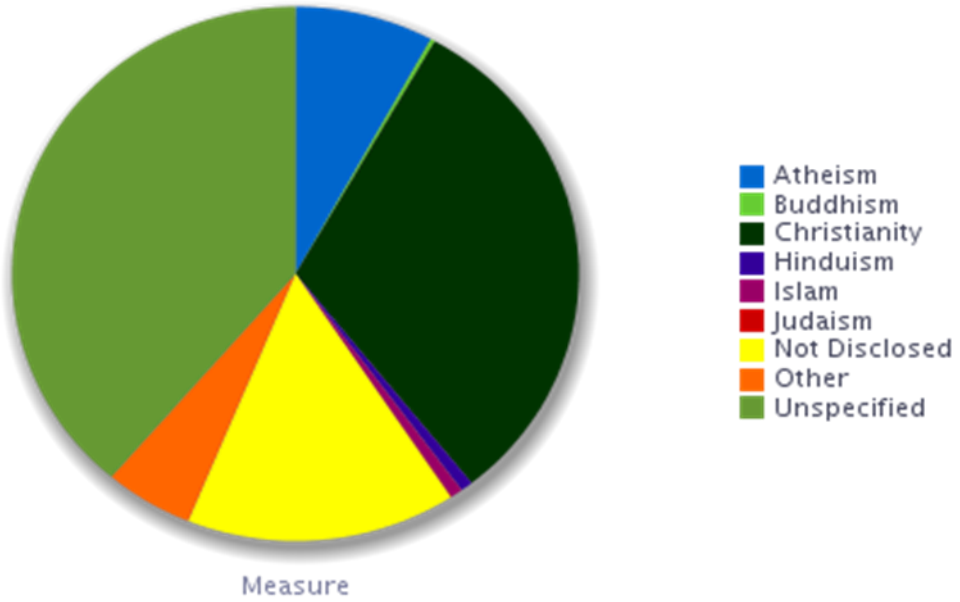
Age Band



Employee Category / Gender



Religion and belief



Staff policies in relation to the employment of disabled persons are included in the Trusts Equality and Diversity policy

Workplace Health

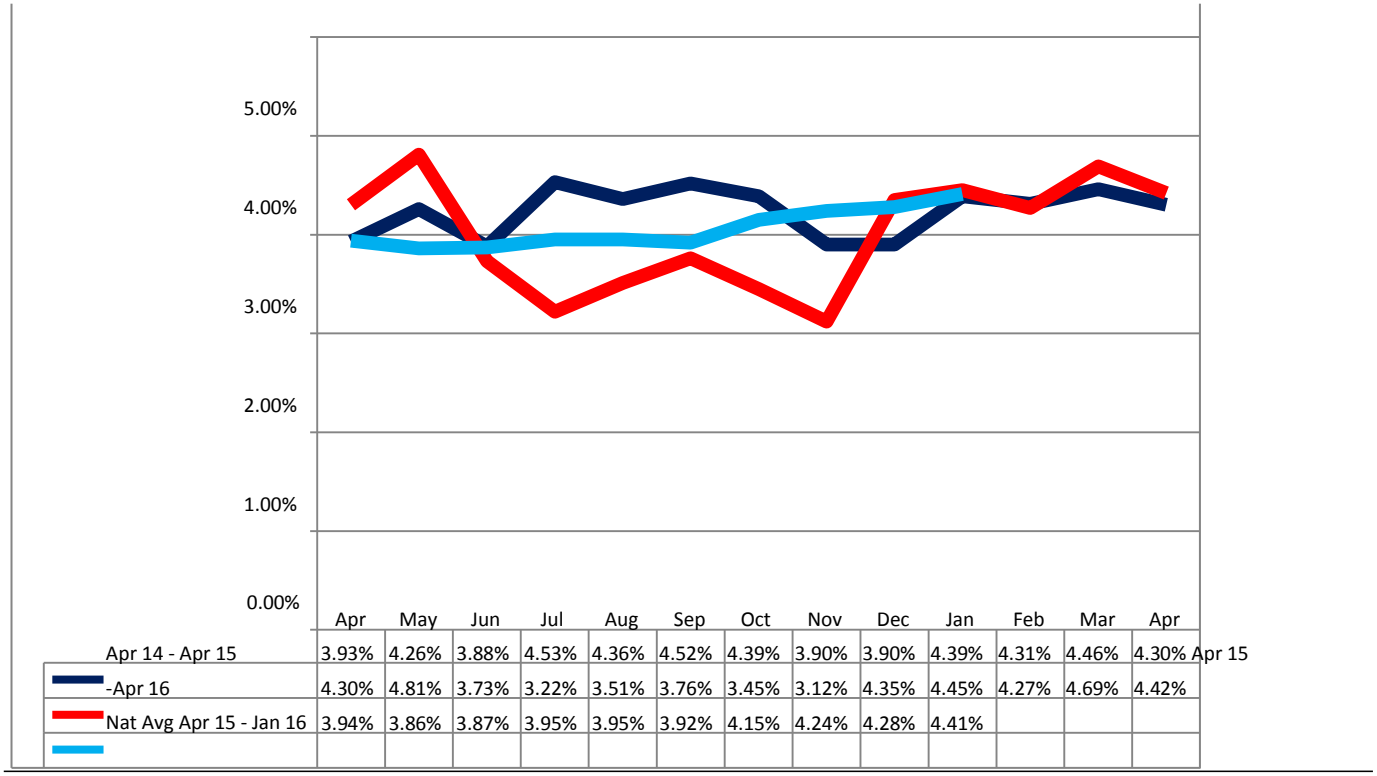
We recognise that the work our staff do can often be very physically and psychologically demanding so we developed a health and wellbeing plan to provide staff with on-site access to physical activities and advice and guidance on their health and wellbeing needs.

Amongst a range of activities, staff have benefitted from yoga and pilates classes, reduced gym membership, dedicated one to one weight management sessions with our own Dietitians and cycle to work schemes. In support of staff experiencing stress we have run Mindfulness classes for approximately 60 staff and have Emotional Resilience training planned for the beginning of the 17/18 financial year.

These activities sit alongside our existing Staff Physiotherapy Service which offers employees suffering from musculoskeletal issues a fast track service and supports sickness prevention. In addition we continue to invest in our Employee Assistance Provider with 17 of our employees accessing face to face counselling sessions between May to December 2016.

Sickness absence between the two years has remained consistent. With a small change in the days lost due to sickness. As recently reported at the Trust Quality and Safety Committee, the Trust continues to perform well when compared to national averages and has a better than average sickness rate when compared to other acute Trust. When we compare ourselves across staff groups the Trust performs better than national average for acute Trust in six of the eight staff groups. The two areas where we are above the national average for acute Trust are Admin and Clerical and Medical and Dental.

Staff Sickness Absence	2016-17	2015-16
Total Days Lost	12,779	12,627
Total Staff Years	1,455	1,455
Average working Days Lost	8.8	8.7



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Apr 14 - Apr 15	3.93%	4.26%	3.88%	4.53%	4.36%	4.52%	4.39%	3.90%	3.90%	4.39%	4.31%	4.46%	4.30% Apr 15
-Apr 16	4.30%	4.81%	3.73%	3.22%	3.51%	3.76%	3.45%	3.12%	4.35%	4.45%	4.27%	4.69%	4.42%
Nat Avg Apr 15 - Jan 16	3.94%	3.86%	3.87%	3.95%	3.95%	3.92%	4.15%	4.24%	4.28%	4.41%			

Travel

The Trust continues to offer staff the opportunity to buy a bicycle(s) and equipment via salary sacrifice, as part of the Government's green travel initiative, and this continues to be very popular and successful.

The Green Travel Group continues to meet periodically to review the action plan and discuss further green travel initiatives in partnership with North Somerset Council, who have expressed their appreciation of our efforts.

Some of the initiatives the Trust has introduced are the provision of secure cycle storage for staff, sustainable travel roadshows, most recently in March 2017, and cycle to work schemes as well as eco-driving lessons, staff cycling groups and cycle repair kit.

Developing the Skills of our Workforce

The on-going development of our staff is a key priority for the Trust and in the last year we have funded over 100 staff to access externally delivered learning and development opportunities, including post-registration university based programmes, national conferences, leadership and management courses and a range of role specific skills training.

Coupled with our comprehensive in-house programme of activity, delivered by our own team of Education Specialists and clinical experts, we offer staff the opportunity to grow and develop in their roles. We continue to support our non-registered Nursing Assistants through the Care Certificate and have developed a Learning Pathway that provides them with a teaching programme covering the first year in employment and giving them the chance to continue to a Level 2 or 3 in Health and Social Care. In the year ahead we will be taking advantage of the increased funds provided by the Apprenticeship Levy and aim to expand the numbers of staff undertaking vocational training and offering opportunities for staff to gain professional qualifications whilst in employment.

Patient and staff safety remains key to our service delivery and during 2016/17, we ran over 550 in-house statutory and mandatory courses, training over 5,500 staff in fire safety, resuscitation, manual handling, health and safety, safeguarding adults and children, infection prevention and control amongst other essential topics.

Each year, as a Teaching Trust, we provide in excess of 500 placements for student nurses, physiotherapists, radiographers, dietitians and speech and language therapists. In support of their on-going education and in supporting our clinical staff to provide care based on the latest evidence, our Library service increased its literature searching services by 32%. The purchase of LibGuides, a web-based content management system, used to curate knowledge and share information enables us to provide knowledge and information to our partners in neighbouring organisations and thus support patients in the wider community. We are proud to announce that our Library service achieved 100% compliance in the Library Quality Assurance Framework for the first time this year.

Consultancy expenditure

Management Consultancy expenditure for the Trust during 2016/17 was £37,000

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

Management Consultants	Number
Number of existing engagements as of 31 March 2017	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 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0

There were no off-payroll engagements for more than £220 a day that lasted longer than six months in year.

For all new off-payroll engagements between 1 April 2016 and 31 March 2017 for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	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 whom 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
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed “board members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements	7

The Chief Executive and six Executive Directors, on payroll engagements, are deemed to have significant financial responsibility.

Following the Director of Operations leaving the Trust a number of her senior responsibilities were distributed

amongst existing Executive Directors whilst other duties were given to an individual who was not required to attend board meetings and did not have any financial accountability and has therefore not been included in this disclosure.

Part 3 – Financial statements and notes

Financial Standing

The Trust's financial plan for 2016/17 was to achieve a planned year-end deficit position of £3,200,000.

The Trust has reported a deficit of £7,185,000 in 2016/17 against the plan of £3,200,000 which is an underperformance of £3,985,000 when compared against the planned year-end deficit position.

To get to this position savings of £2,543,000 were achieved during the year.

The other statutory requirements of absorbing the rate of capital and managing external financing limit (EFL) and capital resource limits (CRL) were satisfactorily met.

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage of dividends paid on public dividend capital, totalling £1,717,000 when compared to the average relevant net assets of £49.1m.

The EFL is a measure of the Trust's change in its borrowings and cash balances during the year. The limit set for 2016/17 was (£6,990,000), which meant the Trust needed to increase its cash or decrease borrowings by at least this amount. This target was met.

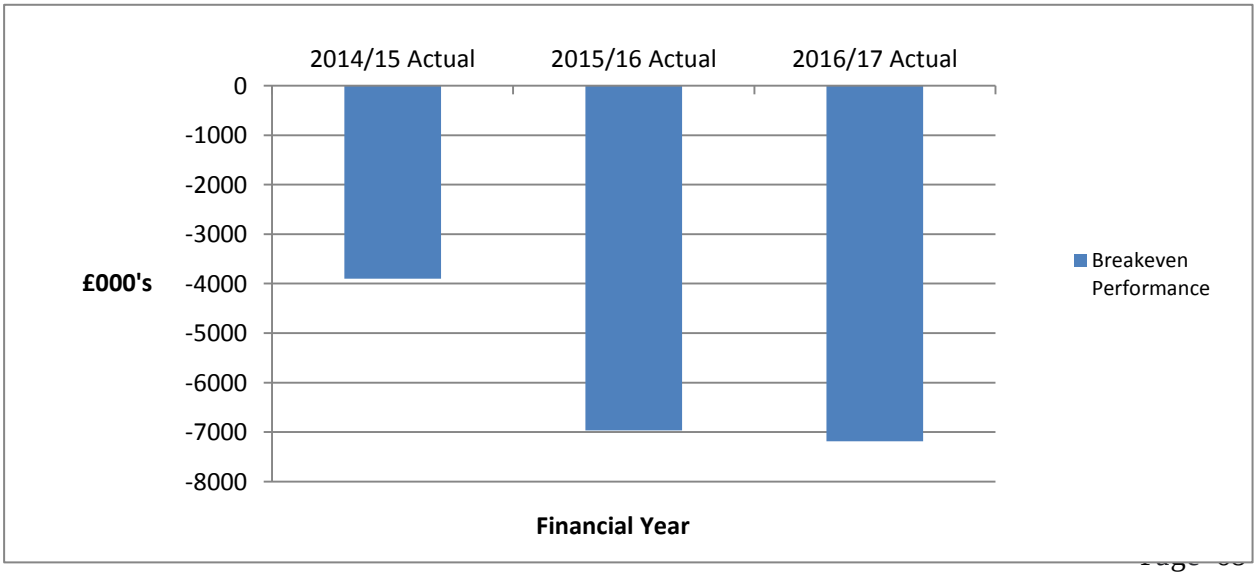
The CRL is a control that measures capital expenditure against a limit set annually by the Department of Health and which the Trust is not allowed to exceed. The limit for 2016/17 was £4,478,000 and the charge made against it was £248,000 below and within an acceptable tolerance taking into account an agreed £203,000 under spend with NHSI.

The Trust maintained its key controls in order to achieve these targets in 2016/17.

Financial Position of the Trust

The Trust has reported a retained deficit of £7,313,000 in 2016/17. The retained deficit is before the elimination of the donated assets reserve of £128,000. As per the Department of Health guidance on break-even duty for NHS Trusts, the costs relating to donated assets are excluded when measuring a Trust's break-even performance (see Note 44.1 of the Annual Accounts).

Therefore, taking this into account the Trust has recorded a deficit of £7,185,000 – an underperformance of
£3,985,000 when compared to the planned deficit of £3,200,000. To get to this position savings of £2,543,000 were achieved during the year.



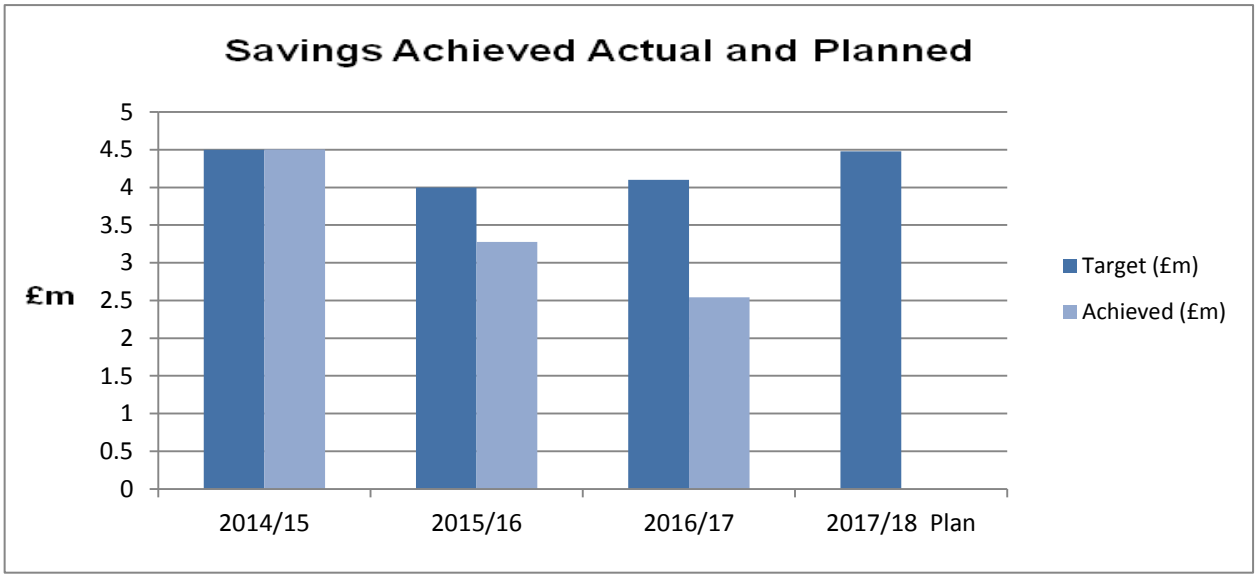
Due to the breach in Trusts' statutory duty the auditors will refer the Trust to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014.

Financial Position 2017/18

The Trust is planning to deliver a deficit of £6,035,000 in 2017/18.

Financial Recovery

A budget for 2017/18 has been approved by the Trust Board and includes details of risks and assumptions. Further significant savings of £4,478,000 are planned to be delivered in 2017/18. These plans will be closely monitored and reported through the Executive Review of monthly Performance Management Review meetings which will include a focus on all aspects the savings plans.



Accounting Policies

These set out the accounting rules that all NHS trusts are required to follow. They explain the basis on which all entries in the accounts are made.

The policies are largely dictated by the Department of Health's Group Accounting Manual, although the Trust is able to tailor the policies as it sees fit. One of the main requirements is for the accounts to be reported on an accruals basis, which means that income and expenditure are recorded in the year they arise, regardless of when the cash is transferred.

These accounting policies follow International Financial Reporting Standards (IFRS) and HM Treasury's Resource Accounting Manual to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

The IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern.

The Trust has prepared the accounts on a going concern basis in accordance with the 2016/17 Department of Health Group Accounting Manual. This is in the context of the NHS Five Year Forward

view and in light of these opportunities the Trust has a Strategic Plan 2016/2021, which describes the Trust's priorities to deliver outstanding safe care and improve the sustainability of all services. The Trust is assured that it will secure sufficient working capital with the agreement of the NHS Improvement from April 2017.

The Trust has a planned deficit in 2017/18 of £6.035m and this requires a £6.035m loan from the Department of Health of equal value to maintain cash flow in 2017/18. Directors have an agreed financial plan with NHS Improvement and are confident that it will support the Trust's application for cash support for 2017/18. The Trust has not yet received formal confirmation from the Department of Health that the full years funding will be forthcoming, although the first instalments of the loan were received in April and May 2017 totaling £1.033m.

Although the Trust is confident that this funding will be made available it represents a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. The Directors, having made appropriate enquiries, still have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. For this reason the going concern basis has been adopted for preparing the accounts.

Paying Our Bills Promptly

All NHS Trusts are required to pay their creditors within 30 days of receipt of a valid invoice unless other terms have been agreed with the supplier. This is in accordance with the Confederation of British Industry (CBI) Better Payments Practice Code. Details of compliance with this code are shown in note 11 of the annual accounts.

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust is signed up to the Prompt Payment Code.

As at the end of the financial year, the Trust had paid 97.1% of the total number of non-NHS invoices against the Code. This compares with 97.0% in 2015/16. With 88.1% of the total number of NHS invoices paid within 30 days compared with 88.2% in 2015/16. The overall total number of invoices paid, both NHS and non NHS, was 96.7%.

Land Valuations

The valuations for land have been undertaken having regards to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance.

The District Valuer has estimated the land value as at 31 March 2017 at £6,870,000. The Directors of the Trust are not aware of any material differences between the carrying values and the current market values.

Pension Liabilities

Past and present employees of the Trust are covered by the provisions of the NHS Pensions Scheme. Further information including how pension liabilities are treated in the accounts can be found in accounting note 1.7 of the full set of the accounts.

Pension information for Directors of the Trust is shown in the Pensions benefit table of the Remuneration Report within this annual report.

Weston Area Health NHS Trust - Annual Accounts 2016-17

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s	
Gross employee benefits	10.1	**(75,712)**	(68,357)	
Other operating costs	8	**(35,276)**	(35,682)	
Revenue from patient care activities	5	**95,673**	88,955	
Other operating revenue	6	**9,883**	9,507	
Operating (deficit)		**(5,432)**	(5,577)	
Investment revenue	12	**9**	11	
Other gains	13	**4**	8	
Finance costs	14	**(177)**	(23)	
(Deficit) for the financial year		**(5,596)**	(5,581)	
Public dividend capital dividends payable		**(1,717)**	(1,903)	
Retained (deficit) for the year	44.1	**(7,313)**	(7,484)	

Other Comprehensive Income

		2016-17 £000s	2015-16 £000s	
Net gain on revaluation of property, plant & equipment	16.1	**2,185**	1,092	
Total comprehensive income for the year		**(5,128)**	(6,392)	

Financial performance for the year

Retained surplus/(deficit) for the year	44.1	**(7,313)**	(7,484)	
Impairments (excluding IFRIC 12 impairments)	18	**0**	386	(a)
Adjustments in respect of donated asset reserve elimination	44.1	**128**	133	(b)
Adjusted retained (deficit)	44.1	**(7,185)**	(6,965)	

The Trust's reported NHS financial performance position is derived from its retained (deficit), but adjusted for:-

a) Impairments to Non-current assets - An impairment charge is not considered part of the organisation's operating position. (see Note 44.1 Trusts breakeven performance and Note 18 Impairments).

b) The impact from the change in accounting for the elimination of the donated asset reserve is neutralised by this adjustment. This relates to depreciation on donated assets £138,000 (£133,000 2015-16) less income for the purchase of non-current assets £10,000 (Nil 2015-16) see Note 6 Other Operating Income.

Statement of Financial Position as at 31 March 2017

	NOTE	31 March 2017 £000s	31 March 2016 £000s
Non-current assets:			
Property, plant and equipment	16	**68,819**	66,613
Intangible assets	17	**2,955**	2,577
Trade and other receivables	22.1	**524**	460
Total non-current assets		72,298	69,650
Current assets:			
Inventories	21	**1,136**	1,054
Trade and other receivables	22.1	**4,282**	3,314
Cash and cash equivalents	26	**1,609**	3,853
Sub-total current assets		**7,027**	8,221
Total current assets		**7,027**	8,221
Total assets		**79,325**	77,871
Current liabilities			
Trade and other payables	28	**(12,107)**	(10,227)
Provisions	35	**(79)**	(60)
DH revenue support loan	30	**(7,700)**	0
Total current liabilities		**(19,886)**	(10,287)
Net current (liabilities)		**(12,859)**	(2,066)
Total assets less current liablilities		**59,439**	67,584
Non-current liabilities			
Provisions	35	**(388)**	(383)
DH revenue support loan	30	**(4,200)**	(7,700)
Total non-current liabilities		**(4,588)**	(8,083)
Total assets employed:		**54,851**	59,501
FINANCED BY:			
Public Dividend Capital		**70,292**	69,814
Retained earnings		**(30,007)**	(22,749)
Revaluation reserve		**14,566**	12,436
Total Taxpayers' Equity:		**54,851**	59,501

The notes on pages 6 to 32 form part of this account.

The financial statements on pages *1 to 32* were approved by the Board on *26th May 2017* and signed on its behalf by

Chief Executive: James Rimmer

Date: 26-May-17

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Note	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
		£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016		**69,814**	**(22,749)**	**12,436**	**0**	**59,501**
Changes in taxpayers' equity for 2016-17						
Retained (deficit) for the year	SOCI	0	(7,313)		0	**(7,313)**
Net gain on revaluation of property, plant, equipment	16.1	0	0	2,185	0	**2,185**
Transfers between reserves			55	(55)	0	**0**
Reclassification Adjustments						
Permanent PDC received - cash		478	0	0	0	**478**
Net recognised revenue/(expense) for the year		**478**	**(7,258)**	**2,130**	**0**	**(4,650)**
Balance at 31 March 2017		**70,292**	**(30,007)**	**14,566**	**0**	**54,851**

The permanent PDC received - cash relates to capital funding of £478k for the upgrade of the patient administration system capital project.

The transfer between retained earnings and the revaluation reserve is due to the reversal of impairment charges that were previously charged to retained earnings as a result of the upward revaluation on buildings at 31st March 2017 of £482k. This is offset by £427k being the difference between the current cost of depreciation compared to the historic cost of depreciation Totalling £55k for transfers between reserves.

Balance at 1 April 2015		**68,057**	**(16,383)**	**12,555**	**(93)**	**64,136**
Changes in taxpayers' equity for the year ended 31 March 2016						
Retained surplus/(deficit) for the year		0	(7,484)	0	0	(7,484)
Net (loss) on revaluation of property, plant, equipment		0	0	1,092	0	1,092
Transfers between reserves		0	1,118	(1,211)	93	0
Reclassification Adjustments						
Permanent PDC received - cash		1,757	0	0	0	1,757
Net recognised revenue/(expense) for the year		**1,757**	**(6,366)**	**(119)**	**93**	**(4,635)**
Balance at 31 March 2016		**69,814**	**(22,749)**	**12,436**	**0**	**59,501**

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s
Cash Flows from Operating Activities			
Operating (deficit)	SOCI	**(5,432)**	(5,577)
Depreciation and amortisation	8	**3,841**	3,583
Impairments and reversals	18	**0**	386
(Increase)/Decrease in Inventories	21	**(82)**	26
(Increase) in Trade and Other Receivables	22.1	**(1,011)**	(256)
Increase in Trade and Other Payables	28	**1,490**	297
Provisions utilised	35	**(52)**	(65)
Increase in movement in non-cash provisions	35	**31**	236
Net Cash (Outflow) from Operating Activities		**(1,215)**	(1,370)
Cash Flows from Investing Activities			
Interest Received		**9**	11
(Payments) for Property, Plant and Equipment		**(2,892)**	(4,649)
(Payments) for Intangible Assets		**(958)**	(776)
Proceeds of disposal of assets held for sale (PPE)		**4**	8
Net Cash (Outflow) from Investing Activities		**(3,837)**	(5,406)
Net Cash (outflow) before Financing		**(5,052)**	(6,776)
Cash Flows from Financing Activities			
Gross Permanent PDC Received	SOCITE	**478**	1,757
Loans received from DH - New Revenue Support Loans		**4,200**	7,700
Interest paid		**(105)**	(20)
PDC Dividend (paid)		**(1,765)**	(1,838)
Net Cash Inflow from Financing Activities		**2,808**	7,599
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(2,244)**	823
Cash and Cash Equivalents at Beginning of the Period		**3,853**	3,030
Cash and Cash Equivalents at year end	**26**	**1,609**	3,853

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2016-17 issued by the Department of Health. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

The Trust did not have any acquisitions or discontinued operations to report in either year.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

As per the Guidance for Consolidation of NHS Charity Accounts into NHS Local Accounts the Charity's transactions are immaterial in the context of the group and transactions do not need to be consolidated. Also see accounting policies note 1.30.

1.5 Critical accounting judgements and key sources of estimation uncertainty

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

1.5.1 Critical judgements in applying accounting policies

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

- Assessing the value of significant accruals of income and expenditure at the year end.
- The Trust has prepared the accounts on a going concern basis in accordance with the 2016/17 Department of Health Group Accounting Manual. This is in the context of the NHS Five Year Forward view and in light of these opportunities the Trust has a Strategic Plan 2016/2021, which describes the Trust's priorities to deliver outstanding safe care and improve the sustainability of all services. The Trust is assured that it will secure sufficient working capital with the agreement of the NHS Improvement from April 2017.

The Trust has a planned deficit in 2017/18 of £6.035m and this requires a £6.035m loan from the Department of Health of equal value to maintain cash flow in 2017/18. Directors have an agreed financial plan with NHS Improvement and are confident that it will support the Trust's application for cash support for 2017/18. The Trust has not yet received formal confirmation from the Department of Health that the full years funding will be forthcoming, although the first instalments of the loan were received in April and May 2017 totalling £1.033m.

Although the Trust is confident that this funding will be made available it represents a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. The Directors, having made appropriate enquiries, still have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. For this reason the going concern basis has been adopted for preparing the accounts.

- Assessing whether significant risks and rewards of ownership of leased assets have transferred.
- Assessing whether impairments to the values of Property Plant and Equipment non-current assets and intangibles have arisen in year.
- Management has declared that the financial statements are free from any misstatement as a result of fraud or any weakness in systems of internal control.

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

- All land and buildings are restated to fair values using the professional valuation provided by the District Valuer Services based on a valuation date of 31st March 2015. The carrying amount for land and buildings as at 31 March 2017 are based on this valuation and adjusted using recognised published indices where the impact of the revaluation is material.
- Holiday pay due to employees but not taken at 31st March is accrued for based on the carried forward leave information received from a representative sample of the Trust's workforce.
- Healthcare SLA over/under performance with some commissioners is estimated based on patient activity.

1.6 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay/costs incurred to date compared to total expected costs.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.7 Employee Benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave 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.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS Trust commits itself to the retirement, regardless of the method of payment.

The Trust does not have any employees who are members of the Local Government Pension Scheme.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.9 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the NHS Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

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

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

The Trust revalues land and buildings every five years and uses the BCIS [Building Cost Information Service] All in Tender Price Index between full valuations for buildings and for land an assessment of current land value is provided by the District Valuer Service, who are RICS qualified. The Trust's last quinquennial valuation of land and buildings was undertaken as at 31 March 2015 by the District Valuer Service on a modern equivalent assets basis.

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

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

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

Subsequent expenditure

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;

● the ability to sell or use the intangible asset;
● how the intangible asset will generate probable future economic benefits or service potential;
● the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
● the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

At each financial year-end, the NHS Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that are to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.15 Leases

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

The NHS Trust as lessee

The Trust does not hold any finance leases for property, plant and equipment.

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.

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

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

The NHS Trust as lessor

The Trust does not have any finance leases as a lessor.

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

1.16 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out method for all inventories, except pharmacy which uses weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.17 Cash and cash equivalents

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

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

1.18 Provisions

Provisions are recognised when the NHS Trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
• A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
• A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the NHS Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 35.

1.20 Non-clinical risk pooling

The NHS Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS Trust pays an annual contribution to the NHS Litigation Authority 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 as and when they become due.

1.21 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS Trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.22 Contingencies

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

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

Where the time value of money is material, contingencies are disclosed at their present value.

1.23 Financial assets

Financial assets are recognised when the NHS Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

The Trust does not hold financial assets in any of the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS Trust assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.24 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

The Trust does not have any other Financial Guarantee contract liabilities or financial liabilities held at fair value through the profit and loss.

1.25 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.

1.26 Foreign currencies

The NHS Trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.27 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 45 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

1.29 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the NHS Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure). See Note 43.

1.30 Subsidiaries

Material entities over which the NHS Trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS Trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS Trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

In line with IFRS 10 Consolidated Financial Statements, the Trust has established that as the Trust is the corporate trustee of the linked NHS Charity Weston Health General Charitable Fund, it effectively has the power to exercise control so as to obtain economic benefits.

However the Charitable Fund's transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties' notes.

1.31 Research and Development

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

1.32 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Pooled budget

Not relevant for trust

3. Operating segments

The Trust has a number of Directorates, all of which operate in the healthcare segment. These Directorates are used for internal management purposes and divide the healthcare and other services of the Trust into various medical and surgical specialties. While these are reported on internally for financial and activity purposes, they have been consolidated, as permitted by IFRS 8 paragraphs 12 and 13, into Trust wide figures for these accounts.

4. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. None of the income generation activities full cost exceeded £1m or was otherwise material.

5. Revenue from patient care activities

		2016-17 £000s	2015-16 £000s
NHS England		**6,446**	6,652
Clinical Commissioning Groups		**86,485**	79,782
Foundation Trusts		**129**	136
Non-NHS:			
Local Authorities		**1,440**	1,427
Private patients		**554**	519
Overseas patients (non-reciprocal)		**27**	2
Injury costs recovery	a	**423**	316
Other Non-NHS patient care income		**169**	121
Total Revenue from patient care activities		**95,673**	88,955

Note a: Injury cost recovery income is subject to a provision for impairment of receivables of 22.94% to reflect expected rates of collection (21.99% 2015-16). This is in line with national guidance.

6. Other operating revenue

		2016-17 £000s	2015-16 £000s
Education, training and research		**3,236**	3,248
Charitable and other contributions to revenue expenditure -non- NHS		**108**	93
Receipt of charitable donations for capital acquisitions		**10**	0
Non-patient care services to other bodies		**2,231**	3,468
Sustainability & Transformation Fund Income		**1,755**	0
Income generation (Other fees and charges)		**582**	544
Rental revenue from operating leases		**133**	179
Other revenue	a	**1,828**	1,975
Total Other Operating Revenue		**9,883**	9,507
Total operating revenue		**105,556**	98,462

Note a: Includes £883k (£864k 2015-16) income from Somerset Surgical Services Ltd for use of an allocation of the Trusts theatre capacity.

7. Overseas Visitors Disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**27**	**2**
Cash payments received in-year (re receivables at 31 March 2016)	**0**	**0**
Cash payments received in-year (re invoices issued 2016-17)	**0**	**2**
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**0**	**0**
Amounts added to provision for impairment of receivables (re invoices issued 2016-17)	**0**	**0**
Amounts written off in-year (irrespective of year of recognition)	**0**	**0**

8. Operating expenses

		2016-17 £000s	2015-16 £000s
Services from other NHS Trusts		**799**	674
Services from other NHS bodies		**157**	166
Services from NHS Foundation Trusts		**1,682**	1,762
Total Services from NHS bodies*		**2,638**	2,602
Purchase of healthcare from non-NHS bodies		**360**	352
Trust Chair and Non-executive Directors		**59**	42
Supplies and services - clinical		**17,369**	17,160
Supplies and services - general		**1,885**	1,710
Consultancy services		**37**	360
Establishment		**597**	951
Transport		**147**	238
Premises		**4,097**	4,169
Hospitality		**24**	35
Insurance		**1**	1
Legal Fees		**61**	72
Impairments and Reversals of Receivables		**29**	24
Depreciation		**3,375**	3,187
Amortisation		**466**	396
Impairments and reversals of intangible assets		**0**	386
Audit fees		**57**	69
Other auditor's remuneration	a	**12**	0
Clinical negligence		**3,095**	2,828
Education and Training		**544**	522
Other		**423**	578
Total Operating expenses (excluding employee benefits)		**35,276**	35,682
Employee Benefits			
Employee benefits excluding Board members		**74,980**	67,741
Board members		**732**	616
Total Employee Benefits		**75,712**	68,357
Total Operating Expenses		**110,988**	104,039

Note a: The Other auditor's remuneration relates to the costs of auditing the Trust's Quality account. In the 2015/16 the £12k cost for the audit of the Quality account is included within Audit fees.

9.1. Weston Area Health NHS Trust as lessee

	Buildings £000s	Other £000s	2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense				
Minimum lease payments			**238**	227
Total			**238**	227
Payable:				
No later than one year	34	107	**141**	138
Between one and five years	168	241	**409**	481
After five years	526	90	**616**	559
Total	**728**	**438**	**1,166**	1,178

The most significant future minimum lease payment in the Buildings category relates to the lease of office space from North Somerset Council until 2032.

The most significant future minimum lease payment in the Other category relates to the Managed Print Service contract with Hewlett-Packard which has 2 years 4 months remaining.

9.2. Weston Area Health NHS Trust as lessor

	2016-17 £000s	2015-16 £000s
Recognised as revenue		
Rental revenue	133	179
Total	**133**	179
Receivable:		
No later than one year	134	183
Between one and five years	532	731
After five years	2,050	4,817
Total	**2,716**	5,731

The Trust receives rental revenue from a number of organisations for the use of its land and buildings. The most significant arrangement is with Avon and Wiltshire Mental Health Partnership NHS Trust for a strip of land which has 57 years remaining. The rental value on this agreement was renegotiated to reflect the actual capital charges incurred which resulted in a reduction in revenue of £50k per year.

10. Employee benefits

10.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**65,131**	58,905
Social security costs	**5,001**	3,935
Employer Contributions to NHS BSA - Pensions Division	**5,964**	5,868
Total employee benefits	**76,096**	68,708
Employee costs capitalised	**384**	351
Gross Employee Benefits excluding capitalised costs	**75,712**	68,357

10.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**2**	1
	£000s	£000s
Total additional pensions liabilities accrued in the year	**71**	79

10.3 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

11. Better Payment Practice Code

11.1. Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**45,850**	**37,850**	35,637	35,477
Total Non-NHS Trade Invoices Paid Within Target	**44,521**	**36,766**	34,572	34,724
Percentage of Non-NHS Trade Invoices Paid Within Target	**97.10%**	**97.14%**	97.01%	97.88%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,445**	**12,817**	1,373	**12,283**
Total NHS Trade Invoices Paid Within Target	**1,273**	**12,169**	1,211	**11,706**
Percentage of NHS Trade Invoices Paid Within Target	**88.10%**	**94.94%**	88.20%	95.30%
Total Payables				
Total Trade Invoices Paid in the Year	**47,295**	**50,667**	37,010	47,760
Total Trade Invoices Paid Within Target	**45,794**	**48,935**	35,783	46,430
Percentage of Trade Invoices Paid Within Target	**96.83%**	**96.58%**	96.68%	97.22%

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 a valid invoice, whichever is later.

12. Investment Revenue

	2016-17 £000s	2015-16 £000s
Interest revenue		
Bank interest	**9**	11
Total investment revenue	**9**	11

13. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain on disposal of assets other than by sale (PPE)	**4**	**8**
Total	**4**	8

14. Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	**131**	**16**
Total interest expense	**131**	16
Other finance costs	**1**	**4**
Provisions - unwinding of discount	**45**	**3**
Total	**177**	23

15. Auditor Disclosures

15.1. Other auditor remuneration

Not relevant for trust

	2016-17 £000s	2015-16 £000s
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	**12**	0
Total	**12**	**0**

The audit-related assurance services relates to the audit of the Trust's Quality account. For 2015/16 the £12k cost was included within Audit fees see Note 8.

16.1. Property, plant and equipment

2016-17	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	
Cost or valuation:								
At 1 April 2016	6,870	51,636	627	18,876	4,671	1,441	**84,121**	
Additions of Assets Under Construction	0	0	1,150	0	0	0	**1,150**	
Additions Purchased	0	652	0	1,258	371	0	**2,281**	a
Additions - Purchases from Cash Donations	0	0	10	0	0	0	**10**	
Reclassifications	0	561	(606)	0	0	0	**(45)**	b
Disposals other than for sale	0	0	0	(255)	0	0	**(255)**	
Revaluation	0	2,287	0	0	0	0	**2,287**	
At 31 March 2017	**6,870**	**55,136**	**1,181**	**19,879**	**5,042**	**1,441**	89,549	
Depreciation								
At 1 April 2016	0	730	0	12,106	3,342	1,330	**17,508**	
Reclassifications	0	0	0	0	0	0	**0**	
Disposals other than for sale	0	0	0	(255)	0	0	**(255)**	
Revaluation	0	102	0	0	0	0	**102**	a
Charged During the Year	0	1,606	0	1,234	512	23	3,375	
At 31 March 2017	**0**	**2,438**	**0**	**13,085**	**3,854**	**1,353**	20,730	
Net Book Value at 31 March 2017	**6,870**	**52,698**	**1,181**	**6,794**	**1,188**	**88**	68,819	
Asset financing:								
Owned - Purchased	6,870	49,399	1,181	6,794	1,188	88	65,520	
Owned - Donated	0	3,299	0	0	0	0	3,299	
Total at 31 March 2017	**6,870**	**52,698**	**1,181**	**6,794**	**1,188**	**88**	68,819	

Note a: The net movement on the Revaluation lines, Cost and Depreciation is £2,185k. See SOCITE.
Note b: Corresponding reclassifications of £45k in intangibles non current assets.

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	4,861	7,575	0	0	0	0	**12,436**
Movements	0	2,130	0	0	0	0	**2,130**
At 31 March 2017	**4,861**	**9,705**	**0**	**0**	**0**	**0**	**14,566**

Additions to Assets Under Construction in 2016-17

Buildings excl Dwellings	891
Plant & Machinery	259
Balance as at YTD	**1,150**

16.2. Property, plant and equipment prior-year

2015-16	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:							
At 1 April 2015	6,870	48,068	916	18,059	4,282	1,436	**79,631**
Additions of Assets Under Construction	0	0	2,101	0	0	0	**2,101**
Additions Purchased	0	1,397	0	1,006	380	4	**2,787**
Reclassifications	0	1,819	(2,390)	(5)	9	1	**(566)**
Disposals other than for sale	0	0	0	(184)	0	0	**(184)**
Revaluation	0	352	0	0	0	0	**352**
At 31 March 2016	**6,870**	**51,636**	**627**	**18,876**	**4,671**	**1,441**	**84,121**
Depreciation							
At 1 April 2015	0	0	0	11,143	2,800	1,302	**15,245**
Disposals other than for sale	0	0	0	(184)	0	0	**(184)**
Revaluation	0	(740)	0	0	0	0	**(740)**
Charged During the Year	0	1,470	0	1,147	542	28	**3,187**
At 31 March 2016	0	730	0	**12,106**	**3,342**	**1,330**	**17,508**
Net Book Value at 31 March 2016	**6,870**	**50,906**	**627**	**6,770**	**1,329**	**111**	**66,613**
Asset financing:							
Owned - Purchased	6,870	47,753	627	6,629	1,329	111	**63,319**
Owned - Donated	0	3,153	0	141	0	0	**3,294**
Total at 31 March 2016	**6,870**	**50,906**	**627**	**6,770**	**1,329**	**111**	**66,613**

16.3. (cont). Property, plant and equipment

Of the totals at 31 March 2017 there are no tangible fixed assets relating to land, buildings, dwellings, installations or fittings valued at open market value. (31 March 2016 also Nil).

The Trust's land and buildings were revalued as at 31st March 2015 by the DVS Valuation Office who are independent to the Trust these values are then adjusted for the movement in the Building Cost Information Service index (BCIS) annually as at 31st March 2016 and 31st March 2017.

The Valuations also accord with the requirements of the RICS Valuation - Professional Standards 2014 UK edition, known as the red book, including the International Valuation Standards, in so far as these are consistent with IFRS and the above mentioned guidance; RICS UKVS 1.15 refers.

The 31st March 2017 valuation of all buildings using the BCIS index resulted in an 4.35% increase in the value of buildings by £2,185k.

The Trust has started a £1.4 million refurbishment project of the Endoscopy Department to run over 2 financial years, with costs of £621k incurred in 2016/17.

The DVS Valuation Office assessed no change in the value of the Land for the period ending 31st March 2017.

Gains relating to MEA Valuation are taken to the Revaluation Reserve. Losses arising from revaluation are recognised as impairments and are charged to the revaluation reserve to the extent that a balance exists in relation to the revalued asset. Losses in excess of that amount are charged to the current year's statement of comprehensive income, unless it can be demonstrated that the recoverable amount is greater than the revalued amount in which case the impairment is taken to the revaluation reserve. This applies where the fall in value is as a result from the fall in market prices however if the fall in value arises from the clear consumption of economic benefit this should then be charged to expenditure.

There were no assets held under finance leases or hire purchase contracts at the balance sheet date. (31 March 2016 also Nil)

No dwellings or transport equipment assets were held in either period.

The donated asset £10k included in assets under construction relates to the professional fees for the refurbishment of the Macmillian Information Centre which is being funded by Macmillan Cancer Support. There are no restrictions imposed on the use of donated assets.

16.4 Economic Lives of Non-Current Assets

Intangible Assets	**Min/Max Life in years**
Software Licences	1 - 8
Property, Plant and Equipment	
Buildings exc Dwellings	9 - 69
Plant & Machinery	1 - 35
Information Technology	3 - 18
Furniture and Fittings	5 - 35

17. Intangible non-current assets

17.1. Intangible non-current assets

2016-17	Computer Licenses £000's	
At 1 April 2016	**3,783**	
Additions Purchased	799	
Reclassifications	45	a
At 31 March 2017	**4,627**	
Amortisation		
At 1 April 2016	**1,206**	
Charged During the Year	**466**	
At 31 March 2017	**1,672**	
Net Book Value at 31 March 2017	**2,955**	
Asset Financing: Net book value at 31 March 2017 comprises:		
Purchased	2,955	
Total at 31 March 2017	**2,955**	

Note a: Corresponding reclassifications of £45k in property plant and equipment. See note 16.1.

There is a Nil balance in the revaluation reserve balance for intangible non-current assets in both periods.

17.2. Intangible non-current assets prior year

2015-16	Computer Licenses £000's
Cost or valuation:	
At 1 April 2015	3,454
Additions - purchased	721
Reclassifications	566
Impairments/reversals charged to operating expenses	(958)
At 31 March 2016	3,783
Amortisation	
At 1 April 2015	1,382
Impairments/reversals charged to operating expenses	(572)
Charged during the year	396
At 31 March 2016	1,206
Net book value at 31 March 2016	2,577
Net book value at 31 March 2016 comprises:	
Purchased	2,577
Total at 31 March 2016	2,577

17.3. Intangible non-current assets

Intangible assets comprise purchased computer software which is carried at amortised historical cost, as a proxy for fair value.

Assets are capitalised and amortised over the useful lives on a straight-line basis. Useful lives are all finite and range from 1 to 8 years.

18. Analysis of impairments and reversals recognised in 2016-17

	2016-17 Total £000s	2015-16 Total £000s
Other	0	386
Total charged to Annually Managed Expenditure	**0**	**386**
Total Impairments of Intangibles charged to SoCI	**0**	386

There were no impairments or reversals recognised in 2016-17. In the previous year the Trust recognised impairment against intangible assets for the implementation of the LC01 upgrade of the Millennium PAS system £346k and obsolete software £40k.

19. Investment property

Not relevant for trust

20. Commitments

20.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2017 993	31 March 2016 £000s
Property, plant and equipment	**993**	96
Total	**993**	96

20.2. Other financial commitments

Not relevant for trust

21. Inventories

	Drugs	Consumables	Energy	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**502**	**540**	**12**	**1,054**	0
Additions	9,540	6,384	0	**15,924**	0
Inventories recognised as an expense in the period	(9,604)	(6,236)	(2)	**(15,842)**	0
Balance at 31 March 2017	**438**	**688**	**10**	**1,136**	**0**

22.1. Trade and other receivables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**2,363**	1,566	**0**	0
Non-NHS receivables - revenue	**1,011**	995	**680**	590
Non-NHS prepayments and accrued income	**437**	516	**0**	0
PDC Dividend prepaid to DH	**73**	25	**0**	0
Provision for the impairment of receivables	**(91)**	(121)	**(156)**	(130)
VAT	**484**	297	**0**	0
Other receivables	**5**	36	**0**	0
Total	**4,282**	3,314	**524**	460
Total current and non current	**4,806**	3,774		

The great majority of trade is with Clinical Commissioning Groups. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2. Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000s	£000s
By up to three months	**439**	280
By three to six months	**248**	220
By more than six months	**873**	766
Total	**1,560**	1,266

22.3. Provision for impairment of receivables

	2016-17 £000s	2015-16 £000s
Balance at 1 April 2016	**(251)**	(233)
Amount written off during the year	**33**	6
(Increase)/decrease in receivables impaired	**(29)**	(24)
Balance at 31 March 2017	**(247)**	(251)

23. NHS LIFT investments

Not relevant for trust

24.1. Other Financial Assets - Current

Not relevant for trust

24.2. Other Financial Assets - Non Current

Not relevant for trust

25. Other current assets

Not relevant for trust

26. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	**3,853**	3,030
Net change in year	**(2,244)**	823
Closing balance	**1,609**	3,853
Made up of		
Cash with Government Banking Service	**1,565**	3,824
Commercial banks	**33**	20
Cash in hand	**11**	9
Cash and cash equivalents as in statement of financial position	**1,609**	3,853
Cash and cash equivalents as in statement of cash flows	**1,609**	3,853

27. Non-current assets held for sale

Not relevant for trust

28. Trade and other payables

	Current	
	31 March 2017 £000s	31 March 2016 £000s
NHS payables - revenue	**3,389**	1,746
Non-NHS payables - revenue	**1,220**	1,232
Non-NHS payables - capital	**1,649**	1,259
Non-NHS accruals and deferred income	**3,668**	4,001
Social security costs	**686**	564
Accrued Interest on DH Loans	**42**	16
Tax	**612**	593
Other	**841**	816
Total	**12,107**	10,227
Total payables (current and non-current)	**12,107**	**10,227**
Included above:		
Outstanding Pension Contributions at the year end	**830**	810

29. Other liabilities

Not relevant for trust

30. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Loans from Department of Health	**7,700**	0	**4,200**	7,700
Total	**7,700**	**0**	**4,200**	**7,700**
Total other liabilities (current and non-current)	**11,900**	**7,700**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	7,700	0	**7,700**
1 - 2 Years	0	0	**0**
2 - 5 Years	4,200	0	**4,200**
Over 5 Years	0	0	**0**
TOTAL	**11,900**	**0**	**11,900**

31. Other financial liabilities

Not relevant for trust

32. Deferred income

	Current	
	31 March 2017 £000s	31 March 2016 £000s
Opening balance at 1 April 2016	**441**	380
Deferred revenue addition	**1**	80
Transfer of deferred revenue	**(101)**	(19)
Current deferred Income at 31 March 2017	**341**	441
Total deferred income all current.	**341**	441

33. Finance lease obligations as lessee

Not relevant for trust

34. Finance lease receivables as lessor

Not relevant for trust

35. Provisions

	Total	Comprising: Early Departure Costs	Legal Claims	Other
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2016	**443**	285	20	138
Arising during the year	**32**	0	32	0
Utilised during the year	**(52)**	(30)	(12)	(10)
Reversed unused	**(1)**	0	(1)	0
Unwinding of discount	**45**	30	0	15
Balance at 31 March 2017	**467**	**285**	**39**	**143**
Expected Timing of Cash Flows:				
No Later than One Year	**79**	30	39	10
Later than One Year and not later than Five Years	**170**	125	0	45
Later than Five Years	**218**	130	0	88

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£000s
As at 31 March 2017	26,969
As at 31 March 2016	14,618

The increase in provisions held by NHS Litigation Authority for clinical negligence liabilities reflects an increase in both the value and number of claims made against the Trust.

Early departure costs provisions are for pre-6 March 1995 early retirement cases where a retirement was due to ill health and consequently not funded by the NHS Pension scheme. The level of payment in these cases is predetermined and uplifted for inflation each year.

Legal claims relate to Employee and Public liability cases where assistance is provided by Insurers where the value of the case exceeds the Trust excess.

Other - £143,000 is made up of a permanent injury benefit case (31 March 2016 £138,000).

36. Contingencies

	31 March 2017 £000s	31 March 2016 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(24)**	(9)
Net value of contingent liabilities	**(24)**	(9)

The contingent liabilities represent possible legal claims against the Trust, these are managed by the NHS Litigation Authority for clinical negligence and liabilities for third parties scheme.

37. Analysis of charitable fund reserves

The Charity's transactions are immaterial in the context of the group and these transactions have not been consolidated.

38. PFI and LIFT - additional information

Not relevant for trust

39. Impact of IFRS treatment - current year

Not relevant for trust

40. Financial Instruments

40.1 . Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government, subject to affordability as confirmed by NHS Improvement. The borrowings from the DH are repayable between 0 and 5 years, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

40.2. Financial Assets

	Loans and receivables
	£000s
Receivables - NHS	**2,363**
Receivables - non-NHS	**1,430**
Cash at bank and in hand	**1,609**
Total at 31 March 2017	**5,402**
Embedded derivatives	0
Receivables - NHS	1,566
Receivables - non-NHS	1,288
Cash at bank and in hand	3,853
Total at 31 March 2016	6,707

40.3. Financial Liabilities

	Other
	£000s
NHS payables	**3,389**
Non-NHS payables	**6,537**
Other borrowings	**11,900**
Total at 31 March 2017	**21,826**
NHS payables	1,746
Non-NHS payables	6,067
Other borrowings	7,160
Total at 31 March 2016	14,973

The approach to valuing financial instruments is intended to reflect the value at which such instruments could be traded. However in the case of loans from DH to NHS bodies, neither party is involved in trading its interest in the loan. The overriding concern is that the loans are valued on a consistent basis across the group to enable the reported balances to be eliminated on consolidation. For 2016/17 the guidance requires the Trust to disclose the gross value of the £11,900 loan, whereas in 2015/16 the loan was discounted.

The fair value of financial assets and liabilities is not materially different from their carrying value in the accounts.

Fair values of Financial Assets and liabilities are not quoted on active markets and are therefore 'Level 2' in the IFRS 13 hierarchy. Hence their fair values have been calculated at amortised cost. The valuation technique requires assumptions regarding the repayment dates of long term assets and liabilities, which are based on best estimates.

41. Events after the end of the reporting period

There are not any events after the end of the reporting period that have a material effect on the accounts.

42. Related party transactions

Weston Area Health NHS Trust is a body corporate established by order of the Secretary of State for Health.

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 Weston Area Health NHS Trust.

The Department of Health is regarded as a related party. During the year Weston Area Health NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

These entities are:
NHS England, South West Specialised Commissioning Hub, Wessex Specialised Commissioning Hub, Health Education England, NHS Litigation Authority, North Bristol NHS Trust, North Somerset CCG, Somerset CCG, University Hospitals Bristol NHS Foundation Trust.

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies e.g. North Somerset Council & HM Revenue and Customs and NHS Pension Scheme.

The Trust has also received revenue payments of £108k from the Weston Health General Charitable funds whose Trustees are the same as those members of the NHS Trust Board. The net assets of the charity are £579k which equates to 1% of the Trusts net assets. The Charity is a separate legal entity (Registered Charity 1057589) and produces its own annual report and accounts that is accessible on the Trust and charity commission websites.

43. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	29,304	17
Special payments	18,370	21
Total losses and special payments and gifts	47,674	38

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	15,014	23
Special payments	25,647	33
Total losses and special payments	40,661	56

44. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

44.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	70,300	80,100	85,914	90,403	93,199	95,306	96,789	96,826	100,378	98,462	105,556
Retained surplus/(deficit) for the year	(6,673)	8	408	(68)	2,110	(1,703)	1,312	(5,117)	(4,456)	(7,484)	(7,313)
Adjustment for:											
Timing/non-cash impacting distortions:											
Adjustments for impairments	0	0	0	2,516	497	5,178	833	385	393	386	0
Adjustments for impact of policy change re donated/government grants assets						135	105	49	161	133	128
Break-even in-year position	**(6,673)**	**8**	**408**	**2,448**	**2,607**	**3,610**	**2,250**	**(4,683)**	**(3,902)**	**(6,965)**	**(7,185)**
Break-even cumulative position	**(14,242)**	**(14,234)**	**(13,826)**	**(11,378)**	**(8,771)**	**(5,161)**	**(2,911)**	**(7,594)**	**(11,496)**	**(18,461)**	**(25,646)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trusts financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	-9.49	0.01	0.47	2.71	2.80	3.79	2.32	-4.84	-3.89	-7.07	-6.81
Break-even cumulative position as a percentage of turnover	-20.26	-17.77	-16.09	-12.59	-9.41	-5.42	-3.01	-7.84	-11.45	-18.75	-24.30

The amounts in the above tables in respect of financial years 2006/07 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

44.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

44.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	6,990	11,487
Cash flow financing	6,922	8,634
External financing requirement	**6,922**	8,634
Under spend against EFL	**68**	2,853

44.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	4,240	5,609
Less: donations towards the acquisition of non-current assets	(10)	0
Charge against the capital resource limit	**4,230**	5,609
Capital resource limit	4,478	5,657
Underspend against the capital resource limit	**248**	48

45. Third party assets

The Trust held no monies relating to patients in either year ending 2016/17 or 2015/16.

Independent auditor's report to the Trust Board of Weston Area Health NHS Trust

We have audited the financial statements of Weston Area Health NHS Trust (the "Trust") for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014 (the "Act"). The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 (the "2016/17 GAM") and the requirements of the National Health Service Act 2006.

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

- the single total figure of remuneration for each director;
- CETV disclosures for each director
- the analysis of staff numbers and costs; and
- the fair pay (pay multiples) disclosures.

This report is made solely to the Directors of Weston Area Health NHS Trust, as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Act to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report by exception where we are not satisfied.

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.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Performance Report and the Accountability Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Opinion on financial statements

In our opinion:

- the financial statements give a true and fair view of the financial position of Weston Area Health NHS Trust as at 31 March 2017 and of its expenditure and income for the year then ended; and
- the financial statements have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the National Health Service Act 2006.

Emphasis of matter - Going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1.5.1 to the financial statements concerning the Trust's ability to continue as a going concern. The Trust incurred a deficit of £7.2 million during the year ended 31 March 2017 and, at that date had net current liabilities of £12.9 million and current liabilities exceeded total assets by £5.8 million. The Directors are seeking support from NHS Improvement for 2017/18 of a loan of £6.0 million of which £1.0 million has already been received. As disclosed in note 1.5.1 to the financial statements, NHS Improvement has not, at the date of our report, confirmed the full amount of the loan it will support. These conditions, along with the other matters explained in note 1.5.1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Opinion on other matters

In our opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the audited financial statements.

Matters on which we are required to report by exception

We are required to report to you if 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 which involves or would involve the body incurring unlawful expenditure, or is about to take, or 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.

On 24 May 2017 we referred a matter to the Secretary of State under section 30b of the Act in relation to Weston Area Health NHS Trust's breach of its break-even duty for the three year period ended 31 March 2017.

We report to you if we are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

The Trust's outturn position for 2016/17 was a £7.2 million deficit, which is a significant deterioration compared to the Trust's budget deficit of £3.2 million. In addition, the Trust's medium term financial plan shows a further forecast deficit of £6.0 million for 2017/18.

The deterioration in the Trust's financial outturn in 2016/17 was primarily due to a significant shortfall in its planned savings of £4.1 million. Actual savings of £2.5 million were achieved, which also led to the loss of £1.8 million of Sustainability and Transformation Fund income due to the Trust's non achievement of its quarter three and year-end financial targets.

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

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2016, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Weston Area Health NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Other matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS Improvement; or

- we have reported a matter in the public interest under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have made a written recommendation to the Trust under section 24 of the Act in the course of, or at the conclusion of the audit; or

We have nothing to report in respect of the above matters.

Certificate

We certify that we have completed the audit of the financial statements of Weston Area Health NHS Trust in accordance with the requirements of the Act and the Code of Audit Practice.

Alex Walling

Alex Walling
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Hartwell House, 55-61 Victoria Street, Bristol, BS1 6FT
30 May 2017

Weston Area Health NHS
NHS Trust

CHIEF EXECUTIVE'S OFFICE
General Hospital
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Weston-super-Mare
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BS23 4TQ

Tel: 01934 636363
Direct Line: 01934 647001
Dept Fax: 01934 647176
Website: http://www.waht.nhs.uk/

Our Ref: RL/

26 May 2017

Grant Thornton UK LLP
Hartwell House
55-61 Victoria Street
Bristol, BS1 6FT

Dear Sirs,

Weston Area Health NHS Trust
Financial Statements for the year ended 31 March 2017

This representation letter is provided in connection with the audit of the financial statements of Weston Area Health NHS Trust for the year ended 31 March 2017 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with International Financial Reporting Standards and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i. As Trust Board members, we have fulfilled our responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with the Department of Health Group Accounting Manual 2016-17 (GAM) and International Financial Reporting Standards which give a true and fair view in accordance therewith.

ii. We have complied with the requirements of all statutory directions affecting the Trust and these matters have been appropriately reflected and disclosed in the financial statements.

iii. The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of the Care Quality Commission or other regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

iv. We acknowledge our

responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

v. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

vi. We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with International Financial Reporting Standards and the GAM, and adequately disclosed in the financial statements. There are no other material judgements that need to be disclosed.

vii. Except as disclosed in the financial statements:
   a. there are no unrecorded liabilities, actual or contingent
   b. none of the assets of the Trust has been assigned, pledged or mortgaged
   c. there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

viii. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

ix. All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the GAM require adjustment or disclosures have been adjusted or disclosed. The financial statements are free of material misstatements, including omissions.

x. In calculating the amount of income to be recognized in the financial statements from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be received by the Trust in accordance with the International Financial Reporting Standards and the GAM.

xi. Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

xii. We acknowledge our responsibility to participate in the Department of Health's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

xiii. We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

xiv. We have not consolidated the accounts of the Weston General Charitable Funds into the Trust's accounts, as they are considered to be immaterial to the results of the Trust and its financial position at the year-end.

xv. The Trust has a planned deficit in 2017/18 of £6.035m and this requires a £6.035m loan from the Department of Health of equal value to maintain cash flow in 2017/18. Directors have an agreed financial plan with NHS Improvement and are confident that it will support the Trust's application for cash support for 2017/18. The Trust has not yet received formal confirmation from the Department of Health that the full years funding will be forthcoming, although the first instalments of the loan were received in April and May 2017 totalling £1.033m.

xvi. Although the Trust is confident that this funding will be made available it represents a material uncertainty that may cast significant doubt about the Trust’s ability to continue as a going concern. The Directors, having made appropriate enquiries, still have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. For this reason the going concern basis has been adopted for preparing the accounts.

Information Provided

xvii. We have provided you with:
   a. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
   b. additional information that you have requested from us for the purpose of your audit; and
   c. unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

xviii. We have communicated to you all deficiencies in internal control of which management is aware.

xix. All transactions have been recorded in the accounting records and are reflected in the financial statements.

xx. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

xxi. We have disclosed to you all our knowledge of fraud or suspected fraud affecting the Trust involving:
   a. management;
   b. employees who have significant roles in internal control; or
   c. others where the fraud could have a material effect on the financial statements.

xxii. We have disclosed to you all our knowledge of any allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, regulators or others.

xxiii. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxiv. We have disclosed to you the identity of all of the Trust's related parties and all the related party relationships and transactions of which we are aware.

xxv. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Annual Report

xxvi. The disclosures within the Annual Report fairly reflect our understanding of the Trust's financial and operating performance over the period covered by the financial statements.

Annual Governance Statement

xxvii. We are satisfied that the Annual Governance Statement (AGS) fairly reflects the Trust's risk assurance framework and we confirm that we are not aware of any significant risks that are not disclosed within the AGS.

Approval

The approval of this letter of representation was minuted by the Trust's Audit and Assurance Committee at its meeting on 26 May 2017.

Signed on behalf of the Trust Board

Signed: ……..

Name: James Rimmer

Position: Chief Executive

Date: 26 May 2017

Signed: ……..

Name: Ian Turner

Position: Chair of Audit and Assurance Committee

Date: 26 May 2017

Part 4 Glossary and abbreviations

Glossary of Financial Terms

Assets	An item that has a value in the future. For example, a debtor (someone who owes money), is an asset as they will in future pay. A building is an asset because it houses activity that will provide a future income stream.
Audit	The process of validation of the accuracy, completeness and adequacy of disclosure of financial records.
Average Relevant Net Assets	Average relevant net assets are normally found by adding the opening and closing balances for the year and by dividing by two. Balances consist of the total capital and reserves (total assets employed), less donated asset reserve less cash balances in Government Banking Services accounts. This is used to calculate the Capital Cost Absorption Rate.
Capital	Land, buildings, equipment and other long-term assets owned by the Trust, the cost of which exceeds £5,000 and has an expected life of more than one year.
Capital Resource Limit (CRL)	A control set by the Department of Health onto NHS organisations to limit the level of capital expenditure that may be incurred in year.
External Financing Limit (EFL)	The External Financing Limit (EFL) is a fundamental element of the NHS Trusts financial regime. It is cash based public control set by the Department of Health. It represents the excess of its approved level of capital spending over the cash a Trust can generate internally (mainly surpluses and depreciation) essentially controlling the amount of "externally" generated funding.
Fixed Assets	Land, buildings, equipment and other long term assets that are expected to have a life of more than one year.
Governance	Governance is a system by which organisations are directed and controlled. It is concerned with how the organisation is run, how it is structured and how it is led. Integration of clinical and corporate governance should underpin all that an organisation does. In the NHS this means it must encompass clinical, financial and organisational aspects.
Impairment loss	The amount by which the carrying amount of an asset or cash-generating unit exceeds its recoverable amount.
Intangible Assets	Intangible assets are assets that cannot be seen, touched or physically measured. Examples include software licences, trademarks, patents and some research and development expenditure.
Property, Plant and Equipment	A sub-classification of fixed assets which include land, buildings, equipment and fixtures and fittings.

Public Capital	Dividend	When NHS trusts were first created, everything they owned (land, buildings, equipment and working capital) was transferred to them from the government. The value of these assets is in effect the public's equity stake in the new NHS trusts and is known as public dividend capital
Retained Reserve	Earnings	Retained earnings are the aggregate surplus or deficit the NHS trust has made in former years.

Glossary of Abbreviations

BNSSSG	Bristol, North Somerset, Somerset & South Gloucestershire Area
CBI	Confederation of British Industry
CBRN	Chemical, Biological, Radioactive, Nuclear
CCA	The Civil Contingencies Act
CCG	Clinical Commissioning Group
CDI	Clostridium difficile infection
CEO	Chief Executive Officer
CETV	Cash Equivalent Transfer Value
CHKS	Caspe Healthcare Knowledge Systems
CHP	Combined Heat and Power
CIP	Cost Improvement Plan
CO2e	Carbon Dioxide Equivalent
CQC	Care Quality Commission
CQUINS	Commissioning for Quality & Innovation Schemes
CRL	Capital Resource Limit
DGH	District General Hospital
DPA	Data Protection Act
EAP	Employee Assistance Programme
ECIP	Emergency Care Improvement Programme
ED	Emergency Department
EFL	External Financing Limit
EPRR	Emergency Preparedness Resilience and. Response
FMAs	Financial Monitoring and Accounts

FT	Foundation Trust
FTE	Full-Time Equivalent
GHG	Green House Gases
GMC	General Medical Council
GP	General practitioner
HES	Hospital Episode Statistics
HM	Her Majesty
HR	Human Resources
ICO	Information Commissioner's Office
IFRS	International Financial Reporting Standards
IHI	Institute for Healthcare improvement
ILM	Institute of Leadership and Management
IM & T	Information Management and Technology KPI
IT	Information Technology
JAG	Joint Advisory Group
KPI	Key Performance Indicator
LED	Light-emitting diode
LHRP	Local Health Resilience Partnership
LQAF	NHS Library Quality Assurance Framework
MRG	Mortality Review Group
MRSA	Methicillin-resistant Staphylococcus Aureus
NHS	National Health Service
NHSI	NHS Improvement
NHSTDA	NHS Trust Development Authority
NICE	National Institute for Health & Clinical Excellence

NPSA	National Patients Safety Agency
OD	Organisational Development
ONS	Office of National Statistics
PALS	Patient Advice & Liaison Service
PPC	Positive People Company
PRIDE	Patients First, Recognize & Respect, Invest in people, Delivery and Explain
QCF	Qualifications & Credit Framework
QI	Quality Indicator
QIPP	Quality, Innovation, Productivity & Prevention
RTT	Referral to treatment
SHMI	Summary Hospital-level Mortality Indicator
SIRI	Serious Incidents Requiring Investigation
SIRO	Senior Information Risk Officer
STP	Sustainability and Transformation Plan
TTO	To Take Out
UHB	University Hospital Bristol
VTE	Venous Thromboembolism
WAHT	Weston Area Health Trust
WRES	Workforce Race Equality Scheme

Weston Area Health NHS Trust

Weston General Hospital

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