Weston Area Health
NHS Trust

Weston Area Health NHS Trust Annual Report and Accounts 2017/18

We are Weston Area Health NHS Trust

Our strategy

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 treatment of ill-health service model to one which prevents illness and improves health and well-being;
- moving from an independent service provider model to one of formal partnership arrangements to;

- maximise the range of local services on site
- support the delivery of care in alternative settings
- improve clinical sustainability
- deliver high quality care within the Trust and across the region
- deliver economies of scale.

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.

2017/18 has been a full and challenging year for the Trust. In terms of improvements, our focus on patient safety has started to show through with the CQC report in June 2017 – showing a change from 'inadequate' to 'requires improvement' in our safe domain. This has been mirrored by an improvement in our mortality rates with our SHMI score now being well within the expected range. During the year however, there have been sustained periods of high demand for care through our Emergency Department. The long term difficulties in recruitment of doctors in some specialties has proved a real test of our resilience.

In March 2017, the Trust received a Warning Notice from the CQC 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. The organisation took action to address the concerns raised and temporarily closed the Emergency Department overnight (from 10pm to 8am) in July 2017 on the grounds of patient safety. This allowed staff to be consolidated within peak times of attendance. The temporary closure remains in place due to challenges surrounding recruitment of medical staff. An unannounced CQC inspection to the Emergency Department in December 2017, found that the Trust had taken action since their report in June 2017. Clear improvements in Emergency and Urgent care services in the hospital were demonstrated, with a requirement to continue to embed and audit practices across the organisation.

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.

All 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 2017 staff survey results are disappointing and a programme of work is underway with staff to better understand their concerns and identify actions required. An Organisational Development assessment has been completed and results are being triangulated with the staff survey results to design an Organisational Development programme.

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.

2017/18 also saw a worsening of the Trust's financial position, primarily due to the temporary overnight closure of the Emergency Department, but also due to unachieved savings and high levels of agency spend (albeit an improvement over 2016/17 agency spend. The Trust finished the year £13.5m in deficit

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 2018

What we do

Weston Area Health NHS Trust is the smallest NHS hospital Trust in England. It was established in April 1991 as 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 commissioned from the Trust by local health bodies that are responsible for purchasing health care for the resident population.

The population that the Trust serves has recently been described and defined in a commissioning context document "Health Weston: joining up services for better care in the Weston Area", published by BNSSG Clinical Commissioning group. The detail of this is provided in Box 1. This work is supported by a report commissioned by the Trust in 2016, which outline that the effective population currently using WAHT services. This is estimated to be circa 160,000 to 180,000. In addition to the local population, Weston-super-Mare attracts 3 million day trippers and approximately 500,000 staying visitors each year and in peak season; up to 10% of emergency department attendances are by out-of-area tourists. Included in the population figures above is the population of North Sedgemoor which has an estimated population 48,400 (GP registered population).

The Trust's largest commissioner during 2017/18 was North Somerset CCG with WAHT accounting for circa £67 million of the CCG expenditure in 2017/18. In addition, the Trust receives other non-patient related income including education and training monies. Key facts about North Somerset can be seen in figure 1.

Box 1. *The commissioning context document "Healthy Weston" describes two discrete health economies in North Somerset (Healthy Weston: Joining up services for better care in the Weston Area (BNSSG Clinical Commissioning Groups)):*

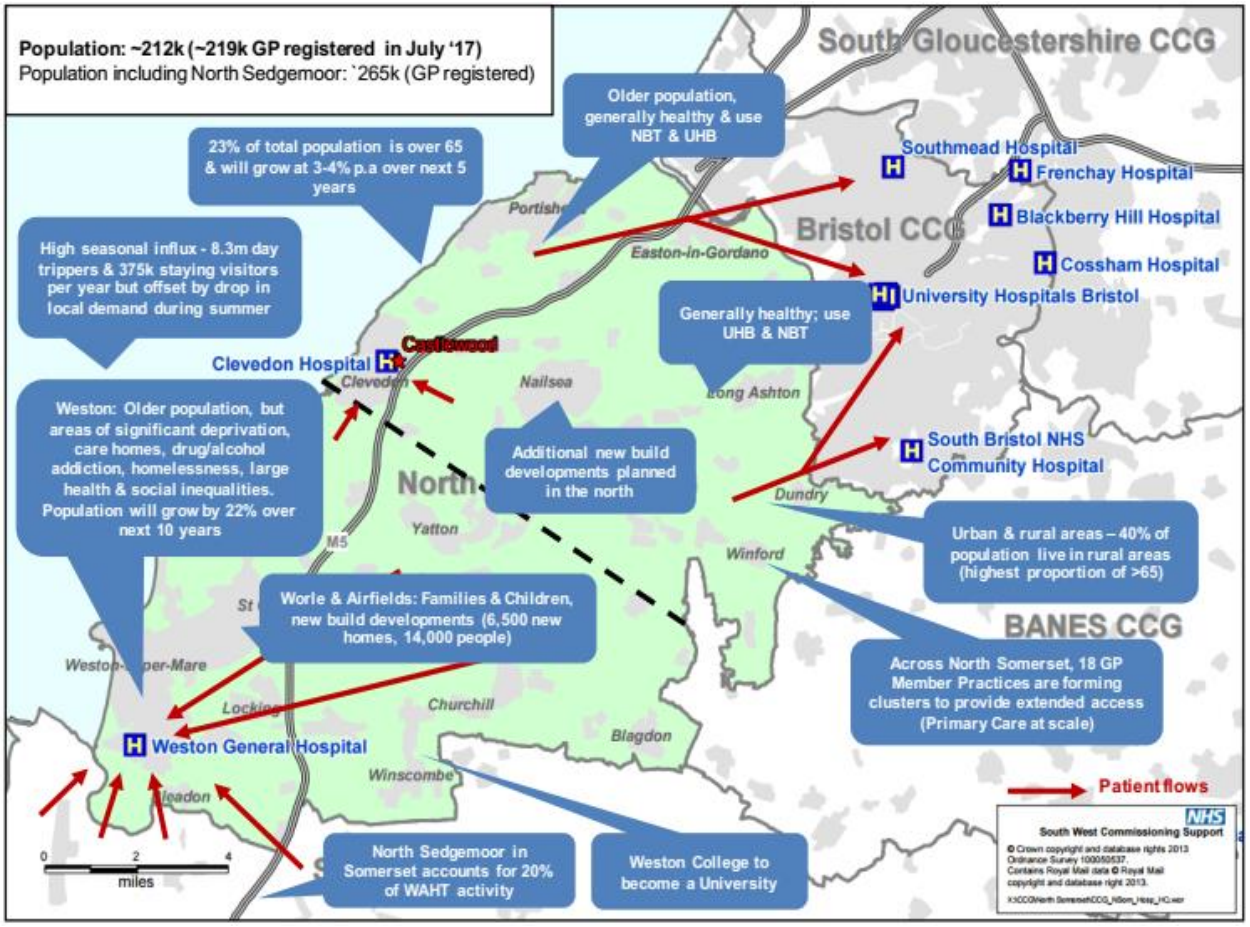
1. **The North** - the northern half of the patch has a total population of approximately 102,000 people centred around the towns of Clevedon (population: ~21,000), Nailsea (population ~15,500) and Portishead (population: ~22,500); and the top half of the GP locality known as 'the Rurals' (43,000). Residents of these areas tend to be healthier than residents in the south, and this population commonly looks to UHB (University Hospitals Bristol (NHS Foundation Trust) and NBT (North Bristol Trust) for their acute care needs.

2. **The South** - the south centres around the town of Weston-super-Mare which according to 2015 ONS data has a population of ~81,200, the adjoining villages of Worle, Winscombe and the surrounding villages that make up the southern half of the Rurals locality (total population ~110,000); where residents typically look to Weston General Hospital for their secondary care needs. Weston-super-Mare currently has an older demographic, with fewer young people under 20. However, this disguises some key differences across Wards, as South Ward has a younger demographic than the North Somerset average and 1-in-10 residents are from non-white backgrounds. The population of Worle, which lies on the northeastern edge of Weston-super-Mare, is younger compared with the average for North Somerset, and has the lowest percentage of people aged over 65 and 85 years (17.7% and 2.4% respectively).
If specialised commissioning (currently commissioned by NHS England) is excluded, around 64% of secondary care activity for North Somerset residents living in the south is provided by WAHT (with the remainder largely provided by UHB, NBT and TSFT). This percentage reduces to 20% for those residents living in the north.

There is a third area known as North Sedgemoor, which lies to the south of Weston-super-Mare and is within the
boundaries of Somerset CCG. North Sedgemoor has a GP registered population of approximately 48,000, which accounts for approximately 20% of WAHT activity.

Whilst North Somerset and North Sedgemoor effectively form the catchment area for WAHT services, this area is geographically wide-spread, and a high proportion of residents travel to neighbouring hospitals for treatment. So, although the combined GP registered population is approximately 265,000, the effective population currently using WAHT services is estimated circa 160,000 to 180,000 (Source: WAHT commissioned GE Finnamore Report, 2016). In addition to the local population, Weston-super-Mare attracts 8 million day trippers and approximately 500,000 staying visitors each year and in peak season; up to 10% of emergency department attendances are by out-of-area tourists.

Figure 1: *Key facts about North Somerset*
(source: Healthy Weston: Joining up services for better care in the Weston Area (BNSSG Clinical Commissioning Groups),



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; this is something that will feature significantly in the Trust's workforce plans as the health and social care workforce is required to expand.
- 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. The housing developments locally mean that Weston-Super-Mare's population is predicted to grow by 22% from 2014-2024 compared to background growth across the whole of North Somerset of 13% across the same timeframe.
- 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;
- People in lower socio economic groups are more likely to have severe and enduring physical and mental health problems; the impact is greatest on children living in poverty. The national rate of children living in poverty is 25% with the average for North Somerset being 19%, however in Weston's central ward it is 36% and in south ward it is 38%.
- There are 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 18.5 years for men and 16.5 years for women.

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 centers providing community children's services which are located in Weston-super-Mare, on Drove Road, and Clevedon at The Barn.

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. Many services are provided as part of a 'clinical network' 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 £69.7m (31 March 2018).

The Trust is registered without conditions with the Care Quality Commission (CQC) the independent regulator of health and social care in England.

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 2017/2018 and in the future

The business plan for the Trust in 2017/18 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 Improvement 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 2017 - 2018

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 Committee • Clinical Effectiveness Group • Quality and Safety • Trust Board

Priority area of delivery	Key supporting programmes of work to deliver	Key Success criteria	Governance
Ensuring consistent delivery of constitutional standards	• ECIP and ED 4hr performance programme • Cancer Survivorship programme • Acute Medical Model programme	• Delivery of constitutional standards	• Monthly directorate performance delivery • Trust Board
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 Effectiveness Group
Maintain/improve junior doctor training environment	• Improving frailty and dementia care • Enhancing communications • Reducing harm from medicines	• Feedback from junior doctors and GMC	• Senior Management Committee • 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 Committee • Trust Board and committees
System alignment, planning and delivery - partnership working to improve care pathways for patients and deliver sustainable clinical and staffing solutions	• Partnership Working UH Bristol • Sustainability Board • Developing strategic opportunities programme/BNSSG programme/ 'Healthy Weston'	• Clear strategic future described • Capacity and demand modelling for new portfolio • STP documented	• Senior Management Committee • Trust Board
Delivery of the Financial Plan	• CIP delivery programme • Capital Investment Programme	• Delivery of financial plan • Delivery of CIP	• Monthly directorate performance delivery • Senior Management Committee • Finance and Performance Committee • Audit and Assurance Committee
IM&T improvements	• Upgrade delivery programme	• Deliver the Millennium 2015 code upgrade	• Information Governance Committee • Trust 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 strengthened Ward to Board governance processes in relation to mortality. 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. 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. The organisation took action to address the concerns raised and temporarily closed the Emergency Department overnight (from 10pm to 8am) in July 2017 on the grounds of patient safety.
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.
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. The Freedom To Speak Up Guardian role is embedded at the Trust and is well used by staff. The Guardian reports quarterly to Public Board.
Maintain/improve junior doctor training environment	Junior doctors' experiences of working at the Trust continue as an area of concern. The Trust has created a Junior Doctor Forum which meets regularly and has also appointed a Guardian of Safe Working and Director of Medical Education to support this.
Embedding strong board assurance, models of delegation and clinical governance throughout the Trust	The Trust has appointed to new governance roles and strengthened oversight of performance to improve transparency of ward to board reporting. Improvements have also been made to the committee structures including the introduction of a new workforce-related board committee and refreshed clinical effectiveness committee..
System alignment, planning and delivery - partnership working to improve care pathways for patients and deliver sustainable clinical and staffing solutions	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. The Trust has participated actively as a member of the BNSSG Sustainability and Transformation Plan development and as part of the Weston Sustainability Programme, a spotlight project within the BNSSG STP Acute Care Collaboration Work stream. The Trust has participated actively in the CCG led public consultation on the future provision of services – 'Healthy Weston'
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	Significant improvements during the year have included enhancements to the Trust Wifi, improved network security in relation to Cyber Attacks and an upgrade to our Patient Administration System.

Analysis of national and local drivers for change clearly demonstrates that existing single organisation-focused 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 Clinical Commissioning Groups and providers with ongoing alignment of commissioning intentions with Sustainability and Transformation 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.

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 collaboration was 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.

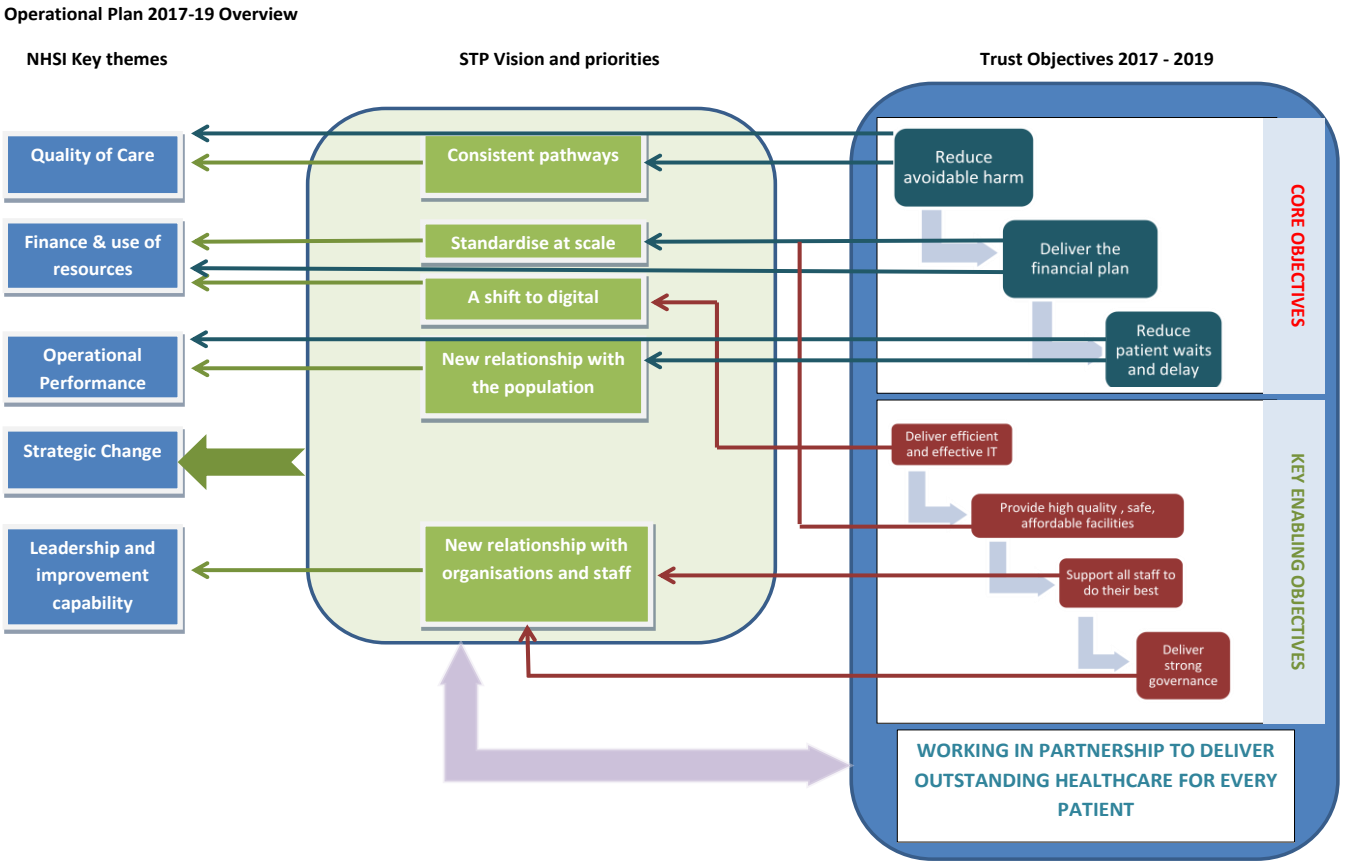
Building on long-standing, positive working relationships which give local people access to a range of services delivered or supported by Bristol and Weston clinicians, the two Trust Boards agreed to:

- 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.

On 31st January 2018, the Trust Board of University Hospitals Bristol NHS Foundation Trust with the support of its Council of Governors, confirmed its intention to pursue an organisational merger with the Trust. This was been welcomed by the WAHT Board who also met to review the potential of the proposal.

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



Key risks to delivery of these objectives include:

- failure to deliver required length of stay improvements due to lack of internal and external partner capacity and capability
- 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
- failure to deliver operational plan due to lack of internal capacity and capability
- that medical staffing will not be at the required numbers/has over reliance on locums to deliver safe and dignified care
- that the Trust will not deliver clinical quality indicators, national performance targets and be a safe and suitable training environment
- that people who use our services are not discharged in a safe and timely fashion
- that the Trust is unable to secure partners to manage the future delivery of clinically and financially viable services
- that the Trust will be unable to deliver a major savings plan

The operational plan describes mitigating actions to remove these risks.

Meeting National Performance Objectives

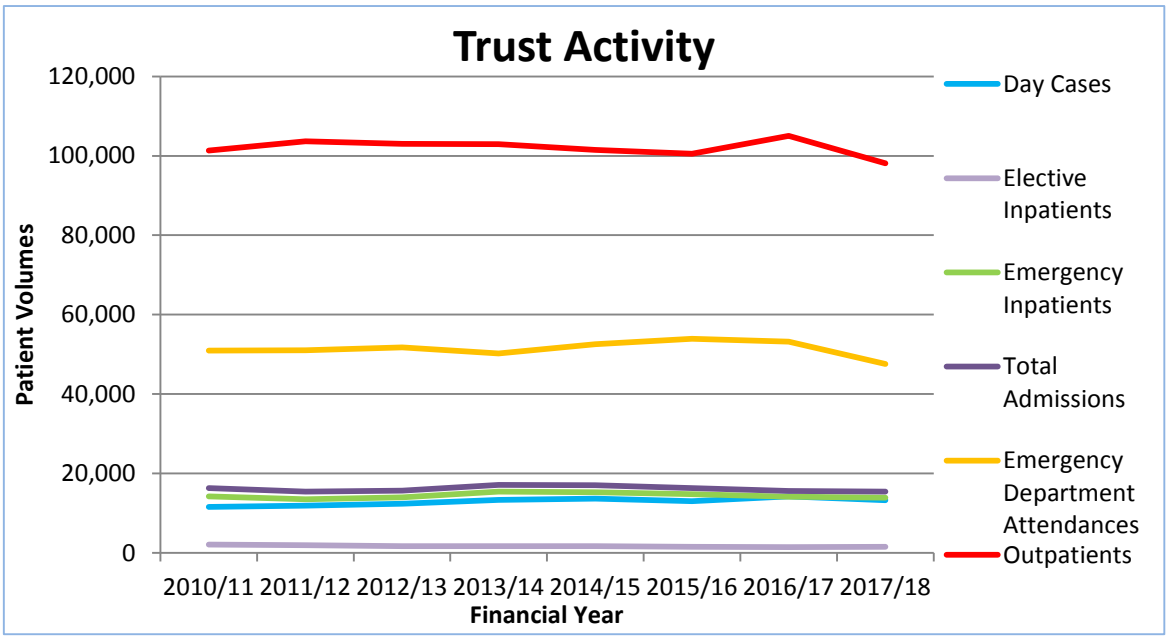
Our Performance

This section sets out the Trust performance for the financial year ending 31st March 2018. 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 as the 'Integrated Performance Report'. Copies of these reports are available on the Trust website at www.waht.nhs.uk.

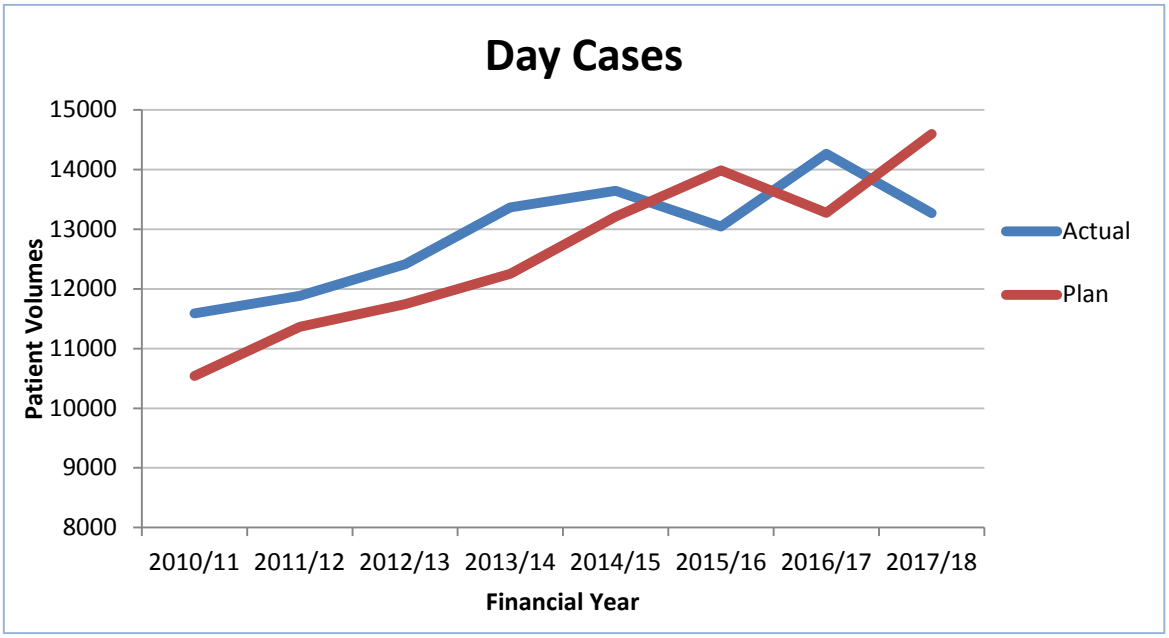
Patient Activity

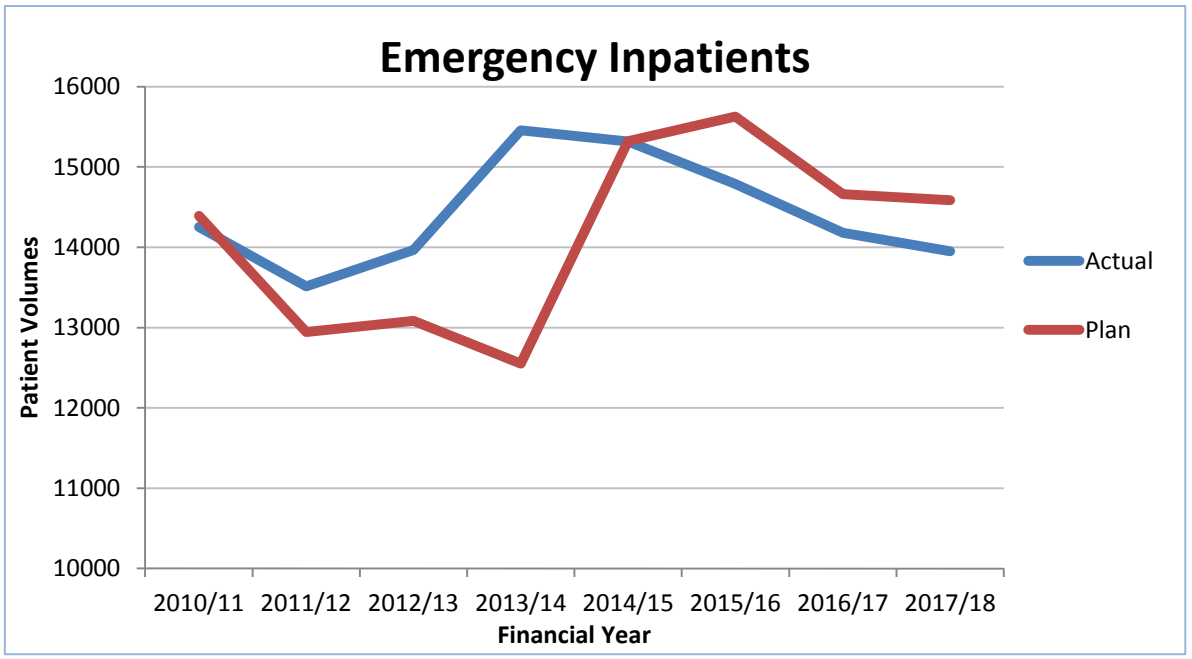
	2016/17	2017/18
Day Cases	14,267	13,270
Elective Inpatients	1,442	1,507
Emergency Inpatients	14,179	13,950
Total Admissions	15,621	15,457
Average Length of Stay	3.2	3.25
Emergency Department Attendances	53,242	47,601
Outpatients	105,036	98,145

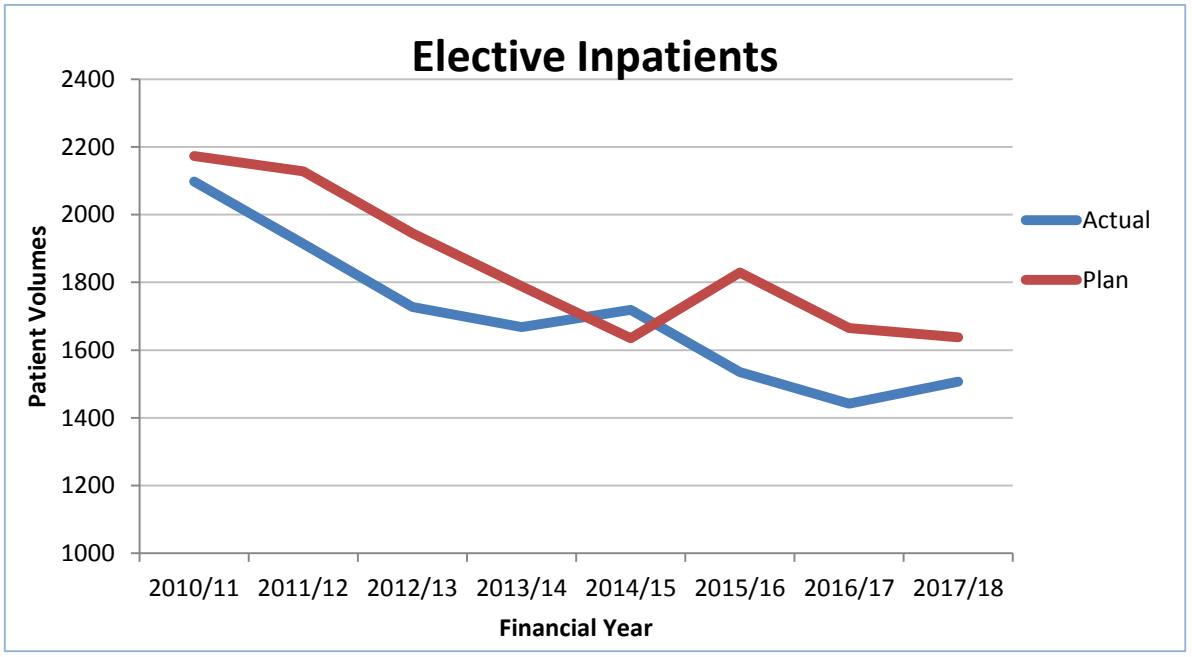
'Elective' Inpatients are patients who come into the hospital for planned operations, procedures and treatment. 'Emergency' patients are admitted without an appointment and generally need urgent treatment.
The population the hospital cares for has a higher than average proportion of people who are elderly 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.

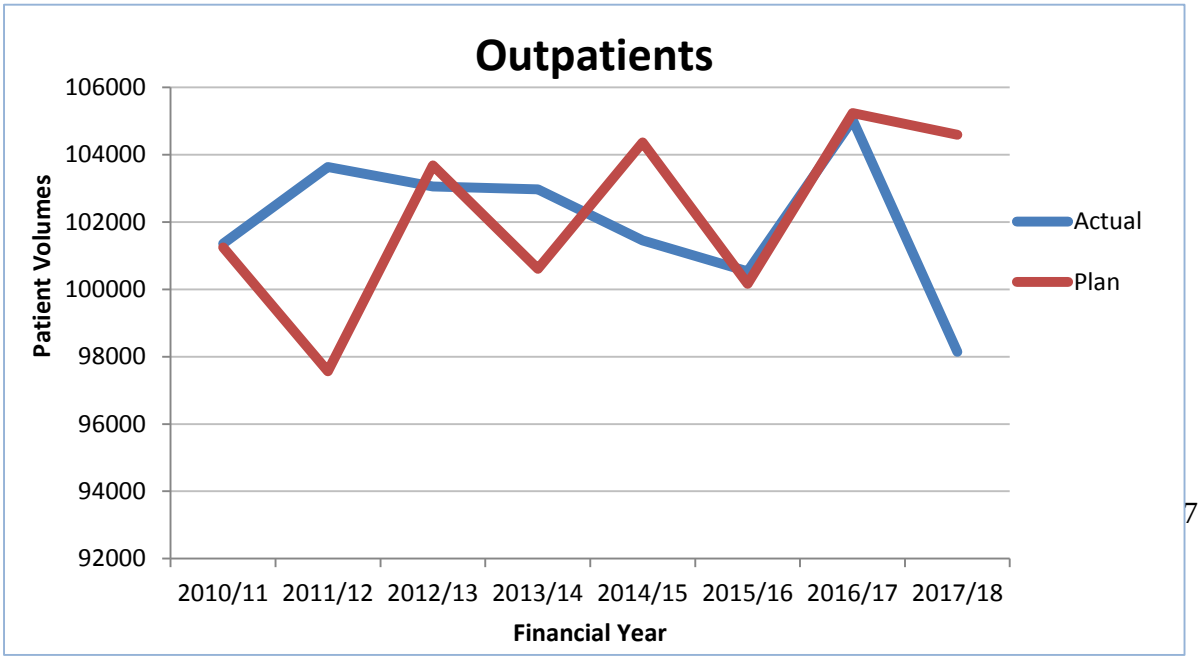


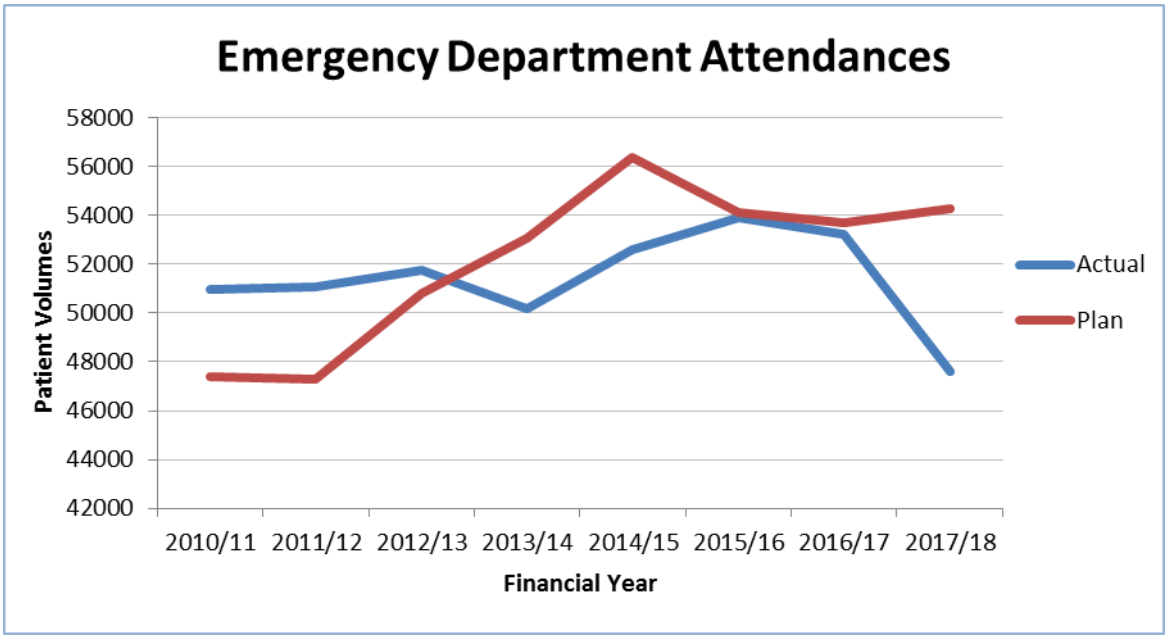
The graph above shows all of the hospital activity between 2010/11 and 2017/18. The following graphs describe the performance against plan for those seven years. ('Plan' is the level of activity each year expected by the hospital in agreement with the Clinical Commissioning Group).




Emergency Inpatients
16000
15000
14000
13000
12000
11000
10000
Patient Volumes
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
Financial Year
Actual
Plan


Elective Inpatients
2400
2200
2000
1800
1600
1400
1200
1000
Patient Volumes
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
Financial Year
Actual
Plan


Outpatients
106000
104000
102000
100000
98000
96000
94000
92000
Patient Volumes
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
Financial Year
Actual
Plan



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	2017/18
18 Weeks Incomplete Pathway	90.12%	90.47%	92.99%	94.72%	97.20%	93.71%	92.94%

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 experienced nationally during the winter months there was a need to cancel elective operations during this period.

	National Target	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
% Operations Cancelled	≤0.8%	0.60%	1.10%	0.18%	2.21%	1.81%	6.95%	2.77%
% Cancelled Operations Rebooked Within 28 days	≥95%	100%	100%	100%	99.88%	100%	95.45%	94.44%

Cancer Patients

The 2009 Cancer Reform Strategy sets out eight national cancer performance objectives for Trusts to deliver against. During 2017/18 the Trust met four of the national targets.

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

	National Target	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
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%	94.56%
31 days for second or subsequent cancer treatment- surgery	**≥94%**	100.00%	98.60%	95.30%	99.30%	98.81%	99.46%	94.66%
31 days for second or subsequent cancer treatment- drug treatment	**≥98%**	100.00%	100.00%	99.10%	99.97%	99.08%	96.36%	97.82%
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%	76.92%
Cancer reform strategy 62 upgrade standard	**≥90%**	94.20%	93.40%	86.10%	77.96%	94.73%	93.20%	80.95%
2 week wait (urgent GP appointment to 1st outpatient appointment)	**≥93%**	96.50%	96.00%	95.30%	97.26%	96.30%	91.55%	94.14%
NHS cancer plan 31 day standard	**≥96%**	99.80%	100.00%	99.20%	99.65%	98.84%	100.00%	98.40%
NHS cancer plan 62 day standard	**≥85%**	92.30%	88.30%	81.40%	89.08%	77.50%	77.00%	70.73%

Four Hour Emergency Access Target

The Emergency Department is the department where many patients initially come for care. Over the past seven years, emergency department attendances have decreased. Following a CQC inspection visit at the end of February 2017 (published in June 2017) Emergency and Urgent Care Services were rated Inadequate as there were not enough doctors to safely staff overnight rotas. Responsiveness (patient flow) was also rated Inadequate. On grounds of patient safety the Trust implemented a temporary overnight closure of A&E from 22:00 – 08:00hrs at Weston from 4th July 2017 including ambulances and walk-in patients.

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 achievement was 84.86% - which we continue to improve

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 84.28% - we continue to improve this.

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-super-Mare therefore, has a large 'risk group' since a high proportion of patients admitted to the hospital fall into these categories – therefore our improving achievement is ever more important for patients.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Target (No More Than)	16	12	11	17	17	17	18
Cases Recorded	20	19	17	20	10	10	4

MRSA Blood Infections

The Trust recorded two cases of hospital apportioned MRSA blood stream infections for 2017/18 against a zero target. Ongoing actions to improve performance include monitoring of practice (including hand washing), isolation practices and care of invasive devices.

Venous Thromboembolism

	National Target	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
% Patients VTE Assessed	≥90%	95.00%	96.10%	78.95%	97.16%	95.34%	63.02%	82.02%

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). Completion of a risk assessment for venous thromboembolism in eligible patients has continued to show a sustained improvement.

Improving Service Quality and Patient Satisfaction

Learning from the Care Quality Commissions 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'.

The CQC carried out a focused follow up inspection between 28th February and 2nd March 2017 this was in response to their previous inspections in May and August 2015. The following areas were inspected;

- Urgent and Emergency Care,
- Medical Care including Care of the Elderly,
- Surgery and
- Critical Care.

For Urgent and Emergency Care services the CQC served the Trust with a Section 29A Warning Notice on 24 March 2017. The notice required the Trust to make the significant improvements by 15 May 2017 in the following areas:

- Systems or processes to manage patient flow through the hospital must operate effectively to ensure care and treatment is being provided in a safe way for patients and to reduce crowding in the emergency department.
- Review the emergency department as the single point of entry to the hospital for both emergency and expected patients to reduce crowding.
- Ensure access to a specialist senior doctor to review patients overnight in the emergency department is timely and does not delay patient admission to wards.
- Ensure the use of the corridor in the emergency department is an appropriate and safe area for patients to receive care and treatment

The full inspection report was published in June 2017 when the Trust was rated as 'requires improvement' overall with the Urgent and Emergency Care services rated as 'inadequate' Medicine and Older People services were rated as 'requires improvement' and Surgery and Critical Care as 'good'.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Services	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Medical Care	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement

In response the Director of Nursing led an improvement plan to support the delivery of the actions required. The improvement plan consisted of 24 'must do' actions and 48 'should do' actions related to patient flow, medicines management, medical workforce, clinical effectiveness, nursing staffing and

agency usage, safety within the Emergency Department, mortality review and risk management.

The detailed improvement plan has been reviewed regularly (no less than monthly) with the respective leads. Directorate governance meetings oversee the implementation of actions specific to them. For example, where an audit is required to ensure that an action has been completed, that audit will report to the respective Directorate Governance Meeting.

Oversight of the improvement plan has occurred via the Senior Management Committee and the Quality and Safety Committee.

Following the release of the CQC report the Trust took the decision in June 2017 to close the Emergency Department to new admissions at night, due to safety concerns arising from a shortage of senior medical staff. This closure took effect in July 2017.

In December 2017, the CQC carried out an unannounced inspection in relation to the Section 29A Warning Notice served in March 2017. The CQC judged that significant progress had been made however new systems were not embedded or tested – and therefore the requirements of the Warning Notice had not been fully met.

A further five 'must do's and one 'should do' actions were described – and subsequently incorporated within the overall CQC implementation plan.

Monitoring Patient Experience

Our ability to measure patient experience is critical to making positive changes and supporting staff in delivering the best care. Throughout 2017/18 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 support provided to the Patients' Council. During 2017/18, Council members have continued to be members of key committees within the Trust, which includes the Trust Board, the Quality and Safety Committee and the Serious Incident Panel. The members have been actively involved in supporting assessments of the care environment, hospital food, patient experience questionnaires.

In addition, the Patient Experience Review Group has continued in its pivotal role in demonstrating openness and accountability to our patients and key stakeholders across the community. The Group includes membership from Healthwatch, our Commissioners and other external agencies such as Alliance Care. The purpose of the group is to ensure that the Trust reviews and acts on the results of patient experience which includes;

- 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.
- Patient Led Assessment of Care yearly audit

National Inpatient Survey - Responsiveness to the personal needs of patients

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 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 2017. 1182 questionnaires were sent to patients. The Trust received 528 completed

responses giving a response rate of 44.7%, slightly lower than the previous year of 46%.

WAHT	2016		2017	
	Weston	National	Weston	National
Survey response rate	46%	45%	44.7%	38.3%

This data compares us with the 83 Picker Trusts.

The Trust was significantly better than average on four questions, significantly worse than average on 20 questions and showed no significant differences on 38 questions. One of the responses worsened significantly; *Discharge , did not feel involved in decisions about discharge from hospital.*

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

- Hospital: room or ward was very/fairly clean – unchanged at 98%.
- Planned admission: specialist given all necessary information - 96%
- Hospital: always enough to drink - 95%
- Hospital: no shared sleeping with opposite sex - 95%
- Care: always enough privacy when being examined or treated - increased to 93%

Areas of concern and ongoing improvement include;

- Discharge; being told the side-effects of medications
- Discharge; not fully told of the danger signals to look for
- Overall; did not receive any information explaining how to complain
- Nurses; did not always know which nurse was in charge
- Knowing which nurse was in charge of care
- Discharge; did not feel involved in decisions about discharge from hospital
- Discharge; did not definitely know what would happen next with care after leaving hospital
- Discharge; not given notice about when discharge would be
- Discharge; did not always get enough support from health or social care professionals

Detailed analysis of the 2017 survey results and our response will be published on www.waht.nhs.uk. A detailed action plan will be developed from this feedback and will be made available on the Trust's website.

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.

			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Would Recommend	In-Patient	WAHT	94%	94%	97%	95%	95%	97%	94%	96%	95%	97%	98%	96%
		England	96%	96%	96%	96%	87%	87%	96%	96%	96%	96%	96%	96%
	A&E	WAHT	88%	92%	93%	95%	87%	82%	79%	79%	90%	100%	95%	88%
		England	87%	87%	88%	86%	87%	87%	87%	87%	85%	86%	85%	84%
	Out patient	Trust	93%	89%	92%	95%	96%	95%	99%	97%	98%	95%	96%	98%
		England	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
	Maternity	Q1	100%	96%	100%	96%	100%	100%	89%	100%	100%	100%	86%	100%
		England	97%	96%	96%	96%	96%	97%	96%	*	97%	97%	97%	97%
		Q2	100%	100%	100%	100%	100%	89%	100%	100%	100%	100%	100%	100%
		England	96%	97%	97%	96%	96%	96%	96%	*	97%	97%	97%	97%
		Q3	100%	100%	100%	100%	100%	63%	100%	100%	100%	100%	100%	100%
		England	95%	95%	95%	94%	94%	94%	94%	*	95%	95%	95%	95%
		Q 4	100%	100%	98%	100%	100%	92%	100%	97%	100%	100%	100%	100%
		England	98%	98%	98%	98%	98%	98%	98%	*	98%	98%	98	98%
Response Rate	In-Patient	WAHT	40.4%	41.9%	41.4%	44.2%	33.4%	35.7%	31.5%	35.5%	31%	26.7%	37.5%	43.7%
		England	25.9%	26.3%	26%	26.2%	13.9%	12.6%	25.5%	25%	22.1%	23.3 %	24.5%	23.2%
	A&E	WAHT	4.9%	5.2%	4.5%	3.5%	5.2%	4.4%	2.9%	3.8%	1.6%	1.1%	1.5%	5%
		England	12.5%	12.5%	13%	12.8%	13.6%	12.5%	12.7%	12.9%	11.6%	12.2 %	13.4%	12.8%
	Maternity	WAHT	66.7%	73.7%	21.4%	81.3%	50%	38.1%	47.4%	100%	100%	100%	100%	100%
		England	23.9%	23.9%	24%	23.6%	22.7%	22.4%	23.3%	*	19.2%	22.5%	23.4%	21.3%

*No national data available

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

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. Staff training in complaints resolution is available a part of the Trusts annual corporate training programme and remains high on the training agenda for the Trust.

The Trust received a total of 235 formal complaints which represents a decrease on the last year's total of 251 for 2016/2017.

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 has risen significantly. The most significant increase however is the number of complaints linked to staff attitude. To improve the standards of care the Trust has delivered a number of initiatives related to each theme:

Medical treatment from doctors

- Establishment of Clinical effectiveness group which oversees the quality of clinical care, mortality, quality improvement and audit. The group also receives Governance reports from the Directorates.
- Appointment of a number of key staff; an Associate Medical Director in April 2017, Chief Registrar in August 2017 and a Emergency Department Consultant clinical lead
- Review of the terms of reference for the Emergency Directorate Clinical Cabinet
- Deputy Director of Quality & Safety has been working alongside the Medical Director on multi-disciplinary agenda.

Staff attitude

- The Trust has committed to pilot "Sage and Thyme" a model for effective communication which started in 2018.
- Value based interview questions are being used in the recruitment process.
- There has been a refocus on Clinical Supervision to support nursing staff.
- Leading with a can do attitude – delivery of transformational change projects throughout year
- Staff feedback on learning and change of practice following incidents/complaints has been a focus.
- A greater focus on the 'patient story ' across the Trust with the aim of making the patient experience real for staff.

A new role of Patient Safety and Quality Facilitator introduced in January has improved engagement and responsiveness to incident and complaint investigations/responses within the Directorates.

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 201/17 and the changes from last year.

Main types of complaints received during 2017/18:

	2016/17	2017/18
Complaints about staff attitude - %	6% (34)	12% (50)
Complaints about medical treatment - %	24.7% (110)	29% (118)
Complaints about nursing care - %	12.9% (66)	9% (38)
Complaints about communication - %	31.5% (192)	25% (104)

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 2017/18 three complaints were accepted by the Ombudsman for investigation. The Ombudsman is still considering their decision on all of these cases.

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. NHS Improvement has published in January 2018 additional requirements for organisations to incorporate within their Quality Accounts for 2017/2018

The content of the Trust's Quality Account for 2017/2018 builds on the 2016/2017 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 'Healthy Weston' programme
- Joint partnership working with University Hospitals Bristol
- 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 other audit data.
- The Trust corporate risk register and Board Assurance Framework
- The views of our staff through engagement within the Quality Conversations workshops
- Our Clinical Effectiveness Committee and Quality and Safety Committee

In order to collate, validate, analyse and report on the data for the annual Quality Account we use the same systems and processes used for other clinical quality and performance information.

The Audit and Assurance Committee commissions independent audit of the quality of our data.

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

Eight 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. that medical staffing will not be at the required numbers to deliver safe and dignified care.
2. that the emergency department will not attain clinical quality indicators, national performance targets and be a safe and suitable training environment.
3. that the Trust will not achieve CQC standards.
4. that we will not comply with national targets for access - cancer
5. that the Trust is unable to secure partners to manage the future delivery of clinically and financially viable services.
6. that the Trust will be unable to deliver a major savings plan.
7. that the Trust will fail to deliver the revenue, capital and cash plan for the year
8. 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:

- Joint Partnership Management Board with University Hospitals Bristol NHS Foundation Trust to support joint clinical pathways
- Temporary overnight closure of the Emergency Department
- New specialist nurse roles supporting the Emergency Department
- Strengthening of the People and Organisational Development Group
- Action plans to address risks around the 62 day cancer target
- Participation in whole healthcare community groups to respond to emergency demand and expedite patient's discharge from the hospital.
- Reporting and monitoring of incidents, concerns and risks.
- 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.

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 University Hospitals Bristol NHS Trust, NHS Improvement, Somerset Clinical Commissioning Group, North Somerset Council, Weston College and the local Healthwatch.

Key regional partnership 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:

- Weston Clinical Oversight Group
- Sustainability Board
- BNSSSG Quality Review Meetings
- North Somerset Infection Prevention and Control Forum
- West of England Academic Health Sciences Network
- A&E Delivery Board
- Urgent Care Programme Board

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:

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, a statutory planning body for health emergency planning.
- The Trust has an experienced Resilience Manager, reviewing and redeveloping the Trusts emergency preparedness and business continuity documents and processes and supporting operational resilience and escalation responses where required.
- The Trust has redeveloped its Incident Response Plan in the year to include scalable arrangements for dealing with major incidents to incidents involving mass casualties.
- The emergency preparedness and business continuity management arrangements were reviewed in an internal audit in March 2017, with the Trust rated as satisfactory. All actions from the audit report have been completed, with agreed timescales for further development of business continuity arrangements at service level.
- The Trusts arrangements for CBRN (Chemical, Biological, Radioactive, Nuclear) were audited by South Western Ambulance NHS Trust in January 2018, with the Trust rated as fully compliant with the relevant standards with some minor suggested improvements to signage required, which are being addresses and will be tested in an upcoming exercise.

Response

- Due to operational pressure in the winter of 2017 /18, The Trust declared an Internal Critical Incident on 4 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. System wide debriefs have been conducted in both Somerset and BNSSG CCG areas and further system-wide opportunities to improve future arrangements have been identified, as have Trust-wide lessons been identified from internal debriefing.

- The snow event of March 2018 required the Trust to manage significant disruption to staff journeys. A staff debrief and system debrief following the worst of the 2 events report largely successful experiences in keeping the hospital safe. There were many opportunities to learn for improving planning for broader themes involving staff disruption. A report has been produced and will be shared with the Board when finalised.

Training

- A range of training activities that staff members have undertaken during 2017/18 have included the following:

- Major Incident Awareness and Setting up the Incident Control Centre (June 2017)
- Strategic Leadership in a Crisis Course (Aug 2017)
- Project Argus - Police led counter terrorism training event (March and September 2017)
- Evacuation (Gas leak) Desktop Exercise (September 2017)
- System wide mass casualty exercise - Exercise Ashanti – (Sept 2017)
- 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:

- Work to meet the national target to reduce carbon emissions by 34% by 2020 (from a 2007 baseline)
- Work with other organisations to improve sustainability outcomes and to identify and take action to reduce carbon emissions along care pathways
- Explore opportunities which will reduce the impact of medical devices, gases and pharmaceuticals on carbon emissions
- Share and learn from best practice
- Actively raise sustainability awareness across the organisation, engaging with staff, visitors, patients and suppliers and embedding sustainable behaviors
- Effectively monitor, evaluate and report on progress at national and local levels
- Ensure that the Trust is recognised as a low carbon and sustainable organisation

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 2018, which enables the Trust to monitor performance against a Department of Health recognised assessment tool and to compare with other similar organisations.

	2016-17 Tonnes CO2e	2017-18 Tonnes CO2e	Change +/- Tonnes CO2e
SCOPE ONE EMISSIONS Fuel Combustion Gas Boilers	815.77	261.32	-554.45
SCOPE TWO EMISSIONS Purchased Energy Consumption Electricity	1991.71	1248.86	-742.85
Water usage: 0.34kg per M3	15.50	17.27	1.77
Non recycled waste			
Clinical Incinerated all types	673.767	1840.08	1166.313
Clinical Alternative treatment	4384.68	2148.8	-2235.88
General waste	86195.7	33149.6	-53046.1
Recycled Waste			
Mixed municipal recycled :	2939.29	2746.8	-192.49
Glass	54.2	90.168	35.968
TOTAL EMISSIONS	**97070.617**	**41502.898**	**-55567.719**

Building Use

During 2017/18 the Trust invested £3.1m to improve and upgrade its estate. Brief outlines of the main projects are highlighted below:

Endoscopy Refurbishment

The refurbishment will see the hospital's endoscopy unit being enhanced to meet strict standards for privacy and dignity, including the introduction of new privacy areas for patients. The Trust invested £1.3m in 2016-17 and the project was completed in November 2017.

The decision to refurbish the unit was based on requirements to meet new dignity and privacy standards and a desire to upgrade our facilities to provide even safer, comfortable and modern environments for our patients to receive their care. The expansion of our endoscopy unit is part of our wider plan to shape a stronger, more sustainable hospital that offers patients an even better service and supports the needs of the local public for decades to come.

Ward Kitchens

During the last internal six-monthly ward hygiene kitchen inspections, it became apparent that the ward kitchens were becoming tired, cluttered and not easy to clean. Therefore the audit recommendation was to refurbish some of the areas with new worktops, remove chipped wall tiles and replace with hygienic wall cladding. This work was completed in October and November 2017.

Medical Gases

The Trust changed its medical gas supplier from BOC to Air Products in 2018. During this changeover the Estates department took the advantage and completed some important work on the pipelines to ensure they comply with HTM 02-01.

Emergency Department

In July 2017 the Trust was awarded a capital sum of £843,600 to improve Primary Care Streaming at the Front Door. The funding was awarded from a £100m capital fund following a Department of Health request to each hospital in England to introduce Primary Care Streaming into the Emergency Department by October 2017. This capital money from NHS England has been specifically ring-fenced to support hospitals across England deliver their national programme as part of the **Next Steps NHS Five Year Forward View**.

The £843,600 awarded to Weston General Hospital was invested into its Emergency Department to improve primary care streaming. Similar to other hospitals who bid for the money, it will mean that Weston can build a primary care facility within its Emergency Department for patients' whose clinical conditions do not need to be treated by an Emergency Doctor. Plans to increase primary care streaming (as per NHS England's national programme) include redesigning A&E so that patients have access to a greater range of health professionals for their needs – including nurse practitioners, pharmacists and physiotherapists, are ongoing.

Due to operational reasons due to the majority of the work being carried out during the busy Winter period the project was divided into two phases. Phase 1 (Reception Area to introduce Primary) was competitively tendered and the work started in October and was completed in December 17. Phase 2 (ED Minors & MAU Waiting Area) was completed on 31 March 2018.

New Macmillan Centre

In 2018 the Macmillan Cancer Information and Support Centre was officially opened by Mr John Penrose MP and The Mayor of Weston-super-Mare Councillor Mrs Jocelyn Holder. Over 35 guests, including Dr Peter Collins, Medical Director Weston Area Health NHS Trust, hospital staff, volunteers, supporters and patients came together to enjoy an afternoon tea party to mark the occasion.

The new Macmillan Cancer Information and Support Centre will offer confidential support, information and advice to anyone affected by cancer. Local patients, family members and carers are welcome to drop in and browse the wide selection of information available on a range of topics related to cancer such as:

support for carers; managing side effects and fatigue; benefits advice; travel insurance; how to talk to children about cancer; and many more. The team of staff and volunteers at the new Centre can help people to access emotional support, counselling, advice about benefits and finances from the North Somerset Macmillan Benefits Advice service. They can also signpost to other support available locally where needed.

Chiller Plant

It became apparent during the theatre project that the Trust's chiller plant was struggling to provide enough comfort cooling for the critical areas of the building.

The hospital was designed and built in 1986 and the requirements for cooling and ventilation systems have significantly advanced over 30 years. The majority of the ventilation still works on the principle of natural ventilation, which basically means the wards windows need to be opened to kept staff and patients comfortable. This method of ventilation is not acceptable within current healthcare regulations.

The key to this new design is its ability to be expanded as and when the requirement is needed, which makes it the most cost effective approach.

Staff Showers

As part of the Health & Wellbeing CQUIN the Trust is required to introduce a range of physical activity including promoting cycling to work. The Trust only had 1 male and 1 female communal shower which was totally inadequate for staff. To encourage more staff to cycle to work the Trust agreed to refurbish the current showers to provide more suitable communal showers for staff. This project was completed in August 2017. The Trust Travel West provided a grant of £3k to support this project.

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
- Cooking Oil

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.

With the ongoing risks associated with Cyber Security attacks, further work has been completed via the Capital programme focusing on the resilience of our IT infrastructure and the capture and quarantine of viruses and malicious attacks.

The Trust Wireless Network has been replaced via the Capital programme, thereby improving security and availability to staff and patients.

Availability security and stability of IT systems has been improved with the implementation of a highly available and secure storage and backup solution.

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 2017/18 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.

The Trust Board met on ten occasions in public during 2017/18 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.

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, a Member of Healthwatch North Somerset and the Chair of the Trusts Medical Advisory Committee 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 2017/18 were Ian Turner (Chairman) - replaced by John Roberts (July 2017), Graham Turner, 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 2017/18 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

Price Waterhouse Coopers 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 opinion, for 2017/18 was that Weston Area Health NHS Trust's financial statements:

- give a true and fair view of the state of Weston Area Health NHS Trust's affairs as at 31 March 2018 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

They note;

We have audited the financial statements, included within the Annual Report and Accounts (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2018; the Statement of Comprehensive Income, the Statement of Cash Flows and the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that Weston Area Health NHS Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

The Trust's financial statements for the 2017/18 financial year disclose a deficit of £13.5m, which exceeds the planned deficit by £7.4m. This included an overspend in pay costs of £2.1m and a shortfall of £2.4m in planned savings. In addition, the Trust's plan for 2018/19 is a deficit of £13.5m, which is reliant on planned savings of £6.8m. The Trust has rejected their proposed control total.

In addition, the Trust was issued with a section 29A warning notice by the Care Quality Commission (CQC) in March 2017 which remains in place. Following the CQCs inspection, the Trust closed the Accident and Emergency Department overnight from July 2017 due to concerns over the ability to maintain safe staffing levels and it remains closed.

These issues are evidence of a weakness in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions, and for planning, organising and developing the workforce effectively to deliver strategic priorities.

In respect of the matters referred to above, we are not satisfied that Weston Area Health Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2018.

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

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

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

Signed.....Chief Executive

Date.....

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board

.....Date.....Chief Executive

.....Date.....Finance Director

Annual Governance Statement 2017/18

1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

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 2018 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

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.

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.

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.

4. The risk and control framework

Trust Board membership during 2017/18 was as follows:

Name	Title
Grahame Paine	Chairman (V)
Brigid Musselwhite	Non-Executive Director (V)
Graham Turner	Non-Executive Director (V)
Rosalind Wyke	Non-Executive Director (V)
Frank Powell	Non-Executive Director (V) (to 25 July 2017)
Ian Turner	Non-Executive Director (V) (to 31 July 2017)
John Roberts	Non-Executive Director (V) (from 22 August 2017 *)
James Rimmer	Chief Executive (V)
Bronwen Bishop	Director of Strategic Development (V) (to 30 June 2017)
Phil Walmsley	Director of Operations (V - from 28 March 2018)
Sheridan Flavin	Director of Human Resources (to 5 January 2018)
Alex Nestor	Director of Human Resources (from 3 January 2018)
Rob Little	Director of Finance / Deputy CEO (V) (to 3 July 2017)
Steve Simmons	Interim Director of Finance (V) (from 4 July 2017 to 31 March 2018)
Peter Collins	Medical Director (V) (from 10 April 2017)
Helen Richardson	Director of Nursing (V) (to 31 December 2017)
Natasha Goswell	Acting Director of Nursing (V) (from 1 to 28 January 2018)
Sarah Dodds	Director of Nursing (V) (from 29 January 2018)

(V) Denotes Voting Member

*To note that John Roberts was appointed as an Associate Non-Executive Director from 1 May 2017, being formally appointed as a Non-Executive Director on 22 August 2017

Board attendance for the year was as follows:

Name	02.05.17	26.05.17	12.06.17	04.07.17	28.07.17	05.09.17	03.10.17	07.11.17	05.12.17	09.01.18	31.01.18	06.02.18	06.03.18
Grahame Paine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Graham Turner	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Brigid Musselwhite	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y
Ian Turner	Y	Y	Y	Y									
John Roberts					Y	Y	Y	Y	Y	Y	Y	Y	Y
Rosalind Wyke	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Frank Powell	Y	Y	N	Y	N								
James Rimmer	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Bronwen Bishop	Y	Y	N										
Phil Walmsley	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Sheridan Flavin	Y	Y	Y	Y	N	Y	Y	Y	Y				
Alex Nestor										Y	Y	Y	Y
Rob Little	Y	Y	Y										
Steve Simmons				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Peter Collins	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Helen Richardson	Y	Y	Y	Y	Y	Y	N	Y	Y			Y	Y
Natasha Goswell										Y			
Sarah Dodds											Y	Y	Y

In 2017/18 the Board has reviewed and approved **Annual Reports** for:

1. Safeguarding Adults and Children at Risk
2. Infection Prevention and Control
3. Emergency Preparedness, Resilience and Response
4. Medical Revalidation and Appraisal
5. Nursing and Midwifery Revalidation

It has also considered and responded to;

- the Learning from Deaths in Hospital Guidance from the National Quality Board
- six monthly reporting on the NHS Workforce Race Equality Standard
- six monthly reporting on postgraduate medical education

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 six 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 Safety Committee
- Remuneration and Terms of Service Committee
- Finance and Performance Committee
- People and Organisational Development Committee
- Senior Management Committee

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 November 2017 the Board approved an **annual review of the committee structure**. The changes:

- Reviewed Executive membership of the delegated subcommittees of the Board
- Agreed the approach to reviewing the effectiveness of committees
- Agreed that all delegated Board committees – Tier 2 - would be entitled 'committee'

In year the Board also:

- Strengthened workforce assurance and reporting by the establishment of a People and Organisational Development Committee and the introduction of staff stories at Public Board.
- Sought to strengthen the remit and membership of the Clinical Advisory Group – relaunching it as the Clinical Effectiveness Group.
- Improved the mortality review process to ensure alignment with national guidance.
- Improved oversight and assurance of Directorate Governance via the Performance Management Group.

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. The Trust commissioned new external auditors during the year – moving from Grant Thornton to PricewaterhouseCoopers LLP. Audit Southwest (internal audit) and Grant Thornton or PricewaterhouseCoopers LLP attend all Audit and Assurance Committee meetings. The Audit and Assurance 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 Safety 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 Safety Committee is supported by two key sub committees:

1. Risk Management
2. Clinical Effectiveness
    - Mortality & Morbidity
    - Patient Experience
    - Research & Development
    - Radiation Protection
    - Resuscitation and Critical care
    - Organ Donation
    - Mental Health Operational
    - Drugs and Therapeutics
    - Hospital Transfusion
    - Harm Free Care

The Committee has also received operational updates from the Senior Management Committee during the year.

The **Finance and Performance 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 Public Meeting in November 2017, the Board mapped its **risk appetite** against its 2017/18 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					

The Board 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 **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 is chaired by the Lead Executive Director for Clinical Risk (the Director of Nursing).

Risk issues are reported to the Audit and Assurance Committee and the Quality and Safety Committee via the Risk Management Committee, the Senior Management Committee 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. Since April 2015 the Trust has three Directorates – Emergency Care, Surgery and Clinical Services.

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 Management Framework** led by the Director of Operations.

The Performance Management 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 Estates and Facilities against key performance indicators as well as 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 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' (scoring 15 or above) for a period of four months or longer as described on the 2017/18 Framework are:

Ref	Risk Title
1.1	Risk that **medical staffing** will not be at the required **numbers** to deliver safe and dignified care.
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.
1.12	Risk that the Trust will not achieve **CQC standards.**
1.15	Risk that **cost improvement programmes** will impact on quality of care
3.3	Risk that we will not comply with national targets **for access - cancer**
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.**
6.2	Risk that the Trust will fail to deliver the **revenue, capital and cash plan** for the year
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 and regular review of how well we are managing risks has occurred by Executive Leads, by the Senior Management Group, by the Audit & Assurance Committee and Board.

In July 2017, the frequency of public board meetings was increased from bimonthly to monthly to enable additional assurance reporting and public scrutiny following the temporary overnight closure of the Emergency Department. A full Board meeting has remained bi-monthly with a short more focused meeting in the months in-between followed by a Board Seminar.

The **Clinical Effectiveness Group** has significantly strengthened the focus on mortality review to ensure the development of a robust process. The group has identified areas where more detailed review of clinical care should take place. Using **Quality Improvement** strategies based on the Institute for Healthcare Improvement 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 Group is also strengthening the oversight and leadership of clinical audit and NICE compliance.

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.

The Governance 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 Safety 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 clinical audit using quality improvement methodology. 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 2017/18 have been identified via mortality review.

The **Freedom to Speak Up Guardian** is a senior member of staff based in NHS trusts. Their role is to work with trust leaders to create effective local processes to enable staff to raise concerns about patient

safety and advise and support staff who seek to do so. The Trust Board Secretary was appointed as the Freedom to Speak Up Guardian in September 2016 and has met monthly with the CEO and regularly with the Non-Executive Lead for the role – as well as regularly reporting to the Board. The Freedom to Speak Up Guardian agrees with the member of staff raising a concern the best way forward and supports them to the point of resolution.

As at 31 March 2018 there were 19 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 and patient flow through the Department**– suboptimal levels of medical staffing, the timeliness of medical review and delay in sepsis treatment.

- Two relate to **governance** arrangements – the overview of standards of clinical effectiveness, immature governance arrangements at Directorate level (safety incidents and policy compliance)
- Two relate to **medical staff vacancies**
- Two relate to the Trust's ability to deliver **financial targets** – achieving the required level of savings when the level of income is lower than expected
- Two relate to the quality of **medical records**
- Two relate to the **sustainability** of services
- One relates to **nursing staff vacancies**
- One relates to the efficiency of the **mortality review** process
- One relates to the ability to achieve national **cancer targets**
- One relates to the incidence of **hospital-acquired pressure ulcers**
- One relates to **medicines** management
- One relates to **resuscitation training**
- One relates to multiple changes in the **Executive Team**

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.

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 risk 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.

During the year the approach to **Executive Walk rounds** was relaunched to include the triangulation of service level risk register entries with safety incidents and staff concerns. 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
- Freedom To Speak Up Guardian Reports

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

The Trust has a range of processes in place to ensure that resources are used economically, efficiently and effectively. This includes clear accountability arrangements for staff and the presentation of monthly finance and performance reports to the Finance and Performance Committee and the Board.

Our external auditors are required as part of their annual audit to satisfy themselves the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the Trust has not.

6. Information governance

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 2017/18. The final self-assessment submission achieved 74% 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 and Assurance 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 processes, I am aware of the risk management systems in place for information governance at the Trust. There were no Information Governance breaches requiring reporting to the Information Commissioners Office during 2017/18.

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

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

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

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

7. Annual Quality Account

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 2017/18 built on the 2016/17 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 2018/19

The 2017/18 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.

8. 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.

9. Clinical and financial sustainability of the Trust

Over the last four years, the Trust's strategy has fundamentally been about organisational change to deliver clinical, service and financial sustainability – as it engages with partners on the BNSSG **Sustainability and Transformation Partnership**. 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 three 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 announced a closer **partnership with University Hospitals Bristol** in 2017 – in order to will build on our existing clinical networks and establish the future services of the Trust. At the same time, this partnership working also supports the work of 'Healthy Weston: joining up services for better care in the Weston area' led by North Somerset CCG. A key aim of Healthy Weston is to create a sustainable hospital at Weston General Hospital that remains at the heart of the community and provides the services it is best placed to do in order to meet the needs of local people.

Both Trusts are working through a comprehensive appraisal of the clinical and financial benefits of a merger within the context of the "Healthy Weston" programme. Depending on the outcome of this appraisal process, UH Bristol would complete a full business case for consideration by the Trust Board, the UH Bristol Trust Board and UH Bristol's Council of Governors with a view to completing the merger in the spring of 2019 at the earliest.

10. External reviews

During 2017 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 formulated an action plan for Board approval. The Clinical Effectiveness Committee has ensured that ongoing mortality in this group has been monitored for improvement.

During 2017 our submissions to the National Hip Fracture Database (NHFD) 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. The report from this review was received in June 2017 again with the Clinical Effectiveness Committee subsequently ensuring monitoring for improvement.

In February 2018 the NHFD Hip Fracture Mortality Summary Graph showed that for November 2017 (the last available data) the Trust has a 30 day mortality of 5.2% (within the hip fracture group) in comparison to the national average of 6.8%

Between 28 February and 15 March 2017 the Trust underwent a **Care Quality Commission 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 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 was initiated by the Director of Operations in response to this.

The full report from the inspection became available during June 2017. The Trust took the decision in June 2017 to close the Emergency Department to new admissions at night, due to safety concerns arising from a shortage of senior medical staff. This closure took effect in July 2017.

On 12 December 2017 the Care Quality Commission (CQC) arrived for an unannounced one day follow up inspection of our Emergency and Urgent Care service - following their application of the Section 29a Warning Notice in March 2017.

The CQC highlighted several areas of improvement including:

1. The reduction in the use of the corridor to accommodate patients in the Emergency Department
2. Patient flow and bed management in the wider hospital
3. The development of alternative admission pathways so that the Emergency Department was not the single point of access to the hospital.
4. The establishment of an integrated discharge team and an acute frailty assessment service to support complex discharges and improve patient flow.

However, areas requiring further improvement were identified;

1. The timeliness of specialist clinical review,
2. Patient discharge and
3. Staffing.

The CQC concluded that further improvements and embedding of existing areas needed to happen before the warning notice could be lifted.

In March 2018 our **2017 national staff survey** results show that whilst the Trust has improved in some areas our results in comparison still remain poor in many areas. Our People and Organisational Development Committee will oversee the review of these results and actions for improvement. Four key priorities are in train as follows;

1. Management and leadership development
2. Workforce development and transformation
3. Health and wellbeing
4. Partnership working and employee relations

11. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee [and risk/ clinical governance/ quality committee, if appropriate] and a plan to address weaknesses and ensure continuous improvement of the system is in place. 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, Quality and Safety, Finance and Performance and People and Organisational Development 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 'limited assurance' for the year ended 31 March 2018.
- 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 Counter Fraud Authority)
- 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

- 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, discussions with the Freedom To Speak Up Guardian, larger group listening events and exit interviews, including feedback from Trade Unions.

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 Safety Committee. The governance structures and systems of internal control described have been in place during 2017/18 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 2018 and up to the date of approval of the annual report and accounts.

12. Conclusion

The significant issues reported during the year would include:

1. The continuation of 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.

2. The Trust did not meet its financial target deficit for the year, with an out-turn deficit of £13.5m, compared to a target deficit of £6m. The financial deficit remains a significant issue

3 The temporary overnight closure of the Emergency Department due to risk around safe staffing – which impacted income detrimentally by £3m

4. The poor results of the 2017 staff survey – placing the trust in the worst 20% of Trusts on many questions.

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

Accountable Officer : James Rimmer, Chief Executive

Organisation: Weston Area Health NHS Trust

Signature: **Date**

Remuneration and Staff Report 2017/18

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 during the year 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 to 03/07/17)
- H Richardson, Interim Director of Nursing (from 15/02/2016 to 30/06/2016), Director of Nursing (from 01/07/2016 to 01/01/18)
- B Bishop, Director of Strategic Development (from 01/10/2008 to 30/06/17)
- S Simmons, Director of Finance and IM&T (from 12/06/17 to 31/03/18)
- S Dodds. Director of Nursing (from 29/01/18)
- P Collins, Director of Medicine (from 10/04/17)

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

- P Walmsley, Director of Operations (from 27/03/17)
- S Flavin, Interim Director of Human Resources (from 01/10/2012 to 30/09/2013) Director of Human Resources (from 01/10/2013 – 05/01/18)
- A Nestor, Director of Human Resources (from 02/01/18)

The Executive Directors who have left their positions in the last two years are:

Mrs K Croker resigned from the position of Director of Operations, effective from 30/09/2016.

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

Mr R Little retired from the position of Director of Finance and IM&T, effective from 03/07/2017.

Ms B Bishop resigned from the position of Director of Strategic Development, effective from 30/06/2017

Ms H Richardson resigned from the position of Director of Nursing, effective from 01/01/2018.

Mrs S Flavin resigned from the position of Director of Human Resources, effective from 05/01/2018.

Mr S Simmons resigned from the position of Director of Finance and IM&T effective from 31/03/2018.

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. This has been extended to 16/11/2019.

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

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

Mr I Turner's term as a Non-Executive Director ended on 31/07/2017.

Mr F Powell's term as a Non-Executive Director ended on 25/07/2017

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 on page x57 to 60 and have been audited by PWC.

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 2017/18 was £145k - £149.9k (2016/17 was £140k - £144.9k). This was 5.5 times (2016/17, 5.3 times) the median remuneration of the workforce, which was £26,649 (2016/17, £26,841).

In 2017/18, eleven (2016/17, thirteen) Trust employees received remuneration in excess of the highest-paid Director. Trust employees remuneration ranged from £6k to £222k (2016/17 £6k to £201k).

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

Signed by: ..... Chief Executive

Salaries and Allowances

Name and Title	2017-18					
	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**
J Rimmer, Interim Chief Executive (from 03/08/15 to 31/12/15) Chief Executive (from 01/01/16) *	145-149	2	nil	nil	75-77.4	220-224
R Little, Director of Finance and IM&T (from 01/07/10 to 03/07/17)	25-29	1	nil	nil	-17.5-19.9	10-14
S Simmons, Interim Director of Finance and IM&T (from 12/06/17 to31/03/18)	95-99	2	nil	nil	nil	95-99
N Lyons, Executive Medical Director (from 08/01/16 to 31/03/17)	Not in post					
P Collins, Executive Medical Director (from 10/04/17)	130-134	nil	nil	nil	82.5-84.9	215-219
H Richardson, Interim Director of Nursing (from 15/02/16 to 30/06/16) Director of Nursing (from 01/07/16 to 01/01/18)	70-74	nil	nil	nil	232-234.9	300-304
S Dodds, Director of Nursing (From 29/01/18)	20-24	nil	nil	nil	nil	20-24
B Bishop, Director of Strategic Development (from 01/10/08 to 30/06/17)**	20-24	nil	nil	nil	7.5-9.9	30-34
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) ****	Not in post					
P Walmsley, Director of Operations (From 27/03/17)	110-114	3	nil	nil	30.0-32.4	140-144
S Flavin, Director of Human Resources (from 01/10/13 to 05/01/18)	65-69	2	nil	nil	37.5-39.9	105-109
A Nestor, Director of Human Resources (From 02/01/18)	25-29	nil	nil	nil	nil	25-29
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 17/11/15)	15-19	2	nil	nil	nil	15-19
A Wyke, Non-Executive Director (from 18/12/15)	5-9	nil	nil	nil	nil	5-9
J Roberts, Non -Executive Director (from 01/05/17	5-9	1	nil	nil	nil	5-9
I Turner, Non-Executive Director (from 01/08/07 - 31/07/17)	0-4	nil	nil	nil	nil	0-4
G Reah, Non-Executive Director (from 01/02/08 to 31/01/17)	Not in post					
B Musselwhite, Non-Executive Director (from 10/10/13)	5-9	3	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)	5-9	2	nil	nil	nil	5-9
F Powell, Non-Executive Director (from 29/06/15 - 25/07/17)	0-4	2	nil	nil	nil	0-4

Name and Title	2016-17					
	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**
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
R Little, Director of Finance and IM&T (from 01/07/10 to 03/07/17)	105-109	nil	nil	nil	67.5-69.9	175-179
S Simmons, Interim Director of Finance and IM&T (from 12/06/17 to31/03/18)						
N Lyons, Executive Medical Director (from 08/01/16 to 31/03/17)	135-139	nil	nil	nil	100.0-102.4	235-239
P Collins, Executive Medical Director (from 10/04/17)						
H Richardson, Interim Director of Nursing (from 15/02/16 to 30/06/16) Director of Nursing (from 01/07/16 to 01/01/18)	100-104	nil	nil	nil	nil	100-104
S Dodds, Director of Nursing (From 29/01/18)						
B Bishop, Director of Strategic Development (from 01/10/08 to 30/06/17)**	90-94	1	nil	nil	25.0-27.4	115-119
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
P Walmsley, Director of Operations (From 27/03/17)	Not in post					
S Flavin, Director of Human Resources (from 01/10/13 to 05/01/18)	85-89	3	nil	nil	30.0-32.4	115-119
A Nestor, Director of Human Resources (From 02/01/18)						
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 17/11/15)	15-19	1	nil	nil	nil	15-19
A Wyke, Non-Executive Director (from 18/12/15)	5-9	nil	nil	nil	nil	5-9
J Roberts, Non -Executive Director (from 01/05/17						
I Turner, Non-Executive Director (from 01/08/07 - 31/07/17)	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
B Musselwhite, Non-Executive Director (from 10/10/13)	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
F Powell, Non-Executive Director (from 29/06/15 - 25/07/17)	5-9	nil	nil	nil	nil	5-9

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 totaling £70.9k, which have been included in full within Mr Rimmer's salary.

** Following B Bishop leaving the Trust her duties were given to an individual who was not required to attend board meetings and does not have any financial accountability and has therefore not been included in this disclosure

**** 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 accountability and has therefore not been included in this disclosure.

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

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 i.e. an annual increase of £10k = £200k.

The increase in H Richardson 2017/18 all pension-related benefits figures reflect the change in values following pension adjustments made in 2016/17.

Pension Benefits

Name and title	A Real increase in pension at age 60 at 31 March 2018 (bands of £2,500)	B Real increase in lump sum at age 60 at 31 March 2018 (bands of £2,500)	C Total accrued pension at age 60 at 31 March 2018 (bands of £5,000)	D Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5,000)	E Cash Equivalent Transfer Value at 01 April 2017	F Cash Equivalent Transfer Value at 31 March 2018	G Real Increase in Cash Equivalent Transfer Value	H Employer's contribution to stateholder 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)	2.5-4.9	2.5-4.9	55-59.9	145-149.9	916	998	83	0
R Little, Director of Finance and IM&T (from 01/07/10 - 03/07/17) *	(0)-(2.4)	7.5-9.9	50-54.9	200-204.9	n/a	n/a	n/a	0
P Collins, Executive Medical Director (from 10/04/17)	2.5-4.9	5-7.4	35-39.9	90-94.9	514	580	64	0
H Richardson, Interim Director of Nursing (from 15/02/16 to 30/06/17) Director of Nursing (from 01/07/16 - 01/01/18)***	7.5-9.9	17.5-19.9	35-39.9	105-109.9	522	782	196	0
B Bishop, Director of Strategic Development (from 01/10/08 - 30/06/17)*	0-2.4	0-2.4	35-39.9	115-119.9	n/a	n/a	n/a	0
P Walmsley, Director of Operations (From 27/03/17)	0-2.4	(0)-(2.4)	15-19.9	45-49.9	311	346	36	0
S Flavin, Director of Human Resources (from 01/10/13 - 05/01/18)**	0-2.4	nil	5-9.9	nil	78	104	20	0

Notes :

** As Mr Little is of pensionable age and B Bishop is drawing her pension, CETV is not applicable.*

*** S Flavin was replaced by A Nestor who is seconded to us from UHBristol NHS Foundation Trust*

**** H Richardson was replaced by S Dodds who is seconded to us from North Bristol NHS Trust*

Mr R Little was replaced on an interim basis by S Simmons who is of pensionable age and not currently in the pension scheme

Following B Bishop leaving the Trust her duties were give to an individual who was not required to attend board meeting and who does not have any financial accountability and has therefore not been included in this disclosure

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.

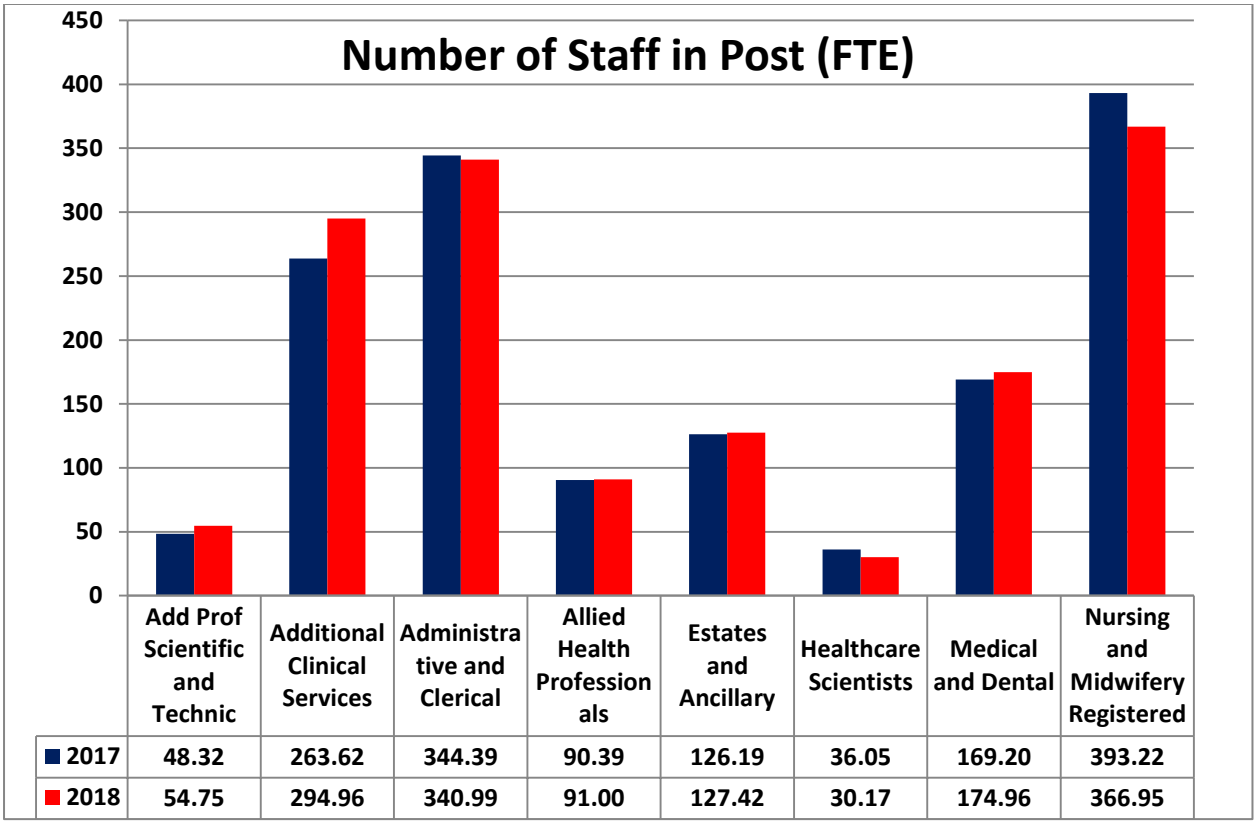
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's

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 2017 to March 2018. 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.



	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
2017	48.32	263.62	344.39	90.39	126.19	36.05	169.20	393.22
2018	54.75	294.96	340.99	91.00	127.42	30.17	174.96	366.95

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 Employed	Other	Total	Permanently Employed	Other
	31/03/2018			**31/03/2017**		
Employee Category	**Number**	Number	Number	**Number**	Number	Number
Medical and Dental	**175**	100	75	**170**	77	93
Administration and Estates	**608**	579	29	**618**	592	26
Healthcare Assistants and Other Support Staff	**351**	336	15	**321**	316	5
Nursing, Midwifery and Health Visiting Staff	**447**	418	29	**464**	445	19
Allied Health Professionals	**118**	116	2	**118**	115	3
Additional Prof, Scientific and Technical Staff	**53**	51	2	**55**	52	3
Healthcare Scientists	**34**	33	1	**40**	40	0
TOTAL	**1787**	1609	178	**1786**	1637	149

Total Gross Employee Benefits

The table below represents the total pay bill for 2017-18 the employee category analysis is as per the year end schedules including agency costs which is not comparable to the 'Number of staff in post' graph.

Employee Category	2017/18 £000
Administration and Estates	**14,320**
Medical and Dental	**23,618**
Nursing, Midwifery and Health Visiting Staff	**30,020**
Allied Health Professionals	**5,914**
Other	**2,262**
Total Gross Employee Benefits	**76,134**

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 2017.

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	2016	2017	Average for acute trusts
Q21a	Care of patients / service users is my organisation's top priority	70%	65%	76%
Q21c	I would recommend my organisation as a place to work	52%	46%	61%
Q21d	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	58%	55%	71%
KF1	**Staff recommendation of the organisation as a place to work or receive treatment**	**3.58**	**3.46**	**3.75**

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 2016 survey results, from 3.73 to 3.67 . The average score for acute Trusts in 2017 is 3.79 compared to 3.81 in 2016.

Table 2: Scores in Overall Staff Engagement

	Key Finding	2016	2017	Change since 2016 survey (benchmark change)	Ranking against all acute trusts
KF1	Staff recommendation of the trust as a place to work or receive treatment	3.58	3.46	Decrease	Worst 20%
KF4	Staff motivation at work	3.88	3.85	No change	Worst 20%
KF7	Percentage of staff able to contribute towards improvements at work	71%	67%	No change	Better than Average
	Overall staff engagement score	3.73	3.67	Decline	Worse than average

Highest and lowest ranking scores in 2017

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 27 and 29 remain one of the highest scores for a second year running.

Table 3: Key Findings with the highest scores

	Key Finding	Score 2016	Score 2017	Average for acute trusts
KF 27	Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	48%	49%	45%
KF29	Percentage of staff reporting errors, near misses or incidents witnessed in the last month	91%	91%	90%
KF13	Quality of non-mandatory learning or development.	4.05	4.07	4.05
KF16*	Percentage of staff working extra hours	72%	72%	72%
KF9	Effective Team working	3.70	3.71	3.72

*****The lower the score the better

In the bottom ranking scores table below (Table 5), key findings 3, 25 and 28 remain as two of the worst scores for a second year running.

Table 4: Key Findings with the worst scores

	Key Finding	Score 2016	Score 2017	Average for acute trusts
KF28*	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	42%	42%	31%
KF3	Percentage of staff agreeing that their role makes a difference to patients / service users	88%	86%	90%
KF6	Percentage of patients agreeing their role makes a difference to patients/service users	25%	20%	33%
KF25*	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	34%	36%	28%
KF5	Recognition and value of staff by managers and the organisation.	3.31	3.28	3.45

*****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;

<u>Errors and incidents</u>
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
Staff continue to report they 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 remains unchanged (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) and the difference their role makes to patients/ service (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 (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 2016 NHS Staff Survey Action Plan.

The Trust will review the actions that were completed in response to the 2016 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 April 2018. NHS Staff Surveys - 2017 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 organization. We recognise that communicating with our staff is something we will always aim to improve. 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.

We continue to develop our traditional channels of communication through our weekly Staff e-Newsletter, updates to the staff Intranet, noticeboards and screen savers. The Nurse Assistant and Student Nurse forums developed in 2016, continue to prove regular opportunities for these groups of staff to come together, share ideas and suggestions for improvement and to hear presentations from clinical specialists.

Last November 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

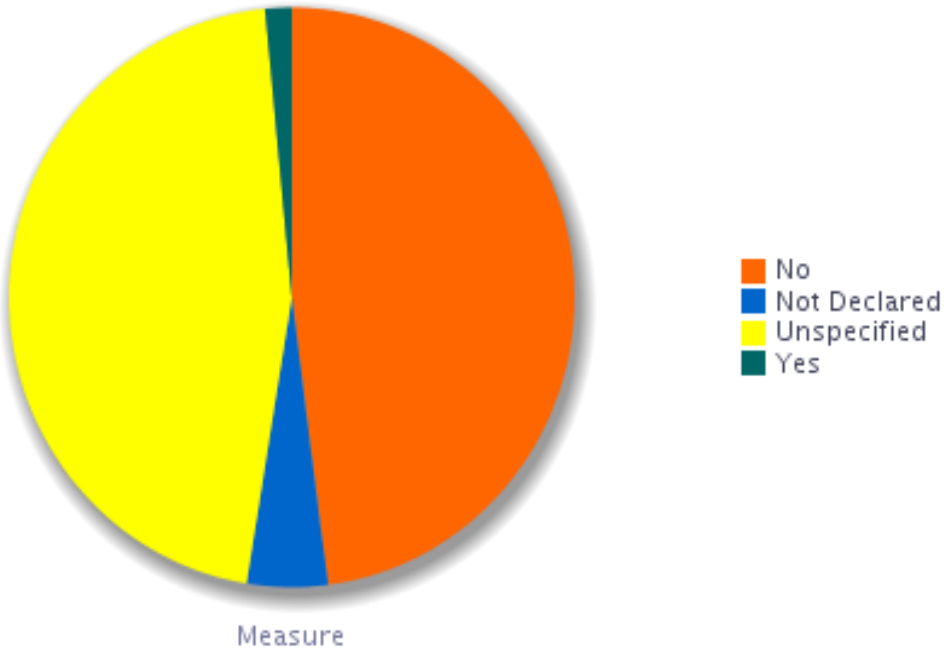
The Trust Equality and Diversity Policy sets out our commitment to promoting equality of opportunity for all and ensuring that staff and patients are free from discrimination. The policy sets out clear responsibilities for directors, managers, staff, patients and visitors.

All staff joining the Trust as part of the induction programme takes part in a dedicated Equality and Diversity session.

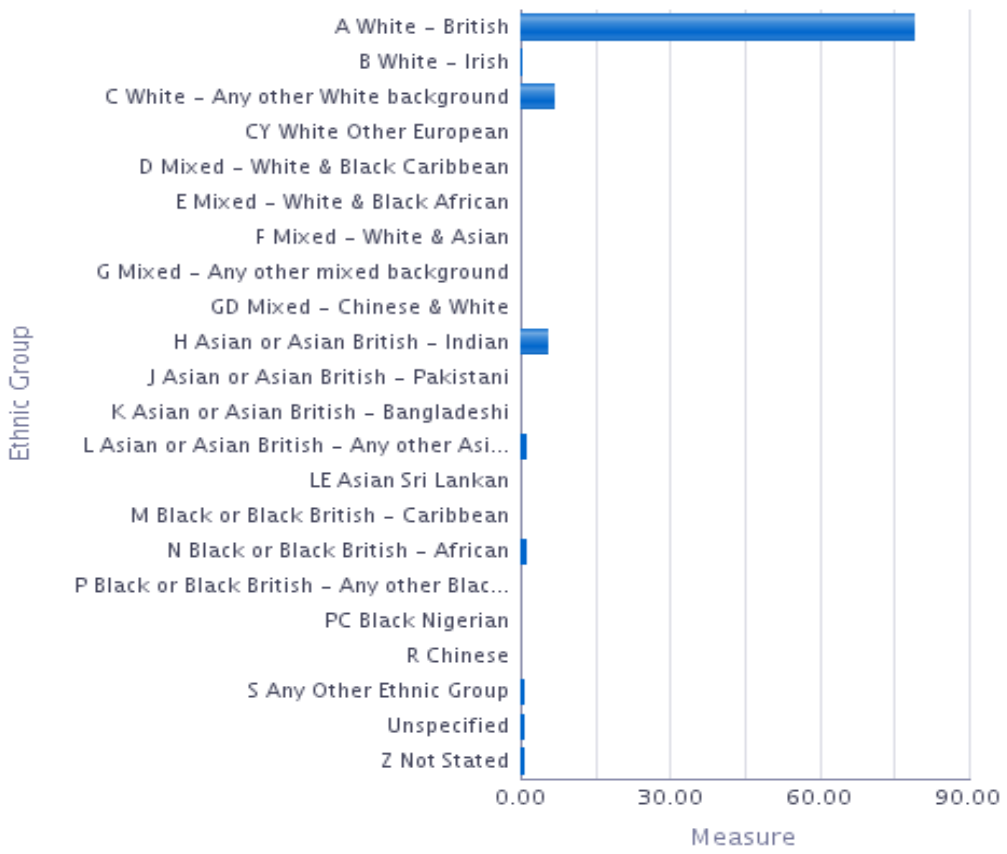
The Trust is accredited to the “positive about disability” initiative, which guarantees applicants an interview where they meet the minim essential criteria for the jobs description. Through the application and shortlisting process, details relating to protected characteristics are kept confidential 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.

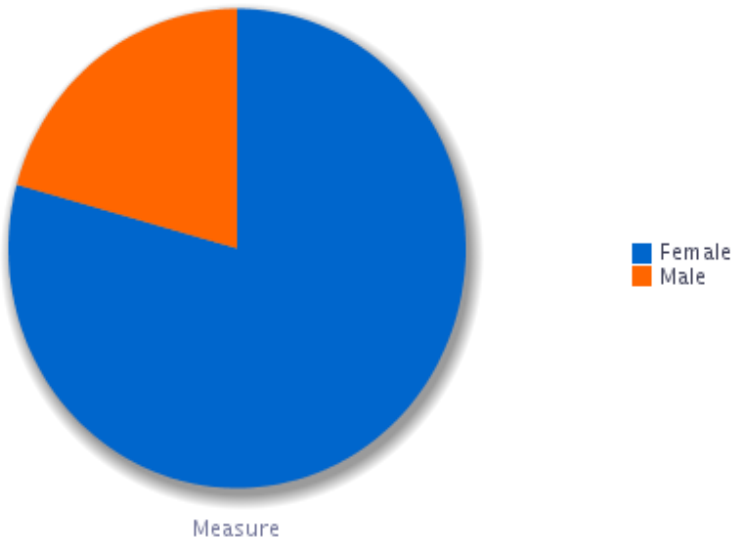
Disability



Ethnicity

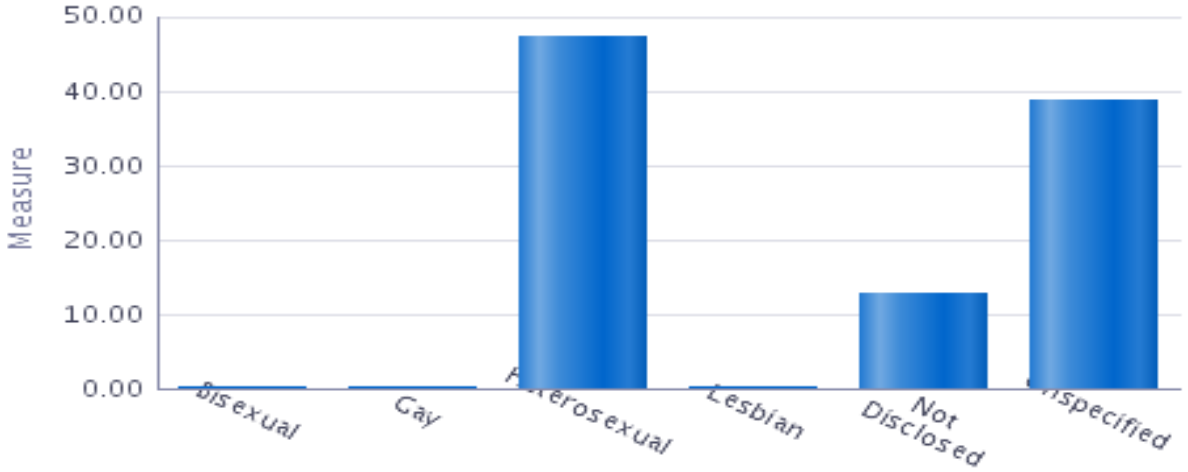


Gender

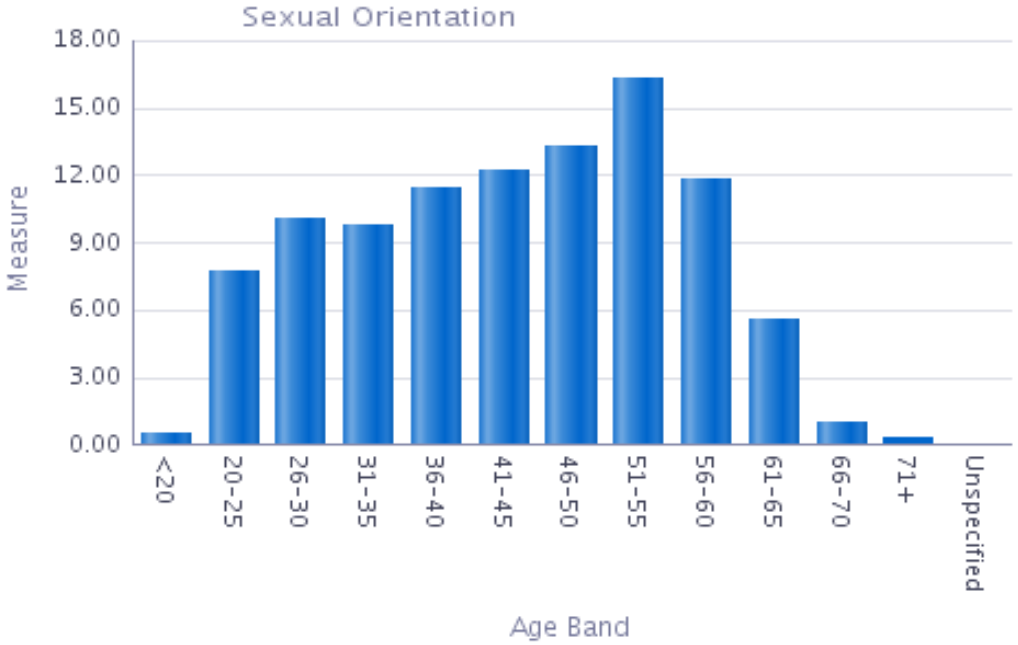


Seven of our Board members are male, six female.

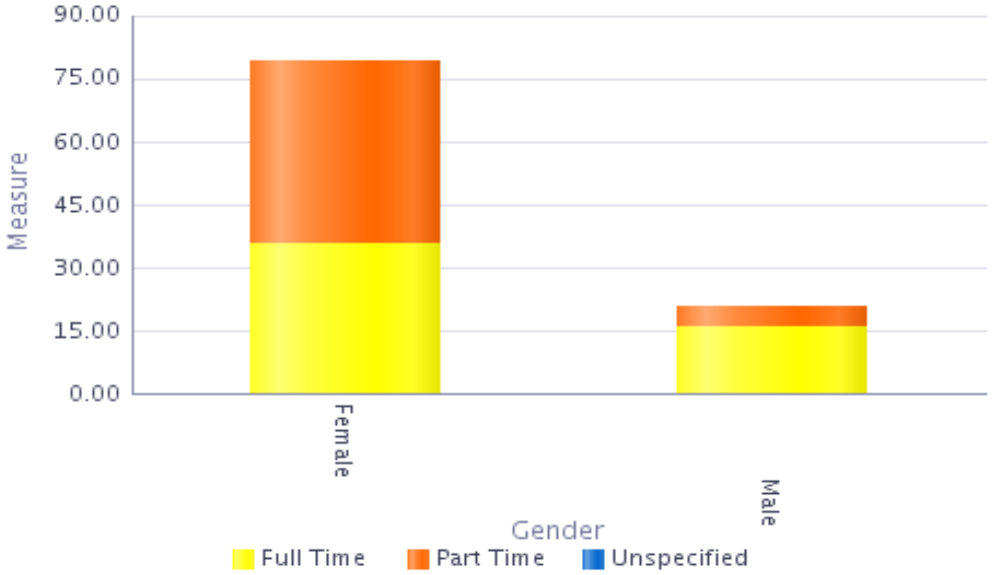
Sexual Orientation



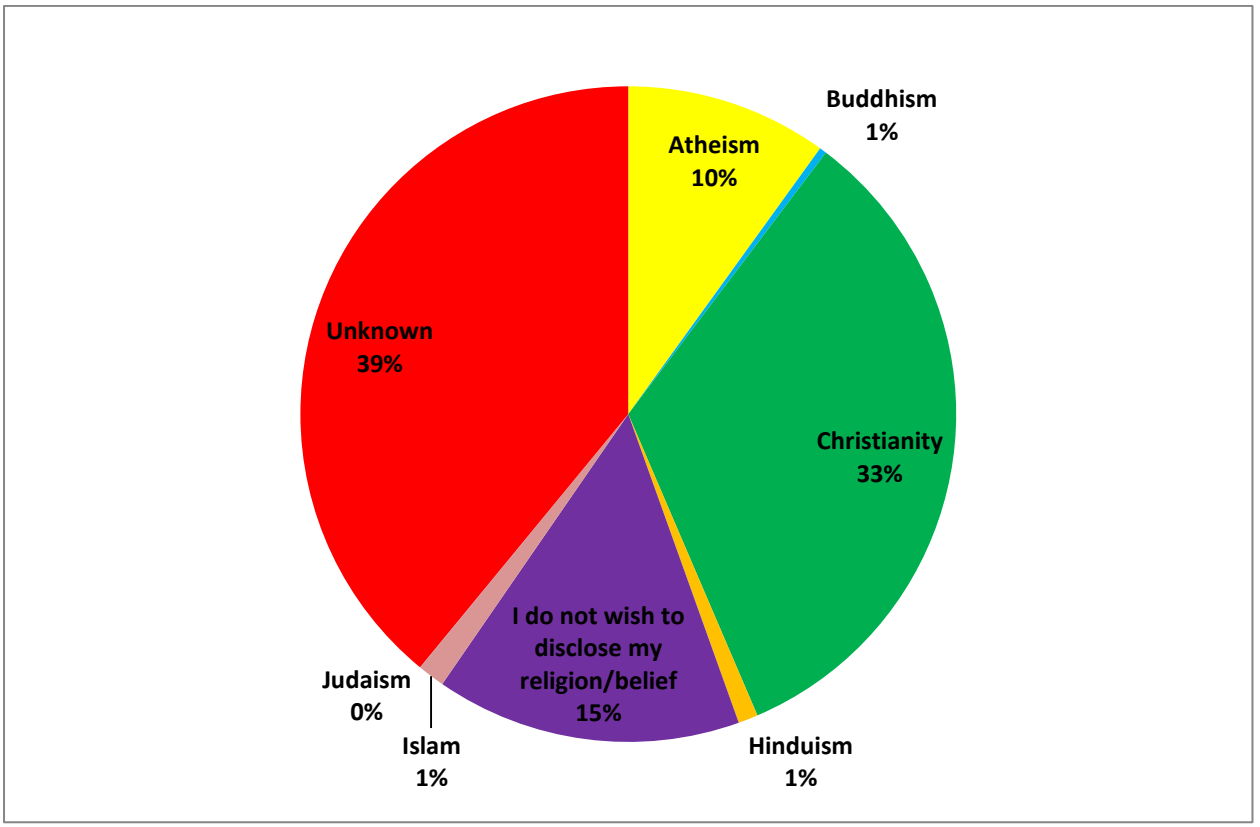
Age Band



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.

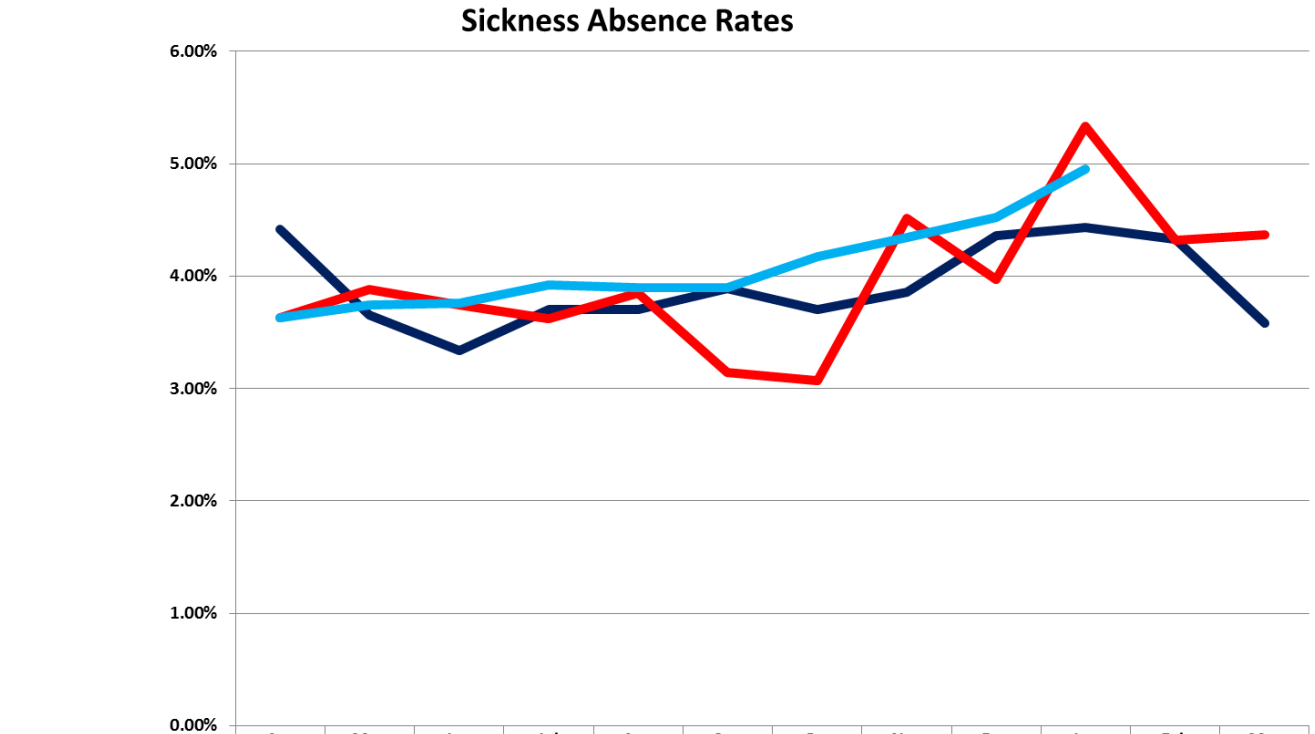
Amongst a range of activities, staff have benefitted from yoga and pilates classes, reduced gym membership, and cycle to work schemes. In support of staff experiencing stress we have run Emotional Resilience training planned.

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 61 of our employees accessing counselling sessions In 2017/18

Sickness absence in 2017 has overall been higher in 2017/18 than 2016/17. In December 17 and January 18 sickness rose to above 5%. As recently reported at the Trust Quality and Safety Committee, with the exception of December and January 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.

Employee category	2017/18 - £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 Sickness Absence	2017-18	2016-17
Total Days Lost	13,686	12,779
Total Staff Years	1478	1,455
Average working Days Lost	9.25	8.8



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Apr 16 - Apr 17	4.42%	3.65%	3.34%	3.70%	3.70%	3.89%	3.70%	3.86%	4.36%	4.43%	4.33%	3.58%
Apr 17 - Apr 18	3.63%	3.88%	3.74%	3.62%	3.85%	3.14%	3.07%	4.51%	3.97%	5.33%	4.32%	4.37%
Nat Avg Apr 17 -Jan 18	3.63%	3.74%	3.76%	3.92%	3.90%	3.90%	4.17%	4.34%	4.52%	4.95%		

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 2017/18 we have expanded our apprenticeship programme to include the nursing assistant role. Our first cohort joined us in January 2018 and a second cohort will be recruited in March 2018

Patient and staff safety remains key to our service delivery and during 2017/18 we ran over 606 in-house statutory and mandatory courses, training over 5,680 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 20%. We are proud to announce that our Library service achieved 95% compliance in the Library Quality Assurance Framework for the first time this year.

Consultancy expenditure

Management Consultancy expenditure for the Trust during 2017/18 was £278,000

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 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 £245 a day that lasted longer than six months in

year.

For all new off-payroll engagements between 1 April 2017 and 31 March 2018 for more than £245 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 2017 and 31 March 2018	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year.	0
Number of engagements that saw a change to IR35 status following the consistency review	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	10

.
The Chief Executive and nine Executive Directors, on payroll engagements, are deemed to have significant financial responsibility during the year.

Part 3 – Financial statements and notes

Financial Standing

The Trust's financial plan for 2017/18 was to achieve a planned year-end net income and expenditure deficit position of £6.035m.

The Trust has reported a net income and expenditure deficit of £13.470m in 2017/18. This position exceeds the planned year-end net deficit by £7.435m.

The reported net deficit includes the delivery of savings of £2.035m.

The other statutory requirements of absorbing the rate of capital and managing External Financing Limit (EFL) and Capital Resource Limits (CRL) were met.

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. This is represented by the PDC dividend payable of £1.406m and is calculated as 3.5% of the average relevant net assets of £40.200m.

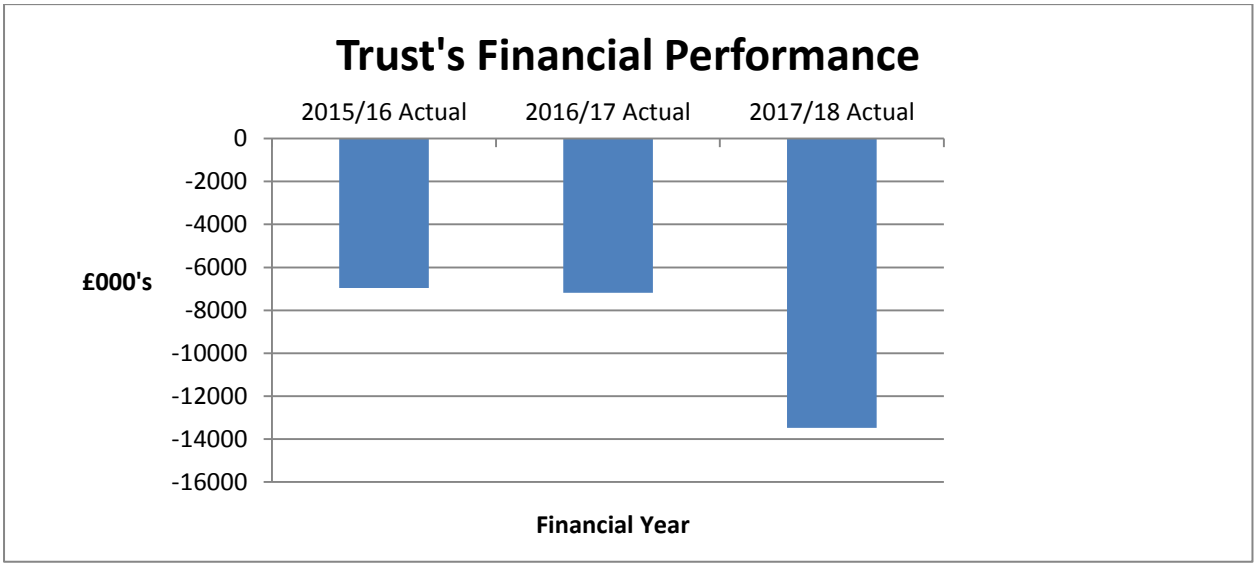
The EFL is a target which determines how much more (or less) cash it can spend over and above that generated by its operating activities. The limit set for 2017/18 was £17.878m, which was met.

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 CRL for 2017/18 was £5.186m and the charge made against the CRL was £5.183m, £0.003m below the CRL which is an acceptable tolerance.

Financial Position of the Trust

The Trust has reported a retained net deficit of £14.955m in 2017/18. The retained net deficit includes the impact of the donated assets reserve and impairments, a net charge of £1.485m. The Department of Health guidance on the break-even duty for NHS Trusts excludes these costs when measuring a Trust's break-even performance (see Statement of Comprehensive Income in the Annual Accounts).

Therefore, by excluding the net charge of £1.485m, the Trust has recorded a net deficit of £13.470m using the break-even duty definition. This net deficit exceeds the planned net deficit of £6.035m by £7.435m. This is mainly due to an overspend in pay costs of £2.110m, a shortfall in planned savings of £2.443m and lower than planned Emergency Department attendances of £1.055m due to the temporary overnight closure of the Emergency Department. Further, the Trust did not earn £1.983m of planned Sustainability & Transformation Funding due to the failure to achieve the Trust's financial plan from July 2017 onwards.



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.

Use of Resources Rating

NHS Improvement using a Use of Resource Rating (URR) to measure financial sustainability and efficiency. The rating ranges from 1, the lowest risk, to 4, the highest risk. The URR is the average of five metric as follows:

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

For 2017/18, the Trust achieved an overall URR of 4. The table below sets the Trust's performance against the metrics. The rating achieved is the lowest score.

Use of Resources Rating 2017/18

Metric	Weighting	Metric performance	Metric rating
Liquidity	20%	-38.1 days	4
Capital servicing capacity	20%	-4.2 times	4
Income and expenditure margin	20%	-13.2%	4
Variance in income and expenditure margin	20%	-7.5	4
Variance from agency ceiling	20%	112.0%	4
Overall URR rounded			4

Financial Position 2018/19

The 2018/19 financial plan is heavily influenced by the setting of a Control Total by the regulator, NHS Improvement. If a Trust accepts the Control Total then it receives Provider Sustainability Funding (PSF), previously known as Sustainability and Transformation Funding (STF), and does not pay fines to Commissioners for core performance target breaches, for example, Referral to Treatment (RTT), A&E and Cancer access. If the Trust rejects the Control Total it receives no PSF and pays core performance fines.

The Control Total for 2018/19 is a net deficit of £1.200m. This was rejected by the Trust Board due to the savings requirement of £11.500m. Savings at c11% of operational expenditure are undeliverable. The final Operating Plan for 2018/19 has been set on the basis of Control Total rejection and results in a £13.510m net deficit plan.

The Trust Board approved the 2018/19 Financial Plan at its meeting on 25th April 2018. The planned deficit of £13.510m requires significant focus on the delivery of the Trust's contracted patient activity volumes and income, the delivery of planned savings at £3.500m and a reduction in agency expenditure of £2.000m. Delivery of the planned deficit will provide financial stability from which the Trust can build and recover in 2019/20.

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 2017/18 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 2018.

The Trust has a planned deficit in 2018/19 of £13.510m and this requires a £13.510m loan from the Department of Health of equal value to maintain cash flow in 2018/19. Directors have a financial plan which is in process of being agreed with NHS Improvement and are confident that it will support the Trust's application for cash support for 2018/19. The Trust has not yet received formal confirmation from the Department of Health that the full year's funding will be forthcoming, although the first instalments of the loan were received in April and May 2018 totaling £2.150m.

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 31 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 97.8% of the total number of non-NHS invoices against the Code. This compares with 97.1% in 2016/17. With 89.9% of the total number of NHS invoices paid within 30 days compared with 88.1% in 2016/17.

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 2018 at £6,870m. 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 1.5 and note 9 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.

Statement of Comprehensive Income for the year ended 31st March 2018

	Note	31 March 2018 £000	31 March 2017 £000	
Operating income from patient care activities	3	92,435	95,673	
Other operating income	4	9,897	9,883	
Operating expenses	6, 8	(115,432)	(110,988)	
Operating (deficit)		**(13,100)**	(5,432)	
Finance income	11	7	9	
Finance expenses	12	(462)	(177)	
PDC dividends payable		(1,406)	(1,717)	
Net finance costs		**(1,861)**	(1,885)	
Other gains	13	6	4	
(Deficit) for the year		**(14,955)**	(7,313)	
Other comprehensive income				
Will not be reclassified to income and expenditure:				
Revaluations	17	(2,093)	2,185	
Total comprehensive (expense) for the period		**(17,048)**	(5,128)	
Financial performance for the year				
Retained (deficit) for the year		(14,955)	(7,313)	
Impairments (excluding IFRIC 12 impairments)	7	1496	0	(a)
Adjustments in respect of donated asset reserve elimination		(11)	128	(b)
Adjusted retained (deficit)	34	**(13,470)**	(7,185)	

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 34 Trusts breakeven duty financial performance and Note 7 Impairment of assets).

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 £135k (£138k 2016-17) less income for the purchase of non-current assets £146k (£10k 2016-17) see Note 4 Other Operating Income.

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	14	2,661	2,955
Property, plant and equipment	15	67,013	68,819
Trade and other receivables	19	560	524
Total non-current assets		**70,234**	72,298
Current assets			
Inventories	18	1,109	1,136
Trade and other receivables	19	6,259	4,282
Cash and cash equivalents	20	2,403	1,609
Total current assets		**9,771**	7,027
Current liabilities			
Trade and other payables	21	(11,684)	(11,766)
Borrowings	23	(7,700)	(7,700)
Provisions	24	(81)	(79)
Other liabilities	22	(676)	(341)
Total current liabilities		**(20,141)**	(19,886)
Total assets less current liabilities		**59,864**	59,439
Non-current liabilities			
Borrowings	23	(20,337)	(4,200)
Provisions	24	(378)	(388)
Total non-current liabilities		**(20,715)**	(4,588)
Total assets employed		**39,149**	54,851
Financed by			
Public dividend capital		71,638	70,292
Revaluation reserve		12,883	14,566
Income and expenditure reserve		(45,372)	(30,007)
Total taxpayers' equity		**39,149**	54,851

The notes on pages 6 to 40 form part of these accounts.

The financial statements on pages *77 to 116* were approved by the Board on *25th May 2018* and signed on its behalf by

James Rimmer

Chief Executive:

Date **25 May 2018**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**70,292**	**14,566**	**(30,007)**	**54,851**
(Deficit) for the year	0	0	(14,955)	**(14,955)**
Revaluations	0	(2,093)	0	**(2,093)**
Public dividend capital received	1,346	0	0	**1,346**
Other reserve movements	0	410	(410)	**-**
Taxpayers' equity at 31 March 2018	**71,638**	**12,883**	**(45,372)**	**39,149**

The permanent PDC received - cash relates to capital funding of £843k A & E GP Primary Care Funding, £450k for the upgrade of the patient administration system capital project and £53k for Cancer Transformation 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 2018 of £91k. This is offset by £501k being the difference between the current cost of depreciation compared to the historic cost of depreciation, totalling £410k for transfers between reserves.

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**69,814**	**12,436**	**(22,749)**	**59,501**
(Deficit) for the year	0	0	(7,313)	**(7,313)**
Other transfers between reserves	0	(55)	55	0
Revaluations	0	2,185	0	**2,185**
Public dividend capital received	478	0	0	**478**
Taxpayers' equity at 31 March 2017	**70,292**	**14,566**	**(30,007)**	**54,851**

Information on reserves

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

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

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

Statement of Cash Flows
for the year ended 31st March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Cash flows from operating activities			
Operating (deficit)		(13,100)	(5,432)
Non-cash income and expense:			
Depreciation and amortisation	6.1	3,840	3,841
Net impairments	7	1,496	0
Income recognised in respect of capital donations	4	(146)	(10)
(Increase) in receivables and other assets		(2,014)	(1,011)
(Increase) / decrease in inventories		27	(82)
Increase / (decrease) in payables and other liabilities		(196)	1,490
(Decrease) in provisions		(39)	(21)
Net cash generated from / (used in) operating activities		**(10,132)**	(1,225)
Cash flows from investing activities			
Interest received		7	9
Purchase of intangible assets		(441)	(958)
Purchase of property, plant, equipment and investment property		(4,469)	(2,892)
Sales of property, plant, equipment and investment property		6	4
Receipt of cash donations to purchase capital assets		146	10
Net cash (used in) investing activities		**(4,751)**	(3,827)
Cash flows from financing activities			
Public dividend capital received		1,346	478
Movement on loans from the Department of Health and Social Care		16,137	4,200
Other interest paid		(401)	(105)
PDC dividend (paid)		(1,405)	(1,765)
Net cash generated from financing activities		**15,677**	2,808
Increase / (decrease) in cash and cash equivalents		**794**	(2,244)
Cash and cash equivalents at 1 April - brought forward		**1,609**	3,853
Cash and cash equivalents at 31 March	20.1	**2,403**	1,609

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

The Trust has prepared the accounts on a going concern basis in accordance with the 2017/18 Department of Health and Social Care 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 2018.

The Trust has a planned deficit in 2018/19 of £13.5m and this requires a £13.5m loan from the Department of Health and Social Care of equal value to maintain cash flow in 2018/19. Directors have a financial plan which is in process of being agreed with NHS Improvement and are confident that it will support the Trust's application for cash support for 2018/19. The Trust has not yet received formal confirmation from the Department of Health and Social Care that the full years funding will be forthcoming, although the first instalments of the loan were received in April and May 2018 totalling £2.150m.

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 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.

Note 1.2 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 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.

Note 1.2.1 Sources of estimation uncertainty

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

a) Revaluation

- 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 2018. The carrying amount for land and buildings as at 31 March 2018 are based on this valuation which uses recognised published indices where the impact of the revaluation is material.

b) Impairment

Impairments are based on the Valuation Office's assesssment of indices or on revaluation of individual assets e.g. when brought into operational use, or identified for disposal. Assumptions and judgements are that valuations used are applicable to the Trust's circumstances. Additionally, management reviews would identify circumstances which may indicate where an impairment has occurred.

c) Holiday pay

- 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.

d) Year end income from patient care activities

- Due to invoicing deadlines for the year end being before the March 2018 patient activity data is available the income from patient care activities over/under performance with some commissioners is estimated based on patient activity as at the end of February 2018 and historic trends.

Note 1.3 Interests in other entities

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.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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

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.

Revenue grants and other contributions to expenditure

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

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension Costs

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.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 Measurement

Valuation

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

All assets are measured subsequently at valuation.

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 using the BCIS [Building Cost Information Service].
All in Tender Price Index 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 valuation of land and buildings was undertaken as at 31 March 2018 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 item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure

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

Depreciation

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

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

Revaluation gains and losses

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

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

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

Impairments

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

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

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

Note 1.7.4 Donated and grant funded assets

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

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

Note 1.7.5 Useful economic lives of property, plant and equipment

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

	Min life	Max life
	Years	Years
Land	-	-
Buildings, excluding dwellings	8	69
Plant & machinery	1	35
Information technology	3	18
Furniture & fittings	5	35

Note 1.8 Intangible assets

Note 1.8.1 Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development

Software

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

Note 1.8.2 Measurement

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

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

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

Amortisation

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

Note 1.8.3 Useful economic lives of intangible assets

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

	Min life	Max life
	Years	Years
Software licenses	1	8

Note 1.9 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.

Note 1.10 Cash and cash equivalents

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

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

Note 1.11 Financial instruments and financial liabilities

Recognition

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

De-recognition

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

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

Classification and measurement

Financial assets are categorised as fair value through income and expenditure, loans and receivables or available-for-sale financial assets.

Financial liabilities are classified as fair value through income and expenditure or as other financial liabilities.

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Note 1.12 Leases

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

Note 1.12.1 The Trust as lessee

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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

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

Leases of land and buildings

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

Note 1.12.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trusts' net investment outstanding in respect of the leases.

Operating leases

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

Note 1.13 Provisions

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at note 24.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

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

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

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Foreign exchange

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.

Note 1.18 Third party assets

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

Note 1.19 Losses and special payments

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

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the trust from another NHS / local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

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

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2017-18 IFRS 9 and IFRS 15 to be implemented in 2018-19, and for IFRS 16 is required for 2019-20.

- 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.

Note 2 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.

Note 3 Operating income from patient care activities			
Note 3.1 Income from patient care activities (by nature)	**31 March 2018**	31 March 2017	
	£000	£000	
Acute services			
Elective income	13,241	14,040	
Non elective income	30,290	29,188	
First outpatient income	4,979	5,445	
Follow up outpatient income	7,379	8,389	
A & E income	7,535	8,120	
High cost drugs income from commissioners	7,547	5,840	
Other NHS clinical income	14,871	17,689	
Mental health services			
Block contract income	2,459	1,584	
Community services			
Community services income from CCGs and NHS England	1,125	1,711	
Income from other sources (e.g. local authorities)	190	1,316	
All services			
Private patient income	242	174	
Other clinical income	2,577	2,177	
Total income from activities	**92,435**	95,673	
Note 3.2 Income from patient care activities (by source)			
Income from patient care activities received from:	**31 March 2018**	31 March 2017	
	£000	£000	
NHS England	6,864	6,446	
Clinical commissioning groups	82,932	86,485	
Other NHS providers	1,669	129	
Local authorities	190	1,440	
Non-NHS: private patients	242	554	
Non-NHS: overseas patients (chargeable to patient)	24	27	
NHS injury scheme	403	423	(a)
Non NHS: other	111	169	
Total income from activities	**92,435**	95,673	
Note a: Injury cost recovery income is subject to a provision for impairment of receivables of 22.84% to reflect expected rates of collection (22.94% 2016-17). This is in line with national guidance.			

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

		31 March 2018	31 March 2017
		£000	£000
Income recognised this year		24	27
Cash payments received in-year		7	0
Amounts added to provision for impairment of receivables		22	0
Amounts written off in-year		2	0

Note 4 Other operating income

		31 March 2018	31 March 2017
		£000	£000
Education and training		3,181	3,236
Receipt of capital grants and donations		146	10
Charitable and other contributions to expenditure		155	108
Non-patient care services to other bodies		2,666	2,231
Sustainability and transformation fund income		1,096	1,755
Rental revenue from operating leases		133	133
Other income	a	2,520	2,410
Total other operating income		**9,897**	9,883

Note a: Includes £822k (£883k 2016-17) income from Somerset Surgical Services Ltd for use of an allocation of the Trusts theatre capacity.

Note 5 Fees and charges

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.

Note 6.1 Operating expenses

	31 March 2018	31 March 2017
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,899	2,638
Purchase of healthcare from non-NHS and non-DHSC bodies	626	360
Staff and executive directors costs	76,118	75,712
Remuneration of non-executive directors	56	59
Supplies and services - clinical (excluding drugs costs)	7,862	7,735
Supplies and services - general	1,876	1,885
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	9,910	9,604
Consultancy costs	278	37
Establishment	738	597
Premises	4,498	3,889
Transport (including patient travel)	158	147
Depreciation on property, plant and equipment	3,372	3,375
Amortisation on intangible assets	468	466
Net impairments	1,496	0
Increase/(decrease) in provision for impairment of receivables	40	29
Audit fees payable to the external auditor		
audit services- statutory audit	50	57
other auditor remuneration (external auditor only)	11	12
Clinical negligence	3,388	3,095
Legal fees	107	61
Insurance	1	1
Education and training	899	544
Rentals under operating leases	137	238
Hospitality	32	24
Other	412	423
Total	**115,432**	110,988

Note 6.2 Other auditor remuneration		
	31 March 2018	31 March 2017
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	11	12
Total	**11**	12

The other auditor remuneration costs are for the audit of the Trusts' Quality account in both years.

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

Note 7 Impairment of assets		
	31 March 2018	31 March 2017
	£000	£000
Net impairments charged to operating deficit resulting from:		
Other	1,496	0
Total net impairments charged to operating deficit	**1,496**	0

The impairments charged to the operating deficit in 2017-18 consist of:

1. The Trust recognised a £665k impairment against the intangible asset value of the costs attributable to the implementation of the 2010 code of the Millennium PAS system. The impairment has been triggered by the upgrade to the 2015 code.

2. Following the annual revaluation of the Trust's property assets on a modern equivalent asset basis, undertaken by the Valuation Office Agency, a £831k impairment charge has been incurred.

Note 8 Employee benefits		
	31 March 2018	31 March 2017
	Total	Total
	£000	£000
Salaries and wages	54,614	53,432
Social security costs	5,138	5,001
Apprenticeship levy	239	0
Employer's contributions to NHS pensions	6,429	5,964
Temporary staff (including agency)	9,922	11,699
Total staff costs	**76,342**	76,096
Of which		
Costs capitalised as part of assets	224	384

Note 8.1 Retirements due to ill-health

During 2017/18 there was 1 early retirement from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £67k (£71k in 2016/17).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. 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.

Note 10 Operating leases

Note 10.1 Weston Area Health NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Weston Area Health NHS Trust is the lessor.

	31 March 2018	31 March 2017
	£000	£000
Operating lease revenue		
Minimum lease receipts	133	133
Total	**133**	133

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	169	134
- later than one year and not later than five years;	674	532
- later than five years.	3,729	2,050
Total	**4,572**	2,716

The Trust receives rental revenue from a number of organisations for the use of it's land and buildings. The most significant arrangement is with Avon and Wiltshire Mental Health Partnership NHS Trust for a strip of land which has 56 years remaining.

Note 10.2 Weston Area Health NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Weston Area Health NHS Trust is the lessee.

	31 March 2018	31 March 2017
	£000	£000
Operating lease expense		
Minimum lease payments	137	238
Total	**137**	238

	31 March 2018	31 March 2017 *Restated
	£000	£000
Future minimum lease payments due:		
- not later than one year;	138	141
- later than one year and not later than five years;	160	241
- later than five years.	291	325
Total	**589**	707

* The future minimum lease payments due as at 31 March 2017 have been restated to correct the analysis of future payments.

- later than one year and not later than five years restated from £409k to £241k
- later than five years restated from £616k to £325k.

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 1 years 4 months remaining.

Note 11 Finance income		
Finance income represents interest received on assets and investments in the period.		
	31 March 2018	31 March 2017
	£000	£000
Interest on bank accounts	7	9
Total	**7**	9

Note 12.1 Finance expenditure		
Finance expenditure represents interest and other charges involved in the borrowing of money.		
	31 March 2018	31 March 2017
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	431	131
Total interest expense	**431**	131
Unwinding of discount on provisions	31	45
Other finance costs	0	1
Total finance costs	**462**	177

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015		
	31 March 2018	31 March 2017
	£000	£000
legislation	0	1

Note 13 Other gains		
	31 March 2018	31 March 2017
	£000	£000
Gains on disposal of assets	6	4
Total gains on disposal of assets	6	4

Note 14 Intangible non-current assets	
Note 14.1 Intangible assets - 2017/18	
	31 March 2018
	Software licences
	£000
Valuation / gross cost at 1 April 2017 - brought forward	**4,627**
Additions	839
Impairments	(665)
Reclassifications	(149)
Gross cost at 31 March 2018	**4,652**
Amortisation at 1 April 2017 - brought forward	**1,672**
Provided during the year	468
Reclassifications	**(149)**
Amortisation at 31 March 2018	**1,991**
Net book value at 31 March 2018	**2,661**
Net book value at 1 April 2017	**2,955**
* Reclassification between gross cost and amortisation net to nil.	
Note 14.2 Intangible assets - prior year	
	31 March 2017
	Software licences
	£000
Valuation / gross cost at 1 April 2016	**3,783**
Additions	799
Reclassifications	45
Valuation / gross cost at 31 March 2017	**4,627**
Amortisation at 1 April 2016	**1,206**
Provided during the year	**466**
Amortisation at 31 March 2017	**1,672**
Net book value at 31 March 2017	**2,955**
Net book value at 1 April 2016	**2,577**

Note 15.1 Property, plant and equipment - 2017/18							
	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**6,870**	**55,136**	**1,181**	**19,879**	**5,042**	**1,441**	**89,549**
Additions	0	1,759	1,804	599	328	0	**4,490**
Impairments	0	(831)	0	0	0	0	**(831)**
Revaluations	0	(6,285)	0	0	0	0	**(6,285)**
Reclassifications	0	1,711	(1,991)	272	8	0	**0**
Disposals / derecognition	0	0	0	(760)	0	0	**(760)**
Valuation/gross cost at 31 March 2018	**6,870**	**51,490**	**994**	**19,990**	**5,378**	**1,441**	**86,163**
Accumulated depreciation at 1 April 2017 - brought forward	0	**2,438**	0	**13,085**	**3,854**	**1,353**	**20,730**
Provided during the year	0	**1,754**	0	**1,124**	**472**	**22**	**3,372**
Revaluations	0	(4,192)	0	0	0	0	**(4,192)**
Reclassifications	0	0	0	(1)	1	0	**0**
Disposals / derecognition	0	0	0	(760)	0	0	**(760)**
Accumulated depreciation at 31 March 2018	**0**	**0**	**0**	**13,448**	**4,327**	**1,375**	**19,150**
Net book value at 31 March 2018	**6,870**	**51,490**	**994**	**6,542**	**1,051**	**66**	**67,013**
Net book value at 1 April 2017	**6,870**	**52,698**	**1,181**	**6,794**	**1,188**	**88**	**68,819**

Note 15.2 Property, plant and equipment - 2016/17							
	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016	**6,870**	**51,636**	**627**	**18,876**	**4,671**	**1,441**	**84,121**
Additions	0	652	1,160	1,258	371	0	**3,441**
Revaluations	0	2,287	0	0	0	0	**2,287**
Reclassifications	0	561	(606)	0	0	0	**(45)**
Disposals / derecognition	0	0	0	(255)	0	0	**(255)**
Valuation/gross cost at 31 March 2017	**6,870**	**55,136**	**1,181**	**19,879**	**5,042**	**1,441**	**89,549**
Accumulated depreciation at 1 April 2016	0	**730**	0	**12,106**	**3,342**	**1,330**	**17,508**
Provided during the year	0	**1,606**	0	**1,234**	**512**	**23**	**3,375**
Revaluations	0	102	0	0	0	0	**102**
Disposals/ derecognition	0	-	0	(255)	0	0	**(255)**
Accumulated depreciation 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**
Net book value at 1 April 2016	**6,870**	**50,906**	**627**	**6,770**	**1,329**	**111**	**66,613**

Note 15.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018							
Owned - purchased	6,870	48,238	976	6,489	1,051	66	**63,690**
Owned - donated	0	3,252	18	53	0	0	**3,323**
NBV total at 31 March 2018	**6,870**	**51,490**	**994**	**6,542**	**1,051**	**66**	**67,013**

Note 15.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017							
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**
NBV total at 31 March 2017	**6,870**	**52,698**	**1,181**	**6,794**	**1,188**	**88**	**68,819**

Note 16 Donations of property, plant and equipment			
Donations towards property, plant and equipment expenditure in year have been received from the following organisations:			
Macmillan Cancer Support			
League of Friends of Weston General Hospital			
There are no restrictions imposed on the use of donated assets.			
Note 17 Revaluations of property, plant and equipment			
Land and building assets are carried at valuation on the Statement of Financial Position. All of the Trust's land and building assets have been revalued as at 31 March 2018 by the District Valuers of the Valuation Office Agency who are independent to the Trust. The valuations have been carried out in accordance with the Royal Institute of Chartered Surveyors' (RICS) Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.			
The DVS Valuation Office assessed no change in the value of the Land for the period ending 31st March 2018.			
The 31st March 2018 valuation of all buildings using the BCIS index, which increased by 3.8%, resulted in a decrease in the value of buildings of £2,924k. With £2,093k charged to the revaluation reserve and £831k charged to the Statement of Comprehensive Income. The decrease in the valuation of buildings has arisen where the investments made in upgrading, improving and changes to the Trust's buildings have not added value when valued on a Modern Equivalent Asset (MEA) basis.			
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 2017 also Nil)			
No dwellings or transport equipment assets were held in either period.			

Note 18 Inventories		
	31 March 2018	31 March 2017
	£000	£000
Drugs	412	438
Consumables	684	688
Energy	13	10
Total inventories	**1,109**	1,136

Inventories recognised in expenses for the year were £16,141k (2016/17: £15,842k).

Note 19.1 Trade receivables and other receivables		
	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	5,632	3,374
Provision for impaired receivables	(103)	(91)
Prepayments (non-PFI)	461	437
PDC dividend receivable	72	73
VAT receivable	173	484
Other receivables	24	5
Total current trade and other receivables	**6,259**	4,282
Non-current		
Trade receivables	726	680
Provision for impaired receivables	(166)	(156)
Total non-current trade and other receivables	**560**	524
Of which receivables from NHS and DHSC group bodies:		
Current	4,901	2,436
Non-current	0	0

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.

Note 19.2 Provision for impairment of receivables		
	31 March 2018	31 March 2017
	£000	£000
At 1 April as previously stated	**247**	251
Increase in provision	40	29
Amounts utilised	(18)	(33)
At 31 March	**269**	247

Note 19.3 Credit quality of financial assets		
	31 March 2018	31 March 2017
	Trade and other receivables	Trade and other receivables
Ageing of impaired financial assets	**£000**	£000
90- 180 days	10	2
Over 180 days	44	42
Total	**54**	44
Ageing of non-impaired financial assets past their due date		
0 - 30 days	317	243
30-60 Days	93	76
60-90 days	155	254
90- 180 days	221	171
Over 180 days	218	133
Total	**1,004**	877

Note 20.1 Cash and cash equivalents movements

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

	31 March 2018	31 March 2017
	£000	£000
At 1 April	**1,609**	3,853
Net change in year	794	(2,244)
At 31 March	**2,403**	1,609
Broken down into:		
Cash at commercial banks and in hand	53	44
Cash with the Government Banking Service	2,350	1,565
Total cash and cash equivalents as in SoFP & SOCF	**2,403**	1,609

Note 20.2 Third party assets held by the trust

The Trust held no monies relating to patients in either year ending 2017/18 or 2016/17.

Note 21.1 Trade and other payables		
	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	3,796	4,609
Capital payables	2,068	1,649
Accruals	3,522	3,327
Social security costs	737	686
Other taxes payable	638	612
Accrued interest on loans	72	42
Other payables	851	841
Total current trade and other payables	**11,684**	11,766
Of which payables from NHS and DHSC group bodies:	**£000**	£000
Current	2,356	3,389
Included in Other payables above:	**£000**	£000
- outstanding pension contributions	842	830

Note 22 Other liabilities		
	31 March 2018	31 March 2017
	£000	£000
Current		
Deferred income	676	341
Total other liabilities	**676**	341

Note 23 Borrowings		
	31 March 2018	31 March 2017
	£000	£000
Current		
Loans from the Department of Health	7,700	7,700
Total current borrowings	**7,700**	**7,700**
Non-current		
Loans from the Department of Health	20,337	4,200
Total non-current borrowings	**20,337**	**4,200**

Note 24.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**285**	**39**	**143**	**467**
Arising during the year	0	25	0	**25**
Utilised during the year	(30)	(14)	(10)	**(54)**
Reversed unused	0	(10)	0	**(10)**
Unwinding of discount	12	0	19	**31**
At 31 March 2018	**267**	**40**	**152**	**459**
Expected timing of cash flows:				
- not later than one year;	31	40	10	**81**
- later than one year and not later than five years;	124	0	45	**169**
- later than five years.	112	0	97	**209**
Total	**267**	**40**	**152**	**459**

Pensions 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 - £152,000 is made up of a permanent injury benefit case (31 March 2017 £143,000).

Note 24.2 Clinical negligence liabilities

At 31 March 2018, £30,927k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Weston Area Health NHS Trust (31 March 2017: £26,969k).

Note 25 Contingent liabilities

	31 March 2018	31 March 2017
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(10)	(24)
Value of contingent liabilities	**(10)**	(24)

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

Note 26 Contractual capital commitments

There were no contracted capital commitments as at 31 March 2018 (2016/17 £993k).

Note 27 Financial instruments

Note 27.1 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 4 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 2018 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.

Note 27.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	5,389	0	0	0	**5,389**
Cash and cash equivalents at bank and in hand	2,403	0	0	0	**2,403**
Total at 31 March 2018	**7,792**	**0**	**0**	**0**	**7,792**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	3,793	0	0	0	**3,793**
Cash and cash equivalents at bank and in hand	1,609	0	0	0	**1,609**
Total at 31 March 2017	**5,402**	**0**	**0**	**0**	**5,402**

Note 27.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings	28,037	0	**28,037**
Trade and other payables excluding non financial liabilities	9,386	0	**9,386**
Total at 31 March 2018	**37,423**	**0**	**37,423**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	11,900	0	**11,900**
Trade and other payables excluding non financial liabilities	9,926	0	**9,926**
Total at 31 March 2017	**21,826**	**0**	**21,826**

Note 27.4 Fair values of financial assets and liabilities

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 2017/18 the guidance requires the Trust to disclose the gross value of the £28,037k loan.

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.

Note 27.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	17,086	17,626
In more than one year but not more than two years	0	0
In more than two years but not more than five years	20,337	4,200
Total	**37,423**	**21,826**

Note 28 Losses and special payments				
	2017/18		2016/17	
	Total number of cases	**Total value of cases**	Total number of cases	Total value of cases
	Number	**£000**	Number	£000
Losses				
Cash losses	4	1	2	0
Bad debts and claims abandoned	49	17	15	29
Total losses	**53**	**18**	17	29
Special payments				
Compensation under court order or legally binding arbitration award	6	25	7	15
Ex-gratia payments	24	14	14	3
Total special payments	**30**	**39**	21	18
Total losses and special payments	**83**	**57**	38	47

Note 29 Related parties

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, Health Education England, NHS Resolution, 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 £155k 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 £467k 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.

Note 30 Events after the reporting date

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

Note 31 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	42,053	38,506	45,850	37,850
Total non-NHS trade invoices paid within target	41,137	37,726	44,521	36,766
Percentage of non-NHS trade invoices paid within target	**97.8%**	**98.0%**	97.10%	97.14%
NHS Payables				
Total NHS trade invoices paid in the year	1,753	15,265	1,445	12,817
Total NHS trade invoices paid within target	1,575	14,585	1,273	12,169
Percentage of NHS trade invoices paid within target	**89.85%**	**95.55%**	88.10%	94.94%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 32 External financing

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

	31 March 2018 £000	31 March 2017 £000
Cash flow financing	16683	6919
Other capital receipts	6	3
External financing requirement	**16,689**	6,922
External financing limit (EFL)	17,878	6,990
Under spend against EFL	**1,189**	68

Note 33 Capital Resource Limit

	31 March 2018 £000	31 March 2017 £000
Gross capital expenditure	5,329	4,240
Less: Donated and granted capital additions	(146)	(10)
Charge against Capital Resource Limit	5,183	4,230
Capital Resource Limit	5,186	4,478
Under spend against CRL	**3**	248

Note 34 Breakeven duty financial performance

	31 March 2018 £000
Adjusted financial performance (deficit) (control total basis)	(13,470)
Breakeven duty financial performance (deficit)	(13,470)

Note 35 Breakeven duty rolling assessment										
	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	408	2,448	2,607	3,610	2,250	(4,683)	(3,902)	(6,965)	(7,185)	(13,470)
Breakeven duty cumulative position	(13,826)	(11,378)	(8,771)	(5,161)	(2,911)	(7,594)	(11,496)	(18,461)	(25,646)	(39,116)
Operating income	85,914	90,403	93,199	95,306	96,789	96,826	100,378	98,462	105,556	102,332
Cumulative breakeven position as a percentage of operating income		-12.59%	-9.41%	-5.42%	-3.01%	-7.84%	-11.45%	-18.75%	-24.30%	-38.22%

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.

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
CCG	Clinical Commissioning Group
CCA	The Civil Contingencies Act
CDI	Clostridium difficile infection
CHKS	Caspe Healthcare Knowledge Systems
CHP	Combined Heat and Power
CO2e	Carbon Dioxide Equivalent
CQC	Care Quality Commission
CQUINS	Commissioning for Quality & Innovation Schemes
CRL	Capital Resource Limit
DGH	District General Hospital
EAP	Employee Assistance Programme
ED	Emergency Department
EFL	External Financing Limit
EPRR	Emergency Preparedness Resilience and. Response
FMAs	Financial Monitoring and Accounts
FT	Foundation Trust
GHG	Green House Gases
GP	General practitioner
HES	Hospital Episode Statistics
IFRS	International Financial Reporting Standards
ILM	Institute of Leadership and Management
IM & T	Information Management and Technology
KPI	Key Performance Indicator
LED	Light-emitting diode
LQAF	NHS Library Quality Assurance Framework

LHRP	Local Health Resilience Partnership
MRSA	Methicillin-resistant Staphylococcus Aureus
NICE	National Institute for Health & Clinical Excellence
NPSA	National Patients Safety Agency
NHSTDA	NHS Trust Development Authority
PALS	Patient Advice & Liaison Service
PPC	Positive People Company
PRIDE	Patients First, Recognize & Respect, Invest in people, Delivery and Explain
QCF	Qualifications & Credit Framework
QIPP	Quality, Innovation, Productivity & Prevention
RTT	Referral to treatment
STP	Sustainability and Transformation Plan
VTE	Venous Thromboembolism

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