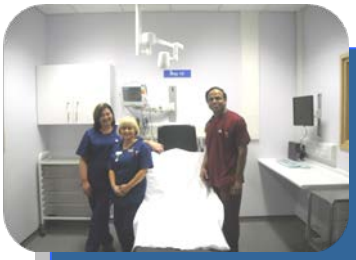
Weston Area Health NHS
NHS Trust



Annual Report and Accounts 2012/13

The Annual Report consists of:

A Directors' Report, based on the requirements of Chapter 5 of Part 15 of the Companies Act 2006, and;

A Remuneration Report based on Chapter 6 of Part 15 of the Companies Act 2006

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Section 1: Companies Act Requirements

1.1 Details of the Directors

During 2012/13 the Weston Area Health NHS Trust Board was made up of 11 members comprising both Executive and Non-Executive Directors led by the Chairman (Mr C Creswick) and the Chief Executive (Mr P Colclough).

The Trust Board met on 12 occasions in public during 2012/13 and the agenda and papers for these meetings are 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 in the local press.

The details of the Trust's Directors are included within the Remuneration Report (page 42).

1.2 Audit and Assurance Committee

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

In performing that role the Committee's work is predominantly focused upon 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 2012/13 were I Turner (Chairman), G Reah, G Paine and R Lloyd.

1.3 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 (page 42).

1.4 Declaration of Interests

Directors are required to declare details of any company directorships or other significant interests held where those companies do business or are seeking to do business with the NHS where this may result in a conflict with their managerial responsibilities. There were no directorships or interests disclosed in 2012/13 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 Trusts auditors are aware of that information.

Section 2: Operating and Financial Review

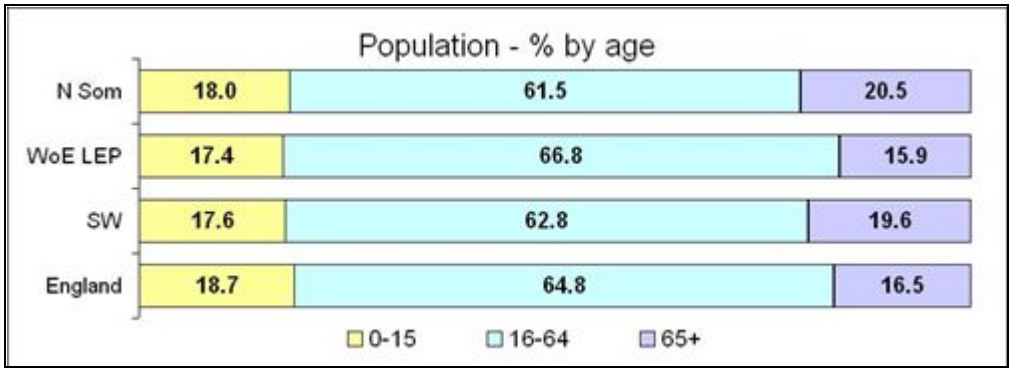
2.1. Nature, Objectives and strategies of the Trust

2.1.1 What we do

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

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

North Somerset has a resident population of around 202,000 people with over 70% of people living in the four main towns of Weston, Clevedon, Portishead and Nailsea. A further 3.3 million day trippers and 375,000 staying visitors increase this base population each year. Life expectancy in North Somerset for both men (79.6 years) and women (83.8 years) in 2012 was higher than both the South West and England average – one result is that there is a much greater proportion of patients aged 65 and over than for the rest of the South West or for England.



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

The Trust provides a wide range of acute health services to the population of North Somerset and Sedgemoor and works closely with other hospitals in Bristol as part of 'clinical networks' including, for example, cancer, pathology and cardiology.

The Trust owns its fixed assets, including the land and buildings at Weston General Hospital. Most assets are "Purchased Assets", valued at £58.5m, which are largely financed through Government borrowing in the form of Public Dividend Capital. Other assets are funded from donations and these are valued at £3.6m.

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

The majority of clinical activity for 2012/13 was commissioned by North Somerset Primary Care Trust.

2.1.2 Our vision and values

The vision of Weston Area Health NHS Trust is to be the local healthcare provider of choice working with partners within an integrated model of care. This vision reflects the sociological and demographic challenges of the area served by the Trust and the relative small size of the Trust which determines that service integration is key to delivery of safe and sustainable local services.

This vision is supported by a series of local values which guide actions, behaviours 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

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

2.2. Development and performance of the Trust during 2012/13 and in the future

The business plan for the Trust in 2012/13 detailed a range of strategic and operational objectives which supported achievement of the Trust's vision (Fig 1). These objectives were developed around the key themes of 'Quality', 'People' and 'Business' and they continue to be the foundation which has driven and supported the organisation during the last year, and will continue to fulfil this role during the next 12 months.

The Trust's vision and strategic objectives are consistent with the vision established for the whole health economy by NHS North Somerset which intends to "make it right for you", the ambition being to get things right for patients, their carers, local people, staff, practitioners and partners.

	TO BE THE LOCAL HEALTHCARE PROVIDER OF CHOICE WORKING WITH PARTNERS WITHIN AN INTEGRATED MODEL OF CARE					
	QUALITY	PEOPLE	BUSINESS			
Strategic Objectives	Work collaboratively to provide effective and safe integrated care	Provide a flexible workforce with the capacity and capability to deliver changing service need	Meet statutory financial duties	Deliver clinical services which meet then exceed national standards and targets	Be a good corporate citizen providing sustainable health care whilst meeting the requirements of the NHS constitution	Work with health and social care partners to deliver service and organisational change
2012/13 Corporate Objectives	1. Protect patients from Health Care Associated Infection (HCAI) / Hospital Acquired Infection (HAI)	1. Deliver effective staff appraisals, training and development	1. Manage within budgets	1. The Trust to be compliant with all the ED quality indicators	1. Further develop the estates strategy to ensure efficient use of resource	1. Engage with the market, with staff and key stakeholders to identify a strategic partner with whom the Trust can work to manage the future delivery of clinical services at Weston General Hospital
	2. Reduce the number of Patient Falls in the Trust	2. Deliver medical revalidation programme	2. Deliver the capital programme and plan	2. All Elective Services treat 90% of patients within 18 weeks	2. Continue to reduce the carbon footprint	
	3. Reduce the number of avoidable Pressure Ulcers	3. Develop a workforce plan which takes into account the change programme	3. Improve data to drive quality improvement	3. Review and design services to ensure they best meet the needs of the local community	3. Work in partnership with local communities to deliver improvements	
	4. Deliver auditable best practice					
	5. Achieve the Quality Mark for elder care					

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

- Finance;
- Estates;
- IM and T;
- Workforce Development
- Communications and engagement
- Governance

These strategies establish clear parameters for action and have been developed to enable the empowerment of all staff within the Trust within a clear framework of delegated responsibility and accountability.

The environment in which health and social care services nationally and specifically within North Somerset and Sedgemoor are operating is becoming increasingly complex. Analysis of national and local drivers for change clearly demonstrates that existing single organisation-focussed responses will be insufficient to

meet the challenges facing health and social care services and that instead there needs to be a fundamental redesign of the way in which these services are delivered.

These drivers include:

- local and regional population projected growth and increasing aging population suggesting increasing demand for services;
- increasing economic constraints and a local commissioning intent which seeks to reduce activity within the Trust and the potential challenge in terms of managing demand and critical mass and interdependencies between specialties arising from these reductions,
- changes to medical training and national recruitment problems in some clinical specialties.

Work undertaken by the Weston Area Health NHS Trust in partnership with NHS North Somerset over the last 3 years has demonstrated that Weston Area Health NHS Trust, as a standalone entity, and, as an integrated Care Organisation in partnership with other local health and social care provider organisations is unable to satisfy the financial requirements required to achieve Foundation status. The key reasons for this are that:

- Despite achieving financial turnaround the commissioning environment is such that it is unlikely that the Trust would be able to demonstrate sufficient strength to satisfy the due diligence process required for a foundation trust application;
- The scale of cost savings required in 2013/14 and beyond is unlikely to be achieved by the organisation in its present form and consequently, financial plans would not withstand the downside sensitivity analysis undertaken as part of the FT assessment;
- There is a growing view that small DGHs are unlikely to have the financial strength to survive market downturns or meet the increasing demands on clinical governance and patient safety, and this is borne out by the pressures being faced by the trust;
- Work undertaken to establish a Health and Social Care Integrated Care Organisation had similarly been unable to demonstrate sufficient financial strength to satisfy Monitor's due diligence requirements.

At a meeting with NHS South on 1 October 2012, it was therefore agreed that a solution and strategic partner should be sought for Weston Area Health NHS Trust by testing the market and running a procurement. The NHS Trust Development Authority (NHS TDA) is therefore running an open and transparent procurement process for a competition that provides for either: (i) an acquisition by an NHS Trust or NHS Foundation Trust; or (ii) an operating franchise open to all sectors.

The vision of this project is to:

- Secure a strategic partner(s) to manage the future delivery of the services provided by Weston Area Health NHS Trust ;
- Deliver a model of services that is clinically and financially viable and which improves experience and outcomes for patients,
- Ensure that these services work in an integrated way with other providers in the local health and social care system, recognising the particular need of the large number of frail elderly and vulnerable patients in the area served by the Trust;
- Ensure that the Trust's specialist clinical services have appropriate links with providers outside North Somerset to support best practice professional standards and service delivery;

In addition to managing the transition, the Trust will also need to focus during the next 12 months on continuing to deliver high quality services. The operational strategy for the forthcoming year is therefore predicated on the following key areas of focus:

- Ensuring that people have a positive experience of care, being treated in a safe environment that protects them from harm
- Providing a flexible workforce with the capacity and capability to deliver high standards of patient care in line with changing service needs
- Providing efficient and effective services, affordable and desirable to patients and referrers.
- Providing affordable services and demonstrate value for money
- Securing a strategic partner(s) to manage the future delivery of clinically and financially sustainable and viable services which improve experience and outcomes for patients

Operational objectives and key result areas for the forthcoming year are detailed below

	Corporate Objectives			
Quality	Deliver dignified care that is responsive to patients' personal needs	Provide a safe environment for patients and reduce the incidence of avoidable harm	Implement a patient experience strategy to ensure that people have a positive experience of care	Deliver a clinically effective service through implementation and audit of evidence based practice
People	Provide a safe and effective workforce	Review and develop effective organisation change and development tools	Develop a Communication strategy to drive two way communication and increase staff engagement	Develop and deliver a Health & Wellbeing plan
Business	Meet and sustain local and national performance standards	Implement best practice in the delivery of services	Ensure efficient use of resources through service redesign across elective and emergency care	Ensure local access for patients to high quality core services
	Deliver the financial plan for revenue income and expenditure, capital expenditure and cash.	Deliver the savings programme for the year.	Develop the management of the cost base and key drivers and income related to activity and capacity at divisional level.	Improve financial management at operational level.

	Corporate Objectives			
(Business)	Deliver the Trust's responsibilities within the procurement programme as defined in the Project Initiation Document			

These Corporate Objectives are analysed in detail on the following pages:

Objective 1: Quality	
Priorities	*Deliver dignified care that is responsive to patients' personal needs* • Increase clinical nursing leadership through protected ward based time for all senior nursing staff • Develop and implement a programme of care and compassion awareness sessions • Refresh the nursing strategy to include the 6Cs of the national nursing strategy • Work in partnership with other groups and individuals to ensure that all transfers of care are appropriate and effectively communicated to all parties • Further review the implications of the Francis Inquiry and Government response, identifying changes and new ways of working for implementation in practice • Continue participation in the Royal College of Psychiatrists Elderly Care Charter Mark programme • Continue the programme of delivery to meet Dementia standards *Provide a safe environment for patients and reduce the incidence of avoidable harm* • Further reduce the levels of healthcare associated infection, meeting national targets for reduction of MRSA and Clostridium difficile • Reduce the levels of hospital acquired pressure ulcers • Improve timeliness of VTE risk assessment and prevent avoidable VTE • Reduce further the level of falls • Reduce the number of medication errors, focusing specifically on high risk medications and missed doses • Collaborate with partner organisations to delivery effective safeguarding services for children and adults • Continue participation in local, regional and national patient safety programmes *Implement a patient experience strategy to ensure that people have a positive experience of care* • Continue to support and strengthen the Patients Council • Fully implement the Friends and Family test and improve the number of people who would recommend the Trust *Deliver a clinically effective service through implementation and audit of evidence based practice* • Review and reissue standards of practice and monitor compliance through the ward assurance framework • Strengthen the nursing governance and assurance structures • Deliver the programme of CQUINs as agreed with Commissioners • Implement a programme of clinical audit

Objective 2: People	
Priorities	*Provide a safe and effective workforce* • Develop and deliver a leadership programme for all staff • Ensure that all employees complete relevant statutory and mandatory training as required in line with Trust policies and target of >90% compliance • Develop and deliver a programme of Overseas Nurse Recruitment to fulfil the workforce plans now and in the future • Reduce staff turnover amongst of all staff groups <12% • Progress current work undertaken to deliver an effective and efficient consultant revalidation system *Review and develop effective organisation change and development tools* • Develop and promote organisation changes practices that are open, transparent and inclusive • Work with Divisional Teams to develop service improvement programmes underpinned by timely organisation change *Develop a Communication strategy to drive two way communication and increase staff engagement* • Develop a communications strategy and implementation plan • Develop a more effective internal communication process that ensures that key messages are communicated in a timely manner to all staff. • Improve the internal staff intranet as one credible source of information about the Trust *Develop and deliver a Health & Wellbeing plan* • Develop a Health & Wellbeing Strategy and implementation plan • Reduce Trust sickness absence to <3%
Objective 3: Business	
Operations	
Priorities	*Meet and sustain local and national performance standards* • We will deliver key performance standards in respect of the 4 hour standard in the emergency department; cancer treatment standards; 18 week access to treatment for elective care and diagnostic tests to be completed within 6 weeks. *Ensure efficient use of resources through service redesign across elective and emergency care* • We will improve the utilisation of our resources through a programme of transformation across theatres, making the best use of our assets – both staff and infrastructure; • Drive improvements in length of stay through work both internally and with our partners to effect timely discharge planning and reduce length of stay • deliver more efficient and effective services through improvements in procurement, better monitoring of contracts, particularly provider to provider, and eliminating unnecessary expenditure *Implement best practice in the delivery of services*. • We will deliver services in the most appropriate setting by expanding and developing our outpatient facilities;

	• We will use technology to bring about innovation in clinical practice & to streamline the way we work. *Ensure local access for patients to high quality core services* • Work with commissioners and other parts of the health and social care system to transform service delivery for patients, to improve the reputation of the Trust with the public and commissioners and to ensure the sustainability of services during the transition period; • We will work with commercial partners to develop new services to enhance the range available to the population locally.
Financial strategy	
Priorities	There are four key priorities: • Deliver the agreed financial plans at all levels within the Trust • Ensure that the appropriate income is received for all activity and services • Improve affordability of services • Demonstrate value for money of services.
Estates strategy	
Priorities	Four key priorities have been identified: • Right sizing the estate to current and anticipated needs and improving functionality wherever possible to include issues of utilisation and fitness for purpose • The active replacement/refurbishment of existing infrastructure where required to offset the impact of economic obsolescence • Meet obligations under the Disabilities Discriminations Act, mandatory fire safety requirements, statutory safety legislation, and other relevant legislation • Improve engineering infrastructure and resilience
IM&T	
Priorities	• IT and mobile working to be better integrated into the organisation's working • Pursue systems which improve accessibility and integration of key patient and service user-focussed systems with and to other users • Refresh the strategic, tactical and operational plan for systems and applications development and investment • Proceed with procurement of replacement systems for patient admin and A&E • Complete existing projects including the data network, consolidation of servers, and increasing resilience and storage. Develop and test disaster recovery plans
Procurement Project	
Priorities	The procurement project is not managed as part of the day to day operations of the Trust. It is subject to a separate project infrastructure and governance arrangements which are detailed in the Project Initiation document (PID). The PID: • Sets out the project vision, outline service specification, key milestones and business objectives; • Identifies the project scope, required outcomes and critical success factors; • Defines the project management structure and governance arrangements including reporting processes, decision making authority, project quality assurance, controls and approvals processes;

	• Defines the roles and responsibilities of the people delivering the project; • Outlines an engagement and communications plan which identifies the methods of engagement with key stakeholders, including articulation of the 'service user voice' and Commissioners; • Outlines a high level project budget which sets out the anticipated financial resources required; • Identifies the key risks and mitigation strategies to ensure that there can be a high degree of transparency and confidence in the deliverability of the project whilst also ensuring that the project does not distract from the overall aim of ensuring safe, high quality services to patients during the transition.

2.2.1. Improving Financial Standing

The Trust's financial plan for 2012/13 was to achieve its planned year end surplus position of £2,250,000

The Trust has reported a retained surplus of £1,312,000 in 2012/13. The retained surplus is after an impairment charge of £833,000 and the elimination of the donated assets reserve of £105,000. As per the Department of Health guidance on break even duty for NHS Trusts the costs relating to impairments are excluded when measuring a Trusts breakeven performance see Note 43.1 of the Annual Accounts. Therefore taking this into account the Trust has achieved its planned surplus of £2,250,000 for year. To get to this position savings of £4,724,000 were achieved during the year. The Trust has met its planned surpluses over the previous three years, after taking into account the Department of Health guidance on break-even duty for NHS Trusts, £3,610,000 (2011-12), £2,607,000 (2010/11), and £2,448,000 (2009/10), which has enabled the Trust to repay the loan in full in line with the agreed 5 year recovery plan. The hard work and dedication of Trust staff throughout the organisation in achieving this is recognised.

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

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage of dividends paid on public dividend capital, totalling £1,840,000 when compared to the average relevant net assets of £52,567,000.

The EFL is a measure of the Trust's change in its borrowings and cash balances during the year. The limit set for 2012/13 was £ (1,150,000), which meant the Trust needed to increase its cash/decrease borrowings by at least this amount. This target was met.

The CRL is a control that measures capital expenditure against a limit set annually by the Department of Health and which the Trust is not allowed to exceed. The limit for 2012/13 was £5,650,000 and the charge made against it was £1,895,000 below, and within accepted tolerance.

The Trust continued to strengthen its key controls in order to achieve these targets in 2012/13 including, improvement in monitoring and reporting of activity and additional measures in year to control costs with delivery of a significant in year savings programme.

2.2.2. Meeting National Performance Objectives

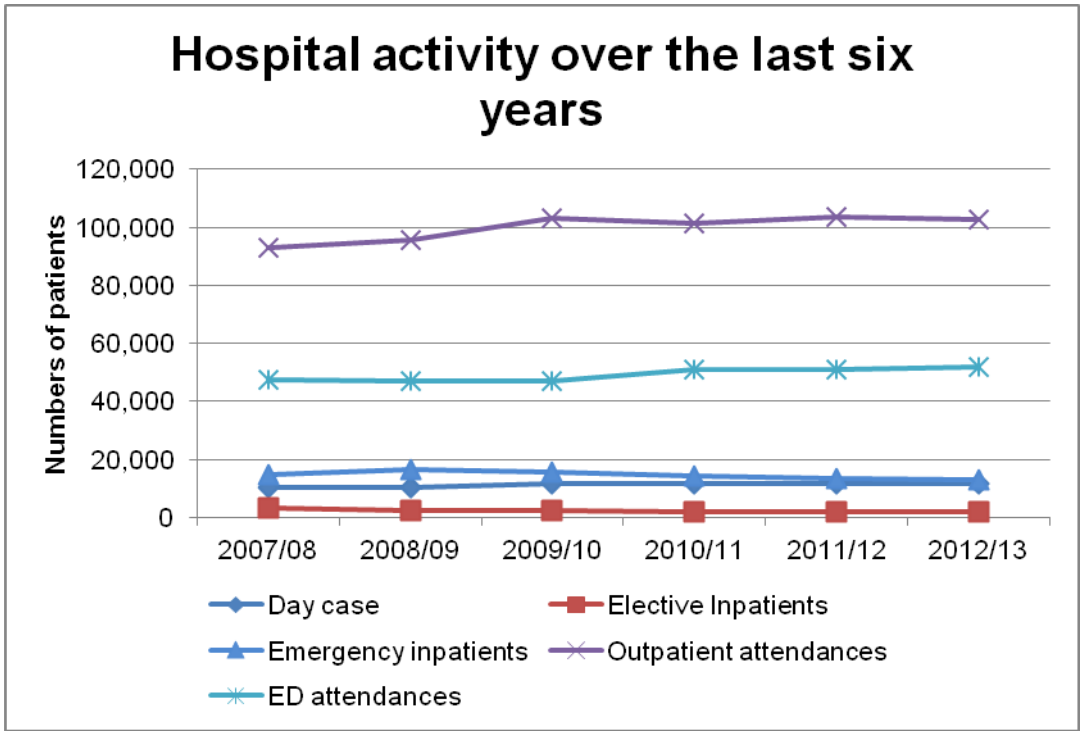
Our Performance

This section sets out the Trust performance for the financial year ending 31st March 2013. The first part describes patient admissions by type of patient, and then the next part shows the Trust's performance against some specific nationally-set targets. All of these targets are reported to the Trust Board in public meeting every month, in the Trust's "Integrated Performance Report".

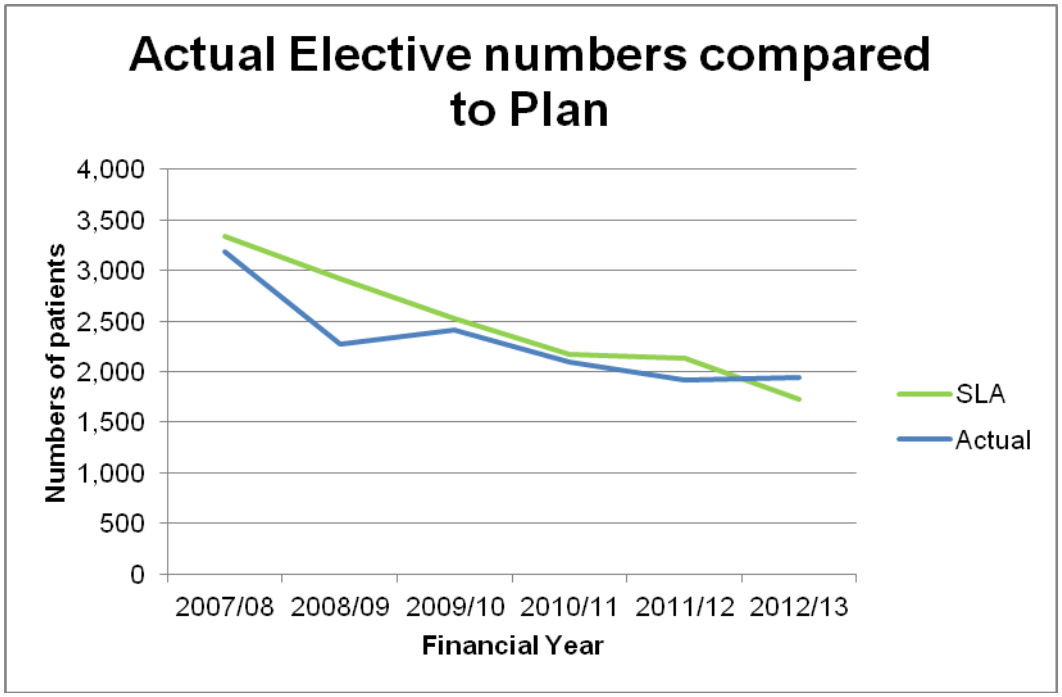
Patient Admissions

	2012/13	*Change from previous year*	2011/12	*Change from previous year*
Day cases	12,416	+4.5%	11,879	+ 2.5%
Elective inpatients	1,727	-9.8%	1,914	- 8.8%
Emergency inpatients	13,966	+3.4%	13,513	- 5.2%
Total admissions	28,109	+2.9%	27,306	- 2.3%
Average length of stay (days)	3.1	-	3.1	-
Emergency Department attendances	51,772	+1.4%	51,062	+ 0.2%
Outpatient attendances	103,057	-0.6%	103,634	+ 2.2%

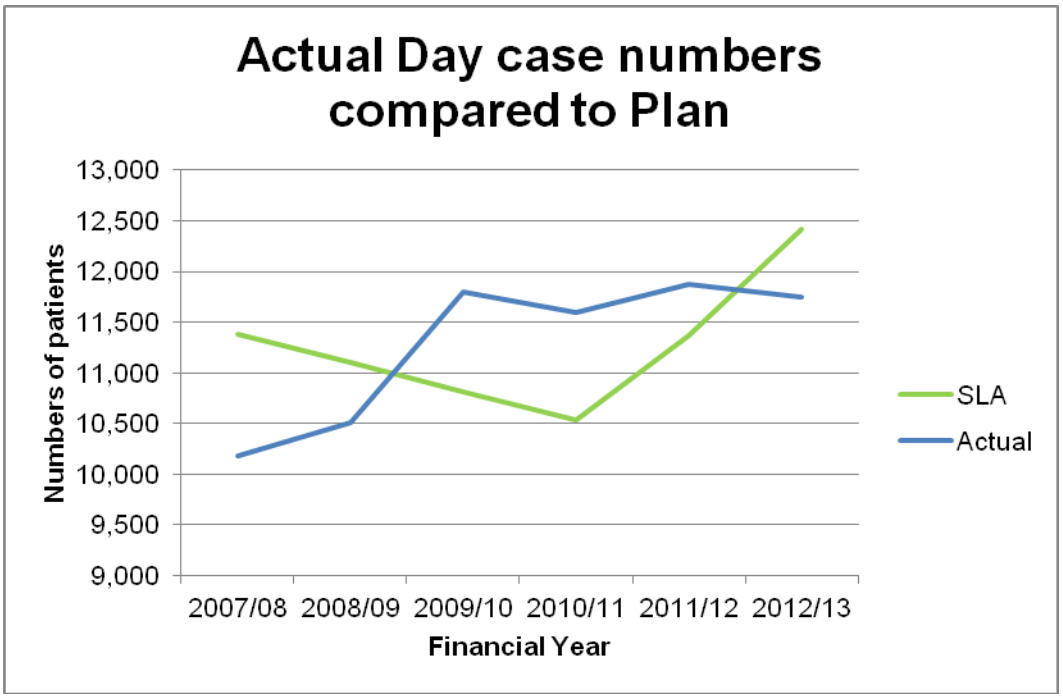
'Elective' inpatients are patients who come into hospital for booked operations, procedures and treatment. 'Emergency' patients are admitted without appointment and generally need priority treatment. The population the hospital cares for has a higher than average proportion of people who are elderly and frail, which means patients often have to be treated for more than one condition and cannot be discharged until there is suitable care available for them at home or in the community. For a small acute hospital Weston has an unusually high proportion of emergency inpatient admissions to beds available, and that means the hospital has less spare bed-capacity to respond quickly when more people come to the Emergency Department and then have to be admitted as patients. Weston's average length of stay during 2012/13 was 3.1 days while the peer-group average was 2.6 days; Weston's Urgent Care patients stayed an average of 5.7 days while the average peer-group stay was 4.8 days. The overall effect is that Weston is "more full" for longer than a typical small acute hospital with the same number of patients would be.



The graph here shows all the hospital activity between 2007/08 and 2012/13; graphs on the following pages describe the performance against plan for those six years. ("Plan" is the level of activity each year expected by the Hospital in agreement with the Strategic Health Authority.)

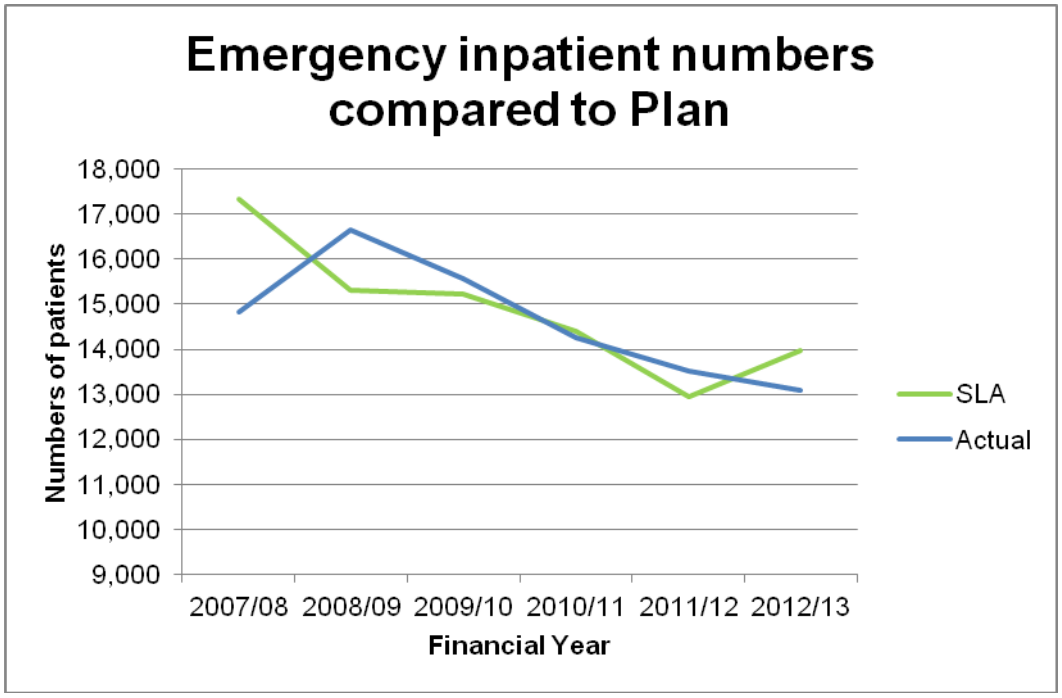


The Trust has experienced a reduction in the number of electives undertaken in line with plan. This is as a result of factors including the increase in procedures undertaken as day cases and outpatient procedures, and the repatriation of specialist work to the specialist hospitals.



The number of day cases undertaken by the Trust has increased by 15.4% over the past six years. This is due in some part to advancements in medicine - many procedures that used to mean patients needed to stay in hospital at least one night can now be done with patients going home the same day ("day cases").

The increase is also due to an increase in demand as a result of the ageing population in the Weston Area Health NHS Trust catchment area with 20% of the population being over 65 compared to the national average of 16%.



The number of emergency inpatients has continued to reduce in line with plan as demonstrated in the graph above. Improvements in partnership working with community teams and social services and the introduction

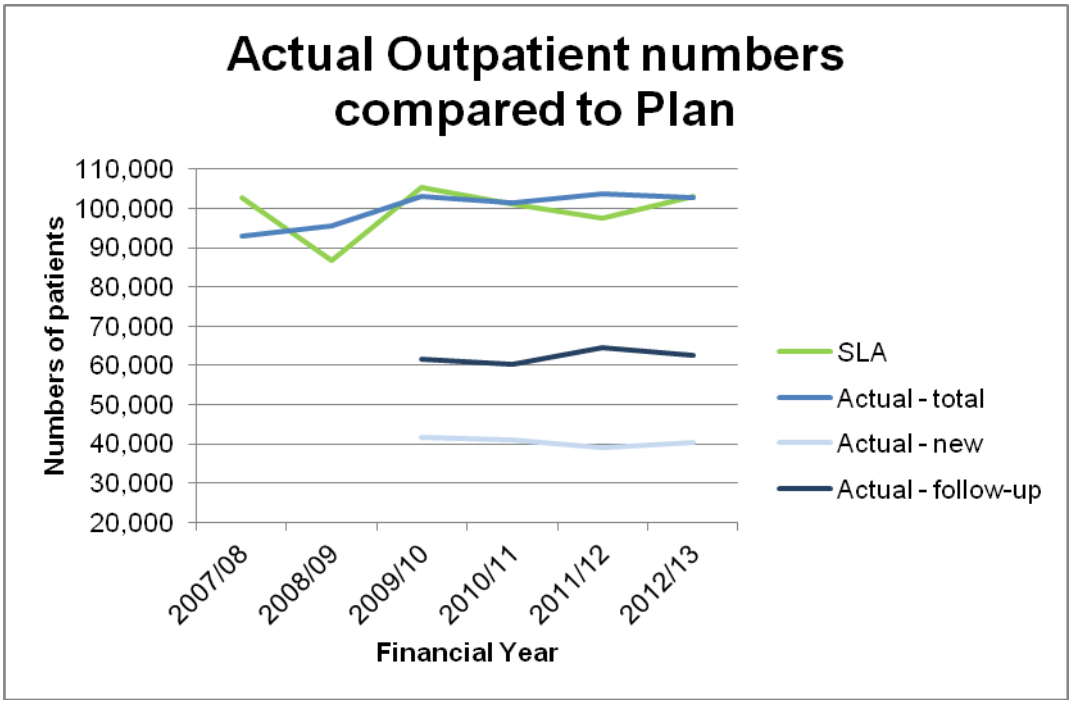
of the Ambulatory Care Centre have ensured where possible patients are treated and cared for closer to home without the need for hospital admission.

Outpatient Clinics

There is a wide range of specialist clinics at Weston, 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.

The total number of patients seen in Outpatients Clinics (includes first and follow up appointments) is shown in the table below.

	2012/13	2011/12	2010/11	2009/10
New Patients	40,344	39,068	40,950	41,703
Follow-up Appointments	62,713	64,566	60,405	61,479
Total Appointments	103,057	103,634	101,355	103,182



The graph above shows that overall the number of outpatient appointments has been around 103,000 for three of the last four years. This has been driven by the rise in the proportion of follow-up outpatient appointments to new appointments, which, although it has dipped slightly for 2012/13, is still running much higher than earlier years.

18 Weeks Referral to Treatment Access Target

The Trust performed well against this national target, which sets a maximum wait of 18 weeks from initial point of referral to the start of any treatment necessary. This demonstrates that the Trust delivers efficient and effective pathways of care to our patients.

	National target	2012/13	2011/12	2010/11
18 Weeks Non-Admitted Pathway	≥ 95.0%	95.9%	96.6%	98.6%
18 Weeks Admitted Pathway	≥ 90.0%	93.6%	92.3%	91.6%

Cancelled Operations

The Trust recognises that having to cancel operations is very distressing for our patients and their families at a time that is already very worrying and stressful. Unfortunately, while the Trust met the national target to cancel no more than 0.8% of operations for the summer months, winter pressures of emergency admissions meant that the Trust was forced to miss the target from September 2012 through to February 2013. However, at least 95% of cancelled patients had their operations rebooked within 28 days.

	National target	2012/13	2011/12	2010/11
% Operations Cancelled	≤ 0.8%	1.1%	0.6%	0.05%
% Cancelled operations rebooked within 28 days.	≥95.0%	100.0%	100.0%	n/a

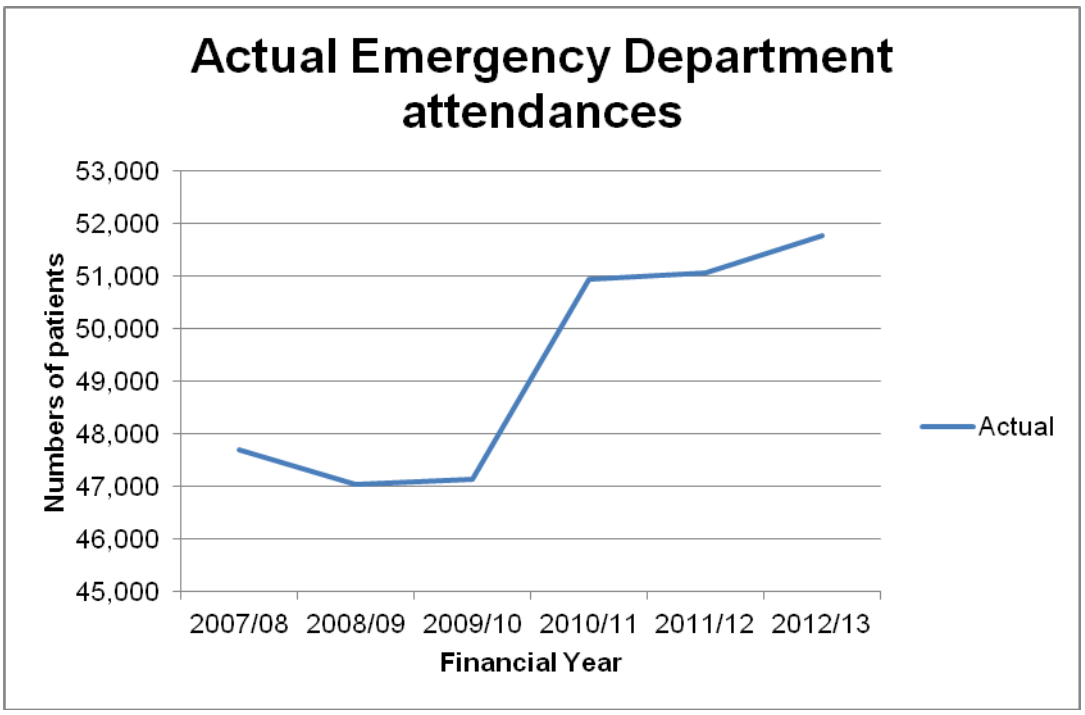
Cancer Patients

The 2009 Cancer Reform Strategy sets out 8 national cancer performance objectives for Trusts to deliver against. During 2012/13 the Trust met 4 of the national targets in full, and full-year performance for all 8 objectives was above the target, but the Trust dipped below the monthly target for 4 objectives – objectives 2 and 5 for 2 months, objective 6 for 1 month and objective 8 for 3 months. The following table sets out the 8 key targets and the Trust performance against each target.

	National target	2012/13	2011/12	2010/11
1. Breast symptoms referred to a specialist who are seen within 2 weeks of referral	≥93%	96.6%	97.2%	90.9%
2. 31 days for second or subsequent cancer treatment - surgery	≥94%	98.6%	100.0%	98.4%
3. 31 days for second or subsequent cancer treatment - drug treatment	≥98%	100.0%	100.0%	98.4%
4. National screening programmes who wait less than 62 days from referral to treatment (RTT)	≥90%	98.1%	95.8%	89.5%
5. Cancer reform strategy 62 day upgrade standard	≥90%	93.4%	94.2%	94.4%
6. 2 Week Wait (urgent GP referral to 1st outpatient appointment, all urgent suspected cancer referrals)	≥93%	96.0%	96.5%	94.6%
7. NHS cancer plan 31 day standard	≥96%	100.0%	99.8%	99.8%
8. NHS cancer plan 62 day standard	≥85%	88.3%	92.3%	93.9%

4 Hour Emergency Access Target

The Emergency Department is the department where many patients come initially for care. The graph below demonstrates the large rise in attendances over the past two years. As well as an increase in attendances the Trust has also experienced an increase in acuity of patients, increasing the challenge to the department.



The Trust is required to meet the target of 95% of patients spending four hours or less from arrival to admission, transfer or discharge. The Trust did not achieve this target with a final year-end position of 92.6% (93.3% at the end of 2011/12). Many Trusts in England and Wales have struggled to meet this target mainly because of the numbers of patients calling into Accident and Emergency.

Stroke

All Trusts have been set a target to ensure 80% of stroke patients spend 90% of their stay in a specialised stroke unit. In 2011/12 the Trust achieved 75.4% of stroke patients spending 90% of their stay in a stroke unit, and for 2012/13 the figure was 81.19% (although the Trust dipped below 80% in 4 months of the year).

Fractured Neck of Femur

Patients who suffer a Fractured Neck of Femur have a high mortality and morbidity (disease) rate with up to 20% needing long-term care post-fracture and a further 30% not returning to their pre-fracture health. Hip fracture accounts for 87% of total fragility fractures. (Fragility fractures are fractures that would not normally occur in a healthy young adult.) Nationally the Government has set a target for 90% of patients being operated on within 2 days. The Trust is currently meeting the target with performance of 100.0%, an improvement on the 2011/12 performance of 92.4%.

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 healthcare either in hospital or in community residential settings..

The two most commonly quoted risk factors for this infection are age (over 65 years) and receiving antibiotic treatment. Weston therefore has a large "risk group" since a high proportion of patients admitted to this hospital are over 65 years in age and up to a third of them are receiving antibiotic treatment at any one time.

	2012/13	2011/12	2010/11
Target – no more than:	12	16	32
Performance – cases recorded:	19	20	11

In response to this performance, the Trust has introduced revised guidelines which promote best practice for the prescription of antibiotics for medical patients.

Early in summer 2013 the Trust will be introducing a new drug prescription chart which has a new and separate section for antibiotics; this will help guide and inform the prescribing clinicians, dispensing pharmacists and nurses. From April 2013 any cases that develop in the hospital will be reviewed in greater detail using a new root cause analysis tool which will highlight in a clearer way any issues that may need to be addressed and communicated as necessary.

MRSA Blood Infections

In both 2012/13 and 2011/12 the Trust was able to continue to demonstrate excellence in care in having no MRSA blood infections known as MRSA bacteraemias. This means that the Trust achieved the target set. The Trust has worked hard to reduce our infection rates and aims to continue to achieve this level of performance in the future.

Venous Thrombo Embolism

Blood clots, or venous thromboembolism (VTEs) are a major cause of death amongst hospital patients. The Trust is committed to doing everything it can to prevent blood clots forming and now undertakes to screen patients who might be at risk of this complication, for example those about to undergo surgery, so that appropriate preventative measures can be taken. In addition to the screening work the Trust also has a comprehensive set of guidelines which describe the best preventative measures to be prescribed for any given level of risk.

	National target	2012/13	2011/12	2010/11
% at-risk patients VTE assessed	≥ 90.0%	96.1%	95.0%	92.0%

2.3 Improving Service Quality and Patient Satisfaction

Weston Area Health NHS Trust is required to register with the Care Quality Commission (CQC) and the Trust's registration status in 2011/12/13 has been 'registered without conditions or restrictions'. The CQC did not take any enforcement action against the Trust in 2012/13 or in 2011/12.

During 2012/13 Ofsted and CQC held a joint children's review. The CQC made a themed inspection (Dignity and Nutrition - DANI 2) in August 2012 and ran a follow-up unannounced inspection in October 2012. They found many examples of good practice and also identified some improvements that needed to be made:

Ofsted/CQC Joint children's review – 9-20 July 2012	Compliant	Not compliant
Inspection of safeguarding and looked after children services – North Somerset – overall finding covering all partner services	Adequate (grade 3)	

The joint Ofsted and CQC review included interviews and focus groups with front line professionals, managers and senior staff from NHS North Somerset, Weston Area Health NHS Trust, North Somerset Community Health Partnership and Avon and Wiltshire Partnership NHS Trust. The overall finding was made up of several 'outcomes' with "Being healthy" reported as Grade 2 (good) and identified the need for better working links between NHS North Somerset, Weston Area Health NHS Trust and North Somerset Community Partnership.

CQC Themed DANI 2 inspection – 20 August 2012	Compliant	Not compliant
Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run		No, with minor impact
Outcome 05: Food and drink should meet people's individual dietary needs	Yes	
Outcome 07: People should be protected from abuse and staff should respect their human rights	Yes	
Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs	Yes	
Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential		No, with minor impact

In response to the visit in August the Trust put in place actions to make improvements after the visit, and when the report was published in January 2013 the Trust reviewed the Action Plan to ensure that improvements had been made.

Follow-up unannounced inspection 24 October 2012	Compliant	Not compliant
Outcome 06 Cooperating with other providers People should get safe and coordinated care when they move between different services	Yes	

Patient Experience Feedback

The Trust places great value on patient feedback and Patient and Public Engagement. The Trust has demonstrated its commitment to improving the experience of patients by setting up a Service User Council (the Patients' Council) which has a remit to challenge and hold the Trust to account on delivering and improving an excellent patient experience. The Chair of the Council has been appointed for three years and attends Trust Board meetings. The Council meets monthly to progress its work plan and the minutes of its meetings will be published on the Trust's website, along with the Council's Terms of Reference.

Patient surveys are of fundamental value to the Trust to inform service developments, so the Trust has participated in two national surveys during the year (the 2011 National Cancer Patient Experience survey, published in August 2012, and the Care Quality Commission Accident and Emergency Department survey published in December 2012). The Trust continues to undertake local surveys on a monthly basis.

National Outpatient Survey

The National Outpatient Survey is conducted every other year. Last year's Annual Report contained the results of the 2011 Survey, and the next survey is expected to take place in June to October 2013.

National Inpatient Survey

The National Inpatient Survey is an annual survey and this year was commissioned by 69 Trusts. The survey was independently run by the Picker Institute Europe.

The study sample for Weston was drawn from 850 patients over the age of 16 years and who had been treated as inpatients during June and July 2012. As with the outpatient survey, the results allow the Trust to consider:

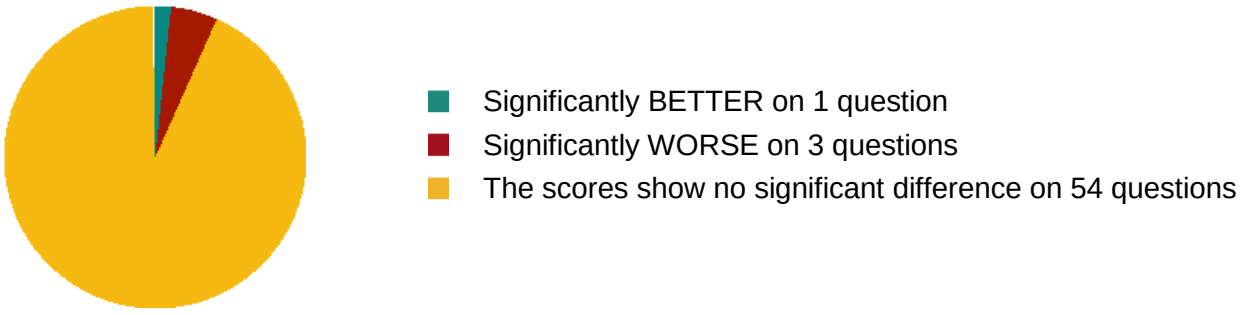
- How do we compare with other Trusts – what can we learn from them?
- Are there areas where our patients report the most problems?

The survey results are a little unusual in that lower scores are better, because the survey is intended to highlight areas where Trusts could improve. The survey results were not published until February 2013, and many actions the Trust was taking during 2012/13 to improve the patient experience will not show in the survey until early 2014.

Have we improved since the 2011 Survey?

A total of 58 questions were used in both the 2011 and the 2012 surveys and the results are shown on the next page.

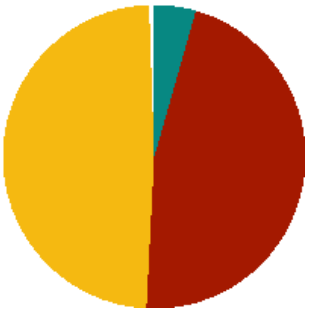
Compared to the 2011 survey Weston Area Health NHS Trust was:



How do we compare to other Trusts?

Looking at the 86 questions asked in total this year (58 asked in both years plus 28 new for 2012), the survey showed that Weston Area Health NHS Trust is:

- Significantly BETTER than average on 4 questions
- Significantly WORSE than average on 40 questions
- The scores were average on 42 questions



The Trust improved significantly in the following areas:

- ✓ Planned admissions were not offered enough choice of hospitals – down to 46% of questionnaire respondents in 2012 from 60% in 2011 (and something which had worsened significantly between 2010 and 2011).

The Trust worsened significantly in the following areas:

- ❖ Hospital: shared sleeping area with the opposite sex – up to 9% in 2012 from 3% in 2011. Although there were no actual recorded breaches in the Trust for this period.
- ❖ Hospital: hand-wash gels not available or empty – up to 7% in 2012 from 2% in 2011
- ❖ Discharge: did not feel involved in decisions about discharge from hospital – up to 56% in 2012 compared with 47% in 2011.

The Trust is significantly better than the 'Picker average' in the following areas:

- ❖ Planned admission: not offered a choice of hospitals
- ❖ Planned admission: not given printed information about condition or treatment
- ❖ Hospital: patients in more than one ward, sharing sleeping area with opposite sex
- ❖ Hospital: patients using bath or shower area who shared it with opposite sex

The Trust is significantly worse than the 'Picker average' in the following areas:

- ❖ Admission: had to wait long time to get to bed on ward
- ❖ Care: did not always get help in getting to the bathroom when needed
- ❖ Hospital: information about ward routines, noise at night, space for personal belongings and all staff introducing themselves
- ❖ Doctors and nurses: communication, confidence and opportunities to talk
- ❖ Care: information given, being involved in treatment
- ❖ Surgery: information and time to discuss with consultants
- ❖ Discharge: communication and information.

The outcomes of this survey have been shared widely with staff in the Trust and were discussed by the Trust Board at their meeting in March immediately after the results had been published. The Trust has begun some internal surveys to see if the results of the Picker Survey are still valid nearly a year after patients had been questioned and has continued work in key improvement areas e.g. discharge planning.

Local Surveys

The Trust currently conducts real time inpatient surveys every month with volunteers surveying up to 100

inpatients against an agreed set of standardised questions. The data from these surveys is reported to the Trust Board each month in the Integrated Performance Report.

Currently 15 questions are asked which are based around the Care Quality Commission outcomes framework. The key question is perhaps the first asked, which shows that 92% of patients who responded said it was “extremely likely” or “likely” that they would recommend their ward to friends and family if they needed similar care or treatment. (3% answered “don’t know”.) Throughout 2012/13 almost 100% of patients surveyed consistently reported feeling being treated with respect, feeling safe, and having been given enough privacy.

Survey question – respondents reported:	% 2012/13 answering Yes	% 2011/12 answering Yes
Feeling they had been treated with respect	99%	96%
Feeling safe in our care	98%	97%
Having been given enough privacy when discussing their condition or treatment	97%	91%
Having had enough to eat	96%	91%
Not having to sleep in an area shared by a member of the opposite sex	99%	n/a
Not having to use toilets or bathrooms shared by a member of the opposite sex	99%	n/a
Aware that Doctors and Nurses were washing their hands	87%	80%
Medicines had been explained to them	85%	84%
Pain was controlled	87%	80% - 10% said they did not experience pain
Disturbed by noise at night (lower score is better)	31%	62%
Rated their overall experience as 5*	39%	42%
It was clear what will happen next in treatment	41%	40%
It was very clear what will happen next in treatment	26%	35%
It was NOT clear what will happen next in treatment	24%	18%
Knew who to talk to if they had worries or fears	53%	60%
Involved in decisions about their care and treatment	49%	60%

The value of patient and service user feedback is critical to enabling the Trust to learn and to inform future developments, particularly where scores have slipped back from previous years. The information generated from the surveys described above along with information from ‘Feedback’ forms which are voluntarily completed by those people who use our services is reviewed and analysed monthly along with the number and types of complaints and compliments received.

Friends and Family test

An NHS 'friends and family' test to improve patient care and identify the best performing hospitals in England is being introduced from April 2013. Patients will be asked a simple question: whether they would recommend hospital wards, accident and emergency units to a friend or relative based on their treatment.

Publishing the answers will allow the public to compare healthcare services and clearly identify the best performers in the eyes of patients - and drive others to take steps to raise their standards. The test will be developed with local hospitals and GPs, including any exclusions to the test, like patients in intensive care, while ensuring that the vast majority of wards are covered. The Trust has implemented a successful pilot across all areas of the Hospital and is ready to meet the national reporting requirements in 2013/14.

Complying with Principles for Remedy

HM Treasury's 'Managing Public Money' contains guidance at Annex 4.14 about the steps public bodies should take where they have caused injustice or hardship by maladministration or service failure. The Parliamentary and Health Service Ombudsman published 'Principles for Remedy' in October 2007, setting out six principles that represent best practice and are directly applicable to the NHS procedures.

Staff

The Trust has a well established Patient Advice and Liaison Service (PALS) and a complaints-management system, supported and facilitated by a Senior Manager who reports directly to an Executive Director. Both services are used to ensure that patients and people using Trust Services and those likely to use 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.

Complaints Training

The Senior Manager for the 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 will remain high on the training agenda for the Trust.

Analyses of Complaints

The Trust received a total of 262 formal complaints which represents a 6.5% increase on the last year's total of 246 for 2011/2012. However there was a decreasing trend for the last seven months of the year.

Trends

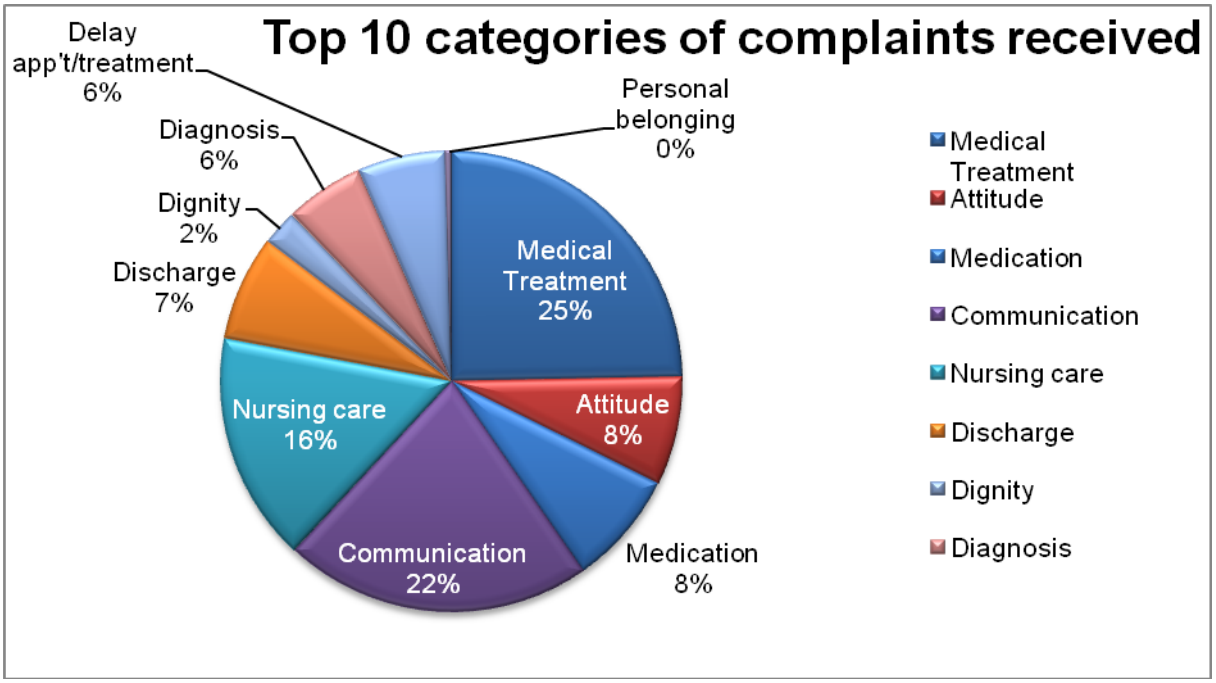
The Trust looks for trends in complaints to see if there are any recurring or growing issues that may need special attention. The proportion of complaints linked to staff attitude has been significantly reduced, and the main subjects of complaint are now around aspects of hospital treatment and care (medical treatment and nursing care), and about communication, both showing an increase on the previous year. 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 on the next page shows the main types of complaints received during 2012/13 and the changes from last year.

Main types of complaints received during 2012/13:

		2012/13	2011/12
Complaints about staff attitude - %		8%	14%
Complaints about medical treatment - %		25%	20%
Complaints about nursing care - %		16%	14%
Complaints about communication - %		22%	18%

The chart below shows all the categories of complaints received during 2012/13.



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 2012/13 13 complainants took their complaint about the Trust to the Ombudsman. The Ombudsman confirmed that 10 would not be investigated, decided that one complaint was “partly upheld”, and is still considering a decision on two cases.

The annual NHS Complaint Handling report was published in October 2012 by the Parliamentary and Health Service Ombudsman. The Trust continues to cooperate with the Ombudsman when required.

Learning by Experience

Learning by experience is important to the Trust. Complaints and compliments help to show what goes well and what needs to be improved, Clinical staff, medical staff and senior managers discuss incidents at regular Divisional Business meetings and a range of specialist committees (for example, the Drugs and

Therapeutic Committee). The Trust has a Quality and Governance Committee where Directors and staff look at all aspects of operational quality and care and report to the Trust Board. The Trust also reports to several outside agencies such as the Care Quality Commission and the Strategic Health Authority.

2.4 Annual Quality Account

All providers of NHS services are required to produce an annual Quality Account as set out in the National Health Service (Quality Account) Regulations 2010. This requirement took effect in April 2010. This is therefore the third year that we have published a mandatory Quality Account.

Quality Accounts are annual 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 a commitment to continuous, evidence-based quality improvement.

The Quality Accounts describe our quality priorities across three 'domains' or areas:

Patient Safety – having the right systems in place to effectively report, analyse and prevent errors, ensuring that our patients receive the safest possible care.

Clinical Effectiveness – providing treatment and care for our patients that produces the best possible outcomes with the most effective use of financial resources.

Patient Experience – meeting our patients' emotional as well as physical needs. This includes being treated with dignity and respect in a comfortable and safe environment, and being given the appropriate information about their care.

The areas we have chosen are priorities for the Trust and areas where we know our performance should be improved. In part 2.2 of the Quality Accounts 2012/13 we have set out our progress against priorities for 2012/13, and in parts 2.3 and 2.4 we explained how we intend to improve our quality for 2013/14.

Throughout the year we will report on our progress to the Trust Board, to our Service User Council and to our Commissioners.

Ensuring Performance Against Our Priorities

Managing effectively to ensure we have and can demonstrate we are achieving our priorities is important for both staff and service users. The Trust has recently 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 and will be shared with our service users through the revised Patient and Public engagement structure we describe above.

Performance against priorities is also subject to scrutiny and review by our commissioners, and the Strategic Health Authority as well as the Care Quality Commission who regulate our service and conduct unannounced inspections, the outcome of which are reported on their web site.

2.5 The Resources, Principal Risks and Uncertainties and Relationships That May Affect the Trust's Long-Term Value

The key risks to achievement of the Trusts objectives during the last year were identified as being:

- Failure to deliver key statutory financial duties
- Failure to deliver the required level of Quality, Innovation, Productivity and Prevention (QIPP) savings
- Inability to manage within budgets due to pressures such as medical locums, drugs, capacity

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

- Establishment of weekly divisional financial and performance management and monthly reviews
- Establishment of agreed budgets with regular monitoring including introduction of processes to ensure savings and re-pay of income to budgets accurately reflected in budgets
- Close contract monitoring and discussion with commissioners and early notification of over performance
- Introduction of an integrated performance management framework, allowing divisions to ensure equal focus on financial and non-financial risk management
- Monthly executive review of all risks, assurances and risk mitigation plans.

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 KPIs, audits (internal and external), assessments by regulatory and monitoring agencies (e.g. Care Quality Commission, CNST, Health and Safety).

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

During the last 12 months, the Trust has continued its active involvement, as required by the Civil Contingencies Act, with the Avon Health Emergency Resilience Group (AHERG) which contributes to and takes into account in terms of health emergency planning, risks identified on the Local Resilience Forum (multi-agency) Community risk register.

The Trust continues to work closely with the main commissioner of services, NHS North Somerset, to jointly plan and develop services. Increasingly during the last year, as a consequence of national organisational changes, the Trust has worked with leaders within the Bristol, North Somerset and South Gloucestershire (BNSSG) Cluster and within the North Somerset Clinical Commissioning Group.

The Trust will continue to work closely with other key partners during the next 12 months, notably the NHS Trust Development Authority, the North Somerset Clinical Commissioning Group, Somerset Clinical Commissioning Group, North Somerset Council, Weston College and the local Healthwatch. The Trust will

also continue to take an active part in sector-wide networks or their successors after the NHS restructuring of 1 April 2013, in particular:

- Forums for Chairs and Chief Executives
- Forums for Chief Executives
- Forums for Directors of Finance, Nursing & Human Resources
- BNSSG Healthy Futures Partnership Board
- Care pathway networks including the Avon Gloucester and Wiltshire Cancer Network, Urgent Care Network, North Somerset Children's Trust Board and the Local Safeguarding Children's Board
- Avon Health Emergency Resilience Group (AHERG) – sub-committee of, and accountable to, the Local Resilience Forum
- North Somerset Health Overview and Scrutiny Committee
- Healthwatch.

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

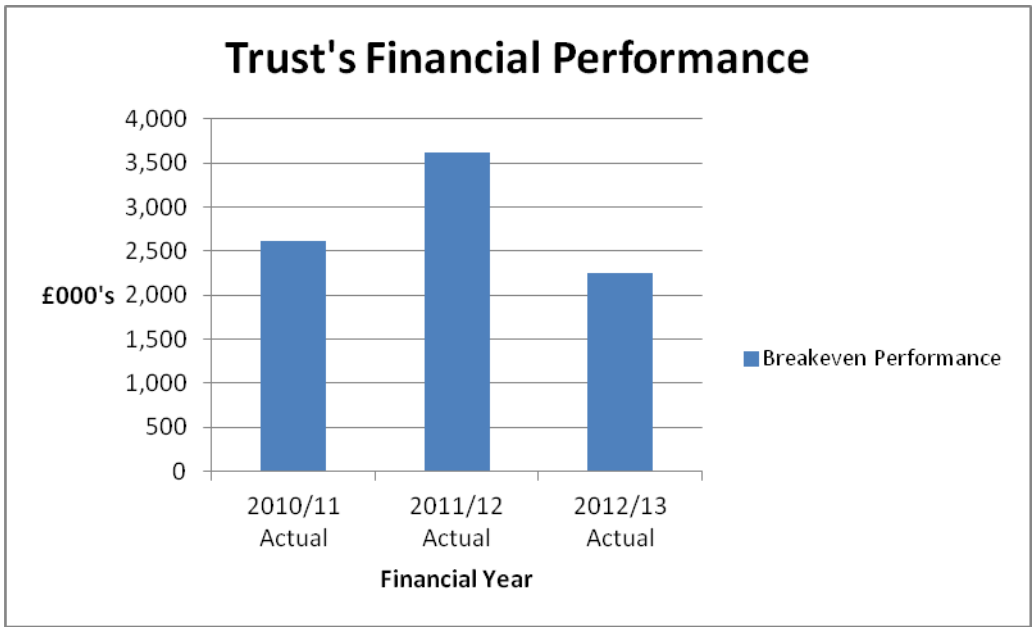
- Revised proposals for the provision of pathology services across the BNSSG network which will strengthen service availability, provision and resilience;
- Contribution to the North Somerset Partnership Health and Wellbeing Partnership sustainable Community Strategy shared priorities, with particular regard to increased integrated working with the local authority and primary care trust to improve hospital discharge timeliness, coordination of care closer to home and avoidance of inappropriate hospital admissions together with active involvement in the local alcohol and smoking cessation strategies;
- Work with the community learning disability team, local authority and user groups to improve services for adults with learning disabilities;
- Active involvement in the safeguarding adults and safeguarding children boards;
- Work with a range of multiagency and multidisciplinary groups to meet the standards detailed within the national dementia strategy;
- Active involvement in the regional south west equality delivery scheme to ensure ongoing improvements in assuring equality and diversity for staff and patients
- Strengthened links with the Avon and Wiltshire Mental Health Partnership Trust to ensure timely and appropriate assessment for patients attending the emergency department;
- Development of water-birth facilities at the birthing unit.

Outcomes from the work undertaken are clearly evident within the Trust, with, for example, improvements in reduced length of stay, positive feedback from a peer review of dementia care which highlighted areas of positive improvement and strengths in the Trust's services.

2.6 Financial Position of the Trust

2.6.1 Financial Position

The Trust has reported a retained surplus of £1,312,000 in 2012/13. The retained surplus is after an impairment charge of £833,000 and elimination of the donated assets reserve of £105,000. As per the Department of Health guidance on break-even duty for NHS Trusts, the costs relating to impairments are excluded when measuring a Trust's break-even performance (see Note 43.1 of the Annual Accounts). Therefore taking this into account the Trust has achieved its planned surplus of £2,250,000 for year. To get to this position savings of £4,724,000 were achieved during the year.



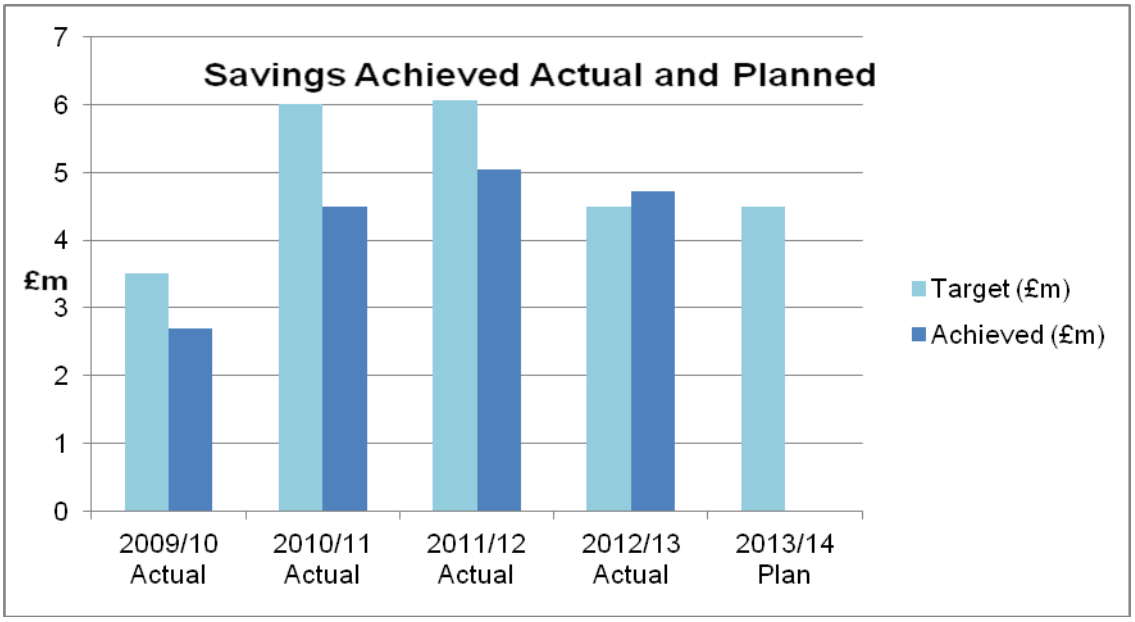
2.6.2 Financial Position 2013/14

The Trust is planning to deliver a deficit of £4,950,000 in 2013/14.

2.6.3 Financial Recovery

The Trust had an agreed recovery plan with the Strategic Health Authority and the Department of Health which resulted in the Trust receiving a working capital loan of £14,300,000 repayable over 7 years. Repayments have been generated from Income & Expenditure surpluses over the period by continued savings plans and ensuring that the Trust is paid for patient care it provides in line with the 'Payment by Results' system. The planned surplus of £2,250,000 for 2012/13 has been met therefore the Trust was able to repay the final element of the loan in line with the 5 year plan agreed with the Strategic Health Authority. The Trust therefore has no loan outstanding at 31st March 2013 and starts 1st April 2013 in effect debt free.

A budget for 2013/14 has been approved by the Trust Board and includes details of risks and clear assumptions. Further significant savings of £4,500,000 are planned to be delivered in 2013/14. These plans are established and will be closely monitored and reported through the Performance Assessment Framework meetings which focus on all aspects of performance and savings.



2.6.4 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 Manual For Accounts, 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.

2.7 Emergency Preparedness

The Civil Contingencies Act 2004 places a clear statutory duty on NHS Trusts as Category 1 responders to develop appropriate plans to manage Major Incidents and to cooperate with other Category 1 responders at all stages of the emergency planning process.

The Trust recognises that planning for a major incident or emergency is a duty under the Act, and therefore an integral part of good business practice for this organization. Fundamental to the success of our planning is interoperability of our procedures with those of the emergency services, neighbouring acute and community providers and local authorities. During the last year, the Trust has continued to work with other agencies, via the Avon Health Emergency Resilience Group (AHERG) which is accountable to the Avon and Somerset Local Resilience Forum (LRF). The LRF meets twice a year to decide on strategic emergency planning policy, to oversee the co-ordination of joint planning, multi agency major emergency training and liaison with other key organisations. The AHERG meets quarterly to discuss the tactical arrangements for ensuring implementation of agreed multi-agency strategy.

During 2012/13, the Trust has revised and ratified key documents in relation to its emergency preparedness responsibilities and responses:

Major Incident Planning

The Trust's Major Incident Plan was reviewed during 2012/13 in light of changes in guidance and lessons learned from incidents elsewhere in the country over recent years. We have updated our plan accordingly to better detail the process and arrangements in place to deliver the capability.

Chemical, Biological, Radiological, Nuclear and Explosive (CBRNe) Incident Training

The preparedness plan for Chemical Biological Radiological Nuclear and Explosive (CBRNe) has been fully revised during the year.

A new decontamination unit purchased through funding from the Strategic Health Authority was commissioned in May 2012. During the summer 2012 staff from the Emergency Department and Estates Department were trained in the use of the new unit. The new equipment will enable the Trust to provide a more robust response to incidents of this nature in the future.

Local Event Multi-Agency Contingency Planning

Standard Operating Procedures for the Trust in line with agreed Police and Ambulance procedures are documented for local events involving all third parties.

Communicable Diseases

The Trust ratified a new plan which sets out arrangements for establishing systems and processes to be implemented in the event of a communicable disease outbreak affecting our health community. This plan has been produced in consultation with local providers, the ambulance service, local authorities and voluntary sector.

Business Continuity

The Civil Contingencies Act 2004 (CCA) has legislated that all Category 1 responders have comprehensive Business Continuity Plans (BCPs) in place. The CCA also requires Category 1 responders to maintain plans to ensure that they can continue to exercise their functions in the event of an emergency so far as is reasonably practicable. As a category 1 responder, Weston Area Health NHS Trust therefore has a responsibility to have comprehensive Business Continuity Plans in place.

During 2012/13 the Trust Business Continuity Plan has been revised in line with the Business Continuity Institute standard (BCI 2007). This plan details the developed principles and processes to ensure that in the event of a service interruption essential services will be maintained and normal services will be restored as soon as possible, regardless of what might happen to our infrastructure and buildings.

2.8 The Trust and the Environment

2.8.1 Environmental Policy

The Trust recognises its environmental and social responsibilities. It also acknowledges the impact its activities may have on the environment. The Board-approved Sustainable Development Management Plan sets out Trust strategy for improving its performance in key areas, including:

- Energy procurement and use.
- Waste production and disposal.
- Transport and car parking.
- Purchasing and contract arrangements.

The Chief Operating Officer is the Executive Lead for sustainability and the operational lead is the Head of Estates and Facilities. The Executive and Operational Lead work with key leads in the Trust and have implemented key elements of the Good Corporate Citizen assessment model. The Operational Lead also monitors progress against the NHS Carbon Reduction Strategy.

2.8.2 Carbon Footprint

The Trust is committed to reducing its carbon footprint, but modern medicine is a high energy user and there is increasing clinical use of computers and electrical equipment. The Trust is committed to meet the challenges of the NHS Carbon Reduction Strategy while continuing to develop patient services.

The Trust has calculated its Carbon Footprint for Year ending 31st March 2013 below, which enables the Trust to monitor performance against a Department of Health recognised assessment tool and to compare with other similar organisations.

	2012-13 Tonnes CO2e	2011-12 Tonnes CO2e	Change +/- Tonnes CO2e
SCOPE ONE EMISSIONS **Fuel Combustion** Gas Boilers	**1,445.46**	**1,175.34**	**+ 270.12**
SCOPE TWO EMISSIONS **Purchased Energy Consumption** Electricity	**2,450.04**	**4,161.13**	**- 1,711.09**
SCOPE TWO EMISSIONS **Admin Travel** Private vehicles used for duty purposes Rail	**32.911** **0.041**	**29.37** **0.086**	**+ 3.541** **- 0.045**

	2012-13 Tonnes CO2e	2011-12 Tonnes CO2e	Change +/- Tonnes CO2e
Water usage: 0.34kg per M3	**13.16**	**16.36**	**- 3.20**
Non recycled waste Clinical Incinerated vol x (1613-347Kgs)	**47.661**	**53.557**	**- 5.896**
Clinical Alternative treatment Vol x (1613-347+199kgs)	**253.884**	**242.368**	**+ 11.516**
Household Landfill : 1,613+199=1,812kgs	**382.151**	**388.493**	**- 6.342**
Recycled Waste Paper/card: 955kgs – 157kgs = 798kgs per tonne	**51.29**	**60.45**	**- 9.16**
Mixed municipal : 1,613kgs – 1,679kgs= 374kgs	**8.30**	**15.18**	**- 6.88**
OPERATIONAL EMISSIONS Not measured REDUCTIONS	**Nil**	**Nil**	**-**
TOTAL EMISSIONS	**4,684.894**	**6,142.334**	**- 1,457.440**

2.8.3 Building Use

Energy use – In 2012/13 the Trust installed a gas-fired Combined Heat and Power Plant (CHP). This plant provides up to 30% of electrical demand significantly reducing the amount of power used from the national grid. However, gas usage has increased proportionally due to the CHP. The year 2012/13 was also colder than recent years and gas usage was higher as a result.

In addition to the CHP the Trust also installed further LED lighting throughout corridors and replaced a major air handling unit providing ventilation to X-ray. The Trust also carried out a major refurbishment of Air Handling Plant in the main hospital including heat recovery which will make them more energy efficient. Emissions were further reduced by the disposal of a number of modular buildings in year 2012-13.

Despite the cold weather in year 2012/13 the Trust reduced emissions by 1,457.44 tonnes CO2e compared to the previous year. As the CHP was only commissioned at the end of September 2012 it is projected to almost double that saving in 2013-14.

In the year ahead there will be further reductions in modular buildings and a further reduction in emissions as a result.

For the third year running the Trust reduced the volume of water used, helped in particular by the outsourcing of HSSU. The year included repair to the mains at the front of the hospital which will help to reduce waste in the future.

2.8.4 Staff Involvement

Staff involvement is critical to the success of Trust performance and there are many individual members of staff who have expressed a keen interest in supporting initiatives to combat climate change, save energy and to reduce waste in particular**.** During the year to 31st March 2013 Trust staff have continued to be involved in reducing the volume of waste and in particular removing waste from the expensive and emission intensive incineration stream.

2.8.5 Travel

With over 2,000 staff and volunteers, the Trust has a key role to play in influencing how people travel to work. During 2011 the Trust introduced a Staff Car Parking charge which has helped to focus minds on the environmental issues regarding travel arrangements to and from work. In the same year The Green Travel Group also secured funding from North Somerset Council for the installation of secure cycle storage and now provides lockable covered cycle storage for 40 bicycles, in 2011 we also launched a database for car sharing on the Trust intranet.

We have had the Sustainable Travel Roadshow in the hospital on several occasions in the last year, the latest time as part of a "Feelgood Friday" event for staff in March 2013, together with free on-site bike servicing from Dr Bike, which has been well received.

We have dedicated webpages for staff on the Trust intranet providing information on public transport, showering facilities in the hospital, discounts on public transport in partnership with the local bus service, cycle route planners etc.

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

The Green Travel Group continue 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.

This year we will be running a staff survey aimed at finding out what further initiatives we can offer to encourage green travel, and will work with North Somerset Council on this.

2.8.6 Purchasing

The Trust is part of the Bristol and Weston purchasing consortium which includes sustainability and whole life costing as part of all procurement.

2.8.7 Waste and Recycling

The Trust continues to recycle and re-use where possible. The Trust reduced landfill waste by 8% and clinical waste to incineration by 10%.

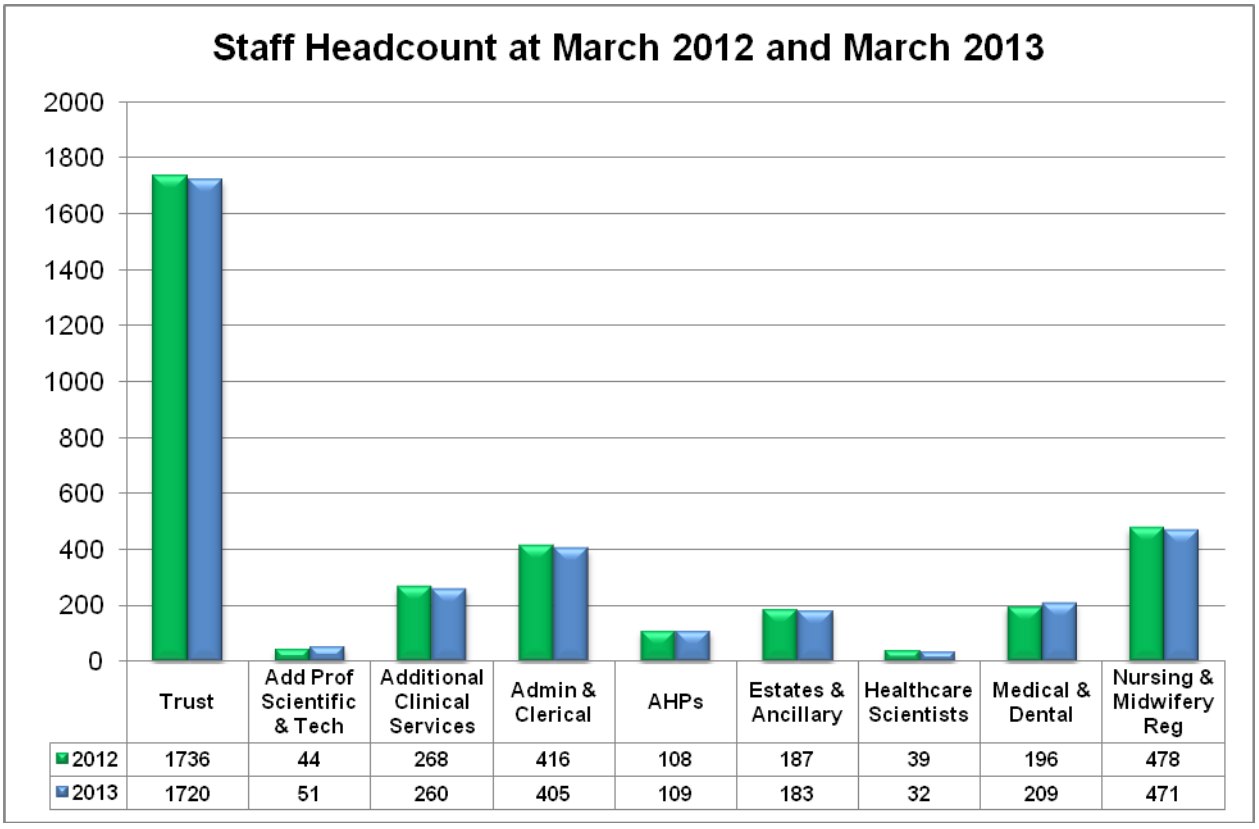
A new domestic waste contract starts in May 2013 including improved recycling, so plastics, paper and metal can all be disposed through a single container to make it easier for people to recycle. Pathology are

now trialing the Offensive Waste stream for waste which has already been autoclaved, this will reduce the amount going for alternative treatment. All of these initiatives will help to reduce costs and reduce emissions.

2.9 Working with Staff

Workforce Profile

The graph presented below demonstrates the workforce headcount by occupational group for the last two years, highlighting changes in the workforce configuration. The overall workforce profile has remained consistent in all areas with some small fluctuations.



	Trust	Add Prof Scientific & Tech	Additional Clinical Services	Admin & Clerical	AHPs	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Nursing & Midwifery Reg
2012	1736	44	268	416	108	187	39	196	478
2013	1720	51	260	405	109	183	32	209	471

2.9.1 Staff Engagement

Staff Engagement is a key issue for any organisation and the Trust seeks to positively engage and gain feedback from its employees through the well-established Staff Experience Group.

Following on from last year's 'Staff Conversations', this year the Trust has continued with staff engagement by members of the executive attending team meetings and ensuring key Trust messages are shared with staff. For the forthcoming year this approach of listening to staff will be built upon.

The Trust also meets on a monthly basis with the Joint Negotiating and Consultative Council (JNCC) which includes membership of all local Trades Unions at which all issues impacting on staff are discussed.

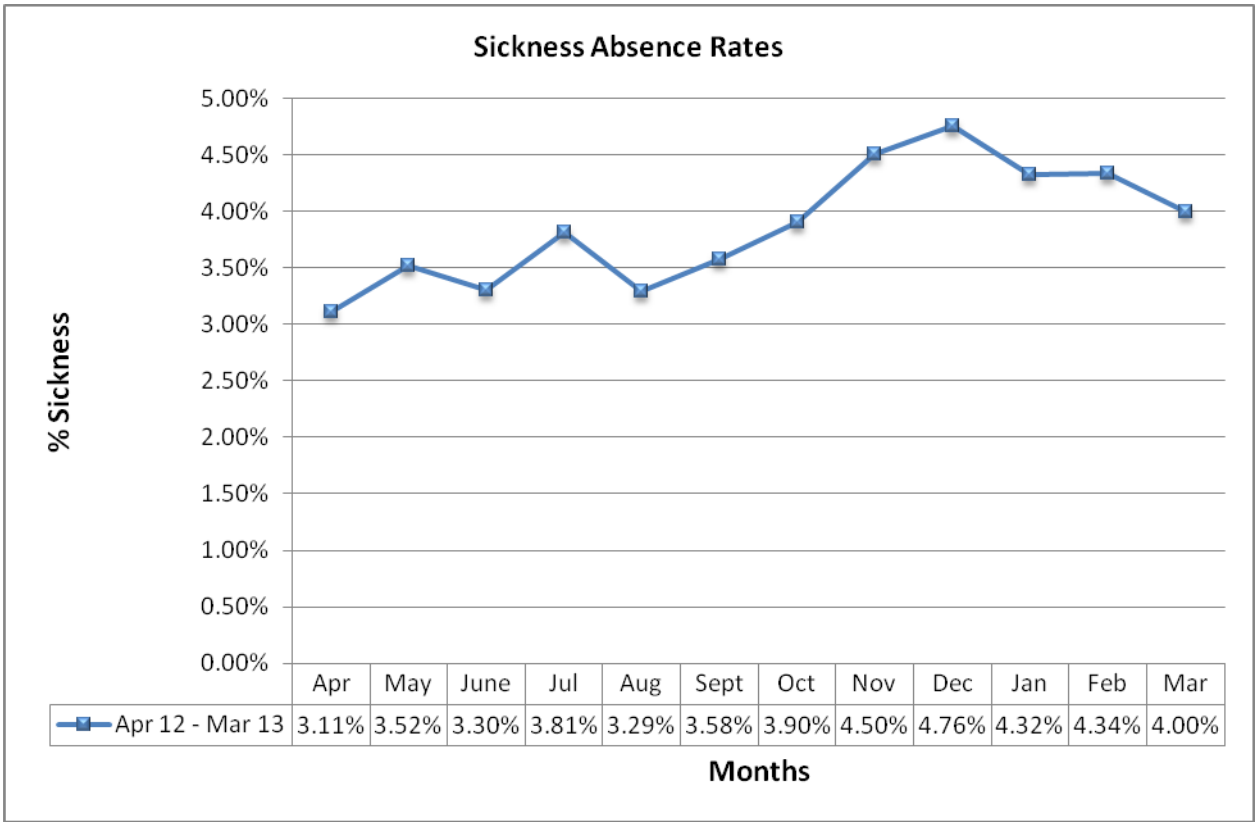
2.9.2 Equality and Diversity

The Equality and Diversity Committee has reviewed the Trust's performance against the National Equality Delivery System (EDS), which measures the Trust's against a specified set out goals and outcomes. This process has informed the Trust's Equality Objectives.

The dedicated Equality and Diversity session provided as part of the induction programme for all staff on joining the Trust has been successful, and has contributed to the improved score within the national staff survey which shows an increase from 50% to 58% of staff having received Equality and Diversity Training in the last year (making the Trust above the national average in this category).

2.9.3 Workplace Health

The Trust has continued to have a strong focus on sickness absence management with a small decrease in sickness absence since 2012. The table below demonstrates the monthly sickness rate for the previous 12 months.



	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Apr 12 - Mar 13	3.11%	3.52%	3.30%	3.81%	3.29%	3.58%	3.90%	4.50%	4.76%	4.32%	4.34%	4.00%

The importance of Health and Wellbeing has been a strong focus for the Trust with a range on initiatives. These have included promoting Health & Wellbeing through the Trust Health and Wellbeing Days, "Feel

Good Friday", which have included a range of Health and Wellbeing activities and have been attended by staff from across a variety of disciplines.

Another initiative is the implementation of a physiotherapy clinic for staff, the purpose of the clinic is to provide early intervention to help prevent a member of staff becoming unfit to attend work, so that aids recovery to ensure a timely return to work.
The Trust's cycle-to-work scheme continues to be popular and in the last year a further 26 employees have participated in the scheme

The Trusts Employee Assistance Provider continues to be well used by staff, with 254 employees using the various advice and support services provided by The Positive People Company (PPC).

2.9.4 Developing the Skills of our Workforce

The Trust recognises the importance of a well trained, highly-skilled workforce and continues to invest in the training and development of its staff.

Patient and staff safety is our first concern. We continue to deliver a comprehensive programme of mandatory training where every member of staff in the Trust receives regular training in essential topics such as infection control, fire safety and manual handling. In the last year the Trust has run 477 mandatory classroom teaching sessions with a total of 3,981 attendances.

In 2012/13, recognising the increasing number of patients we see with dementia, we made dementia awareness training compulsory for all staff. Staff access the training through the South West Learning4Health e-learning platform. All staff are now registered on the platform and able to access a full range of learning content. The successful promotion of e-learning as a flexible learning option has resulted in 3,190 completions during the last year and has led to the Trust consistently ranking in the top 10 Trusts in the South West for e-learning usage.

We continue to invest in our Bands 1-4 staff. In 2012 we saw our first cohort of Trainee Assistant Practitioners successfully achieving their Foundation degrees in Health and Social Care and securing permanent Band 4 positions. We supported Nurse Assistants through their QCF Level 2 and 3 qualifications and we continued to employ Modern Apprentices through collaboration with Weston College. During 2012/13, the Trust employed 9 Modern Apprentices with one going on to achieve *'Apprentice of the Year'* by Weston College and many going on to secure permanent employment at the end of the apprenticeship period.

Key priorities for 2013/14 will include an enhanced focus on Leadership Development for our managers and aspiring leaders, with a Level 5 ILM Diploma in Leadership and a Level 3 Award in Leadership planned for the Autumn.

2.9.5 Staff Survey Outcomes

One of the priority areas for action during 2011/2012 was to increase the quality and number of staff appraisals. Results from the 2012 National Staff Survey have been encouraging with the Trust performing well against Pledge 2: To provide all staff with personal development, access to appropriate training and line manager support. In particular the Trust scored well against the category of *'% of staff appraised in the previous 12 months'* where we scored in the top 20% of the country for Acute Trusts.

During 2013, the Trust will be reviewing the use of the Knowledge Skills Framework, with involvement from staff, managers and staff side, with the aim of creating a more robust and consistent approach across all staff groups.

Perhaps unsurprisingly against a backdrop of financial challenges and uncertainty around the future organisational form, less favourable results were received around staff morale and satisfaction levels. We are working hard with our staff and union colleagues through the Trust's Staff Experience Group to develop action plans for the areas we need to improve and we hope to see an improvement in next year's results in these areas.

2.10 Paying Our Bills Promptly

All 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 the summary financial statements and in note 11 of the full set of 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 96.6% of the total number of non-NHS invoices against the Code. This compares with 94.5% in 2011/12. With 85.1% of the total number of NHS invoices paid within 30 days compared with 75.2% in 2011/12.

The overall total number of invoices paid, both NHS and non NHS, was 96.1%.

2.11 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 2012 at £9,905,000. The Directors of the Trust are not aware of any material differences between the carrying values and the current market values.

2.12 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 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.

2.13 Auditors

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

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

The audit opinion, for 2012/13 was that the accounts do give a 'true and fair' view and have been prepared in accordance with accounting policies.

The audit report also comments on the Trusts arrangements for securing economy, efficiency and effectiveness. The opinion states that the auditor is satisfied that in all significant respects Weston Area Health NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2013, except for securing financial resilience.

In 2012/13, the Trust's external audit fees were £89,000 compared to £131,000 in 2011/12.

2.14 Protecting Information

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

There were no serious untoward incidents involving data loss in 2012/13.

2.15 Compliance with Charges for Information

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

Section 3: Remuneration Report 2012/13

3.1 Remuneration Report 2012/13

The Chair and all non-executive directors of the Trust form the remuneration committee with the Chair of the Trust also being Chair of the committee.

The committee reviews the salaries of the executive directors of the Trust, taking regard of duties and responsibility, span of control and rates of pay prevalent at the time of recruitment. The variation to this arrangement is the Executive Medical Director who receives remuneration for clinical duties together with remuneration for executive duties.

Executive Directors do not receive performance related pay.

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

Peter Colclough, Chief Executive (Interim from September 2011)
Nicholas Wood, Chief Operating Officer (Interim from December 2011, substantive from August 2012) (Voting rights from May 2012 onwards)
Rob Little, Finance Director (Interim on secondment from Devon PCT from January 2010, substantive appointment from July 2010)
Nicholas Gallegos, Medical Director (Acting from March 2009, substantive from May 2010)
Irene Gray, Director of Nursing (Interim on an agency contract basis from January 2012)
Bronwen Bishop, Director of Strategic Development (Interim April 2008, substantive from October 2008) (Voting rights in April & May 2012 only)

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

Alison Kingscott, Director of Workforce and Corporate services (Interim from February 2008, substantive from September 2008)
Sheridan Flavin, Interim Director of Human Resources (from October 2012)
Christine Bryant, Director of Service Development (from May 2009)

The following ceased to be Executive Directors during the year:
Peter Colclough, Chief Executive (Interim to March 2013)
Alison Kingscott, Director of Workforce and Corporate services (to October 2012)
Christine Bryant, Director of Service Development (to December 2012)

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.

The NHS Appointments Commission 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.

The Chair, Mr C Creswick, was appointed from 1st December 2007 initially for 6 months followed by a 4 year permanent appointment from July 2008. He was then reappointed for a further 4 year term from July 2012.

Other non- executive directors were appointed, or reappointed on 4 year appointments from the following dates:

Ms J Ferguson	January 2013 (reappointment)
Mr I Turner	August 2011 (reappointment)
Mr G Reah	February 2012 (reappointment)
Mr G Paine	March 2012 (reappointment)
Mr R Lloyd	September 2011

No awards have been made to past senior managers of the Trust.

The salaries and allowances and pension benefits for the Trusts senior managers are detailed on page 43 and 44 respectively and have been audited by Grant Thornton.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Director and the median remuneration of the organisations workforce. The median employee has been calculated based only on staff directly contracted to the Trust, agency and bank employees have been excluded.

The banded remuneration of the highest paid director in Weston Area Health NHS Trust in the financial year 2012/13 was £170k - £174.9k (2011/12, £170k - £174.9k). This was 6.2 times (2011/12, 6.4) the median remuneration of the workforce, which was £27,350 (2011/12, £26,483). The median employee has been calculated based on contracted staff only; agency and bank employees have been excluded from the calculation.

In 2012/13, 3 (2011/12, 3) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £10k to £187k (2011/12 £10k to £183k).

Total remuneration includes salary, non-consolidated payments-related pay, benefits-in-kind as well as severance payments. It does not include employers pension contributions and the cash equivalent transfer value of pensions.

Signed by: …  …. Chief Executive

3.2 Salaries and Allowances

Name and Title	2012-13				2011-12			
	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Bonus payments (bands of £5,000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Bonus payments (bands of £5,000) £000	Benefits in Kind Rounded to the nearest £100
P Colclough, Interim Chief Executive (from 01/09/11 to 31/03/13) *	170-174	nil	nil	nil	20-24	nil	nil	nil
L Read, Chief Executive (from 01/04/07 to 31/08/11)	Not in post				50-54	nil	nil	nil
N Wood, Interim Chief Operating Officer (from 05/12/11 to 31/07/12), Chief Operating Officer (from 01/08/12)	95-99	nil	nil	nil	30-34	nil	nil	nil
R Little, Director of Finance and IM&T (from 1/7/10) **	95-99	nil	nil	nil	100-104	nil	nil	nil
N Gallegos, Executive Medical Director (from 1/5/10) & Consultant - General Surgery	35-39	115-119	20-25	nil	35-39	120-124	20-25	nil
I Gray, Interim Director of Nursing (from 23/01/12 to 31/03/13) ***	90-94	nil	nil	nil	20-24	nil	nil	nil
I Bramley, Acting Director of Nursing (from 26/4/10 to 31/12/11)	Not in post				50-54	nil	nil	nil
C Bryant, Director of Service Development and Interim Director of Hospital Services (from 14/09/09 to 14/12/12)	55-59	nil	nil	nil	80-84	nil	nil	nil
E Gatling, Director of Emergency Services (from 01/05/11 to 31/10/11)	Not in post				45-49	nil	nil	nil
A Kingscott, Director of HR (from 01/09/08), Director of Workforce and Corporate services (from 27/10/10 to 05/10/12)	40-44	nil	nil	nil	80-84	nil	nil	nil
S Flavin, Interim Director of HR (from 01/10/12)	35-39	nil	nil	nil	Not in post			
B Bishop, Director of Strategic Development (from 01/10/08)	80-84	nil	nil	nil	80-84	nil	nil	nil
A Hunt, Interim Trust Board Secretary (from 27/02/12 to 31/07/12), Associate Director of Governance & Assurance (from 01/08/12 to 02/12/12)	45-49	nil	nil	nil	5-9	nil	nil	nil
A Rutter, Interim Trust Board Secretary (from 26/11/12)	15-19	nil	nil	nil	Not in post			
C Creswick, Chair	15-19	nil	nil	nil	15-19	nil	nil	nil
J Ferguson, Non Executive Director	5-9	nil	nil	nil	5-9	nil	nil	nil
I Turner, Non Executive Director	5-9	nil	nil	nil	5-9	nil	nil	nil
G Reah, Non Executive Director	5-9	nil	nil	nil	5-9	nil	nil	nil
S Calverley, Non Executive Director (from 3/12/09 to 31/05/11)	Not in post				0-4	nil	nil	nil
R Lloyd, Non Executive Director (from 01/09/11)	5-9	nil	nil	nil	0-4	nil	nil	nil
G Paine, Non Executive Director	5-9	nil	nil	nil	5-9	nil	nil	nil

Other remuneration' relates to payments to a clinician for the performance of clinical duties whilst holding an executive board position.
* Mr Colclough was on a secondment from Royal Cornwall Hospitals NHS Trust from 1/9/11 to 31/1/12 for which WAHT did not incur any costs.

* Mr Colclough's annual salary is protected at £170k. As Mr Colclough also acted as the lead on the North Somerset Integrated Care programme, North Somerset PCT paid the additional amount over the WAHT CEO salary of £127k from 1/2/12 to 31/7/12.

** Mr Little's salary was protected at £110k by his previous employer before 30/09/11. Devon PCT paid the additional amount over his agreed WAHT salary of £100k.

*** Mrs Gray's appointment into the role of Interim Director of Nursing appointment is via 3rd party agency agreement. The figure listed relates to the amount paid to the supplying agency not the individual's salary.

3.3 Pension Benefits

Name and title	Real increase in pension at age 60 at 31 March 2013 (bands of £2,500)	Real increase in lump sum at age 60 at 31 March 2013 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real Increase in Cash Equivalent Transfer Value £000	Employer funded contribution to growth in CETV £000
N Wood, Interim Chief Operating Officer (to 31/07/12), Chief Operating Officer (from 01/08/12)	0-2.4	0-2.4	0-4	0-4	51	27	22	16
R Little, Director of Finance & IM&T	0-(2.4)	(2.5)-(4.9)	45-49	135-139	1,051	993	6	4
N Gallegos, Executive Medical Director & Consultant Surgeon	0-(2.4)	(2.5)-(4.9)	60-64	190-194	1,318	1,240	14	10
C Bryant, Director of Service Development & Interim Director Of Hospital Services (to 14/12/12)	0-(2.4)	0-(2.4)	15-19	50-54	0	375	-	-
B Bishop, Director of Strategic Development	0-(2.4)	0-(2.4)	30-34	90-94	594	558	7	5
A Kingscott, Director of Workforce and Corporate Services (to 05/10/12)	0-2.4	0-2.4	20-24	60-64	334	291	15	10
S Flavin, Interim Director of Human Resources (from 01/10/12)	0-2.4	0-2.4	0-4	0-4	6	0	3	2
A Hunt, Interim Trust Board Secretary (to 31/07/12), Associate Director of Governance & Assurance (from 01/08/12 to 02/12/12)	0-(2.4)	(7.5)-(9.9)	0-4	0-4	68	80	(11)	(8)
A Rutter, Interim Trust Board Secretary (from 26/11/12)	0-2.4	0-2.4	0-4	0-4	5	0	2	1

Notes :

P. Colclough, Interim Chief Executive left the Pension scheme on 31/3/12 and therefore is excluded from the disclosure above.

C Bryant, Director of Service Development & Interim Director Of Hospital Services has a CETV of Nil as she claimed her pension benefits in December 2012.

Real increases and Employer's contributions are shown for the time in post where this has been less than the whole year.

Figures in (brackets) indicate a decrease

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

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

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and, in previous years, in accordance with the DH's Manual for Accounts, used common market valuation factors for the start and end of the period. However, for 2011/12, the market valuation factors used in the calculation were different at the start and end of the period.

3.4 For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012

	Number
Number in place on 31 January 2012	1
Of which:	
Number that have since come onto the Organisation's payroll	0
Of which:	
Number that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the Trust to seek assurance as to their tax obligations	1
Number that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the Trust to seek assurance as to their tax obligations	0
Number that have come to an end	0
Total	1

Section 4: Annual Governance Statement

4. Annual Governance Statement 2012/13

1.0 Scope of responsibility

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

Scrutiny by the Non Executive Directors in the Remuneration and Terms of Service Committee, by Non Executive Directors and Auditors in the Audit and Assurance Committee, by Non Executive Directors and Executive Directors in the Quality and Governance Committee and by Non Executive Directors and Executive Directors in the Finance Committee, provides me with assurance of internal control including probity in the application of public funds and in the conduct of the organisation's responsibilities. Reports from these Committees are received in the Board meetings in public.

In my role as Accountable Officer I fulfil my responsibilities in close association with the Chief Executive and senior officers of NHS South of England (formerly South West Strategic Health Authority) and the Chief Executive and directors of BNSSSG (Bristol, North Somerset, Somerset & South Gloucester) Area Team (formerly PCT Cluster) and the Leaders of North Somerset Clinical Commissioning Group. Governance and risk issues are regularly discussed at a variety of Health Economy wide forums. Regular meetings take place with our Partners covering performance and strategy. The Trust also meets regularly and works closely with its key partners, notably North Somerset Council, North Somerset Community Social Enterprise, Weston College and the local Healthwatch (formerly LINKs). The Trust takes an active part in sector-wide networks and I and my Executive Directors represent the Trust in key strategic alliances such as:

NHS South of England Meetings and Forums:
- Chairs and Chief Executives
- Chief Executives
- Forums for Directors of Finance, Nursing & Human Resources
- Director of Infection Prevention and Control Forum

Bristol, North Somerset, Somerset & South Gloucester Area Team (formerly PCT Cluster) (BNSSSG):
- BNSSSG Healthy Futures Programme Board
- BNSSSG Quality Review meetings

Clinical Networking:
- Care pathway networks including the Avon, Gloucester and Wiltshire Cancer Network, Urgent Care Network, North Somerset Children's Trust Board and the Local Safeguarding Children's Board
- Health and Well-Being Strategic Partnership
- Avon and Somerset Local Health Resilience Partnership
- North Somerset Health Overview and Scrutiny Committee

2.0 The Governance Framework of the Organisation

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives;
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The foundations of good governance are the means by which an NHS Trust pulls together all of the competing pressures on the Trust Board and its supporting structures to enable good governance. Good governance is a means to create greater focus, capacity and capability for NHS Boards, it allows NHS Board members to work more corporately as a team, to challenge NHS Board agendas, deliver objectives in a coherent way and review the NHS Board support structures that enable them to govern effectively.

Weston Area Health NHS Trust is committed to complying with the Corporate Governance Code, implementing the principles of good governance to ensure the delivery of high quality patient-focused care that is well managed, cost effective, and has a well trained and motivated work force. The Trust is also committed to complying with the principles set out in "Governing the NHS - A guide for NHS Boards" published by the NHS Appointments Commission in June 2003.

Effective corporate and clinical governance is fundamental for the success of every NHS organisation. As we embark on our journey of strategic change, it is essential that the Trust has a healthy and effective NHS Board in place which can operate to the highest of corporate governance standards.

The "Healthy NHS Board Principles for Good Governance" report (published by the NHS National Leadership Council) highlights the requirement for all NHS Trust Boards to have a key role in safeguarding quality and to seek assurance that systems of control are robust and reliable. The "Operating Framework for the NHS in England 2012/13" set out four key principles - Getting the basics right every time, Maintaining a grip on performance, Meeting the quality and productivity challenge, and Building the new delivery system – which underpin the work of the Trust Board, its committees, and staff at the Trust.

It is against these principles and also from guidance and best practice from the NHS Code of Governance, The Intelligent Board and Foundations of Good Governance that the Trust's current governance arrangements were first reviewed and assessed during 2011/12 and then consolidated by the Trust Board throughout 2012/13.

In order to enable accountability, NHS Boards are statutorily required to establish committees responsible for audit and remuneration. In addition the Boards of NHS organisations have a statutory duty of quality.

The **Trust Board** is governed by the Trust Standing Orders and has overall responsibility for agreeing the risks, controls and assurances detailed in the Board Assurance Framework and for the framework's maintenance and monitoring during the year. The Trust Board is also actively engaged through the year in monitoring progress towards achievement of the Care Quality Commission standards and other compliance requirements.

The **Audit and Assurance Committee** considers the annual plans and reports of both the External and Internal Auditors and reviews the Corporate Risk Register and Board Assurance Framework. The Committee provides an independent and objective review of the Trust's systems, information, internal

control and probity, compliance with laws, guidance and regulations governing the NHS. The Committee of Non-Executive Directors met five times during 2012/13 and reports on its work to the Trust Board. It is chaired by a Non-Executive Director.

The **Remuneration and Terms of Service Committee** has delegated powers to determine arrangements on matters relating to remuneration and terms and conditions for Board level post holders (excluding Non Executive Directors) and to determine for all staff, under delegated powers, arrangements for any non-contractual payments, in line with Department of Health, NHS Trust Development Authority and NHS South of England guidance.

The **Finance Committee** was established in April 2011, partly in response to the business requirements of an NHS Trust and partly in recognition of the development needs of the organisation. It is recognised that whilst the Trust Board as a whole has collective responsibility for financial matters, the degree of planning and scrutiny required goes beyond the scope of the Board's normal meeting agenda. The Committee provides an independent and objective review of the Trust's financial policy, management and reporting systems, and the medium term capital strategy. The Committee meets at least quarterly and reports to the Trust Board. It has Non Executive and Executive Director membership and is chaired by a Non Executive Director.

The **Quality and Governance Committee** is concerned with assurance in relation to clinical care and governance against Key Performance Indicators and against national standards, eg Care Quality Commission Standards, NHS Litigation Authority (NHSLA) Risk Management Standards and National Patient Safety Agency reporting standards. It reviews the Corporate Risk Register and Board Assurance Framework in relation to clinical governance and risk. It also reviews the terms of reference of a wide range of its reporting committees. The Committee meets bi-monthly and reports on its work to the Audit and Assurance Committee and the Trust Board. It is chaired by a Non-Executive Director. The Committee is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

The **Risk Management Committee,** established in July 2012, directs 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 Board Assurance Framework. The Risk Management Committee reports to both the Quality and Governance Committee and the Audit and Assurance Committee. It is chaired by the Lead Director for Clinical Risk who is the Director of Nursing.

The **Health Informatics Committee**, chaired by the Director of Finance, meets on a bi-monthly basis. The Group receives a regular update from the Information Governance Sub Group who is responsible for reviewing any breaches of patient confidentiality and information security incidents recommending appropriate action where necessary. Information Governance policy is overseen ensuring relevant legislation is adhered to, safeguarding person identifiable information at all times.

The **Nursing and Midwifery Committee** was established in March 2012 to provide a forum for nurses and midwives from all grades to contribute to the development, delivery and measure of corporate, Regional and National Nursing & Midwifery objectives.

The Trust also set up a **Patients' Council** which met monthly from September 2012 and with members appointed through interviews conducted by external parties, not by the Trust. A representative of the Patients' Council sits on the following Trust's committees (Nursing and Midwifery, Quality and Governance, Infection Control, Safeguarding, Clinical Audit and Equality and Diversity).The Chair or Deputy Chair of the Patients' Council attends all Trust public Board meetings.

The Executive Management Group weekly meeting includes Executive and Divisional Directors, and when necessary calls-in representation from specialists such as members of the Trust finance function or

external advisors. This forum ensures that control issues are constantly reviewed, monitored, and where necessary, updated.

The **Board Assurance Framework** links the main elements and aims of the Trust's internal control and governance policies, identifying the risks to the Trust's strategic objectives, the key controls in place to manage these risks and the level of assurance with regard to the effectiveness of the controls. The framework identifies any gaps in both the controls and the assurances that the controls are effective.

In line with national guidance it is structured around the high level risks which were deemed to be the most significant risks to prevent delivery of the corporate objectives in 2012/13. It has been considered by the Audit and Assurance Committee on behalf of the Trust Board at each of the five meetings held during the year . It has also been considered by the Trust Board directly twice during the year during public meetings.

The Framework is reviewed and updated by Executive Directors on a regular basis to ensure that it remains aligned with the Trust's strategic objectives and the key risks to their achievement. Action plans to address key risks have been fully documented during the year with revised processes being carried forward into the coming year to ensure that gaps in control are closed.

3.0 Risk Assessment

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 Trust Development Authority 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.

The Medical Director and Director of Nursing have responsibility for managing the implementation of clinical risk management and clinical governance. 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 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 etc, and within 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. Further training is given to appropriate staff on other risk related topics and there is ongoing support from the Governance Team which includes Health and Safety expertise. All staff receive written information on risk, safety and relevant Trust policies;

- Promotes good governance and risk management practice which is disseminated using a variety of methods including training sessions, Divisional Governance Meetings, all user bulletins, staff intranet and other staff briefing sessions.

Through the **Quality and Governance Committee** chaired by a Non Executive Director and attended by a range of Directors, Senior Managers, and Clinicians, the Trust seeks to learn and share good practice through rigorous assessment of the Corporate Risk Register, incidents and complaints and Registration compliance, and shares this information widely, together with learning from these events and identified good practice to Directorate Teams through formal briefings, training and active support.

The Board receives assurance from the **Audit and Assurance Committee** on processes employed by management with regard to the assessing and evaluating the control and the mitigation of significant risk. Specifically, the Audit and Assurance Committee provides the Board with the assurance that the Trust has in place:

- Key controls to assist in securing and delivering Trust business objectives, through the Board Assurance Framework;

- Effective and reliable control systems; and

- Agreed and timely corrective action plans for any gaps in controls, systems or assurances.

Internal and external audit reports are reviewed by the Audit and Assurance Committee and references to best practice are identified and adopted wherever possible.

The Trust's significant Strategic Risk relates to the organisational change agenda. At the end of 2012 the Trust announced that it would be working with the NHS Strategic Health Authority and local stakeholders to identify an organisational form for 2015/16 onwards, with the Trust either being acquired by another NHS organisation or entering into an NHS "Operating Franchise" Agreement with a third party. Throughout that "procurement process" the Trust Board has maintained its commitment to deliver safe, high-quality treatment and care to patients. The procurement process itself was the responsibility of the Strategic Health Authority during 2012/13 and is being managed by a Procurement Project Board established in late 2012. The vendor being the newly established NHS Trust Development Authority (TDA).

The Trust's principal operational risks were the achievement of A&E clinical indicators, Clostridium Difficile targets and financial performance. The Trust did achieve its financial target for the year overall with successful mitigating actions.

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 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 2012/13. The final self-assessment submission achieved 67% compliance with the Connecting for Health requirements and is graded green and satisfactory.

Risks to information are managed and controlled via the Health Informatics Service risk register, divisional risk registers if appropriate, the Trust's corporate risk register and incident reporting mechanism. Through these above processes I am aware of the risk management systems in place for Information governance at the Trust. There have been no lapses of data security in 2012/13.

4.0 The Risk and Control Framework

The Trust's **Risk Management Strategy** defines:

- The Trust's attitude to risk
- Unacceptable and Acceptable risk
- The principles of risk management which are to identify risk exposure, analyse the risk exposure, to select an appropriate risk management method to control the risk, to implement the chosen method of risk management, and to monitor and control to ensure actions are effective.

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

The Trust's **Performance Management meetings** review and discuss the Trust's Performance Assurance Framework. This monthly meeting monitors the performance of the Operational Divisions against key performance indicators including financial targets.

During 2012/13, the Board sought assurance that the Trust's objectives were being achieved and the risks controlled through a framework of assurance processes, including performance reports with high level KPIs, regular presentation and update of the Assurance Framework, regular review of the Corporate Risk Register, audits (internal and external), assessments by regulatory and monitoring agencies (eg Care Quality Commission, CNST, Health and Safety) and reports from its assurance committees.

The Board has taken the following steps to assure itself that the Trust's Quality Account is accurate with the Director of Nursing leading the development of the annual Quality Accounts. The Board reviews the quality metrics and performance data presented throughout the year and as summarised within the Quality Accounts, through the work of its Committees and Executive Management Group. Key areas of the Trust are audited and monitored against internal and external standards. This work is reviewed and scrutinised by the Trust Board through the Audit & Assurance Committee. There are genuinely sound internal controls over the collection and reporting of the measures of performance included in the Quality account and these controls are subject to review by our internal and external auditors to confirm that they are working effectively in practice. Key stakeholders have been involved in the development of the report.

5.0 Review of the Effectiveness of Risk Management and Internal Control

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control.

My review is informed in a number of ways:

- The 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 a 'Significant Assurance' opinion for the year ended 31 March 2013.

- Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance;

- The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

- The work of the Audit and Assurance Committee provides 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.

- Reports and feedback from planned and unannounced visits from the Care Quality Commission 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 include:

External Assurance

- Audits (clinical, financial, internal, external)
- External body assessments/reports (NHS Litigation Authority, Care Quality Commission, Audit Commission)
- Care Quality Standards and Trust registration process– reports and full engagement of executive and non-executive directors throughout the process
- Peer Reviews and Re-accreditation of specific functions within the organisation
- Benchmarking of key performance data where possible, including use of the CHKS benchmarking system
- SHA analysis of Financial Information Management System (FIMS) returns
- Local public perception including feedback from regular meetings with 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 – reports detailing organisational compliance relative to other organisations

Internal Assurance

- Patient and Staff surveys and questionnaires
- Incidents, Inquests, complaints and claims – reports to committees and trend analysis
- Training reports detailing feedback from training and compliance with attendance
- Feedback from staff through direct one-to-one, larger group listening events and exit interviews, including feedback from Trades 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 Governance Committee. The governance structures and systems of internal control detailed below have been in place during 2012/13 and the effectiveness of the Committee structure is regularly monitored. Board and Committee minutes record attendance at each meeting, and the Trust Public Board Meeting of April 2013 received a summary of Board members' attendance at Trust Board and Committee meetings .

Internal Audit is provided by Audit South West and carries out a continuous review of the internal control system and reports the results of reviews and recommendations for improvements in control to management and the Trust's Audit and Assurance Committee. The annual internal audit programme is based around the Trust's key objectives and the Assurance Framework. The results of audit are reviewed

through the Audit and Assurance Committee and the Internal Auditors attend every meeting of that Committee. On 28 March 2013 the Trust's External Auditors concluded that "IA is contributing to an effective internal control environment in place in the Trust" .

External Audit had been provided to the Trust by the Audit Commission, but this was taken over by Grant Thornton UK LLP with effect from 1 April 2012. The results of external audits are reviewed through the Audit and Assurance Committee and the External Auditors attend the meetings of that Committee.

Other Assurance Mechanisms:

Special Reviews are undertaken from time to time by the Care Quality Commission, NHS Litigation Authority, External Audit, NHSLA Auditors and the Health and Safety Executive as well as other various external bodies. Peer reviews are also undertaken.

The Payroll Service for Weston Area Health NHS Trust is provided by the Payroll Bureau of University Hospitals Birmingham NHS Foundation Trust. Third party assurance of this service was provided by an audit carried out by Deloitte which gave an overall conclusion of substantial assurance.

The system of internal control has been in place in Weston Area Health NHS Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

6.0 Significant Issues

There were no significant internal control issues identified during 2012/13.

The Trust is working closely with the NHS Trust Development Authority to identify a new organisational form, probably effective from 2015/16, due to issues concerning sustainability, including a challenging financial position. This is a significant strategic risk which is managed by the Trust and NHS TDA.

The Head of Internal Audit has given a 'Significant Assurance' opinion for the year ended 31 March 2013. The opinion confirms that there is a generally sound system of internal control, designed to meet the Trust's objectives and that controls are generally being applied consistently.

Concluding Statement

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

Accountable Officer : Nick Wood, Acting Chief Executive

Organisation: Weston Area Health NHS Trust

Signature: 

Date: 05 June 2013

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

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

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

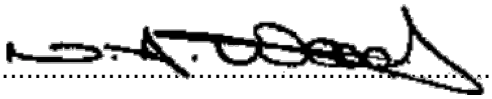
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

nb: sign and date in any colour ink except black

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

Date **05 June 2013**

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

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

- make judgements and estimates which are reasonable and prudent;

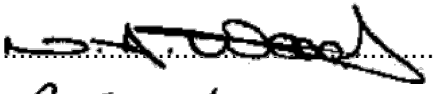
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

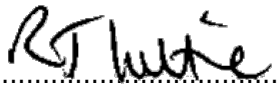
The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They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

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

By order of the Board

nb: sign and date in any colour ink except black

05 June 2013 Date .....  .....Chief Executive

05 June 2013 Date .....  .....Finance Director

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

We have audited the financial statements of Weston Area Health NHS Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

- the table of salaries and allowances of senior managers on page 44
- the table of pension benefits of senior managers on page 45
- the table of pay multiples on page 43.

This report is made solely to the responsible officers of Weston Area Health NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of responsible officers and auditor

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

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Weston Area Health NHS Trust as at 31 March 2013 and of its expenditure and income for the year then ended
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance
- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998. We have nothing to report in these respects.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources Respective responsibilities of the Trust and auditor

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section S of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report jf significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in November 2012, as to whether the Trust has proper arrangements for:

- securing financial resilience
- challenging how it secures economy, efficiency and effectiveness. The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2013. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we

undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for qualified VFM conclusion

In seeking to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, we have considered the following matter in relation to financial resilience: The Trust has been unable to set a balanced budget for 2013/14, forecasting an underlying deficit of £4.95million. The Trust received written confirmation from the Trust Development Authority on 28 May 2013 confirming that it will provide financial support to address any shortfall in cash funding for 2013/14.

Qualified VFM conclusion

On the basis of our work, and having regard to the guidance on the specified criteria published by the Audit Commission, with the exception of the matter reported in the basis for qualified conclusion paragraphs above, we are satisfied that in all significant respects Weston Area Health NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2013.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to provide assurance over the Trust's annual quality accounts. We are satisfied that this work does not have a material effect on the financial statements or on our value for money conclusion.

[Signed on original]

Peter Barber Senior Statutory Auditor, for and on behalf of Grant Thornton UK lLP
Hartwell House I 55-61 Victoria Street I Bristol I B51 6FT
6 June 2013

Statement of Comprehensive Income for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Gross employee benefits	10.1	**(63,709)**	(63,218)
Other costs	8	**(29,820)**	(31,564)
Revenue from patient care activities	5	**81,749**	78,865
Other Operating revenue	6	**15,040**	16,441
Operating surplus		**3,260**	524
Investment revenue	12	**11**	10
Other (losses)	13	**(3)**	(21)
Finance costs	14	**(116)**	(373)
Surplus for the financial year		**3,152**	140
Public dividend capital dividends payable		**(1,840)**	(1,843)
Retained surplus/(deficit) for the year		**1,312**	(1,703)
Other Comprehensive Income			
Impairments and reversals	17	**(1,335)**	(380)
Net gain on revaluation of property, plant & equipment	15.2	**0**	680
Total comprehensive income for the year		**(23)**	(1,403)

Financial performance for the year

Retained surplus/(deficit) for the year		**1,312**	(1,703)
Impairments	17	**833**	5,178
Adjustments in respect of donated asset reserve elimination		**(105)**	(135)
Adjusted retained surplus		**2,250**	**3,610**

The calculation above for the adjusted retained surplus in respect of donated assets is as prescribed by the Department of Health and adds on the effect of the donated asset reserve elimination.
The Trust's reported NHS financial performance position is derived from its Retained surplus, but adjusted for:
a) Impairments to Non-current assets -An impairment charge is not considered part of the organisation's operating position.
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 £164,000 less income for the purchase of non-current assets £59,000 see Note 6.

Memorandum

PDC dividend: balance receivable/(payable) at 31 March	**60**	**(13)**

The notes on pages 65 to 99 form part of this account

Statement of Financial Position as at 31 March 2013

	NOTE	31 March 2013 £000s	31 March 2012 £000s
Non-current assets:			
Property, plant and equipment	15	**60,188**	61,505
Intangible assets	16	**1,880**	2,476
Trade and other receivables	22.1	**410**	382
Total non-current assets		**62,478**	64,363
Current assets:			
Inventories	21	**1,397**	1,248
Trade and other receivables	22.1	**2,745**	3,103
Cash and cash equivalents	26	**2,213**	1,987
Total current assets		**6,355**	6,338
Total assets		**68,833**	70,701
Current liabilities			
Trade and other payables	28	**(9,765)**	(9,383)
Provisions	35	**(430)**	(300)
Working capital loan from Department	30	**0**	(2,250)
Total current liabilities		**(10,195)**	(11,933)
Non-current assets less net current liabilities		**58,638**	58,768
Non-current liabilities			
Provisions	35	**(250)**	(357)
Total non-current liabilities		**(250)**	(357)
Total Assets Employed:		**58,388**	58,411
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**57,879**	57,879
Retained earnings		**(8,954)**	(10,265)
Revaluation reserve		**9,556**	10,890
Other reserves		**(93)**	(93)
Total Taxpayers' Equity:	SOCITE	**58,388**	58,411

The financial statements on pages 61 *to 99* were approved by the Board on *5 June 2013* and signed on its behalf by:

Chief Executive:  Date: **05 June 2013**

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2013

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2012	**57,879**	**(10,265)**	**10,890**	**(93)**	**58,411**
Changes in taxpayers' equity for 2012-13					
Retained surplus for the year		1,312			**1,312**
Impairments and reversals			(1,335)		**(1,335)**
Transfers between reserves		(1)	1	0	**0**
Net recognised revenue/(expense) for the year	**0**	**1,311**	**(1,334)**	**0**	**(23)**
Balance at 31 March 2013	**57,879**	**(8,954)**	**9,556**	**(93)**	**58,388**
Changes in taxpayers' equity for the year ended 31 March 2012					
Balance at 1 April 2011	54,879	(9,106)	11,134	(93)	56,814
Retained (deficit) for the year		(1,703)			(1,703)
Net gain on revaluation of property, plant, equipment			680		680
Impairments and reversals			(380)		(380)
Transfers between reserves		544	(544)	0	0
Reclassification Adjustments					
New PDC Received	3,000				3,000
Net recognised revenue/(expense) for the year	3,000	(1,159)	(244)	0	1,597
Balance at 31 March 2012	57,879	(10,265)	10,890	(93)	58,411

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2013

	NOTE	2012-13 £000s	2011-12 £000s
Cash Flows from Operating Activities			
Operating Surplus	SOCI	**3,260**	524
Depreciation and Amortisation	8	**3,559**	3,340
Impairments and Reversals	17	**833**	5,178
Donated Assets received credited to revenue but non-cash	6	**(59)**	(46)
Interest Paid	SOCI	**(110)**	(364)
Dividend (Paid)	SOCI	**(1,913)**	(1,873)
(Increase) in Inventories	21	**(149)**	(138)
Decrease in Trade and Other Receivables	22.1	**330**	200
Increase in Trade and Other Payables	28	**569**	1,137
Provisions Utilised	35	**(334)**	(72)
Increase in Provisions	35	**351**	102
Net Cash Inflow from Operating Activities		**6,337**	7,988
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received		**11**	10
(Payments) for Property, Plant and Equipment		**(3,306)**	(3,219)
(Payments) for Intangible Assets		**(628)**	(403)
Proceeds of disposal of assets held for sale (PPE)		**3**	19
Net Cash (Outflow) from Investing Activities		**(3,920)**	(3,593)
NET CASH INFLOW BEFORE FINANCING		**2,417**	4,395
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital Received	SOCITE	**0**	3,000
Loans repaid to DH - Revenue Support Loans	30	**(2,250)**	(5,610)
Capital grants and other capital receipts	6	**59**	46
Net Cash (Outflow) from Financing Activities		**(2,191)**	(2,564)
NET INCREASE IN CASH AND CASH EQUIVALENTS		**226**	1,831
Cash and Cash Equivalents at beginning of the period		**1,987**	156
Cash and Cash Equivalents at year end	26	**2,213**	1,987

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Critical judgements in applying accounting policies

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

- Assessing the value of significant accruals of income and expenditure at the year end.
- The Trust has prepared the accounts on a going concern basis. The Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the forseeable future. This is in the context of determining the future organisational form and during the transitional period it is assured that it will secure sufficient working capital with the agreement of the NHS Trust Development Authority. For this reason the going concern basis has been adopted for preparing the accounts.
- Assessing whether significant risks and rewards of ownership of leased assets have transferred.
- Assessing whether impairments to the values of Property Plant and Equipment non current assets and intangibles have arisen in year.
- Management has declared that the financial statements are free from any misstatement as a result of fraud or any weakness in systems of internal control.

1.3.2 Key sources of estimation uncertainty

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

- All land and buildings are restated to fair values using the professional valuation provided by the District Valuer based on a valuation date of 1st April 2010. The carrying amount for land and buildings as at 31 March 2013 has been assessed using recognised published indices and where the impact of the revaluation is material the assets have been revalued (see note 15).
- Holiday pay due to employees but not taken at 31st March is accrued for based on the carried forward leave information received from a representative sample of the Trust's workforce.
- Healthcare SLA over/under performance with some commissioners is estimated based on patient activity; the final agreement of income will be made when the information is validated in accordance with the contracting timetable
- The accounting treatment for partially completed spells is to recognise the income for a treatment or spell once the patient is admitted and treatment begins on or prior to 31st March 2013. This is recognised on an agreed average of partially completed spells during the year.

1.4 Revenue

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

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

The 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 Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.5 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 scheme is accounted for as if it were a defined contribution scheme: the cost to the

NHS body of participating in the 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 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.

1.6 Other expenses

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

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- 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 a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations 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. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost.

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. 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 instructed the Health Service District Valuer Service to value Land and Buildings on a modern equivalent assets basis as at 1 April 2010. The revaluation produced a reduction in values which have been reflected through the Statement of Financial Position.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

Subsequent expenditure

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

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

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

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it

- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

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

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.9 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

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

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

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

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.10 Donated assets

Following the accounting policy change outlined in the Treasury Financial Reporting Manual (FReM) for 2011/12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as

described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.11 Government grants

The Trust has not received any government grants in either year.

1.12 Non-current assets held for sale

The Trust did not hold any non-current assets held for sale in either year.

1.13 Leases

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

The Trust as lessee

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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

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

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

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

The Trust as lessor

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

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

1.14 Private Finance Initiative (PFI) transactions

The Trust has no PFI arrangements or transactions.

1.15 Inventories

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

1.16 Cash and cash equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are

repayable on demand and that form an integral part of the Trust's cash management.

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (2.35% for employee early departure obligations, 2.8% at 31 March 2012).

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

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

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

1.18 Clinical negligence costs

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

1.19 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 the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.20 EU Emissions Trading Scheme

The Trust has not received an EU Emissions Trading scheme allowance in either year.

1.21 Contingencies

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

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

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

1.22 Financial assets

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

Financial assets are initially recognised at fair value.

The Trust does not hold financial assets in any of the following categories: financial assets at fair value through profit and loss; held to maturity investments and available for sale financial assets.

1.23 Loans and receivables

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

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

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

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

1.24 Financial liabilities

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

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

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

1.25 Value Added Tax

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

1.26 Foreign currencies

The Trust did have any foreign currency translated into sterling in either year.

1.27 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend

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

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

1.29 Losses and Special Payments

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

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

1.30 Subsidiaries

The Trust does not have any subsidiaries.

For 2010-11 to 2012-13 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate Trustee.

1.31 Associates

The Trust does not have any associates.

1.32 Joint ventures

Joint ventures are accounted for by the equity method.

The Trust does not have any Joint ventures that are 'held for sale'.

1.33 Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.34 Research and Development

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

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2012-13.

The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:
IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Pooled Budget

The Trust has not entered into any pooled budget arrangements.

3. Operating segments

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

4. Income generation activities

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

5. Revenue from patient care activities 2012-13

	2012-13 £000s	2011-12 £000s		
NHS Trusts	**0**	2		
Primary Care Trusts - tariff	**69,035**	68,139	a	2011-12 Restated
Primary Care Trusts - non-tariff	**11,130**	8,728	a	2011-12 Restated
Local Authorities	**266**	250		
Non-NHS:				
Private patients	**725**	960		
Overseas patients (non-reciprocal)	**10**	1		
Injury costs recovery	**418**	539	b	
Other	**165**	246		
Total Revenue from patient care activities	**81,749**	78,865		

Note a: The tariff and non tariff revenue from Primary Care Trusts has been restated for 2011-12 due to £3,117k reclassification.

Note b: Injury cost recovery income is subject to a provision for impairment of receivables of 12.6% to reflect expected rates of collection (10.5% 2011-12). This is in line with national guidance.

6. Other operating revenue 2012-13

	NOTE	2012-13 £000s	2011-12 £000s	
Education, training and research		**3,137**	3,101	
Charitable and other contributions to revenue expenditure - non NHS		**215**	133	
Receipt of donations for capital acquisitions - NHS Charity		**59**	46	
Non-patient care services to other bodies		**9,486**	11,261	c
Income generation		**651**	614	
Rental revenue from operating leases	9.2	**237**	231	
Other revenue		**1,255**	1,055	
Total Other Operating Revenue		**15,040**	16,441	
Total operating revenue		**96,789**	95,306	

Note c: The Trust received non recurrent funding of £6,600k (2011-12 £9,191k).

7. Revenue 2012-13

	2012-13 £000	2011-12 £000
From rendering of services	**96,789**	95,306

Revenue is from the supply of services.

8. Operating expenses (excluding employee benefits)

	2012-13 £000s	2011-12 £000s
Services from other NHS Trusts	**434**	548
Services from PCTs	**13**	28
Services from other NHS bodies	**193**	123
Services from Foundation Trusts	**945**	863
Purchase of healthcare from non NHS bodies	**54**	35
Trust Chair and Non-executive Directors	**51**	49
Supplies and services - clinical	**14,897**	13,321
Supplies and services - general	**1,685**	1,632
Consultancy services	**900**	378
Establishment	**658**	746
Transport	**275**	128
Premises	**2,950**	3,097
Impairments and Reversals of Receivables	**23**	(37)
Depreciation	**3,298**	3,089
Amortisation	**261**	251
Impairments and reversals of property, plant and equipment	**294**	5,178
Impairments and reversals of intangible assets	**539**	0
Audit fees	**89**	131
Clinical negligence	**1,440**	1,120
Education and Training	**389**	408
Other	**432**	476
Total Operating expenses (excluding employee benefits)	**29,820**	31,564
Employee benefits		
Employee benefits excluding Board members	**63,126**	62,764
Board members	**583**	454
Total employee benefits	**63,709**	63,218
Total operating expenses	**93,529**	94,782

9. Operating Leases

9.1 Trust as lessee

	Buildings £000s	Other £000s	2012-13 Total £000s	2011-12 Total £000s
Payments recognised as an expense				
Minimum lease payments	**119**	**74**	**193**	158
Total	**119**	**74**	**193**	158
Payable:				
No later than one year	**67**	**95**	**162**	157
Between one and five years	**134**	**262**	**396**	409
After five years	**660**	**0**	**660**	0
Total	**861**	**357**	**1,218**	566

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

The most significant future minimum lease payment in the Other category relates to the Pathology Managed Equipment Service contract with Roche Diagnostics which has 3 years remaining.

9.2 Trust as lessor

	2012-13 £000	2011-12 £000s
Recognised as income		
Rental revenue	**237**	231
Total	**237**	231
Receivable:		
No later than one year	**237**	231
Between one and five years	**341**	389
After five years	**4,773**	4,858
Total	**5,351**	5,478

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 61 years remaining.

10. Employee benefits and staff numbers

10.1 Employee benefits

	2012-13 Total £000s	Permanently employed £000s	Other £000s	2011-12 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure						
Salaries and wages	**54,013**	**48,274**	**5,739**	53,287	48,376	4,911
Social security costs	**3,810**	**3,810**	**0**	4,022	4,022	0
Employer Contributions to NHS BSA - Pensions Division	**5,730**	**5,730**	**0**	5,828	5,828	0
Other pension costs	**0**	**0**	**0**	126	126	0
Termination benefits	**292**	**292**	**0**	0	0	0
Total employee benefits	**63,845**	**58,106**	**5,739**	63,263	58,352	4,911
Total - Employee Benefits including capitalised costs	**63,845**	**58,106**	**5,739**	63,263	58,352	4,911
Employee costs capitalised	**136**	**50**	**86**	45	25	20
Gross Employee Benefits excluding capitalised costs	**63,709**	**58,056**	**5,653**	63,218	58,327	4,891

10.2 Staff Numbers

	2012-13 Total Number	Permanently employed Number	Other Number	2011-12 Total Number
Average Staff Numbers				
Medical and dental	**213.6**	**188.8**	**24.8**	217.6
Administration and estates	**323.9**	**321.0**	**2.9**	342.6
Healthcare assistants and other support staff	**371.5**	**315.6**	**55.9**	347.4
Nursing, midwifery and health visiting staff	**429.5**	**393.3**	**36.2**	436.0
Scientific, therapeutic and technical staff	**172.5**	**171.2**	**1.3**	177.6
Other	**5.8**	**5.8**	**0.0**	0.0
TOTAL	**1,516.8**	**1,395.7**	**121.1**	1,521.2
Of the above - staff engaged on capital projects	**3.0**	**1.2**	**1.8**	1.1

10.3 Staff Sickness absence and ill health retirements

Staff Sickness absence	**2012-13 Number**	2011-12 Number
Total Days Lost	**12,110**	12,192
Total Staff Years	**1,415**	1,465
Average working Days Lost	**8.6**	8.3

Ill Health retirements	**2012-13 Number**	2011-12 Number
Number of persons retired early on ill health grounds	**1**	0
	£000s	£000s
Total additional pensions liabilities on ill health grounds accrued in the year	**102**	0

10.4 Exit Packages Agreed in 2012-13

Exit package cost band (including any special payment element)	**2012-13 Number of other departures agreed Number**	2011-12 Number of other departures agreed Number
Less than £10,000	**3**	0
£10,001-£25,000	**3**	0
£25,001-£50,000	**3**	0
£50,001-£100,000	**1**	0
£100,001 - £150,000	**1**	0
Total number of exit packages by type	**11**	0
Total resource cost (£000s)	**354**	0

Departure costs have been paid in accordance with the provisions of a mutually agreed resignation scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

10.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the 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 the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.
The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

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 the employer. Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Measure of compliance

	2012-13 Number	2012-13 £000s	2011-12 Number	2011-12 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**30,076**	**27,399**	27,425	22,578
Total Non-NHS Trade Invoices Paid Within Target	**29,058**	**26,497**	25,902	21,149
Percentage of NHS Trade Invoices Paid Within Target	**96.62%**	**96.71%**	94.45%	93.67%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,258**	**8,932**	1,268	8,832
Total NHS Trade Invoices Paid Within Target	**1,071**	**8,152**	954	7,141
Percentage of NHS Trade Invoices Paid Within Target	**85.14%**	**91.27%**	75.24%	80.85%
Total Payables				
Total Trade Invoices Paid in the Year	**31,334**	**36,331**	28,693	31,410
Total Trade Invoices Paid Within Target	**30,129**	**34,649**	26,856	28,290
Percentage of Trade Invoices Paid Within Target	**96.15%**	**95.37%**	93.60%	90.07%

The Better Payment Practice Code requires the Trust to aim to pay 95% of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust met this target.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

No claims for interest in respect of late payment of invoices have been made against the Trust by other businesses under this legislation in either period.

No claims for compensations to cover debt recovery costs have been made against the Trust in either period.

12 Investment Income

	2012-13 £000s	2011-12 £000s
Interest Income		
Bank interest	**11**	10
Total investment income	**11**	10

13 Other Gains and Losses

	2012-13 £000s	2011-12 £000s
(Loss) on disposal of assets other than by sale property plant and equipment	**(3)**	(21)
Total	**(3)**	(21)

14 Finance Costs

	2012-13 £000s	2011-12 £000s
Interest		
Interest on loans and overdrafts	**110**	364
Provisions - unwinding of discount	**6**	9
Total	**116**	373

15.1 Property, plant and equipment

2012-13	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's		£000's	£000's	£000's	£000's	£000's
Cost or valuation:							
Opening Cost or Valuation	**9,905**	**44,790**	**1,660**	**14,426**	**3,421**	**1,300**	**75,502**
Opening Balance Adjustment	0	6	0	(20)	0	144	**130**
At 1 April 2012	**9,905**	**44,796**	**1,660**	**14,406**	**3,421**	**1,444**	**75,632**
Additions of Assets Under Construction	**0**	**0**	1,061	**0**	**0**	**0**	**1,061**
Additions Purchased	0	643		1,077	685	0	**2,405**
Additions Donated	0	0	0	59	0	0	**59**
Reclassifications	0	6	(1,765)	1,759	90	0	**90**
Disposals other than for sale	0	(18)	0	0	0	(76)	**(94)**
Impairments/negative indexation	0	(1,335)	0	0	0	0	**(1,335)**
At 31 March 2013	**9,905**	**44,092**	**956**	**17,301**	**4,196**	**1,368**	**77,818**
Depreciation							
Opening Depreciation	**0**	**2,987**	**0**	**8,447**	**1,544**	**1,019**	**13,997**
Opening Balance Adjustment	0	6	0	(20)	0	144	**130**
At 1 April 2012	**0**	**2,993**	**0**	**8,427**	**1,544**	**1,163**	**14,127**
Disposals other than for sale	0	(18)	0	0	0	(71)	**(89)**
Impairments	0	319	0	0	0	0	**319**
Reversal of Impairments	0	(25)	0	0	0	0	**(25)**
Charged During the Year	0	1,616		1,088	494	100	**3,298**
At 31 March 2013	**0**	**4,885**	**0**	**9,515**	**2,038**	**1,192**	**17,630**
Net Book Value at 31 March 2013	**9,905**	**39,207**	**956**	**7,786**	**2,158**	**176**	**60,188**
Purchased	9,905	35,932	956	7,497	2,158	175	**56,623**
Donated	0	3,275	0	289	0	1	**3,565**
Total at 31 March 2013	**9,905**	**39,207**	**956**	**7,786**	**2,158**	**176**	**60,188**
Asset financing:							
Owned	9,905	39,207	956	7,786	2,158	176	**60,188**
Total at 31 March 2013	**9,905**	**39,207**	**956**	**7,786**	**2,158**	**176**	**60,188**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	7,845	3,019	0	26	0	0	**10,890**
Movements	0	(1,334)	0	0	0	0	**(1,334)**
At 31 March 2013	**7,845**	**1,685**	**0**	**26**	**0**	**0**	**9,556**

Additions to Assets Under Construction in 2012-13

	£000's
Buildings excluding Dwellings	810
Plant & Machinery	251
Balance as at Year to date	**1,061**

15.2 Property, plant and equipment prior-year

2011-12	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:							
At 1 April 2011	9,905	41,036	8,520	13,024	3,706	1,398	77,589
Additions - purchased	0	431	1,777	1,263	342	0	3,813
Additions – donated	0	0	0	46	0	0	46
Reclassifications	0	8,244	(8,637)	320	19	46	(8)
Disposals other than by sale	0	0	0	(227)	(646)	(144)	(1,017)
Revaluation & indexation gains	0	729	0	0	0	0	729
Impairments	0	(380)	0	0	0	0	(380)
Cumulative dep'n netted off cost following revaluation	0	(5,270)	0	0	0	0	(5,270)
At 31 March 2012	9,905	44,790	1,660	14,426	3,421	1,300	75,502
Depreciation							
At 1 April 2011	0	1,478	0	7,625	1,765	1,060	11,928
Disposals other than for sale	0	0	0	(188)	(645)	(144)	(977)
Upward revaluation/positive indexation	0	49	0	0	0	0	49
Impairments	0	5,178	0	0	0	0	5,178
Charged During the Year	0	1,552	0	1,010	424	103	3,089
Cumulative dep'n netted off cost following revaluation	0	(5,270)	0	0	0	0	(5,270)
At 31 March 2012	0	2,987	0	8,447	1,544	1,019	13,997
Net book value at 31 March 2012	9,905	41,803	1,660	5,979	1,877	281	61,505
Purchased	9,905	38,290	1,660	5,695	1,877	271	57,698
Donated	0	3,513	0	284	0	10	3,807
Total at 31 March 2012	9,905	41,803	1,660	5,979	1,877	281	61,505
Asset financing:							
Owned	9,905	41,803	1,660	5,979	1,877	281	61,505
Total at 31 March 2012	9,905	41,803	1,660	5,979	1,877	281	61,505

15.3 (cont). Property, plant and equipment

Of the totals at 31 March 2013 there are no tangible fixed assets relating to land, buildings, dwellings, installations or fittings valued at open market value. (31 March 2012 also Nil).

The Trust property, plant and equipment was last revalued on 1 April 2010 by the Valuation Office Agency who are independent to the Trust. The valuation was undertaken having regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition, in so far as these terms are consistent with the requirements of HM Treasury, the National Health Service and Department of Health and carried out on the basis of Depreciated Replacement Cost for specialised operational property and existing use value for non specialised operational property.

Gains relating to indexation 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.

As at the 31st March 2013 the Building Cost Information service (BCIS) index for buildings had fallen by 4% over the year. This resulted in a reduction in the value of buildings by £1,629,000.

There were no assets held under finance leases or hire purchase contracts at the balance sheet date. (31 March 2012 also Nil)

No dwellings or transport equipment assets were held in either period.
Donations towards plant and equipment expenditure in the year have been provided by the Weston Health General Charitable Fund.

There are no restrictions imposed on the use of donated assets.

15.4 Economic Lives of Non-Current Assets

Intangible Assets	**Min/Max Life in years**
Software Licences	5 - 8
Property, Plant and Equipment	
Buildings exc Dwellings	5 - 77
Plant & Machinery	5 - 35
Information Technology	5 - 18
Furniture and Fittings	5 - 15

16.1 Intangible non-current assets

2012-13	Software purchased £000's
At 1 April 2012	**3,326**
Additions - purchased	**294**
Reclassifications	**(90)**
Disposals other than by sale	**0**
At 31 March 2013	**3,530**
Amortisation	
At 1 April 2012	**850**
Reclassifications	**0**
Impairments charged to operating expenses	**539**
Charged during the year	**261**
At 31 March 2013	**1,650**
Net Book Value at 31 March 2013	**1,880**
Net book value at 31 March 2013 comprises:	
Purchased	**1,880**
Total at 31 March 2013	**1,880**

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

16.2 Intangible non-current assets prior year

2011-12	Software purchased £000s
Cost or valuation:	
At 1 April 2011	2,701
Additions - purchased	761
Reclassifications	8
Disposals other than by sale	(144)
At 31 March 2012	3,326
Amortisation	
At 1 April 2011	743
Disposals other than by sale	(144)
Charged during the year	251
At 31 March 2012	850
Net book value at 31 March 2012	2,476
Net book value at 31 March 2012 comprises:	
Purchased	2,476
Total at 31 March 2012	2,476

16.3 Intangible non-current assets

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

Assets are capitalised and amortised over the useful lives on a straight-line basis. Useful lives are all finite and range from 5 to 8 years.

17 Analysis of impairments and reversals recognised in 2012-13

	2012-13 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Total charged to Departmental Expenditure Limit	**0**
Changes in market price	**294**
Total charged to Annually Managed Expenditure	**294**
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Changes in market price	**1,335**
Total impairments for PPE charged to reserves	**1,335**
Total Impairments of Property, Plant and Equipment	**1,629**
Intangible assets impairments and reversals charged to SoCI	
Other	**539**
Total charged to Annually Managed Expenditure	**539**
Total Impairments of Intangibles	**539**
Total Impairments charged to Revaluation Reserve	**1,335**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**833**
Overall Total Impairments	**2,168**

As at the 31st March 2013 the Building Cost Information Service (BCIS) index for buildings had fallen by 4% over the year. This resulted in a reduction in the value of buildings by £1,629,000 of which £1,335,000 was charged to the revaluation reserve to the extent that the balance existed previously and £294,000 impaired and charged to the Statement of Comprehensive Income.

An impairment loss for intangible assets was recognised where the holding value exceeded the recoverable amount by £539,000. This was made up as follows:

- Picture Archive & Communication System (PACS) and Radiology Information Systems (RIS) £529,000
- Other software £10,000 (Finance system and Performance Accelerator system for Auditors Local Evaluation)

18 Investment property

The Trust did not hold investment property for either year.

19 Commitments

19.1 Capital commitments

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

	31 March 2013	31 March 2012
	£000s	£000s
Property, plant and equipment	**1,006**	336
Total	**1,006**	336

19.2 Other financial commitments

The Trust did not have any other financial commitments in 2012-13 or 2011-12.

20 Intra-Government and other balances

	Current receivables	**Non-current receivables**	**Current payables**	**Non-current payables**
	£000s	**£000s**	**£000s**	**£000s**
Balances with other Central Government Bodies	1,443	0	2,079	0
Balances with Local Authorities	8	0	4	0
Balances with NHS bodies outside the Departmental Group	20	0	0	0
Balances with NHS Trusts and Foundation Trusts	145	0	566	0
Balances with bodies external to government	1,129	410	7,116	0
At 31 March 2013	**2,745**	**410**	**9,765**	**0**
Prior period:				
Balances with other Central Government Bodies	1,207	0	2,182	0
Balances with Local Authorities	7	0	0	0
Balances with NHS Trusts and Foundation Trusts	548	0	509	0
Balances with bodies external to government	1,341	382	6,692	0
At 31 March 2012	**3,103**	**382**	**9,383**	**0**

21 Inventories

	Drugs	**Consumables**	**Energy**	**Total**
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2012	612	626	10	**1,248**
Additions	7,701	6,996	0	**14,697**
Inventories recognised as an expense in the period	(7,557)	(6,990)	(1)	**(14,548)**
Balance at 31 March 2013	**756**	**632**	**9**	**1,397**

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
NHS receivables - revenue	**1,354**	1,586	**0**	0
Non-NHS receivables - revenue	**201**	619	**469**	441
Non-NHS prepayments and accrued income	**601**	446	**0**	0
Provision for the impairment of receivables	**(98)**	(89)	**(59)**	(59)
VAT	**187**	169	**0**	0
Interest receivables	**0**	1	**0**	0
Other receivables	**500**	371	**0**	0
Total	**2,745**	3,103	**410**	382
Total current and non current	**3,155**	3,485		

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2 Receivables past their due date but not impaired

	31 March 2013 £000s	31 March 2012 £000s
By up to three months	**163**	277
By three to six months	**83**	367
By more than six months	**528**	708
Total	**774**	1,352

22.3 Provision for impairment of receivables

	2012-13 £000s	2011-12 £000s
Opening balance at 1 April	**(148)**	(217)
Amount written off during the year	**14**	32
(Increase)/decrease in receivables impaired	**(23)**	37
Closing balance at 31 March	**(157)**	(148)

23 NHS LIFT investments

The Trust does not hold NHS Lift investments in either 2012-13 or 2011-12.

24.1 Other Financial Assets - Current

The Trust has not held any fixed or current asset investments during either year.

25 Other current assets

The Trust did not have any other current assets in 2012-13 or 2011-12.

26 Cash and Cash Equivalents

	31 March 2013 £000s	31 March 2012 £000s
Opening balance at 1 April	**1,987**	156
Net change in year	**226**	1,831
Closing balance at 31 March	**2,213**	1,987
Made up of		
Cash with Government Banking Service	**2,181**	2,053
Commercial banks	**25**	(69)
Cash in hand	**7**	3
Cash and cash equivalents as in statement of financial position	**2,213**	1,987
Cash and cash equivalents as in statement of cash flows	**2,213**	1,987

27 Non-current assets held for sale

The Trust did not hold any non current assets held for sale in either 2012-13 or 2011-12.

28 Trade and other payables

	Current	
	31 March 2013 £000s	31 March 2012 £000s
NHS payables - revenue	**632**	582
NHS payables - capital	**17**	22
NHS accruals and deferred income	**0**	110
Non-NHS payables - revenue	**1,750**	918
Non-NHS payables - capital	**1,810**	1,979
Non-NHS accruals and deferred income	**3,548**	3,758
Social security costs	**583**	568
Tax	**654**	693
Other	**771**	753
Total	**9,765**	9,383
Total payables (current and non-current)	**9,765**	9,383
Included above:		
Outstanding Pension Contributions at the year end	**759**	714

29 Other liabilities

The Trust did not have any other liabilities as at 31 March 2013 (Nil 31 March 2012).

30 Borrowings

	Current	
	31 March 2013	31 March 2012
	£000s	£000s
Loans from Department of Health	**0**	2,250
Total other liabilities (current and non-current)	**0**	2,250

The Trust agreed a capital loan facility with the Department of Health on 15th July 2008 for £14,300,000 repayable over 7 years at an interest rate of 5.32% to repay historic debts. The Trust has fully repaid the loan in line with the terms of the 5 year recovery plan agreed with the Strategic Health Authority.

31 Other financial liabilities

The Trust had no other financial liabilities during 2012-13 and 2011-12.

32 Deferred income

32 Deferred income

	Current	
	31 March 2013	31 March 2012
	£000s	£000s
Opening balance at 1 April	**512**	660
Deferred income addition	**51**	17
Transfer of deferred income	**(67)**	(165)
Current deferred income at 31 March	**496**	512
Total deferred income	**496**	512

33 Finance lease obligations as lessee

The Trust had no finance lease obligations during 2012-13 and 2011-12.

34 Finance lease receivables as lessor

The Trust had no finance lease receivables during 2012-13 and 2011-12.

35 Provisions

	Total	Comprising: Pensions Relating to Other Staff	Legal Claims	Restructuring	Other
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2012	**657**	155	9	252	241
Arising During the Year	**389**	0	18	294	77
Utilised During the Year	**(334)**	(29)	(5)	(216)	(84)
Reversed Unused	**(38)**	0	(2)	(36)	0
Unwinding of Discount	**6**	3	0	0	3
Balance at 31 March 2013	**680**	**129**	**20**	**294**	**237**
Expected Timing of Cash Flows:					
No Later than One Year	**430**	29	20	294	87
Later than One Year and not later than Five Years	**140**	100	0	0	40
Later than Five Years	**110**	0	0	0	110

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

	£000s
As at 31 March 2013	**2,595**
As at 31 March 2012	2,878

Provisions for 'Pensions relating to other staff' 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.

The Trust has reviewed the provision for restructuring using a mutually agreed resignation scheme. As at 31st March 2013 there are 11 cases identified.

Other - £237,000 is made up of 2 cases, a permanent injury benefit £161,000 and 2 other contractual claims (31 March 2011 £167,000 permanent injury benefit case).

36 Contingencies

	31 March 2013	31 March 2012
	£000s	£000s
Contingent liabilities		
Other	**(16)**	(13)
Net Value of Contingent Liabilities	**(16)**	(13)

The contingent liabilities represent possible legal claims against the Trust, these are managed by the NHS Litigation Authority for clinical negligence and liabilities for third parties scheme, £16,000 31 March 2013, (£13,000 31 March 2012).

37 PFI and LIFT - additional information

The Trust did not have any PFI and LIFT dealings or transactions in either 2012-13 or 2011-12.

38 Impact of IFRS treatment - current year

The was not any revenue consequences resulting from impact of IFRS in 2012-13 or 2011-12.

39 Financial Instruments

39.1 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 Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS 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 NHS 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 NHS 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. Trust 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 for capital expenditure, subject to affordability as confirmed by the Strategic Health Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, 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 income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

The maximum exposures as at 31 March 2013 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 Primary Care Trusts, 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.

39.2 Financial Assets

	Loans and receivables £000s
Receivables - NHS	**1,354**
Receivables - non-NHS	**999**
Cash at bank and in hand	**2,213**
Total at 31 March 2013	**4,566**
Receivables - NHS	1,586
Receivables - non-NHS	1,271
Cash at bank and in hand	1,987
Total at 31 March 2012	4,844

39.3 Financial Liabilities

	Other £000s
NHS payables	**845**
Non-NHS payables	**6,621**
Other financial liabilities	**135**
Total at 31 March 2013	**7,601**
NHS payables	1,176
Non-NHS payables	5,720
Other borrowings	2,250
Other financial liabilities	72
Total at 31 March 2012	9,218

40 Events after the end of the reporting period

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

The financial statements were authorised for issue on 05 June 2013, following approval by the Trust Board.

41 Related party transactions

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

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

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

These entities are: Bristol PCT, NHS Blood and Transplant, NHS Litigation Authority, North Bristol NHS Trust, North Somerset PCT, Somerset PCT, South Gloucestershire PCT, South West Strategic Health Authority, University Hospitals of 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. HM Revenue and Customs.

The Trust has also received revenue and capital payments of £215,000 from the Weston Health General Charitable funds whose Trustees are the same as those members of the NHS Trust Board. The Charity is a separate legal entity (Registered Charity 1057589) and produces its own annual report of accounts that is open to public view on the charity commission website.

42 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	**14,116**	**39**
Special payments	**13,909**	**21**
Total losses and special payments	**28,025**	**60**

The total number of losses cases in 2011-12 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	13,709	49
Special payments	10,139	15
Total losses and special payments	23,848	64

43 Financial performance targets

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

43.1 Breakeven performance

	2005-06 £000s	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s
Turnover	68,162	70,300	80,100	85,914	90,403	93,199	95,306	**96,789**
Retained surplus/(deficit) for the year	(6,989)	(6,673)	8	408	(68)	2,110	(1,703)	**1,312**
Adjustment for:								
Impairments				0	2,516	497	5,178	**833**
Impact of policy change re donated assets							135	**105**
Other agreed adjustments	5,154	0	0	0	0	0	0	**0**
Break-even in-year position	**(1,835)**	**(6,673)**	**8**	**408**	**2,448**	**2,607**	**3,610**	**2,250**
Break-even cumulative position	**(7,569)**	**(14,242)**	**(14,234)**	**(13,826)**	**(11,378)**	**(8,771)**	**(5,161)**	**(2,911)**

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's 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.

The Trust has delivered it's recovery plan for the 5 years from the 1 April 2008 to 31 March 2013.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %
Materiality test (I.e. is it equal to or less than 0.5%):								
Break-even in-year position as a percentage of turnover	-2.7	-9.5	0.0	0.5	2.7	2.8	3.8	**2.3**
Break-even cumulative position as a percentage of turnover	-11.1	-20.3	-17.8	-16.1	-12.6	-9.4	-5.4	**-3.0**

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

43.2 Capital cost absorption rate

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

43.3 External financing

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

	£000s	**2012-13 £000s**	2011-12 £000s
External financing limit		**1,150**	(2,576)
Cash flow financing	**(2,417)**		(4,395)
Other capital receipts	**(59)**		(46)
External financing requirement		**(2,476)**	(4,441)
Undershoot		**3,626**	1,865

43.4 Capital resource limit

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

	2012-13 £000s	2011-12 £000s
Gross capital expenditure	**3,819**	4,620
Less: book value of assets disposed of	**(5)**	(40)
Less: donations towards the acquisition of non-current assets	**(59)**	(46)
Charge against the capital resource limit	**3,755**	4,534
Capital resource limit	**5,650**	6,529
Underspend against the capital resource limit	**1,895**	1,995

44 Third party assets

The Trust held £375 cash and cash equivalents at 31 March 2013 (£232 at 31 March 2012) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Letter of Representation June 2013

5 June 2013

Weston Area Health NHS
NHS Trust

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

FINANCE DEPARTMENT
Weston General Hospital
Grange Road, Uphill
Weston-super-Mare
Somerset
BS23 4TQ

Tel: 01934 636363
Direct Line: 01934 647002

Website: http://www.waht.nhs.uk/

Dear Sirs

Weston Area Health NHS Trust
Financial Statements for the year ended 31 March 2013

This representation letter is provided in connection with the audit of the financial statements of Weston Area Health NHS Trust for the year ended 31 March 2013 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with International Financial Reporting Standards and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

Financial Statements

i We acknowledge, as Trust Board members our responsibilities under the National Health Services Act 2006 for preparing financial statements which give a true and fair view and for making accurate representation to you.

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

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

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

v All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the Manual for Accounts require adjustment or disclosures have been adjusted or disclosed.

vi We have adjusted the misclassifications and disclosure changes brought to our attention in the Audit Findings report, with the exception of those findings which are considered to be immaterial to the results of the Trust and its financial position at the year-end. The financial statements are free of material misstatements, including omissions.

vii In calculating the amount of income to be recognised in the accounts from the NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be received by the Trust in accordance with the Accounting Standards and Manual for Accounts.

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

Information Provided

ix We have provided you with:

- x access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- xi additional information that you have requested from us for the purpose of your audit; and
- xii unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

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

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

xv We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the Trust and involves:

- xvi management;
- xvii employees who have significant roles in internal control; or
- xviii others where the fraud could have a material effect on the financial statements.

xix We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, regulators or others.

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

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

We have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. This is in the context of determining the future organisational form and during the transitional period it is assured that it will secure sufficient working capital with the agreement of the NHS Trust Development Authority.

The Trust received written confirmation from the Trust Development Authority (TDA) on 28 May 2013 confirming that the TDA will provide financial support to address any shortfall in cash funding for 2013/14.

Annual Report

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

Annual Governance Statement

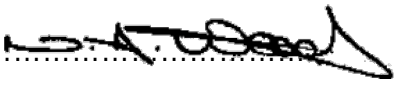
xxiii The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of the Care Quality Commission or other regulatory authorities that could have a material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

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

Approval

The approval of this letter of representation was minuted by the Trust's Audit Committee at its meeting on 5 June 2013.

Signed on behalf of the Board

Name…Nick Wood……Signed…… 

Position Chief Executive

Date **05 June 2013**

Name……Ian Turner…… Signed **[Signed on original]**

Position Chair of Audit & Assurance Committee

Date **05 June 2013**

Glossary

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 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. Corporate Governance should underpin all that an organisation does. In the NHS this means it must encompass clinical, financial and organisational aspects.
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 Dividend Capital	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 Earnings Reserve	Retained earnings are the aggregate surplus or deficit the NHS trust has made in former years.

Glossary of Abbreviations

AHERG	Avon Health Emergency Resilience Group
AHP	Allied Health Professional
BCP	Business Continuity Plans
BNSSG	Bristol, North Somerset, South Gloucestershire
CBI	Confederation of British Industry
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosive
CCA	The Civil Contingencies Act
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQUINS	Commissioning for Quality & Innovation Schemes
CRES	Cash Releasing Efficiency Savings
CRL	Capital Resource Limit
DNA	"Did Not Attend"
ED	Emergency Department
EFL	External Financing Limit
HCAIs	Healthcare Acquired Infections
IFRS	International Financial Reporting Standards
IM & T	Information Management and Technology
KPI	Key Performance Indicator
LOS	Length of stay
LRF	Avon and Somerset Resilience Forum
MRSA	*Methicillin-resistant Staphylococcus Aureus*
NICE	National Institute for Health & Clinical Excellence
NPSA	National Patients Safety Agency

NVQ	National Vocational Qualification
OPD	Outpatient Department
PALS	Patient Advice & Liaison Service
PCT	Primary Care Trust
PRIDE	Patients First, Recognise & Respect, Invest in people, Delivery and Explain
QCF	Qualifications & Credit Framework
QIPP	Quality, Innovation, Productivity & Prevention
SHA	Strategic Health Authority
SLA	Service Level Agreement
VTE	Venous Thromboembolism