Weston Area Health NHS Trust

Annual Report and Accounts 2015/16

We are WAHT.

Our strategic aim

Work in partnership to provide outstanding healthcare.

Our values

- **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 (**C**are and **C**ommitment)
- **Reputation** –actions which build and maintain the Trust's good name in the community (**C**ommunication)
- **Innovation** – demonstrating a fresh approach or finding new solutions to problems (**C**ourage)
- **Dignity** – Contributing to the Trust's Dignity in Care priorities (**C**ompassion)
- **Excellence and equality** – demonstrating excellence in and equality of service provision (**C**ompetence)

Our vision

To work in parntership to provide outstanding healthcare

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

Our new business model

- moving to a "value added" approach to patient treatment focused on delivery of consistent and standardised processes to deliver consistent results and evidence-based treatment. This approach will allow for a more radical workforce planning process with staff including nurse practitioners and physician assistants to competently perform tasks doctors used to manage. This will allow the Trust to reduce complexity and cost, ensure that treatments are performed at lower cost with equal outcomes outside of an acute environment where appropriate and release capacity to potentially grow some services.
- moving from a "treatment of ill-health" service model to one which embeds proactive "ill-health prevention" and "improving health and well-being" focus;
- moving from an "independent" service provider model to one of "formal partnership" allowing a range of service provision partnership arrangements in our place.

Contents

Part 1 – Performance report

Chief Executive's Overview

Welcome to the Weston Area Health NHS Trust's Annual Report for 2015/16

Our Annual Report is an important publication for the Trust. It sets out the steps we have taken to improve services for our patients and how we are performing against national standards and benchmarks.

2015/16 has been a full and challenging year for the Trust. The numbers of people attending our Emergency Department has continued to increase. During the year there have been sustained periods of peak demand that proved a real test of our resilience.

The acquisition of the Trust by Taunton and Somerset NHS Foundation Trust was terminated by the NHS Trust Development Authority in mid October 2015. The transaction termination does not place the Hospital or its Community Services at risk; however it does provide greater freedom to make the changes needed to innovate and modernise services.

In May 2015 the Trust underwent a full CQC inspection with a further follow-up visit in August 2015. Reports following the visit were published in August and September 2015 respectively. These reports gave the Trust an overall rating of 'Requires Improvement' noting that our Children and Adolescent Mental Health services were 'outstanding' and 'caring' was found to be good or outstanding across the board. The 'safe' domain was more of a challenge however, (particularly for urgent and emergency services) with an overall rating of 'inadequate' Much work has been done to address this rating and the Trust remains on an improvement trajectory for this work.

The Trust also received challenges from the Health Education England and the General Medical Council (GMC) following a poor rating in our junior doctor training survey. Much improvement has been undertaken arising from this feedback although again the Trust remains on an improvement pathway. Our current focus of improvement is in our Emergency Department where we are working with nearby Trusts to support our local services.

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

We are committed to supporting our staff and delighted to note that we are improving in four key findings of;

- KF1. Staff recommendation of the trust as a place to work or receive treatment
- KF4. Staff motivation at work
- KF10. Support from immediate managers
- KF32. Effective use of patient / service user feedback

We also need to note that we have further work to do for staff to report that communications with senior managers are good and that senior managers take action to support the health and wellbeing of staff.

I hope you find this report an informative read and take assurance from the steps the trust continues to take to improve services for our patients whilst making best use of the resources available to us.

James Rimmer, Chief Executive - May 2016

What we do

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

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

The Trust serves a resident population which, in 2011 was estimated to be 202,566 people (source: 2011 census), 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. The Trust also provides services to North Sedgemoor which has an estimated population (April 2012) of 47,825. The largest town is Bridgewater, followed by Burnham-on-Sea and Highbridge.

NHS North Somerset Clinical Commissioning Group is the Trust's main commissioner accounting for approximately 69% of Trust healthcare income, with NHS Somerset accounting for circa 16% of income. In addition, the Trust receives other non-patient related income including education and training monies.

The age structure in North Somerset is older with fewer younger dependents and people aged under 40. One in five people in North Somerset are aged over 65 compared to 18% in England. The total North Somerset population is expected to increase by 40% by 2033 (national average growth is 18%)

The largest increases have been and are expected to continue to be in the older people. Between the 2001 census and the 2014 mid-year estimates the number of people aged 65 years and over has increased by 31% and for those aged 85 years and over by 33%. The population aged 65 yrs + is higher than England and the South West. Older people make up 23.8% of Nth Somerset's population (19.5% national). The number of people aged 85yrs and over is expected to increase by 36% by 2021.

However, higher birth rates in recent years have resulted in growth of the under 5s and there is an anticipated increase in the number of 5 – 14 yrs old by 2021. In addition the expansion plans of Weston College, its recent designation as a University Centre, and the development of a Law and Professional Services Academy within the Town Centre will be the catalyst for bringing significantly more students to the town, further expanding the younger population.

The number of new houses is planned to increase in North Somerset by up to 36,000 over the next ten years and is anticipated to substantially increase the number of younger families with children living within the Trust's catchment population.

The temporary resident population is considerably increased in North Somerset during summer months as a consequence of tourism.

North Sedgemoor lies almost entirely within Sedgemoor District, which is projected by the ONS to grow by 18% between 2012 and 2037. The largest town is Bridgwater, followed by Burnham-on-Sea and Highbridge. The population aged 65 years and over in Sedgemoor is expected to increase by circa 42% over the same period with the population aged 85 and over expected to increase by 24.2% which is above the county average.

There is a greater proportion of people in their sixties and seventies in particular than the Somerset average, with relatively few in the 15-39 age bracket, both males and females. In particular, almost one in three people in Burnham-On-Sea North ward are of retirement age.

Approximately 700 dwellings are planned in North Sedgemoor to accommodate growth.

The composition of households in North Somerset is changing. In 2001 29% of households in North Somerset consisted of one person, by 2011 this had risen to 31%. Nearly one in three people (29%) aged over 65 in North Somerset lives alone. In 2011, 6% of all households consisted of a single parent with dependent children, a rise of 35% since 2001 and at a faster rate than in England and Wales (19% rise).

There are approximately 4,800 households with dependent children in the North Sedgemoor area, accounting for about one in four of all households, similar to the county and regional averages.

The population of North Somerset is less ethnically diverse than England and Wales with 97% of people living in North Somerset classifying themselves as belonging to a white ethnic group, a decrease of one percentage point since 2001. Of those from a black or minority ethnic group 44% classified themselves as Asian and a further 37% classified themselves as mixed race.

In North Sedgemoor, those identifying themselves as White non-British comprise half of the BME population in the area.

North Somerset is a very diverse area with extremes of affluence and considerable deprivation and is therefore more likely to experience wider inequalities than areas with more similar populations. Using the 2010 Index of Multiple Deprivation North Somerset has the 7th widest inequalities gap in the country. Evidence shows that levels of relative deprivation have increased in North Somerset in recent years. Weston-super-Mare Central and Weston-super-Mare South wards are the most deprived areas in North Somerset, falling in the bottom 1% in the country. High levels of deprivation translate to lower than average life expectancy figures. Within North Somerset the gap in life expectancy is 22 years for men and 15 years for women between the 10% most deprived areas and 10% most affluent areas. There is evidence that this gap is widening because life expectancy in the most affluent areas has risen faster than in the most deprived areas.

In North Sedgemoor, the Index of Multiple Deprivation score is lower than that of the surrounding Somerset area and England scores, indicating a lower prevalence of deprivation with the exception of areas around Highbridge and Burnham-On-Sea. 3% of the area's population live within one of the 20% most deprived areas within England, below the regional average.

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. The Trust's asset base is valued at £66.6m (31 March 2016)

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

Our vision and values

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

Work in partnership to provide outstanding healthcare

By achieving this vision we will***:***

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

Our key strategic aim is to:

Deliver safe, caring and responsive services

This vision and strategic aims are supported by a series of local values which guide actions, 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 (**C**are and **C**ommitment)
Reputation –actions which help to build and maintain the Trust's good name in the community (**C**ommunication)
Innovation – demonstrating a fresh approach or finding a new solution to a problem (**C**ourage)
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Performance analysis

Development and performance of the Trust during 2015/16 and in the future

The business plan for the Trust in 2015/16 detailed a range of strategic and operational objectives which supported achievement of the Trust's vision. These objectives were aligned with the key Care Quality Commission and NHS Trust Development Authority themes of ensuring that services are Safe, Caring, Well Led, Responsive and Effective.

Strategic Objectives 2014-16

CQC/TDA						
	Ensuring services are safe	Ensuring services are caring	Ensuring services are well led	Ensuring services are responsive	Ensuring services are effective	
Strategic Objectives	Ensure that people have a positive experience of care, being treated in a safe environment that protects them from harm		Provide a flexible workforce with the capacity and capability to deliver high standards of patient care in line with changing service needs	Provide efficient and effective services, affordable and desirable to patients and referrers	Provide affordable services and demonstrate value for money	Secure a strategic partner(s) to manage the future delivery of clinically and financially sustainable and viable services which improve experience and outcomes for patients

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

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

The strategic objectives were also supported by a range of operational objectives, in turn supported by department and division work plans.

Operational Objectives 2014 - 2016

CQC/TDA key themes	Operational objectives			
Ensuring services are safe	Deliver clinically effective services which meet benchmarked best practice through implementation and audit of evidence based practice	Embed clinical leadership providing clinicians sufficient time to lead together with clear, deliverable, objectives		
Ensuring services are caring	Deliver dignified care that is responsive to patients' personal needs, ensures a positive experience of care and which meets CQUINs	Provide a safe environment for patients and reduce the incidence of avoidable harm, maintaining the level of harm free care above 93% as		

CQC/TDA key themes	Operational objectives			
	Family and Friend test standards	measured by the patient safety thermometer		
Ensuring services are well led	Provide a safe, effective and affordable workforce	Improve and drive two way communication to increase staff engagement and build staff confidence and capability	Invest in and develop our staff to continually deliver high standards	Improve the Health and Wellbeing of our staff
Ensuring services are responsive	Meet and sustain national performance standards	Provide responsive, flexible and consistent services, appropriate to the needs of the patient and in line with commissioner intentions	Make efficient use of resources through service redesign across Emergency and Planned Care	
Ensuring services are effective	Deliver the financial plan for revenue income and expenditure, capital expenditure and cash.	Deliver the savings programme for each year.	Develop the IM&T plan to support safe, effective and efficient service delivery	
	Deliver the Trust's responsibilities within the transition programme as defined in the transition plan.			

The Trust demonstrated a generally strong service delivery and performance against objectives during 2015/16.

Ensuring services are safe	CQC	Hospital rating of "requires improvement" post full inspection in May 2015. Internal and system-wide action plans in place to address regulatory non-compliance together with a delivery oversight and facilitative "Sustainability Board" established to deliver system-wide solution to clinical and service sustainability issues.
	GMC	Concerns post Junior Doctor survey regarding training and education experience at WGH with potential for removal of Junior Doctors from site. Detailed improvement action plans addressing Trust-wide and specific ED concerns in place with oversight of progress and support to clinical sustainability through Sustainability Board and regular review by Health Education England and the GMC.
Ensuring services are caring	Infection Control	Excellent improvements following focused leadership from infection prevention and control team that has yielded some impressive results including no MRSA blood stream infections for 570 days (May 16) and a 50% reduction in the cases of hospital attributed C- Diff. To date there have been 9 reported cases, with one lapse in care due to suboptimal prescribing of antibiotics. The Trust has the 5TH lowest rate in the South West region with a rate of 12.69 per 100,000 bed days. The national rate for England is 15.32 per 100,000 bed days. Trust consistently meets the standard for hand hygiene which is also externally validated on a quarterly basis. These impressive results have been help with the support of clinically based link practitioners. Data outcomes are shared with the divisions in 14 key areas that are updated monthly.
	Harm Free Care	**NHS Safety Thermometer.** In the last year (February 2015 to February 2016) the Trust has fallen below mean twice in new harms in hospital with 10 months at mean or exceeding. The harms reported in this tool look at inpatient falls, hospital acquired pressure ulcers (HAPU), use of indwelling urinary catheters and Venothrombosis assessments (VTE) **Incidents reported via the Trust Datix system**. The Trust reports on average 500 incidents a month from various areas. From February 2015 to February 2016 a total of 6615 incidence were reported., a welcomed increase indicating that staff are involved in the safety and harm free care agenda. NRLS report highlight that the Trust is in the top 25% for reporting of incidents for non speciality acute trusts. The Governance team is supporting learning in practice from incidence and use of thematic review is in place in high risk incidence such as falls and HAPU. **Standardised Hospital Mortality Indicators (SHMI)** – *112 (Oct 14 – Sept 15)*
Ensuring services are well led	Leadership and management development	Providing leadership and management development opportunities continued to be a high focus for the Trust throughout 2015. Offered through the NHS National Leadership Academy, the Trust has taken full advantage of the opportunities available for its managers and supervisors to gain nationally recognised qualifications in Leadership. Throughout 2015/16, we have been able to support 8 members of staff through the Nationally accredited programmes such as PG. Cert in Leadership. We have also supported a number of our staff through various one day master class courses such as Personality and Human Behaviour for Leaders. The Trust recognises that the way our managers lead and manager their staff is vital to ensure that the culture of the Trust supports staff to carry out their roles to their best ability and in so doing provide excellent patient care. The Trust has a series of local values which continue to guide actions, behaviours and decision making within the Trust and we intend to launch a programme for managers and leaders to further embed our values "PRIDE" into the Trust. We have also recognised the benefit of one-to-one coaching opportunities and we aim to extend our coaching opportunities to a wider audience during 2016.
	Staff development and Modern Apprentices	The Trust is keen to support the development of its Band 1-4 workforce and during 2015 enrolled 24 staff of all ages on an Apprenticeship programme run through Weston College. We will continue to work in partnership with Weston College and other providers to offer a range of Apprenticeship opportunities, which are dependent on staff job role. These include Customer Services, Team Leading, Business Administration and Health and Social Care. Staff have told us that achieving a nationally recognised qualification has not only improved their performance in role but has given them the confidence to go on to further NHS career opportunities. The Trust is also pleased to recognise the value of its Modern Apprentices (MA), recruited though Weston College, 8 during 2015, who offer a young and vibrant contribution to the workforce. We are also keen to encourage MAs to go on to secure permanent employment with the Trust.
Ensuring services are responsive	Emergency Department four hour target	The Emergency Access Four Hour Standard has been a particular challenge for the Trust having met the 95% standard for one month in the last twelve only. The Trust is working with the Emergency Care Improvement Programme to drive a number of changes both internally and through the North Somerset Urgent Care system. A system-wide improvement plan has been developed which aligns with the Trust internal actions to improve timeliness of emergency access for patients and address delays in transferring medically fit patients from hospital when treatment has concluded.
	Cancer targets	Improved as a result of work undertaken by the Trust with primary care to improve pathways and address issues of data completeness and patient availability on referral. Targets remain fragile due to number of complex pathways to tertiary centres for a proportion of our patients but we continue to work with these centres to ensure a seamless transfer of care where this is necessary.
	RTT	The Trust has consistently maintained the Referral to Treatment Time statutory target for over the last twelve months and has low waiting times for the majority of elective specialities. Delivery against the eight cancer standards has been challenging in respect of the 62 day target. This is due to small patient numbers and pathways between neighbouring tertiary centres which can affect timeliness, the Trust is committed to work with partners to ensure streamlined timed pathways are developed during 2016/17 so patients have streamlined care despite moves between providers
Ensuring services are effective	Financial Plan	The Trust delivered the stretch financial plan for the current year, 2015/16. The main risks relate to commissioner income due to a number of factors.

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.

In recognition of these challenges, NHS England (NHSE) published the NHS five year forward view in October 2014. This Forward View sets out a clear direction for the NHS – showing why change is needed and what it will look like, focussing on clinical models of care rather than organisational models and setting out a vision for 2020 intended to close 3 key "gaps" to ensure that the needs of future patients are addressed in a sustainable way

The Five Year Forward View challenge

Health & Wellbeing Gap	Radical upgrade in prevention	National action required on major health risks such as smoking, drinking and obesity • Targeted prevention initiatives e.g. diabetes • Much greater patient awareness • Harnessing the 'renewable energy' of communities
Care & Quality Gap	New Care Models + new support	Defining and measuring quality and tackling unwanted variation • A menu of New Care Models for local areas to consider, backed investment and flexibility in implementation • New whole systems intervention regimes to transform local health economies and raise standards
Funding & Efficiency Gap	Efficiency & investment	• Action required on three fronts: demand, efficiency and funding. • Action on prevention and care could deliver significant efficiency gains • The Government has committed to an additional £8bn in funding by 2020 and, with this investment and implementation of new care models believes that 2% could be achieved rising to 3% over the next Parliament, closing the £22bn gap.

Additional and specific local drivers also include

- 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;
- ensuring resilience in terms of service delivery and staffing.

Work undertaken by the Trust in partnership with the local health and social care economy over the last few years has demonstrated that Weston Area Health NHS Trust, as a stand-alone 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 Trust status.

Following processes to test the market through an open market and then NHS-only procurement, a decision was made by the NHS Trust Development Authority in October 2015 that the Trust should instead seek to maximise the new opportunities presented by the Five Year Forward View.

Planning Guidance issued for 2016-17 requires that local health and social care systems develop a system-wide Sustainability and Transformation Plan (STP).

The BNSSG health system has agreed to develop a single STP for the services provided to a population of over 900,000 people. It reflects a commitment jointly made by the leaders of health and social care services in BNSSG to a collective effort to transform services and improve outcomes for this population. The STP will bring together the work of 3 CCGs, 3 acute providers, 3 community providers, 3 local authorities and a provider of mental health services and involve over 100 GP practices.

Work on the BNSSG STP is underway, and leaders across the system have agreed that Robert Woolley, the CEO of University Hospitals Bristol NHS Foundation Trust (UHB), will lead the development phase.

An initial view of the strategic priorities for the BNSSG STP has been agreed, although it is likely that these will be revised and extended as work proceeds. These joint strategic priorities are:

- Sustainable and efficient acute configuration, including the future of Weston hospital;
- Transformation of community and primary care services, shifting care out of acute hospital settings;
- Step-change in the coordination of health and social care, supported by the roll out of the Connecting Care (interoperable patient records) programme;
- Shift in working practices and organisational culture to make prevention and self-care a priority in service delivery;
- Transformation in identified key disease areas to deliver value and improved outcomes, likely to include long term conditions, cancer, frailty, musculoskeletal (MSK) services and mental health pathways; and
- Workforce and Informatics to support required transformational change.

Initial governance arrangements for developing the STP are in place. These will need to be expanded in order to ensure engagement of partner organisations and to establish effective communication channels with local politicians and the public on the need for change

The BNSSG STP will focus its priorities around addressing the identified gaps in the three key areas of Health and Wellbeing, Care and Quality and Finance and Efficiency, with the overall aim of demonstrating how we will deliver and maintain system-wide sustainability across each of these areas.

The vision is described by two key themes:

- Improving peoples experience of health and social care;
- Developing a sustainable health and social care system that makes better use of existing capacity and resources;

The Trust's operational plan is consistent with this vision and clearly describes how the Trust is actively participating in both BNSSG and local system transformation and sustainability programmes and how the Trust's activities support ongoing progress towards achieving the themes described in the BNSSG vision and to closing the 3 gaps identified in the Five Year Forward View.

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

The plan also reflects the key principles expected in developing an STP including strong joint working, developing financial viability across the whole system, delivering high quality care and making the most efficient use of resources including the use of technology.

The Trust is therefore actively participating in four key delivery processes to ensure delivery of internal and external imperatives:

Sustainability Board

A Sustainability Board has been established, with membership comprising local providers (Weston Area Health NHS Trust, University Hospitals Bristol NHS Foundation Trust, North Bristol NHS Trust and Taunton and Somerset NHS Foundation Trust), commissioners (North Somerset CCG and Somerset CCG), NHS

England, the NHS Trust Development Authority (chair) and South West Ambulance Services NHS Foundation Trust. The CQC and GMC have an open invite to attend meetings.

This aim of this collaboration across system partners is to mobilise a health economy wide sustainability agenda. In broad terms, the sustainability work stream will focus primarily on:

- Providing clarity over commissioning intentions and core services to be provided (based on populations current and future needs) and their respective priorities for development/investment; and
- Consideration of network pathways and new models of care, in line with the Five Year Forward View.

The Sustainability board will also act as a focal point to bring together other system-wide collaboration initiatives, such as flow. A roadmap establishing the high level activities to be undertaken has been documented, and will need to be underpinned by clinical engagement mechanisms, leveraging good practice and innovation forums in the consideration and design of new models of care. The intention is to leverage existing insights and diagnostic work previously undertaken and build on (where appropriate) joint working and collaboration initiatives that already exist between Weston and neighbouring providers.

North Somerset CCG Transformation programme

In addition to the work being undertaken by the Sustainability Board, North Somerset CCG is commencing a transformation programme designed to achieve change by working in a different way with partners, patients and the public. The approach will be needs based and service model focused, challenging pre-existing ideas of what has to happen where and how. Integration to drive new and more clinically and financially sustainable models will be a key part of this programme.

Key areas of focus with which the Trust will be actively engaged during 2016/17 will be:

- Right care
- Diabetes
- Rehab/stroke including discharge to assess
- Co-morbidities
- Urgent care
- Children and CAMHS

The Trust will work in partnership with both the Sustainability Board workstreams and North Somerset CCG strategic change projects.

***Working Together*: a joint vision for health and social care in Bristol, North Somerset and South Gloucestershire.**

Leaders of health and social care services in Bristol, North Somerset and South Gloucestershire have committed to collective effort to transform services and improve outcomes for local populations. An initial vision has been established which will form the basis for future collective working. The vision describes 14 key themes based around improving experience and building a sustainable health and social care system. This work will clearly inform the work of the Sustainability Board, the North Somerset CCG Transformation programme and Internal service transformation work and will a key driver of the system-wide Sustainability and Transformation plan development.

Internal service transformation programme

In the short to medium term the Trust needs to address internal service delivery consistency, quality, safety, efficiency and sustainability issues. A programme of work which will deliver required internal change and serve to inform the work of the Sustainability Board and CCG programme has therefore been developed and is being undertaken by GE Finnamores Healthcare. This will report in April 2016 enabling further development of the clinical strategy during 2016/17.

The Trust is participating in the ECIP programme for which a programme of work to improve consistency of delivery of the 4hr Emergency Department target through Trust-wide ownership and action had been developed and which will continue during 2016/17.

The Trust has also expressed an interest in becoming a “small DGH” test site although the implications of this remain unclear at this time. .

The Trust’s Integrated Operational plan and directorate operational plans provide specific detail on key workstreams and outcomes planned for 2016.17.

Fig 1 Strategic system planning interdependencies

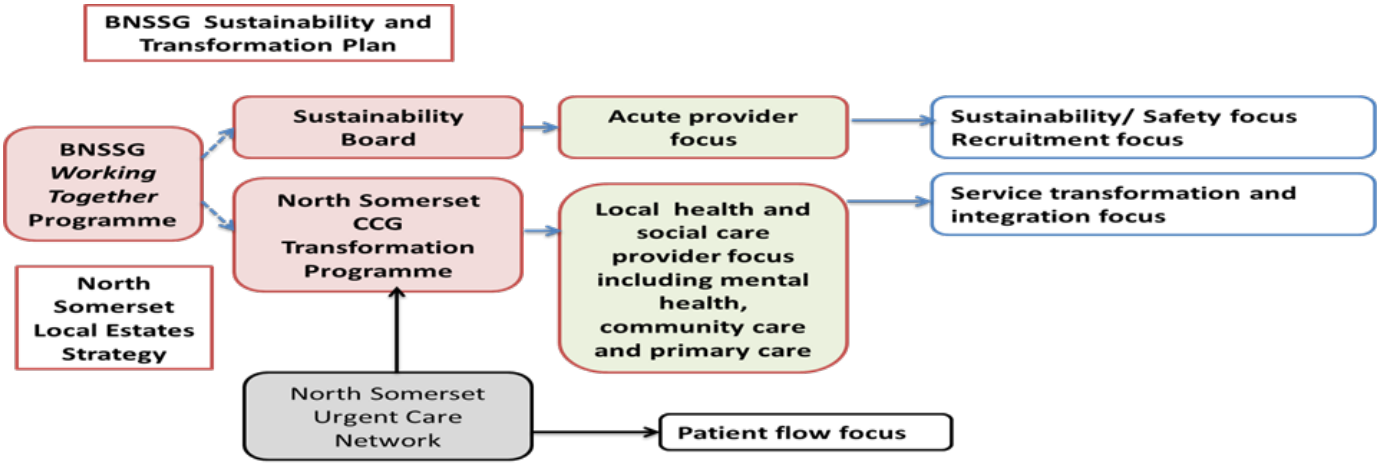
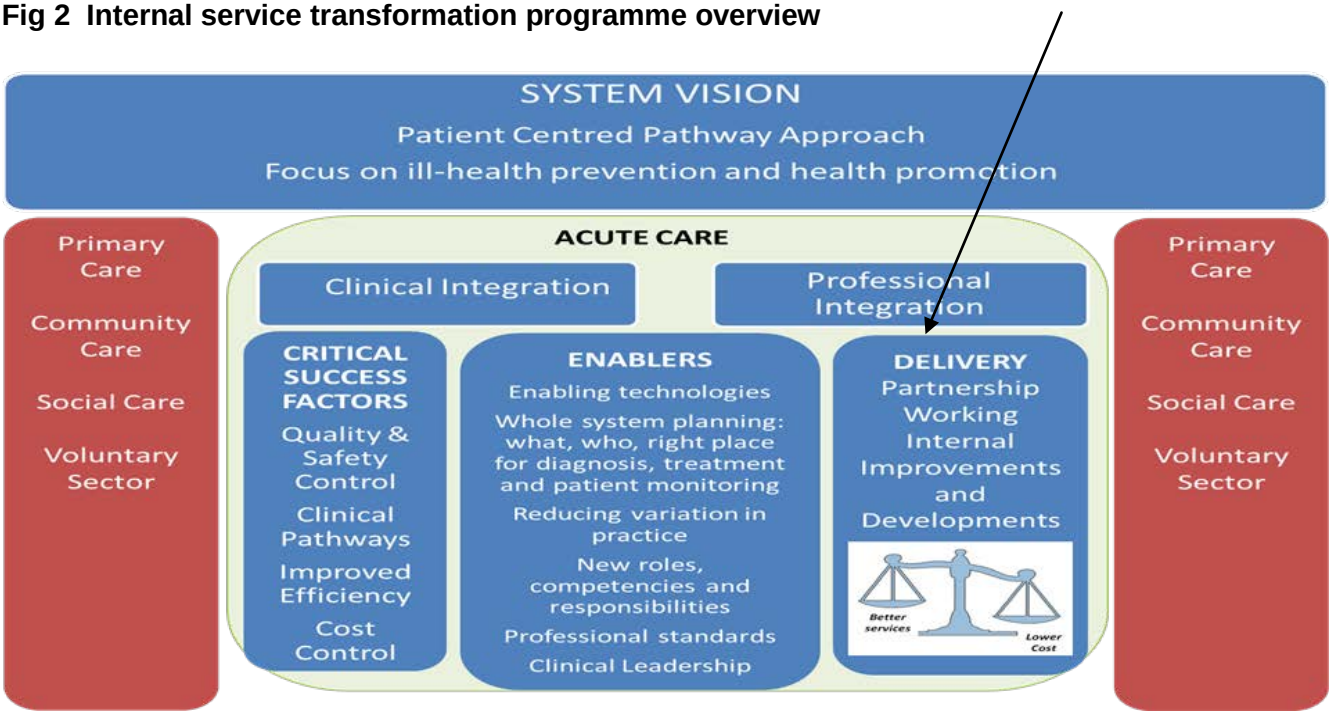


Fig 2 Internal service transformation programme overview



This approach is consistent with the Five Year Forward View which recognises that increasingly, system-wide service planning and service delivery will be required to ensure that capacity is appropriately aligned to enable demographic challenges over the next 5 years to be managed within existing resource.

During 2016/17, whilst work on the future clinical strategy is being developed, the Trust will focus on delivering a solid foundation on which to build for the future through a focus on seven key areas of work:

- Patient Safety First
- Consistent delivery of constitutional standards
- Cultural Change including clinical engagement
- Embed strong Integrated Governance
- Maintain/improve Junior Doctor training environment
- Work with partners to improve care pathways for patients and deliver sustainable clinical and staffing solutions
- Deliver the Financial Plan
- Deliver IM&T improvements

Meeting National Performance Objectives

Our Performance

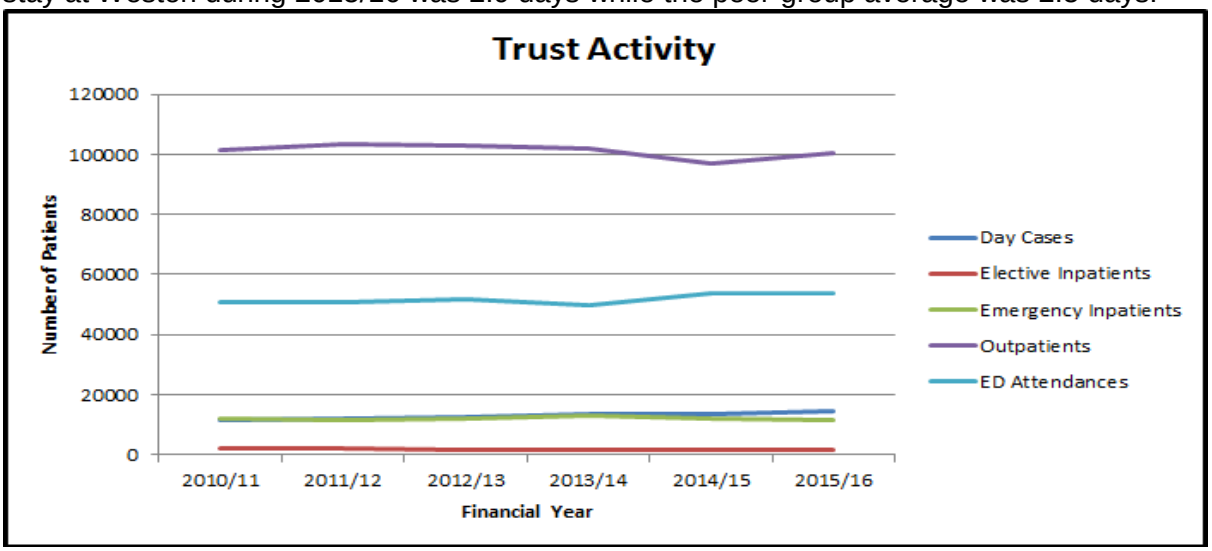
This section sets out the Trust performance for the financial year ending 31st March 2016. The first part describes patient admissions by type of patient. The second part shows the Trust's performance against some specific, nationally-set operational access and quality targets. Performance against each of these targets together with a wide range of clinical quality, patient safety, operational, human resource and financial targets is reported to the Trust Board in public meeting, in the Trust's 'Integrated Performance Report'. Copies of these reports are available on the Trust website at www.waht.nhs.uk.

Patient Admissions

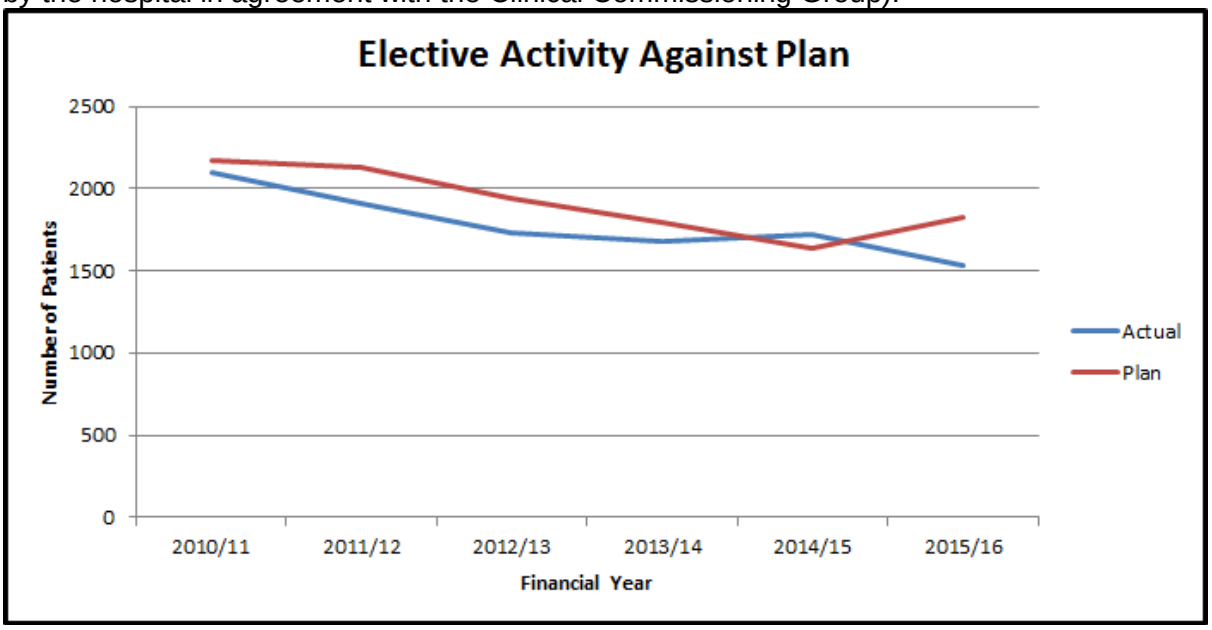
	2015/16	2014/15
Day cases	13047	13645
Elective inpatients	1535	1719
Emergency inpatients	14789	15317
Total admissions	29371	30681
Average length of stay	2.9	2.7
Emergency Department attendances	53931	52577
Outpatient attendances	100531	98406

'Elective' Inpatients are patients who come into hospital for planned operations, procedures and treatment. 'Emergency' patients are admitted without appointment and generally need urgent treatment. The population the hospital cares for has a higher than average proportion of people who are elderly and frail, which means patients often are treated for more than one condition and on occasions, their discharge is dependent on suitable care being available for them at home or in the community. For a small acute

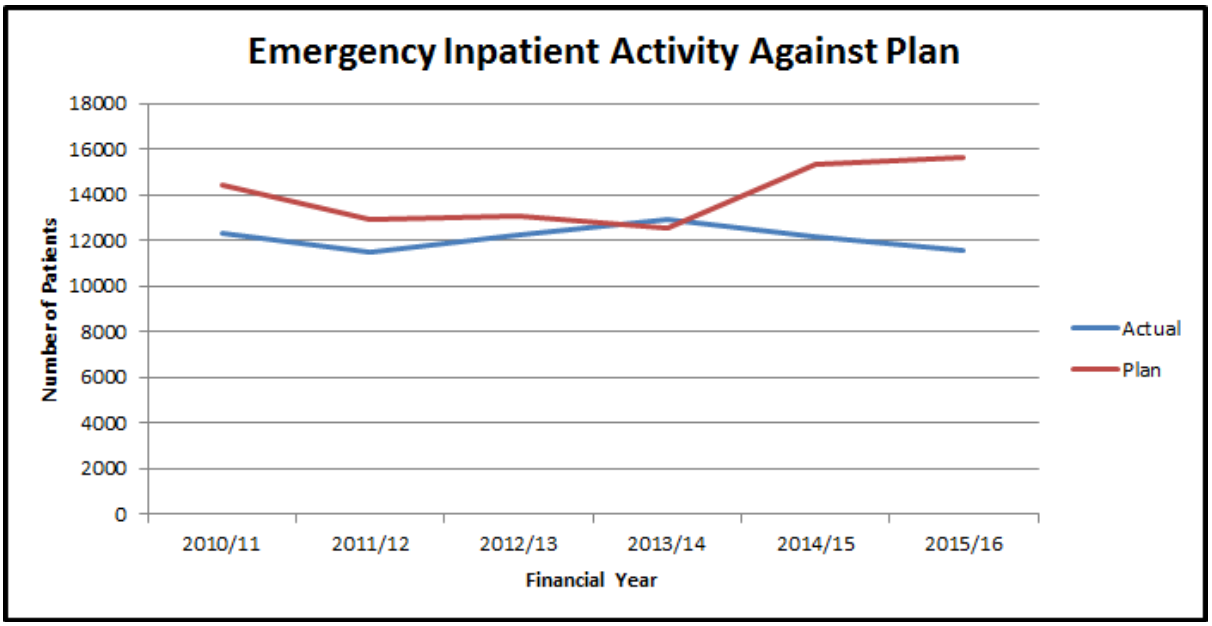
hospital, Weston has a high proportion of emergency inpatient admissions to beds. The average length of stay at Weston during 2015/16 was 2.9 days while the peer-group average was 2.5 days.



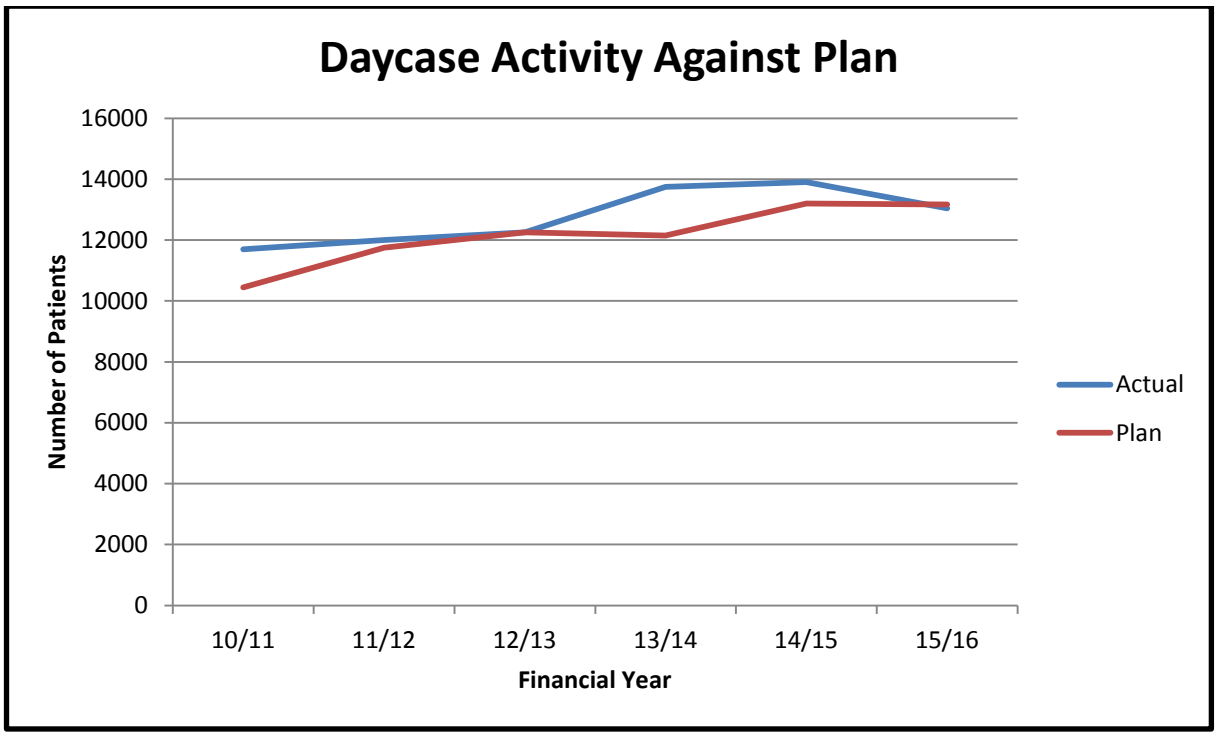
The graph above shows all of the hospital activity between 2010/11 and 2015/16. The following graphs describe the performance against plan for those five years. ('Plan' is the level of activity each year expected by the hospital in agreement with the Clinical Commissioning Group).



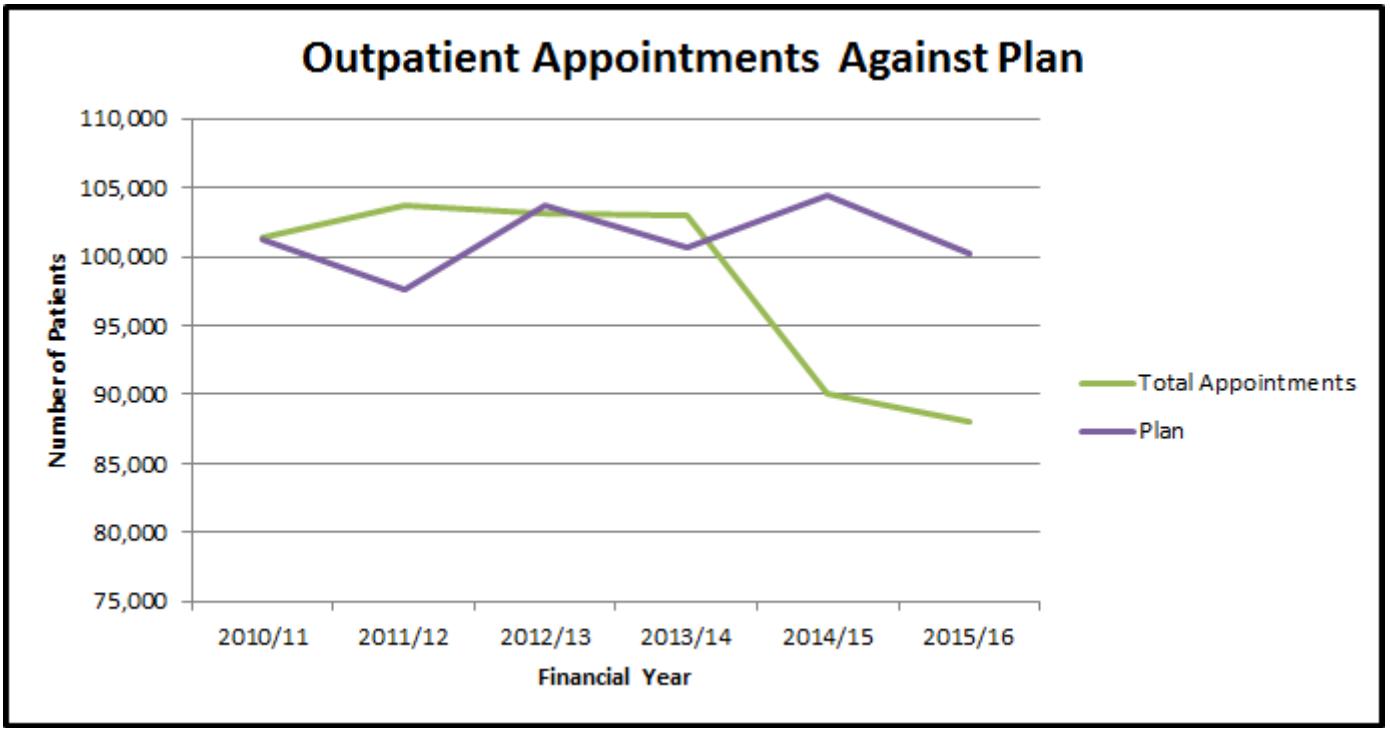
The Trust has experienced a decrease in elective activity against plan in 2015/16 which is reflective of increased length of stay and pressure on flow. There was also a programme of refurbishment for Theatres during the year.



The number of emergency inpatients within the Trust has decreased, showing the improvements made in partnership working between the Trust, Local Authority and Community Teams.



Daycase activity has been slightly higher than planned.



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

The graph above shows that the actual outpatient activity was below plan for the financial year 2015/16. Overall outpatient activity has reduced over the six year period, in part due to anticoagulation, oral surgery, orthodontics, dermatology, neurology and vascular services ceasing to be provided by the Trust. From April 2014, Maternity Services outpatients are recorded as part of the maternity pathway.

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

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

Cancelled Operations
The Trust recognises that having to cancel operations is very distressing for patients and their families at a time that is already very worrying and stressful. The Trust missed the national target to cancel no more than 0.8% of operations for the year, partly due to pressures of emergency admissions and partly due to the British Medical Association Industrial Action days. 100% of patients cancelled in 2015/16 had their operations rebooked within 28 days.

	National Target	2011/12	2012/13	2013/14	2014/15	2015/16
% Operations Cancelled	≤0.8%	0.60%	1.10%	0.18%	2.21%	1.81%
% Cancelled Operations Rebooked Within 28 Days	≥95%	100.00%	100.00%	100.00%	99.88%	100.00%

Cancer Patients

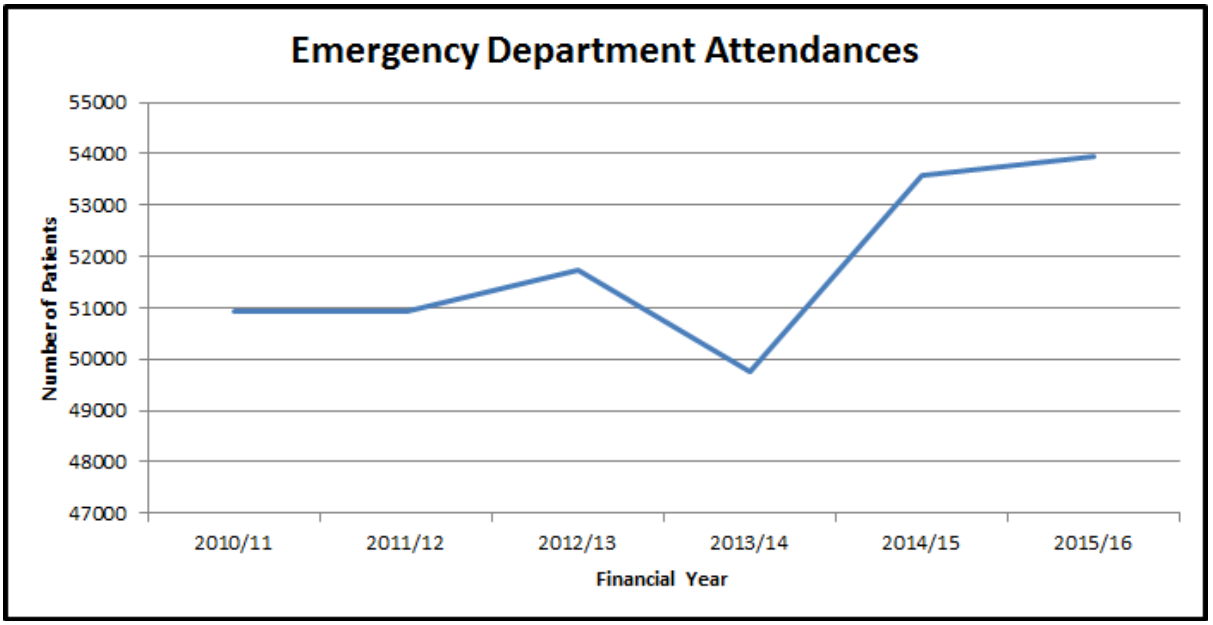
The 2009 Cancer Reform Strategy sets out 8 national cancer performance objectives for Trusts to deliver against. During 2015/16 the Trust met six of the national targets in full.

The following table sets out the 8 key targets and the Trust performance against each.

	National Target	2011/12	2012/13	2013/14	2014/15	2015/16
Breast symptoms referred to a specialist who are seen within 2 weeks of referral	≥93%	97.20%	96.60%	93.50%	90.90%	88.68%
31 days for second or subsequent cancer treatment - surgery	≥94%	100.00%	98.60%	95.30%	99.30%	98.81%
31 days for second or subsequent cancer treatment - drug treatment	≥98%	100.00%	100.00%	99.10%	99.97%	99.08%
National screening programme who wait less than 62 days from referral to treatment	≥90%	95.80%	98.10%	86.40%	100.00%	92.05%
Cancer reform strategy 62 day upgrade standard	≥90%	94.20%	93.40%	86.10%	77.96%	94.73%
2 Week Wait (urgent GP appointment to 1st outpatient appointment)	≥93%	96.50%	96.00%	95.30%	97.26%	96.30%
NHS Cancer Plan 31 day standard	≥96%	99.80%	100.00%	99.20%	99.65%	98.84%
NHS Cancer Plan 62 day standard	≥85%	92.30%	88.30%	81.40%	89.08%	77.50%

4 Hour Emergency Access Target

The Emergency Department is the department where many patients initially come for care. The graph below demonstrates that over the past six years, emergency department attendances have risen overall by 5.9%.



The Trust is required to meet the target of 95% of patients spending four hours or less from arrival to admission, transfer or discharge. The Trust did not achieve the target for the year with a final position of 86.63%.

Stroke
All Trusts have been set a target to ensure 80% of stroke patients spend 90% or more of their stay in a specialised stroke unit. In 2015/16 the Trust achieved 88.54%.

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 a community residential setting. The two most commonly quoted risk factors for this infection are age (over 65 years) and receiving antibiotic treatment. Weston therefore has a large 'risk group' since a high proportion of patients admitted to the hospital fall into these categories. Monitoring antibiotic prescribing and introducing new cleaning and disinfection technologies during 2015/16 saw an improvement in cases recorded.

	2010/11	2011/12	2012/13	2013/14	2015/16
Target (No More Than)	*16*	*12*	*11*	*17*	*17*
Cases Recorded	*20*	*19*	*17*	*20*	*10*

MRSA Blood Infections
The Trust were pleased to record zero cases of hospital apportioned MRSA blood stream infections in 2015/16. Ongoing actions to maintain the zero rate include monitoring of practice (including hand washing), isolation practices and care of invasive devices.

Venous Thrombo Embolism
It is a national requirement that 95% of patients admitted to hospital should be assessed as to their risk of developing a venous thrombosis (blood clot). The Trust achieved this target in 2015/16.

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

Improving Service Quality and Patient Satisfaction

Learning from the Care Quality Commissions new inspection framework

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

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

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

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

Following a Quality Summit with the Care Quality Commission in September 2015, the Trust developed action plans to address the 'must do' actions from the inspection, in conjunction with partners. Of the 22 'must do' actions seven relate to the Emergency Department, four to operating theatres, two to staff attendance at mandatory training, two to patient flow, two to governance at Directorate and service level, one to medical cover out of hours, one to avoidable harm across the organisation (pressure ulcers, falls and medication incidents),one to acuity and staffing levels on the High Care Unit, one to IT systems and one to the security of medical records.

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

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

Patient Experience Monitoring

Our ability to measure patient experience is critical to making positive changes and supporting staff in delivering best care. Throughout 2015/16 there has been a significant focus on care delivery and the engagement of patients in informing how care and hospital services should and can be delivered.

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

During 2015/16 Council members have continued as members of the key committees in the Trust. They have piloted two new approaches to assessing the quality of care at the Trust through gathering patient stories using a modified 'Discovery Interview' and surveying patients using prompts from the Care Quality Commission caring domain.

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

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

During 2015/16 both the Patients' Council and Patient Experience Review Group worked with us to agree our patient experience improvement priorities for 2016/17 described in our 2015/16 Quality Account. Both of these documents are available on the Trust's website.

National Inpatient Survey

The annual adult inpatient survey is carried out in 156 Trusts (www.cqc.org.uk). The survey is based on a sample of consecutively discharged inpatients who attended Weston in July 2015. 1250 questionnaires were sent to patients of which 1175 were eligible to partake in the survey. The Trust received 580 completed responses giving a response rate of 49%, slightly higher than the previous year of 48%.

Overall the results have changed little since the 2014 survey. Of the questions used in both the 2014 and 2015 surveys, the Trust did not perform significantly better on any question, and was significantly worse on one question and showed no significant differences in 61 questions.

In comparison with other Trusts, in 2014 we scored worse than average on 22 questions. In 2015 this figure is slightly higher and we scored worse than average on 24 questions.

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

- 82% of respondents rated care 7+ out of 10.
- 83% of respondents believed they were treated with respect and dignity.
- 77% always had confidence and trust in doctors.
- 98% reported that their room or ward was very/fairly clean.
- 97% reported that toilets and bathrooms were very/fairly clean.
- 91% felt that they were always given enough privacy when being examined or treated.

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

Areas of concern and ongoing improvement include;

- Involving patients more in decisions about their discharge
- Patients being given notice of when discharge from hospital would occur
- Patients being informed of the side effects of medication
- Being fully told of the danger signals to look for after discharge
- Patients being asked to give views on the quality of care
- Being given information explaining how to complain

The Trust is investing in improving the ways it provides information to patients, for example by A Standard Operating Procedure has been developed to guide staff on what information should be provided to patients regarding discharge medication. An advice slip is being added to the discharge medication directing patients to medication information leaflets that are available on the internet in different formats. Registered nursing staff in discharge lounge are now talking through the discharge summary and medications with patients to ensure that they understand their medication. The patient information booklet 'Your Bedside Book' containing information on how to complain is being moved to make it more accessible to patients and the success of this is being monitored.

Local inpatient survey

The Trust currently conducts real time inpatient surveys every month with volunteers surveying up to 100 inpatients against an agreed set of standardised questions.

Currently, 43 questions are asked which are based around the Care Quality Commission inspection framework.

Survey question – respondents reported:	2014/15 % answering Yes	2015/16 % answering Yes
They were told how they would expect to feel after their operation	69%	77%
If they had surgery, all of their questions were fully answered beforehand	*	96%
If they had surgery, all the risks and benefits of the surgery were clearly explained to them	*	73%
If they had surgery, their results of their surgery was explained clearly to them	*	93%
Were given enough time to discuss their operation/procedure with their consultant	55%	90%
Rated their overall experience as 5*	47%	97%
Were welcomed on arrival to the ward	85%	84%
Did not have to wait long for a bed on the ward	85%	36%
Received enough information about ward routines	51%	67%
Were not bothered by noise at night from other patients	52%	90%
Were not bothered by noise at night from staff	80%	89%
Had somewhere to keep their belongings safe	70%	93%
All the staff introduced themselves	82%	99%
Did not sleep in an area shared by a member of the opposite sex	98%	96%
Were given enough privacy when discussing their condition/treatment	94%	99%
Were treated with dignity and respect	Not reported	93%
Always got clear answers from their doctors to their questions	86%	97%
Had confidence and trust in the doctors	93%	91%
The doctors didn't talk in front of them as if they weren't there	85%	92%
They had the opportunity to talk to their doctor when needed	68%	94%
Their family had the opportunity to talk to their doctor when needed	57%	96%
The doctors knew enough about their condition/treatment	82%	97%
They always got clear answers from nurses to their questions	90%	92%
Had confidence and trust in their nurses	94%	57%
The nurses didn't talk in front of them as if they weren't there	90%	97%
They felt there were enough nurses on duty	49%	78%
They had the opportunity to talk to the nurses when needed	90%	24%

The nurses knew enough about their condition/treatment	82%	98%
They were involved in decisions affecting their care and treatment	71%	29%
They had been given enough information about their condition/treatment	86%	88%
Had never taken more than 5 minutes to answer their call bell	58%	58%
Pain was controlled effectively	*	64%
Patient was given written or printed information about their medication and what they should or should not do after leaving hospital	*	42%
Patient had been told the purpose of their medication	*	38%
Patient had been clearly told how to take medication when they leave hospital	*	68%
Patient had been clearly told how to take medication when they leave hospital	*	77%
Patient had been fully told of danger signals to look for	*	96%
Patient had been told who to contact if they were worried	*	73%
Rated the food as good or excellent (4 or 5)	Not reported	93%

* New question added in 2015/16

In 2015/16 the survey used has undergone revision following feedback from volunteers and patients and therefore direct comparison between previous years' results is not possible for all questions.

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 at our Patient Experience Review Group – who also seek assurance that any themes identified are addressed.

The results of the surveys are fed back immediately to the person in charge of the area, enabling staff to improve individual patients experience in a timely way, for example: facilitating special food orders, altering a bathroom layout and repositioning mirrors to make it easier for patients to use and providing additional bedding.

Our Friends and Family Test results

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

Each Directorate and Ward receives a breakdown of the outcome of their survey results to allow them to take relevant action.

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

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

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

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

The graphs below give further detail.

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

			Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
	In-Patient	Trust	97%	99%	96%	95%	96%	95%	96%	94%	94%	95%	97%	95%
Would Recommend		England	95.20%	95.40%	95.60%	95.60%	96%	95.60%	95%	95%	95%	95%	95%	96%
	A&E	Trust	96%	91%	93%	98%	92%	91%	88%	93%	91%	95%	92%	85%
		England	87.50%	88.30%	88.40%	88.20%	88%	88%	87%	87%	87%	86%	85%	84%
	Out patient	Trust	N/A	N/A	N/A	N/A	N/A	N/A	91%	96%	92%	79%	98%	97%
		England	N/A	N/A	N/A	N/A	N/A	N/A	N/A	92%	92%	93%	93%	93%
	Maternity	Trust 1	100%	95%	100%	100%	100%	100%	96%	98%	94%	100%	88%	10%
		England	95.30%	95.90%	95.90%	94.60%	95%	95%	95%	96%	95%	96%	95%	95%
		Trust 2	100%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%
		England	97.20%	97%	97%	97%	97%	97%	96%	96%	97%	97%	96%	97%
		Trust 3	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		England	93.70%	93.30%	93.40%	94.20%	94%	93%	94%	94%	94%	94%	94%	94%
		Trust 4	100%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%
		England	97.70%	97.80%	97.70%	97.50%	98%	98%	98%	98%	98%	98%	98%	98%
Response	In-	Trust	64.80%	84.20%	81%	88.10%	37.40%	43.70%	40.90%	36%	41.70%	39%	38.10%	37.6%

Rate	Patient	England	25.60%	25.90%	26.70%	27.60%	24.80%	26.70%	24.40%	24.40%	22.60%	24.3%	24.1%	24.1%
	A&E	Trust	19.90%	13.70%	15.90%	11.90%	8.80%	16.60%	10.40%	6.70%	2.10%	5.30%	6.70%	4.3%
		England	14.80%	14.10%	15.10%	15.20%	14%	14.10%	13.60%	13.10%	12.70%	12.9%	10.9%	12%
	Maternity (Births)	Trust	19.30%	33.30%	50%	76.20%	53.30%	41.20%	36.40%	47.10%	50%	64.30%	66.70%	36.7%
		England	23.60%	23.20%	23.6%	22.40%	21.20%	22.70%	22.30%	23.40%	21.30%	23.1%	24.6%	23%

Learning from PALs and complaints

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

The Senior Manager for complaints and PALS actively engages in supporting the development of staff to ensure they are able to respond appropriately and sensitively to complaints, whilst handling sensitive situations and data. Staff training in complaints resolution will remain high on the training agenda for the Trust.

The Trust received a total of 216 formal complaints which represents a 9.2% decrease on the last year's total of 238 for 2014/2015.

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 nursing care has continued to decrease reflecting the work that has been undertaken across the Trust to improve the standards of nursing care with initiatives such as ward Wednesday which involves formal weekly ward visits by the Directorate Matrons, Director and Associate Director of Nursing and other senior nurses. The purpose is to monitor how care is delivered, specifically looking at the dignity, safety and the welfare of patients.. The main subjects of complaint are around medical treatment and communication however both have seen a reduction in numbers this year.

Throughout the year the themes of all complaints are reviewed and where it is felt appropriate due to volume or the unusual nature of the complaints a more detailed review is undertaken within the area identified. Specific reviews have been undertaken for complaints linked to end of life care and the Orthopaedic Department, also the fluctuations in Medication themed complaints were reviewed. As a result of these reviews the Leads have reflected with the Consultants and other staff on the themes identified to learn from the patients' experience and improve the way treatment is delivered in the future.

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

The table below shows the main types of complaints received during 2015/16 and the changes from last year.

Main types of complaints received during 2014/15:

	2013/14	2014/15	2015/16
Complaints about staff attitude - %	6.9%	8%	6%
Complaints about medical treatment - %	30%	24%	23%

Complaints about nursing care - %	14%	11%	10%
Complaints about communication - %	23%	23%	23%

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 2015/16 three complaints were accepted by the Ombudsman for investigation. The Ombudsman confirmed that two of these complaints would be "partially upheld", and is still considering their decision on one case.

Complying with the vision of good complaint handling
The Trust continues to cooperate with the Ombudsman when required. The framework introduced by the Parliamentary and Health Service Ombudsman in their report published in November 2014 was used in the complaints satisfaction survey for 2015/16.

Annual Quality Account

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

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

The content of the Trust's Quality Account for 2015/16 builds on the 2014/15 report. In it we describe our progress against the priorities that we established for the year. We also identify a number of areas for focus during the next twelve months and we explain how we intend to improve quality during 2016/17.

Our improvement goals for 2016/17 were informed by;

- The Care Quality Commission 'must do' action plan agreed following the inspection of the Trust in 2015.
- National requirements included in the NHS Constitution and Five Year Forward View.
- The NHS Trust Development Authority Accountability Framework.
- The priorities of our commissioners – incorporating for example agreed CQUIN targets
- The needs of our population as described in the latest Joint Strategic Needs Assessment.
- The experiences of our patients – captured by the work of our Patients' Council, Patient Experience Review Group and Healthwatch North Somerset.
- Performance data about the Trust – including mortality, incidents, complaints/PALs and audit data.
- Our corporate risk register and Board Assurance Framework
- An external review of our governance processes.

The Trust uses the same systems and processes to collate, validate, analyse and report on data for the annual Quality Account as it does for other clinical quality and performance information. The Audit and Assurance Committee commission external auditors to undertake a review of the data assurance

underpinning the Quality Account and through this process and other review of data, the Board are assured that the Quality Account represents a balanced view.

Ensuring Performance Against Our Priorities
Managing effectively to ensure we have and can demonstrate 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 has been shared with our service users through the revised Patient and Public Engagement Strategy we describe above.

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

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:

- Risk that **medical staffing** will not be at the required numbers or skills to deliver safe and dignified care.
- Risk that people who use our services are not **discharged** in a safe and timely fashion.
- Failure to support the improvement in quality of care and efficiency across the trust through the delivery of an innovative and **robust IT** programme.
- Risk that the Trust will be unable to deliver a major **savings** plan.
- Risk that the Trust is unable to deliver a **sustainable solution** in a reasonable timescale as the process is external to the Trust and subject to national approvals and policy directives.

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

- Action plans to address risks around the quality of supervision for junior doctors – overseen by the General Medical Council and Sustainability Board Clinical Oversight Group.
- Participation in whole healthcare community groups to respond to emergency demand and expedite patients discharge from hospital.
- Daily monitoring, risk scoring and reporting of incidents, concerns, and staff risks in each service area.
- Monthly executive review of all risks, assurances and risk mitigation plans.
- CEO active participation in Sustainability and Transformation Planning with partners

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

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

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

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

The Trust will continue to work closely with other key partners during the coming months, notably the NHS 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 in particular:

Regional meetings and forums:

- Chairs and Chief Executives with the Trust Development Authority
- Specialist forums for Directors of Finance, Nursing & Human Resources

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

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

Clinical Networking:

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

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

- 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, community services social enterprise, voluntary agencies and clinical commissioning group 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,

- Partnership working with North Somerset Community Partnership, the Local Authority, NHS 111, South West Ambulance Service and Avon and Wiltshire Mental Health Partnership was significantly strengthened this winter through improved working across the health and social care economy. Daily operational meetings improved further the already well-formed urgent care network forums and this led to a significant positive improvement in winter performance. This partnership working further strengthens the already strong foundations for service delivery during the next twelve months of seamless care for patients,
- 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.

Outcomes from the work undertaken are clearly evident within the Trust, including for example:

- Continued progress against the national quality targets. In particular we have reinforced our cancer pathways to ensure that we meet the national standards for cancer treatment. Throughout 2015/16 we saw a sustained improvement in our delivery of these targets

- Reducing the number of patients waiting for planned treatments to ensure that we met the national guidance on Referral to Treatments. We have continued to meet all of these targets throughout 2015/6 with over 90% of patients being treated within 18 weeks,

- Reducing wait times for children and young people who use our community paediatric services. This had been a very challenging area for us over the past couple of years, but deployment of further specialist staff this year has maintained initial wait times to 18 weeks,

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 responders at all stages of the emergency planning process.

Weston Area Health NHS Trust recognises its duties and responsibilities as a Category 1 responder under the Civil Contingencies Act (2004). In addition its responsibility for ensuring it meets the legal requirements and care standards for Emergency Preparedness Resilience and Response (EPRR) and business continuity as detailed in the NHS Commissioning Board EPRR and Business Continuity Management Frameworks.

Preparedness

- The new structures include the formation of health subgroup of the Local Resilience Forum, the Local Health Resilience Partnership which has as it's focus a planning remit. The Director of Operations is the Trust representative on the Strategic LHRP group, and the Emergency Planning Lead is the representative on the Tactical Planning Group. The latter has produced a work programme based on the risks within the Community Risk Register.
- The Trust has a current Major Incident Plan.
- The Business Continuity management system has been reviewed to align it to the new standard IS023301 and three staff undertook certified Business Continuity Management Training.

Response

- The Trust had the opportunity to test elements of this and the Trust CBRN (Chemical, Biological, Radioactive, Nuclear) Plan in a joint exercise with the Avon Fire and Rescue Service
- The Winter Plan 2015/6 was activated with actions put in place to maintain a safe service despite sustained periods of high demand and operational pressure.
- The Radiology department have activated their Business Continuity plan for the planned loss of the CT Scanner during regular maintenance. The disruptive event went as planned with individual teams taking appropriate actions. There were learning points which have been acted upon as highlighted in the Business Continuity Standard IS023301.

Training
A range of training activities have been undertaken in 2015/16 and these have included the following:

- Strategic Leadership in a Crisis
- Surviving Public Enquiries
- Loggist Training
- Business Continuity Planning Workshops
- Certificate of Business Continuity
- Major Incident Awareness
- Setting up the Incident Control Room
-

Environmental Policy

The Trust recognises its environmental and social responsibilities and acknowledges the potential impact its activities may have on the environment. It is committed to achieving best practice procedures through investment in training, guidance, and changes in the process of its business so that environmental management is an integral part of healthcare provision.

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

• Energy Procurement and Use

• Water Use and Conservation

• Waste Production and Disposal

• Transport and Access

• Purchasing and Contract Arrangements

Carbon footprint

The Trust has calculated its Carbon Footprint for Year ending 31st March 2016, which enables the Trust to monitor performance against a Department of Health recognised assessment tool and to compare with other similar organisations.

	2015-16 Tonnes CO2e	2014-15 Tonnes CO2e	Change +/- Tonnes CO2e
SCOPE ONE EMISSIONS Fuel Combustion Gas Boilers	**1227.74**	**1209.9**	**18.74**
SCOPE TWO EMISSIONS Purchased Energy Consumption Electricity	**2389.4**	**3220.76**	**-831.42**

	2015-16 Tonnes CO2e	2014-15 Tonnes CO2e	Change +/- Tonnes CO2e
Water usage: 0.34kg per M3	**17.92**	**19.36**	**-1.34**
Non recycled waste Clinical Incinerated all types Clinical Alternative treatment General waste	 **22.08** **18.80** **66.54**	 **14.39** **18.45** **69.793**	 **+7.69** **+0.35** **-3.25**
Recycled Waste Mixed municipal recycled : Glass	 **1.34** **70.02**	 **1.96** **57.22**	 **-0.62** **+12.80**
TOTAL EMISSIONS	**3813.84**	**4651.60**	**-797.99**

Building Use

During 2015/16 the Trust invested £2.4m upgrading its whole suite of operating theatres. The four main operating theatres were renovated equipped with an upgraded air flow system which allows staff to monitor air and humidly levels – the upgrade also improved operating lights and high tech control panels which allow surgeons to control all the equipment in the room at the touch of a button. This is a very exciting development for the Trust in terms of delivering more modern and efficient operating theatres and a much improved working environment for staff. The refurbished operating theatres offer higher levels of clinical care for patients and a safer, cleaner environment which will reduce risks of infection.

The Mayor of Weston-super-Mare, attended a special ribbon cutting ceremony to mark the official opening of the theatre. The event was hosted by the Trust's Chief Executive, and was attended by nearly 40 members of staff and partners involved in the project, who took the opportunity to visit the new theatre as part of the open day.

Sustainable Procurement

The majority of the Trust procurement is managed by the Bristol & Weston NHS Purchasing Consortium (BWPC) which provides a comprehensive range of purchasing services to support the Trust.

In the context of broader sustainability, maintaining the balance between financial, social and environmental factors, focusing on energy efficiency, carbon reduction and recycling and to ensure social justice and equity. BWPC aims to lead by example by removing barriers to sustainable development, by engaging with

a mix of small, medium and large businesses and enterprises, whilst simultaneously driving innovation, cost efficiency and responsible procurement practice.

BWPC has a Sustainable Procurement Strategy and Policy that is focused on the outsourced products and services that it acquires on behalf of its members, underpinning supply chains and which should be read in conjunction with each organisations individual environmental management policy, namely:

- Environmental Policy

- Carbon Management Plan

The BWPC has an important role in delivering sustainable value from its procurement, which evidences the organisations commitment to patients, staff, local community and society in general.

This approach supports the core values of the trust including quality and excellence, equality and diversity, working responsibly and with respect for each other and best environmental practice. By embedding good sustainable procurement practice we enhance value for money by ensuring long term cost effectiveness, as well as reducing waste, protecting biodiversity, and supporting sustainable economic growth that is underpinned by a stable and resilient supply chain, operational excellence and cost savings.

Waste and Recycling

The Trust seeks to minimise waste production and reduce the environmental impact of waste by:

- Seeking, wherever possible, to reduce the amount of waste produced across all of its properties
- Where reduction is not an option, the Trust will aim to introduce reuse and recycling schemes, to minimise the amount of waste requiring final disposal
- Employing purchasing strategies designed to reduce unnecessary packaging
- Promoting the reduction, reuse, recycling and segregation of different waste streams where economically viable
- Implementing sustainable systems and management of waste, wherever feasible.

During 2015/16 the Trust invested £34k to improve waste segregation by refurbishing the main waste compound. The Trust is keen to ensure the safe and sustainable management of wastes produced from its healthcare activities. The Trust continually requires to demonstrate that sufficient measures are in place to comply with healthcare waste regulations.

Protecting Information

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

There were no serious incidents involving data loss in 2015/16.

Compliance with Charges for Information

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

Part 2 – Accountability report

Corporate Governance report – Directors report

Details of the Directors

During 2015/16 the Weston Area Health NHS Trust Board was made up of thirteen members comprising Executive and Non-Executive Directors. The Chair, the Non-Executive Directors and five of the Executive Directors are voting members. The Board was led by the Chairman, Peter Carr to 30 April 2015 then by Grahame Paine. The Chief Executive was Nick Wood to 31 July 2015 then James Rimmer.

Two additional Non Executive Directors were appointed during 2015/16, Frank Powell (29 June 2015) and Rosalinde Wyke (1 August 2015) In addition, Nick Lyons replaced Bee Martin as Medical Director (8 January 2016) and Helen Richardson replaced Christine Perry as Director of Nursing (15 February 2016).

The Trust Board met on eight occasions in public during 2015/16 and the agenda and papers for these meetings were sent out in advance of the meeting and are made available through the Trust's website.

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

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

Audit and Assurance Committee

The Trust Audit and Assurance Committee comprises four Non-Executive Directors of the Trust. It's 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 2015/16 were Ian Turner (Chairman), George Reah, Grahame Paine/Rosalinde Wyke and Brigid Musselwhite. The committee reviewed it's effectiveness using the Audit Committee Handbook assessment tool in May 2015.

Remuneration Committee

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

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

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

Declaration of Interests

Directors are required to declare details of any 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 2015/16 that would have resulted in significant conflict.

All the Directors have stated that:

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

Auditors

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

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

Only the following elements of the Accountability report are covered by the auditors opinion:

- Single total figure of remuneration for each director
- CETV disclosures for each director
- Payments to past directors, if relevant
- Payments for loss of office, if relevant
- "Fair pay" (pay multiples) disclosures
- Exit packages, if relevant, and
- Analysis of staff numbers.'

The audit opinion, for 2015/16 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 2016, except for matters in relation to:

- overall arrangements for planning finances to support its strategic priorities
- arrangements to work with other parties to deliver strategic priorities
- arrangements in place to demonstrate and apply the principles of good governance and to deploy workforce to deliver its priorities effectively

In 2015/16, the Trust's external audit fees were £69,000 compared to £88,000 in 2014/15.

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

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

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

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

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

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

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

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

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

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

Signed; **James Rimmer, Chief Executive**

Date; 27 May 2016

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

27 May 2016; James Rimmer, Chief Executive

27 May 2016.....Rob Little, Finance Director

Annual Governance Statement 2015/16

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

2.The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives - it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Weston Area Health NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place at Weston Area Health NHS Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

3. The risk and control framework

The Trust has a governance system in place which has been developed and enhanced over a number of years and continues to be subject to regular review to ensure its continued fitness for purpose. An Internal Audit review of risk management systems was undertaken in June 2015 and provided assurance that the Trust has a fit for purpose risk management framework in place. The Care Quality Commission planned inspection in May 2015 and follow up visit in August 2015 identified areas for improvement in Directorate and service level governance – particularly in surgery and critical care. Progress with the delivery of plans to address these actions has been monitored monthly by the Senior Management Group and updates provided to the Quality and Governance Committee and Trust Board.

The Trust Board operates in accordance with the Trust Standing Orders and has overall responsibility for agreeing the risks, controls and assurances detailed in the Board Assurance Framework and for the frameworks maintenance and monitoring during the year. Membership during 2015/16 has been as follows;

Name	Title
Peter Carr/ Grahame Paine	Chairman (V)
Grahame Paine/George Reah	Vice Chair / Non Executive Director
Brigid Musselwhite	Non Executive Director (V)
George Reah	Non Executive Director (V)
Ian Turner	Non Executive Director (V)
Rosalinde Wyke	Non Executive Director (V)
Frank Powell	Non Executive Director (V)
Nick Wood/James Rimmer	Chief Executive (V)
Bronwen Bishop	Director of Strategic Development (V)
Karen Croker	Director of Operations
Sheridan Flavin	Director of Human Resources

Rob Little	Director of Finance (V)
Bee Martin/Nick Lyons	Executive Medical Director (V)
Christine Perry/Helen Richardson	Director of Nursing (V)

(V) Denotes Voting Member

Board attendance for the year (excluding two accounts and budget setting meetings) was as follows;

Name	**May '15**	**July '15**	**Sept '15**	**Nov '15**	**Jan '16**	**Mar '16**
Peter Carr/ Grahame Paine	Y	Y	Y	Y	Y	Y
Brigid Musselwhite	Y	Y	Y	Y	Y	Y
George Reah	Y	N	Y	N	Y	Y
Ian Turner	Y	N	Y	Y	Y	Y
Rosalinde Wyke			Y	Y	Y	Y
Frank Powell			Y	Y	N	Y
Nick Wood/James Rimmer	Y		Y	Y	Y	Y
Bronwen Bishop	Y	Y	Y	Y	Y	Y
Karen Croker	Y	Y	N	Y	N	Y
Sheridan Flavin	Y	Y	N	Y	Y	Y
Rob Little	Y	Y	Y	Y	Y	Y
Bee Martin/Nick Lyons	Y	Y	Y	N		Y
Christine Perry/Helen Richardson	Y	Y	Y	Y		Y

In 2015/16 the Board has reviewed and approved 2014/15 Annual Reports for;

- Complaints,
- Safeguarding,
- Infection Prevention and Control,
- Health and Safety

It has also considered and responded to the report from the CQC inspection of the Trust in May and August, the Fit and Proper Persons Regulation, the Freedom to Speak Up requirements, the False and Misleading Information Offence and the Kirkup (Morecambe Bay) and Lampard (Savile) Reports.

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

- Audit and Assurance Committee
- Quality and Governance Committee
- Remuneration and Terms of Service Committee
- Finance Committee
- Trust and Charitable Funds Board

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

1. Are services safe?
2. Are services effective?
3. Are services caring?
4. Are services responsive?
5. Are services well led?

The Audit and Assurance Committee is a committee of Non-Executive Directors. The committee monitors and oversees both internal control issues and the process for risk management. Audit Southwest (internal audit) and Grant Thornton (external auditors) attend all Audit and Assurance Committee meetings. The Audit Committee receives all reports of the Internal and External Auditors

and reports regularly to the Board. The work of the Audit and Assurance Committee is supported by four key sub committees:

- Risk Management Committee
- Health Informatics Committee
- Emergency Planning and Preparedness Committee
- Counter Fraud Steering Group

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

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

- Safeguarding Committee
- Patient Experience Review Group
- Infection Prevention and Control Committee
- Drugs and Therapeutics Committee
- Clinical Advisory Group
- Staff Experience and Engagement Group
- Directorate Governance Committees

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, clinical governance and quality impact assessment. All managers and clinicians accept the management of risks as one of their fundamental duties. These duties are defined in the Risk Management Strategy, which identifies the roles and responsibilities of Directors, managers and staff in relation to risk identification, analysis and control. Additionally the strategy recognises that every member of staff must be committed to identifying and reducing risks.

To this end the Trust:

- Promotes an environment of accountability to encourage staff at all levels to report when things go wrong, allowing 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, 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, Directorate Governance Meetings, safety bulletins, staff intranet and other staff briefing sessions.

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

Risk issues are reported to both the Audit and Assurance Committee and the Quality and Governance Committee via the Risk Management Committee, the Senior (previously Executive) Management Group and the Trust's management structure. Management and ownership of risk is delegated to the appropriate level from executive director through to local management through the directorate management teams. In April 2015 the two Divisions of Emergency and Planned Care were restructured to create a third Clinical Services Directorate. Each Directorate has since established a Directorate Governance Group to manage risk and report and escalate concerns. Performance management of any governance/risk action plans are managed via the Directorate Performance Assurance Framework (PAF) led by the Director of Operations. The Performance Assurance Framework is also reviewed and discussed at the Performance Management Review (formerly Business Planning & Delivery Group) chaired by myself and including all executive directors. This monthly meeting monitors the performance of the clinical Directorates and of Estates and Facilities against key performance indicators including risk.

Strategic risks are managed via the Board owned Board Assurance Framework. This document focuses on risks that could prevent the Trust from achieving its strategic objectives. Executive and Non Executive Directors review this and the Corporate Risk Register document every two months via the Senior Management Group and Audit and Assurance Committee. The Board reviews this document at six monthly intervals – paying particular attention to any material gaps in controls or assurance. The Audit and Assurance Committee considers the Board Assurance Framework and the Corporate Risk Register when setting the Internal Audit annual work plan.

An electronic governance system, which has the ability to record and monitor incidents, complaints and risks, has been operational since 2010. The system facilitates the reporting and management of incidents. It has been extended to include the complaints and risk register module to provide comprehensive reporting to support greater triangulation of risk. Each week day all incidents are risk scored by the Governance Team. Integration with other assurance reporting streams (for example concerns raised via Patient Advice & Liaison Services and agency staff usage) takes place and Executive and Operational leads are updated through the Senior Management Group meeting regarding any apparent trends.

The Head of Governance and team co-ordinate Serious Incidents Requiring Investigation and adverse incidents, which are reported and managed through the Directorate Governance Committees, Quality and Governance Committee and by the Trust Board. The Serious Incident Review Panel ensures that serious incidents are adequately investigated and that lessons learned are identified. All SIRI investigation reports and action plans are shared with the Trust's lead commissioner, North Somerset Clinical Commissioning Group. During 2015 the Trust has improved the means by which lessons learned from incidents are shared with staff. The need to do so was identified by the Care Quality Commission planned inspection of the Trust in May 2015. Progress with this and other 'must do' actions has been monitored by the Senior Management Group and Trust Board.

Following the publications of the Berwick, Francis and Keogh Reports in 2013 the Quality Improvement Hub was developed in October 2013. The aim of the Hub is to engage clinicians to focus on quality improvement methodology. The Hub is located in a central area in the hospital, enabling clinical staff to gain more direct support and guidance to undertake quality improvement

projects. Clinical staff receive coaching and support to undertake baseline audits, to collect and organise data and to build improvement projects. Outcome data from various sources (including clinical incidents, complaints, mortality indices and audits) is used to identify priority areas for improvement.

There is an established Information Governance Framework within the Trust, with the role of Caldicott Guardian being held by the Associate Medical Director (prior to the appointment of the current Medical Director in February 2016) and the SIRO (Senior Information Risk Officer) role being held by the Director of Finance. Operational management of data protection is the responsibility of the Trust's in-house Solicitor.

The Trust has monitored and implemented the Information Governance toolkit plan in 2015/16. The final self-assessment submission achieved 74% compliance with the NHS Health and Social Care Information Centre requirements.

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

The Trust actively promotes the importance of good data quality throughout the Trust to ensure accuracy, completeness and timeliness and the risks associated with any inaccuracies.

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

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

In order to achieve further transparency the Trust continues to benchmark its data and performance against HES via CHKS statistics (an independent provider of healthcare intelligence and quality improvement services)

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

During 2015/16 the Trust had one Level 2 Information Governance Serious Incident which was reported to the Information Commissioners Office in line with the Department of Health document "Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation". The incident, relating to some patient letters being sent to the incorrect GP practice, was fully investigated. The Information Commissioner has responded to the incident, recommending that the Trust should take this opportunity to review its handling of personal data, specifically with regard to the circumstances arising in this case - therefore recommending that the Trust;

1. Reviews its policies and procedures for handling data

2. Reviews its approach to staff training.

During 2015, in response to the CQC inspection in May and August and an increasing trend in mortality rates (noted as outside expected variability in March 2016) reported at the Trust, the Medical Director and Director of Patient Safety have worked to improve the frequency and quality of mortality review. A revised reporting template and process – overseen by a newly formed Mortality Review Group is demonstrating improvements to this process – improvements which will be fully realised in the coming year.

During 2015 in response to identified risk the Trust commissioned an external review of its estates and facilities. This Canty Compliance Report identified a number of actions for improvement which the Trust has addressed. Further external review post implementation of required actions has demonstrated that the Trust is now operating at a satisfactory level of compliance.

4. Risk identification and evaluation

There are currently 26 risks scored 9 or above on the Corporate Risk Register. (We score risks using a matrix that measures the likelihood of a risk occurring against its impact should it occur. A risk can score up to a maximum of 25). All identified risks have clear mitigation plans in place. Of the Trust's highest scoring risks three relate to the Emergency Department – the impact of the planned removal of FY2 junior doctors overnight, the ability to achieve the ambulance turnaround and 4 hour targets and environmental issues within the Ambulatory Emergency Centre. Of the rest;

- two relate to the Trust's ability to deliver end of year financial balance – achieving the required level of savings when the level of income is lower than expected
- two relate to I.T. legacy systems
- one relates to medical staff vacancies
- one relates to the Trust's ability to deliver pharmacist led medicines reconciliation
- one relates to the timeliness of discharge and patient flow
- one relates to the Trust's ability to achieve accreditation of its endoscopy department
- one relates to the administration support to some clinical specialties
- one relates to the incidence of hospital acquired pressure ulcers
- one relates to the management of medical records
- one relates to the clinical and financial sustainability of the Trust and
- one relates to the challenges of attaining the CQUIN schemes agreed with commissioners.

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

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

Other sources used to identify risks include:

- Complaints and Health Service Ombudsman reports and recommendations
- Inquest findings and reports from HM Coroner
- External/peer review
- Audit of standards
- Feedback from patients and carers
- Internal and external audit reports
- Performance Assurance Framework

- Feedback from staff
- Clinical audit

Risks to the achievement of the Trust's strategic objectives are considered, assessed and managed via the Board Assurance Framework (BAF) which is discussed by the Board on a six monthly basis at its public meeting. The Board has identified medical staffing numbers and skills being insufficient to deliver safe and dignified care as the most significant risk to the achievement of its strategic objectives.

5. Quality governance

In a review of governance in 2014, the Board agreed the key elements of monitoring Ward to Board assurance as;

1. Risk identification and management
2. Incident reporting and responsiveness
3. Audit of standards
4. Patient, carer and staff experience

These key assurance streams are in turn reinforced by our;

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

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

The Executive Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The content of the Trust's Quality Account for 2015/16 builds on the 2014/15 report. In it we describe our progress against the priorities that we established for the year. We also identify a number of areas for focus during the next twelve months and we explain how we intend to improve quality during 2016/17.

The 2015/16 Quality Account has been agreed by the Board – subject to any amendments required following completion of external audit review. The Quality Account incorporates the views of our Patients' Council and experiences of patients. It reflects the performance and risk data about the Trust and national requirements included in the NHS Constitution and NHS TDA Accountability Framework.

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

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

6. Clinical and financial sustainability of the Trust

Over the last four years the Trust's strategy has fundamentally been about organisational form change to deliver clinical, service and financial sustainability. The Trust has focused on "business as usual" as it progressed through firstly an open market procurement process and, more recently through an "as is" NHS-only transaction process designed to create a sustainable future.

Throughout these processes, our priority has been to deliver high quality, safe services that meet the needs and expectations of our patients. Whilst the Trust has continued to undertake service development, the approach has necessarily been predominantly operational rather than strategic.

In October 2015, a decision was made by the NHS Trust Development Authority that the transaction would no longer proceed as the solution proposed by the preferred provider, Taunton and Somerset NHS FT would not represent a clinically or financially viable solution, and as a result, an acquisition was not the right solution.

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

- quality of care remains variable;
- preventable illness remains widespread;
- health inequalities are deep rooted and growing in many areas –new treatment options are emerging;
- demographic pressures, particularly with regard to care and support for frail older patients are growing;
- financial pressures are building nationally.

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

- Delivering sustainable, high quality clinical services;
- Delivering a financially viable health economy;
- Recruitment of staff (capability and capacity);
- Delivery of seven-day non-elective services;
- Effective management of non-elective patients and sustainable achievement of the emergency care standard;

The 5 Year Forward View for the NHS, focused on models of care rather than organisational form presents new opportunities for the Trust to address both internal and system-wide challenges.

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

7. External reviews

Following the CQC planned inspection in May 2015 and follow up visit in August 2015 the CQC gave an overall rating for the Trust of 'requires improvement'. The CQC report from the visit highlighted many areas of challenge but also many areas of excellence. The CQC described three areas of 'outstanding performance' – Children's Care in Hospital for Caring and Child & Adolescent Mental

Health Services for Caring and Effectiveness. However three areas were highlighted as 'inadequate' – the safety of the Emergency Department, Medical Care in ED and the Trust wide leadership of Medical Care.

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

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

Following a Quality Summit with the Care Quality Commission in September 2015, the Trust developed action plans to address the 'must do' actions from the inspection, in conjunction with partners. Of the 22 'must do' actions seven relate to the Emergency Department, four to operating theatres, two to staff attendance at mandatory training, two to patient flow, two to governance at Directorate and service level, one to medical cover out of hours, one to avoidable harm across the organisation (pressure ulcers, falls and medication incidents),one to acuity and staffing levels on the High Care Unit, one to IT systems and one to the security of medical records.

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

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

The Trust performed badly in the GMC survey of junior doctors in 2015. At a Risk Summit with Health Education South West (HESW) and the GMC in September it was agreed that the Trust needed to;

- Strengthen clinical leadership and initiate cultural change in the Emergency Department and
- Improve Out of Hours clinical supervision arrangements for Foundation Programme Doctors in the Emergency Department to ensure that only those Middle Grades who meet the minimum requirements set by the GMC provide support.

In October the Trust invited the Royal College of Emergency Medicine to review the Emergency Department and make suggestions for improvement. The visit occurred in December 2015. The findings were received by the Trust in February 2016 and reviewed by the Board in March 2016. Significant concerns were discussed with respect to;

- Organisational leadership and culture
- Leadership, management and culture within the Emergency Department (ED)
- Medical staffing within the ED and the wider trust, during evenings, nights and weekends
- Operational pressure and ED crowding
- Progressive degradation of ED role and function within the local healthcare landscape, combined with a failure to develop and respond to the changing environment.

The Trust had previously enlisted the support of the Emergency Care Improvement Programme with the improvement actions following the GMC survey results. The required actions from the Royal College review will be included within these work streams.

Since August 2015 an external review of governance systems at the Trust has been led by the NHS Trust Development Authority. The review aims to look for opportunities for further streamlining and increasing the effectiveness of the Board and its current governance current processes. Triggers for the review were the significant in year changes in the Board membership requiring the appointment of a new Chair, Chief Executive Officer, Director of Nursing and Medical Director. This plus the requirement to introduce Sustainability and Transformation Plans presented an opportune platform to review, refresh and reinvigorate governance mechanisms.

Terms of reference for the review included a review of;

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

The Board discussed this review at its seminar in February and closed Board meeting in March 2016.

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

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

- The Board Assurance Framework provides me with evidence of the effective controls that manage the risks to the organisation achieving its principal objectives.
- The work of the Audit and Assurance and Quality and Governance Committees provide me with assurance on key controls to assist in securing and delivering the Trust's business objectives, effective and reliable control systems and agreed and timely corrective action plans for any gaps in controls, systems or assurances.
- The Head of Internal Audit who provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework, and on the controls reviewed as part of the internal audit work. Within the annual opinion, the Head of Internal Audit has given 'significant assurance' for the year ended 31 March 2016.
- Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance on the performance of key performance indicators and delivery of operational plans.
- Reports and feedback from external agencies to the Trust provide me with independent evidence on quality and patient safety outcomes and learning.

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

External Assurance

- Care Quality Commission Monitoring Reports and Inspections.
- Peer Reviews and re-accreditation of specific functions within the organisation (Royal Colleges)
- Audits (clinical, financial, internal, external).
- Other external body assessments/reports (Trust Development Authority, Healthwatch, NHS Protect).
- Benchmarking of key performance data where possible, including use of the CHKS benchmarking system.
- Financial Monitoring and Accounts (FMA) returns.
- Local public perception including feedback from regular meetings with the Patients' Council, key local stakeholders and media coverage reports.

- Hazard/safety notices – reports regarding compliance.
- External professional guidelines (NICE, NPSA) – reports regarding compliance.
- Reports on the effectiveness of work undertaken by the Local Counter Fraud Specialist.
- National reports and surveys – reports detailing organisational compliance relative to other organizations (e.g. Friends and Family Test, National Inpatient survey, National Staff Survey).

Internal Assurance

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit and Assurance Committee and the Quality and Governance Committee. The governance structures and systems of internal control described have been in place during 2015/16 and the effectiveness of committees monitored. Board and Committee minutes record attendance at each meeting.

The system of internal control has been in place in Weston Area Health NHS Trust during the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

9. Significant Issues

The significant issues reported during the year would include;

1/ The three areas highlighted as 'inadequate' following the CQC planned inspection;

- The safety of the Emergency Department
- Medical Care in the Emergency Department and
- 'Well led' for medical care in general

2/ Junior Doctors response to the GMC survey of the quality of training supervision – in particular highlighting supervison out-of-hours in the Emergency Department.

3/ The termination of the Trust acquisition process and the ability to deliver a clinically or financially sustainable solution in a reasonable timescale.

4/ The Trust continues to deliver its planned financial performance however the financial deficit remains a significant issue. The Trust will not achieve its statutory duty to breakeven and has required temporary financing to support the cash position.

10. Concluding Statement

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

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

Otherwise my review confirms that Weston Area Health NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.
Accountable Officer : James Rimmer, Chief Executive **Organisation: Weston Area Health NHS Trust**    **Signature:** **Date:27/05/2016**

Remuneration Report 2015/16 including policy

The Chair and all Non-Executive Directors of the Trust form the Remuneration and Terms of Service Committee with the Chair of the Trust also being Chair of the Committee.

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

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

- N Wood, Interim Chief Executive (from 01/04/2013 to 30/09/2013) Chief Executive (from 01/10/2013)
- J Rimmer, Interim Chief Executive (from 03/08/2015 to 31/12/2015) Chief Executive (from 01/01/16)
- R Little, Director of Finance and IM&T (from 01/07/2010)
- A Martin, Interim Executive Medical Director (from 01/05/2014 to 30/04/15), Executive Medical Director (from 01/05/2015)
- N Lyons , Medical Director (from 8/1/16)
- C Perry, Interim Director of Nursing (from 01/04/2013 to 30/09/2013) Director of Nursing (from 01/10/2013)
- H Richardson, Interim Director of Nursing (from 15/02/2016)
- B Bishop, Director of Strategic Development (from 01/10/2008)

Miss J Stroud was an employee with voting rights during her tenure as Deputy Director of Nursing (Corporate) from 1 December 2015 to 14 February 2016.

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

- K Croker, Interim Director of Operations (from 02/04/2013 to 30/09/2013) Director of Operations (from 01/10/2013)
- S Flavin, Interim Director of Human Resources (from 01/10/2012 to 30/09/2013) Director of Human Resources (from 01/10/2013)

Mrs C Perry was seconded to Royal Cornwall Hospitals NHS Foundation Trust from 03/12/2015.

Mr N Wood stood resigned from the position of Chief Executive, effective from 04/07/2015.

Miss A Martin stood down from her Director duties during the year 2015/16 but continued her Consultant Vascular Surgeon duties with the Trust.

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

Mr P Carr was appointed to the post of Chair from 01/08/2013 for a two year term. He resigned from his post on 30/04/15.

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

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

- Dr G Reah — February 2016 (reappointment – 1 year)
- Mr I Turner — August 2015 (reappointment)
- Mr G Paine — March 2012 (reappointment) became Chairman 16/11/15
- Mrs B Musselwhite — October 2015 (reappointment)
- Mr F Powell — January 2016 (reappointment)
- Mrs A Wyke — December 2015

No awards have been made to past Senior Managers of the Trust. There were no termination or exit package payments made to Senior Managers of the Trust. The analysis of staff numbers and related narrative notes is included in Note 10.2 on page 16 of the Annual Accounts.

The salaries and allowances and pension benefits for the Trust's Senior Managers are detailed on page 56 and 57 and have been audited by Grant Thornton.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

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

The banded remuneration of the highest paid Director in Weston Area Health NHS Trust in the financial year 2015/16 was £125k - £129.9k (2014/15, £150k - £154.9k). This was 4.8 times (2014/15, 6.5 times) the median remuneration of the workforce, which was £26,438 (2014/15, £24,293).

The reason for the reduction in the highest paid Director between 2015/16 and 2014/15 is due to the fact that whilst the highest paid director was in post for 12 months in 2014/15 they were in post for only nine months in 2015/16. The reduction in highest paid director also reduces the ratio of median salary to highest paid director.

In 2015/16, eighteen (2014/15, two) Trust employees received remuneration in excess of the highest-paid Director. Trust employees remuneration ranged from £6k to £191k (2014/15 £6k to £175k).

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

Signed by: .... Chief Executive

Salaries and Allowances

Weston Area Health NHS Trust - Annual Report 2015/16

Remuneration Report

Salaries and Allowances

Name and Title	2015-16						2014-15					
	Salary (bands of £5,000)	Expenses Payments (taxable) total to nearest £100	Performance Pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	Expenses Payments (taxable) total to nearest £100	Performance Pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
J Rimmer, Interim Chief Executive (from 03/08/15 to 31/12/15) Chief Executive (from 01/01/16) *	105-109	nil	nil	nil	127.5-129.9	235-239	Not in post					
N Wood, Interim Chief Executive (from 01/04/13 to 30/09/13) Chief Executive (from 01/10/13 to 04/07/15)	35-39	nil	nil	nil	10.0-12.4	45-49	145-149	nil	nil	nil	65-67.4	205-209
R Little, Director of Finance and IM&T (from 01/07/10)	105-109	nil	nil	nil	15.0-17.4	120-124	105-109	nil	nil	nil	25-27.4	130-134
N Lyons, Executive Medical Director (from 08/01/16)	20-24	nil	nil	nil	2.5-4.9	25-29	Not in post					
A Martin, Interim Executive Medical Director (from 01/05/14 to) Executive Medical Director (from 01/05/15 to 06/01/16) **	125-129	nil	nil	nil	25.0-27.4	150-154	150-154	nil	nil	nil	90-92.4	240-244
N Gallegos, Executive Medical Director (from 01/05/10 to 30/04/14)	Not in post						10-14	nil	nil	nil	nil	10-14
H Richardson, Interim Director of Nursing (from 15/02/16) ***	15-19	nil	nil	nil	72.5-74.9	90-94	Not in post					
C Perry, Interim Director of Nursing (from 01/04/2013 to 30/09/13) Director of Nursing (from 01/10/13 to 02/12/15) ****	60-64	nil	nil	nil	nil	60-64	95-99	nil	nil	nil	47.5-49.9	140-144
J Stroud, Deputy Director of Nursing (from 01/12/15 to 14/02/16)	10-14	nil	nil	nil	55.0-57.4	65-69	Not in post					
B Bishop, Director of Strategic Development (from 01/10/08)	90-94	nil	nil	nil	15.0-17.4	105-109	90-94	nil	nil	nil	120-122.4	210-214
K Croker, Interim Director of Operations (from 02/04/13 to 30/09/13) Director of Operations (from 01/10/13)****	85-89	1	nil	nil	25.0-27.4	110-114	85-89	nil	nil	nil	42.5-44.9	130-134
S Flavin, Interim Director of Human Resources (from 01/10/12 to 30/09/13) Director of Human Resources (from 01/10/13)	80-84	2	nil	nil	30.0-32.4	115-119	80-84	nil	nil	nil	40-42.4	125-129
P Carr, Chair (from 01/08/13 to 30/04/15)	0-4	2	nil	nil	nil	0-4	15-19	20	nil	nil	nil	20-24
G Paine, Non Executive Director (from 01/03/08 to 29/02/15) Acting Chairman (from 01/05/15 to 16/11/15) Chairman (from 17/11/15)	15-19	nil	nil	nil	nil	15-19	5-9	nil	nil	nil	nil	5-9
A Wyke, Non Executive Director (from 18/12/15	0-4	nil	nil	nil	nil	0-4	Not in post					
I Turner, Non Executive Director (from 01/08/07)	5-9	nil	nil	nil	nil	5-9	5-9	nil	nil	nil	nil	5-9
G Reah, Non Executive Director (from 01/02/08)	5-9	nil	nil	nil	nil	5-9	5-9	nil	nil	nil	nil	5-9
B Musselwhite, Non Executive Director (from 10/10/13) ***	5-9	nil	nil	nil	nil	5-9	5-9	2	nil	nil	nil	5-9
R Lloyd, Non Executive Director (from 01/09/11 to 30/04/14)	Not in post						0-4	nil	nil	nil	nil	0-4
F Powell, Non Executive Director (from 29/06/15)	0-4	nil	nil	nil	nil	0-4	Not in post					
G Hoskins, Associate Director of Governance and Patient Experience (from 01/07/13)	60-64	1	nil	nil	17.5-19.9	80-84	60-64	nil	nil	nil	5-7.4	65-69

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

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

*** H Richardson was seconded from the Care Quality Commission for the entire period shown above. There was one invoice from the CQC for £16.7k, which has been included in full within Mrs Richardson's salary.

**** C Perry holds responsibilities at Swindon CCG for which the Trust has invoiced £7.9k (£11.9k in 2014-15), the value disclosed above is the cost to the Trust prior to the secondment commencing.

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

The amounts shown in the All pension-related benefits column of the table are calculated according to the Manual for Accounts 2015/16 guidance: The annual pension increase, adjusted for inflation, is expressed over an expected 20 year payment period ie. An annual increase of £10k = £200k.

Pension Benefits

Weston Area Health NHS Trust - Annual Report 2015/16

Pension Benefits

Name and title	A Real increase in pension at age 60 at 31 March 2016 (bands of £2,500)	B Real increase in lump sum at age 60 at 31 March 2016 (bands of £2,500)	C Total accrued pension at age 60 at 31 March 2016 (bands of £5,000)	D Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)	E Cash Equivalent Transfer Value at 01 April 2015	F Cash Equivalent Transfer Value at 31 March 2016	G Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
J Rimmer, Interim Chief Executive (from 03/08/15 to 31/12/15) Chief Executive (from 01/01/16)	2.5-4.9	5-7.4	45-49	125-129	666	764	59
N Wood, Interim Chief Executive (from 01/04/13 to 30/09/13) Chief Executive (from 01/10/13 to 04/07/15)	0-2.4	nil	10-14	nil	135	145	8
R Little, Director of Finance and IM&T (from 01/07/10) *	0-2.4	0-2.4	50-54	155-159	n/a	n/a	n/a
N Lyons, Executive Medical Director (from 08/01/16)	0-2.4	0-2.4	12.5-14.9	37.5-39.9	229	241	2
A Martin, Interim Executive Medical Director (from 01/05/14 to) Executive Medical Director (from 01/05/15 to 06/01/16)	0-2.4	2.5-4.9	35-39	110-114	719	758	23
H Richardson, Interim Director of Nursing (from 15/02/16)	0-2.4	0-2.4	30-34	90-94	489	567	9
C Perry, Interim Director of Nursing (from 01/04/2013 to 30/09/13) Director of Nursing (from 01/10/13 to 02/12/15) **	0-(2.4)	0-(2.4)	30-34	95-99	621	632	2
J Stroud, Deputy Director of Nursing (from 01/12/15 to 14/02/16)	0-2.4	0-2.4	20-24	70-74	417	494	15
B Bishop, Director of Strategic Development (from 01/10/08)	0-2.4	0-2.4	35-39	110-114	755	786	22
K Croker, Interim Director of Operations (From 02/04/13 to 30/09/13) Director of Operations (from 01/10/13)	0-2.4	0-(2.4)	30-34	85-89	448	467	14
S Flavin, Interim Director of Human Resources (from 01/10/12 to 30/09/13) Director of Human Resources (from 01/10/13)	0-2.4	nil	5-9	nil	42	60	17
G Hoskins, Associate Director of Governance and Patient Experience (from 01/07/13)	0-2.4	0-2.4	22.5-24.9	70-74	401	425	19

Notes :

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

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

Figures in (brackets) indicate a decrease

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

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

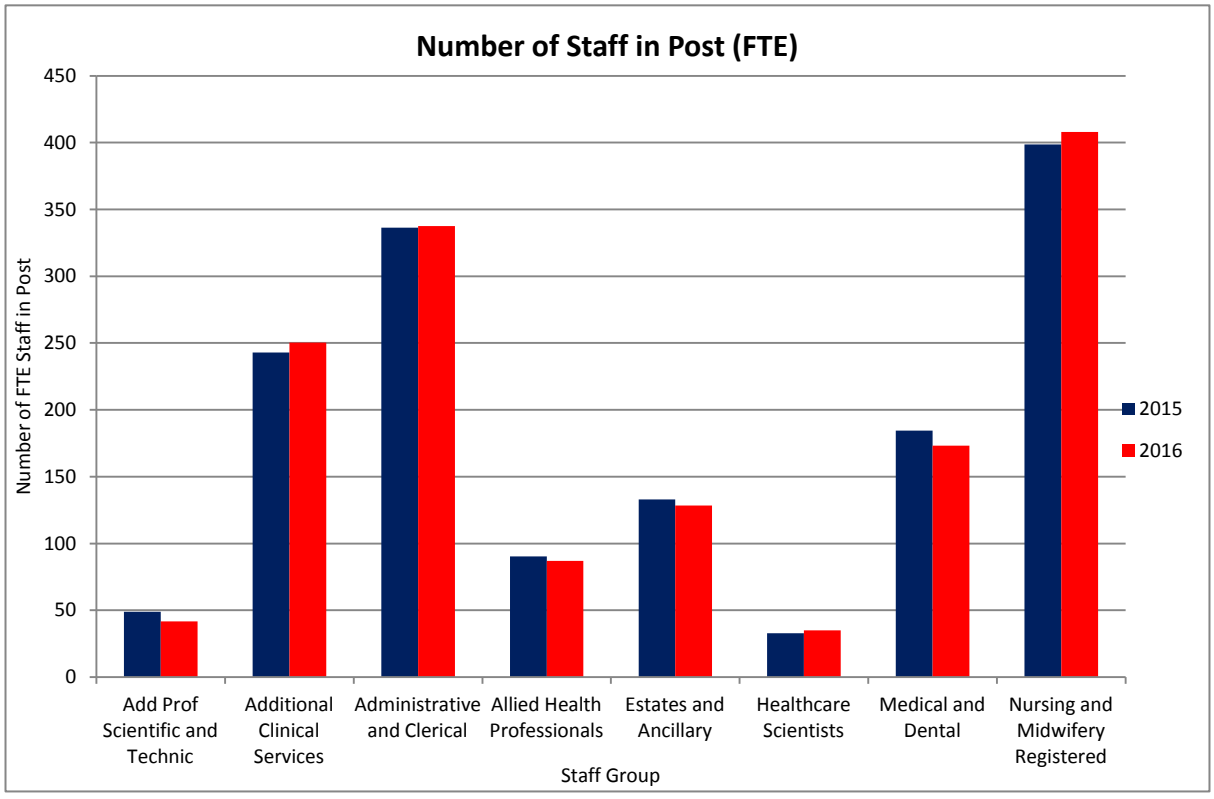
Column H in the guidance for 'Employer's contribution to stakeholder pension' does not apply here as all Directors are part of the Defined Benefit Scheme only.

Staff report

Workforce Profile

The graph presented below shows the workforce (permanent and fixed term) analysed using full time equivalents for staff in post, by occupational group for the last two years, highlighting changes in the workforce configuration. The overall workforce profile has remained consistent from March 2015 to March 2016.

There have however been fluctuations within staff groups, the most notable changes are within Nursing and Midwifery and Medical and Dental. The increase in Nursing and Midwifery relates to a continued focus on recruitment and success of recruiting locally, within the UK and from abroad. The Medical and Dental workforce has seen a higher than average turnover, and the Trust has experienced challenges recruiting into some of the vacated posts.



Staff Engagement

The Trust recognises that a high level of staff engagement is crucial to improving the patient experience and uses a variety of tools and methods to encourage staff feedback and to drive forward actions to improve the staff experience.

The Trust has a formal recognition agreement with our staff side colleagues and runs a monthly forum through the Joint Negotiating and Consultative Committee where union representatives are able to raise staff issues and to be kept informed of organisational changes.

We have also relaunched the Staff Experience and Engagement Group whose remit is to represent the views of their teams/departments, raise any concerns and make suggestions on a range of issues from Health and Wellbeing to Equality and Diversity.

During 2015 we have continued to develop our channels of communication with staff through 'Ask James', a monthly team brief where every member of staff has the opportunity to ask the Chief Executive any question about any Trust matter, through our monthly Staff Newsletter and through our monthly PRIDE awards which recognises those teams and individuals who have demonstrated outstanding commitment or contribution to one or more of the Trust's PRIDE values.

National NHS Staff Survey 2015

The NHS Staff Survey took place between September and December 2015. Of the 750 Weston Area Health NHS Trust (WAHT) staff surveyed, 394 staff took part, giving a response rate of 49% which compared well against the national average response rate of 41%.

The table below shows the results for the 3 Key Findings from the 2015 Staff Survey that are combined to give an overall score for Staff Engagement. Whilst it can be seen that there has been an improvement, the overall score is worse than the national average for acute trusts.

Improving scores in overall Staff Engagement

	Key Finding	2014	2015	Change since 2014 survey	Ranking against all acute trusts
KF1	Staff recommendation of the trust as a place to work or receive treatment	3.42	3.59	Improvement	Worst 20%
KF4	Staff motivation at work	3.76	3.94	Improvement	Average
KF7	Staff ability to contribute towards improvements at work	69%	70%	No change	Average
	Overall staff engagement score	**3.63**	**3.77**	**Improvement**	**Worse than average**

Results for the survey questions that make up the result for Key Finding 1: St*aff recommendation of the trust as a place to work or receive treatment'* have also shown an improvement and will continue to be a focus for the year ahead.

Improving scores in Key Finding 1

	Question	2014	2015	Change since 2014 survey	Average for acute trusts
Q21a	Care of patients / service users is my organisation's top priority	61%	72%	Improvement	75%
Q21c	I would recommend my organisation as a place to work	48%	54%	Improvement	61%
Q21d	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	51%	56%	Improvement	70%
KF1	**Staff recommendation of the organisation as a place to work or receive treatment**	**3.42**	**3.59**	**Improvement**	**3.76**

Equality and Diversity

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

All staff joining the Trust as part of the induction programme take part in a dedicated Equality and Diversity session. During 2015/16 the equality and diversity induction programme has been reviewed and reinvigorated to ensure we continue develop and improve the information provided to staff. The new programme has received positive feedback.

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

The following table shows the gender distribution across all staff, senior managers and directors.

All Staff

Gender	Total
Female	1368
Male	381
Grand Total	**1749**

Board Directors (Including Non Executives)

Gender	Org P4	Role	Total
Female	Executive Directors	Director of Strategic Development	1
		Director of Nursing	1
		Director of Operations	1
		Director of Human Resources	1
	Non Executive Directors	Board Level Director	2
Female Total			**6**
Male	Executive Directors	Chief Executive	1
		Finance Director	1
		Medical Director	1

Senior Managers

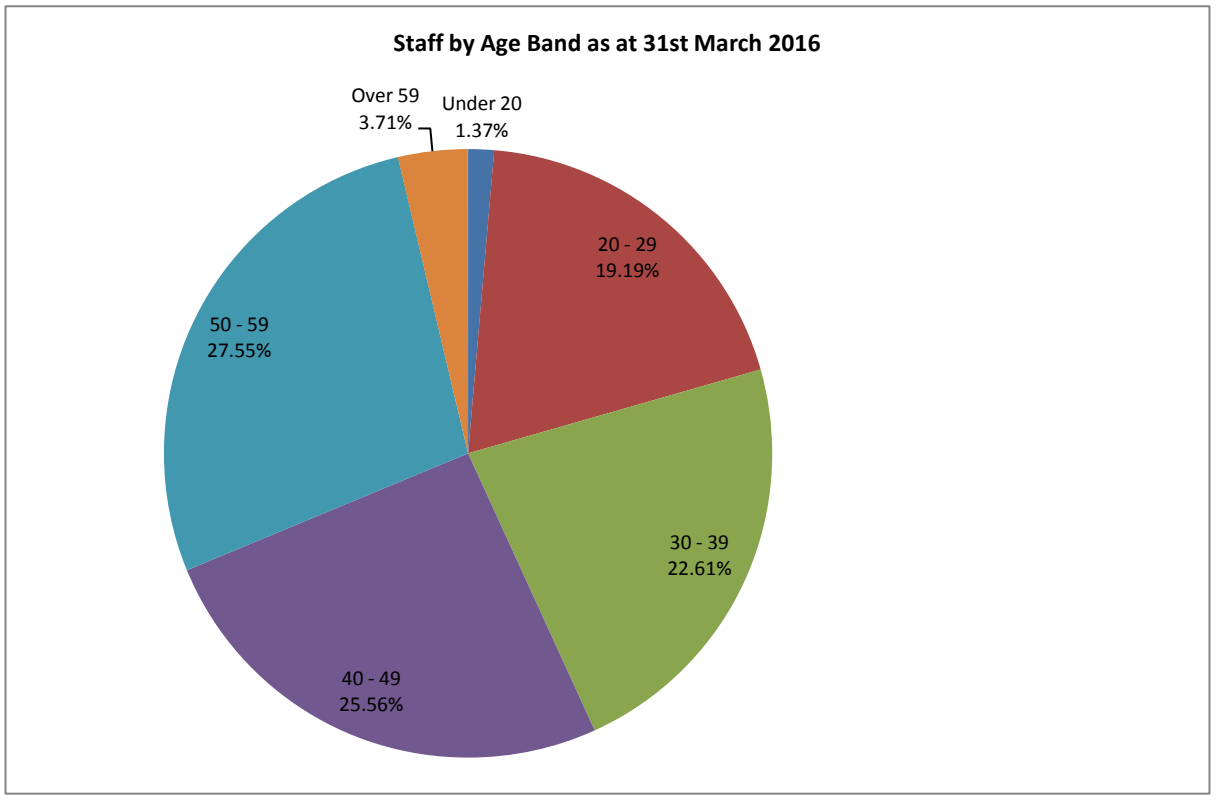
Gender	Total
Female	42
Male	17
Grand Total	**59**

	Non Executive Directors	Board Level Director	3
		Chair	1
Male Total			**7**
Grand Total			**13**

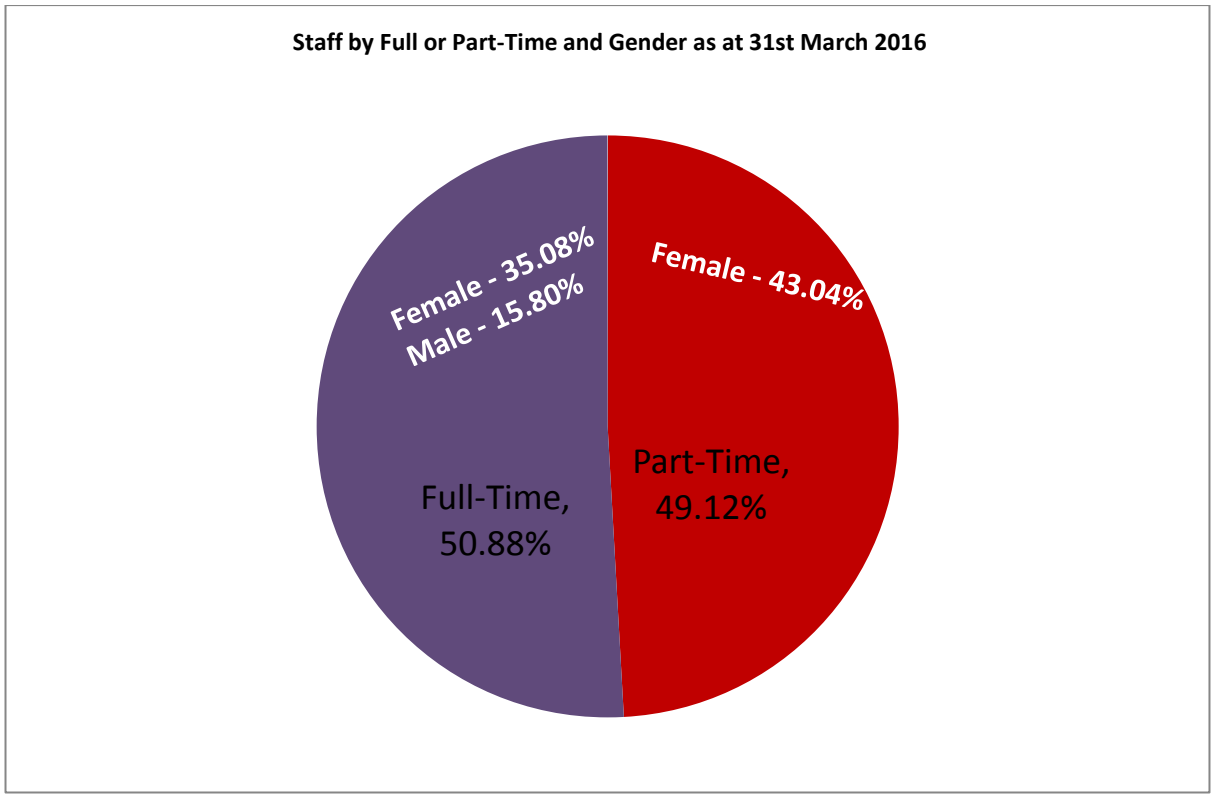
During the last 12 months, the Trust Board membership has been compliant with the legal Order which establishes the Trust both in terms of numbers and in relation to the required executive membership; specifically a Medical Director, Director of Nursing, Director of Finance and Chief Executive. Non-Executive members offer a range of skills including finance, strategy, and statistical analysis, information technology, commercial and legal.

The following tables shows the workforce profile by, age, gender, disability, ethnicity, sexual orientation, religious belief.

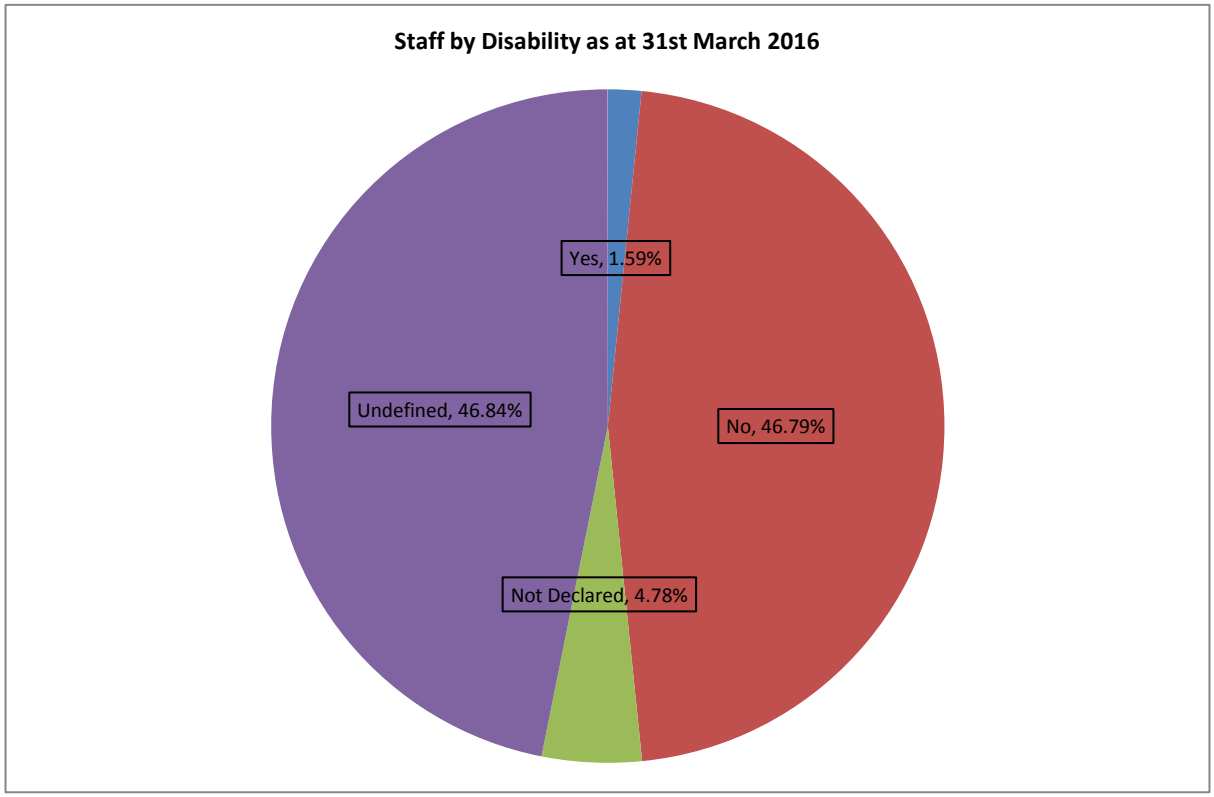
Age



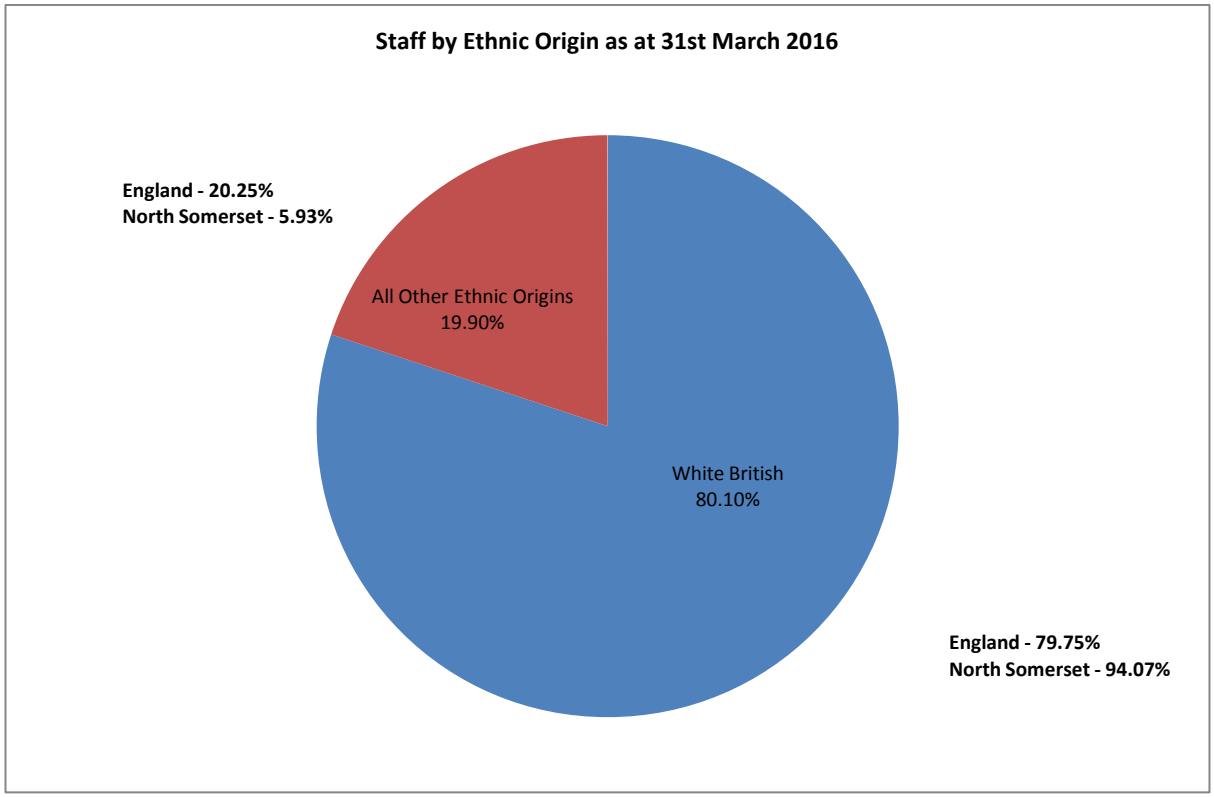
Gender


Staff by Full or Part-Time and Gender as at 31st March 2016
Female - 35.08%
Male - 15.80%
Female - 43.04%
Full-Time,
50.88%
Part-Time,
49.12%

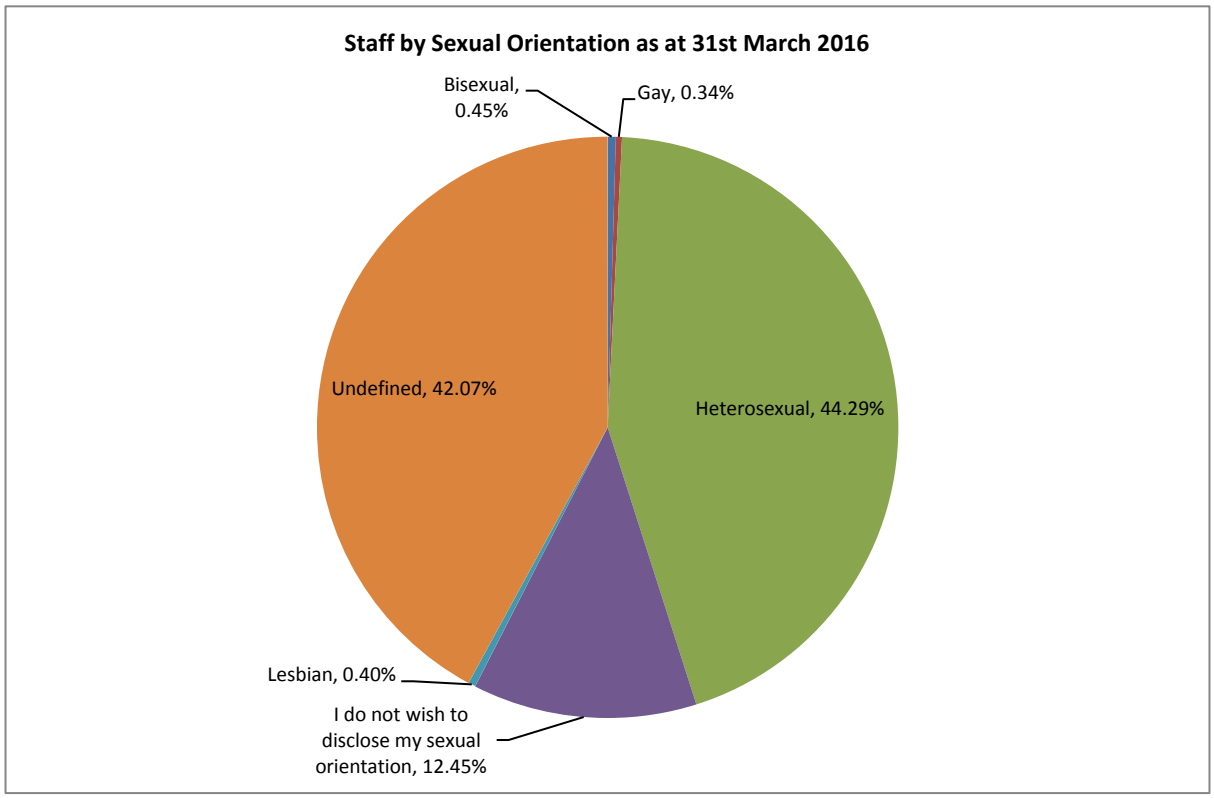
Disability


Staff by Disability as at 31st March 2016
Yes, 1.59%
Undefined, 46.84%
No, 46.79%
Not Declared, 4.78%

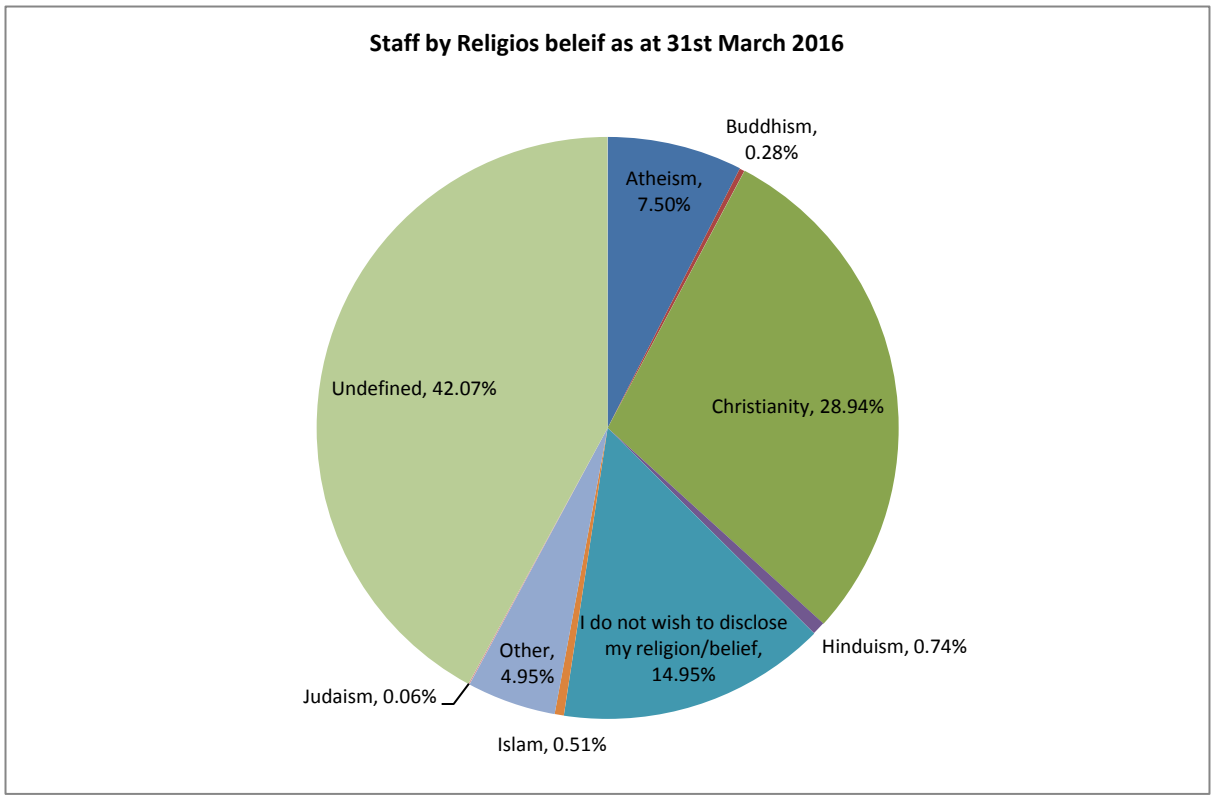
Ethnicity



Sexual Orientation



Region and Belief



Staff policies in relation to the employment of disabled persons are included in the Trusts Equality and Diversity policy – which is available on the Trusts website.

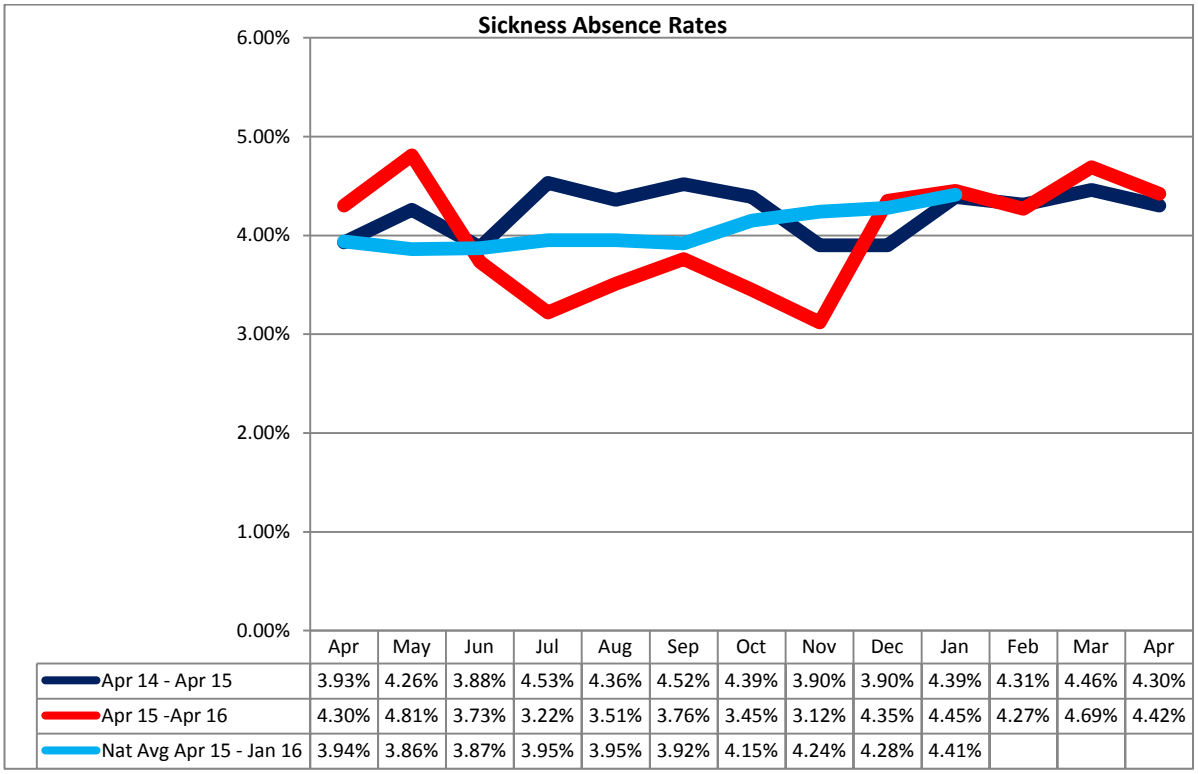
Workplace Health

Workplace health and improving the health of our employees is a continued committed from the Trust which we seek to improve and develop each year. During 2015/16, the Trust has renewed investment in our Employee Assistance Programme (EAP) Optum. Optum provide a confidential advice and information service on work and personal matters ranging from legal and financial advice to telephone and face to face counselling. We encourage our employees to access our EAP provider as soon as issues arise and feedback has been positive with counselling services receiving the highest usage during this reporting period.

The staff physiotherapy clinics have continued for a third year and during 2015/16 over 339 staff have accessed the service, which has increased from 2013/14. This service helps form part of the Trusts Health and Wellbeing programme and focuses on reducing sickness and aiding staff in returning to work sooner.

Through the Trusts Staff Engagement Group, the Trust has sought feedback on health and wellbeing initiatives that staff most wanted. From the feedback received the Trust purchased health kiosks that could be used by staff to measure weight, BMI, blood pressure and, body fat, heart rate and hydration.

The chart below shows the Trust sickness absence rate for the last two years, the chart also compares Trust sickness to national comparators. During 2015/16 the Trust sickness has improved when compared to the previous year and also when compared to national comparators.



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

Travel

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

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

We were celebrated for our sustainable travel efforts at the Travelwest Sustainable Travel Business Awards (Thursday, 26 November 2015), when we were awarded 'Silver Accreditation' at the awards ceremony for our work in encouraging staff to use environmentally friendly transport.

The Trust was praised for overcoming the challenging travel needs of shift-working staff, and facilitating a variety of travel options for staff.

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

The awards, which were held at the Grand Pier, Weston-super-Mare, are in their fourth year and are organised by North Somerset Council, South Gloucestershire Council, Bristol City Council and Bath and North Somerset Council.

Sheridan Flavin, Director of Human Resources at the Trust said: “We’re really proud to receive this accreditation because we are committed to encouraging our staff to use sustainable transport. The increase in staff walking, cycling and using public transport to work demonstrates that the Trust’s travel initiatives are working effectively and this accreditation is a recognition that we are doing our part to help build a sustainable future in North Somerset.”

The groups plans for 2016/2017 include a written communication strategy, an update of the Trusts green travel pages after the recent “re vamp” of the Trusts intranet pages, more sustainable roadshows and initiatives aimed at helping staff travel more sustainably, thereby benefiting the environment and their health and wellbeing.

2.7.5 Developing the Skills of our Workforce

The Trust is committed to providing a range of on-going learning and development opportunities for all of our current staff, trainees and students. Starting with a comprehensive induction package, staff go on to access a full range of learning solutions from in-house clinical skills classroom teaching to accredited professional development studies at the University of the West of England.

Our 6-week in-house induction package for Nurse Assistants has been extended and mapped to the National Care Certificate and this is part of a learning pathway that has been developed for our non-registered nursing workforce leading ultimately to the opportunity to be sponsored into the pre-reg nursing degree programme.

Despite challenging service pressures, patient and staff safety remains a number one priority for the Trust and mandatory training compliance now exceeds 85%.

Apprenticeships and work experience as also seen as an essential part of our future workforce development, offering a variety of ways to introduce young people into the NHS. We have continued to work closely with Weston College to develop the skills of our Bands 1-4 workforce through apprenticeships in Business Administration, Customer Service and Team Leading.

Our Library has focused on improving the quality of service offered through a variety of innovative measures over the last year; the introduction of state of the art RFID security providing greater monitoring of the existing stock; the introduction of Summon, a self-discovery service allowing staff to search and locate articles via one search engine and the introduction of Knowledgeshare, a current awareness service giving staff access to a personalised subject email encompassing the latest information from articles and reports on a topic chosen by them.

Consultancy expenditure

Management Consultancy expenditure for the Trust during 2015/16 was £360,000

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2016	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0

There was one off-payroll engagements for more than £220 a day that lasted longer than six months in year however this engagement finished in December 2015.
This engagement was subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

For all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	1
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	1
Number for whom assurance has been requested	0
Of which:	
assurance has been received	0

assurance has not been received	0
engagements terminated as a result of assurance not being received	0
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	11

The Chief Executive and six Executive Directors, on payroll engagements, are deemed to have significant financial responsibility. The following posts had more than one individual occupying the post in year: Chief Executive (2) Medical Director (2), Director of Nursing (2) bringing the total individuals to eleven.

Part 3 – Financial statements and notes

Improving Financial Standing

The Trust's financial plan for 2015/16 was to achieve a planned year end deficit position of £7,950,000. As part of the 2015/16 Financial Improvement programme the Trust reduced its financial plan to a £7,700,000 deficit which was in line with the stretch target set by the NHS Trust Development Authority.

The Trust has reported a deficit of £6,965,000 in 2015/16 against the plan of £7,700,000 which is an improvement of £735,000 when compared against the revised planned year end deficit position.

To get to this position savings of £3,278,000 were achieved during the year. The Trust has also met or improved on its planned position over the previous three years, after taking into account the Department of Health guidance on break-even duty for NHS Trusts, £3,902,000 deficit (2014-15), £4,683,000 deficit (2013-14) and £2,250,000 surplus (2012-13).

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 £1,903,000 when compared to the average relevant net assets of £54.4m.

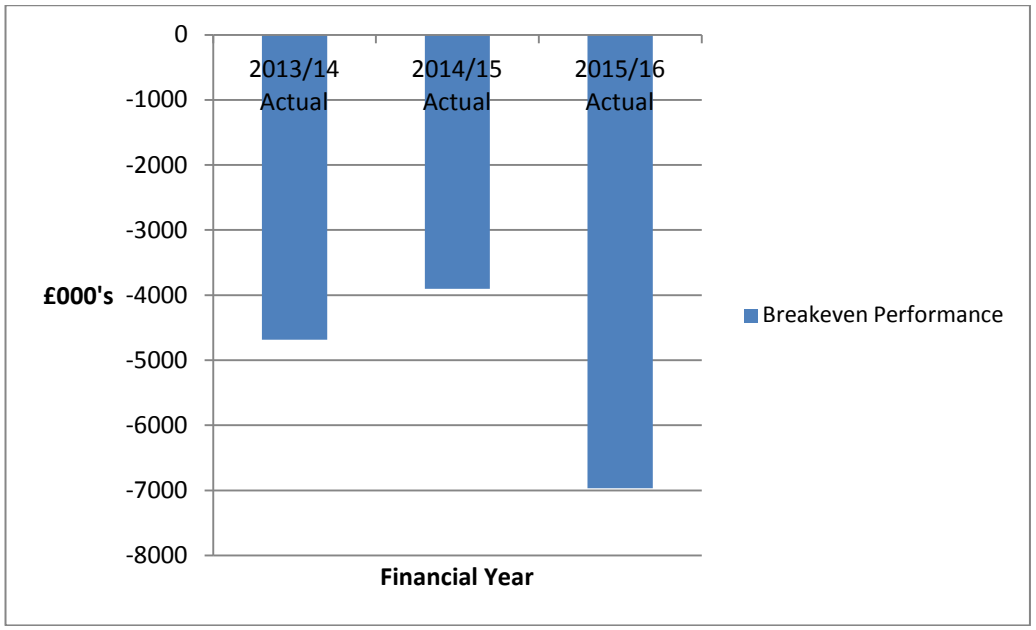
The EFL is a measure of the Trust's change in its borrowings and cash balances during the year. The limit set for 2015/16 was (£11,487,000), which meant the Trust needed to increase its cash or decrease borrowings by at least this amount. This target was met.

The CRL is a control that measures capital expenditure against a limit set annually by the Department of Health and which the Trust is not allowed to exceed. The limit for 2015/16 was £5,657,000 and the charge made against it was £48,000 below, and within an acceptable tolerance.

The Trust maintained its key controls in order to achieve these targets in 2015/16.

Financial Position of the Trust

The Trust has reported a retained deficit of £7,484,000 in 2015/16. The retained deficit is after an impairment charge of £386,000 and the elimination of the donated assets reserve of £133,000. As per the Department of Health guidance on break-even duty for NHS Trusts, the costs relating to impairments and donated assets 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 recorded a deficit of £6,965,000 an improvement of £735,000 when compared to the revised planned deficit of £7,700,000. To get to this position savings of £3,278,000 were achieved during the year.

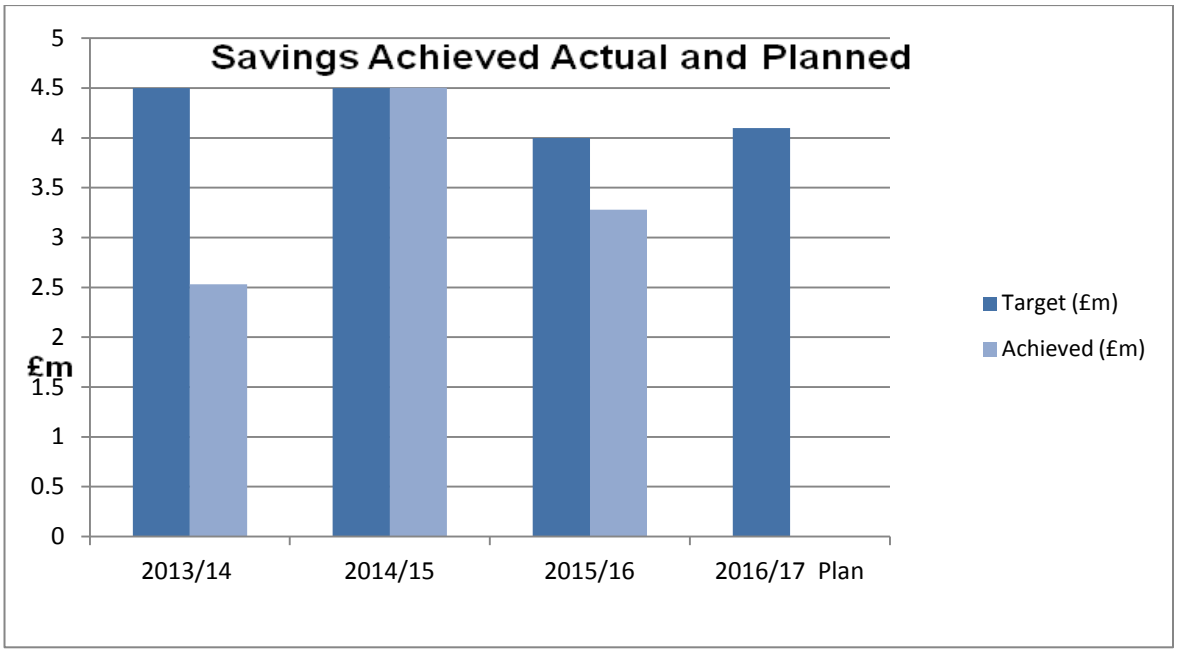


Financial Position 2016/17

The Trust is planning to deliver a deficit of £3,200,000 in 2016/17.

Financial Recovery

A budget for 2016/17 has been approved by the Trust Board and includes details of risks and assumptions. Further significant savings of £4,099,000 are planned to be delivered in 2016/17. These plans will be closely monitored and reported through the Executive Review of monthly Performance Management Review meetings which will include a focus on all aspects the savings plans.



Accounting Policies

These set out the accounting rules that all NHS trusts are required to follow. They explain the basis on which all entries in the accounts are made. The policies are largely dictated by the Department of Health's 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.

Paying Our Bills Promptly

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

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

As at the end of the financial year, the Trust had paid 97.0% of the total number of non-NHS invoices against the Code. This compares with 97.2% in 2014/15. With 88.2% of the total number of NHS invoices paid within 30 days compared with 84.0% in 2014/15. The overall total number of invoices paid, both NHS and non NHS, was 96.7%.

Land Valuations

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

The District Valuer has estimated the land value as at 31 March 2016 at £6,870,000. The Directors of the Trust are not aware of any material differences between the carrying values and the current market values

Pension Liabilities

Past and present employees of the Trust are covered by the provisions of the NHS Pensions Scheme. Further information including how pension liabilities are treated in the accounts can be found in accounting note 1.7 of the full set of the accounts. Pension information for Directors of the Trust is shown in the Pensions benefit table of the Remuneration Report within this annual report

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	10.1	**(68,357)**	(67,821)
Other operating costs	8	**(35,682)**	(35,134)
Revenue from patient care activities	5	**88,955**	90,689
Other operating revenue	6	**9,507**	9,689
Operating (deficit)		**(5,577)**	(2,577)
Investment revenue	12	**11**	14
Other gains	13	**8**	5
Finance costs	14	**(23)**	(3)
(Deficit) for the financial year		**(5,581)**	(2,561)
Public dividend capital dividends payable		**(1,903)**	(1,895)
Retained (deficit) for the year		**(7,484)**	(4,456)

Other Comprehensive Income

	NOTE	2015-16 £000s	2014-15 £000s
Net gain on revaluation of property, plant & equipment	15.1	**1,092**	785
Total Other Comprehensive Income		**1,092**	785
Total comprehensive income for the year		**(6,392)**	(3,671)

Financial performance for the year

Retained (deficit) for the year		**(7,484)**	(4,456)	
Impairments (excluding IFRIC 12 impairments)	17	**386**	393	a
Adjustments in respect of donated asset reserve elimination		**133**	161	b
Adjusted retained (deficit)		**(6,965)**	(3,902)	

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

a) Impairments to Non-current assets - An impairment charge is not considered part of the organisation's operating position. (see Note 42.1 Trusts breakeven performance and Note 17 Impairments).

b) The impact from the change in accounting for the elimination of the donated asset reserve is neutralised
by this adjustment. This relates to depreciation on donated assets £133,000 (£161,000 2014-15).

Statement of Financial Position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	15	**66,613**	64,386
Intangible assets	16	**2,577**	2,072
Trade and other receivables	22.1	**460**	427
Total non-current assets		**69,650**	66,885
Current assets:			
Inventories	21	**1,054**	1,080
Trade and other receivables	22.1	**3,314**	3,091
Cash and cash equivalents	26	**3,853**	3,030
Total current assets		**8,221**	7,201
Total assets		**77,871**	74,086
Current liabilities			
Trade and other payables	28	**(10,227)**	(9,681)
Provisions	35	**(60)**	(88)
Total current liabilities		**(10,287)**	(9,769)
Net current assets/(liabilities)		**(2,066)**	(2,568)
Total assets less current liablilities		**67,584**	64,317
Non-current liabilities			
Provisions	35	**(383)**	(181)
DH revenue support loan	30	**(7,700)**	0
Total non-current liabilities		**(8,083)**	(181)
Total assets employed:		**59,501**	64,136
FINANCED BY:			
Public Dividend Capital		**69,814**	68,057
Retained earnings		**(22,749)**	(16,383)
Revaluation reserve		**12,436**	12,555
Other reserves		**0**	(93)
Total Taxpayers' Equity:		**59,501**	64,136

The financial statements on pages 1 to 33 were approved by the Board on 27th May 2016 and signed on its behalf by

Chief Executive: Date: 27-May-16

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Note	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
		£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015		**68,057**	**(16,383)**	**12,555**	**(93)**	**64,136**
Changes in taxpayers' equity for 2015-16						
Retained (deficit) for the year			(7,484)			**(7,484)**
Net gain on revaluation of property, plant, equipment	15.1			1,092		**1,092**
Transfers between reserves			1,118	(1,211)	93	**0**
Reclassification Adjustments						
Permanent PDC received - cash		1,757				**1,757**
Net recognised revenue/(expense) for the year		**1,757**	**(6,366)**	**(119)**	**93**	**(4,635)**
Balance at 31 March 2016		**69,814**	**(22,749)**	**12,436**	**0**	**59,501**

The permanent PDC received -cash relates to capital funding of £1,048k Capital Incentive Funding and £709k for the Interim patient administration system capital project. New PDC received total of £1,757k.

The transfer between retained earnings and the revaluation reserve is due to the reversal of impairment charges that were previously charged to retained earnings as a result of the upward revaluation on buildings at 31st March 2016 £1,604k. This is offset by £393k being the difference between the current cost of depreciation compared to the historic cost of depreciation and the balance of £93k moved from other reserves. Totalling £1,211k for transfers between reserves.

Balance at 1 April 2014	**62,983**	**(12,748)**	**12,591**	**(93)**	**62,733**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year		(4,456)			(4,456)
Net gain on revaluation of property, plant, equipment			785		785
Transfers between reserves		821	(821)	0	0
Reclassification Adjustments					
New temporary and permanent PDC received - cash	5,074				5,074
Net recognised revenue/(expense) for the year	**5,074**	**(3,635)**	**(36)**	**0**	**1,403**
Balance at 31 March 2015	**68,057**	**(16,383)**	**12,555**	**(93)**	**64,136**

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)	SOCI	**(5,577)**	(2,577)
Depreciation and amortisation	8	**3,583**	3,855
Impairments and reversals	17	**386**	393
Interest paid	14	**(20)**	0
PDC Dividend (paid)/refunded	SOCI	**(1,838)**	(1,906)
(Increase)/Decrease in Inventories	21	**26**	98
(Increase)/Decrease in Trade and Other Receivables	22.1	**(256)**	754
Increase/(Decrease) in Trade and Other Payables	28	**297**	67
Provisions utilised	35	**(65)**	(67)
Increase/(Decrease) in movement in non cash provisions	35	**236**	39
Net Cash Inflow/(Outflow) from Operating Activities		**(3,228)**	656
Cash Flows from Investing Activities			
Interest Received		**11**	14
(Payments) for Property, Plant and Equipment		**(4,649)**	(3,228)
(Payments) for Intangible Assets		**(776)**	(241)
Proceeds of disposal of assets held for sale (PPE)		**8**	5
Net Cash Inflow/(Outflow) from Investing Activities		**(5,406)**	(3,450)
Net Cash Inform / (outflow) before Financing		**(8,634)**	(2,794)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received	SOCITE	**1,757**	5,074
Loans received from DH - New Revenue Support Loans		**7,700**	0
Net Cash Inflow/(Outflow) from Financing Activities		**9,457**	5,074
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**823**	2,280
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**3,030**	750
Cash and Cash Equivalents (and Bank Overdraft) at year end	**26**	**3,853**	3,030

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Movement of assets within the DH Group

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

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

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements.

As per the Guidance for Consolidation of NHS Charity Accounts into NHS Local Accounts the Charity's transactions are immaterial in the context of the group and transactions do not need to be consolidated. Also see accounting policies note 1.28.

1.5 Critical accounting judgements and key sources of estimation uncertainty

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

1.5.1 Critical judgements in applying accounting policies

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

- Assessing the value of significant accruals of income and expenditure at the year end.
- The Trust has prepared the accounts on a going concern basis. The Directors 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 the NHS Five Year Forward view and in light of these new opportunities the Trust has developed a Strategic Plan 2016/2021, which describes the Trust's priorities for the next four years to deliver outstanding safe care and improve the sustainability of all services. The Trust is assured that it will secure sufficient working capital with the agreement of the NHS Improvement (formerly NHS Trust Development Authority) from April 2016. For this reason the going concern basis has been adopted for preparing the accounts. The Trust has a planned deficit in 2016/17 of £3.2m and this requires a £3.2m loan from the Department of Health of equal value to maintain cash flow in 2016/17. Directors have confirmation from the NHS Improvement (formerly NHS TDA) that it will support the Trust's application for cash support for 2016/17.
- Assessing whether significant risks and rewards of ownership of leased assets have transferred.
- Assessing whether impairments to the values of Property Plant and Equipment non current assets and intangibles have arisen in year.
- Management has declared that the financial statements are free from any misstatement as a result of fraud or any weakness
in systems of internal control.

1.5.2 Key sources of estimation uncertainty

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

- All land and buildings are restated to fair values using the professional valuation provided by the District Valuer Services based on a valuation date of 31st March 2015. The carrying amount for land and buildings as at 31 March 2016 are based on this valuation and adjusted using recognised published indices where the impact of the revaluation is material.
- Holiday pay due to employees but not taken at 31st March is accrued for based on the carried forward leave information received from a representative sample of the Trust's workforce.
- Healthcare SLA over/under performance with some commissioners is estimated based on patient activity;

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 2016. This is recognised on an agreed average of partially completed spells during the year.
- Under maternity payment by results a commissioner will pay a provider for all the pregnancy-related care a woman may need for the duration of her pregnancy, birth and postnatal care. The Trust has apportioned the income from antenatal care over the six months following registration, charged for the birth at the time of the delivery and post natal care in the month following delivery. This is a local agreement and the treatment is not as prescribed under the payment by results guidance. This results in no income being deferred and does not have a material impact on the Trust's income.

1.6 Revenue

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

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

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

1.7 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS 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 NHS Trust commits itself to the retirement, regardless of the method of payment.

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

1.8 Other expenses

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

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

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the 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 current value in their existing use.

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 current value in their existing use at the date of revaluation less any impairment.

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

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.

In line with the Trust's decision to revalue land and buildings every five years and use the BCIS [Building Cost Information Service] All in Tender Price Index between full valuations, the Trust instructed the District Valuer Service, who are RICS qualified, to value land and buildings on a modern equivalent assets basis as at 31 March 2015. In the current year after the completion of the Theatre refurbishment works in December 2015 the District Valuer revalued the main building of the Trust which produced a reduction in value which was charged against the revaluation reserve.

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.

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.

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

1.10 Intangible assets

Recognition

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

1.11 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 NHS Trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over 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.

1.12 Donated assets

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.

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

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 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.

1.15 Cash and cash equivalents

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

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

1.16 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 minus 1.55% (minus 1.5% 2014-15) and 1.37% (1.30% 2014-15) for employee early departure obligations.

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

A restructuring provision is recognised when the 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.

1.17 Clinical negligence costs

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

1.18 Non-clinical risk pooling

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

1.19 Carbon Reduction Commitment Scheme (CRC)

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

1.20 Contingencies

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

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

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

1.21 Financial assets

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

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

1.22 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.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques. Where the financial instrument is not linked to an inflationary index, a nominal rate quoted by the Department of Health may be used.

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

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

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

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

1.23 Financial liabilities

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

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

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

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

1.24 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.

1.25 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 43 to the accounts.

1.26 Public Dividend Capital (PDC) and PDC dividend

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

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

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

1.27 Losses and Special Payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). See Note 41.

1.28 Subsidiaries

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

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

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

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

1.29 Research and Development

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

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Pooled budget

Not relevant for trust

3. Operating segments

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

4. Income generation activities

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

5. Revenue from patient care activities

		2015-16 £000s	2014-15 £000s
NHS England		**6,652**	6,485
Clinical Commissioning Groups		**79,782**	81,335
Foundation Trusts		**136**	174
Non-NHS:			
Local Authorities		**1,427**	1,437
Private patients		**519**	609
Overseas patients (non-reciprocal)		**2**	5
Injury costs recovery	a	**316**	516
Other		**121**	128
Total Revenue from patient care activities		**88,955**	90,689

Note a: Injury cost recovery income is subject to a provision for impairment of receivables of 21.99% to reflect expected rates of collection (18.9% 2014-15). This is in line with national guidance.

6. Other operating revenue

		2015-16 £000s	2014-15 £000s
Education, training and research		**3,248**	3,237
Charitable and other contributions to revenue expenditure -non- NHS		**93**	114
Non-patient care services to other bodies		**3,468**	3,885
Income generation (Other fees and charges)		**544**	564
Rental revenue from operating leases		**179**	185
Other revenue	a	**1,975**	1,704
Total Other Operating Revenue		**9,507**	9,689
Total operating revenue		**98,462**	100,378

Note a: Includes £864k (£592K 2014-15) income from Somerset Surgical Services Ltd for use of a proportion of the Trusts theatre capacity.

7. Overseas Visitors Disclosure

	2015-16 £000	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	2	5
Cash payments received in-year (re receivables at 31 March 2015)	0	0
Cash payments received in-year (iro invoices issued 2015-16)	2	5
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	0	0
Amounts added to provision for impairment of receivables (iro invoices issued 2015-16)	0	0
Amounts written off in-year (irrespective of year of recognition)	0	7

8. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	674	508
Services from other NHS bodies	166	162
Services from NHS Foundation Trusts	1,762	1,662
Total Services from NHS bodies	2,602	2,332
Purchase of healthcare from non-NHS bodies	352	437
Trust Chair and Non-executive Directors	42	57
Supplies and services - clinical	17,160	16,845
Supplies and services - general	1,710	1,745
Consultancy services	360	1,447
Establishment	951	916
Transport	238	243
Premises	4,169	3,617
Hospitality	35	25
Insurance	1	3
Legal Fees	72	291
Impairments and Reversals of Receivables	24	103
Depreciation	3,187	3,515
Amortisation	396	340
Impairments and reversals of property, plant and equipment	0	393
Impairments and reversals of intangible assets	386	0
Audit fees	69	88
Clinical negligence	2,828	1,859
Education and Training	522	486
Other	578	392
Total Operating expenses (excluding employee benefits)	35,682	35,134
Employee Benefits		
Employee benefits excluding Board members	67,741	67,177
Board members	616	644
Total Employee Benefits	68,357	67,821
Total Operating Expenses	104,039	102,955

9. Operating Leases

9.1. Weston Area Health NHS Trust as lessee

	2015-16			
	Buildings £000s	Other £000s	Total £000s	2014-15 £000s
Payments recognised as an expense				
Minimum lease payments	34	193	**227**	215
Total	**34**	**193**	**227**	215
Payable:				
No later than one year	34	104	**138**	227
Between one and five years	168	313	**481**	675
After five years	559	0	**559**	593
Total	**761**	**417**	**1,178**	1,495

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

The most significant future minimum lease payment in the Other category relates to the Managed Print Service contract with Hewlett-Packard which has 3 years 4 months remaining.

9.2. Weston Area Health NHS Trust as lessor

	2015-16 £000	2014-15 £000s
Recognised as revenue		
Rental revenue	179	185
Total	**179**	185
Receivable:		
No later than one year	183	187
Between one and five years	731	731
After five years	4,817	5,000
Total	**5,731**	5,918

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 58 years remaining.

10. Employee benefits and staff numbers

10.1. Employee benefits

	2015-16 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**58,905**	48,755	10,150
Social security costs	**3,935**	3,935	0
Employer Contributions to NHS BSA - Pensions Division	**5,868**	5,868	0
Total employee benefits	**68,708**	**58,558**	**10,150**
Employee costs capitalised	**351**	304	47
Gross Employee Benefits excluding capitalised costs	**68,357**	**58,254**	**10,103**

Employee Benefits - Gross Expenditure 2014-15	2014-15 Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	58,231	49,046	9,185
Social security costs	4,005	4,005	0
Employer Contributions to NHS BSA - Pensions Division	5,746	5,746	0
Termination benefits	62	62	0
TOTAL - including capitalised costs	68,044	58,859	9,185
Employee costs capitalised	223	180	43
Gross Employee Benefits excluding capitalised costs	67,821	58,679	9,142

10.2. Staff Numbers

	2015-16 Total Number	Permanently employed Number	Other Number	2014-15 Total Number
Average Staff Numbers				
Medical and dental	**233**	163	70	227
Administration and estates	**335**	331	4	330
Healthcare assistants and other support staff	**387**	357	30	381
Nursing, midwifery and health visiting staff	**459**	418	41	477
Scientific, therapeutic and technical staff	**170**	165	5	175
TOTAL	**1,584**	**1,434**	**150**	1,590
Of the above - staff engaged on capital projects	**8**	7	1	6

10.3. Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	12,627	13,951
Total Staff Years	1,455	1,483
Average working Days Lost	8.68	9.41

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	**1**	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	**79**	320

10.4. Exit Packages agreed in 2015-16

2015-16
There were no exit packages in 2015-16

2014-15

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Total number of exit packages	Total cost of exit packages
	Number	**£s**	**Number**	**£s**
£10,000-£25,000	1	22,022	**1**	**22,022**
£25,001-£50,000	1	39,583	**1**	**39,583**
Total	**2**	**61,605**	**2**	**61,605**

Redundancy and other departure costs have been paid in accordance with the provisions of the agenda for change NHS redundancy 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.

10.5. Exit packages - Other Departures analysis

Not relevant for trust

10.6. Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

11. Better Payment Practice Code

11.1. Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**35,637**	**35,477**	33,126	31,218
Total Non-NHS Trade Invoices Paid Within Target	**34,572**	**34,724**	32,200	30,428
Percentage of NHS Trade Invoices Paid Within Target	**97.01%**	**97.88%**	97.20%	97.47%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,373**	**12,283**	1,326	**11,367**
Total NHS Trade Invoices Paid Within Target	**1,211**	**11,706**	1,114	**10,529**
Percentage of NHS Trade Invoices Paid Within Target	**88.20%**	**95.30%**	84.01%	92.63%
Total Payables				
Total Trade Invoices Paid in the Year	**37,010**	**47,760**	34,452	42,585
Total Trade Invoices Paid Within Target	**35,783**	**46,430**	33,314	40,957
Percentage of Trade Invoices Paid Within Target	**96.68%**	**97.22%**	96.70%	96.18%

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

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

	2015-16 £000s	2014-15 £000s
Compensation paid to cover debt recovery costs under this legislation	**4**	0
Total	**4**	0

12. Investment Revenue

	2015-16 £000s	2014-15 £000s
Bank interest	**11**	14
Total investment revenue	**11**	14

13. Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**8**	5
Total	**8**	5

14. Finance Costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	**16**	0
Other finance costs	**4**	0
Provisions - unwinding of discount	**3**	3
Total	**23**	3

15.1. Property, plant and equipment

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

Note a: The net movement on the Revaluation lines, Cost and Depreciation is £1,092k. See SOCITE.
Note b: Corresponding reclassifications of £566k in intangibles non current assets.

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	4,861	7,694	0	0	0	0	**12,555**
Movements	0	(119)	0	0	0	0	**(119)**
At 31 March 2016	**4,861**	**7,575**	**0**	**0**	**0**	**0**	**12,436**

Additions to Assets Under Construction in 2015-16

Buildings excl Dwellings	2,101
Balance as at YTD	**2,101**

15.2. Property, plant and equipment prior-year

2014-15	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:							
At 1 April 2014	9,905	51,564	361	17,536	4,612	1,430	**85,408**
Additions of Assets Under Construction	0	0	922	0	0	0	**922**
Additions Purchased	0	678	0	1,413	273	5	**2,369**
Reclassifications	0	788	(367)	(771)	181	0	**(169)**
Disposals other than for sale	0	0	0	(101)	0	0	**(101)**
Revaluation	(3,035)	(4,962)	0	(18)	(784)	1	**(8,798)**
At 31 March 2015	**6,870**	**48,068**	**916**	**18,059**	**4,282**	**1,436**	**79,631**
Depreciation							
At 1 April 2014	0	6,851	0	10,274	2,638	1,258	**21,021**
Reclassifications	0	44	0	(44)	0	0	**0**
Disposals other than for sale	0	0	0	(101)	0	0	**(101)**
Revaluation	(51)	(8,731)	0	(18)	(784)	1	**(9,583)**
Impairments/negative indexation charged to operating expenses	51	0	0	0	342	0	**393**
Charged During the Year	0	1,836	0	1,032	604	43	**3,515**
At 31 March 2015	**0**	**0**	**0**	**11,143**	**2,800**	**1,302**	**15,245**
Net Book Value at 31 March 2015	**6,870**	**48,068**	**916**	**6,916**	**1,482**	**134**	**64,386**
Asset financing:							
Owned - Purchased	6,870	45,019	916	6,726	1,482	134	**61,147**
Owned - Donated	0	3,049	0	190	0	0	**3,239**
Total at 31 March 2015	**6,870**	**48,068**	**916**	**6,916**	**1,482**	**134**	**64,386**

15.3. (cont). Property, plant and equipment

Of the totals at 31 March 2016 there are no tangible fixed assets relating to land, buildings, dwellings, installations or fittings valued at open market value. (31 March 2015 also Nil).

The Trust's land and buildings were revalued as at 31st March 2015 by the DVS Valuation Office who are independent to the Trust these values are then adjusted for the movement in the Building Cost Information Service index (BCIS) as at 31st March 2016.
The Valuations also accord with the requirements of the RICS Valuation - Professional Standards 2014 UK edition, known as the red book, including the International Valuation Standards, in so far as these are consistent with IFRS and the above mentioned guidance; RICS UKVS 1.15 refers.
The Trust undertook a £2.1 million refurbishment project of 4 Theatres over 2 financial years which was completed in December 2015. The Valuation Office were instructed to undertake a valuation on the main building in which the Theatres are part of on 14th January 2016 with a valuation date 31st March 2016.

This identified a loss on the works undertaken on the main building. As these relate to refurbishment of the existing asset and there is a balance on the revaluation reserve for the main building in excess of this value, the impairment charge £349k is wholly charged against the revaluation reserve

The subsequent valuation of all buildings using the BCIS index resulted in an increase in the value of buildings by £1,441k. Therefore the net gain on property, plant and equipment is £1,441k less £349k which equals £1,092k. See note 15.1.

The DVS Valuation Office assessed no change in the value of the Land for the period ending 31st March 2016.

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

There were no assets held under finance leases or hire purchase contracts at the balance sheet date. (31 March 2015 also Nil)

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

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

15.4 Economic Lives of Non-Current Assets

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

16. Intangible non-current assets

16.1. Intangible non-current assets

2015-16		Computer Licenses
		£000's
At 1 April 2015		**3,454**
Additions Purchased		721
Reclassifications	a	566
Impairments/reversals charged to operating expenses		(958)
At 31 March 2016		**3,783**
Amortisation		
At 1 April 2015		**1,382**
Impairments/reversals charged to operating expenses		(572)
Charged During the Year		396
At 31 March 2016		**1,206**
Net Book Value at 31 March 2016		**2,577**
Asset Financing: Net book value at 31 March 2016 comprises:		
Purchased		2,577
Total at 31 March 2016		**2,577**

Note a: Corresponding reclassifications of £566k in property plant and equipment. See note 15.1.

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

2014-15	Computer Licenses
	£000's
Cost or valuation:	
At 1 April 2014	3,708
Additions - purchased	505
Reclassifications	169
Upward revaluation/positive indexation	(928)
At 31 March 2015	3,454
Amortisation	
At 1 April 2014	1,970
Upward revaluation/positive indexation	(928)
Charged during the year	340
At 31 March 2015	1,382
Net book value at 31 March 2015	2,072

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 1 to 8 years.

17. Analysis of impairments and reversals recognised in 2015-16

	2015-16 Total £000s	2014-15 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI		
Other	0	342
Changes in market price	0	51
Total charged to Annually Managed Expenditure	**0**	**393**
Total Impairments of Property, Plant and Equipment changed to SoCI	**0**	**393**
Intangible assets impairments and reversals charged to SoCI		
Other	386	0
Total charged to Annually Managed Expenditure	**386**	**0**
Total Impairments of Intangibles charged to SoCI	**386**	**0**
Total Impairments charged to SoCI - AME	**386**	**393**
Overall Total Impairments	**386**	**393**

The Trust recognised impairment against the intangible asset value of the costs attributable to the implementation of the LC01 upgrade of the Millennium PAS system. The impairment has been triggered by the national contract for BT Cerner Millennium expiring on 31st October 2015. This has resulted in an impairment charge of £346k.

The remaining £40k impairment was for other obsolete software.

18. Investment property

Not relevant for trust

19. Commitments

19.1. Capital commitments

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

	31 March 2016 £000s	31 March 2015 £000s
Property, plant and equipment	**96**	0
Intangible assets	**0**	774
Total	**96**	774

The capital commitment as at 31st March 2016 relates to the modernisation works on the lifts.

19.2. Other financial commitments

Not relevant for trust

20. Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with Other Central Government Bodies	297	0	1,967	0
Balances with Local Authorities	158	0	0	0
Balances with NHS bodies inside the Departmental Group	1,591	0	1,746	7,700
Balances with Bodies External to Government	1,268	460	6,514	0
At 31 March 2016	**3,314**	**460**	**10,227**	**7,700**
prior period:				
Balances with Other Central Government Bodies	225	0	2,003	0
Balances with NHS bodies outside the Departmental Group	0	0	1	0
Balances with NHS bodies inside the Departmental Group	2,035	0	753	0
Balances with Bodies External to Government	831	427	6,924	0
At 31 March 2015	**3,091**	**427**	**9,681**	**0**

21. Inventories

	Drugs	Consumables	Energy	Total
	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**464**	**608**	**8**	**1,080**
Additions	9,462	5,931	4	**15,397**
Inventories recognised as an expense in the period	(9,424)	(5,999)	0	**(15,423)**
Balance at 31 March 2016	**502**	**540**	**12**	**1,054**

22.1. Trade and other receivables

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**1,566**	1,945	**0**	0
Non-NHS receivables - revenue	**995**	662	**590**	526
Non-NHS prepayments and accrued income	**516**	296	**0**	0
PDC Dividend prepaid to DH	**25**	90	**0**	0
Provision for the impairment of receivables	**(121)**	(134)	**(130)**	(99)
VAT	**297**	225	**0**	0
Other receivables	**36**	7	**0**	0
Total	**3,314**	3,091	**460**	427
Total current and non current	**3,774**	3,518		

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

22.2. Receivables past their due date but not impaired

	31 March 2016	31 March 2015
	£000s	£000s
By up to three months	**280**	596
By three to six months	**220**	118
By more than six months	**766**	645
Total	**1,266**	1,359

22.3. Provision for impairment of receivables

	2015-16 £000s	2014-15 £000s
Balance at 1 April 2015	**(233)**	(139)
Amount written off during the year	**6**	9
(Increase)/decrease in receivables impaired	**(24)**	(103)
Balance at 31 March 2016	**(251)**	(233)

23. NHS LIFT investments

Not relevant for trust

24.1. Other Financial Assets - Current

Not relevant for trust

24.2. Other Financial Assets - Non Current

Not relevant for trust

25. Other current assets

Not relevant for trust

26. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**3,030**	750
Net change in year	**823**	2,280
Closing balance	**3,853**	3,030
Made up of		
Cash with Government Banking Service	**3,824**	2,984
Commercial banks	**20**	25
Cash in hand	**9**	21
Cash and cash equivalents as in statement of financial position	**3,853**	3,030
Cash and cash equivalents as in statement of cash flows	**3,853**	3,030

27. Non-current assets held for sale

Not relevant for trust

28. Trade and other payables

	Current	
	31 March 2016 £000s	31 March 2015 £000s
NHS payables - revenue	**1,746**	732
NHS accruals and deferred income	**0**	21
Non-NHS payables - revenue	**1,232**	2,041
Non-NHS payables - capital	**1,259**	1,075
Non-NHS accruals and deferred income	**4,001**	3,800
Social security costs	**564**	581
Accrued Interest on DH Loans	**16**	0
Tax	**593**	621
Other	**816**	810
Total	**10,227**	9,681
Total payables	**10,227**	**9,681**
Included above:		
outstanding Pension Contributions at the year end	**810**	801

29. Other liabilities

Not relevant for trust

30. Borrowings

	Non-current	
	31 March 2016 £000s	31 March 2015 £000s
Loans from Department of Health	**7,700**	0
Total	**7,700**	**0**
Total other liabilities non-current	**7,700**	

Due to a change in policy by the DH, operating deficits are no longer financed by Public Dividend Capital. The Trust received approval from the Independent Trust Financing Facilty for an interim revenue support loan of £7,700k to fund the Trust's operating deficit.

Borrowings / Loans - repayment of principal falling due in:

	DH £000s	**Total £000s**
0-1 Years	0	**0**
1 - 2 Years	7,700	**7,700**
TOTAL	**7,700**	**7,700**

The loan awarded is a maturity loan facility repayable in November 2017 with the option to extend for a further year.

31. Other financial liabilities

Not relevant for trust

32. Deferred income

	Current	
	31 March 2016 £000s	31 March 2015 £000s
Opening balance at 1 April 2015	**380**	413
Deferred revenue addition	**80**	9
Transfer of deferred revenue	**(19)**	(42)
Current deferred Income at 31 March 2016	**441**	380
Total deferred income (current and non-current)	**441**	380

33. Finance lease obligations as lessee

Not relevant for trust

34. Finance lease receivables as lessor

Not relevant for trust

35. Provisions

		Comprising:		
	Total	**Early Departure Costs**	**Legal Claims**	**Other**
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**269**	74	49	146
Arising during the year	**243**	240	3	0
Utilised during the year	**(65)**	(30)	(25)	(10)
Reversed unused	**(7)**	0	(7)	0
Unwinding of discount	3	1	0	2
Balance at 31 March 2016	**443**	**285**	**20**	**138**
Expected Timing of Cash Flows:				
Current liabilities				
No Later than One Year	**60**	30	20	10
Non-current liabilities				
Later than One Year and not later than Five Years	**165**	122	0	43
Later than Five Years	**218**	133	0	85
Total Non-current liabilities	**383**	**255**	**0**	**128**

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

As at 31 March 2016	14,618
As at 31 March 2015	7,639

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

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

Other - £138,000 is made up of a permanent injury benefit (31 March 2015 £146,000 permanent injury benefit case).

36. Contingencies

	31 March 2016	31 March 2015
	£000s	£000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(9)**	(19)
Net value of contingent liabilities	**(9)**	(19)

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

37. Impact of IFRS treatment - current year

Not relevant for trust

38. Financial Instruments

38.1. Financial risk management

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

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

Currency risk

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

Interest rate risk

The Trust borrows from government, subject to affordability as confirmed by the NHS Trust Development Authority. The borrowings are for 2 years, extendable by a further year, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

38.2. Financial Assets

	Loans and receivables £000s
Receivables - NHS	**1,566**
Receivables - non-NHS	**1,288**
Cash at bank and in hand	**3,853**
Total at 31 March 2016	**6,707**
Receivables - NHS	1,945
Receivables - non-NHS	947
Cash at bank and in hand	3,030
Total at 31 March 2015	5,922

38.3. Financial Liabilities

	Other £000s
NHS payables	**1,746**
Non-NHS payables	**6,067**
Other borrowings	**7,160**
Total at 31 March 2016	**14,973**
NHS payables	753
Non-NHS payables	6,537
Total at 31 March 2015	7,290

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

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

39. 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.

40. 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 These entities are:
NHS England Specialist Commissioning Support Units, Health Education England, NHS Litigation Authority, North Bristol NHS Trust, North Somerset CCG, Somerset CCG, 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. North Somerset Council & HM Revenue and Customs and NHS Pension Scheme.

The Trust has also received revenue payments of £93k from the Weston Health General Charitable funds whose Trustees are the same as those members of the NHS Trust Board. The net assets of the charity are £437k which equates to less than 1% of the Trusts net assets. 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.

41. Losses and special payments

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

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

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	10,368	35
Special payments	16,856	25
Total losses and special payments	27,224	60

42. 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.

42.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015- £0(
Turnover	70,300	80,100	85,914	90,403	93,199	95,306	96,789	96,826	100,378	**98,4**
Retained surplus/(deficit) for the year	(6,673)	8	408	(68)	2,110	(1,703)	1,312	(5,117)	(4,456)	**(7,4**
Adjustment for:										
Timing/non-cash impacting distortions:										
Adjustments for impairments			0	2,516	497	5,178	833	385	393	3
Adjustments for impact of policy change re donated/government grants assets						135	105	49	161	**1**
Break-even in-year position	(6,673)	8	408	2,448	2,607	3,610	2,250	(4,683)	(3,902)	(6,9
Break-even cumulative position	(14,242)	(14,234)	(13,826)	(11,378)	(8,771)	(5,161)	(2,911)	(7,594)	(11,496)	(18,4

* 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 nc cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	-9.49	0.01	0.47	2.71	2.80	3.79	2.32	-4.84	-3.89	**-7.**
Break-even cumulative position as a percentage of turnover	-20.26	-17.77	-16.09	-12.59	-9.41	-5.42	-3.01	-7.84	-11.45	**-18.**

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.

42.2. Capital cost absorption rate

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

42.3. External financing

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

	2015-16	2014-15
	£000s	£000s
External financing limit (EFL)	**11,487**	5,292
Cash flow financing	**8,634**	2,794
External financing requirement	**8,634**	2,794
Under spend against EFL	**2,853**	2,498

42.4. Capital resource limit

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

	2015-16	2014-15
	£000s	£000s
Gross capital expenditure	**5,609**	3,796
Charge against the capital resource limit	**5,609**	3,796
Capital resource limit	**5,657**	3,982
Underspend against the capital resource limit	**48**	186

43. Third party assets

The Trust held £nil cash and cash equivalents at 31 March 2016 (£169 at 31 March 2015) relating 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.

Independent auditor's report to the Trustees of Weston Health General Charitable Fund

We have audited the financial statements of Weston Health General Charitable Fund for the year ended 31 March 2016 which comprise the statement of financial position, the statement of comprehensive income, the cash flow statement, the reconciliation of movements in shareholders' funds and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland.

This report is made solely to the charity's trustees, as a body, in accordance with Section 154 of the Charities Act 2011. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its trustees as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of trustees and auditor

As explained more fully in the Trustees' Responsibilities Statement set out on page 1, the trustees are responsible for the preparation of financial statements which give a true and fair view.

We have been appointed as auditor under section 149 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act. 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 (APB's) Ethical Standards for Auditors.

Scope of the audit of the financial statements

A description of the scope of an audit of financial statements is provided on the Financial Reporting Council's website at www.frc.org.uk/auditscopeukprivate.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2016 and of its incoming resources and application of resources, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Charities Act 2011 requires us to report to you if, in our opinion:

- the information given in the Trustees' Annual Report is inconsistent in any material respect with the financial statements; or
- sufficient accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

Alex Walling

Alex Walling
for and on behalf of Grant Thornton UK LLP, Appointed Auditor
Hartwell House
55-61 Victoria Street
Bristol
BS1 6FT

31 August 2016

Grant Thornton UK LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

27 May 2016

Weston Area Health NHS
NHS Trust

EXECUTIVE'S OFFICE
General Hospital
Grange Road, Uphill
Weston-super-Mare
Somerset
BS23 4TQ

Direct Line: 01934 647001
Website: http://www.waht.nhs.uk/

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

Dear Sirs,

Weston Area Health NHS Trust
Financial Statements for the year ended 31 March 2016

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 2016 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with International Financial Reporting Standards and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

Financial Statements

i As Trust Board members we have fulfilled our responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with the Department of Health Group Manual for Accounts 2015-16 (Manual for Accounts) and International Financial Reporting Standards which give a true and fair view in accordance therewith.

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

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

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

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

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

vii Except as disclosed in the financial statements:

a there are no unrecorded liabilities, actual or contingent

b none of the assets of the Trust has been assigned, pledged or mortgaged

c there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

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

ix 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.

x We have considered the disclosure changes schedules included in your Audit Findings Report. The financial statements have been amended for these disclosure changes and are free of material misstatements, including omissions. The financial statements are free of material misstatements, including omissions.

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

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

xiii 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.

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

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

Information Provided

xvi We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;

b. additional information that you have requested from us for the purpose of your audit; and

c. unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

xvii We have communicated to you all deficiencies in internal control of which management are aware.

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

xix 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.

xx We have disclosed to you all our knowledge of fraud or suspected fraud affecting the Trust involving:

a. management;

b. employees who have significant roles in internal control; or

c. others where the fraud could have a material effect on the financial statements.

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

xxii 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.

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

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

xxv 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 the NHS Five Year Forward view and in light of these new opportunities the Trust has developed a Strategic Plan 2016/2021, which describes the Trust's priorities for the next four years to deliver outstanding safe care and improve the sustainability of all services. The Trust is assured that it will secure sufficient working capital with the agreement of the NHS Improvement (formerly NHS Trust Development Authority) from April 2016. For this reason the going concern basis has been adopted for preparing the accounts. The Trust has a planned deficit in 2016/17 of £3.2m and this requires a £3.2m loan from the Department of Health of equal value to maintain cash flow in 2016/17. Directors have confirmation from the NHS Improvement (formerly NHS TDA) that it will support the Trust's application for cash support for 2016/17 to enable it to pay its liabilities as they fall due for a period of at least twelve months from 31 May 2016.

Annual Report

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

Annual Governance Statement

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

Approval

The approval of this letter of representation was minuted by the Trust's Audit and Assurance Committee at its meeting on 27 May 2016.

Signed on behalf of the Board

Name James Rimmer Signed..... Date 27 May 2016

Position Chief Executive

Name Ian Turner Signed..... Date 27 May 2016

Position Chair of Audit and Assurance Committee

Approval

The approval of this letter of representation was minuted by the Trust's Audit and Assurance Committee at its meeting on 27 May 2016.

Signed on behalf of the Board

Name James Rimmer Signed  Date 27 May 2016

Position Chief Executive

Name Ian Turner Signed…… Date 27 May 2016

Position Chair of Audit and Assurance Committee

Part 4 -Glossary and abbreviations

Glossary of Financial Terms

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

Property, Plant and Equipment	A sub-classification of fixed assets which include land, buildings, equipment and fixtures and fittings.
Public 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

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

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