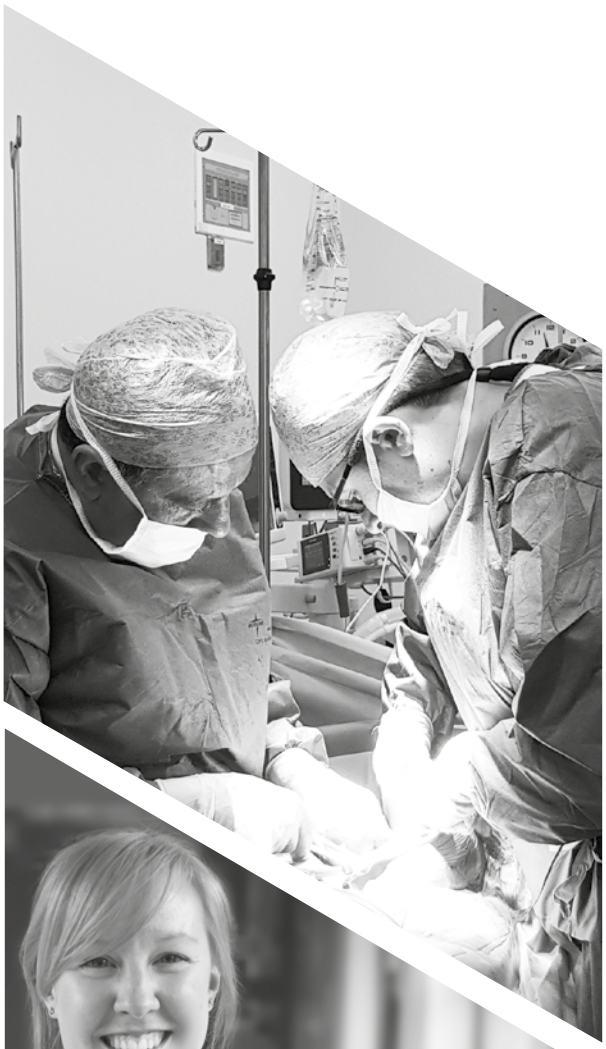
NHS

Worcestershire Acute Hospitals

NHS Trust



Annual Report

2018/2019

Acknowledgements and feedback

Acknowledgements

Worcestershire Acute Hospitals NHS Trust wishes to thank its entire staff and the contributors to this Annual Report.

Feedback

Readers can provide feedback on the report and make suggestions for the content of future reports to the Communications Department.

Communications
Worcestershire Acute Hospitals NHS Trust
3 Kings Court
Charles Hastings Way
Worcester
WR5 IDD
01905 760453
wah-tr.Communications@nhs.net

Contents

Chief Executive's Welcome

Welcome to Worcestershire Acute Hospitals NHS Trust's 2018/19 Annual Report.

It is undeniable that over the last 12 months the Trust has continued to face immense operational and financial challenges, and continued external scrutiny. In spite of this, there are many achievements and successes we can rightly celebrate and which I will highlight later. I would like to take this opportunity to thank colleagues across all our hospitals for their continuing commitment to providing the best and most compassionate care for our patients. I would also like to thank our many volunteers for their invaluable contribution over the year.

Meeting our key performance targets has remained challenging, though there are some green shoots of recovery beginning to emerge. Significant work to improve our Urgent Care pathway has been, and continues, to be done.

A CQC report in March 2019, following a focussed inspection of the Emergency Departments at the Alexandra and Worcestershire Royal Hospitals in January, found that the Trust must make improvements to urgent and emergency services to ensure people receive timely and safe care.

Since the start of 2019 a number of improvements – including the transfer of our frailty service to the Alexandra Hospital, and the opening up of additional beds - has started to make a difference to the quality of care for our patients. Importantly, we have been able to significantly reduce our reliance on non-inpatient areas for patient care. While our Emergency Access Standard and ambulance handover figures are still far away from what we want them to be, we do have robust recovery plans in place which, throughout 2019/20, aim to yield improvements. The CQC's recognition of the hard work that colleagues in our Emergency Departments are making every day to deliver the best, safest care possible for their patients in very difficult circumstances was welcomed.

Matthew Hopkins
Chief Executive

Meeting the 18 week Referral to Treatment (RTT) standard remains a challenge, and diagnostic treatment targets have not been met. There has, however, been some improvement in cancer performance, with the Trust meeting two week wait standards for five consecutive months.

The Trust remains under the 'special measures' regime which started in December 2015. In June 2018, the Care Quality Commission published their report from their visits to six core services between January and March 2018. The Trust ratings remain Good for being caring, Requires Improvement for being effective, and Inadequate for being safe and responsive.

The Trust has improved from Inadequate to Requires Improvement for being well-led.

While it is acknowledged that there is much more we need to do, recognition for our multi-award winning maternity services which are now rated "Good" overall was pleasing.

In further recognition for our women and children's division, the CQC also improved their rating of the care we provide for children and young people, and we also welcomed the improved ratings for our diagnostic imaging services.

The publication of our Trustwide Quality Improvement Strategy set out in some detail how we will build on what we have already achieved and set ourselves challenging targets for further improvement. This strategy is supported by detailed plans focussing on the key areas of patient safety, clinical effectiveness and patient, carer and community engagement.

Our 4ward culture programme continues to embed, with staff regularly showcasing how our four 4ward behaviours are influencing their individual and collective achievements.

And in what was the 70th year of the NHS we did have much to celebrate.

This included national accreditation for both our anaesthetists and urogynaecology team, national awards for our Professional Development Team, and Wyre Forest Maternity Hub, and the expansion of children's surgery at Kidderminster Hospital. We also celebrated the opening of a new state-of-the-art simulation ward for our staff to access the most up to date and comprehensive training opportunities, a new Theatre Admissions Unit, a new discharge lounge, and the long-awaited £3m link bridge between Worcestershire Royal Hospital and the Aconbury buildings.

All of our staff continue to work under considerable pressure and have continued to deliver care through another challenging 12 months. We would like to put on record our thanks for their continued commitment and professionalism, as well as recognising the invaluable support we receive from our army of volunteers.

As we look to the year ahead, everyone in our Trust, from ward to Board, understands the challenges which we still face on our improvement journey and we share the desire of our inspection and regulatory bodies, as well as people in our local communities, to see progress continue to be made quickly and sustained.

Matthew Hopkins
Chief Executive

Chairman's welcome

Despite a challenging year across our Trust, the ongoing passion, dedication and determination of staff to put patients first has remained unflinching and resolute. As more patients than ever before arrived in our Emergency Departments, and we struggled to meet key performance and financial targets, our caring staff – the heart and soul of our organisation - have continued to show pride in their work and demonstrate the improvement journey that they and their services are on to inspection teams and regulatory bodies. There have been many success stories – too many to mention – which clearly show how the quality of care for patients across the county and further afield continues to get better, with innovative ideas and new technologies being embraced at all levels. Improved ratings for maternity services and the care provided for children and young people is particularly good news to the thousands of people who access the services and deserves acknowledgement and thanks to all who played a part in this success. We are also indebted to the hundreds of volunteers who give up thousands of hours of their valuable time to offer support for our staff and our patients across all areas of our hospitals. The volunteer's Tea Dance in October was a small token of our appreciation for the work they carry out, and a joyful way to celebrate our volunteers as well as the 70th anniversary of the NHS.

The arrival of Matthew Hopkins as our Chief Executive in January brought a fresh approach, and a strong focus on our priority areas to further improve to the quality of care we provide for our patients.

My role, and the role of the rest of the board and the senior leadership team is to support the delivery of these improvements by creating an environment where every single member of staff is supported and encouraged to do their jobs to the very best of their ability. We are also grateful for the support of our partners across the local health

David Nicholson
Chairman

economy, and I look forward to further developing our role in the Herefordshire and Worcestershire Sustainability and Transformation Partnership and the work taking place in support of the NHS Long Term Plan to ensure local people have joined up care, delivered in the best pace by the most appropriate people.

No one underestimates the scale of the challenge but my Board colleagues and I, including our team of highly experienced non-executive directors, look forward to Matthew's leadership in the months ahead as we implement the Trust's new strategy of Putting Patients First and ensuring the people of Worcestershire have a health service to be proud of.

David Nicholson
Chairman

Performance Report

Performance Overview

What we do

Worcestershire Acute Hospitals NHS Trust provides hospital-based services from three main sites - the Alexandra Hospital in Redditch, Kidderminster Hospital and Treatment Centre, and Worcestershire Royal Hospital in Worcester as well as some community based services.

We provide a wide range of services to a population of more than 575,000 people in Worcestershire as well as caring for patients from surrounding counties and further afield.

In 2018/19 we provided care to more than 231,448 different Worcestershire patients – that is 40% of the Worcestershire population received care at one of our hospitals.

We saw 634 patients per day, including:

- 156,160 A&E attendances
- 152,712 Inpatients
- 641,486 Outpatients
- 5,261 births
- 641,486 outpatient attendances

We employ nearly 6,000 people and around 800 local people volunteer with us helping to deliver care. We have an annual turnover

of over £400 million. The Trust provides a range of Acute Services for the people of Worcestershire. This includes general surgery, general medicine, oncology, emergency care and women and children services. There are a range of support services as well including diagnostics and pharmacy.

A list of the services provided can be found on our website www.worcsacute.nhs.uk/services

The Trust's catchment population is both growing and ageing when considered within the population demographics. Both the male and female population show a projected increase by 2025 in the 70-plus age groups. This is especially apparent in the 75-79 age range, although proportionally the projected rise in the 90-plus age range is higher. The forecast increase in numbers of older people is due to increased life expectancy resulting in greater numbers of older people, particularly females, surviving to very old age (ONS, 2010). The population demographic impacts the type of patients that present at our Hospitals and the types of conditions we treat.

We note from national statistical data that the number of older people with dementia is expected to double in the next 20 years. Of note the rate of population growth is greatest in the very old age groups who present the greatest requirements for 'substantial and critical' care. Worcestershire has proportionally a greater number of resident older people than the nation in general.

The Trust's catchment population extends beyond Worcestershire itself, as patients are also attracted from neighbouring areas including South Birmingham, Warwickshire, Shropshire, Herefordshire, Gloucestershire and South Staffordshire. This results in a catchment population which varies between 420,000 and 800,000 depending on the service type.

Referrals from GP practices outside of Worcestershire currently represent some 13% of the Trust's market share.

A YEAR IN NUMBERS
2018/2019

143,429
Walk-in patients (A&E)

51,619
Patients arriving by ambulance

152,712
Inpatients

641,486
Outpatients

5,261
Births

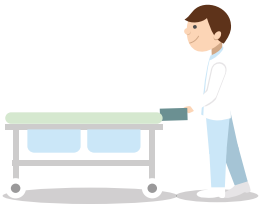
4,120
Emergency Operations

24,242
Elective Operations

1,848
Trauma Operations

6.7 days
Average length of stay

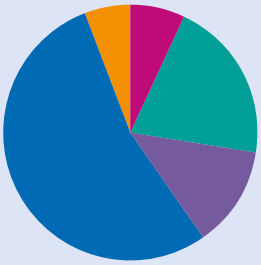
522,615
Number of meals served



2,505,646
Number of sheets laundered

£47m
Value of prescriptions issued

Diagnostics



- MRI scans - **23,278**
- Non-obstetric ultrasound scans - **72,443**
- CT scans - **50,204**
- Plain film X-Rays - **218,729**
- Endoscopies - **28,660**

Staff

Total Staff
5,283

Nurses
1,464

Doctors
324

Consultants
283

Allied Health Professionals
364

Midwives and Midwifery Support Workers
253

Other Support Staff*
2,595

Volunteers
436

*includes Scientists, professional and technical, estates and ancillary, student nurses and admin and clerical

Performance Summary

Description	Indicator	2018/19 Target	Year End	Period
Quality				
Mortality	HSMR – Hospital Standardised Mortality Ratio	<=100	111.39 (higher than expected)	Rolling 12 months to January 2019
	SHMI – Summary Hospital Mortality Indicator	<=1	1.1132 (as expected)	Rolling 12 months to September 2018
Infection Control	Clostridium Difficile	<=32	43	April 2018 - Mar 2019
	MRSA	0	0	April 2018 - Mar 2019
Prevention	VTE - Venous Thromboembolism Risk Assessment	>=95%	94.56%	April 2018 - Dec 2018
Patient Experience	Mixed Sex Accommodation Breaches	0	619	April 2018 - Mar 2019
Operational				
Cancer	62 days: Wait for first treatment from urgent GP referral: All Cancers (unadjusted)	>=85%	72.02%	April 2018 - Mar 2019
	31 days: Wait for first treatment: All Cancers	>=96%	97.47%	April 2018 - Mar 2019
	2 Week Wait: All Cancer Two Week Wait (suspected Cancer)	>=93%	85.09%	April 2018 - Mar 2019
	2 Week Wait: Wait for symptomatic breast patients (Cancer not initially suspected)	>=93%	76.41%	April 2018 - Mar 2019
18 Weeks Waiting Time	RTT - Referral to Treatment: Incomplete - 92% in 18 weeks	>=92%	80.77%	March 2019
Diagnostic Waiting Time	6 week Diagnostic Waits (% of breaches on the waiting list)	<=1%	7.60%	March 2019
A&E Waiting Time	4 Hour Waits (%) - Trust inc MIU	>=95%	75.93%	April 2018 - Mar 2019

Description	Indicator	2018/19 Target	Year End	Period
Stroke	80% of patients spend 90% of time in a Stroke Ward	>=80%	71.4%	April 2018 - Mar 2019
	Direct admission (via A&E) to Stroke Ward	>=90%	33.5%	April 2018 - Mar 2019
	TIA - Transient Ischaemic Attack - High Risk Patients seen within 24 hours	>=70%	58.4%	April 2018 - Mar 2019
	CT scan within 24 hours of arrival	>=80%	42.9%	April 2018 - Mar 2019
Patient Experience				
Friends and Family Test	Acute Wards (% recommend)	-	94.38%	April 2018 - Mar 2019
	Acute Wards (Response Rate %)	>=30%	16.98%	April 2018 - Mar 2019
	A&E (% recommend)	-	81.06%	April 2018 - Mar 2019
	A&E (Response Rate %)	>=20%	5.75%	April 2018 - Mar 2019
	Maternity (% recommend)	-	98.16%	April 2018 - Mar 2019
	Maternity (Response Rate %)	>=30%	28.07%	April 2018 - Mar 2019

Performance Analysis

Performance Measurement

Trust performance is measured with reference to a range of national priority standards and targets, covering operational performance, quality and safety, patient experience and the statutory duty to achieve financial break even and future sustainability.

The Trust had three priorities for 2018/19 which were:

- Improvement in Patient Flow across the Trust to ensure improved patient care and experience.
- Improvement in the 62 day Cancer standard – from urgent referral to treatment.
- Adherence to the financial recovery plan working towards a future sustainable financial position.

Care Quality Commission

Since July 2015 there have been nine announced inspections undertaken by the Care Quality Commission (CQC); a number of unannounced Core Service inspections and 2 focused 'Is it Safe' inspections of our Urgent Care Services. At the time of writing this Annual Report the overall rating for the Trust remains as 'inadequate' as per the most recent 'Trust-wide' report issued in November 2016.

Between 23 January and 22 March 2018, the CQC visited the Trust to inspect six core services; Urgent Care (including Minor Injuries Unit), Surgery, Maternity, Children and Young People, Outpatient and Diagnostics. A review of the 'Well-led' Domain was also conducted.

The inspection report published in June 2018 identified the following as outstanding:

- The Meadow Birth Centre won the MaMa 2017 national birth centre of the year award, in recognition of its outstanding health care environment. Feedback from women who had had their baby in the birth centre was overwhelmingly positive, and staff were often described as having gone "the extra mile".
- The service was especially caring and responsive to parents who had suffered a pregnancy loss, such as miscarriage, stillbirth or neonatal death. They were committed to continually improving the care and services they provided for bereaved parents, and had recently raised over £50,000 in charitable donations for a second bereavement suite
- .All healthcare support workers in the MIU were enrolled on a Care Certificate course. This is a course that covers 15 Standards of care in health and social care.

In addition to the above, the inspection report identified the following as areas of improvement:

- Management of incidents – urgent and emergency care
- Nurse staffing levels urgent and emergency care
- Generally care and treatment based on national guidance
- Compassionate care
- Complaints taken seriously, investigated and lessons learnt
- Improvement in back log of x rays
- Engagement with public and partners
- 4ward cultural change programme
- Stable executive team

The June 2018 inspection report recognised the stability of our executive team and the improvements made at a Trust level, increasing our overall rating for Well-Led from 'inadequate' to 'requires improvement'. Overall, the Trust continues to be rated positively 'Good' in the Caring domain, Effective and Well-Led as 'requires improvement' and Safe and Responsive as 'inadequate'

The Trust does not currently have any Conditions or Warning notices placed on the Trust by the CQC.

CQC Inspection Report published: 5 June 2018

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate	Requires improvement	Good	Inadequate	Requires improvement	Inadequate
June 2018	June 2018	June 2018	June 2018	June 2018	June 2018

The rating for well-led is based on our inspection at Trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for the acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Worcestershire Royal Hospital	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018
Alexandra Hospital	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018
Kidderminster Hospital and Treatment Centre	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Inadequate June 2018	Inadequate June 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Evesham Community Hospital	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015	Good Dec 2015
Overall trust	Inadequate June 2018	Requires improvement June 2018	Good June 2018	Inadequate June 2018	Requires improvement June 2018	Inadequate June 2018

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

Performance Management Framework

In April 2017 the Trust developed a Performance Management and Accountability Framework for implementation across the organisation. It continues to be revised to ensure it aligns itself with the Trust's operating model whilst drawing on best practice across the NHS.

Performance is reviewed in line with the five themes set out in the Single Oversight Framework:

- Quality of care
- Finance and use of resources
- Operational performance
- Leadership and improvement capability
- Strategic change

The divisional performance matrix aligns metrics to these five themes whilst ensuring that all of the annual priorities have been accounted for. Performance is monitored against the targets set out in the Single Oversight Framework or against agreed improvement trajectories. In all other cases targets or improvement trajectories are agreed with Divisions.

Performance tracking is based on these general principles:

- High quality care and patient safety is the over-riding goal.
- Transparency of performance metrics and reporting.
- Decisions are based on transparent quality (determined by the Data Quality Kitemark), timely and reliable information built on clinical leadership of data quality.
- Information is shown in trends; using SPC charts where appropriate.
- Clear targets are set reflecting national and local priorities.
- Targets provide a balanced view of performance across the Single Oversight Framework themes.
- Key performance indicators are established, with clear links to drivers so that changed be understood, and subject to continual review.

- Corporate objectives/priorities targets are broken down to Divisions and sub specialities and where appropriate team and individual targets, in order to enhance accountability.

Delivery of Operational Performance Standards

The Trust is committed to delivering strong operational performance and ensuring safe, high quality, efficient services, which provide a good experience for the patient and their families.

High levels of emergency demand, the lack of available capacity and flow within the Trust and within the wider health and social care system, have continued to be significant challenges in 2018/19. These have been key limiting factors in the Trust achieving best possible operational performance and quality of care. Workforce capacity has been a major contributing factor to the deterioration in operational performance particularly in relation to high numbers of consultant vacancies.

Consequently, the four key national standards in relation to Emergency Access, Referral To Treatment (RTT), 62 day Cancer waiting time and Diagnostics have not been met during 2018/19. Plans to improve performance are highly dependent on the ability to recruit consultants, the availability of beds and delivery of planned productivity improvements.

Development of specialty level improvement trajectories for the key national performance standards based on demand and capacity modelling will provide clear actions and performance requirements against which divisions will be held to account through the monthly performance reviews.

The summary of performance can be seen within the Performance Summary section, page 10 and is described in more detail below.

Emergency Access Standard
95% of patients treated/admitted from A&E within 4 hours of arriving in A&E

Performance for the Emergency Access Standard has not met the national target of 95% for more than 4 years. With 75.93% of patients admitted, transferred or discharged within 4 hours, the EAS performance has deteriorated in 2018/19 by 2.98 percentage points compared to the 2017/18 performance of 78.91%; this decrease in performance should be seen in the context of 10,000 more patients attending A&E this year.

The principal reason for the performance level is the lack of bed availability caused by delays in discharging some patients with complex needs following completion of their hospital based treatment. The lack of bed availability, particularly during winter, also resulted in 535 patients waiting more than 12 hours in the A&E Departments from the point at which a decision had been made to admit them; a significant increase from 140 in 2017/18.

The focus is on supporting the timely discharge of patients through the implementation of national best practice and closer working with partner organisations across the county.

Referral to Treatment (RTT)

92% of patients to be treated within 18 weeks of referral

The Trust has not met the 92% standard in 2018/19. In March 2019 80.77% of patients were seen within 18 weeks of referral compared to 83.24% the previous year. However, there have been no reported month end breaches of patients waiting for longer than 52 weeks since June 2018 and the Trust continues to focus on reducing the number of patients waiting longer than 40 weeks; 405 reported in March 2018 down to 357 reported at March 2019. Performance is not expected to improve significantly during 2019/20 as Commissioners have not contracted for the activity required to achieve the 92% standard.

Diagnostics

No more than 1% of patients to wait more than 6 weeks for a diagnostic test

The Diagnostics standard not been met in 2018/19 with 7.60% of patients waiting more than 6 weeks at the 31st March 2019. The previous year's performance in 2017/18 did not hit the standard with 3.79% of patients waiting more than 6 weeks. The delay in patients receiving diagnostic tests is having an adverse impact on the time elapsed before cancer treatment commences. Plans are in place to address the capacity issues in endoscopy and CT scanning with the expectation that the standard will be delivered at the end of the next financial year; but only if appropriate funding levels are provided.

Cancer

85% of cancer patients to commence treatment within 62 days of referral

Over the year 72.02% of patients have commenced treatment within 62 days. This is a slight decrease from the previous year which saw 72.65% of patients commencing treatment within the required timescales. However, there has been an increase in the number of patients treated 2,130 in 2018/19 compared to 1,759 in 2017/18. Performance against this standard continued to be impacted by increased referrals resulting from national awareness cancer campaigns, emergency pressures and medical staffing gaps across a number of specialties. Delays in diagnostic tests are also impacting performance against this standard.

Performance is planned to improve in 2019/20 but the standard is not expected to be achieved until September 2019.

Matthew Hopkins
Chief Executive
Date: 22 May 2019

Financial Performance in 2018/19

The Trust has three key financial duties and has achieved compliance with the Capital Resource Limit and External Financing Limit but has not achieved the Statutory Breakeven duty.

The Breakeven duty is where the Trust must achieve a breakeven position over a 3 year period (or where agreed with NHSI a 5 year period). The Trust has struggled with this in recent years and as required under statute, our external auditors have formally notified the Department of Health.

The Trust has reported an Operational Financial Performance excluding Provider Sustainability Fund (PSF) and impairments, deficit of £(73.7m against a comparable plan target of £(41.5)m for the 2018/19 financial year. This is in line with the revised forecast outturn discussed with NHS Improvement through quarter 4 in 2018/19.

The Trust has additionally been awarded indicative Provider Sustainability Fund (PSF) of £4.922m as part of the year end general distribution. There are then also a number of other below the line adjustments adjusting for Capital Donations; Grants; and Impairments as detailed below which are included in the overall Income and Expenditure position.

Financial Position - Income and Expenditure	Plan 2018/19 £000s	Actual 2018/19 £000s	Variance 2018/19 £000s
Operational Financial performance [Control Total] surplus/ (deficit) excluding PSF and impairments	**(41,511)**	**(73,712)**	**(32,201)**
Less provider sustainability fund (PSF)	17,807	4,922	(12,885)
Performance against Control Total adjusted to include PSF	**(23,704)**	**(68,790)**	**45,086**
Adjustment Removal of capital donations/grants	(90)	(86)	4
Adjustment for I&E impairments (reversals)	0	(6,828)	(6,828)
Surplus/(deficit) for the year including PSF and after impairments	**(23,794)**	**(75,704)**	**(51,910)**

The Trust achieved £7.6m of nominal gross Cost Improvement Programme savings during the year. The recurrent effect of this programme secured £6.2m improving the Trust's underlying position. Scaled up programmes of work in respect of theatre and outpatient productivity and workforce transformation did not translate into measurable cost efficiencies to the level originally envisaged in 2018/19.

The increase in the Trust's deficit in 2018/19, above the original planned level has resulted in a tight cash flow which impacts timeliness of payments to creditors within the required Better Payment Practise Code (BPPC) target. The Trust has received c.£70m revenue cash support from the Department of Health and Social Care to be able to maintain the payment of creditors through the year. The Trust also received capital loans of

£10.3m making the total borrowings of £80.3m in 2018/19. An improved cash flow, despite the increased deficit, has led to an improvement in performance in 2018/19 compared to 2017/18. The Trust achieved 80% by number and 76% of value in 2018/19.

The Trust has invested £17.1m of capital resources in 2018/19 in line with its Capital Resource Limit. This included major developments such as the ASR Link Bridge and Aconbury East scheme; ED/Ward expansion (via purchase of portacabins); Cyber security; improvements to the Telephony system; replacement of clinical equipment; improvements in IT systems/infrastructure; and maintenance of the estate. £2.6m of the urgent loan applied for in 2017/18 was drawn down in 2018/19. The Trust has also received £10m of ASR Funding; £3m of PDC Funding for the Link Bridge and £7m of Loan Funding for the refurbishment of Aconbury in the financial year.

Looking forward to 2019/20 and beyond

The Trust still has a challenging financial outlook entering 2019/20 and has not been able to sign up to the Control Total (now £(64.6)m [58.6+6.0]), forgoing the ability to access up to £26.9m of financial support funding. The financial plan for 2019/20 is a deficit of £(82.803)m. This includes an assumed Cost Improvement Programme ("CIP") delivery of £13.6m. We are committed to identifying and developing an efficiency/CIP plan that is in excess of £22.5m.

The NHS faces continued pressure with substantial challenges driven by an ageing population; increases in the prevalence of long-term conditions; and rising costs and public expectations within a challenging financial environment. In order to respond to these significant challenges health and social care providers across Worcestershire are working towards a longer term vision for a truly integrated health and social care system.

Worcestershire Commissioners are developing demand management plans jointly with providers focused on reducing demand for services and enabling providers to take costs out.

In conjunction with the development of the Sustainability and Transformation Plans and the move towards Integrated Care Systems, across the county the Trust's financial plans for the next five years will need to demonstrate a sustainable return to financial balance.

The Trust's internal capital resources will remain extremely limited in 2019/20 and beyond and as such further capital loan requests will be made in 2019/20 and future years. DHSC have confirmed that £5.64m capital loan funding will be granted in 2019/20 and a further loan application will be submitted in year to fund critical and urgent schemes.

We will submit the Full Business Case for the Acute Service Reconfiguration and in doing so will access the £17.534m of capital allocated for the scheme in 2019/20.

An application for Sustainability and Transformation Plan (STP) funding was successful and consequently we will receive £2m PDC in 2019/20 and £1.964m in 2020/21 to fund the Breast Service Improvement scheme.

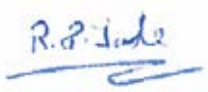
The Trust faces a range of risks and operates in a challenging financial environment. In March 2019 the Board made an assessment of the risks, opportunities and uncertainties faced and considers itself to be a going concern in line with published guidance. The published accounts are therefore produced on a going concern basis. There is clear evidence of continued provision of services being planned by NHSI, Commissioners and within the Trust. The primary risk to the Trust remaining as a going concern is the financial deficit and resultant cash shortfall to discharge our liabilities. In 2018/19 we accessed £70m of revenue support to support the deficit position. The continued breach in the achievement of the

breakeven duty resulted in the s30 referral by the external auditor to the Secretary of State. The 2019/20 financial plan deficit of £(82.8)m exceeds the notified control total meaning the Trust will continue to require cash support. In addition there is a requirement to repay £107.731m principal of existing revenue loans during 2019/20. Access to cash remains through monthly requests to the Department of Health and Social Care (DHSC) and to date all requests in line with national policy have been approved. As such we have no reason to believe this support will cease to be made available to us. We actively engage with DHSC and NHSI to proactively manage this risk.

Better Payments

The Better Payments Practice Code (BPPC) targets NHS bodies with paying all non-NHS trade creditors within 30 days of the receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The increase in the Trust's deficit in 2018/19, above the original planned level has resulted in a tight cash flow and impacts payments to creditors within the required Better Payment Practise Code (BPPC) target. An improved Cash flow despite the increased deficit arising from the Trust's financial position has led to an improvement in performance in 2018/19 compared to 2017/18. The Trust performance in 2017/18 was 64% by number and 65% of value, against the national target of 95%. The Trust achieved 80% and 76% respectively in 2018/19. The Trust's cash position will remain challenging in 2019/20 with another deficit forecast but plans have been put in place to manage liquidity.

The audited financial statements are attached to this report and give a more detailed understanding of the financial position.



Robert D Toole
Chief Finance Officer (Interim)

BPPC Target Performance : 95%	Number	£000
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	102,230	226,631
Total Non-NHS Trade Invoices Paid Within Target	82,637	176,310
% of Non-NHS Invoices Paid Within Target	80.8%	77.8%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	3,029	12,136
Total NHS Trade Invoices Paid Within Target	1,823	4,626
% of NHS Invoices Paid Within Target	60.2%	38.1%
Total Payables		
Total Invoices Paid in the Year	105,259	238,767
Total Invoices Paid Within Target	84,460	180,936
% of Invoices Paid Within Target	80.2%	75.8%

Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP)

The vision for 2020/21 across the STP footprint of Herefordshire and Worcestershire is that:

"Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people".

The STP plan contains four transformational themes:

Transformation Priority 1:

Maximise efficiency and effectiveness across clinical, service and support functions to improve experience and reduce cost, through minimising unnecessary avoidable contacts, reducing variation and improving outcomes.

Transformation Priority 2:

Reshape our **approach to prevention**, to create an environment where people stay healthy and which supports resilient communities, where self-care is the norm, digitally enabled where possible, and staff include prevention in all that they do.

Transformation Priority 3:

Develop an improved **out of hospital care** model, by investing in sustainable primary care which integrates with community based physical and mental health teams, working alongside social care to reduce reliance on hospital and social care beds through emphasising "own bed instead".

Transformation Priority 4:

Establish sustainable services through development of the right networks and collaborations across and beyond the STP footprint to improve urgent care, cancer care, elective care, maternity services, specialist Mental Health and Learning Disability services.

Worcestershire Acute Hospitals NHS Trust is represented at the STP Partnership Board and is involved in a range of programmes supporting the STP transformation priorities. The Trust is leading on, and is critical to, the successful delivery in a number of these areas.

Acute Services Review (ASR)

In July 2017, following an extensive development and consultation process on the Future of Acute Hospital Services in Worcestershire programme (FoAHSW), the Governing Bodies of Worcestershire's three Clinical Commissioning Groups (CCGs) formally stated their support for the clinical model designed to bring stability and certainty to the local acute health service.

The model, which took more than five years to develop, encompasses:

- Centralisation of emergency surgery to Worcestershire Royal Hospital (WRH) with appropriately skilled staff ,which will improve outcomes and patient experience
- Creation of centres of excellence for planned surgery at the Alexandra Hospital (AH), Redditch
- Retention of emergency and urgent care services at the Alexandra Hospital
- Centralisation of inpatient care for children at Worcestershire Royal Hospital with the majority of children's access to care remaining local
- Centralisation of births at Worcestershire Royal Hospital with ante-natal and post-natal care remaining local.

Delivery of the clinical model is supported by a capital business case and capital development at both WRH and AH, totalling £29.6m. These include 79 additional acute beds at the Worcestershire Royal Hospital and at the Alexandra Hospital plans include the refurbishment and modernisation of the main operating theatres and improvements to endoscopy facilities.

An outline business case for £29.6m capital to support capital developments was approved in January 2018. Refinement into a Full Business Case (FBC) is now nearing completion.

During the first half of 2018, the Trust was able to access £11 million in capital loans to allow work to begin on the construction a link bridge (pictured above) between the main Worcester hospital building and Aconbury East building in advance of the approval of the FBC to support the winter pressures. The link bridge opened in January 2019 and the refurbishment of the Aconbury East building is well advanced with the first new ward opening in June 2019.

Engaging with our stakeholders

Developing our relationships with our partner organisations has continued throughout 2018/19.

The Trust works collaboratively wherever possible with the appropriate Local Authorities, voluntary sector, Universities and other local education establishments as well as NHS Commissioners, NHS Improvement, and other NHS providers. The Trust has a range of formal and informal mechanisms in place to facilitate effective working with key partners in the Worcestershire Health Economy and is an active partner in the Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP).

The Trust continues to benefit from a formal partnership arrangement with University Hospitals Coventry and Warwickshire NHS Trust.

We also continue to work closely with a wide range of external agencies, including the Health Overview and Scrutiny Committee and Healthwatch – as well as regional and national organisations who monitor and assess the Trust, including West Midlands Clinical Senate, Cancer Peer Review, Royal Colleges, Health Education West Midlands, NHS Improvement (NHS I), NHS England (NHS E), the Care Quality Commission, NHS Resolution and the Health and Safety Executive.

The Trust has continued to build relationships with a wide range of stakeholders including our local MPs and other elected representatives. Our emerging Communications and Engagement Strategy will further outline our approach to collaborative relationships with our stakeholders.

Engaging with our patients, carers, volunteers and the public

The Trust's Quality Improvement Strategy, launched in May 2018, is underpinned by the Patient, Carer and Community Engagement Plan which demonstrates our commitment to widening and increasing engagement, working in true co-production and enabling us to drive forward our aim to be a person–centred Trust.

Our ambition is for a positive patient, carer, friends and family experience and the past 12 months have focused on "getting it right" from the ground up. We are excited about where we are going in the 12 months ahead and who we will be working with on our journey.

We are continuing to grow our volunteering offer and explore ways to enhance the patient experience.

The Trust was successful as one of 10 Trust's nationally to be selected to join the Helpforce Daily Mail campaign. The campaign will enable us to recruit 170 volunteers to support key areas of our work, significantly supporting our staff and patients at a vulnerable time – as well as enriching the lives of volunteers themselves.

In October we brought together 150 volunteers from across our three hospitals to share and celebrate and to say "thank you" as part of our NHS70 celebrations. This was the largest event we have held with our volunteers and it provided the opportunity for networking, sharing stories, experiences and dancing. The event, planned following feedback from our volunteers, was an overwhelming success. We continue to listen to our valued teams of volunteers and have shaped our volunteering strategy for 2019-2010 from conversations at the event and from discussions throughout the year.

We have utilised the "Always Event" framework to enable us to re-design services and bring in new initiatives with our patients and carers' direct involvement and engagement. Over the past year we have developed an initiative to support patients with learning disabilities and their carers and we worked in partnership with service users and organisations across the county.

Reaching out to engage with our communities has been a focus, resulting in volunteer drop in sessions, working with community choirs , a youth orchestra, poetry slams, deaf awareness sessions, signing carols for staff and volunteers and increased visits from our therapy dogs.

In November and December 2018, alongside our Patient Public Forum we engaged with over 100 members of the public aged 7+ across our three hospital sites. Conversations have directly informed our 2019-2020 Quality Priorities alongside CQC Must and Should Dos.

In 2019 we will be launching our first ever hospital youth forum to increase our capacity to listen to seldom heard voices – we have developed a model of engagement learning from best practice nationally which we will be embedded across and supported by the Trust.

Our Friends of Worcestershire Royal Hospital and League of Friends at the Alexandra and Kidderminster hospitals continue to fundraise tirelessly, contributing to many projects both large and small across the Trust that improve the patient experience. Contributions this year have included new wheelchairs, British Sign Language courses for staff, a high tech age simulation suite and state of the art urology equipment.

Accountability Report

Corporate Governance Report

Directors Report

The Board of Worcestershire Acute Hospitals NHS Trust sets the strategic direction for the Trust.

The aim of the Board is to lead by example and to learn from experience and oversee the delivery of safe, effective, personalised and integrated care for local people, delivered consistently across all services by skilled and compassionate staff.

In 2018/19 the Board met in public on nine occasions, with meetings covering all three of our main sites. In the period covered by this annual report, the Board also held development sessions covering a wide range of topics including Human Factors awareness, risk management and learning from mortality. The Board also held development sessions covering a wide range of topics including cyber security awareness, risk management and learning from mortality.

The Trust is committed to setting high standards and the whole board has signed up to the Nolan principles, requiring honesty and integrity in all matters.

The Trust Board

The voting members of Trust Board during 2018/19 were as follows:

- **Paul Brennan,** Chief Operating Officer/ Deputy CEO from 1 October 2018, Acting CEO from 15 December 2018 to 13 January 2019
- **Anita Day**, Non-Executive Director from 1 August 2018
- **Matthew Hopkins**, Chief Executive from 14 January 2019
- **Caragh Merrick**, Chairman until 30 April 2018
- **Michelle McKay**, Chief Executive until 14 December 2018
- **Suneil Kapadia**, Chief Medical Officer from May 2017
- **Philip Mayhew**, Non-Executive Director until 22 December 2018
- **Dame Julie Moore**, Non-Executive Director from 1 April 2019
- **Vicky Morris**, Chief Nursing Officer
- **Sir David Nicholson**, Chairman from 14 May 2018
- **Inese Robotham**, Interim Chief Operating Officer until 30 Sept 2018
- **Jill Robinson**, Chief Finance Officer until 13 March 2019
- **Chris Swan**, Non-Executive Director until 30 April 2018
- **Robert Toole**, Interim Chief Finance Officer from 14 March 2019
- **Bill Tunnicliffe**, Non-Executive Director
- **Steve Williams**, Non-Executive Director
- **Mark Yates**, Non-Executive Director Acting Chairman from 1 May – 13 May 2018

Non-voting members of Trust Board

- **Richard Haynes**, Director of Communications and Engagement
- **Colin Horwath**, Associate Non-Executive Director from 1 February 2019
- **Dame Julie Moore**, Associate Non-Executive Director from 1 October 2018 to 31 March 2019
- **Tina Ricketts**, Director of People and Culture
- **Richard Oosterom**, Associate Non-Executive Director
- **Kimara Sharpe**, Company Secretary
- **Sarah Smith**, Director of Strategy and Planning

Details of all the Board members and their declaration of interests can be viewed at www.worcsacute.nhs.uk/our-trust/our-board

Non-Executive Directors

The non-executive directors (NEDs) bring a wealth of experience to the Trust Board, from private sector commercial business to management within a large public sector organisation. Associate non-executives were also appointed during the year to support the work of the board.

Clinical Engagement in decision making

Input from senior clinicians to the strategic direction of the Trust has been led by the five clinical divisions and the active engagement of their leadership teams.

The Trust Management Executive meets monthly to discuss the operational direction of the Trust. This Group, chaired by the Chief Executive, consists of the Board Executive Directors and the Divisional Medical Directors.

Governance

The Governance Structure for the Trust was revised during the year. The revised structure allows the board to gain assurance on the delivery of the corporate objectives, quality of services and the financial and operational performance of the Trust.

The Board has been reviewed through the Deloittes review undertaken in October 2018. This process also reviewed the Quality Governance, People and Culture and the Finance and Performance Committees. Audit and Assurance Committee has reviewed Finance and Performance, People and Culture and Quality Governance Committees. Audit and Assurance Committee has undertaken a self-assessment in accordance with guidance in the Audit Committee handbook.

The **Quality Governance Committee's** purpose is to enable the Board to obtain assurance that the quality of care within the Trust is of the highest possible standard and ensure that there are appropriate clinical governance systems and processes and controls are in place throughout the Trust. The Committee is chaired by Dr Bill Tunnicliffe.

The **Finance and Performance Committee's** purpose is to give the Board assurance on the management of the financial and corporate performance of the Trust and to monitor and support the financial planning and budget

setting process. The Committee is chaired by Richard Oosterom.

The **Audit and Assurance Committee's** role is to critically review the governance and assurance processes upon which the Trust Board places reliance, ensuring that the organisation operates effectively and meets its strategic objectives. The Audit and Assurance committee works closely with the External and Internal Auditors. The process for managing the Board Assurance Framework is presented to the Committee on a regular basis. It also receives regular reports from the Freedom to Speak Up Guardian, Data Quality Champion, Local Anti-Fraud Specialist and Local Security Management Specialist. The Trust currently complies fully with the National Strategy to combat and reduce NHS fraud. The Committee is chaired by Steve Williams.

The **Charitable Funds Committee** has been established to manage the Trust's Charitable Funds on behalf of the Trust, as Corporate Trustee. The Committee is chaired by Mark Yates.

The **Remuneration and Terms of Service Committee** is constituted as a standing committee of the Board for reviewing the structure, size and composition of the Board of Directors and making recommendations for changes where appropriate. The Committee is chaired by Mark Yates.

The **People and Culture Committee** oversees the implementation of the Trust's People and Culture Strategy and is chaired by Mark Yates.

There is overlap of membership of NEDs on the board subcommittees.

Full details of membership of the Trust Committees can be found on page 42 in the Annual Governance Statement section.

Personal Data Incidents 2018/19

Details of Information Governance related incidents can be found on page 47 in the Annual Governance Statement.

Statement on disclosure to auditors

Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and has taken 'all the steps that he or she ought to have taken' to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Matthew Hopkins
Chief Executive

Date: 22 May 2019

Annual Governance Statement 2018/19

Scope of responsibility

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

I have a duty of partnership to discharge, and therefore work collaboratively with other partner organisations. The Trust is working collaboratively wherever possible with the appropriate Local Authorities, voluntary sector, University and other local education establishments as well as NHS Commissioners (CCGs and NHS England) and other NHS providers of services. The Trust has a range of formal and informal mechanisms in place to facilitate effective working with key partners in the Worcestershire Health Economy. We are an active partner in the Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP), with a number of our Executives and senior leaders leading key bodies of work, such as the Herefordshire and Worcestershire Local Maternity Service development. We also attend the Health Overview and Scrutiny Committee when requested.

Other partnership groups have been operationally focussed due to the operational and financial challenges currently faced by the Health Economy. These groups include the A&E Delivery Board and the Quality Improvement Review Group. The Trust also has a formal partnership arrangement with University Hospitals Coventry and Warwickshire NHS Trust in relation to Oncology services for Worcestershire.

The Trust is monitored and assessed by a wide range of external agencies. These have included the three local Clinical Commissioning Groups, West Midlands Clinical Senate, Cancer Peer Review, Royal Colleges, Health Education West Midlands, NHS Improvement (NHS I), NHS England (NHS E), the Care Quality Commission (CQC), NHS Resolution and the Health and Safety Executive. This is not an exhaustive list of organisations that monitor and assess the Trust for assurance purposes.

I have regular contact with NHS I and NHS E through a range of group, individual, informal and formal meetings. Effective relationships are also in place with the three Worcestershire clinical commissioning groups (which are now operating under one executive team), NHS South Worcestershire, NHS Redditch and Bromsgrove and NHS Wyre Forest. All Executive Directors are fully engaged in the relevant networks, including nursing, medical, finance, operations and human resources.

Throughout the year 2018/19, the Trust has remained in special measures in relation to quality and the CQC rating has remained at inadequate. NHS Improvement has supported the Trust with an improvement director.

The Trust has three key financial duties and has achieved compliance with the Capital Resource Limit and External Financing Limit but has not achieved the Statutory Breakeven duty. The Breakeven duty is where the Trust must achieve a breakeven position over a 3 year period (or where agreed with NHSI a 5 year period). The Trust has struggled with this in recent years and as required under statute, our external auditors have formally notified the Department of Health and Social Care (DHSC).

The Trust has reported an Operational Financial Performance excluding Provider Sustainability Fund (PSF) and impairments, deficit of £(73.7)m against a comparable plan target of £(41.5)m for the 2018/19 financial year. This is in line with the revised forecast outturn discussed with NHS Improvement through quarter 4 in 2018/19.

The Trust has additionally been awarded indicative Provider Sustainability Fund (PSF) of £4.922m as part of the year end general distribution. There are then also a number of other below the line adjustments adjusting for Capital Donations; Grants; and Impairments as detailed below which are included in the overall Income and Expenditure position.

The table below shows the financial details:

Financial Position - Income and Expenditure	Plan 2018/19 £000s	Actual 2018/19 £000s	Variance 2018/19 £000s
Operational Financial performance [Control Total] surplus/ (deficit) excluding PSF and impairments	**(41,511)**	**(73,712)**	**(32,201)**
Less provider sustainability fund (PSF)	17,807	4,922	(12,885)
Performance against Control Total adjusted to include PSF	**(23,704)**	**(68,790)**	**45,086**
Adjustment Removal of capital donations/grants	(90)	(86)	4
Adjustment for I&E impairments (reversals)	0	(6,828)	(6,828)
Surplus/(deficit) for the year including PSF and after impairments	**(23,794)**	**(75,704)**	**(51,910)**

The Trust's cumulative deficit against the break-even duty was £(268.367)m. The Trust did not achieve the financial control total in 2018/19 and has therefore foregone part of the PSF income.

The deficit was largely driven by both inability to achieve targeted patient care income as well as lack of identification and under delivery of cost improvement plans. Operational variances include increased expenditure as a result of diagnostic demand, premium costs of supporting vacancies and the provision of additional capacity.

The Trust has this year, meet its statutory duties of External Funding Limit and Capital Resources Limit. However the Trust has not complied with its statutory Break Even Duty required by the National Health Service Act 2006. Grant Thornton, the Trust's external auditors, issued a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in March 2019 due to the Trust's failure to comply with the Break Even Duty.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Worcestershire Acute Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Worcestershire Acute Hospitals NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Executive Lead for Clinical Risk Management is the Chief Nursing Officer. The Chief Nursing Officer is also the appointed Executive Lead on Clinical Governance. The Chief Medical Officer is the appointed lead for medical education, audit and effectiveness and research and development. The Chief Medical Officer has a remit to provide executive responsibility for patient safety and medical revalidation. During 2018/19, the Chief Finance Officer led on information governance, financial risk and anti-fraud and the Company Secretary on corporate governance. In early 2019/20, a Chief Information Officer will be appointed who will lead on information governance. The Audit and Assurance Committee gives assurance on the implementation of the Risk Management Strategy. The Company Secretary is also the Data Protection Officer as required under the GDPR (General Data Protection Regulations).

The Risk Management Strategy (RMS) is an integral part of the Trust's approach to continuous quality improvement and is intended to support and assist the organisation in delivering its key objectives as well as meeting the requirements contained within the NHS Constitution. A revised RMS was presented to and approved by the Board in July 2017 and will be reviewed during 2019. There is continuous review of the risk registers and the Board Assurance Framework shows clear links to the risks on the corporate risk register.

Staff continue to be made aware of their risk management responsibilities as part of the induction process, and existing staff are required to attend a mandatory annual update in respect of risk management. Training needs of staff in relation to risk management are assessed through a formal training needs analysis process with staff receiving training appropriate to their authority and duties. The role of individual staff in managing risk is also supported by a framework of policies and procedures which promote learning from experience and sharing of good practice. Specific training targeted at executive directors, non-executive directors and managers has been undertaken. The role of the Risk Management Group was reviewed during 2018/19 and was relaunched in January 2019 with revised terms of reference and clear accountability to the Trust Management Executive (TME). The Group is chaired by the Chief Nursing Officer. Membership now includes operational directors who have a clear remit for the management of risk within the divisions. High rated risks are presented to the Risk Management Group which then recommends risks for inclusion within the Corporate Risk Register to TME.

Staff were given the opportunity to attend a risk and governance drop in session in February 2019. 80 members of staff attended and advice was given in respect of risk management and clinical governance throughout the Trust. Two further sessions were held at the end of March 2019, therefore covering all three sites. Attendees were from all areas of the Trust. Additionally, the Board considered its risk appetite in relation to the Trust strategic objectives at an externally facilitated Board Development session in March 2019.

The consolidation of this work will be undertaken at a board development session in July.

Bespoke training is undertaken with Divisions around risk identification, grading, mitigation and management. The Trust has an on-going training programme around Datix, the Trusts e-based reporting system, and how to register incidents, risks and complaints that is open to all staff from Board to Ward on both a classroom based approach and 1-2-1 intensive training.

Our systems and processes in relation to the monitoring of mandatory training have much improved during 2018/19. Staff are able to undertake a large part of mandatory training through e-learning and can attend any of the Trust's libraries for support. The monitoring of mandatory training levels takes place through the performance management system and is monitored via the Trust Management Executive and the People and Culture Committee.

There has been significant improvement in the mandatory training levels attained by all staff across all subject areas.

The Trust continues to learn lessons in a variety of ways, including from the following sources:

- Patients' Advice and Liaison Service (PALS)
- Complaints and compliments
- Friends and Family Test
- Litigation Claims
- Clinical Audit and Clinical Outcome Reviews
- Clinical Incident Reports, reviews and analysis including serious incidents and never events
- Morbidity and Mortality data (HSMR/SHMI)
- External Reports (for example the National Confidential Enquiry into Peri-operative Death, reports from the Royal Colleges)
- Patient and Staff surveys
- Internal quality inspections
- Huddles
- Mortality reviews
- Duty of Candour
- Quality performance metrics
- Board Executive and Non-Executive Director safety walk rounds
- Health Education West Midlands – visits and inspections
- External reviews by the CQC, Royal Colleges and Clinical Commissioning Groups.

This is not an exhaustive list. Learning lessons is programmed into the weekly serious incident meeting and there is a regular newsletter on learning lessons.

Serious incidents and never events as well as complaints are thoroughly investigated and improvements made at local and corporate levels to reduce the likelihood of reoccurrence. The Trust recognises that response times for investigation could be better and have reviewed the way in which investigations are undertaken.

We have also committed to ensuring that we do not delay in responding to complaints and investigating serious incidents. By 31 March 2019, we had 17 complaints overdue which compares to 20 in March 2018. We also had 1 serious incident overdue which compares to 1 in March 2018.

A fundamental part of embedding a safety culture is ensuring robust identification and management of incidents and ensuring learning is shared at an organisational level. The Trust has weekly multi-disciplinary Serious Incident (SI) Learning and Review meetings in place chaired by the Chief Medical Officer. All incidents are categorised for level of harm by the divisional governance teams using a checklist and escalated to the SI group accordingly. The group reviews the root cause analyses of all SIs and assess whether any deaths as a consequence of the event, were avoidable or not through the mortality review process. They also consider Initial Case Reviews (ICRs) for all new incidents which Divisions have categorised the outcome as moderate harm or above, and those which may require external notification. In addition the group discuss compliance with Duty of Candour, whether the terms of reference are appropriate, and that an investigating officer has

been allocated. Each meeting concludes with a lesson of the week for wider learning across the Trust. Once a month cases with important learning which affect multiple divisions are presented at the start of the meeting which is open to all staff to attend.

A quarterly report from the group is submitted to the Clinical Governance Group (CGG, an operational group consisting of all the senior clinical leaders) and then to the Trust Management Executive (TME) followed by the Quality Governance Committee (QGC).

The Board Assurance Framework (BAF) was revised in the summer of 2018 to more adequately reflect the strategic risks facing the Trust and the Trust Board approved the revised BAF at its September meeting and took updates to the November, January and May meetings. Each Committee reviews the risks that have been allocated to that Committee on a bi monthly basis. The Audit and Assurance Committee reviews the process and controls at each meeting.

The board reviewed its strategic objectives in March 2019 and is currently engaging staff in this work. It is anticipated that a revised BAF will be presented to the Board at its July meeting.

The Safety and Quality Information Dashboard (SQuID) continues to evolve and is utilised within the Trust. The system is a Ward to Board system which highlights performance around quality and safety, and when the Trust is not where expected to be, what is being done about it. It incorporates all our agreed key quality metrics, and is aligned to risks, gaps in controls and corrective actions. This can be viewed by all and is used as part of the Trust's process to provide Ward to Board assurance.

To support this, and to triangulate evidence of compliance, the Trust undertakes quality audits. These audits provide regular information at a ward level as to documentation completeness and identify areas where further training or support is required.

Safety and leadership walkabouts by the executive management team and non-executive directors have been introduced. These planned visits use a standard checklist to review compliance with professional standards.

In respect of Ward to Board line of sight, the Clinical Governance Group (CGG), meeting monthly, provides the forum for the senior clinical staff to discuss all issues relating to quality and safety. The CGG reports every month to the Trust Management Executive and then to the Quality Governance Committee for assurance. It is supported by the Divisional Governance Forums and specialist groups covering areas such as infection control, clinical effectiveness and safeguarding. Attendance by the clinicians is now excellent and they present their quality exception reports, key risks and mitigations through the corrective action statements.

The Board commissioned Deloittes to undertake an external review of the Board governance arrangements. The review reported in October 2018. As a result of the review, the Trust ceased the Trust Leadership Group and introduced the Trust Management Executive (TME) which meets once a month. This is the operational decision making forum of the Trust and consists of the executive management team and the divisional medical directors. TME discusses and decides key items before they are presented to the relevant committee for assurance. Other actions resulting from the Deloittes review include the continual review of our Board and Committee papers to enable focussed discussions, including more benchmarking data within papers and ensuring that the executive summary is fit for purpose.

Our Quality Improvement Strategy and associated plans, presented to the Trust Board in March 2018, have been monitored through the Quality Governance Committee and latterly the TME and reported to the Trust Board. Divisional implementation plans are in place to support implementation and ensure a golden thread from Board to Ward.

We have refined and developed our process for ensuring that quality impact assessments are undertaken for all developments and cost improvement plans that could have an impact on quality. These are reported to the TME and Quality Governance Committee. This process will be reviewed in early 2019/20 to ensure inclusion of equality and diversity.

The Trust risk management strategy was updated and approved in July 2017 and further updated in 2018.

The Trust identifies risks from a range of internal, external, proactive and reactive sources.

The stages involved in risk management are defined in the Trust risk strategy as follows:

- Identify the risk and the owner
- Evaluate the risk
- Compare against tolerance
- Identify controls and actions required
- Implement controls
- Monitor/measure effectiveness

The strategic risks, controls and mitigations presented to the Board through the Board Assurance Framework, identified by the Board and monitored through the Committees, are as follows:

Priority/risk	Summary of controls/mitigations*
Priority 1. Deliver safe, high quality compassionate patient care	
IF we do not have in place robust clinical governance for the delivery of high quality compassionate care THEN we may fail to consistently deliver what matters to patients RESULTING IN negative impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.	Development of a framework for clinical governance
IF we do not deliver the Quality Improvement Strategy (incorporating the CQC 'must and should' dos) THEN we may fail to deliver sustained change RESULTING IN required improvements not being delivered for patient care and reputational damage.	Ongoing sustained implementation of the Quality Improvement Strategy including a refreshed strategy and year 2 divisional plans Publication of Quality Account
IF we do not deliver the statutory requirements under the Health and Social Care Act (Hygiene code) THEN there is a risk that patient safety may be adversely affected RESULTING IN poor patient experience and inconsistent/varying patient outcomes.	Ongoing sustained implementation of the Quality Improvement Strategy including a refreshed strategy and year 2 divisional plans Publication of Quality Account
IF we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning THEN we will fail the national quality and performance standards RESULTING IN a negative patient experience and a failure to exit special measures and to attain STF funding.	Development of an Urgent Care Improvement Plan

Priority/risk	Summary of controls/mitigations*
IF we do not have effective IT systems which are used optimally THEN we will be unable to utilise the systems for the benefit of patients RESULTING IN poorly coordinated care for patients and a poor patient experience.	Development of a Digital Strategy
Priority 2. Design healthcare around the needs of our patients, with our partners	
IF there is a lack of a strategic plan which balances demand and capacity across the county THEN there will be delays to patient treatment RESULTING IN a major impact on the Trust's ability to deliver safe, effective and efficient care to patients.	Development of the winter plan and system plan
Priority 3. Invest and realise the full potential of our staff to provide compassionate and personalised care	
IF we do not deliver a cultural change programme THEN we may fail to attract and retain staff with the values and behaviours required RESULTING IN lower quality care for our patients.	Implementation of 4ward
IF are unable to recruit, retain and develop sufficient numbers of skilled, competent and trained staff, including those from the EU THEN there is a risk to the sustainability of some clinical services RESULTING IN lower quality care for our patients.	Implementation of the learning and development plan and the recruitment and retention plan
Priority 4. Ensure the Trust is financially viable and makes the best use of resources for our patients.	
IF we are unable to resolve the structural imbalance in the Trust's income and expenditure position THEN we will not be able to fulfill our financial duties RESULTING IN the inability to invest in services to meet the needs of our patients.	Development of a medium term financial strategy
IF we are not able to unlock funding for investment THEN we will not be able to modernise our estate, replace equipment or develop the IT infrastructure RESULTING IN the lack of ability to deliver safe, effective and efficient care to patients.	Development of a medium term financial strategy
Priority 5. Continuously improve our services to secure our reputation as the local provider of choice.	
IF we are unable to sustain our clinical services THEN the Trust will become unviable RESULTING IN inequity of access for our patients.	Development of a clinical services strategy
IF we have a poor reputation THEN we will be unable to recruit or retain staff RESULTING IN loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care.	Implementation of the People and Culture Strategy.

** the full controls, mitigations and assurances can be reviewed in the Board Assurance Framework approved at the Trust Board in May 2019.*

The Trust has a Corporate Risk Register in place which outlines the key corporate risks for the organisation and action identified to mitigate these risks. This register has been formed from the risks identified within clinical divisions and corporate services, Trust Committees and through other risk identification activities. The Trust Management Executive approves risks for inclusion onto the Corporate Risk Register. In relation to clinical risks, the Trust Management Executive oversees the mitigations for each risk and the Quality Governance Committee receives reports for assurance. Outcomes are assessed at the Risk Management Group where the risk rating is determined and changed, according to the progress of the mitigations. The key clinical risks are:

- Infection Prevention and Control
- Non-delivery of the Quality Improvement Strategy
- Patient Flow
- Junior Doctors' experience
- Robust Clinical Governance systems and processes

The Trust is committed to continuous improvement in data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. Identified risks and relevant mitigation measures are included in the risk register. Work continues to ensure the completeness and validity of all data entry, analysis and reporting.

Waiting time elective data and quality of data

The Trust has a Data Quality Framework to facilitate an understanding amongst Trust staff as to what 'Data Quality' means, the methodology to use when monitoring data quality, and to emphasise that any individual who creates, records or uses data is accountable for understanding and making transparent the level of confidence using the data quality domains.

The clinically led Data Quality Steering Group meets bi monthly and has oversight of the data quality log for the Trust. The Trust operates a Data Quality Kitemark for key data items, highlighting known issues within the six domains as defined in the Data Quality Framework (accuracy, validity, reliability, timeliness, relevance and completeness).

The risk and control framework

Risk Management is embedded within the organisation through the Trust's committee structure, through the development of future plans and through the consideration of all risk management issues at the planning stage of organisational/clinical changes. Embedding also takes place through the existence of an incident reporting and feedback system, the inclusion of risk management within job descriptions (including both training and the processes for the assessment of risk) and the reporting and investigation of incidents.

Innovation and learning in relation to risk management is considered to be critical. The Trust's e-based reporting system, Datix, has been rolled out throughout the organisation so that incidents can be input at source and data can be interrogated through ward, team and locality processes, thus encouraging local ownership and accountability for incident management. The Trust identifies and makes improvements as a result of incidents and near misses in order to ensure it learns lessons and closes the loop by improving safety for service users, staff and visitors.

The Head of Internal Audit Opinion for 2018/19

Only limited assurance can be given as weakness in the design, and inconsistent application of control, put the achievement of the organisation's objectives at risk. The Trust has been operating under the quality Special Measures regime since December 2015, which was put in place by the NHS regulatory body the Care Quality Commission (CQC), following inspection at that

time. Whilst we recognise that the Trust has delivered some improvements that have been reported in subsequent inspection (reported June 2018, which saw the well led domain improve to "requires improvement") and also the Trust is no longer operating under any licence conditions, the Trust remains rated as "inadequate" overall. In addition to this, the Trust has highlighted other significant internal control issues within its Annual Governance Statement, which includes its ongoing, serious financial difficulties. Furthermore, our internal audit reviews have resulted in a significant number of moderate and limited assurance opinions as cited below.
We provided significant assurance for the following reviews:

- Budget setting, Monitoring and Reporting
- Financial Systems

We provided moderate assurance for the following reviews:

- Financial Sustainability and Outcomes
- Complaints
- Patients Monies
- Health & Safety

We provided limited assurance for the following reviews:

- Governance Arrangements - Divisions
- Quality Systems
- Delayed Discharges

I should like to emphasise the importance of the Quality Governance Committee (QGC) and the Clinical Governance Group (CGG). The CGG consists of the Trust senior clinical staff who then are able to assure the QGC on the work of the Trust wide Groups and Divisions. The Groups accountable to the CGG are as follows:

- Patient and Carer
- Research and Development
- Trust Infection, Prevention and Control
- Safeguarding
- Medicine optimisation
- Incident learning and review
- Medical devices
- Improving patient outcomes
- Avoidable mortality
- Blood transfusion
- Harm free

The Trust has put considerable effort into reviewing and streamlining the process for reviewing deaths. We have adopted a policy and appointed medical examiners in line with the recommendations within the publication *Learning, candour and accountability: A review of the way NHS Trusts review and investigate deaths of patients in England*. We report quarterly to the Trust Board on the learning from deaths.

During the year, the Trust received no Regulation 28 letters (a report to prevent future deaths) from the Coroner.

The Trust has been in the Trust Special Measures regime since December 2015. During the year 2018/19, the Trust had the following conditions/ warning notices from the CQC:

- Section 31 Condition placed on registration (requirement to report 15 minute triage breaches and Harm Reviews) emergency department, Worcestershire Royal Hospital (imposed 30 March 2015, removed 25 July 2018)

- Section 31 Condition, Radiology, Trust wide (imposed 16 August 2016, removed 11 May 2018)

The CQC undertook an unannounced visit on 14 January 2019 to the emergency departments at the Worcestershire Royal and Alexandra Hospitals. The reports were received at the end of February 2019 and an action plan was developed which was returned to the CQC by 27 March 2019.

The CQC identified examples of good practice, treatment and care and these are highlighted in

the report. However, the CQC also identified areas for improvement and again these are outlined within the report. Whilst we have not been issued with any enforcement actions, we have been issued with the following regulatory action:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

As this was a partial inspection, not all domains were reviewed, no rating has been issued.

We also had a 'Use of Resources' inspection on 7 May 2019 and we are anticipating a full inspection by the CQC before 3 July 2019. The well-led inspection will take place on 19-21 June.

Oxford University Hospitals NHS Foundation Trust updated their risk maturity assessment in quarter 4 of 2017/18. The Trust has worked through the action plan to improve and embed risk management. A follow up was undertaken in April 2019 and we await the results. We undertook a self-assessment in respect of the Well Led Framework and we await the CQC inspection focussing on the Well Led domain. In preparation for this inspection, NHS Improvement (Midlands and East) undertook a review in April/May 2019 and the feedback is awaited.

The Trust monitors its culture through the triangulation of the NHS staff survey results and themes raised through the Freedom to Speak Up Guardian, HR casework, Occupational Health and staff engagement events. This analysis had confirmed that there is further work to do to improve our culture with actions being identified to address the root causes. This includes realigning our 4ward cultural change programme to focus on board and leadership development and supporting colleagues to demonstrate our 4 signature behaviours at every opportunity.

The 2018 national staff survey results were disappointing but understandable given the turmoil within the Trust in the past year. These results confirm that the Trust remains in the bottom quartile for its overall results. The survey has 5 sections containing 89 questions, with the results summarised in the table below.

Section of survey	Total No of Qs	No of Qs improved since 2017	No of Qs remaining the same as 2017	No of Qs deteriorating since 2017
Your job	30	11 (37%)	10 (33%)	9 (30%)
Your manager	11	0	0	11 (100%)
Your health, wellbeing and safety at work	30	9 (30%)	5 (17%)	16 (53%)
Your personal development	8	7 (88%)	1 (12%)	0
Your organisation	10	4 (40%)	2 (20%)	4 (40%)

The Trust is in year two of its People and Culture Strategy which is structured around three themes – an engaged, skilled and supported workforce. Work is underway to ensure the Trust has effective workforce systems in place to maximise the benefits of job planning, e-rostering, safe staffing and leave management. In addition, the Trust has recently launched a new model for the supply/ management of its temporary workforce. Recruitment and retention remains a key focus for the Trust and we are moving away from reactive short term actions to pro-active strategic workforce plans which are being developed alongside our clinical services strategy.

The People and Culture Strategy covers the short, medium and long term workforce strategies. This is reported through the Trust Management Executive for action and the People and Culture Committee for assurance. Two acuity studies have been undertaken to review nurse staffing. These reviews have been reported to the Trust Management Executive, the People and Culture Committee and Trust Board. Additionally, the Board receives a monthly analysis of safe staffing levels. In May 2019, the Chief Nursing Officer was able to assure the Board that she was satisfied that nurse staffing is safe, effective and sustainable.

We have appointed a Freedom to Speak Up Guardian. There are regular reports to the People and Culture Committee and Trust Board on his work and the Audit and Assurance Committee have a role in reviewing the systems and processes in place to ensure staff have every opportunity to discuss workplace attitudes. He attended the Trust board meeting in March 2019 to give an overview of the themes raised with him in the course of his work.

The Clinical Lead for data quality is ensuring that the clinical voice is heard in respect of data issues. We are implementing a strategy to assure the complete, accurate and timely recording of all patient information.

The Trust Data Quality Steering Group (DQSG) has been running for three years and work is underway to support the improvement in the recording of all patient data at source in line with the 'Right First Time' policy. Work is ongoing with clinical staff to improve the timeliness and quality of the Electronic Discharge Summary (EDS) and with clerical staff to ensure the correct GP is recorded at source.

The DQSG and the Health Records Committee report to the Information Governance Steering Group (IGSG) and through to the Trust Management Executive on a regular basis.

The Trust Board and key senior staff attended a GCHQ certified cyber security training event in February 2019. This is supplemented with e-learning. We are working with Templar Executives, who are working on behalf of NHS digital, to improve our cybersecurity working practices. A report, classified as 'official-secret' will be made available to the Trust which will be considered by the Audit and Assurance Committee.

The Trust works closely with public stakeholders to involve them in understanding and supporting the management of risks that impact upon them. Stakeholders are able to influence the Trust in a number of ways, including patient involvement groups and public involvement in the activities of the Trust. In addition, the Chief Executive and Chairman meet the local MPs regularly. The Trust has directly engaged public stakeholders in the risk management process through the Patient and Public Forum and through PALS. In addition a patient and public forum member sits on the Quality Governance Committee. Public involvement also occurs through the Trust complaints procedure and summaries of complaints are reviewed at the Patient and Public Involvement Forum. There is an opportunity for questions from the public following each Trust Board meeting held in public. We have reviewed our quality priorities as part of the Quality Account and have actively sought views from patients and the public in this review.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. Due to Board changes, we have updated and therefore managed our registration with the CQC during 2018/19. This provides assurance that our registration details have been checked and meet the statutory requirements.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the *'Managing Conflicts of Interest in the NHS'* guidance. This is available on the Trust website at www.worcsacute.nhs.uk/our-trust/our-board

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

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

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust considered its compliance with conditions FT4 and G6 of the provider licence (as at 31 March 2019) at the Board meeting in May 2019. This will be published on the website by 31 May 2019 as required by NHS Improvement.

We are committed to ensuring NHS resources are appropriately protected from fraud, bribery and corruption and follow the national NHS counter fraud strategy and the series of standards for providers of NHS services. As an NHS Provider the Trust ensures that NHS funds and resources are safeguarded against those minded to commit fraud, bribery or corruption. Failure to do so impacts on our ability to deliver services and treatment, as NHS funds and resources are wrongfully diverted from patient care.

In order to reduce economic crime against the NHS, it is necessary to take a multi-faceted approach that is both proactive and reactive. The Trust's local Counter Fraud Specialist (LCFS) follows the four key principles, in accordance with the NHS counter fraud strategy. These are designed to minimise the incidence of economic crime against the NHS and to deal effectively with those who commit crime. The four key principles are:

A. **Strategic Governance** - this standard sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

B. **Inform and involve** those who work for, or use the NHS, about economic crime and how to tackle it. NHS staff and the public should be informed and involved to increase everyone's understanding of the impact of economic crime against the NHS. This takes place through communications and promotion such as face to face counter fraud presentations, public awareness campaigns and media management. Working relationships with stakeholders are strengthened and maintained through active engagement.

C. **Prevent and deter** economic crime in the NHS to take away the opportunity for crime to occur or to re-occur and discourage those individuals who may be tempted to commit economic crime. Successes are publicised internally during counter fraud presentations and using other media opportunities so that the risk and consequences of detection are

clear to potential offenders. Those individuals who are not deterred should be prevented from committing economic crime by robust systems, which will be put in place in line with policy, standards and guidance.

D. **Hold to account** those who have committed economic crime against the NHS. The Trust's LCFS is a professionally accredited investigator and is qualified to the required standards. Once allegations of suspected economic crime are received by the Trust, the LCFS must ensure that investigations are undertaken to satisfy national legislation. The Trust encourages the prosecution of offenders, and where appropriate refers offenders to their professional bodies for disciplinary sanction. Economic crimes must be detected and investigated, suspects prosecuted where appropriate, and other methods of redress sought where possible. Where necessary and appropriate, economic crime, investigation and prosecution will take place locally wherever possible. Nevertheless the LCFS also works in partnership with the police and other crime prevention agencies to take investigations forward to criminal prosecution.

The Trust Board

The Board of Worcestershire Acute Hospitals NHS Trust sets the strategic direction for the Trust. The aim of the Board is to lead by example and to learn from experience and oversee the delivery of safe, effective, personalised and integrated care for local people, delivered consistently across all services by skilled and compassionate staff.

In 2018/19 the Board met in public on 9 occasions, with meetings covering all three of our main sites. In the period covered by this annual report, the Board also held development sessions covering a wide range of topics including cyber security awareness, risk management and learning from mortality.

The Trust is committed to setting high standards and the whole board has signed up to the Nolan principles, requiring honesty and integrity in all matters.

The non-executive directors (NEDs) bring a wealth of experience to the Trust Board, from private sector commercial business to management within a large public sector organisation. Associate non-executives were also appointed during the year to support the work of the board.

The voting members of Trust Board during 2018/19 were as follows:

- **Paul Brennan**, Chief Operating Officer/ Deputy CEO from 1 October 2018, Acting CEO from 15 December 2018 to 13 January 2019
- **Anita Day**, Non-Executive Director from 1 August 2018
- **Matthew Hopkins**, Chief Executive from 14 January 2019
- **Caragh Merrick**, Chairman until 30 April 2018
- **Michelle McKay**, Chief Executive until 14 December 2018
- **Suneil Kapadia**, Chief Medical Officer from May 2017
- **Philip Mayhew,** Non-Executive Director until 22 December 2018
- **Dame Julie Moore**, Non-Executive Director from 1 April 2019
- **Vicky Morris**, Chief Nursing Officer
- **Sir David Nicholson**, Chairman from 14 May 2018
- **Inese Robotham**, Interim Chief Operating Officer until 30 Sept 2018
- **Jill Robinson**, Chief Finance Officer until 13 March 2019
- **Chris Swan**, Non-Executive Director until 30 April 2018
- **Robert Toole**, Interim Chief Finance Officer from 14 March 2019
- **Bill Tunnicliffe**, Non-Executive Director
- **Steve Williams**, Non-Executive Director
- **Mark Yates**, Non-Executive Director Acting Chairman from 1 May – 13 May 2018

Non-voting members of Trust Board

- **Richard Haynes**, Director of Communication and Engagement
- **Colin Horwath**, Associate Non-Executive Director from 1 February 2019
- **Dame Julie Moore**, Associate Non-Executive Director from 1 October 2018 to 31 March 2019

- **Tina Ricketts**, Director of People and Culture
- **Richard Oosterom,** Associate Non-Executive Director
- **Kimara Sharpe**, Company Secretary
- **Sarah Smith**, Director of Strategy and Planning

At all meetings there were more non-executive voting members present then executive voting director members.

The Board has been reviewed through the Deloittes review undertaken in October 2018. This process also reviewed the Quality Governance, People and Culture and the Finance and Performance Committees. Audit and Assurance Committee has reviewed Finance and Performance, People and Culture and Quality Governance. Audit and Assurance Committee has undertaken a self-assessment in accordance with guidance in the Audit Committee handbook.

We have also been preparing for the CQC inspection with NHSE and NHSI mock inspection undertaken in March 2019.

Public Board attendance

(maximum number of meetings – 9. Attendance is shown relative to the number of meetings that could have been attended)

		Attended
David Nicholson	Chairman	8/8
Matthew Hopkins	Chief Executive	2/2
Paul Brennan	Chief Operating Officer/Deputy CEO	4/4
Anita Day	Non-executive director	5/6
Colin Horwath	Associate Non-Executive Director	2/2
Richard Haynes	Director of Communications	9/9
Suneil Kapadia	Chief Medical Officer	7/9
Julie Moore	Associate Non-Executive Director	3/5
Vicky Morris	Chief Nursing Officer	8/9
Richard Oosterom	Associate Non-Executive Director	6/9
Tina Ricketts	Director of People and Culture	9/9
Kimara Sharpe	Company Secretary	9/9
Sarah Smith	Director of Strategy and Planning	8/9
Robert Toole	Chief Finance Officer (Interim)	1/1
Bill Tunnicliffe	Non-executive director	9/9
Steve Williams	Non-executive director	9/9
Mark Yates	Non-executive director	9/9
Phil Mayhew	Non-executive director	5/6
Caragh Merrick	Chairman	0/0
Michelle McKay	Chief Executive	6/6
Jill Robinson	Chief Finance Officer	6/8
Inese Robotham	Interim Chief Operating Officer	4/4
Chris Swan	Non-executive director	0/0

Committees

During 2018/19, the Trust Board had the following Committees:

- Audit and Assurance
- Charitable Funds
- Finance and Performance
- Quality Governance
- Remuneration and Terms of Service
- People and Culture

All terms of reference for the Committees have been revised during the year and approved by the Trust Board.

Each Committee reports to the Trust Board following a meeting. These reports highlight the activities of the Committee and draw the Board's attention to areas of concern. The highlights of the Quality Governance and Audit and Assurance Committee reports to the Trust Board are follows (this is not an exhaustive list):

Quality Governance
Learning from deaths Quality Improvement Strategy oversight Fractured neck of femur – time to theatre Ward to Board reporting Deep dives Serious Incidents Complaints
Audit and Assurance
Review of effectiveness of Quality Governance/Finance and Performance/People and Culture Board Assurance Framework Data quality Local Security Management Specialist Anti-Fraud Internal Audit Reports

The purpose together with the attendance for each Committee is shown below:

Audit and Assurance Committee

Purpose: The Audit and Assurance Committee has been established to critically review the governance and assurance processes upon which the Trust Board places reliance, ensuring that the organisation operates effectively and meets its strategic objectives. The Audit and Assurance committee works closely with the External and Internal Auditors. The process for managing the Board Assurance Framework is presented to the Committee on a regular basis. It also receives regular reports from the Freedom to Speak Up Guardian, Data Quality Champion, Local Anti-Fraud Specialist and Local Security Management Specialist. The Trust currently complies fully with the National Strategy to combat and reduce NHS fraud.

(maximum number of meetings – 7. Attendance is shown relative to the number of meetings that could have been attended)

Chairman	Steve Williams	7/7
Non-Executive Director (from Jan 2019)	Anita Day	2/2
Non-Executive Director	Mark Yates	5/6
Non-Executive Director (until Dec 2018)	Phil Mayhew	5/5

Charitable Funds Committee

Purpose: The Charitable Funds Committee has been established to manage the Trust's Charitable Funds on behalf of the Trust, as Corporate Trustee.

(maximum number of meetings – 2. Attendance is shown relative to the number of meetings that could have been attended)

Chairman	Mark Yates	2/2
Non-Executive Director	Anita Day	2/2
Non-Executive Director	Steve Williams	2/2

Finance and Performance Committee

Purpose: The purpose of the Finance and Performance Committee (F&P) is to give the Board assurance on the management of the financial and corporate performance of the Trust and to monitor and support the financial planning and budget setting process. The Committee also reviews business cases with a significant financial impact or those referred by the Trust Management Executive and oversee developments in financial systems and reporting, for example Service Line Reporting and Patient Level Information and Costing Systems.

(maximum number of meetings – 12. Attendance is shown relative to the number of meetings that could have been attended)

Chairman (from Jan 2019)	Richard Oosterom	3/3
Chairman (until Dec 2018)	Phil Mayhew	9/9
Non-Executive Director	Steve Williams	12/12
Associate Non-Executive Director	Richard Oosterom	5/9
Director of People and Culture	Tina Ricketts	1/2
Chief Medical Officer/ Chief Nursing Officer	Suneil Kapadia/ Vicky Morris	11/12
Chief Executive	Matthew Hopkins	3/3
Chief Operating Officer	Paul Brennan	5/6
Chief Finance Officer (Interim)	Robert Toole	1/1
Director of Strategy and Planning	Sarah Smith	11/12
Chief Executive	Michelle McKay	7/8
Chief Finance Officer	Jill Robinson	9/11
Interim Chief Operating Officer	Inese Robotham	6/6

Quality Governance Committee

Purpose: The Quality Governance Committee is constituted as a Standing Committee of the Board to:

- Enable the Board to obtain assurance that the quality of care within the Trust is of the highest possible standard.
- Ensure that there are appropriate clinical governance systems and processes and controls are in place throughout the Trust in order to:
  - Promote safety and excellence in patient care
  - Identify, prioritise and manage risk arising from clinical care
  - Review and comment on compliance with avoidable mortality incidence
  - Ensure the effective and efficient use of resources through evidence based clinical practice.

The Committee oversees clinical audit activities within the Trust. Clinical audit provides assurance that the Trust is measuring patient care against best practice standards and continuously improving where necessary and is an important feature of our induction and training programme in clinical governance. Compliance with NICE guidance is also monitored.

The Quality Governance Committee is key to the assurance to the Trust Board in respect of the Quality Improvement.

There was one never event reported in the Trust between 1 April 2018 and 31 March 2019, related to wrong site surgery where a surgical incision was made on the incorrect section of the forearm. This resulted in minor harm to the patient; an apology and explanation was given to the patient as part of Duty of Candour. Learning from the incident highlighted that familiar tasks are often carried out subconsciously and require active cues to trigger the mind that something is different so it starts working consciously. Whilst an active cue identified the incision was incorrect, it occurred

after the incision had already been made. The benefits of educating staff in human factors as an aid to increase their awareness of how human behaviour can influence events was highlighted, and training was recommended to continue to be delivered for surgeons and theatre staff.

Two further never events were reported in May 2019. One related to a retained swab from surgery performed in 2015. The second was retained 23 gauge PPV ports. The ports were removed from the eye under local anaesthetic. PPV ports will now be included as part of the surgical count. The incident investigations are underway and will be reported through the quality governance system, including to the Trust Management Executive, culminating in an assurance review at the Quality Governance Committee.

QGC reviews the details associated with avoidable mortality at its monthly meetings. QGC reports these details to the Trust Board. In addition, there is a separate report to Trust Board which focusses specifically on learning from deaths.

The Trust has a mortality review process which is overseen by the Chief Medical Officer and QGC reviews the details associated with avoidable mortality at its monthly meetings. QGC reports these details to the Trust Board. In addition, there is a separate report to Trust Board which focusses specifically on learning from deaths.

There were 102 confirmed serious incidents reported between 1 April 2018 and 31 March 2019 (compared to 141 the previous year).

Of these 102, 12 are under investigation and are still within the timescales for submission; one exceeds the 60 day deadline. Of the 89 that have been submitted, 79% were submitted to Commissioners within the national timescale of 60 days. The Trust has made considerable progress in closing SIs within the required timescales and will continue to improve on this target during 2019/20.

All serious incidents are managed and reviewed at the weekly Serious Incident Review and Learning Group, which is chaired by the Chief Medical Officer; these meetings allow for objective and transparent multidisciplinary scrutiny of investigation reports.

Work needs to continue to ensure that the actions are completed and documented appropriately so that lessons can be learnt across the Trust.

As well as this, a 'lesson of the week' is communicated via the weekly brief and some lessons communicated have been in relation to: the impact of medications on the risk of patients falling, the importance of utilising radiological expertise to aid diagnoses from radiological imaging, good practice to follow when discharging a patient who lacks mental capacity and the use of safety huddles as an effective way of improving communication about patient care to reduce the possibility of patient harm.

The QGC discussed progress against the Research and Development Strategy 2018-21 at its meeting in November 2018. This strategy lays out plans and priorities for research within the Trust over the next three years in order to make research a quality-driven, self-funding department that benefits staff and patients. It is part of the Clinical Effectiveness Plan of the Quality Improvement strategy. The Trust is progressing in line with its targets of increasing activity based funding target of 1.5% (actual 1.6%), increasing new principal investigators (6 new PIs in the last 12 months). A third target was increasing the number of specialities participating in R&D to 18. We currently have 16 specialities participating in R&D.

Membership and attendance at the QGC is shown below. The QGC also has regular attendance by a patient forum representative, HealthWatch and the CCGs.

(maximum number of meetings – 12. Attendance is shown relative to the number of meetings that could have been attended)

Chairman	Bill Tunnicliffe	12/12
Chief Operating Officer	Paul Brennan	3/6
Chief Executive	Matthew Hopkins	2/3
Chief Medical Officer	Suneil Kapadia	9/12
Associate Non-executive Director	Julie Moore	3/6
Chief Nursing Officer	Vicky Morris	9/12
Non-Executive Director	Mark Yates	8/12
Non-Executive Director	Chris Swan	0/1
Non-Executive Director	Phil Mayhew	7/9
Chief Executive	Michelle McKay	7/8
Interim Chief Operating Officer	Inese Robotham	2/6

Remuneration and Terms of Service Committee

Purpose: The Remuneration and Terms of Service Committee is constituted as a standing committee of the Board for reviewing the structure, size and composition of the Board of Directors and making recommendations for changes where appropriate.

The Committee gives full consideration to and makes plans for succession planning for the Chief Executive and other Executive Board Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

The Committee is responsible for setting the remuneration of executive members of staff, senior managers earning over £70,000 or accountable directly to an executive director and on locally-determined pay.

(maximum number of meetings – 7. Attendance is shown relative to the number of meetings that could have been attended)

Chairman	Mark Yates	1/1
Chairman	Sir David Nicholson	6/6
Non-executive director	Mark Yates	6/6
Non-Executive director	Steve Williams	6/6
Chairman	Caragh Merrick	0/0

People and Culture Committee

This Committee has set the strategy for People and Culture and is monitoring and reviewing its implementation.

Purpose: The People and Culture Committee assess the workforce implications of the Trust strategic objectives, national HR workforce strategies, employment legislation and local initiatives. It oversees the development and implementation of the Trust's People and Culture Strategy and associated plans and monitors the effectiveness of the strategy and reports on progress against plan. It also provides assurance to the Board on the operation of effective and robust HR Workforce & organisational development practices and governance frameworks.

(maximum number of meetings – 6. Attendance is shown relative to the number of meetings that could have been attended)

Chairman	Mark Yates	6/6
Non-Executive Director	Anita Day	4/4
Chief Executive	Matthew Hopkins	1/1
Director of People and Culture	Tina Ricketts	6/6
Associate Non-Executive Director	Richard Oosterom	4/6
Chief Executive	Michelle McKay	3/4
Director of Communications	Richard Haynes	5/6
Chief Medical Officer	Suneil Kapadia	5/6
Chief Nursing Officer	Vicky Morris	6/6
Chief Finance Officer	Jill Robinson	4/6
Chairman	Chris Swan	0/0

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

The External Auditor has indicated that he intends to issue a qualified Value for Money (VfM) Conclusion for 2018/19. This is due to the Trust's financial deficit, performance management metrics, the CQC inspection and the Trust remaining in Special Measures. The qualified VfM Conclusion means that External Audit will not be providing assurance on effective use of resources for the year 2018/19. Similarly, the Head of Internal Audit's limited assurance opinion indicates that there are caveats to his opinion with respect to the Trust's use of resources.

For 2018/19, the Board continued with the five strategic objectives set in 2017/18. The objectives linked the financial strategy to the corporate objectives, scrutiny of cost savings plans both to ensure achievement and their impact upon the quality of patient care, compliance with terms of authorisation and co-ordination of individual objectives with corporate objectives as identified in the Annual Plan. The safe management of the operational pressures has led to significant levels of expenditure on temporary staffing. A combination of these factors resulted in the Trust setting a deficit plan of £(23.704)m inclusive of PSF for 2018/19 which was not met as a result of risks materialising that could not be fully mitigated.

Performance against objectives is monitored and actions identified through a number of channels:

- Approval of annual budget by the Trust Board.
- Detailed Monthly review by the Finance and Performance Committee on key performance indicators covering finance and activity
- Monthly reporting to the Quality Governance Committee on patient safety and quality.
- Bimonthly reporting to the People and Culture Committee on human resource performance indicators
- Reporting by the Committees to the Trust Board at each meeting
- Monthly review of the delivery of Cost Improvement Plans by the Finance and Performance Committee to ensure that savings targets are being met.
- Monthly divisional performance meetings
- Fortnightly Trust Leadership Group meetings until December 2019 and monthly Trust Management Executive meetings where key operational decisions are made

The Trust has reported an Operational Financial Performance excluding Provider Sustainability Fund (PSF) and impairments, deficit of £(73.7) m against a comparable plan target of £(41.5)m for the 2018/19 financial year. This is in line with the revised forecast outturn discussed with NHS Improvement through quarter 4 in 2018/19.

The Trust has additionally been awarded indicative Provider Sustainability Fund (PSF) of £4.922m as part of the year end general distribution. There are then also a number of other below the line adjustments adjusting for Capital Donations; Grants; and Impairments as detailed below which are included in the overall Income and Expenditure position.

The Trust achieved £7.6m of nominal gross Cost Improvement Programme savings during the year. The recurrent effect of this programme secured £6.2m improving the Trust's underlying position. Scaled up programmes of work in respect of theatre and outpatient productivity and workforce transformation did not translate into measurable cost efficiencies to the level originally envisaged in 2018/19.

The increase in the Trust's deficit in 2018/19, above the original planned level has resulted in a tight cash flow which impacts timeliness of payments to creditors within the required Better Payment Practise Code (BPPC) target. The Trust has received c.£70m revenue cash support from the Department of Health and Social Care to be able to maintain the payment of creditors through the year. The Trust also received capital loans of £10.3m making the total borrowings of £80.3m in 2018/19.

The Trust has an annual planning process which considers the resources required to deliver the organisation's service plans in support of the strategic objectives. These annual plans detail the workforce and financial resources required to deliver the service objectives and include the identification of cost savings based on an assessment of benchmarked opportunities including the use of Model Hospital and the Get It Right First Time (GIRFT) programme. Cost savings are aligned to the drivers of the deficit analysis to target those areas that will improve the financial run rate including productivity and efficiency and workforce.

The Trust has a standard assessment process for future business plans to ensure value for money and full appraisal processes are employed when considering the effect on the organisation.

Procedures are in place to ensure all strategic decisions are considered at Executive and Board level.

The emphasis in Internal Audit work is providing assurances on internal controls, risk management and governance systems to the Audit and Assurance Committee and to the Board. Where scope for improvement, in terms of value for money was identified during an Internal Audit review, appropriate recommendations were made and actions were agreed with management for implementation. All internal audit reports are presented to a Trust Management Executive meeting prior to being approved by the Audit and Assurance Committee.

As part of the annual accounts review, the Trust's efficiency and effectiveness of its use of resources in delivering clinical services are assessed by its External Auditors and the auditor's qualified Value for Money Conclusion is published with the Trust's 2018/19 accounts.

Information governance

We place a high priority on the secure handling and accurate recording of personal identifiable information (PII) on behalf of our patients and staff. The General Data Protection Regulations came into force on 25 May 2018. We set up a working group, chaired by the Data Protection Officer to oversee the introduction of the regulations. A key piece of work was the mapping of the data flows within and external to the Trust. Over 30 awareness sessions were given to ensure that key staff were appraised of the new regulations. The Trust Board also had an awareness session, in May 2018.

We submitted the Data Security and Protection Toolkit assessment at the end of March with an approved action plan to complete any outstanding mandatory requirements by September 2019. The action plan is monitored by the Information Governance Steering Group. This forms assurance against the CQC registration for data security. In addition, we have an IT Security and Risk Forum which brings together operational IT staff, the Data Protection Officer and the Caldicott Guardian to determine the data security risks, including cybersecurity. This group reports into the Information Governance Steering Group which in turn reports to the Trust Management Executive.

We reported to the Information Commissioner's Office (ICO) zero Information Governance Serious Incidents during 2018/19. Lessons learned in respect of any internally investigated IG or data security incidents have been shared within the Trust.

Our staff are aware of their responsibilities in relation to handling personal information in

a confidential and secure manner through completion of the national data security awareness training. As at 31st March 85% of staff had completed their annual training and there is an action plan in place to improve the compliance rate. Staff are also provided with guidance in the Weekly Brief, PC home screens and awareness sessions at the Trust Induction. The Information Governance team provide day to day support and guidance for staff.

Our Board has completed Cyber Security awareness training (February 2019) and specialist training has been provided to support the roles of the Senior Information Risk Owner (SIRO), the Data Protection Officer (DPO), the Caldicott Guardian and the Information Asset Owners (IAO).

In order to reduce the risk of cyber incidents the Information Security Risk Forum meets on a monthly basis to manage information and cyber risks through the implementation of its action plan.

The Information Security Risk Forum, General Data Protection Regulations (GDPR) Working Group and Data Quality Steering Group all report into the Information Governance Steering Group who report directly to the Trust Management Group.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Quality Governance Committee assures the Trust Board in relation to the quality account and is overseeing the production of the 2018/19 Quality Account. The quality priorities have been developed following consultation with our staff and patients and were agreed at the February 2019 meeting of the Committee. Comments will be sought from partners to ensure a balanced view.

We assure the quality and accuracy of the elective waiting time data through rigorous quality assurance mechanisms, checks on patient level daily reporting, regular internal training around use of systems and RTT rules, and operational sign off of data. The risks to the quality and accuracy of this data are as follows: issues with data entry can lead to reporting inaccuracies, enabling staff to access systems without having untaken training, application of the Trust Access Policy, complex workarounds being in place to compensate for limited validation within our systems and staff capturing data outside of the electronic systems.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit and Assurance Committee, Quality Governance Committee and the People and Culture Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Assurance Framework provides me with evidence that the effectiveness of controls put in place to manage the risks to the organisation achieving its principle objectives have been reviewed. The Assurance Framework will be reviewed in 2019/20 to ensure that it aligns with the strategic objectives of the Trust.

My review is also informed by reports from external inspecting bodies including External Audit and the PLACE (Patient-Led Assessments of the Care Environment) inspections. This is the system for assessing the quality of the patient environment. The action plans developed following the PLACE inspections are reviewed by the Patient and Carer Experience Committee. Our Patient and Public Forum carry out regular assessments across the Trust. These focus on the patient environment. The Forum also regularly carry out audits for example care in the corridor, drinks and mixed sex breaches.

All Committees of Trust Board are chaired by a Non-Executive Director to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. This structure ensures that the performance of the organisation is fully scrutinised. The Committee structure supports the necessary control mechanisms throughout the Trust. The Committees have met regularly throughout the year and each report to the Board following their meetings.

The Audit and Assurance Committee is charged with monitoring the effectiveness of internal control systems on behalf of the Board and continues to do so as part of its work programme.

The role of Internal Audit at the Trust is to provide an independent and objective opinion on the system of control. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of Internal Audit is undertaken in compliance with the NHS Public Sector Internal Audit Standards. The work to be undertaken by Internal Audit is detailed in the annual audit programme. The audit programme includes a risk assessment of the Trust, based on the Trust's assurance framework, an evaluation of other risks identified in the Trust's risk register and through discussion with management. Internal Audit reports the findings of its work to management, and action plans are agreed to address any identified weaknesses.

All internal audit reports are reported to the Audit and Assurance Committee for consideration and further action if required. TME receives the reports for action where appropriate. A follow up process is in place to ensure that agreed actions are implemented. Internal Audit is required to identify any areas at the Audit and Assurance Committee where it is felt that insufficient action is being taken to implement recommendations to address identified risks and weaknesses.

The Head of Internal Audit's overall opinion for 2018/19 is that only limited assurance can be given as weaknesses in the design and/or inconsistent application of controls put the achievement of the Trust's objectives at risk in a number of areas reviewed.

The External Auditors have made a referral to the Secretary of State for Health and Social Care under s30 of the Local Audit and Accountability Act 2014 due to the breach of the statutory duty to break even.

I am supported by the Executive Team, consisting of the Executive Directors. The Divisional Structure ensures that the Trust is clinically led. This structure enables me to ensure that clinical leadership and management arrangements are in place supported by robust and clear governance and accountability processes. Since my appointment in January 2019, I have reviewed the directors' portfolios and clarified responsibilities. I am also appointing a Chief Information Officer who will have overall accountability for information governance and information technology. This post will also be the Senior Information Risk Owner (SIRO). The Chief Operating Officer is now accountable for the estates and facilities function. The change in portfolios means that the Chief Finance Officer can concentrate on Finance and Performance.

NHS Improvement appointed an Improvement Director to support us in turning around our performance. This post has been in place throughout 2018/19.

NHS bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our corporate governance arrangements by drawing upon the best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the Trust and best practice.

Compliance with key national targets and standards

The Trust is committed to delivering all national and contractual targets and standards. On 31 March 2019, the Trust was non-compliant with the following key targets:

- Emergency Access Target
- 18 weeks referral to treatment – incomplete pathways
- Cancer performance (62 days) and
- Diagnostics waiting time.

Conclusion

I consider that we have had four significant issues during the year 2018/19 as detailed below.

ISSUE 1

The Trust has remained in Quality Special Measures. This means that the Trust has enhanced oversight from NHS Improvement. The Trust has agreed to a Statement of Undertakings (May 2019). The following conditions were lifted by the CQC during part of the year:

- Section 31 Condition placed on registration (requirement to report 15 minute triage breaches and Harm Reviews) emergency department, Worcestershire Royal Hospital (imposed 30 March 2015, removed 25 July 2018)
- Section 31 Condition, Radiology, Trust wide (imposed 16 August 2016, removed 11 May 2018)

As a result, the Trust no longer has any conditions on its provider licence.

The Trust continues to implement the Quality Improvement Strategy and progress is presented the Quality Governance Committee and the Quality (QIRG) meetings. The QGC reports to the Board at each meeting in public.

The reports from the visits in January and February 2018 were published on 5 June. This showed an improved overall rating for the 'Well Led Domain' from 'inadequate' to 'requires improvement' and improvements in the paediatric and maternity services.

The CQC undertook an unannounced visit to the two Accident and Emergency Departments on 14 January 2019. The CQC published their findings in two reports on 28 February 2019. It is pleasing to note the CQC identified examples of good practice, treatment and care and these are highlighted in the report. However, the CQC also identified areas for improvement and again these are outlined within the report. Whilst we have not been issued any enforcement actions, we have been issued with the regulatory action regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.

We are required to respond to the CQC within the month outlining the actions we will take to return to compliance. As this was a partial inspection, not all domains were reviewed, no rating has been issued.

No further section 29A notice has been received by the Trust.

The key actions the Trust is taking to expedite exiting quality special measures and financial oversight are as follows:

- Development of Trust Strategy launched week commencing 6 May 2019 with one year goals and improvement priorities agreed at the May board for 2019/20
- Development of Clinical Services Strategy,
- Refresh of the Quality Improvement Strategy going into year 2 of a 3 year strategy with associated support from a bespoke database
- Refresh of the People and Culture Strategy going into year 2 of a 3 year strategy
- Development of additional enabling strategies i.e. Digital, Estates, Medium Term Financial Strategy, Communications and Engagement Strategy
- Operational recovery plans in relation to Urgent and Emergency Care, RTT, Cancer,
- Completion of the Acute Service Reconfiguration across Trust sites, aligning resources to demand and achieving optimum efficiency and productivity
- Building capacity and capability within the Executive Management Team and senior and middle managers within the Trust.
- Package of tailored support from regulators
- Implementing a single approach to quality improvement

ISSUE 2

The Trust ended financial year 2018/19 with a deficit significantly above the level originally planned. The adverse position is driven largely by inability to achieve targeted patient care income, the non-delivery of the planned CIP, the provision of additional capacity and workforce pressures. A focussed piece of work was undertaken by the external auditors in January 2019 due to the deteriorating financial position as part of their Value for Money Conclusion work. Eight issues were identified which the Trust has acted upon and are being monitored at Committee level.

The eight issues are:

- Trust Board approval of a financial plan that is deliverable based on the information available at the time of approval.
- Ensuring cost improvement plans are achievable.
- Start point budgets should be fully allocated to budget holders, including cost improvement requirements.
- Financial monitoring and reporting should have a clear and consistent focus on the "drivers of the deficit".
- The Board should approve a medium term financial strategy that has realistic and achievable financial targets for the next three years and update annually.
- Financial turnaround should be an integrated part of the Trust financial management.
- The Board needs to ensure that there is adequate capacity and capability to deliver the changes needed to improve financial performance.
- Finance and performance committee need to ensure they have clear understanding of the key risks to financial delivery and the impact of mitigating actions and that issues of concern are clearly reported to the Board.

We continue to focus on recruitment and retention and the People and Culture Committee received monthly reports in relation to the progress of the People and Culture Strategy.

ISSUE 3

The Trust continues to have significant challenges in delivering key national standards. These include the 4 hour Emergency Access Target, 18 weeks referral to treatment – incomplete pathways, 62 day cancer performance standard and the 6 week wait diagnostics standard. There were no patients who were waiting over 52 weeks for an appointment as at 31 March 2019. In 2018/19 there were 6 reported breaches where patients were waiting longer than 52 weeks to receive their first definitive treatment on the RTT pathway, compared to 282 breaches in 2017/18 – however this will include patients who have been reported as breaches in consecutive months – not individual patients. There have been no incomplete breaches of patients waiting 52+ weeks reported since June 2018.

The Trust Board received the System Resilience Winter Plan at its meeting in November 2018. Work is continuing to ensure the right capacity in the right area and the Trust continues dialogue with external partners such as social services, commissioners to agree as much support as possible around packages of care around the County. We opened an extra 90 beds across Worcestershire Royal Hospital and the Alexandra Hospital during January to March 2019. Despite this, we still have a significant difficulty in ensuring that patients do not wait in the emergency department corridor or in ambulances at times of high demand. We are committed ensuring that patients wait in appropriate areas. We have developed an urgent care plan which was presented to the board in May 2019.

We have continued to develop our frailty unit at the Alexandra Hospital and we have moved the surgery for people with a fractured neck of femur to the Alexandra Hospital to free up beds at the Worcestershire Royal Hospital.

We are committed to develop our clinical services strategy in 2019/20 which will give direction to the clinical services on all our sites.

ISSUE 4

We have had significant challenges with infection prevention and control. In July 2018, the Trust was escalated to red by NHS Improvement, and then de-escalated to amber. In October 2018 the Trust was re-escalated to red, and we continue to be red rated. An action plan was implemented to address the issues identified including hand hygiene and cleanliness, and work with the PFI provider and contractors. We have not met our national objectives on *Clostridium difficile* infection, *E coli* bacteraemia and MSSA bacteraemia for 2018/19.

We have implemented *Back to the Floor Friday* led by our Chief Nursing Officer, to ensure highly visible senior nursing leadership across our wards and departments and to support clinical staff achieve high standards of care. We have also put into place a programme of quality and safety walkabouts by senior leaders and the Executive Team. There has been a change of leadership within the Infection Prevention and Control Team with a Deputy Director of Infection Prevention and Control joining us in January 2019 to strengthen leadership arrangements. Since then, we have launched our comprehensive *Key Standards to Prevent Infection* and have strengthened our monitoring of cleanliness standards. We continue to focus on improving cleanliness including reviewing ourselves against national standards, improving hand hygiene, and the care of patients with invasive devices.

Matthew Hopkins
Chief Executive

Date: 22 May 2019

Statement of the Chief Executive's responsibilities as the Trust's accountable officer

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

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

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

Matthew Hopkins
Chief Executive

Date: 22 May 2019

Statement of directors' responsibilities in respect of the accounts

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

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

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

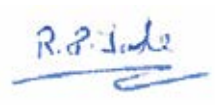
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

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

By order of the Board.

Matthew Hopkins
Chief Executive

Date: 22 May 2019



Robert D Tool
Chief Finance Officer (Interim)

Date: 22 May 2019

Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2018/19 have been completed and this certificate accompanies them.

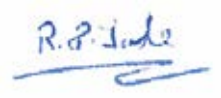
Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:

   - the financial records maintained by the NHS Trust
   - accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
   - the template accounting policies for NHS Trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.

2. I certify that the TAC schedules are internally consistent and that there is one validation error relating to PDC dividend cash payments which cannot be corrected.

3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.statements of the NHS Trust.



Robert D Tool
Chief Finance Officer (Interim)

Date: 22 May 2019

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Trust is required to submit to NHS Improvement.

2. I have reviewed the schedules and agree the statements made by the Chief Finance Officer (Interim) opposite.

Matthew Hopkins
Chief Executive

Date: 22 May 2019

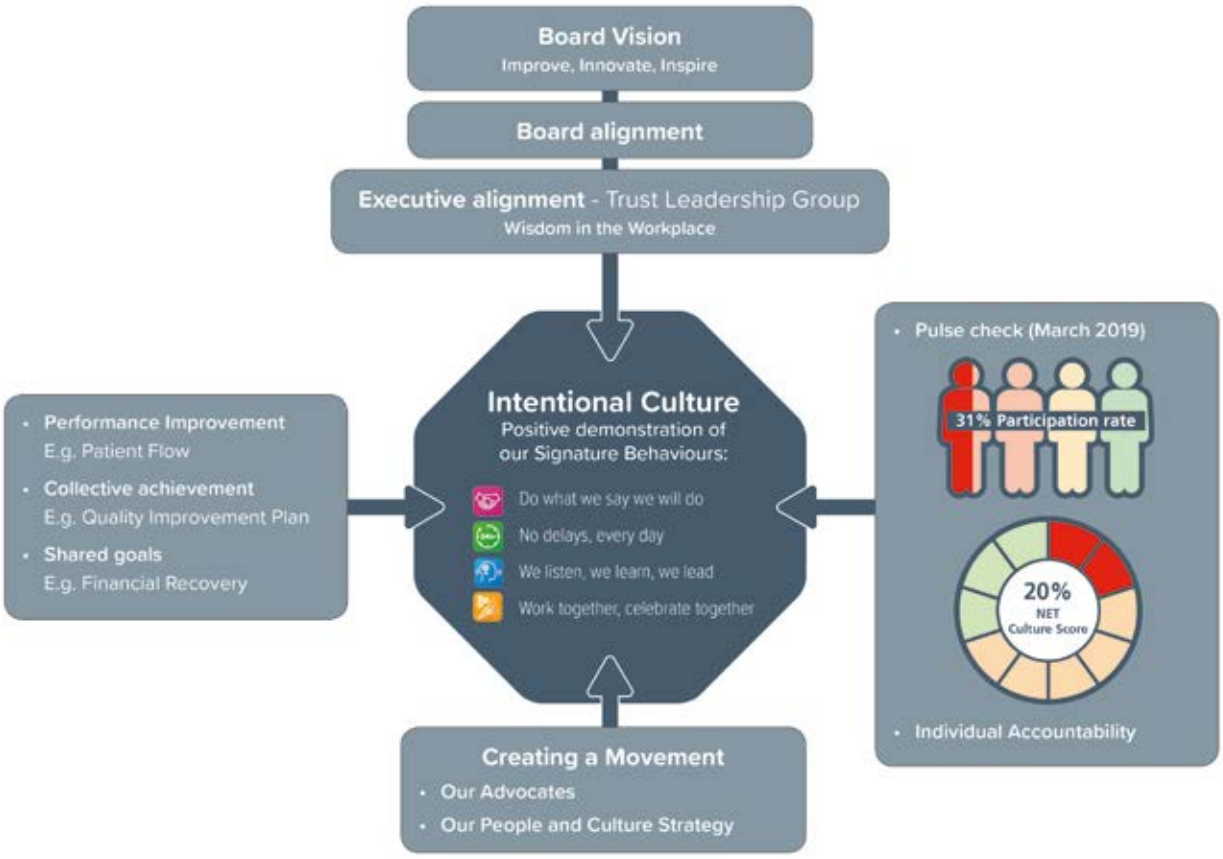
Staff Report - Creating a Great Place to Work

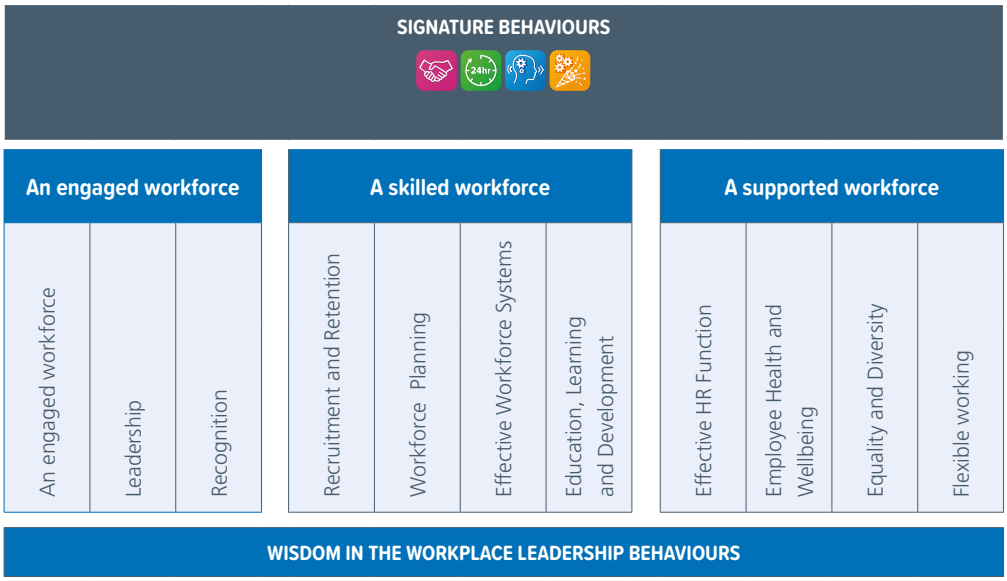
The Trust's *People and Culture* strategy was agreed by the Trust Board in November 2017. Its purpose is to ensure the Trust's workforce is safely configured and empowered to provide high quality care. It undertakes to assure the board that the workforce is engaged, skilled and supported, working in a culture shaped by our 4 signature behaviours. The breadth of the strategy's implementation plan is shown right. Work is in progress to deliver all 11 elements of the strategy

In May 2018, the Trust undertook a baseline review of our workforce and identified priority areas to maximise efficiency. A workforce transformation programme was established with the first phase being the implementation of an end to end job planning, e-rostering, leave, management and bank and agency solution for all staff groups. Implementation of these enablers commenced in the last quarter of 2018/19.

The 4ward Programme

The 4ward programme has been designed to achieve an intentional culture of collective achievement through the positive demonstration of the Trust's 4 signature behaviours. The diagram below details the current structure of the programme:





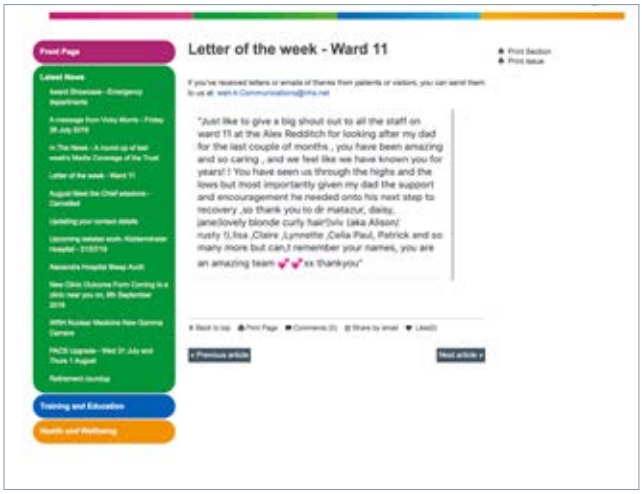
Staff Engagement

All staff have access to information through a number of different communication channels. Our Chief Executive provides a weekly email update to all staff, and weekly staff e-bulletin; 'Worcestershire Weekly' shares key information about Trust initiatives and news. We also publish comprehensive news updates, policies and other information of relevance and interest to staff on the Trust intranet.

There are a number of other Trust gatherings, such as our Senior Leadership Group which act as an opportunity for leaders to be consulted on policy and performance issues.

We work in partnership with Staff Side colleagues through the formal Joint Negotiation and Consultative Committee, which meets monthly. In addition, we encourage participation from Staff

Side representatives, and staff at all levels from across the Trust, to take a role within our People and Culture Committee Group including, 4ward Culture Change Group.



Freedom to Speak Up Themes

The following table provides an overview of the concerns raised through the Freedom to Speak up Guardian in 2018. From the table it can be seen that 57% of the cases relate to poor attitudes and behaviours followed by the inconsistent application of policies, procedures and processes at 28%.

This would suggest that colleagues are choosing to raise behavioural concerns through the Guardian rather than directly with their line manager or by tackling the behaviours themselves.

Summary of concerns raised to the Freedom to Speak Up Guardian in 2018:

Our Freedom to Speak Up Guardian, Bryan McGinty (pictured above), has the role of supporting and encouraging colleagues to 'speak up' if they have concerns about safety, quality and issues that have Trustwide impact and may jeopardise patient or staff safety.

FTSU Cases	Attitudes & Behaviours	Staffing Levels	Policies, Procedures and Processes	Quality & Safety	Patient Experience	Performance Capability	Total Cases
Total	38	2	19	1	4	3	67

Our Workforce

Our staff have been commended by the CQC for the care that they provide to service users, and the Board is proud of the commitment and contribution of every member of staff.

The Trust launched its Recruitment and Retention Plan in February 2018. The recruitment and retention of our staff remains a key priority and focus has been given to the challenging areas this year, of doctors and nurses. Significant reductions in vacancy numbers and staff turnover have been achieved in both staff groups following various campaigns which have included showcasing the Trust as an employer of choice through social media campaigns, targeted local recruitment within specialist areas, open days and an overseas recruitment project for doctors.

However, there are a number of service changes that have taken place this year that have increased our workforce by 116.81 fte due to recruitment to vacancies and opening of additional wards to respond to capacity and flow issues.

Snapshot of key workforce indicators:

	2014/15	2015/16	2016/17	2017/18	2018/19
Cumulative Sickness Absence Rate	4.09%	4.35%	4.27%	4.17%	4.20%
Actual staff in post full-time equivalent (FTE)	5079.14	5083	5106.18	5,199.57	5,316.38
Headcount staff in post	5959	5935	5951	6055	6207
Mandatory Training Compliance	78%	76%	89%	89%	84%**
Appraisal Completion %	78%	80%	76%	65%	77%
Staff Turnover	10.42%	12.97%	12.57%	11.04%	12.30%

*** Drop in compliance in 2018/19 is due to breaking mandatory training down into levels rather than reporting at base level. In real terms our annual training activity has increased from 36,719 to 60,658 individual training activities due to the breakdown of the 11 mandatory topics to 33 different levels.*

Sickness Absence

In the last year the cumulative absence rate has deteriorated slightly by 0.03% to 4.20%. We monitor our sickness rates against the national and peer median via the Model Hospital. Our sickness was better than the national average on Model Hospital in October 2018 which is the most up to date comparison data. Our sickness was 4.20% on Model Hospital compared to national average of 4.27% which demonstrates that we are not an outlier:

Staff Sickness	2016-2017	2017-2018	2018-2019
Total FTE Days lost	80,277	76,071	80,266
Total staff (headcount)	5,591	6,055	6,207
Average number of working days lost	13.48	12.56	12.93

Staff Turnover

We have been closely monitoring overall Trust turnover since it started steadily increasing in July 2015 peaking at 13.03% in November 2016. Our overall staff turnover has been reducing since July 2015 to 11.04% in March 2018 which is within Trust target of 10-12%. Turnover has increased at end of March 2019 to 12.30% although this is now showing a downward trend.

Our breakdown of staff by staff group as at 31 March 2019 is as follows:

Workforce profile	FTE			
Staff group	31 March 2016	31 March 2017	31 March 2018	31 March 2019
Additional Prof. Scientific and Technic.	169.96	179.43	174	191.32
Additional Clinical Services	942.48	950.72	977.43	995.04
Administrative and Clerical	913.58	957.75	966.76	995.65
Allied Health Professionals	339.21	332.92	344.64	363.15
Estates and Ancillary	256.12	246.11	259.68	278.94
Healthcare Scientists	175.17	176.75	178.88	178.88
Medical and Dental	590.93	553.15	581.88	606.82
Nursing and Midwifery Registered	1,673.65	1,678.35	1,692.29	1,697.58
Students	19	29	24	9.00
Grand Total	**5,080.09**	**5,104.18**	**5,199.57**	**5,316.38**

Our profile of Senior Managers as at 31 March 2019 was as follows:

Senior Managers Profile as at 31 March 2019					
Staff Category	Band 8	Band 9	Consultant Clinical Leads	Trust Board	Total
Trust Board (Female)				5	5
Trust Board (Male)				10	10
Senior Manager (Female)	62	4	5		71
Senior Manager (Male)	23	1	25		49
Grand Total	**85**	**5**	**30**	**15**	**135**

The Trust has relied on a high percentage of agency workers to address additional capacity due to the opening of winter wards. The breakdown of staff as at 31st March 2019 was as follows:

Substantive/Bank/Agency as at Month 12 (Ledger source)	Funded WTE	Contracted WTE	Vacant WTE	Worked WTE
Agency	3	0	3	328.75
Bank	71.54	0	71.54	402.54
Substantive	5848.54	5372.54	476.30	5265.10
Grand Total	**5923.08**	**5372.24**	**550.84**	**5996.39**

NB. Contracted on Finance ledger differs from ESR Staff in Post due to leavers part month who remain on the finance ledger for budget purposes for the whole month.

From the staff on our payroll as at 31 March 2019 we had the following assignment categories:

Assignment Category	Sum of FTE	Sum of Employee Headcount
Fixed Term Temp	478.49	515
Locum	1.13	2
Permanent	4,836.76	5690
Grand Total	**5,316.38**	**6207**

The total staff costs for 2018/19, excluding remuneration of non-executive directors are:

Staff costs 2018/19	Permanent £000	Other £000	Total £000
Total gross staff costs	236,058	46,269	282,327

The analysis of average WTE employed are below by category:

Average number of employees (WTE basis) 2018/19	Permanent Number	Other Number	Total Number
Medical and dental	597	108	**705**
Ambulance staff	2	-	**2**
Administration and estates	1,011	15	**1,026**
Healthcare assistants and other support staff	1,213	179	**1,392**
Nursing, midwifery and health visiting staff	1,681	243	**1,924**
Nursing, midwifery and health visiting learners	15	-	**15**
Scientific, therapeutic and technical staff	544	18	**562**
Healthcare science staff	178	3	**181**
Total average numbers	**5,241**	**566**	**5,807**

Health and Wellbeing

Our Occupational Health and Wellbeing service promotes and helps improve the health and wellbeing of people in work – both within our Trust and for external public and private sector organisations.

The service offers independent advice both to managers and employees, which includes staff counselling, physiotherapy, return to work guidance, advice on the working environment; and assessment of health risks associated with the workplace. In addition, the team offer a range of services including a 'Self Care Programme' to help staff to make lifestyle changes and improve their health and wellbeing, and a Stress Awareness course for Managers and vaccination and surveillance programmes such as winter flu campaign to keep our staff and patients safe.

Occupational Health record the reasons (from the staff member's perspective) of what is contributing to their work related stress. Of the 79 cases recorded, 7 (9%) of the reasons relate to poor behaviours by manager or colleagues, 23 (29%) relate to feeling unsupported by their line manager and 31 (39%) are due to workload pressures.

Staff Appraisals

The Trust believes appraisals are vital in valuing staff and all staff should have an appraisal every year. The Trusts appraisal rate for non-medical staff as at 31 March 2019 improved to 77% from 65% last year. However this is still far short of our target against a Model Hospital average of 83%. Appraisal will be linked to pay progression for new managers and staff from 2019 and for all staff from 2021 which will be a key driver in improving our appraisal rates.

Electronic Staff Record – Self Service

The Trust rolled out ESR Employee Self Service in October 2017. This enables all staff to view the information that is recorded about them on the payroll system and to update their own personal information. It also enables them to view their training compliance via a Competency Matrix which is RAG rated and sends them reminders four months before their training is due to expire. This has been a key tool in improving our training compliance. It has also enabled us to assign different levels of eligibility to staff. In real terms our annual training activity has increased from

36,719 to 60,658 individual training activities due to the breakdown of the 11 mandatory topics to 33 different levels.

Employee Policies

We have a programme for reviewing and consulting on changes to staff policies prior to approval at the JNCC. All agreed policies and any other information for staff are subject to an Equalities Impact Assessment and are available through email, Worcestershire Weekly and on the intranet. We regularly monitor our workforce KPIs at JNCC, People and Culture Committee Group and Trust Board.

Equality and Diversity

Our commitment to Equality and Diversity is stated in all relevant policies including our Recruitment and Selection Policy, Dignity at Work Policy, Equality, Diversity and Inclusion Policy and Freedom to Speak Up Policy which are available to all staff on the intranet. The Trust is committed to providing fair opportunities and treatment for all applicants and employees which respects diversity and dignity.

We offer guaranteed interviews to all applicants who declare themselves as disabled and meet the minimum criteria. We also offer proactive return to work plans and redeployment opportunities or reasonable adjustments, for staff who develop health problems or disabilities during their career.

The Trust Board aims to ensure that all staff are aware that any form of discrimination against people because of their gender, marital status, race, age, sexual orientation, religion, disability, part-time or fixed-term working, or any other unfair reason, is prohibited. Equality and Diversity Training is part of induction and mandatory training and all staff are required to complete a national e-learning programme at least once every 3 years.

We have published our Workforce Race Equality Scheme (WRES) data on the national portal and on our intranet and website.

As at 31st March 23019 the ethnic breakdown of our staff was as follows:

Headcount by Ethnicity as at 31 March 2019			
Ethnicity	**Female**	**Male**	**Total**
Asian or Asian British	370	212	582
Black or Black British	77	31	108
Mixed Race	39	25	64
Not Stated / Undisclosed	35	7	42
Other	73	39	112
White	4508	791	5299
Grand Total	**5102**	**1105**	**6207**

Gender Pay Gap

In accordance with the Equality Act 2010 (Gender Pay Gap Information Regulations 2017), the Trust has undertaken a gender pay gap review for 31 March 2017 and 31st March 2018. The results have been uploaded into the designated government portal and on the Trust's website.

As at 31st March 2018, the Trust had 6055 employees of which 4997 (82.53%) were female and 1058 (17.47%) were male. It is noted that in including all staff, this information is skewed by the numbers of male employees in senior medical posts and particularly bank/agency doctor posts. 69.62% of our consultant workforce are male. When we remove all doctors (including agency/ bank doctors) from the calculation the gender pay gap shows that females are in a more favorable position than males by 1.51%.

Average Mean Hourly Rates as at 31 March 2018	
Gender	**Average Hourly Rate**
Male	£22.9622
Female	£15.2254
Difference	£7.7368
Pay Gap %	**33.6935%**

The Trust's average hourly rate of pay is £22.96 for males and £15.23 for females. The gap has therefore shortened since the last Gender Pay Gap report from £8.13 to £7.73 (33.69%).

Remuneration Report

This report sets out the salaries, allowances and pension entitlements of the Chief Executive and Executive Directors (Senior Managers) of the Trust. In addition the remuneration and expenses of the Chairman and Non-Executive Directors are included. For the purpose of this report we provide details of the remuneration and staff that users of the accounts see as key to accountability.

Role of the Remuneration Committee

The Committee establishes pay ranges, progression and pay uplifts for the Chief Executive, Executive Directors and other Senior Manager posts including their terms of employment.

Membership of the Remuneration Committee
The membership of the Trust's Remuneration Committee comprises of two Non-Executive Directors, plus the Chairman and Chief Executive (except when the matter under discussion relates to the Chief Executive).

- Chairman Sir David Nicholson commenced from 14 May 2018 until the present date.
- C Merrick, Chairman from 1st April 2018 until 30th April 2018.

Non-Executive Directors:

- Mr Mark Yates (Acting Chairman from 1 May 2018 until 13 May 2018)
- Mr Stephen Williams

Chief Executive Michelle McKay ceased employment at the Trust on 14 December 2018; Paul Brennan was acting Chief Executive from 15 December 2018 until 13 January 2019. Matthew Hopkins commenced from 14 January 2019.

Senior Manager's Remuneration Policy

Seniors Manager's Remuneration is determined by the Remuneration Committee with reference to national guidance, pay awards made to other staff groups through national awards and by obtaining intelligence from independent specialists in pay and labour market research. In line with NHS Improvement requirements the Committee also undertakes a review of executive director performance each year which includes benchmarking pay against comparative roles within the NHS.

All Executive Directors are on permanent contracts with the exception of the Interim Chief Finance Officer who is covering the role on a fixed term basis. Notice and termination payments are made in accordance with NHS Improvement guidance and contracts of employment.

New Executive Directors were appointed this year: Matthew Hopkins (Chief Executive); Paul Brennan (Chief Operating Officer); and Robert D Toole (Chief Finance Officer Interim). The Chief Finance Officer (Ms J Robinson) resigned as Chief Finance Officer on the 31st March 2019.

The following disclosures in respect of Executive remuneration are made in accordance with the Department of Health and Social Care (DHSC) Group Accounting Manual.

		2018/19										2017/18									
		Salary and fees			All taxable benefits	All pension-related benefits			Total			Salary and fees			Benefits	All pension-related benefits			Total		
		£000s (in bands of £5k)			£s (nearest £100)	£000s (in bands of £2.5k)			£000s (bands of £5k)			£000s (in bands of £5k)			£s (nearest £100)	£000s (in bands of £2.5k)			£000s (bands of £5k)		
Job title (and period of office if relevant)																					
Caragh Merrick	Chairman to 30.04.18	0	-	5	0	-	-	-	0	-	5	40	-	45	0	-	-	-	40	-	45
David Nicholson	Chairman from 14.05.18	35	-	40	0	-	-	-	35	-	40	5	-	10	0	-	-	-	5	-	10
Michelle McKay	Chief Executive to 14.12.18	140	-	145	0	-	-	-	140	-	145	200	-	205	0	45.0	-	47.5	245	-	250
Matthew Hopkins	Chief Executive from 14.01.19	40	-	45	0	-	-	-	40	-	45	-	-	-	-	-	-	-	-	-	-
Paul Brennan	Chief Operating Officer from 01.10.18. Acting Chief Executive 15.12.18 to 13.01.19	75	-	80	0	0	-	0	75	-	80	-	-	-	-	-	-	-	-	-	-
Inese Robotham	Interim Chief Operating Officer to 18.11.18	75	-	80	200	62.5	-	65.0	135	-	140	75	-	80	0	117.5	-	120.0	190	-	195
Jill Robinson	Chief Finance Officer to 31.03.19	140	-	145	200	22.5	-	25.0	160	-	165	140	-	145	0	82.5	-	85.0	220	-	225
Robert D Toole	Chief Finance Officer from 11.3.19	5	-	10	0	0	-	0	-	-	-	-	-	-	-	-	-	-	-	-	
Vicky Morris	Chief Nursing Officer	125	-	130	0	0	-	0	120	-	125	120	-	125	0	152.5	-	155.0	275	-	280
Suneil Kapadia	Chief Medical Director	185	-	190	0	0	-	0	185	-	190	160	-	165	0	0.0	-	2.5	160	-	165
Tina Pitt (Ricketts)	Director of People and Culture	110	-	115	100	60.0	-	62.5	170	-	175	45	-	50	0	0.0	-	2.5	45	-	50
Sarah Smith	Director of Planning and Development	95	-	100	0	115.0	-	117.5	210	-	215	95	-	100	0	25.0	-	27.5	120	-	125
Richard Haynes	Director of Communications	95	-	100	100	65.0	-	67.5	160	-	165	50	-	55	0	247.5	-	250.0	300	-	305

NOTES

- All taxable benefits relate to cars and the benefits in kind are based on the HMRC guidance.
- Mr Robert D Toole commenced in the role of Chief Finance Officer (Interim) on 11 March 2019 and therefore there are no pension details from the Greenbury statement for 31 March 2019.
- M McKay opted out of the NHS pension scheme in 2018/19. Pension related benefits have been calculated in line with the 2018/19 Group Accounting Manual 2018/19.
- There are no performance pay, long-term performance pay or bonuses for the directors in either 2017/18 or 2018/19.
- **Chair** - Ms C. Merrick resigned on 30th April 2018. Mr M. Yates was acting Chairman from 1st May 2018 until 13th May 2018. Sir D. Nicholson was appointed from 14th May 2018.
- **Chief Executive** - Mrs M. McKay resigned as the Chief Executive on 14th December 2018; Mr P. Brennan was acting Chief Executive from 15th December 2018 until 13th January 2019. Mr M. Hopkins was appointed as the Chief Executive from 14th January 2019.
- **Chief Finance Officer** - Ms J. Robinson resigned as the Chief Finance Officer on the 31st March 2019. Mr R. D Toole commenced 11th March 2019 as the interim Chief Finance Officer.
- **Chief Operating Officer** - Ms I. Robotham resigned as the Interim Chief Operating Officer on the 18th November 2018. Mr P. Brennan commenced as Chief Operating Officer from 1st October 2018.
- **Chief Nursing Officer** - Ms V. Morris remains as the Chief Nursing Officer.
- **Chief Medical Officer** - Dr S. Kapadia remains as the Chief Medical Officer.

Non-Executive Directors

The following disclosures in respect of Non- Executive remuneration are made in accordance with the DHSC Group Accounting Manual.

		2018/19										2017/18									
		Salary and fees			All taxable benefits	All pension-related benefits			Total			Salary and fees			Benefits	All pension-related benefits			Total		
		£000s (in bands of £5k)			£s (nearest £100)	£000s (in bands of £2.5k)			£000s (bands of £5k)			£000s (in bands of £5k)			£s (nearest £100)	£000s (in bands of £2.5k)			£000s (bands of £5k)		
Job title (and period of office if relevant)																					
Mark Yates	Non Executive Director. Acting Chairman 01.05.18 to 13.05.18	5	-	10	800	-	-	-	5	-	10	5	-	10	1,400	0.0	-	2.5	5	-	10
William Tunnicliffe	Non Executive Director	5	-	10	0	-	-	-	5	-	10	5	-	10	0	0.0	-	2.5	5	-	10
Philip Mayhew	Non Executive Director to 31.12.18	0	-	5	300	-	-	-	0	-	5	5	-	10	1,100	0.0	-	2.5	5	-	10
Chris Swan	Non Executive Director to 30.04.18	0	-	5	200	-	-	-	0	-	5	5	-	10	900	0.0	-	2.5	5	-	10
Steven Williams	Non Executive Director	5	-	10	700	-	-	-	5	-	10	5	-	10	700	0.0	-	2.5	5	-	10
Richard Oosterom	Non Executive Director	5	-	10	0	-	-	-	5	-	10	5	-	10	0	0.0	-	2.5	5	-	10
Anita Day	Non Executive Director from 01.08.18	0	-	5	1,000	-	-	-	0	-	5	-	-	-	-	-	-	-	-	-	-
Julie Moore	Non Executive Director from 01.11.18	0	-	5	0	-	-	-	0	-	5	-	-	-	-	-	-	-	-	-	-
Colin Horwarth	Non Executive Director from 01.02.19	0	-	5	0	-	-	-	0	-	5	-	-	-	-	-	-	-	-	-	-

Pension Benefits

Pension related benefits represent the benefit in year from participating in the NHS Pension Scheme, including any previous posts held in the Trust prior to becoming a Very Senior Manager (Board Member). The amount is calculated by taking the full pension due to the Director upon retirement if they were to retire at 31 March 2019 and deducting the equivalent value from the amount due at 31 March 2018.

This includes lump sum and annual pension entitlement and uses a factor of 20 for grossing up purposes in accordance with the HMRC method (derived from section 229 of the Finance Act 2004). Where no figures are calculated for 2018/19 the Director was either not a Director at the beginning of the year or is not a member of the NHS Pension Scheme.

Salary and Pension Entitlements of Senior Managers – Pension Benefits

	Increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension age at pension age at 31 March 2019	Lump sum at pension age related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 01 April 2018	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)		£000	£000	£000	£000
Michelle McKay	0-2.5	0-2.5	0-5	0-5	48	0	48	12,268
Jill Robinson	0-2.5	0-2.5	20-25	0-5	316	365	316	20,132
Inese Robotham	2.5-5	2.5-5	25-30	60-65	371	499	371	11,361
Victoria Morris	0-2.5	0-2.5	45-50	135-140	875	961	875	17,975
Tina Pitt (Ricketts)	2.5-5	5-7.5	25-30	55-60	368	464	368	15,818
Sarah Smith	5-7.5	2.5-5	40-45	105-110	750	940	750	14,373
Richard Haynes	2.5-5	5-7.5	15-20	35-40	214	278	214	13,798
Paul Brennan	0-2.5	0-0	75-80	230-235	1,802	1,802	1,693	11,345

Notes

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 as a particular point in time. The CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension 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.The Real increase in CETV takes into account the increase in accrued pension due to inflation, contributions paid by the employee.

Trust employees are covered by the provisions of the NHS Pension Scheme which is a defined contribution scheme and provides pensions related to final salary. No payments are made to any other pension scheme on behalf of Executive Directors.

The table above details the current pension benefits of the Trust's senior managers. As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of Non Executives. Where the Executive Director in post at 31 March 2019 is not a member of the NHS Pension Scheme, there are no pension benefits to be disclosed.

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 NHS Pension Scheme, not just their service in a senior capacity to which the 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.

The Real Increase in CETV does not include the effects of inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Exit Packages

The figures disclosed below relate to exit packages agreed in the year. The actual date of departure might be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost and expenditure notes in the accounts.

A single Exit Package can be made up of several components, each of which is counted separately in this note. No non-contractual payments were made to employees where the payment value was more than 12 months' of their annual salary. The Remuneration Report includes disclosure of exit payments made to individuals named in that report.

Exit Package Cost Band (including any special payment element)	Number of Compulsory Redundancies	Cost of Compulsory Redundancies £	Number of Other Departures Agreed	Cost of Other Departures Agreed £	Total Number of Exit Packages	Total Cost of Exit Packages £	Departures Where Special Payments Have Been Made	Payment Element included in Exit Packages £
Less than £10,000			3	14,756				
£10,000 to £25,000			2	21,328				
£25,001 to £50,000			1	35,000				
£50,001 to £100,000								
£100,001 to £150,000								
£150,001 to £200,000								
> £200,000								

Exit Package - disclosures (excluding compulsory redundancies)	Number of Exit Package Agreements	Total Value of Agreements £
Voluntary Redundancies including Early Retirement Contractual Costs		
Mutually Agreed Resignations (MARS) Contractual Costs		
Early Retirements in the Efficiency of the Service Contractual Costs		
Contractual Payments in Lieu of Notice	6	71,084
Exit Payments Following Employment Tribunals or Court Orders		
Non-Contractual Payments Requiring HM Treasury Approval		

Off Payroll Engagements

When a vacancy or project post is to be filled, the Trust considers if an off-payroll Business Case Approval needs to be completed and submitted to NHS Improvement to gain their approval before the worker is engaged. With the changes to IR35 rules in April 2017 the Trust established a review process for any off payroll posts as per the HMRC guidance. The Trust was audited in 2017 by CW Audit around its IR35 processes and received "full assurance".

When an engagement is agreed whereby the worker is not directly employed by the Trust, then the relevant checks are made to assess against the IR35 rules using HMRC guidance and the online assessment tool.

During 2018/19, NHS Improvement approved a business cases for a one off-payroll engagement to provide support to the Financial Recovery Programme. This engagement was for a Turnaround Director as an additional experienced, senior financial recovery expertise was necessary to mitigate the risk of a deteriorating financial position and to develop the medium term recovery plan as well as to drive the challenging Recovery programme.

Off-payroll engagements longer than 6 months: For all payroll engagements as at 31 March 2019, for more than £245 per day and that last longer than six months.	Number of engagements
Number of existing engagements as at 31 March 2019	2
Number that have existed for less than one year at a time of reporting	0
Number that have existed for between one and two years at a time of reporting	1
Number that have existed for between two and three years at a time of reporting	0
Number that have existed for between three and four years at a time of reporting	1
Number that have existed for between four and five years at a time of reporting	0

New off-payroll engagements: All new payroll engagements, or those that have reached six months in duration, between 1 April 2018 and March 2019, for more than £245 per day and that last for longer than six months.	Number of engagements
Number of new engagements, or those that reached six months duration between 1 April 2018 and 31 March 2019	1
Of which:	
▶ Number assessed as within the scope of IR35	
▶ Number assessed as not within the scope of IR35	1
▶ Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	
▶ Number of engagements reassessed for consistency/assurance purposes during the year	
▶ Number of engagements that saw a change to IR35 status following the consistency review	

Off-payroll engagements of board members, and/or senior officials with significant financial responsibility between 1 April 2018 and 31 March 2019	Number of Engagements
Number of off –payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and /or senior official's with significant financial responsibility' during the financial year, including both off-payroll and on-payroll engagements	22

Fair Pay Disclosure

The Trust is required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the workforce.

The banded remuneration of the highest paid Director at Worcestershire Acute Hospitals NHS Trust in the financial year 2018/19 was between £185-£190k. This was 7.7 times the median remuneration of the workforce, which was £28050.

In 2017/18 the banded remuneration highest paid Director was £200-£205k which was 7.9 times the median remuneration of £25,800. There has been a change to the most highly paid Director due to a new appointment in 2018/19.

Calculations are based on the full time equivalent of all staff in post at 31 March and salaries have been annualised. Total remuneration of the highest paid director includes salary and benefits in kind. It does not include employer pension contributions or the cash equivalent transfer value of pensions and also excludes any severance payments.

During the year 6 employees received remuneration in excess of the highest paid director. In 2017/18 5 employees received remuneration in excess of the highest paid director.

Remuneration ranged from £4,100 and £237,300 for 2018/19. The range of remuneration for 2017/18 was between £15,700 and £274,700.

Notice of the Trust's Annual General Meeting

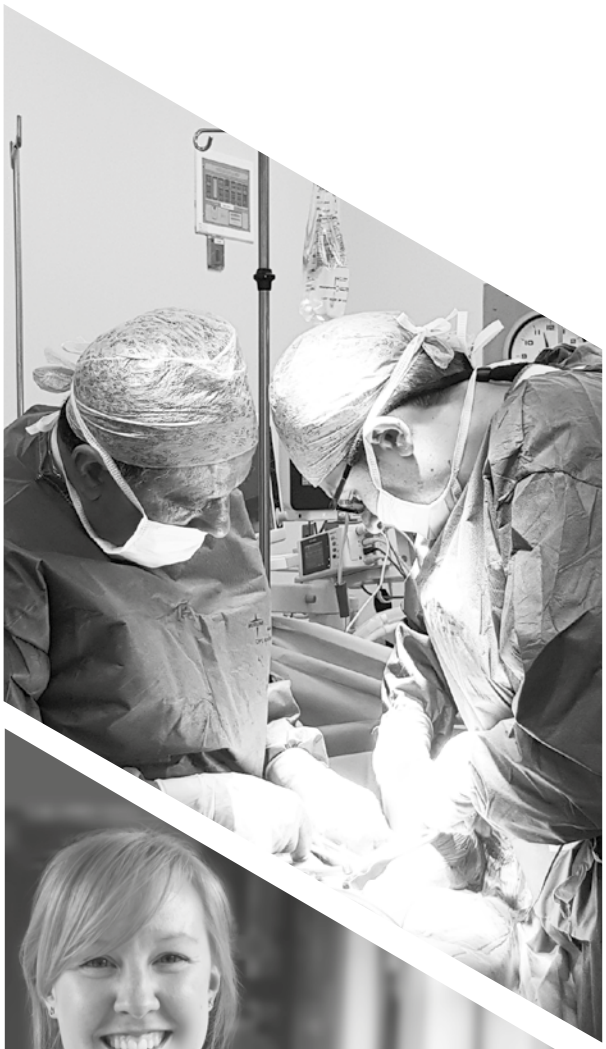
The Annual General Meeting of Worcestershire Acute Hospitals NHS Trust will be held on **Thursday, September 19, 2019 at 2pm** at the Charles Hastings Education Centre, Worcestershire Royal Hospital, Charles Hastings Way, Worcester, WR5 1DD.

Further information can be obtained by writing to:

Mrs Kimara Sharpe
Company Secretary
Worcestershire Acute Hospitals NHS Trust
Charles Hastings Way
Newtown Road
Worcester
WR5 1DD

Alternatively further information can be obtained from our website www.worcsacute.nhs.uk

Please note: The hyperlinks within the Annual Report and Accounts are not subject to audit.



www.worcsacute.nhs.uk

WorcsAcuteNHS

WorcestershireAcute

Published: July 2019

Worcestershire Acute Hospitals NHS Trust

Annual Accounts for the year ended 31 March 2019

Statement of Comprehensive Income	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3.1	381,078	369,226
Other operating income	4	30,888	31,692
Operating expenses	7.1	(472,151)	(437,734)
Operating surplus/(deficit) from continuing operations		**(60,185)**	**(36,816)**
Finance income	12	134	48
Finance expenses	12.1	(15,693)	(14,056)
PDC dividends payable	23	-	(18)
Net finance costs		**(15,559)**	**(14,026)**
Other gains / (losses)	13	40	(124)
Surplus / (deficit) for the year		**(75,704)**	**(50,966)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	13,694	8,055
Revaluations	15.1	7,109	2,989
Total comprehensive income / (expense) for the period		**(54,901)**	**(39,922)**
Optional for NHS Trusts			
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(75,704)	(50,966)
Remove net impairments not scoring to the Departmental expenditure limit		6,828	(1,717)
Remove I&E impact of capital grants and donations		86	121
Remove 2016/17 post audit STF reallocation (2017/18 only)		-	(419)
Adjusted financial performance surplus / (deficit)		**(68,790)**	**(52,981)**

The Trust deficit of £(75.704)m does not include the exceptional item of £(6.828)m for asset impairments and transfers, which along with the donated asset impact of £86k, does not count against the NHSI Control Total. These items are due to the Trust requirement to report its assets at the current fair value over the appropriate life of the asset. This is a non cash technical adjustment. The adjusted financial deficit is £(68.790)m after these adjustments.

Financial Position - Income & Expenditure	Actual 2018/19 £000's
Operational Financial performance [Control Total] surplus/(deficit) excluding PSF & Impairments	**(73,712)**
Less provider sustainability fund (PSF)	4,922
Performance against Control Total adjusted to include PSF	**(68,790)**
Adjustment Removal of capital donations/grants	(86)
Adjustment for I&E impairments(reversals)	(6,828)
Surplus/(deficit) for the year including PSF and after Impairments	**(75,704)**

Statement of Financial Position	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	2,574	2,708
Property, plant and equipment	15.1	289,447	267,721
Receivables	18.1	2,987	2,725
Total non-current assets		**295,008**	**273,154**
Current assets			
Inventories	17	8,759	10,118
Receivables	18.1	28,927	27,088
Non-current assets held for sale	20	400	400
Cash and cash equivalents	21	2,002	2,107
Total current assets		**40,088**	**39,713**
Current liabilities			
Trade and other payables	23	(35,028)	(37,808)
Borrowings	25	(114,919)	(44,516)
Provisions	27	(784)	(771)
Other liabilities	24	(3,603)	(1,755)
Total current liabilities		**(154,334)**	**(84,850)**
Total assets less current liabilities		**180,762**	**228,017**
Non-current liabilities			
Borrowings	25	(219,384)	(213,089)
Provisions	27	(2,802)	(3,013)
Other liabilities	24	(2,840)	(3,214)
Total non-current liabilities		**(225,026)**	**(219,316)**
Total assets employed		**(44,264)**	**8,701**
Financed by			
Public dividend capital		191,257	187,347
Revaluation reserve		88,746	69,238
Other reserves		(861)	(861)
Income and expenditure reserve		(323,406)	(247,023)
Total taxpayers' equity		**(44,264)**	**8,701**

The notes on pages 7 to 60 form part of these accounts.

The financial statements on pages 2 to 6 were approved by the Board on 22nd May 2019 and signed on its behalf by

Name Matthew Hopkins

Chief Executive

Date **22 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**187,347**	**69,238**	**(861)**	**(247,023)**	**8,701**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	(1,974)	**(1,974)**
Surplus/(deficit) for the year	-	-	-	(75,704)	**(75,704)**
Other transfers between reserves	-	(1,295)	-	1,295	**-**
Impairments	-	13,694	-	-	**13,694**
Revaluations	-	7,109	-	-	**7,109**
Public dividend capital received	3,910	-	-	-	**3,910**
Taxpayers' equity at 31 March 2019	**191,257**	**88,746**	**(861)**	**(323,406)**	**(44,264)**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of Changes in Equity for the year ended 31 March 2018	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**185,017**	**59,107**	**(861)**	**(196,970)**	**46,293**
Surplus/(deficit) for the year	-	-	-	(50,966)	**(50,966)**
Other transfers between reserves	-	(913)	-	913	**-**
Impairments	-	8,055	-	-	**8,055**
Revaluations	-	2,989	-	-	**2,989**
Public dividend capital received	2,330	-	-	-	**2,330**
Taxpayers' equity at 31 March 2018	**187,347**	**69,238**	**(861)**	**(247,023)**	**8,701**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Other reserves

The Other reserve reflects the differences between the value of the fixed assets taken over by the Trust at inception and the corresponding figure in its originating debt.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS Trust.

Statement of Cash Flows	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(60,185)	(36,816)
Non-cash income and expense:			
Depreciation and amortisation	7.1	10,475	10,668
Net impairments	8	6,828	(1,717)
Amortisation of PFI deferred credit		(650)	(1,084)
(Increase) / decrease in receivables and other assets		(708)	(1,221)
(Increase) / decrease in inventories		1,359	(1,591)
Increase / (decrease) in payables and other liabilities		1,154	(2,296)
Increase / (decrease) in provisions		(248)	(135)
Net cash generated from / (used in) operating activities		**(41,975)**	**(34,192)**
Cash flows from investing activities			
Interest received	12	134	48
Purchase of intangible assets		(960)	(359)
Purchase of property, plant, equipment and investment property		(21,161)	(7,774)
Sales of property, plant, equipment and investment property		39	28
Net cash generated from / (used in) investing activities		**(21,948)**	**(8,057)**
Cash flows from financing activities			
Public dividend capital received		3,910	2,330
Movement on loans from the Department of Health and Social Care		77,379	55,442
Capital element of PFI, LIFT and other service concession payments		(2,106)	(1,941)
Interest on loans		(3,183)	(2,267)
Interest paid on PFI, LIFT and other service concession obligations		(12,188)	(11,542)
PDC dividend (paid) / refunded		5	193
Cash flows from (used in) other financing activities		-	91
Net cash generated from / (used in) financing activities		**63,817**	**42,306**
Increase / (decrease) in cash and cash equivalents		**(106)**	**57**
Cash and cash equivalents at 1 April - brought forward		**2,107**	**2,050**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**2,107**	**2,050**
Cash and cash equivalents at start of period for new FTs		**-**	**-**
Unrealised gains / (losses) on foreign exchange		1	-
Cash and cash equivalents at 31 March	20	**2,002**	**2,107**

Notes to the Accounts

1. Accounting policies and other information

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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 Going concern

These accounts have been prepared on a going concern basis.

NHS Trusts are required to prepare their accounts in accordance with the relevant accounting rules, which are set out in the International Accounting Standards (IFRSs) and as interpreted by the DHSC Annual Reporting Manual (GAM).
IFRS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern.

Key considerations in assessing the Trust as a going concern

• The Board has considered the overall financial position of the Trust. This has included the financial position against the control total, the level of support already received, future cash flows, feedback from the ongoing engagement of NHS Improvement, the contractual position with commissioners, the 2018/19 CIP programme, financial plans, executive leadership and CQC inspections.

• The Trust incurred a deficit of £(75.704) million during the year ended 31 March 2019 and at that date had net current liabilities of £114.246 million.

• The Trust has taken out a number of revenue loans over recent years (£70.0 million in 2018/19) and will require further loans in 2019/20 to support the planned deficit of £(82.8) million and planned principal repayments.

• Of the existing loans, £38.2 million was due for repayment in 2018/19 relating to revenue loans. A further £2.947m relating to the capital loans was repaid. The schedule of repayments for existing Trust borrowing shows a requirement to repay principal of £107.7 million in 2019/20. The Trust is in discussion with NHS Improvement following guidance that it may be possible to renegotiate an extended repayment period for principal, rather than further increase borrowings.

• As the financial deficit is unlikely to be resolved within one year, ongoing cash support will be required in 2019/20.

• NHS Improvement has not formally confirmed this support to be available, which indicates there is a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. However, to date all requests have been approved and the Board has no reason to assume that this support will cease to be made available to the Trust.

The Board has endorsed the preparation of the accounts on a going concern basis. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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

1.4 Revenue from NHS contracts

Income in respect of services provided is recognised when and to the extent that performance occurs and is measured at the fair value of the consideration receivable.
The main source of income for the Trust is contracts with commissioners for health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.
The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

The Trust contracts have performance clauses which are reviewed with the commissioners. Where these clauses result in a financial penalty, the financial value of the penalty are reflected within its recognition of revenue.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price as per the contract.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The CQUIN payments are considered distinct performance obligations in their own right.

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

Accounting policy for maternity pathway income has changed in the year to bring policies in line with IFRS15. Previously, pathway income was recognised at the point of first appointment as the payment was due regardless of the volume of activity performed thereafter. From 2018/19 the income is recognised over the period of the patient pathway, and a deferred income amount calculated at the year end. This results in a one off opening period adjustment in the SoCIE of (£2m) as the impact of implementing IFRS15. The in year movement as a result of the accounting policy change is less than £10,000.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

1.5 NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.6 Revenue grants and other contributions to expenditure

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

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

1.7 Other income

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

1.8 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period. However, accruals for Consultant's leave, which is calculated from the date of appointment rather than the start of the financial year is accrued on the basis of materiality.

Pension costs

NHS Pension Scheme : Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

Some employees not entitled to join the NHS Pension Scheme are auto-enrolled in the National Employment Savings Trust (NEST) pension scheme. This is a defined contribution scheme.

1.9 Expenditure on other goods and services

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

1.10 Property, plant and equipment

1.10.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control; or
- Items forming 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 e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2 Measurement

Valuation

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

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

HM Treasury currently adopts a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust engaged a professional property adviser to undertake a full revaluation in 2018/19.

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

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

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

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

1.11 Depreciation

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

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

Useful lives of property, plant and equipment

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

	Min life	Max life
	Years	Years
Land	-	-
Buildings, excluding dwellings	17	57
Dwellings	29	37
Plant & machinery	1	20
Transport equipment	4	8
Information technology	3	9
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.12 Revaluation gains and losses

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

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

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

Impairments

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

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

1.13 De-recognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:

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

1.14 Donated and grant funded assets

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

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

1.15 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.
The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.
The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.
The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.
An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

1.16 Intangible assets

1.16.1 Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Software

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

1.16.2 Measurement

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

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

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

Amortisation

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

1.16.3 Useful economic life of intangible assets

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

	Min life	Max life
	Years	Years
Information technology	5	5
Software licences	5	5

1.17 Inventories

Inventories (excluding drugs) are valued at the lower of cost and net realisable value using the first-in-first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.
Drugs inventories are valued using the weighted average cost method.

1.18 Cash and cash equivalents

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

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

1.19 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 27 refers - Provisions for Liabilities and Charges

1.20 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract, in line with HM Treasury's adaptation of IFRS9, to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax.

Financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instruments including the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

- Financial assets are categorises as loans and receivables.
- Financial liabilities are classified as other financial liabilities.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

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

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

1.22 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.

1.22.1 The Trust as lessee

Finance leases

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

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

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

Operating leases

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

Leases of land and buildings

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

1.22.2 The Trust as lessor

Finance leases

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

Operating leases

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

1.23 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.
Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A short term rate of positive 0.76% (2017-18: negative 2.42%) for expected cash flows up to and including 5 years
- A medium term rate of positive 1.14% (2017-18: negative 1.85%) for expected cash flows over 5 years up to and including 10 years
- A long term rate of positive 1.99% (2017-18: negative 1.56%) for expected cash flows over 10 years.

All percentages are in nominal terms, with 2017/18 the last year recorded at real general provision discount rates.

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.

1.24 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 28 but is not recognised in the Trust's accounts.

1.25 Non-clinical risk pooling

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

1.26 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

1.27 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.
Additional PDC may also be issued to Trusts by the DHSC, whereby a charge reflecting the cost of the capital utilised by the Trust is payable to the DHSC as the public dividend capital dividend. PDC is recorded at the value received.
The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the DHSC (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.

1.28 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.

1.29 Corporation tax

Under the Corporation Tax Act 2010, a Health Service body is not liable to corporation tax, section 986.

1.30 Third party assets

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

1.31 Losses and special payments

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

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

1.32 Gifts

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

1.33 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.

1.33.1 PFI

In 2013 the PFI provider was found to be in default of the service agreement due to building defects. A settlement was reached between the Trust and the PFI provider in June 2016. The Deed of Variation included two broad elements, a lump sum compensation payment and alterations to future service charges. The lump sum payment of £7.3m was credited to other operating revenue.

In 2016/17 the Trust recognised the revenue coming from future service price alterations in other operating revenue. The Trust looked at the reduction in future service provider margins that would not have been agreed without the building defects. The contractual value was used as the basis for the calculation allowing both for cost of capital adjustments and future service price increases based on predicted RPI changes. The gain on the alteration to future service charges was recognised in other operating revenues to be consistent with the recognition of the lump sum compensation payment. This gain reduced the PFI liability as the settlement related to the compensation for the building defects.

By adopting this accounting treatment annual Unitary Payments from 2018/19 do not reflect the full value of the service received. The service element of the Unitary Payment is therefore adjusted by an amount equivalent to the full value of the service received and the PFI lability is increased. This adjustment will 'unwind' the 2016/17 revenue recognition over the remaining life of the PFI contract.

1.33.2 LEASES

Under IAS 17 a finance lease is one that transfers to the lessee 'substantially all the risks and rewards incidental to ownership of an asset'. This requires the consideration of a number of factors for each lease. The total outstanding commitment for operating leases at 31st March 2019 is £27.1m, and for finance leases £61.2m.

Within the operating leases, Charles Hastings Education Centre and Kings Court have an outstanding commitment as at the 31st March 2019 at £22.5m

1.33.3 Sources of estimation uncertainty

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

• Valuation of property, plant and equipment (see note 15) is based upon an assessment undertaken by professional property valuers which by its nature includes an element of subjectivity. Property, plant and equipment is depreciated over its useful life taking into account residual values, where appropriate. The actual lives of the assets and residual values are assessed annually and may vary depending on a number of factors. In reassessing asset lives, factors such as technological innovation and maintenance programmes are taken into account. Residual value assessments consider issues such as the remaining life of the asset and projected disposal values;

• The Trust engaged a professional property adviser to undertake a full revaluation in 2018/19. The valuers confirmed the methodology for assessing useful life for depreciation accounting purposes was compliant with the RICS guidance and IAS 16 applicable prior to the revised RICS guidance becoming effective from January 2019.
The valuers consider their methodology was compliant with the relevant standards and guidance. The Trust has adopted a prudent approach and accrued costs for Q4 2018/19 based on the revised asset life valuation.

• IFRS 15 paragraphs 124 to 126 also requires disclosure of estimations in determining transaction price or satisfaction of performance obligations where they are satisfied over time. Accrued income for partially completed spells at the end of the financial year (note 5) is based upon an estimate of income receivable at the completion of an episode of care apportioned between activity completed and activity to be completed in the next financial year;

• Provision for the impairment of receivables (note 18.2) is estimated on a risk based assessment of the likelihood of non payment which by its nature includes an element of subjectivity.

• The Trust received income in 2018/19 for the extension of a land lease with Rooftop Homes Limited. The Trust accounted for the income in 2018/19 as per IAS17; assets which are subject to Operating leases are recognised in the Trusts Statements. The Trust has not recognised a straight line basis of income recognition as the lessee's benefits from the leased asset in 2018/19 and the variable lease payment should be recognised as income in the period it is earned.

1.34 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

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

• IFRS16: on 22nd November 2018 the Financial Reporting Advisory Board decided to defer the implementation of IFRS until the 2020/21 financial year. HM Treasury are expected to issue application guidance where principles on how the standard will be adopted are finalised. The Trust continues its preparatory work for implementing IFRS 16 in 2020/21. Subject to the final guidance, the new standard will potentially have a significant impact on the Trust, where existing leases may need to be reclassified.

2. Operating Segments

The Trust Board is considered to be the chief operating decision maker of the organisation. The Trust Board is of the view that whilst it receives limited financial information broken down by division, the information received does not show the full trading position of that division. Furthermore the activities undertaken by these divisions have a high degree of interdependence and therefore the Trust Board has determined that is appropriate to aggregate these divisions for segmental reporting purposes.

The rationale for determining the chief operating decision maker and for aggregating segments is as follows:

Chief operating decision maker:

International Financial Reporting Standard 8: Operating Segments; states that the chief operating decision maker will have responsibility for allocating resources and assessing the performance of the entity's operating segments.
For the Worcestershire Acute Hospitals NHS Trust, responsibility for these functions is set out in the Trust's Scheme of Reservation and Delegation. This document includes (amongst others) the following key decisions which are reserved to the Trust Board:

- The approval of strategies, plans and budgets;
- The agreement of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust;
- The monitoring and review of financial performance;

Consequently it has been determined that the Trust Board is the Chief operating decision maker.

Operating Segments:
IFRS 8 sets out the criteria for identifying operating segments and for reporting individual or aggregated segmental data. The Trust Board has considered the requirements of IFRS 8 and whilst it does receive budgetary performance information at a specialty group level based upon groups of services (including for example medical specialties, surgical specialties etc.), this information is limited in that:

- Costs associated with any one specialty or service provided by the Trust are split across several specialty groups;
- Cross charging for services between specialty groups is not widely undertaken; and
- Many services provided by the Trust are not operationally independent.

In addition to the above key factors, consideration has also been given to the principles around aggregation of operating segments set out in IFRS 8 which concludes that segments may be aggregated if the segments have similar economic characteristics, and the segments are similar in each of the following respects:

(a) the nature of the products and services:
The services provided are very similar in that they represent the provision of healthcare to ill/vulnerable people. Furthermore many of the services are interconnected with care for an individual being shared across different specialties and departments.

(b) the nature of the production processes:
Services are provided in very similar ways (albeit to differing extents) to the majority of patients including outpatient consultations, inpatient care, diagnostic tests, medical and surgical interventions.

(c) the type or class of customer for their products and services:
The Trust's customers are similar across all services in that they are ill/vulnerable people – whilst certain patient groups may be more susceptible to different healthcare needs, most services are provided to customers of all ages, gender etc.

(d) the methods used to distribute their products or provide their services:
The majority of services are delivered to customers through attendance at hospital as outpatients, day cases or inpatients.

(e) if applicable, the nature of the regulatory environment:
The regulatory environment in which the Trust's services are provided is NHS healthcare.

The Trust Board has therefore concluded that further segmental analysis is not appropriate and that the specialty financial information should be aggregated for the purpose of segmental reporting.

Financial Performance Reporting

The Trust Board receives reports on the Trust's financial performance based upon the Statement of Comprehensive Income (or Net Expenditure) which is adjusted in accordance with HM Treasury rules on measuring financial performance. These adjustments are set out below the Statement of Comprehensive Income (or Net Expenditure) and in note 41 relating to breakeven performance.

Income Sources

Key information on the Trust's sources of income is as follows:
- Clinical Commissioning Groups (CCGs) from which £307.9 million (£297.1 million in 2017/18) was received; and
- NHS England from which £64.2 million (£67.1 million in 2017/18) was received.

There are no other sources of income which exceed 10% of the Trust's total revenue.

All income derives from services provided in England, although the source of a small part of this income will come from NHS bodies in other parts of the United Kingdom, the Isle of Man or from overseas visitors who are treated in the Trust's hospitals. However, income from such sources is not material.

3. Operating income from patient care activities

3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Acute services		
Elective income	60,377	59,661
Non elective income	123,983	116,993
First outpatient income	26,941	25,715
Follow up outpatient income	20,985	20,415
A & E income	21,755	20,821
High cost drugs income from commissioners (excluding pass-through costs)	36,168	36,075
Other NHS clinical income	86,282	88,964
All services		
Private patient income	456	582
Agenda for Change pay award central funding	3,927	-
Other clinical income	204	-
Total income from activities	**381,078**	**369,226**

Of the total income, Contracted income in 2018 is £363.3m (£355.5m 2017/18) and non contract income is £17.8m (£13.7m 2017/18).

3.2 Income from patient care activities (by source) Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	64,206	67,107
Clinical commissioning groups	307,872	297,082
Department of Health and Social Care	3,927	-
Other NHS providers	2,324	2,136
NHS other	204	815
Non-NHS: private patients	389	497
Non-NHS: overseas patients (chargeable to patient)	67	85
Injury cost recovery scheme	1,308	1,430
Non NHS: other	781	74
Total income from activities	**381,078**	**369,226**
Of which:		
Related to continuing operations	381,078	369,226

3.3 Overseas visitors (relating to patients charged directly by the provider)	2018/19 £000	2017/18 £000
Income recognised this year	67	85
Cash payments received in-year	25	23
Amounts added to provision for impairment of receivables	10	11
Amounts written off in-year	-	4

4. Other operating income	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	910	727
Education and training (excluding notional apprenticeship levy income)	12,041	11,912
Non-patient care services to other bodies	7,708	7,366
Provider sustainability / sustainability and transformation fund income (PSF / STF)	4,922	5,322
Other contract income	4,167	4,513
Other non-contract operating income		
Charitable and other contributions to expenditure	340	658
Rental revenue from operating leases	42	110
Amortisation of PFI deferred income / credits	650	1,084
Other non-contract income	108	-
Total other operating income	**30,888**	**31,692**
Of which:		
Related to continuing operations	30,888	31,692

The income in 2017/18 includes Sustainability and Transformation Fund (STF)/ Provider Sustainability Fund (PSF) income of £5.322m of which £0.419m relates to an adjustment for 2016/17 post accounts STF reallocation.
The Trust received £4.922m indicative PSF in 2018/19.

Non Patient care Services to other bodies includes items such as Mortuary Services, Transport Services and Occupational Health services.

5. Additional information on revenue from contracts with customers recognised in the period	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,974
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	2,518

5.1 Transaction price allocated to remaining performance obligations	
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	**31 March 2019 £000**
within one year	5,116
after one year, not later than five years	-
after five years	-
Total revenue allocated to remaining performance obligations	**5,116**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

6. Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018/19 £000	2017/18 £0
Income	2,479	2,619
Full cost	(1,974)	(1,953)
Surplus / (deficit)	**505**	**666**

The income and costs relate to the Trust car parking which are included in other income note 4

7.1 Operating expenses	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,313	4,978
Purchase of healthcare from non-NHS and non-DHSC bodies	1,960	2,031
Staff and executive directors costs	282,327	267,417
Remuneration of non-executive directors	83	84
Supplies and services - clinical (excluding drugs costs)	43,951	41,622
Supplies and services - general	17,736	16,238
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	44,477	44,902
Inventories written down	336	300
Consultancy costs	1,904	1,493
Establishment	4,125	3,802
Premises	15,184	12,118
Transport (including patient travel)	1,790	1,869
Depreciation on property, plant and equipment	9,253	8,796
Amortisation on intangible assets	1,222	1,872
Net impairments	6,828	(1,717)
Movement in credit loss allowance: contract receivables / contract assets	350	
Movement in credit loss allowance: all other receivables and investments	-	354
Increase/(decrease) in other provisions	426	523
Change in provisions discount rate(s)	-	46
Audit fees payable to the external auditor		
audit services- statutory audit	68	54
other auditor remuneration (external auditor only)	-	63
Internal audit costs	75	80
Clinical negligence	14,117	11,706
Legal fees	291	675
Insurance	257	214
Education and training	800	852
Rentals under operating leases	3,156	2,650
Redundancy	9	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	16,034	14,700
Other	79	12
Total	**472,151**	**437,734**
Of which:		
Related to continuing operations	472,151	437,734

7.2 Other auditor remuneration	2018/19	2017/18
	£000	£000
Other auditor remuneration paid to the external auditor:		Amended
2. Audit-related assurance services	-	-
Total	-	-

7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

8. Impairment of assets	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	6,828	(1,717)
Total net impairments charged to operating surplus / deficit	**6,828**	**(1,717)**
Impairments charged to the revaluation reserve	(13,694)	(8,055)
Total net impairments	**(6,866)**	**(9,772)**

The Trust engaged a professional property advisor to undertake a full revaluation in 2018/19. All land and buildings have been assessed for physical depreciation and obsolescence which has resulted in changes in valuation of the Trusts assets. Any buildings assets which reduced in value were impaired to either the revaluation reserve or to I&E .

9. Employee benefits	2018/19 Total £000	2017/18 Total £000
Salaries and wages	192,653	185,134
Social security costs	19,020	20,505
Apprenticeship levy	1,001	980
Employer's contributions to NHS pensions	23,395	23,347
Pension cost - other	34	17
Termination benefits	71	-
Temporary staff (including agency)	46,269	37,827
Total staff costs	**282,443**	**267,810**
Of which		
Costs capitalised as part of assets	116	393

The Trust has had increased reliance on temporary staff including agency in 2018/19, partly related to continued high vacancy levels, and also to enable the opening of additional capacity during the year as part of the urgent care improvement plan.

9.1 Retirements due to ill-health

During 2018/19 there were 6 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £254k (£222k in 2017/18).

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

10. Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The DHSC have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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

11. Operating leases

This note discloses operating lease arrangements where Worcestershire Acute Hospitals NHS Trust is the lessor or lessee.

11.1 The Trust as a lessor	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	42	110
Total	**42**	**110**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	42	110
Total	**42**	**110**

This note discloses income generated in operating lease agreements where Worcestershire Acute Hospitals NHS Trust is the lessor.

The Trust receives rental income from leasing land and accommodation space.

11.2 The Trust as a lessee	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	3,156	2,650
Total	**3,156**	**2,650**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	2,909	1,506
- later than one year and not later than five years;	5,721	4,890
- later than five years.	18,506	19,392
Total	**27,136**	**25,788**
Future minimum sublease payments to be received	-	-

This note discloses costs and commitments incurred in operating lease arrangements where Worcestershire Acute Hospitals NHS Trust is the lessee.

The Trust's operating leases for short term fixed leases include equipment and premises. The increase in lease payments due later than five years relates to the Charles Hasting Education Centre and Kings Court as the agreement is more than a 5 years commitment.

12. Finance income	2018/19	2017/18
	£000	£000
Interest on bank accounts	134	18
Other finance income	-	30
Total finance income	**134**	**48**

Finance income represents interest received on assets and investments in the period.
The Trust benefited from the timing of capital receipts in advance of capital payables during 2018/19.

12.1 Finance Expenses	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	3,457	2,506
Interest on late payment of commercial debt	44	-
Main finance costs on PFI and LIFT schemes obligations	5,774	5,938
Contingent finance costs on PFI and LIFT scheme obligations	6,415	5,604
Total interest expense	**15,690**	**14,048**
Unwinding of discount on provisions	3	8
Total finance costs	**15,693**	**14,056**

Finance expenditure represents interest and other charges involved in the borrowing of money including obligations under the PFI contracts.
The Trust's financial deficit position results in an ongoing requirement for revenue loan support which increases the interest charge.

12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims under this legislation	44	-

13. Other gains / (losses)	2018/19	2017/18
	£000	£000
Gains on disposal of assets	39	28
Losses on disposal of assets	-	(152)
Total gains / (losses) on disposal of assets	**39**	**(124)**
Gains / (losses) on foreign exchange	1	-
Total other gains / (losses)	**40**	**(124)**

14. Intangible assets - 2018/19	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**7,691**	**2,392**	**178**	**10,261**
Additions	97	115	966	**1,178**
Reclassifications	30	-	(120)	**(90)**
Valuation / gross cost at 31 March 2019	**7,818**	**2,507**	**1,024**	**11,349**
Amortisation at 1 April 2018 - brought forward	**5,970**	**1,583**	**-**	**7,553**
Provided during the year	755	467	-	**1,222**
Amortisation at 31 March 2019	**6,725**	**2,050**	**-**	**8,775**
Net book value at 31 March 2019	**1,093**	**457**	**1,024**	**2,574**
Net book value at 1 April 2018	**1,721**	**809**	**178**	**2,708**

14.2 Intangible assets - 2017/18	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	**9,335**	**2,260**	**-**	**11,595**
Prior period adjustments	-	-	-	**-**
Valuation / gross cost at 1 April 2017 - restated	**9,335**	**2,260**	**-**	**11,595**
Additions	139	132	88	**359**
Reclassifications	(90)	-	90	**-**
Disposals / derecognition	(1,693)	-	-	**(1,693)**
Valuation / gross cost at 31 March 2018	**7,691**	**2,392**	**178**	**10,261**
Amortisation at 1 April 2017 - as previously stated	**6,292**	**1,082**	**-**	**7,374**
Amortisation at 1 April 2017 - restated	**6,292**	**1,082**	**-**	**7,374**
Provided during the year	1,371	501	-	**1,872**
Disposals / derecognition	(1,693)	-	-	**(1,693)**
Amortisation at 31 March 2018	**5,970**	**1,583**	**-**	**7,553**
Net book value at 31 March 2018	**1,721**	**809**	**178**	**2,708**
Net book value at 1 April 2017	**3,043**	**1,178**	**-**	**4,221**

15.1 Property, plant and equipment - 2018/19	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**37,316**	**207,275**	**893**	**4,654**	**44,146**	**302**	**22,771**	**133**	**317,490**
Additions	-	6,098	-	9,453	769	-	591	3	**16,914**
Impairments	-	(13,884)	(4)	-	-	-	-	-	**(13,888)**
Reversals of impairments	896	19,824	34	-	-	-	-	-	**20,754**
Revaluations	1,821	808	(22)	-	-	-	-	-	**2,607**
Reclassifications	(18)	2,506	-	(2,416)	-	-	-	-	**72**
Disposals / derecognition	-	-	-	-	(1,958)	-	(222)	-	**(2,180)**
Valuation/gross cost at 31 March 2019	**40,015**	**222,627**	**901**	**11,691**	**42,957**	**302**	**23,140**	**136**	**341,769**
Accumulated depreciation at 1 April 2018 - brought forward	**18**	**181**	**-**	**-**	**32,727**	**302**	**16,432**	**109**	**49,769**
Provided during the year	-	4,743	22	-	2,480	-	1,994	14	**9,253**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(4,480)	(22)	-	-	-	-	-	**(4,502)**
Reclassifications	(18)	-	-	-	-	-	-	-	**(18)**
Disposals / derecognition	-	-	-	-	(1,958)	-	(222)	-	**(2,180)**
Accumulated depreciation at 31 March 2019	**-**	**444**	**-**	**-**	**33,249**	**302**	**18,204**	**123**	**52,322**
Net book value at 31 March 2019	**40,015**	**222,183**	**901**	**11,691**	**9,708**	**-**	**4,936**	**13**	**289,447**
Net book value at 1 April 2018	**37,298**	**207,094**	**893**	**4,654**	**11,419**	**-**	**6,339**	**24**	**267,721**

15.2 Property, plant and equipment - 2017/18	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£0	£0	£000	£0	£0	£0	£0	£000	£0
Valuation / gross cost at 1 April 2017 - restated	**36,798**	**194,770**	**937**	**538**	**47,405**	**320**	**21,675**	**160**	**302,603**
Additions	-	3,682	-	4,116	1,685	-	1,108	9	**10,600**
Impairments	-	(135)	(56)	-	-	-	-	-	**(191)**
Reversals of impairments	-	8,174	72	-	-	-	-	-	**8,246**
Revaluations	-	1,302	(60)	-	-	-	-	-	**1,242**
Reclassifications	518	(518)	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(4,944)	(18)	(12)	(36)	**(5,010)**
Valuation/gross cost at 31 March 2018	**37,316**	**207,275**	**893**	**4,654**	**44,146**	**302**	**22,771**	**133**	**317,490**
Accumulated depreciation at 1 April 2017 - restated	**-**	**45**	**-**	**-**	**34,627**	**320**	**14,341**	**132**	**49,465**
Provided during the year	-	3,767	21	-	2,892	-	2,103	13	**8,796**
Impairments	-	102	41	-	-	-	-	-	**143**
Reversals of impairments	-	(2,028)	(2)	-	-	-	-	-	**(2,030)**
Revaluations	-	(1,687)	(60)	-	-	-	-	-	**(1,747)**
Reclassifications	18	(18)	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(4,792)	(18)	(12)	(36)	**(4,858)**
Accumulated depreciation at 31 March 2018	**18**	**181**	**-**	**-**	**32,727**	**302**	**16,432**	**109**	**49,769**
Net book value at 31 March 2018	**37,298**	**207,094**	**893**	**4,654**	**11,419**	**-**	**6,339**	**24**	**267,721**
Net book value at 1 April 2017	**36,798**	**194,725**	**937**	**538**	**12,778**	**-**	**7,334**	**28**	**253,138**

15.3 Property, plant and equipment financing - 2018/19	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	40,015	134,255	901	11,691	4,887	4,936	13	**196,698**
On-SoFP PFI contracts and other service concession arrangements	-	87,685	-	-	4,821	-	-	**92,506**
Owned - donated	-	243	-	-	-	-	-	**243**
NBV total at 31 March 2019	**40,015**	**222,183**	**901**	**11,691**	**9,708**	**4,936**	**13**	**289,447**

15.4 Property, plant and equipment financing - 2017/18	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	37,298	123,885	893	4,654	5,800	6,102	24	**178,656**
On-SoFP PFI contracts and other service concession arrangements	-	82,950	-	-	5,600	-	-	**88,550**
Owned - donated	-	259	-	-	19	237	-	**515**
NBV total at 31 March 2018	**37,298**	**207,094**	**893**	**4,654**	**11,419**	**6,339**	**24**	**267,721**

16. Revaluations of property, plant and equipment

A full valuation of the Trust's land and buildings was undertaken by Cushman and Wakefield (RICS Registered Valuers), as at 31st March 2019.

The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the DHSC and HM Treasury. In accordance with the requirements of the DHSC, the asset valuations were undertaken in December 2018, as at the prospective valuation date of 31 March 2019.

The valuations have been carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for nonspecialised operational property

In line with HM Treasury guidance, the revaluation as at 31st March 2019 was based on the 'Modern Equivalent Asset' approach to valuation.

The Trust engaged a professional property advisor, Cushman and Wakefield to undertake a full revaluation in 2018/19. The Valuers reviewed the Trusts asset base including a condition survey which informed the Trust’s assessment of useful economic lives. After taking professional advice the Trust has revised the useful economic lives based on the condition survey to more accurately reflect the future economic benefit from property assets. The valuers confirmed the methodology for assessing useful life for depreciation accounting purposes was compliant with the RICS guidance and IAS 16 applicable prior to the revised RICS guidance becoming effective from January 2019. Each site is now defined as the "property asset" with the 3 significant components defined as land, buildings and external works. This has had the overall effect of reducing the useful economic lives. During the March 2019 valuation exercise, these asset lives were checked and revised where necessary.

17. Inventories	31 March 2019	31 March 2018
	£000	£000
Drugs	3,421	3,663
Work In progress	90	108
Consumables	5,223	6,333
Energy	25	14
Total inventories	**8,759**	**10,118**

Inventories recognised in expenses for the year were £49,657k (2017/18: £50,134k). Write-down of inventories recognised as expenses for the year were £336k (2017/18: £300k).

18.1 Trade receivables and other receivables	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	21,847	
Trade receivables*		12,104
Accrued income*		8,396
Allowance for impaired contract receivables / assets*	(1,999)	
Allowance for other impaired receivables	-	(1,746)
Deposits and advances	1	6
Prepayments (non-PFI)	1,940	2,155
PFI lifecycle prepayments	4,680	3,264
PDC dividend receivable	-	23
VAT receivable	1,391	2,224
Other receivables	1,067	662
Total current trade and other receivables	**28,927**	**27,088**
Non-current		
Contract receivables*	2,987	
Trade receivables*		2,725
Total non-current trade and other receivables	**2,987**	**2,725**
Of which receivables from NHS and DHSC group bodies:		
Current	18,454	18,181

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

18.2 Allowances for credit losses - 2018/19	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 Apr 2018 - brought forward		**1,746**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,746	(1,746)
New allowances arising	350	-
Utilisation of allowances (write offs)	(97)	-
Allowances as at 31 Mar 2019	**1,999**	**-**

The Trust's policy for allowances for credit losses is as follows:

- Injury cost recovery income: subject to a provision for credit losses of 21.89% (22.84% 2017/18) as per DHSC guidance.
- Non-NHS receivables that are over 3 months old: subject to a provision for credit losses of 100%
- Non-NHS receivables less than 3 months old: individually assessed and an appropriate provision made
- NHS receivables: individually assessed and an appropriate provision made (taking account of the NHS agreement of balances exercise)

18.3 Allowances for credit losses - 2017/18	All receivables £000
Allowances as at 1 Apr 2017 - as previously stated	
Prior period adjustments	
Allowances as at 1 Apr 2017 - restated	**1,829**
Increase in provision	354
Amounts utilised	(437)
Unused amounts reversed	
Allowances as at 31 Mar 2018	**1,746**

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

19. Exposure to 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 31st March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

20. Non-current assets held for sale and assets in disposal groups	2018/19	2017/18
	£000	£0
NBV of non-current assets for sale and assets in disposal groups at 1 April	**400**	**570**
Prior period adjustment		-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**400**	**570**
Impairment of assets held for sale	-	(170)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**400**	**400**

21. Cash and cash equivalents movements	2018/19	2017/18
	£000	£000
At 1 April	**2,107**	**2,050**
Net change in year	(105)	57
At 31 March	**2,002**	**2,107**
Broken down into:		
Cash at commercial banks and in hand	51	30
Cash with the Government Banking Service	1,951	2,077
Total cash and cash equivalents as in SoFP	**2,002**	**2,107**

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

22. Third party assets held by the Trust	31 March 2019	31 March 2018
	£000	£000
Bank balances	1	-
Total third party assets	**1**	**-**

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

23. Trade and other payables	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	14,409	10,420
Capital payables	2,880	5,493
Accruals	17,318	12,335
Receipts in advance (including payments on account)	-	28
Social security costs	92	3,285
Other taxes payable	95	5,448
PDC dividend payable	-	18
Accrued interest on loans*		630
Other payables	234	151
Total current trade and other payables	**35,028**	**37,808**
Of which payables from NHS and DHSC group bodies:		
Current	10,088	4,270

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 25. IFRS 9 is applied without restatement therefore comparatives have not been restated.

24. Other liabilities	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	2,953	1,105
PFI deferred income / credits	650	650
Total other current liabilities	**3,603**	**1,755**
Non-current		
PFI deferred income / credits	2,840	3,214
Total other non-current liabilities	**2,840**	**3,214**

Trust Deferred Income Contract Liabilities include the maternity pathway deferred element where the provision of service will continue into 2019/20. This pathway income was treated under a different accounting policy in 2017/18.

25. Borrowings	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	113,136	42,410
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,783	2,106
Total current borrowings	**114,919**	**44,516**
Non-current		
Loans from the Department of Health and Social Care	159,941	152,386
Obligations under PFI, LIFT or other service concession contracts	59,443	60,703
Total non-current borrowings	**219,384**	**213,089**

The Trust continues to rely on borrowing from government, with material amounts due for repayment within 12 months. The Trust is in discussion with NHS Improvement following guidance that it may be possible to renegotiate an extended repayment period for principal, rather than further increase borrowings.

25.1 Reconciliation of liabilities arising from financing activities	Loans from DHSC £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2018	**194,796**	**62,809**	**257,605**
Cash movements:			
Financing cash flows - payments and receipts of principal	77,379	(2,106)	**75,273**
Financing cash flows - payments of interest	(3,183)	(5,774)	**(8,957)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	630	-	**630**
Application of effective interest rate	3,455	5,774	**9,229**
Other changes	-	523	**523**
Carrying value at 31 March 2019	**273,077**	**61,226**	**334,303**

26. Finance leases

This note discloses finance lease arrangements where Worcestershire Acute Hospitals NHS Trust is the lessor or lessee. The Trust does not have any finance lease agreements except the PFI agreement (note 32)

27. Provisions for liabilities and charges analysis	Pensions: early departure costs £000	Legal claims £000	Other £000	Total £000
At 1 April 2018	**3,226**	**168**	**390**	**3,784**
Arising during the year	-	123	400	**523**
Utilised during the year	(214)	(100)	(313)	**(627)**
Reversed unused	-	(10)	(87)	**(97)**
Unwinding of discount	3	-	-	**3**
At 31 March 2019	**3,015**	**181**	**390**	**3,586**
Expected timing of cash flows:				
- not later than one year;	213	181	390	**784**
- later than one year and not later than five years;	850	-	-	**850**
- later than five years.	1,952	-	-	**1,952**
Total	**3,015**	**181**	**390**	**3,586**

• Early departure costs are pensions relating to former staff are based upon actuarial estimates and are reviewed annually. Payments are made quarterly to the NHS Pensions Agency in respect of the Trust's liability.
• Legal claims relate to employers'/third party liability claims. Cost estimates and timings are based on information held by the Legal Services team who work closely with the NHS Litigation Authority.
• Other provisions include Carbon Reduction Charge (CRC).

28. Clinical negligence liabilities

At 31 March 2019, £181k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Worcestershire Acute Hospitals NHS Trust (31 March 2018: £165k).

29. Contingent assets and liabilities	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(27)	(59)
Gross value of contingent liabilities	**(27)**	**(59)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(27)**	**(59)**

30. Contractual capital commitments	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	-	1,955
Intangible assets	-	-
Total	**-**	**1,955**

31. Other financial commitments	31 March 2019 £000	31 March 2018 £000
not later than 1 year	9,283	-
after 1 year and not later than 5 years	11,757	-
Total	**21,040**	**-**

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:
The Trust has made an assessmnent of non-cancellable contracts from its contract register. These are primarly related to equipment provided as part a contract (MES).
No comparator was reported in 2017/18.

32. On-SoFP PFI, LIFT or other service concession arrangements

The information below is required by the Department of Heath for inclusion in national statutory accounts. The Trust has commitments to the PFI scheme covering the redevelopment of the Worcester Hospital site, facilities management services, PACS equipment, a managed equipment service and network and communications equipment.
The Trust retains existing estates at the Worcester Site including Aconbury East and West which were not part of PFI originally in addition to new buildings covered by the PFI scheme.

The main PFI contract ends in December 2031. A monthly unitary payment will be paid up to that point. The unitary payment is subject to annual increases in line with RPI. Services are subject to market testing every 5 years. The arrangement requires the operator to deliver services to the Trust in accordance with the service delivery specification. Non delivery of quality or performance can lead to a reduction in the service charge being paid by the Trust.

The Trust retains step in rights should the contractor fail to meet minimum standards as set out within the contract. Under IFRIC 12 the asset is treated as an asset of the Trust. The substance of the contract is that the Trust has a financial lease and payments comprise 2 elements – imputed finance lease charges and service charges. Details of the imputed finance lease charges are included within the table below.

32.1 Imputed finance lease obligations	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**106,235**	**113,591**
Of which liabilities are due		
- not later than one year;	7,378	7,879
- later than one year and not later than five years;	32,263	33,212
- later than five years.	66,594	72,500
Finance charges allocated to future periods	(45,009)	(50,782)
Net PFI, LIFT or other service concession arrangement obligation	**61,226**	**62,809**
- not later than one year;	1,783	2,106
- later than one year and not later than five years;	12,240	12,138
- later than five years.	47,203	48,565

Worcestershire Acute Hospitals NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

32.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments	31 March 2019 £0	31 March 2018 £0
Total future obligations under these on-SoFP schemes are as follows:		
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**483,919**	**500,193**
Of which liabilities are due:		
- not later than one year;	32,521	31,302
- later than one year and not later than five years;	138,553	133,231
- later than five years.	312,845	335,660

32.3 Analysis of amounts payable to service concession operator	2018/19 £0	2017/18 £0
This note provides an analysis of the unitary payments made to the service concession operator:		
Unitary payment payable to service concession operator	**31,302**	**30,244**
Consisting of:		
- Interest charge	5,774	5,938
- Repayment of finance lease liability	2,106	1,941
- Service element and other charges to operating expenditure	16,034	14,700
- Capital lifecycle maintenance	973	1,872
- Contingent rent	6,415	5,604
- Addition to lifecycle prepayment	-	189
Total amount paid to service concession operator	**31,302**	**30,244**

33. Financial instruments

33.1 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 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 treasury activity is subject to review by the Trust's internal auditors.

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 31st March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contract 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.

Currency risk

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

Interest Rate risk

The Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust also borrows from government to support the financial deficit and ensure sufficient cash flow to maintain day to day operations. The interest rate on these loans remained fixed during 2018/19.

33.2. Carrying values of financial assets	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9			
Trade and other receivables excluding non financial assets	23,902	-	**23,902**
Other investments / financial assets	-	-	**-**
Cash and cash equivalents at bank and in hand	2,002	-	**2,002**
Total at 31 March 2019	**25,904**	**-**	**25,904**

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Total book value £000
Carrying values of financial assets as at 31 March 2018 under IAS 39				
Trade and other receivables excluding non financial assets	19,422	-	-	**19,422**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents at bank and in hand	2,107	-	-	**2,107**
Total at 31 March 2018	**21,529**	**-**	**-**	**21,529**

33.3 Carrying value of financial liabilities	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	273,077	**273,077**
Obligations under finance leases	-	**-**
Obligations under PFI, LIFT and other service concession contracts	61,226	**61,226**
Other borrowings	-	**-**
Trade and other payables excluding non financial liabilities	34,841	**34,841**
Other financial liabilities	-	**-**
Provisions under contract	-	**-**
Total at 31 March 2019	**369,144**	**369,144**

	Other financial liabilities £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	194,796	**194,796**
Obligations under finance leases	-	**-**
Obligations under PFI, LIFT and other service concession contracts	62,809	**62,809**
Other borrowings	-	**-**
Trade and other payables excluding non financial liabilities	29,051	**29,051**
Other financial liabilities	-	**-**
Provisions under contract	-	**-**
Total at 31 March 2018	**286,656**	**286,656**

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

The Trust was due to repay £38.2m principal of revenue support loan in December 2018, in line with the original loan agreement. The Trust engaged with NHSI / DHSC and a deferral of the principal repayment was formally agreed.

33.4 Maturity of financial liabilities	31 March 2019 £000	31 March 2018 £000
In one year or less	149,760	73,567
In more than one year but not more than two years	64,460	74,713
In more than two years but not more than five years	91,002	75,875
In more than five years	63,922	62,501
Total	**369,144**	**286,656**

34. Losses and special payments	2018/19 Total number of cases Number	2018/19 Total value of cases £000	2017/18 Total number of cases Number	2017/18 Total value of cases £000
Losses				
Cash losses	-	-	2	0
Bad debts and claims abandoned	126	44	140	44
Stores losses and damage to property	12	337	13	360
Total losses	**138**	**381**	**155**	**404**
Special payments				
Ex-gratia payments	75	92	82	281
Extra-statutory and extra-regulatory payments	-	-	1	116
Total special payments	**75**	**92**	**83**	**397**
Total losses and special payments	**213**	**473**	**238**	**801**
Compensation payments received		-		-

35. Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the DHSC, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £630k, and trade payables correspondingly reduced.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

The Trust has previously accounted for Injury Recovery Costs in full and adjusted as per the GAM.

36. Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

37. Related parties

During the year none of the Department of Health Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Worcestershire Acute Hospitals NHS Trust.

The DHSC is regarded as a related party. During the year Worcestershire Acute Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example:

- NHS England
- NHS Redditch and Bromsgrove CCG
- NHS South Worcestershire CCG
- NHS Wyre Forest CCG
- NHS South Warwickshire CCG
- Worcestershire Health and Care NHS Trust
- NHS Litigation Authority
- Local Authorities
- NHS Business Services Authority

The Trust has also received revenue and capital payments from Worcestershire Acute Hospitals Charity amounting to £527,622 (£434,854 in 2017/18). All of these payments relate to expenditure made by the Trust on behalf of the Worcestershire Acute Hospitals Charity. All Board Members are Trustees of the Trust's Charitable Funds. The summary financial statements of the funds held on Trust are included in the annual report and accounts.

38. Better Payment Practice code	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	102,230	226,631	95,966	200,703
Total non-NHS trade invoices paid within target	82,637	176,310	61,872	127,906
Percentage of non-NHS trade invoices paid within target	80.8%	77.8%	64.5%	63.7%
NHS Payables				
Total NHS trade invoices paid in the year	3,029	12,136	2,857	33,423
Total NHS trade invoices paid within target	1,823	4,626	1,466	24,506
Percentage of NHS trade invoices paid within target	60.2%	38.1%	51.3%	73.3%

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

39. External financing	2018/19 £000	2017/18 £000
Cash flow financing	79,289	55,774
External financing requirement	**79,289**	**55,774**
External financing limit (EFL)	79,359	56,745
Under / (over) spend against EFL	**70**	**971**

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

40. Capital Resource Limit	2018/19 £000	2017/18 £000
Gross capital expenditure	18,092	10,959
Less: Disposals	-	(152)
Charge against Capital Resource Limit	**18,092**	**10,807**
Capital Resource Limit	18,970	10,959
Under / (over) spend against CRL	**878**	**152**

The Trust underspend against the CRL relates to IFRIC12, PFI replacement of equipment.

41. Breakeven duty financial performance	2018/19 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(68,790)
Breakeven duty financial performance surplus / (deficit)	**(68,790)**

42. Breakeven duty rolling assessment	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Breakeven duty in-year financial performance	3,135	287	88	17	(14,191)	(25,918)	(59,831)	(28,748)	(52,562)	(68,790)
Breakeven duty cumulative position	(18,719)	(18,432)	(18,344)	(18,327)	(32,518)	(58,436)	(118,267)	(147,015)	(199,577)	(268,367)
Operating income	312,889	321,829	336,594	348,763	346,029	364,656	368,981	403,348	400,918	411,966
Cumulative breakeven position as a percentage of operating income	(5.98%)	(5.73%)	(5.45%)	(5.25%)	(9.40%)	(16.02%)	(32.05%)	(36.45%)	(49.78%)	(65.14%)

The Department of Health and Social Care has previously agreed with HM Treasury that the breakeven duty will be assumed to have been met if expenditure is covered by income over a three year period. 2009/10 is assume to be the first year of International Financial Reporting Standards (IFRS) implementation is a suitable point from which the breakeven duty should now be assessed. *(NHS Improvement April 2018 Publication code: CG 57/18)*

Independent auditor's report to the Directors of Worcestershire Acute Hospitals NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Worcestershire Acute Hospitals NHS Trust (the 'Trust') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty related to going concern

We draw attention to note 1.2 to the financial statements, which indicates that the Trust incurred a deficit of £75.8 million during the year ended 31 March 2019 and at that date had net current liabilities of £114.2 million.

As stated in note 2.1, the Trust has taken out a number of revenue loans over recent years (£70.0 million in 2018/19) and will require further loans in 2019/20 to support the planned deficit of £82.8 million and planned principal repayments. As the financial deficit is unlikely to be resolved within one year, ongoing cash support will be required in 2019/20. NHS Improvement has not formally confirmed this support to be available.

These events or conditions, along with the other matters as set forth in note 1.2, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine

whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 28 March 2019 we referred a matter to the Secretary of State under section 30b of the Local Audit and Accountability Act 2014 in relation to the Trust's breach of its break-even duty for the three-year period ending 31 March 2019. In the referral we also make reference to the referral we made on 28 April 2018 where we reported the Trust's ongoing planned deficit in 2018/19, and that it had no plans to achieve cumulative financial balance over the period of its medium-term financial plan to 2020/21 and was therefore likely to continue to breach its break-even duty over this period. In our 28 March 2019 letter we also made a referral under section 30a of the Local Audit and Accountability Act as the Trust has set a deficit budget for the year ended 31 March 2020 and has no plans to achieve cumulative financial balance

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities set out on page 53, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control

as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit and Assurance Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2017, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects, Worcestershire Acute Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for adverse conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- The Trust's outturn position for 2018/19 was a £75.7 million deficit against the £41.5 million deficit budget. The Trust planned to achieve Cost Improvement Plan (CIP) savings of £22.5 million in 2018/19, but only achieved £7.6 million of this target; and
- The Trust's adjusted retained cumulative deficit is £268.4 million at 31 March 2019 and it does not yet have a financial recovery plan in place to achieve an in-year break-even position.

This identifies weaknesses in the Trust's arrangements for setting and agreeing a sustainable budget and delivery of that budget.

- The Care Quality Commission published its inspection report in November 2017 with an overall judgement of inadequate and that rating remains in place. The Trust was rated as inadequate in three of the five inspection domains; 'are services safe?', 'are services responsive?', and 'are service well led?'. In the most recent report, published in June 2018, the overall judgement remains inadequate, although 'are services well-led' is now assessed as requires improvement. The Trust remains in "Special Measures" which started in November 2015 due to concerns over quality and patient care.
- During the year the Trust reported that it had failed to meet the national priority targets in relation to the Emergency Access Standard (4 hour waits in Accident and Emergency), Cancer Waiting Times (including 2 weeks and 62 day waits for first treatment), and Referral to Treatment (both 18 week and 52 week waits); and diagnostic waiting times.

This identifies weaknesses in the Trust's arrangements for responding to service delivery issues raised by regulators.

These matters are evidence of weaknesses in proper arrangements for sustainable resource deployment and informed decision making in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions, and for understanding and using appropriate and reliable financial and performance information to support informed decision making and performance management including where relevant, business cases supporting significant investment decisions.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Worcestershire Acute Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Richard Percival

Richard Percival, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham
28 May 2019