NHS
Worcestershire Health and Care
NHS Trust

ANNUAL REPORT
2017-18

www.hacw.nhs.uk

Working together for
outstanding care

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WELCOME TO OUR ANNUAL REPORT 2017/18

The annual report is a summary of our performance against all our national and local performance indicators and targets which, alongside our Quality Account, provides an accurate picture of how the organisation is performing.

The Trust was rated 'Good' by the CQC in 2016 following a full inspection of our services. Between January and March 2018 we were re-inspected with a particular focus on the Well-Led domain which is one of the CQCs key inspection areas. The Well Led domain looks at the role of Board and senior leaders within the organisation and seeks assurances that the vision and values of the Trust are embedded across the organisation.

At the time of writing we are awaiting formal confirmation of the outcome of the Well-Led inspection but the verbal feedback from the inspection teams was largely positive, with the visibility of the Board, and the supportive and empowering culture in place throughout the organisation reserved for specific praise.

Our aim is to provide Outstanding services to all those who come into contact with us each and every day and we will continue to develop a learning and supportive culture where staff have the freedom to do what is right and are champions of the care and treatment we provide.

Behind any successful organisation is a strong and high performing corporate team who work together with our clinical and front-line staff to support the delivery of care. Like all NHS providers we face the challenge of maintaining and where possible improving quality of care at the same time as having to make significant financial savings. This really tests our ability to think and work differently, and places partnership working at the heart of our long-term strategy.

We have continued to rise to that challenge and have met all of our financial targets, including achieving a year end surplus. This helps us invest in our estate and other elements of patient care so we will maintain our responsible approach to financial management. We have and will always remain true to our values in ensuring patient safety and quality of care is not compromised, while recognising the need to make every effort to operate as efficiently as possible

We continue to make a significant contribution to our local Sustainability and Transformation Partnership (STP). We work with partners across Herefordshire and Worcestershire to address some of the known health gaps or inconsistencies, to improve outcomes, and to work towards a position where we can collectively live within our means financially.

The STP is now in a delivery or implementation phase which will undoubtedly change the way patients access some of our services. In addition to that some of our specific services have been redesigned or transformed and credit must go to our staff to maintaining focus and resilience in the context of a number of changes.

We hope you find the Annual Report useful and informative but remember we welcome your comments and feedback throughout the year and there are also lots of opportunities to get involved in shaping the future of local services. You can contact us via our Patient Advice and Liaison Service (PALs) on 01905 681517.

We believe that to the best of our knowledge the information in this document is accurate.

Chris Burdon, Chairman

Sarah Dugan, Chief Executive

ABOUT THE TRUST

We are the county's main provider of community and mental health services. We have services for people of all ages, including health visiting, speech and language and physical and mental health care for children and young people, to a range of services for adults and older people, including OT, physio and dementia care. We also run the county's community hospitals and recovery units, and inpatient wards for those recovering from mental health conditions. In collaboration with Taurus GP Federation we provide sexual health services in Herefordshire.

Visit www.hacw.nhs.uk for a full list of services.

Key stats:

- Rated **Good** by the Care Quality Commission (CQC)
- Population of Worcestershire is around 560,000
- Provide services from over 100 locations, including community centres, care homes and schools
- We employ around 4,000 staff

Our services:

Over the last 12months we have re-organised our internal service delivery units to better reflect the developments of our new integrated Neighbourhood Teams. Since January 2018 we organise our services into the SDUs (Service Delivery Units) below:

- Adult Mental Health and Learning Disabilities
- Children, Young People & Familes and Specialist Primary Care
- Community Care
- Integrated Community Services

THE LOCAL SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP)

The STP brings together local health and care organisations across Herefordshire and Worcestershire, supported by patient/carer representatives and voluntary and community groups.

It is a collaborative approach to work together to address some of the local health and care inequalities, to improve health outcomes and to ensure we can provide safe, effective and sustainable care for the future within our financial allocation.

The Partnership's vision:

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 has agreed some priority headlines under which there are lots of different work-streams at different stages of development. There is a commitment that wherever possible changes to services will be developed with local people.

The STP priorities are:

- Maximise efficiency and effectiveness
- Prevention, self-care and promoting independence
- Developing out of hospital care
- Establishing clinically and financially sustainable services

If you would like to find out more about the STP then visit **www.yourconversationhw.nhs.uk**

Our Vision:

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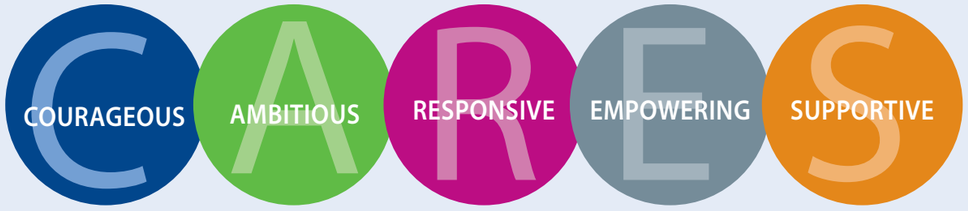
OUR VISION

Working together for **outstanding care**

OUR VALUES



Courageous: Displaying integrity and having the courage to do what is right.

Ambitious: Always striving for outstanding care.

Responsive: Listen, learn and act.

Empowering: Freedom to choose and live well.

Supportive: Support each other and be proud of what we do.

For further information visit **nww.hacw.nhs.uk/aboutus**

Strategic Priorities and Enablers:

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STRATEGIC PRIORITIES

- To be efficient and effective
- To focus on prevention
- To provide integrated care with partners
- To provide sustainable pathways for specialist services

KEY ENABLERS

- Quality Improvement
- Co-production
- Partnership with Staff
- Estates
- Digital Innovation

For further information visit **nww.hacw.nhs.uk/aboutus**

OUR 2017/18

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Good

Rated Good by the CQC

Mental Health Rehab Units: Outstanding

Leadership in Community Hospitals: Outstanding

95%

95% Friends and Family Test Approval

Health Education West Mids. Apprenticeship Employer of the Year 2017

Achieved all financial targets, including year-end surplus

Hit targets for MIU waiting times

Named in top 15% of Trusts in NHS Improvements Single Oversight Framework

Development of a new integrated stroke rehab service leading to better care and reduced lengths of stay for patients

Childrens Speech and Language Service cited as national example of best practice

Working with partners across the county we've launched our first integrated community teams, called Neighbourhood Teams

RED2GREEN

First community and mental health provider to fully introduce the 'Red2Green' initiative. Shortlisted for HSJ award 2017

COURAGEOUS AMBITIOUS RESPONSIVE EMPOWERING SUPPORTIVE

PERFORMANCE REPORT

PERFORMANCE UPDATE

Board Assurance Framework

The Trust Board understands its role in managing the principal risks to ensure delivery of its strategic objectives and the effective operation of the Trust. The Trust is committed to ensuring that risk management is fully embedded in the organisation's culture and processes and a robust risk management strategy and procedures are in place.

A Board Assurance Framework (BAF) is in place together with the associated controls and assurances; Operational risk registers feed into the high level risk register which informs the BAF.

The BAF is reviewed at every public Board meeting, with in-depth reviews taking place at six monthly intervals. Following an in-depth review in January 2018 the end of the year BAF was amended to include:

Strategic Goals	Reference	Risk
To focus on prevention to provide integrated care with providers. To provide sustainable pathways for specialist services.	SO 2/3/4	Failure to deliver acceptable standards of care.
To be effective and efficient. To provide integrated care with partners. To provide sustainable pathways for specialist services.	SO 1/3/4	The Trust has approved a strategy supporting the STP and national direction of travel and continues to work to support these agendas whilst operating within a framework focused on different regulatory regime without updated national legislation or guidance.
To be efficient and effective. To provide sustainable pathways for specialist services.	SO 1/4	Failure of the medium to long term financial sustainability of the Trust.
To be efficient and effective. To focus on prevention. To provide integrated care with partners. To provide sustainable pathways for specialist services.	SO 1/2/3/4	The Trust needs to attract, develop and retain an appropriate workforce to deliver appropriate services within resources.

Specific risks identified within the BAF have been mapped as downside scenarios, for example failure to deliver a proportion of the Cost Improvement Programme or loss of income.

In each case a series of actions have been defined that the Trust will implement to manage the impact of these scenarios. The mitigating actions include, for example, immediate management control actions (bridging actions) and the reduction of the planned level of surplus and contingency.

Going Concern

The Trust Board has considered its ability to continue as a going concern and is satisfied that it has sustainable service and financial plans that have been appropriately risk assessed. The financial statements for 2017/18 have therefore been prepared on this basis.

PERFORMANCE SUMMARY

Worcestershire Health and Care NHS Trust performed strongly against the wide span of key performance indicators against which it is measured.

Integrated Dashboard

On a monthly basis the Trust produces an integrated dashboard which looks to pull together the key performance indicators that fall underneath the broad headings of finance, quantitative performance, quality performance and workforce. This approach allows the Trust to view those measures that are considered important to be viewed in one place and to identify at an early stage any relationships between failing indicators. The following tables show the dashboard at the end of March 2018.

Financial Performance

	Target £m	Achieved £m
Bottom line I&E position - Forecast compared to plan	4.4	7.3
Bottom line I&E position - Year to date actual compared to plan	4.4	7.3
Efficiency YTD Actual Compared to plan (delivered)	5.0	5.0
Actual efficiency recurring compared to plan – Forecast compared to plan	5.0	5.0
Forecast underlying surplus/deficit compared to plan	4.4	7.3
Forecast year end charge to capital resource limit (Capital Spend)	7.5	7.5
Is the Trust forecasting permanent PDC for – liquidity purposes	No	No
Agency Spend – Year to date actual compared to plan	7.0	6.0

Workforce Performance

	Target	Achieved
Trust sickness rate - monthly position	≤ 4.00%	4.7%
Staff Appraisals	95%	94%
Mandatory Training	90%	92%
Agency as a % of Employee Benefit Spend	–	4%
Workforce WTE	–	2,991
In month turnover rate	–	2%
Executive Team turnover rate	–	0%
Vacancy Rate	–	9%

Quantitative Performance

	Target	Achieved
RTT waiting times incomplete pathways	92%	96%
RTT over 52 week waiters	0	0
Proportion of patients spending less than 4 hours in A&E	95%	100%
Referral to IAPT will be treated within 6 weeks of referral	75%	89%
Referral to IAPT will be treated within 18 weeks of referral	95%	97%
Early Intervention: 1st episode of psychosis treated within 2 weeks	50%	100%
IAPT - Patients receiving psychological therapies (Q4 Target 4.2%)	4.2%	4.3%
IAPT - Patients who complete treatment moving to recovery	50%	50%
Patients on CPA who had a CPA review within the last 12 months	95%	97%
Patients on CPA receiving follow-up contact within 7 days of discharge	95%	97%
Inappropriate out-of-area placements for Adult Mental Health Services (total number of bed days)	0	11
Delayed Transfers of Care - Mental Health	≤ 3.5%	1%
Delayed Transfers of Care – Community Hospitals	≤ 3.5%	4.8%
Mental Health Clustering	95%	88%
Mental Health Clustering Reviews	95%	82%
Data Quality Maturity Index (DQMI) - MHSDS dataset score	95%	99%

Quality Performance

	Target	Achieved
Incidence of C.diff (Monthly Trajectory 11, Full Year Target ≤ 11)	≤ 11	3
Incidents of MRSA	0	0
Never Event incidence	0	0
VTE Risk Assessment	95%	98%
Safety Thermometer - % of patients free from harm	95%	96%
% of incidents categorised as resulting in moderate, severe harm or death	<=7.7%	13.8%
Admissions to Adult Mental Health for patients under 16.	0	0
Number of Prone restraints	0	2
Single Sex Accommodation Breaches	0	0
Inpatient scores from Friends & Family test - % Positive	–	96%
Staff FFT response Rate	–	Q2 3%
Staff FFT Percentage recommended work	–	Q2 59%
Staff FFT Percentage recommended care	–	Q2 73%
Number of avoidable grade 3 & 4 pressure ulcers (February)	0	2
Number of complaints	–	32
Number of complaints upheld by the Ombudsman	0	0

PERFORMANCE ANALYSIS

In September 2016, NHS Improvement (NHSI) introduced the Single Oversight Framework.

The Framework is based on the allocation of NHS Trusts into segments, which are driven jointly by performance against targets and the perception of NHSI of the level of support that the Trust requires to improve performance. A Trust may be failing against an indicator; however so long as robust, deliverable action plans are in place, and NHSI are assured of the ability of the Trust to deliver, then the highest level of segmentation can be achieved.

The Trust was allocated to Segment 2 by NHSI during 2017/18 whereby providers are offered targeted support - potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS Trusts) and/or formal action is not needed.

The performance of the Trust against the NHSI Single Oversight Framework for March 2018 is shown below. The Framework seeks to measure the performance of NHS Providers against a suite of key performance indicators grouped into the Care Quality Commission domains.

The overall performance regime employed by the Trust covers a far wider range of indicators and draws from national targets, contractual requirements and local initiatives.

The Trust operates against an agreed performance management framework. This framework outlines the lines of accountability and governance within the organisation, the forums within which performance is scrutinised and the approach that is taken when performance falls below the required standards. During the course of each month, performance against a broader suite of metrics is reviewed at Team and Service Delivery Unit level, as well as at Board Committees and the Trust Board.

There are indicators that prove to be a challenge, most notably where patients experience a delay in being discharged from community hospitals. The Trust deals with an increasingly frail elderly population and there are a growing number of instances where people are unable to return home after a period in hospital and require nursing or residential home accommodation. There are problems in identifying appropriate accommodation and as a result, these patients stay in hospital longer than intended; however, extensive work has been undertaken with partner agencies, such as Worcestershire County Council to address this shortfall. It should be stressed that these problems are being experienced nationally and are not unique to Worcestershire.

There have also been issues during the year in meeting waiting time targets for the Improving Access to Psychological Therapies Service. Extensive work has been undertaken with the service to ensure there is sufficient capacity to meet demand, and we were pleased that since September 2017, both the waiting time standards and the recovery rate target have been met.

NHS Improvement Single Oversight Framework: Quality of Care Monitoring Metrics 2017-18

Safe	**Target**	**March 18**
Clostridium Difficile – variance from plan	≤ 0	-8
Clostridium Difficile – incident rate (February trajectory less than or equal to 11)	≤ 11	3
Never Event – count	0	0
Patient Safety Alerts outstanding	0	0
VTE Risk Assessment	95%	98%
Admissions to adult facilities of patients who are under 16 years of age (Number)	0	0
Effective	**Target**	**March 18**
% of clients in settled accommodation	60%	62%
% clients in employment	10%	10%
CPA follow up within 7 days of discharge	95%	97%
Caring	**Target**	**March 18**
Staff FFT Percentage Recommended – Care	–	Q2 73%
Inpatient Scores from Friends and Family Test – % Positive	–	96%
FFT – Minor Injury Units	85%	95%
FFT – Mental Health	85%	89%
FFT – Community	85%	97%
Written Complaints – rate	–	32
Mixed Sex Accommodation Breaches (number)	0	0
Well-led – (renamed Organisational health)	**Target**	**March 18**
Proportion of temporary staff	£7.0m	£6.0m
Aggressive cost reduction plans	£5.0m	£5.0
Trust level total sickness rate *	≤ 4.0%	5%
Staff turnover rate (monthly)	–	2%

* As per the updated Single Oversight Framework, sickness rates are now reported monthly from December 2017 where previously it was reported as a rolling position.

NHS Improvement Single Oversight Framework: Finance and Use of Resources 2017-18

Financial Risk	Target	March 18
Liquidity Rating	1	1
Capital Servicing Capacity Metric	1	1
I & E Margin Rating	1	1
Distance from Plan Rating	1	1
Agency Metric	1	1
Use of Resources Rating	1	1

NHS Improvement Single Oversight Framework: Operational Performance Metrics 2017-18

Governance Risk	Threshold	March 18
Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway	92%	96%
A&E: maximum waiting time of four hours from arrival to admission/transfer/ discharge	95%	100%
Early Intervention in Psychosis: 1st episode of psychosis treated with a NICE approved care package within 2 weeks	50%	100%
Improving access to psychological therapies (IAPT):		
Proportion of people completeing treatment who move to recovery	50%	50%
referral to the IAPT programme will be treated within 6 weeks of referral	75%	89%
6 weeks 3-month rolling position as per Single Oversight Framework		86%
referral to the IAPT programme will be treated within 18 weeks of referral	95%	97%
18 weeks 3-month rolling position as per Single Oversight Framework		97%
Data Quality Maturity Index (DQMI) - MHSDS dataset score	95%	99%
Inappropriate out-of-area placements for Adult Mental Health Services (total number of bed days)	0	11

FINANCIAL ANALYSIS

Revenue

For 2017/18, the total turnover for the Trust (mainly received via healthcare contracts with the three Worcestershire Clinical Commissioning Groups, Worcestershire County Council and other NHS Commissioners) was £179.5m (£173.5m 2016/17). Budgets are set throughout the Trust up to this limit and it is the responsibility of budget holders to ensure that the Service Delivery Units are managed within their allocated budget. Progress during the year on this important area of responsibility is reported at Trust Board meetings and in detail at the Finance and Performance Committee. The business of the Trust is governed by the Trust's Standing Orders and Standing Financial Instructions; and spending decisions regulated through an approved Scheme of Delegation.

The reported NHS financial performance for the year ended 31 March 2018 is a surplus of £9.6m (2016/17 deficit of £7.1m). This financial performance is adjusted for technical items: impairments of the Trust's assets (resulting from professional valuations) and depreciation on the Trust's donated assets.

The adjusted retained surplus is therefore £7.3m (2016/17 £5.1m). This is the surplus which the Trust is monitored by NHSI.

Capital

In 2017/18 the Trust used internally generated funds from depreciation, brought forward revenue surpluses and Public Dividend Capital (PDC) funding to cover a capital programme of £7.5m. The Trust spent its 2017/18 Capital Resource Limit, which was approved by NHSI.

The Trust's main areas of expenditure were: £4.2m on Information Technology (which included the Global Digital Exemplar and Cyber Resilience programmes – whereby the Trust received PDC funding for both); £2.3m implementing its estates strategy, £0.3m on backlog maintenance. Other areas of substantial expenditure included the replacement of equipment of £0.2m and £0.1m spent on PLACE.

Working Capital

Over the last number of years, the Trust has taken active measures to secure its working capital and cash liquidity. This initiative and move above the 10 days minimum operating cash required by NHSI, resulted in a retained cash balance of £7.5m in excess of its External Financial Limit (EFL). This over-delivery is allowable by NHSI.

Financial statutory and non-statutory targets

Target	Achieved	Explanation
Surplus	✓	Achieved a year end surplus of £7.3m
Remain within the Capital Resource Limit	✓	The Trust spent its capital resource limit £7.5m
Remain within the External Financial Limit	✓	The Trust under-spent against its limit by £7.5m (allowed)
Capital Cost Absorption rate (3.5%)	✓	The Trust achieved the 3.5% rate
Pay 95% of valid invoices within 30 days of receipt	✓	BPPC compliance rate of 98%
Efficiencies	✓	£5.0m delivered recurrently

SUSTAINABLE DEVELOPMENT

Our Trust and the Natural Environment

The incentive to reduce the effect we have on our environment is stronger than ever; doing so not only helps to reduce the impact of climate change but also saves money and improves our efficiency. Our staff and patients benefit too: sustainable lifestyles, with more active travel and less energy intensive diets, are healthier lifestyles.

The Trust emitted 22,172 tonnes of CO_2 equivalents (TCO_2e) a year (based on 2013/14 baseline) and our target for reduction figure is 15,964 tonnes CO_2e by 2020/21. In 2017/18 the Trust emitted 18,637 TCO_2e against a target of 19,068 TCO_2e. The Trust implemented the following projects moving towards this target.

- Installation of LED lighting throughout the Trust's premises
- Continued maintenance upgrades (boilers, water saving anti-ligature taps, reducing pump speed)
- Continued estate rationalisation
- Improved data quality from the Acute Trust energy suppliers

Contracts

The Trust has procured its energy supply requirements for 2 years through LASER. By procuring energy through the LASER we get the best value energy on the market. LASER ensure tariff charges are competitive, not least because of the overall buying power but also savings from wholesale procurement and procuring in advance.

The Trust still has energy contracts in place with the following energy suppliers:

- Total Gas & Power
- NPOWER

The Trust is a key member of the Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP). STP procurement has been set up to explore spend and efficiency opportunities, this includes environmental services. This may allow the Trust to make further savings in future contracts.

Deregulation of the non-domestic water market in England came into effect in April 2017. Customers are now able to choose a provider that best suits their individual needs, or who can offer cost savings on their water supply.

There are over 18 licenced retailers participating in the new retail market giving 1.2 million businesses, charities and public-sector organisations the opportunity to choose the best provider of their water and waste-water retail services. The Trust has decided to explore the market for 2017/18.

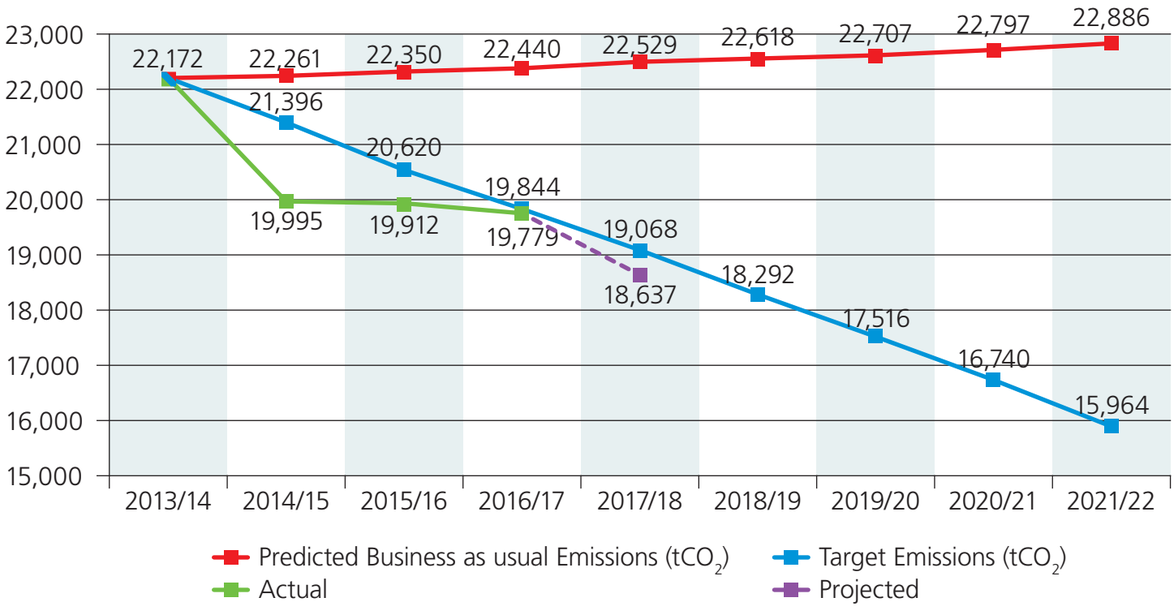
Travel

Table 1: Travel Data

Business Travel	Units	2016/17	2017/18
Business Mileage – Road	km	6,493,248	6,483,043
	£	£2,070,606	2,007,668
	TCO_2e	1,213.91	1,182.64

The data shows in 2017/18 shows we have decreased our business travel carbon emissions by 31.28 tonnes. This may be attributed to staff planning their journeys better.

Figure 1: Carbon Dioxide Emissions resulting from Trust operations



The green line in the graph illustrates that the Trust is reducing its emissions (Actual) against both the "Do Nothing" and "Target emissions" lines. At the end of the 2016/17 financial year we calculated that the CO_2 emissions had reduced to 19,779 tonnes against the trajectory target of 15,964 tonnes. The graph also shows the estimated year end position well below the target for 2017/18.

Table 2: Carbon Emissions from Energy

Resource		2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	16,691,553	13,486,050	14,335,484	14,323,964
	tCO_2e	3,502	2,822	2,996	3,037
Oil	Use (kWh)	24,630	43,937	33,126	33,126
	tCO_2e	8	14	11	11
Coal	Use (kWh)	0	0	0	0
	tCO_2e	0	0	0	0
Electricity	Use (kWh)	1,491,763	2,487,313	5,643,729	4,332,443
	tCO_2e	924	1,430	2,917	1,931
Green Electricity	Use (kWh)	4,537,607	3,454,644	43,845	994,254
	tCO_2e	0	0	0	424
Total Energy CO_2e		4,434	4,266	5,923	5,403
Total Energy Spend		£1,333,483	£1,269,853	£1,238,547	£1,258,547

The table above illustrates that our measured energy carbon emissions has decreased since last year whilst costs have increased. However, this is primarily due to improved data quality from the Acute Trust energy suppliers and financial billing errors.

Table 3: Water consumption for the Trust

Water		2016/17	2017/18
Mains	m3	59,092	61,297
	tCO_2e	54	56
Water & Sewage Spend		£245,123	£247,154

Our water consumption has increased in comparison to 2016/17; this is due to water leaks and plant failure at Newtown and estimated data.

Table 4: Trust waste production

Waste		2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	198.00	197.00	191.00	193.00
	tCO_2e	4.16	3.94	4.01	4.20
Other recovery	(tonnes)	2.00	2.00	311.00	313.00
	tCO_2e	0.04	0.04	6.53	6.81
High Temp disposal	(tonnes)	38.00	47.00	0.00	0.00
	tCO_2e	8.36	10.29	0.00	0.00
Landfill	(tonnes)	413.00	371.00	142.00	142.00
	tCO_2e	100.94	90.68	44.02	48.92
Total Waste (tonnes)		651.00	617.00	644.00	648.00
% Recycled or Re-used		30%	32%	30%	30%
Total Waste tCO_2e		113.50	104.95	54.56	59.93

Our waste production has generally reduced in comparison to previous years but has increased slightly in 2017/18. This change is due to services like providing more services to elderly patients; Worcester City Inpatient Unit and Wyre Forest Ward. The Trust is modernising its waste compounds on larger estates, when funding is available. The new Evesham Waste compound has been operational since April 2018. The new compound will improve the storage of waste, vehicular access to waste receptacles, reduced noise and odour nuisance.

Some of the Trust's 2017/18 data are estimated based on Estate Return Information Collection (ERIC) data.

Performance Report

The Trust confirms adherence to the reporting framework within the Department of Health Group Accounting Manual.

Chief Executive
Date: 24th May 2018.

ACCOUNTABILITY REPORT

Corporate Governance Report – Directors' Report

Chris Burdon, Chairman: Chris took up his appointment in July 2011 having been Chairman Designate since February 2011. He is the Chair of the Remuneration Committee and the Mental Health Legislation Committee. Chris was appointed as a NED with NHS Worcestershire in December 2008 and chaired their Provider Services Board. Prior to that Chris held a series of senior executive positions in the metal processing sector. His last post was with Bradken, an Australian PLC, where he had responsibility for worldwide activity in the power generation and cement production markets and the management of three sites in the UK.

Sarah Dugan, Chief Executive: Having been Chief Executive designate since March 2011 Sarah took up her role on 1st July 2011. She attends the Quality and Safety and Finance Performance Committees. Sarah is a trained Nurse and previously worked for NHS Dudley as Chief Executive as well as holding a range of senior positions with community and mental health service providers and commissioning organisations.

Michelle Clarke, Director of Nursing and Quality: Michelle Clarke joined the Trust in April 2016 following a 3 month secondment from Wye Valley NHS Trust where she had been Director of Nursing and Quality since 2011. Previously Michelle has been Managing Director for Warwickshire Community Services and has been involved in professional development, service improvement, education and leadership. Michelle has been a Registered Nurse since 1998 and has extensive knowledge of community healthcare with a background in District Nursing. She obtained her Masters in Health Sciences in early 2000.

Dr Andy Sant, Medical Director: In November 2015 Dr Andy Sant joined the Trust from a similar post in Plymouth having trained and previously worked as a GP. Dr Andy Sant left the Trust in February 2018 with Dr David Lewis appointed interim Medical Director.

Stephen Collman, Chief Operations Officer: Joining the Trust in 2009, Stephen has held a number of senior roles and became a Director in 2014. He is responsible for the day to day running of the Service Delivery Units and operations and management teams as well as Workforce and HR department teams. Stephen qualified as a Nurse in 1990 and has held a number of management posts in mental health and community services. He sits on the Workforce Committee, Finance and Performance Committee and the Quality and Safety Committee.

Robert Mackie, Director of Finance: Robert joined the Trust as a Director in 2011. He has previously worked for the NHS in Walsall as Director of Resources from October 2008 and then from November 2010 as Interim Chief Executive. A qualified accountant, Robert first began working for the NHS in 1998 as part of the national financial management training scheme. He is a member of the Finance & Performance Committee and attends Audit Committee.

Sue Harris, Director of Strategy and Business Development: Sue was appointed in May 2012. Sue has 15 years of business development experience in the health and social care sector. From 2009 Sue was the Lead Commissioner for mental health services in Worcestershire. Prior to this she was a national director for Turning Point, a leading social enterprise. In 2011 Sue was seconded to the Strategic Health Authority.

Gill Harrad, Company Secretary: Gill joined the Trust from Birmingham and Solihull Mental Health NHS Foundation Trust, where she was Company Secretary/Head of Legal Services. Gill first qualified as a solicitor in 1994 working in local authorities in Warrington, Gloucestershire and Birmingham, undertaking a broad range of legal work. Gill moved into the NHS in 2007 working in a specialist Mental Health Trust. Since joining the Trust she built an in-house legal team providing advice and representation for its staff on a wide range of subjects, but particularly inquests, employment disputes, litigation and court of protection matters, as well as advising and supporting the Board on their duties and obligations.

Jill Gramman, Non-Executive Director: Jill had been a Non-Executive Director with the Trust since July 2011. She Chaired the Workforce Committee and was a member of the Finance and Performance and Audit Committees. She has a special interest role in patient experience. In a previous role Jill heard appeals by patients on section under the Mental Health Act. Jill is a former Director and Trustee of SCOPE and BILD. As well as running her own marketing research company for 30 years, Jill is also a Magistrate, a former Chair of the Kidderminster Bench and currently the lay judicial member of the Sentencing Council of England and Wales. Jill left the Trust in July 2017.

Rick Roberts, Non-Executive Director: Rick has been a Non-Executive Director with the Trust since April 2014, having previously served as a Designate Non-Executive Director from November 2013. Rick chairs the Quality & Safety Committee and also sits on the Audit and Remuneration committees. Rick retired as Medical Director of the Birmingham Community Healthcare NHS Trust in April 2013 having served as an Executive Director in successive NHS Trusts for some 20 years. His appointments include Clinical Director of the Birmingham Dental Hospital and Consultant in Oral Surgery.

Steve Peak, Non-Executive Director: Steve joined the Trust in 2013. He is the Chair of the Finance and Performance Committee and sits on the Workforce and Remuneration committees. Steve lectures for Keele University and is Development and Delivery Director for Vanguard Healthcare Solutions Ltd. Over the past 29 years he has held previous senior leadership roles in acute hospitals including a period of time as CEO of Birmingham Women's NHS Foundation Trust.

Stephen Tilton, Non-Executive Director: Stephen has been a Non-Executive Director with the Trust since September 2016. Having qualified as a Chartered Accountant, Stephen held a series of senior executive positions in the financial services sector, including three years with the Financial Services Authority before taking up the position of Director of Legal and Compliance with a global private equity firm. He is also an accomplished musician, and for 10 years was Master of Music at the Chapels Royal, HM Tower of London. Stephen chairs the Audit and Charitable Funds Committees and sits on the Quality and Safety Committee.

Jamie Morris, Non-Executive Director: Jamie joined the Trust as a Non-Executive Director in November 2016, having previously served as an Associate Non-Executive Director from September 2016. A retired senior executive, Jamie have held roles in various public and private sector organisations, most recently as an Executive Director at Walsall Metropolitan Council, where he had responsibility for all neighbourhood services. Before that he was Assistant Chief Executive at Birmingham City Council and a Management Consultant with Deloitte advising local and central government on strategy and performance improvement. Jamie chairs the Workforce Committee and sits on the Finance & Performance Committee.

Tessa Norris, Non-Executive Director: Tessa joined the Board as an Associate Non-Executive Director in January 2018 after retiring from her role as the Trust's lead for Children, Young People & Families and Specialist Primary Care. Prior to joining the Trust, Tessa worked in a variety of roles across the NHS, including Director of Operations at Shropshire Community Health Trust and Managing Director for Dudley Community Services. She is also a qualified coach and has provided support on career development, conflict management and personal development to NHS staff over the last 7 years. Tessa sits on the Workforce Committee and Quality and Safety Committee.

Directors' Statement

The Trust's Directors have considered and confirm that 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 they ought to have taken to make themself aware of any such information and to establish that the auditors are aware of it.

The Trust's Register of Interests is open to the public and may be accessed, by contacting the Executive Personal Assistant to the Company Secretary, either by telephone on 01905 681558 or email at: hayley.payne@nhs.net.

STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

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

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

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

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

Chief Executive
Date: 24th May 2018.

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board

Chief Executive
Date: 24th May 2018.

Finance Director
Date: 24th May 2018.

ANNUAL GOVERNANCE STATEMENT

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.

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 Health and Care 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 Health and Care NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust currently assesses and monitors risk by a variety of methods, not least via an assurance framework. This is the key document for the Trust Board to ensure all principal risks against strategic objectives are identified, managed, controlled and reported upon. The assurance framework is presented to, and approved by, the Trust Board at each public meeting.

The Risk Management processes are guided and provided for by the Risk Management Strategy. This sets out the organisation's approach to risk and defines responsibilities and roles of the Chief Executive, Directors, senior managers and all other staff in relation to the effective delivery of the risk management agenda. It also highlights the links between risk management, the assurance framework and the business planning process. There is documented guidance for staff supported by comprehensive policies and procedures available via the Trust's intranet. The Trust Board discusses the risk appetite of the Trust at least annually and once agreed this is incorporated into the Risk Management Strategy.

Whilst ultimate accountability rests with the Chief Executive, responsibility for risk management has been delegated to the executive leads for risk. The Director of Nursing and Quality and Medical Director have joint delegated responsibility for clinical risk management and clinical governance. The Director of Finance is responsible for financial risk management. The Company Secretary has delegated responsibility for managing the strategic development and implementation of corporate risk management and assurance, and is responsible for the development and maintenance of the high level risk register. The work of the Quality and Safety Committee is supported by a number of sub committees and working groups. The Risk Moderation Group supports risk register owners in ensuring consistency and compliance with the Risk Management Strategy in completing and reviewing risk registers and reports to the Audit Committee. The Finance and Performance Committee and Workforce Committee, similarly supported by sub-committees identifies and provides assurance to Trust Board on key financial, performance and workforce risks. Mental Health Legislation Committee receives reports on all complaints and incidents arising out of the Trust's usage of the Mental Health Act. All of the above committees review key risks each meeting and consider any changes that ought to be escalated to Trust Board's attention.

As part of the risk management strategy, training is delivered to managers and to other staff across the Trust, both at induction to the Trust and also as part of on-going development. Areas covered include: risk management, risk assessment, incident reporting, health and safety, infection control and the handling of complaints. The extent and level of training is dependent on a member of staff's delegated responsibility. The legislative requirements of risk management and risk assessment within a safe system of work are actively promoted by the Trust. The Risk Moderation Group has run sessions for corporate and operational risk register owners, team leaders and ward managers, to emphasise the principles of the risk management strategy as well as sharing good practice.

The Trust uses an on line integrated risk management system. The Incident Reporting Module has an e-mail trigger facility, which alerts responsible managers to recent incidents. A trigger is also sent to key governance staff such as the Patient Safety Manager, Risk and Security Manager and Quality Leads for each Service Delivery Unit, who review recently submitted incidents and forward guidance on the information which is needed to complete the incident report to the responsible manager.

The software contains data entry forms, which are used to record details of investigations, recommendations, actions and lessons learned. Monthly incident data reports are provided to the responsible managers and monthly reports are provided to the Integrated Governance sub-committee. These give all relevant details about the incidents and managers provide further contextual information to the Serious Incident Forum meeting to facilitate the organisational learning from incidents.

Trend analysis reports have been developed to further inform managers and senior managers about any developing incident trends across the Service Delivery Units and the wider Trust.

The need to engage each and every staff member and to provide the appropriate level of training to them remains a key objective and priority within the Trust. There are systems in place for staff to raise concerns/ risks/near misses to allow action to be taken and for lessons to be learned.

The risk and control framework

The key elements of the risk management strategy focus on:

- Individual and corporate responsibility.
- A structured framework for the management of risk with a clear definition of the roles and responsibilities for directors, managers, clinicians and allied health professionals.
- A purposeful approach to enabling the Trust to embed risk management within its structure and so support the Trust in meeting its new functions and objectives.
- Compliance with all relevant statutory and non-statutory standards relating to the assessment and control of risk.
- Identifying, and where possible eliminating, risk and controlling any remaining risk. Monitoring the controls and procedures to ensure effective risk management within the Trust.

Formal risk assessments are being undertaken locally, with specialist support and guidance provided as required. If advice and/or training is required on clinical risk assessment this will be provided by the Quality Governance Department. If advice and/or training is required on non-clinical/generic risk assessment this will be provided by the Risk and Security Manager and/or Health and Safety Manager.

Risk assessment and incident reporting systems remain key to the on-going assessment of risk. Evaluation of any, or all, control measures are considered, not only by line management but also by the Quality Governance department or Risk Moderation Group. This provides a robust double check within the system.

All cost improvement plans are subject to a detailed quality and equality impact assessment involving the Director of Nursing and Quality and Medical Director.

Risk management continues to be promoted and embedded throughout the Trust. During 2017/18 there has been a significant emphasis in ensuring that there is consistent adherence to the Risk Management Strategy, with training, support and challenge being provided by the Risk Moderation Group – a sub-committee of Audit Committee. The Board has also been engaged in this process in ensuring that there is greater clarity in the risks potentially impacting on our ability to achieve our strategic objectives. This has led to more consistent application of the assessment of risks, as identified in our Risk Management Strategy. In turn this has impacted on those risks that are contained in the board assurance framework.

Major Risks 2017/18

The Trust has identified the following in year risks:

The Trust Board developed a board assurance framework to identify and monitor their major risks for 2017/18. In the final quarter of the year, this was refreshed, with additional support being provided to risk register owners to manage their own risks appropriately and allowing greater clarity as to the highest level or emerging risks to be identified.

The following items are included on the board assurance framework as at 31 March 2018:

Risk	Mitigation	Outcome
Failure to deliver acceptable standards of care leading to poor patient experience	– Training for staff in patient centred care – Mechanisms for capturing patient experience – PALS and complaints processes – Membership engagement process – Board patient safety walkabouts – Francis et al action plan – Safety thermometer – Wide ranging governance arrangements – Serious incidents process – Revalidation of medical staff and in due course nursing staff – Audit, research and clinical effectiveness activities – Performance framework – Developing consultant dashboard – External assessments	– Positive and safe outcomes for patients. – Good quality care being provided. – Positive patient experience being reported
Long term financial sustainability	– Focused attention to identify, on a prospective basis, opportunities to increase efficiency and cost effectiveness of delivery of services. A programme management office structure is in place with robust project management applied to each CIP scheme. – Regular and robust processes to ensure good performance management. – Established and robust processes in place to ensure compliance and oversight with key performance indicators.	– Increased confidence about deliverability of recurrent CIPs. – Performance and financial indicators reviewed at each Finance and Performance Committee. – Compliance with key financial and performance indicators
The Trust has approved a strategy supporting the STP and national direction of travel and continues to work to support those agendas, whilst operating within a framework focused on different regulatory regime without updated national legislation or guidance	– National guidance published and regular national and regional events to benchmark progress – Submissions made in accordance with guidance – STP subject to public consultation – Processes in place to address plans in dedicated workstreams with governance processes embedded	– Governance Structure being agreed and overseen by NHS England – Reviewing STP based on public consultation. – Capacity being built nationally to address leadership challenges
SO1/2/3/4 – The Trust needs to attract, develop and retain an appropriate workforce to deliver appropriate services within limited resources	– Undertaking a number of initiatives relating to recruitment and supporting new roles, e.g nursing associates – Specific workstreams to look at retention of existing employees – Improving staff engagement through go-engage initiative	Delivering services with appropriately trained and skilled staff

Action plans are in place to manage the aforementioned risks. These are subject to scrutiny by Board and the relevant Board committees.

The risk and control framework

Board and Board Committee Effectiveness

Trust Board operates in accordance with the Trust's Establishment Order, Standing Orders, Scheme of Delegation and Standing Financial Instructions. The Trust has seven Committees that report directly to it:

- Audit Committee
- Quality and Safety Committee
- Finance and Performance Committee
- Workforce Committee
- Remuneration Committee
- Mental Health Legislation Committee
- Charitable Funds Committee

Mental Health Legislation Committee was only established as a Board Committee in November 2017. Each Committee is chaired by a Non-Executive Director, for all of the Committees other than Audit and Remuneration, specific Executive Directors are also members, for Audit and Remuneration Committees executive staff are invited to attend as appropriate to discharge the business of the Committee. The executive team hold the following responsibilities:

Sarah Dugan, Chief Executive, is the Accountable Officer for the Trust and leads the Executive team					
Robert Mackie, Director of Finance/ Deputy CEO	**Stephen Collman, Chief Operating Officer**	**Michelle Clarke, Director of Nursing and Quality**	**Andy Sant, Medical Director/ David Lewis, Interim Medical Director**	**Susan Harris, Director of Strategy and Partnerships**	**Gill Harrad, Company Secretary**
Finance Performance Business and Budgetary Planning Information Infrastructure Estates and Facilities Contracting Procurement Senior Information Risk Owner	Operational Management of Services Service Transformation Integrated Service Delivery Service Improvement and Productivity Emergency Planning Workforce/HR	Quality Improvement Patient Safety Clinical Strategy Safeguarding Professional Standards Training & Development Organisational Development Infection Prevention and Control Health and safety Security Management Complaints	Quality Improvement Patient Safety Clinical Strategy Medical and Dental Standards Medical Revalidation Caldicott Guardian Research & Development Clinical Audit and Effectiveness Medicines Management Chief Clinical Information Officer	Strategy New Business Development Interface with Partners (inc HOSC/HWBB) Customer Relationships Marketing Communications Programme Management Office Community Engagement Membership Systems	Board/ Corporate Support Corporate Governance and Risk Assurance Framework Legal Services Mental Health Act Lead Board Development Information Governance

The Board of the Trust provides its leadership and is charged with securing the organisation's long term success. The Board is collectively responsible for controlling the Trust. The Board sets strategic direction and supervises the work of the executive to ensure that corporate objectives and performance targets are achieved. The Board makes those decisions reserved unto itself, defines and sets the approach to risk and risk management and conducts itself in such a way that it takes the view of key stakeholders into account. The Trust has continued to review and update self-assessments against the Well Led Framework throughout the reporting period.

Annually, Non-Executive Director membership of Board committees are reviewed by the Chairman and changes were last implemented with effect from 8 January 2018. Following the departure of Jill Gramann in July 2017 a recruitment exercise was undertaken and a new Associate Non-Executive Director Tessa

Norris was appointed. A further recruitment exercise was undertaken in the final quarter of the year and a new Non-Executive Director and Associate Non-Executive Director will commence with the Trust in the next reporting period.

At each formal Board meeting Board members are asked to declare any conflict of interest. The Board annually affirm their commitment to the Nolan Principles of Public Life. There have been no departures from the requirements of the Standards of Business Conduct and Anti-Bribery policy and the overarching corporate governance framework. An annual declaration of interests is made and each member of the Board has confirmed, at least annually, that they meet the requirements of the Fit and Proper Persons regulations introduced in November 2014.

Annually Board and Committee members are asked to complete a proforma self-assessment checklist designed to elicit comments on the effectiveness of the committee and Board meetings. The checklist is derived from the proforma checklist for audit committees published in the NHS Audit Committee Handbook. In November 2017 the Trust Board reported on their effectiveness evaluation, which included outputs from the effectiveness reviews of the main Board Committees. The effectiveness evaluation was also linked to the Board development programme for the following 12 months.

Each Board member has a set of objectives that are agreed with their respective appraiser against which performance is measured and which are subject to formal appraisal at least annually. In terms of individuals' performance on the Board, feedback is provided from the non-executive members of the Board to inform the appraisal process for the executive members. Feedback includes commenting on the contribution they make to the Board and provide an overview of how the Board as a whole is performing. This also informs areas for development as well as the results being reviewed and actions adopted by the Committee to address any areas of deficiency.

The NEDs are determined by the Board to be independent on the basis that none:

- has been an employee of the trust within the last five years;
- has, or has had, within the last three years, a material business relationship with the trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust;
- has received or receives additional remuneration from the trust apart from a director's fee, or is a member of the trust's pension scheme;
- has close family ties with any of the trust's advisers, directors or senior employees;
- holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;
- has served on the board of the trust for more than nine years from the date of their first appointment.

The quality and safety of patient services has been maintained overall. There has been no loss of control of the Trust's finances. Performance levels have been maintained against the key indicators contained within the NHS Improvement single oversight framework, and the mental health performance framework.

The table below lists attendance at Board and Board Committee meetings for the reporting period.

Attendance by Board members at Trust Board and Board Committee Meetings 1 April 2017 – 31 March 2018

Meeting	Number held	Chris Burdon	Jill Gramann*	Stephen Tilton	Rick Roberts	Steve Peak	Jamie Morris	Tessa Norris***	Sarah Dugan	Andy Sant	David Lewis**	Stephen Collman	Michelle Clarke	Robert Mackie	Sue Harris	Gill Harrad
Trust Board****	9	9	3	5	9	7	7	3	8	8	2	8	9	8	9	8
Board Development	6	6		4	6	6	5	2	5	5	1	6	6	5	6	5
Audit Committee	6	○ 1		6	4	2								5		6
Quality & Safety Committee	12	□ 3	2	8	10			3	7	10	2	9	12			9
Finance & Performance Committee	12	□ 11				11	10		7	□ 9	□ 1	10		12	7	
Charitable Funds Committee	2			2								□ 1		2		
Remuneration Committee	3	3			3	3			3							
Workforce Committee	10	□ 4	2			4	9	1				9	10			
Mental Health Legislation Cttee	1				1		1	1								1

□ Attended in observer capacity
○ Attended to cover absence of a member

* Jill Gramann left 12/07/2017
** David Lewis – Interim Medical Director from 01/02/2018 following departure of Andy Sant
*** Tessa Norris – Associate NED from 01/01/2018
**** Includes 7 x public and private sessions plus 2 x additional private sessions

Balance, Completeness and Appropriateness of the Board membership 1 April 2017 – 31 March 2018															
	Chris Burdon (Chairman)	Jill Gramann	Stephen Tilton	Rick Roberts	Steve Peak	Jamie Morris	Tessa Norris	Sarah Dugan (Chief Executive)	Andy Sant	David Lewis	Stephen Collman	Michelle Clarke	Robert Mackie	Sue Harris	Gill Harrad
Non-Executive Director – voting rights	✓	✓	✓	✓	✓	✓									
Non-Executive Director – non-voting							✓								
Executive Director – voting rights								✓	✓	✓	✓	✓	✓		
Executive Director – non-voting														✓	✓
Gender	M	F	M	M	M	M	F	F	M	M	M	F	M	F	F
Individual's Appraisal undertaken by NHS Improvement	✓														
Individuals' Appraisals undertaken by Chairman		✓	✓	✓	✓	✓	✓	✓							
Individuals' Appraisals undertaken by Chief Executive									✓	✓	✓	✓	✓	✓	✓

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

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

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

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

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

Chairs of Board Committees present reports to the Board on the matters considered by their respective Committees. In the case of the Audit Committee the report informs the Board of the level of assurance that has been given by Internal Audit on the reviews that they have been commissioned to undertake in 2017/18. Twenty two reviews have been undertaken during this period, of which sixteen have been given either level A or significant assurance on the Trust's controls, and five were given moderate assurance and one that was not rated as it was an advisory audit.

Level A / significant assurance:

- Performance management of medical staff
- Emergency planning
- Delayed discharges
- Commissioning for quality and innovation (CQUIN)
- Site visits
- Capital
- Procurement
- Cost Improvement Programme (CIP)
- Financial management
- Charitable funds
- Client end financials and payroll
- Debtors
- Treasury management
- Deprivation of liberty safeguards – (follow up)
- Pharmacy (follow-up)
- Assurance Framework

Moderate assurance:

- Implementation and systems access Care Notes
- Pharmacy
- Data Quality
- E Rostering – follow up
- IT security management

Not Rated:

- IG Toolkit

For all audits, action plans are agreed to address the issues identified and specific attention is paid to those areas in which significant assurance is not obtained, with follow up audits planned. The Audit Committee reports to the Trust Board informing the Board of the programme of work that is undertaken by both the Internal and External Auditors.

The Trust's Counter Fraud function is outsourced to our Internal Auditors who in conjunction with their Local Counter Fraud Specialist attend the Audit Committee. The Trust has an internal Local Security Management Specialist, who also attends Audit Committee.

At the start of the reporting period the Audit Committee had three sub-committees; namely the Risk Moderation Group, Data Quality Improvement Group and the Auditor Panel that reviewed and managed the process relating to the appointment by the Trust of internal and external auditors. The first two groups meet and feed back to each Audit Committee with the Auditor Panel meeting as and when required.

Data Quality

The Trust complies with all statutory reporting requirements with regard to waiting lists. All waiting lists are validated on a monthly basis prior to these statutory submissions being made by representatives from the Information Team and clinical services. The processes involved in waiting list management have been reviewed by the Data Quality Improvement Group and have been found to be sound. This Group reports to the Audit Committee of the Trust. All waiting lists are reported routinely within the Trust performance reporting structure; this includes greater granularity depending on the audience for the report (i.e Service, Directorate, Committee, Trust Board). Any areas of poor performance are identified are required to have recovery plans produced in line with the Performance management Framework of the Trust.

Information governance

The Trust recognises the importance of the security, confidentiality, integrity and availability of, personal confidential data about patients, staff, other persons and business sensitive information.

In accordance with the Data Protection Act 1998, the Trust is registered with the Information Commissioner's Office (ICO) for the purpose of processing personal information; Reference Number Z2745227.

The Director of Finance is the Senior Information Risk Owner (SIRO) and takes overall ownership of the Trust's Information Risk Management Programme. The SIRO undertakes annual training. No major information risks have been identified.

The Medical Director is the Trust's Caldicott Guardian and is the designated senior medical officer to oversee all procedures affecting access to patient identifiable information. The Caldicott Guardian undertakes annual training. The Head of Information Governance works closely with, and offers advice to, the Caldicott Guardian.

In light of the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 2018) the Head of Information Governance has been appointed as the Trust's Data Protection Officer (DPO). He has completed the International Board for IT Governance Qualification (IBITGQ) EU GDPR Practitioner. An implementation plan has been developed and significant progress has been made ahead of the implementation of the GDPR on 25 May 2018.

All key Information Assets have been identified on the Trust's Information Asset Register. Information Asset Owners have been identified and information risk assessments have been undertaken or are planned.

Defined authorised access to specific information systems are documented in specific System Level Security Policies.

A robust Information Governance Management Framework is in place including:

- terms of reference for the Information Governance Steering Group and the Records Management Steering Group.
- key information governance (IG) policies are in place such as, Information Governance, Confidentiality, Data Protection, Information Risk, Information Security, Records Management, Freedom of Information and IG Incident Reporting.

The Information Governance Steering Group derives its authority from the Quality and Safety Committee and is chaired by the Company Secretary; the SIRO and Caldicott Guardian are both members. All three are Board Members. Quarterly reports are provided to the Quality and Safety Committee.

The Records Management Steering Group gets its authority from the Information Governance Steering Group and is chaired by the Caldicott Guardian; there is representation from every area of the Trust. Quarterly reports are provided to the Information Governance Steering Group.

The latest version of the mandatory annual NHS Information Governance Toolkit has been published for 2017/18. The Trust has attained the required performance level and achieved an overall score of 74% (Graded as Green, Satisfactory – the highest grade obtainable).

The current NHS Information Governance Toolkit is being replaced with the 'new' NHS Data Security and Protection Toolkit (from 1 April 2018). The 'new' Toolkit is based upon the 10 x data security standards identified in the National Data Guardian (NDG) Review. The Trust has developed a comprehensive action plan for the 'new' Toolkit and the supporting evidence portfolio is currently being reviewed by the Trust's Internal Auditors.

There is a procedure in place for granting contractors/third parties access to Trust systems that hold personal confidential information

All staff are required to complete mandatory annual Information Governance training.

All new staff and volunteers are required to attend Trust induction including Information Governance awareness.

All Information Governance related incidents are reported on the Trust's incident reporting system and an automated email is sent to the Information Governance Team for investigation.

All Information Governance Serious Incidents Requiring Investigation (SIRIs) Level 2 (Reportable) are recorded on the Information Governance Incident Reporting Tool, on the strategic executive information system (STEIS) and are published on the Trust's website and in the Trust's Annual Report. This includes cyber incidents. There have been no Level 2 Information Governance SIRIs in the reporting period.

A Service Level Agreement is in place with Computacenter which requires compliance with the relevant standards in the latest version of the NHS Information Governance Toolkit.

The Head of Information Governance is the Chair of the Worcestershire Countywide Information Governance Steering Group whose members are drawn from: Worcestershire Health and Care NHS Trust, Worcestershire Acute Hospitals NHS Trust, 3 x Worcestershire NHS Clinical Commissioning Groups, NHS Midlands and Lancashire Commissioning Support Unit and Information Security Specialist support from Computacenter.

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.

In particular this should explain how the trust assures the quality and accuracy of elective waiting time data, and the risks to the quality and accuracy of this data.

Summary of Quality Governance Arrangements

The Quality and Safety Committee is a key component of the Trust's strategic business and integrated governance arrangements.

The Committee provides a strategic control of quality governance arrangements in accordance with clearly defined terms of reference. Monitoring of key performance indicators combined with qualitative and narrative reporting enables effective monitoring and assurance on the quality of care in services across the Trust.

Following a self-assessment of the effectiveness of the Committee (an anonymous online survey from members) of the Quality and Safety Committee, the governance arrangements to support the Committee were revised in August 2017 with the aim of further enhancing the Trust's 'check and challenge' approach to assurance. The Quality and Safety Committee is now underpinned by an Integrated Governance meeting which brings together the monthly quality, financial and performance reports to provide a comprehensive and rounded overview of integrated performance in each Service Delivery Unit.

This arrangement facilitates an ability to undertake a forensic analysis of quality within the scope of financial and performance influences, allowing for a shared understanding of key risks, mitigations and achievements. A highlight report is provided from the Integrated Governance meeting to the Quality and Safety Committee each month.

In addition to this a monthly Clinical Quality Improvement Forum focuses on shared learning particularly in relation to serious incidents. The Forum uses additional intelligence from related governance sources such as complaints and compliments, clinical audit and patient experience feedback to recognise key improvements that can be made.

The Trust's Quality Governance Policy documents the framework for quality governance arrangements across the trust, and ensures there is a clear understanding of how our systems support the delivery of safe, high quality care so that the Trust consistently:

- Identifies and shares good practice, quality improvement and innovation;
- Shares learning from improvement actions from when things have not gone well;
- Directs resources and support to areas that are not reaching expected standards and targets;
- Has clarity and openness in measuring and sharing performance;
- Invites challenge from stakeholders, in particular patients, carers, staff and commissioners;
- Celebrates and shares successes.

Each Service Delivery Unit has its own documented Quality Governance framework in support of the overall policy. Monthly Service Delivery Unit quality reports ensure key risks are identified together with actions being taken to address and mitigate risks. Key metrics relating to quality, as defined within the Trust's Performance Management Framework, are also reviewed in the monthly Integrated Governance meeting. In line with the Terms of Reference for this meeting recovery plans are commissioned, approved and reviewed against the identified key metrics.

All Cost Improvement Programmes or new service developments undergo a Quality and Equality Impact Assessment. These are presented by the project lead to a Quality and Equality Impact Review panel who oversee the quality and safety implications of each programme. The full assessment must be signed off by the Director of Nursing and Quality and the Medical Director who require assurance that all quality and safety considerations have been fully assessed. Each project will then have measurements identified to monitor longer term effects on the quality of services.

Our governance arrangements for learning from deaths are based on the National Quality Board's guidance with a focus on the review, investigation and reporting of deaths. Our Mortality Review Group, chaired by the Medical Director, oversees the development and implementation of the Trust's Mortality Review Policy. Quarterly reports are provided to the Quality and Safety Committee, Trust Board and our commissioners, using combination of data and narrative updates to gain an understanding of mortality rates and the quality of care that patients and carers/relatives have experienced.

All deaths of services users who have a learning disability are referred through to the local Learning Disabilities Mortality Review (LeDer) co-ordinator.

We are actively seeking out mortality data and trend information from peer providers to help identify improvements in undertaking mortality reviews and to enable benchmarking and more meaningful data.

The Trust's web-based monitoring tool for staffing levels, which allows senior managers and the Director of Nursing and Quality to have access to real time staffing level information, ensures that there are strong controls around safe staffing. An in-depth review of staffing data is undertaken every 6 months. Staff are encouraged to report any issues around staffing levels onto the web-based incident reporting system, Ulysses. Any such reports are automatically forwarded to the Director of Nursing and Quality who will take appropriate action. The Trust Board receives staffing reports every two months. Board members visit teams on a programme of Patient Safety Walkabouts so that the information contained within board reports can be verified with staff working in clinical teams.

Patients are actively encouraged to complete the patient Family and Friends test, either on discharge from the service or at significant intervals of care for longer term community patients. Each bedded unit has a 'Friends and Family Champion' who ensures the survey is promoted to patients and carers. The results of the surveys are fed back to the staff in the services in order that high levels of satisfaction are recognised and valued and so that any suggestions for changes are taken forward. The Friends and Family Test results are overwhelmingly positive with many verbatim comments about individual staff who 'go the extra mile' for patients and carers. Where individual staff members are named in any positive feedback, then the Director of Nursing and Quality writes to that member of staff thanking them for their contribution to outstanding patient care. Any suggestions for changes or negative comments from the Friends and Family Test responses are reviewed and acted upon and 'you said, we did' posters advertise the changes that have been made.

We held our annual Patient Experience Conference in November 2017. Over 90 representatives from a range of stakeholders came together to celebrate good practice and to help shape the plans for the focus of our patient experience work going forward. This successful event has helped to galvanise a more joined-up approach, so that we can work more closely with our neighbouring Acute Trust, our Local Authority partners, commissioners and voluntary organisations to understand the patient experience across the system.

This programme of patient experience work, the patient safety walkabouts undertaken by the Trust Board, patient and staff stories to Board, together with analysis of complaints and compliments provides triangulated information about where we are getting it right, and where improvements are needed. We publish a summary of all complaints (anonymised) on the Trust's public facing website and use our data to identify any themes or trends. We pay particular attention to complaints about staff attitude to identify any services that may need particular support. The Trust adopts a proactive approach to enquiries received by our Patient Advice and Liaison Service, trying to resolve matters as early as possible. This is described in detail in the Trust's Policy for Receiving, Investigating, Responding to and Learning from Complaints, PALS enquiries and Professional Enquiries.

In terms of quality improvement, the Trust applies the 'Plan, Do, Study, Act' approach. During 2017/18 our quality improvement capabilities developed at pace with a number of staff attending NHS England's 'Quality Service Improvement Review' (QSIR) programme. This means we are now able to tap into the skills of staff trained in quality improvement methodology to support initiatives such as Red2Green, Safety Huddles, Patient Flow, Safe Wards, Pressure Ulcer prevention and Falls prevention. This added expertise leads to greater project efficiency and enhanced project outcomes. During 2017/18 five Quality Aims were identified, after consultation, by Trust Board. These also formed our Quality Account priorities:

- To learn from patient safety incidents at all levels.
- To be a dementia friendly organisation.
- To always ensure our patients and carer have the best possible experience.
- To ensure there is parity of esteem for mental health patients.
- To be an employer of choice.

Each Quality Aim was aligned with one of the Trust's values. The Quality Aims have been actively promoted with staff Quality Improvement Champion (QICs) - staff who have registered an interest in Quality Improvement and who then receive targeted support in quality improvement skills. The Quality Aim Project Leads have been held to account by the Quality and Safety Committee through regular update reports.

Arrangements for assurance on the content and publication of the Quality Account

The Trust's Quality Account complies with the Department of Health requirements. A rigorous review is undertaken by the Quality and Safety Committee to ensure that the information contained in the account is balanced and accurate. Our Commissioners and local partners, including Healthwatch, are invited to scrutinise the Account and provide comment to certify we have provided a fair representation. We respond to this consultation and will make amendments to the Quality Account as required although to date any such necessary amendments have been minimal. The Quality Account is subject to external audit, and full assurance has been gained for all of the published Quality Accounts to date.

Arrangements for assurance on Clinical Audit

There is a 3 year rolling audit programme in the Trust which is overseen by the Clinical Audit and Effectiveness Group. The rolling programme allows time for major audits and re-audits to flow through from one year to another. The Clinical Audit and Effectiveness Group, which is chaired by the Deputy Medical Director, reports through to the Quality and Safety committee. The 2017/18 Clinical Audit plans were agreed by the Service Delivery Units in early 2017, identifying audit topics that relate back to, for example, NICE Guidance compliance, issues that have emerged through incidents and complaints or through assessed risk.

The Trust takes part in relevant national clinical audits and subscribes to the Prescribing Observatory for Mental Health audit programme. Trust Board is provided with an annual report regarding compliance with the audit plan, which provides examples of improvement outcomes as a result of the audit programme.

Arrangements for Never Events and Serious Incidents

The Trust actively supports staff in the process of identifying, reporting and managing incidents. The NHS England Serious Incident Framework is used as the basis for incident reporting arrangements. All incidents reported on the web-based system (Ulysses) are reviewed by the Patient Safety Team to ensure the incidents have been correctly risk assessed and to identify those incidents that need immediate actions or meet the Never Event criteria. The Trust has not reported any Never Events in 2017/18.

Each Serious Incident has a Root Cause Analysis undertaken by a trained Investigating Officer. A round table meeting is held for each Serious Incident resulting in action plans that are approved by the Serious Incident Forum. Careful checks are undertaken to ensure patients and families have been involved in the investigation and are fully appraised of the outcome in line with the Trust's approach to openness and our duty of candour.

The Serious Incident Forum, chaired by the Director of Nursing and Quality and attended by clinical staff interrogates the final drafts of the individual Serious Incident reports to ensure the underlying cause has been identified, and that appropriate actions are being taken to support those involved in the incident. A summary of key learning is collated and issued via the Trust-wide Team Brief newsletter, with a strong emphasis on the importance of human factors in open reporting, learning and improvement.

Our Being Open and Duty of Candour policy sets out how we involve patients and, with consent, their families in the investigation and resultant learning. We have on-line Duty of Candour training available for all staff. Bespoke individual Duty of Candour training sessions are also held with clinical teams using examples of real cases to promote reflective discussion. The Duty of Candour policy was reviewed in November 2017 to include clearer processes and support for staff involved in Duty of Candour cases.

External Review of the quality of services provided

When our commissioners, the CCG, undertake an announced inspection of services we accompany the visiting team with staff from similar teams in our own Trust. This helps to support learning between clinical teams. Between 1st April 2017 and 31st March 2018 16 services took part in a peer review with the CCG.

Overall, the peer review visits have reported positive findings. Action plans are drawn up by the services themselves after each visit and are monitored until all actions have been completed. The following is a list of the peer review visits during 2017/18.

Date	Type of CCG Inspection	Location/Service Inspected
17/04/2017	CCG Assurance	Evening Service District Nurse Team Wyre Forest
03/05/2017	CCG Assurance	Crisis Team
12/05/2017	CCG Assurance	Tenbury Community Hospital
07/06/2017	CCG Assurance	Admiral Nursing Service
07/06/2017	CCG Assurance	Redditch & Bromsgrove CTLD
05/07/2017	CCG Assurance	Home Treatment Team, South Worcestershire
07/07/2017	CCG Assurance	Worcester City District Nurse Team
25/07/2017	CCG Assurance	Lympheodema Service
14/09/2017	CCG Assurance	Community Assessment and Reablement Services (CARS) North
20/09/2017	CCG Assurance	Reach 4 Wellbeing
06/10/2017	CCG Assurance	Malvern Integrated Team
16/10/2017	CCG Assurance	Princess of Wales Community Hospital Minor Injuries Unit
20/11/2017	CCG Assurance	Community Assessment and Review Service South
15/12/2017	CCG Assurance	Childrens Eating Disorder Service
09/01/2018	CCG Assurance	Wyre Forest Ward
12/01/2018	CCG Assurance	Complex Neurology

We underwent a major 'Well-Led' inspection in January 2018 with the Care Quality Commission (CQC) visiting a large number of teams. The following is a list of all CQC inspections undertaken in the Trust during 2017/18.

Date	Type of CQC Inspection	Team visited
15/05/2017	Mental Health Act	Hadley Psychiatric Intensive Care Unit
02/01/2018	Mental Health Act	Hadley Psychiatric Intensive Care Unit
09/01/2018	Well-led	Home Treatment Team (Wyre Forest)
10/01/2018	Well-led	Home Treatment Team (South)
10/01/2018	Well-led	Crisis Resolution Team
10/01/2018	Well-led	Mental Health Managers
11/01/2018	Well-led	Recovery Unit
11/01/2018	Well-led	Home Treatment Team
11/01/2018	Well-led	Crisis Resolution Team
12/01/2018	Well-led	Recovery Unit
15/01/2018	Well-led	Community Assessment and Recovery Services (CARS)Team North
15/01/2018	Well-led	CARS Team Worcester
16/01/2018	Well-led	CARS Team North
16/01/2018	Well-led	CARS Team Worcester
15/01/2018	Well-led	Hillcrest Ward
16/01/2018	Well-led	Hadley Psychiatric Intensive Care Unit
16/01/2018	Well-led	Holt Ward
16/01/2018	Well-led	Neurology Services
16/01/2018	Well-led	Admiral Nurses
16/01/2018	Well-led	Enhanced Care
16/01/2018	Well-led	Evesham Hospital in-patients
16/01/2018	Well-led	Pershore Hospital in-patients
17/01/2017	Well-led	Tenbury Hospital in-patients
17/01/2018	Well-led	Princess of Wales Community Hospital in-patients
17/01/2018	Well-led	Hadley Psychiatric Intensive Care Unit
17/01/2018	Well-led	Lymphoedema Service
17/01/2018	Well-led	Community Stroke Service
17/01/2018	Well-led	Podiatry Service
17/01/2018	Well-led	Community Adults Service Manager
17/01/2018	Well-led	Lead for Rapid Response/Rehab Services
17/01/2018	Well-led	Community Matron
17/01/2018	Well-led	CARS Worcester
17/01/2018	Well-led	CARS North
17/01/2018	Well-led	Podiatry (consultation event)
18/01/2018	Well-led	District Nurse Team
18/01/2018	Well-led	Lymphoedema Service
18/01/2017	Well-led	Worcester City Inpatient Unit
23/01/2018	Well-led	New Haven Wards
24/01/2018	Well-led	Athelon Ward

Verbal feedback was provided immediately following the visits, although formal written feedback is still awaited.

Community Engagement and Patient Involvement

The re-design of the Older Adult Mental Health Services that commenced in the first half of the year, concluded with the work being presented to the Health Overview and Scrutiny Committee, and presentation of a final Equality Impact Assessment for discussion at the Equality Advisory Group. Work to implement the new service is now being undertaken.

There has also been work undertaken around the re-design of Podiatry services. This commenced with some extensive gathering of recent patient feedback and engagement with patients and staff, plus a baseline equality assessment being presented to the Advisory Group – all of which was key information used in a series of co-production workshops and events involving staff, patients, carers and a range of other stakeholders. As a result of discussions at the Equality Advisory Group, further engagement work was undertaken with a range of seldom heard groups. The events produced some key themes that are now being used to develop possible service models that will be the subject of further engagement.

Much work has been undertaken to further develop the Community Engagement Panel, including the recruitment of new members who bring with them a range of experiences to add further diversity to discussions, and who, along with other members have worked to develop new Terms of Reference and a Mission Statement that reflect their key aims – to act in an advisory and ambassadorial capacity and so increase our reach into the communities we serve. Panel members have supported a range of projects and groups including the Mortality Review Group, the Global Digital Exemplar work, the Neighbourhood teams and the Equality Advisory Group, and many have been involved in the recruitment of new Trust staff and service redesigns, feeding back to their panel peers about their work and working together to offer a considered view on Trust projects and initiatives. A number of panel and virtual group members were involved in the recruitment of the new Trust Medical Director, piloting a new approach to involvement in recruitment and selection by working with NHS Leadership Academy. To help them in their work, panel members have identified and received training on a range of topics including recruitment and selection, co-production, and chairing skills.

The team has undertaken an evaluation of the effectiveness of the Youth Board, and a new framework has been developed using the contributions of young people and staff. As a result, we now have a new model of Youth Consulters and a virtual group of Youth Ambassadors. We are currently working to train and develop the young people, to allow them to step into advisory and ambassadorial roles, so ensuring we hear the young person's perspective and helping us extend our reach into the local community of young people. The young people have engaged in a range of projects to date – this includes providing feedback to the Communications department around the use of social media to share prevention and self-care messages; the development of a health and well-being app for CAMHS; work with the Reach4wellbeing service; speaking at a Patient experience day around self-management of long term conditions, and the development of a Support group for parents of children with eating disorders. Current work involves raising staff awareness in teams to increase young people's participation in decision making – for example by including a young person in recruitment and selection of new staff. Other projects include working with partners around the county Children and Young People's Plan, and working with a range of voluntary and community sector groups.

The team continue to support and deliver on a number of projects in relation to the Sustainability and Transformation Partnership. Attendance at the Communications and Engagement workstream, Prevention Board and Organisational Development/workforce meetings continues, and the team offers engagement support/supervision to the STP Project Management Office. A key area of work has been organising a working group to support the required engagement around the development of the Neighbourhood Teams, which commenced with some staff engagement to identify key areas of focus. This work will involve the development of some Patient and Partnership groups, engagement with prospective members, and the development of the group Terms of Reference. The team are also working with volunteers to explore the possibility of embedding patient self-management approaches within the teams. Another key area of work has been the Building Health Partnership Programme. A year-long piece of work, this programme is looking to develop new ways of working with carers so that they are recognised by all staff as true expert care partners. It involves recognising the challenges, looking at best practice, and finding solutions with the aim of developing a system wide approach that will see all staff working with carers in new ways. A final area of system work has been the work undertaken to align provider approaches to recruiting, developing and supporting volunteers, in accordance with the People Strategy. The work is commencing with providers in Worcestershire with the aim of then working with colleagues in Herefordshire.

Other work undertaken by the team includes a refresh of the Volunteer Policy to reflect changes to induction following the gathering of feedback from volunteers. The team has also supported a task and finish group to develop some clear guidelines around the involvement of families and carers following the death of a patient. Currently, the team are working on a refresh of the Strategic Approach to Co-production and have engaged with a number of patient groups, stakeholder groups and will be undertaking extensive staff engagement in the coming weeks. The refreshed document will be launched in the summer of 2018 at a planned system-wide co-production event, set within the context of NHS 70.

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, Audit Committee and Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Conclusion

There have been no significant control issues identified in the year and the Board are satisfied the Trust remains a going concern.

Signed

Chief Executive
Date: 24th May 2018

REMUNERATION AND STAFF REPORT

REMUNERATION POLICY

The Remuneration Committee of the Trust is a sub-committee of the Trust Board, which determines the remuneration, allowances and terms of service of the Chief Executive and those Executive Directors reporting directly to the Chief Executive. The membership of the Committee comprises of the Chairman of the Trust and two Non-Executive Directors. The Committee undertakes the following duties:

a) To agree appropriate remuneration and terms of service for the Chief Executive and other directors including:
   - All aspects of salary (including any performance-related elements/bonuses)
   - Provisions for other benefits, including pensions.
   - Arrangements for terminations of employment and other contractual terms.

b) To monitor and evaluate the performance of individual directors.

c) To advise on, and oversee, appropriate contractual arrangements for directors, including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

d) To oversee the proper calculation and scrutiny of all business cases for redundancy payments taking account of relevant guidance.

e) To monitor and review the level of remuneration of senior management, including those who report to Board members.

The policy on the remuneration of senior managers for current and future financial years

This is decided by the Remuneration Committee and for 2017-18 the agreement was in line with the national guidance. A work plan is in place to address the duties of the committee.

SINGLE TOTAL FIGURE TABLE

Name and Title	Date Started	Date Left	2017/18 Salary (bands of £5,000) £'000s	2017/18 Expense payments (taxable) total to nearest £100 £'00s	2017/18 Performance pay and bonuses (bands of £5,000) £'000s	2017/18 Long term performance pay and bonuses (bands of £5,000) £'000s	2017/18 All pension-related benefits (bands of £2,500) £'000s	2017/18 TOTAL (bands of £5,000) £'000s	2016/17 Salary (bands of £5,000) £'000s	2016/17 Expense payments (taxable) total to nearest £100 £'00s	2016/17 Performance pay and bonuses (bands of £5,000) £'000s	2016/17 Long term performance pay and bonuses (bands of £5,000) £'000s	2016/17 All pension-related benefits (bands of £2,500) £'000s	2016/17 TOTAL (bands of £5,000) £'000s
Chris Burdon, Chairman			25 - 30	Nil	Nil	Nil	Nil	25 - 30	25 - 30	Nil	Nil	Nil	Nil	25 - 30
Jill Gramann, Non-executive Director		Jul-17	0 - 5	Nil	Nil	Nil	Nil	0 - 5	5 - 10	Nil	Nil	Nil	Nil	5 - 10
Martin Connor, Non-executive Director		Aug-16	Nil	Nil	Nil	Nil	Nil	Nil	0 - 5	Nil	Nil	Nil	Nil	0 - 5
Peter Lachecki, Non-executive Director		Nov-16	Nil	Nil	Nil	Nil	Nil	Nil	0 - 5	Nil	Nil	Nil	Nil	0 - 5
Richard Roberts, Non-executive Director			5 - 10	Nil	Nil	Nil	Nil	5 - 10	5 - 10	Nil	Nil	Nil	Nil	5 - 10
Steven Peak, Non-executive Director			5 - 10	Nil	Nil	Nil	Nil	5 - 10	5 - 10	Nil	Nil	Nil	Nil	5 - 10
Stephen Tilton, Non Executive Director			5 - 10	Nil	Nil	Nil	Nil	5 - 10	0 - 5	Nil	Nil	Nil	Nil	0 - 5

Name and Title	Date Started	Date Left	2017/18						2016/17					
			Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
			£'000s	£'00s	£'000s	£'000s	£'000s	£'000s	£'000s	£'00s	£'000s	£'000s	£'000s	£'000s
James Morris, Non Executive Director			5 - 10	Nil	Nil	Nil	Nil	5 - 10	0 - 5	Nil	Nil	Nil	Nil	0 - 5
Tessa Norris, Non-Executive Director	Jan-18		0 - 5	Nil	Nil	Nil	Nil	0 - 5	Nil	Nil	Nil	Nil	Nil	Nil
Sarah Dugan, Chief Executive			140 - 145	Nil	10 - 15	Nil	30 - 32.5	185 - 190	140 - 145	1	5 - 10	Nil	30 - 32.5	180 - 185
Andrew Sant, Medical Director *		Feb-18	95 - 100	Nil	0 - 5	Nil	0 - 2.5	105 - 110	135 - 140	Nil	Nil	Nil	85 - 87.5	220 - 225
David Lewis, Interim Medical Director	Feb-18		20 - 25	1	Nil	Nil	37.5 - 40	60 - 65	Nil	Nil	Nil	Nil	Nil	Nil
Robert Mackie, Director of Finance			125 - 130	Nil	0 - 5	Nil	40 - 42.5	170 - 175	125 - 130	Nil	Nil	Nil	45 - 47.5	170 - 175
Stephen Collman, Chief Operating Officer			95 - 100	Nil	0 - 5	Nil	65 - 67.5	170 - 175	95 - 100	Nil	Nil	Nil	30 - 32.5	125 - 130
Michelle Clarke, Director of Nursing and Quality			95 - 100	Nil	0 - 5	Nil	25 - 27.5	130 - 135	100 - 105	Nil	Nil	Nil	45 - 47.5	145 - 150
Susan Harris, Director of Strategy and Partnerships			95 - 100	Nil	0 - 5	Nil	22.5 - 25	125 - 130	95 - 100	Nil	Nil	Nil	27.5 - 30	125 - 130
Gill Harrad, Company Secretary			95 - 100	Nil	0 - 5	Nil	25 - 27.5	125 - 130	90 - 95	Nil	Nil	Nil	32.5 - 35	125 - 130

The figure for Dr Andrew Sant includes remuneration paid in respect of clinical work done as well as directorship duties. The remuneration for clinical work amounts to £19,920 (2016/17, £27,373).

PENSIONS ENTITLEMENT TABLE

Name and Title	Date Started	Date Left	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
			£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'00s
Sarah Dugan, Chief Executive			2.5 - 5	0 - 2.5	50 - 55	155 - 160	979	88	1067	0
Andrew Sant, Medical Director		05-Feb-18	0 – 2.5	nil	20 - 25	45 - 50	326	2	328	nil
David Lewis, Interim Medical Director	06-Feb-18		2.5 - 5	0 - 2.5	35 - 40	85 - 90	568	48	616	0
Robert Mackie, Director of Finance			2.5 - 5	0 - 2.5	35 - 40	90 - 95	558	53	611	0
Stephen Collman, Chief Operating Officer			2.5 - 5	5 - 7.5	30 - 35	75 - 80	413	76	489	0
Michelle Clarke, Director of Nursing and Quality			0 - 2.5	0 - 2.5	35 - 40	95 - 100	606	59	665	0
Susan Harris, Director of Strategy and Partnerships			0 - 2.5	0 - 2.5	30 - 35	0	286	38	324	0
Gill Harrad, Company Secretary			0 - 2.5	0 - 2.5	30 - 35	75 - 80	461	51	511	0

FAIR PAY

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2017/18 was £155k - £160k (2016/17, £150k - £155k). This was 6.2 times (2016/17, 5.5) the median remuneration of the workforce, which was £26k (2016/17, £27k). In 2017/18, there was one (2016/17, one) employee receiving remuneration in excess of the highest-paid director. Total remuneration includes salary, nonconsolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The increase in the highest paid director/median remuneration ratio is a result of drop in the median salary as a result of cost improvement programme restructuring and an increase in support workers.

STAFF REPORT

Inclusion – Equality and Diversity

During this annual reporting period there have been a number of inclusion initiatives and interventions, most significantly the publication of our Inclusion Strategy 2018-2022. The Strategy describes our vision and direction when implementing equality and diversity for those who use our services and our workforce.

Our Inclusion Aim is to integrate equality and diversity into everything we do – a natural part of everyday practice, owned by everyone.

In accordance with the Public Sector Equality Duty the following Equality Objectives are incorporated in the Strategy, to:

- Improve communication and information access for those who have a disability, impairment, sensory loss, who do not speak English as their first language and those who have difficulty in reading and/or writing. To record and monitor communication needs.
- Ensure Equality Impact Analysis is undertaken for all Trust activity. In the event of a new service, service re-design or change to service the Trust seeks community involvement through the Equality Advisory Group.
- Reduce health inequalities that affect patient care e.g. mental health, seldom heard groups by engaging with communities via for example LGBT+ PRIDE events, Black History Month, Anti-Slavery day etc.
- Each Service Delivery Unit will identify an inclusion, diversity and equality goal that is specific to their area of service delivery and embed inclusion into the decision-making processes of their service.
- Develop accessible and inclusive engagement processes so that patients, carers and service users are empowered to influence patient experience of healthcare and reduce healthcare inequalities.

The Strategy with full details can be found on our website
http://www.hacw.nhs.uk/our-services/equality-and-diversity/inclusion-diversity-and-equality-strategy-2018-2022/

During the past year the following are key contributors to the inclusion agenda:

- Our Equality and Inclusion Policy was reviewed and fully updated in line with new requirements and actions, e.g. Modern Slavery Act 2015/16, updated definitions around marriage and civil partnership and definitions around gender identity. The Policy outlines the Trust's commitment to advance equal opportunities, tackle discrimination and foster good relations is integral in supporting the Inclusion Strategy.

We **supported community events**, in particular, we are proud to have been part of the Worcestershire PRIDE event. We had the opportunity to promote our services such as the Stroke team, Eating Disorders, Healthy Minds, Sexual Health and us as an Employer of choice, along with NHS Professionals and Apprenticeships.

- **Disability Confident** is a government-run scheme to help organisations successfully employ and retain disabled people and those with health conditions. Our Level 2 status means that from a recruitment perspective we:
- provide a fully inclusive and accessible recruitment process
- offer an interview to all disabled applicants who meet the minimum criteria for a vacancy
- are flexible when assessing people so disabled job applicants have the best opportunity to demonstrate that they can do the job

We are equally committed to supporting our current employees who have a disability, or who become disabled during their employment.

- **Equality Impact Analysis** (EIA) is a tool for helping us to identify the potential or actual impact that our Trust activities (services, projects, strategies, policies etc.) might have on our community (staff, patients, carers & others), from different equality perspectives. The Trust's approach to EIA was reviewed and updated in 2017 with the intent to help us :
  - provide better services to our patients and staff, by making sure that all our activities help to **promote equality, challenge discrimination**, and are genuinely accessible to all.
  - fulfil our **legal obligations** as a Trust under equality legislation.

- In the summer of 2017, an **Equality Advisory Group** was set up to advise the Trust on equality matters in relation to service transformation (eg service re-design), Trust policies and guidelines, and the Equality Delivery System. The group consists of members who represent the communities of the nine protected characteristics. Members meet monthly to review EIAs and advise if additional engagement is required, supporting access to communities and groups where possible.

- The Trust appointed a **Chaplain/Provider of Pastoral Support** who leads teams of volunteer chaplains, including an interfaith minister and ministers from a variety of denominations and faiths as well as members of the laity. The provision of non-religious, non-judgemental pastoral support is particularly important. All aspects of chaplaincy support extend to relatives, carers and staff.

Evesham Community Hospital now has a multi-faith space including a non-religious spiritual area for reflection and contemplation. Where possible similar spaces are to be developed in our other community hospitals, with Princess of Wales Hospital due to undergo refurbishment next.

- The new **Interpreting and Translation Policy** is based on best practice in interpreting and translation with the intention of providing high quality, safe, equitable and effective healthcare that is responsive to the needs of all patients. The Trust does not support the use of family members/friends, minors or web-based translation (except in exceptional circumstances). Instead The Trust advocates the use of an interpreter or translator via the Trust official providers. The policy has been developed to reflect requirements of the Equality Act (2010) and the Accessible Information Standard (AIS) (ISB 1605), it is worth noting the policy complements AIS

For more further information on these initiatives and interventions and details other activities during the past year please go to http://www.hacw.nhs.uk/our-services/equality-and-diversity/

All of the above been scrutinised by our Governance arrangements which includes an Inclusion Steering Group who report to the Workforce Committee or the Quality and Safety Committee. These committees in turn ratify actions and outcomes for Board approval. The Steering Group are informed by a number of sub groups who are responsible for specific areas of Inclusion and externally the introduction of the Equality Advisory Group made the governance of inclusion robust.

Emergency Preparedness

The Trust continues to work with local responders to ensure that it is able to provide the best possible response to a major emergency.

There is an Incident Plan in place which is regularly tested and reviewed in line with statutory and non-statutory requirements including NHS England EPRR (Emergency Preparedness, Resilience and Response) Framework 2015. The Trust also has a Business Continuity Plan which ensures that critical activities can still be delivered in exceptional circumstances. The Trust has an established Emergency Planning, Resilience and Response (EPRR) sub-committee which provides assurance that we are able to meet our statutory and contractual requirements in relation to EPRR. For the year 2017-18 the Trust was validated as having 'Substantial' compliance with the NHS England Core Standards.

Modern Slavery Act

Modern Slavery is a global issue existing in every type of economy. Worcestershire Health & Care NHS Trust has a zero tolerance approach to Modern Slavery within our service and supply chain. All members of staff have a personal responsibility for the prevention of slavery and human trafficking with the procurement department taking responsibility for overall compliance.

The Trust has evaluated the principal risks related to slavery and human trafficking as:

- Lack of assurances from suppliers;
- Lack of appropriate clauses in contracts;
- Reputational.

Should there be a breach of the Modern Slavery Act within the supply chain the Trust will take action in accordance to the investigatory evidence. This may range from termination of the contract, to the Trust giving notice to a supplier to make improvements within a specified time. Failure to respond could then result in the termination of the contract.

Whistleblowing

As a Trust we are committed to ensuring staff are encouraged to flag up anything which concerns them. In fact one of the key messages to staff following the Francis Report has been to take a step back and look critically at services to see if they are up to standard. We have also made a point of re-iterating our Raising Concerns at Work policy to staff so they are comfortable with the process and the options available should they feel something needs bringing to attention. We pride ourselves on being an open and transparent organisation. We are confident that we have a culture and an environment that does encourage staff to come forward but we know we need to keep on top of this. Our message to staff is clear: if it's not right, speak up! This is in keeping with one of our key values, **courageous** – *displaying integrity and having the courage to always do what is right.*

The Trust appointed a Freedom to Speak Up Guardian in late 2016 and communicated this appointment across the Trust along with establishing an intranet page. Increasing staff awareness of the role is on-going. Regular drop in sessions have been established to offer staff an additional avenue to raise any concerns confidentially.

Civil service staff (by band)

This is based on executive and non-executive directors in post as at 31 March 2018.

Band	Number
Personal Salary	7
Trust Non-Executive Director, including Associate Non-Executive Directors	6
Grand Total	**13**

Staff composition

This is based on executive and non-executive directors in post as at 31st March 2018.

Gender	Number
Female	5
Male	8
Grand Total	**13**

Sickness

Rolling 12 month sickness data for the Trust as a whole and as reported on the monthly workforce dashboards.

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2018	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
3,110	35,162	11.3	1,134,993	57,040

Average number of employees

This is based on ESR (Electronic Staff Record) staff groups and Whole Time Equivalent (WTE) staff in post at month end. Data is based on monthly average not weekly and excludes externally contracted staff.

Staff Group	Permanently Employed Staff		Other Staff		Total	
	£000s	Average WTE	£000s	Average WTE	£000s	Average WTE
Medical and dental	10,290	73	6,390	45	**16,680**	**118**
Administration and estates	18,895	576	2,051	59	**20,946**	**635**
Healthcare assistants and other supporting staff	17,540	795	3,552	122	**21,092**	**917**
Nursing, midwifery and health visiting staff	46,245	1020	4,509	85	**50,754**	**1,105**
Nursing, midwifery and health visiting learners	248	15	17	1	**265**	**16**
Scientific, therapeutic and technical staff	20,731	393	2,153	39	**22,884**	**432**
Social care staff	622	17	37	1	**659**	**18**
Healthcare science staff	41	1	0	0	**41**	**1**
Total	**114,612**	**2,890**	**18,709**	**352**	**133,321**	**3,242**

Reporting related to the review of tax arrangements of public sector appointees

A Treasury requirement for public sector bodies to report arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and NI arrangements, not being classed as employees) has been promulgated in Public Expenditure System (PES) guidance. Treasury's guidance on this is summarised below.

Reformed off-payroll Working Rules

The Government has reformed the legislation for the off-payroll working rules within the public sector applying to payments made on or after 6 April 2017. Under the reformed off-payroll working rules, Departments must determine whether the rules apply when engaging a worker through a Personal Service Company (PSC).

DHSC group bodies will already be operating the new rules to provide employment status determinations for all of their off-payroll engagements.

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, departments and their arm's length bodies must publish information on their highly paid and/or senior off-payroll engagements.

The three disclosure tables required are:

Table 1: Off-payroll engagements longer than 6 months

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

	Number
Number of existing engagements as of 31 March 2018	23
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	2
for between 2 and 3 years at the time of reporting	4
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	15

Table 2: New Off-payroll engagements

Where the reformed public sector rules apply, entities must complete for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and March 2018, form more than £245 per day and that last for longer than six months

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	3
Of which:	
No. assessed as caught by IR35	3
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review.	0

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.	15

Consultancy Expenditure

The Trust did not incur any consultancy expenditure in 2017/18.

COMPENSATION OF LOSS

Reporting of compensation schemes – exit packages 2017/18

The Trust did not make any severance payments or provide any exit packages.

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
<£10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**-**	**-**	**-**
Total resource cost (£)	**£0**	**£0**	**£0**

Reporting of compensation schemes – exit packages 2016/17

The Trust had 8 mutually agreed resignations (MARS) contractual costs during the period.

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
<£10,000	-	4	**4**
£10,001 - £25,000	-	4	**4**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**8**	**8**
Total resource cost (£)	**£0**	**£79,844**	**£79,844**

Exit packages: other (non-compulsory) departure payments

	2017/18		2016/17	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	8	80
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**-**	**-**	**8**	**80**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Accountability Report

The Trust confirms adherence to the reporting framework within the Department of Health Group Accounting Manual.

Chief Executive
Date: 24th May 2018.

FINANCIAL STATEMENTS AND NOTES

FINANCIAL STATEMENTS AND NOTES

The Financial Statements shown on the following pages set out the Trust's statutory accounts for the year ended 31 March 2018. The Annual Report and Accounts (ARA) document is available on request from the Director of Finance at Isaac Maddox House, Shrub Hill Road, Worcester, WR4 9RW (Tel. 01905 681321).

As in previous years the auditor's report on the full annual report and accounts for 2017/18 was unqualified. It is pleasing to report that for the seventh consecutive year the Trust has achieved each of its statutory financial duties by delivering overall financial balance, operating within its external financing limit and managing capital expenditure within its capital resource limit.

The Trust is well placed to deliver its healthcare responsibilities over the longer term with the Trust Board having approved a robust 5 year long term financial plan and integrated business plan.

Independent auditor's report to the Directors of Worcestershire Health and Care NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Worcestershire Health and Care NHS Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers 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 the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 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 2017-18; 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.

Who we are reporting to

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.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report set out on page 1 to 49, 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 course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource 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 this 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 Report 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 2017-18 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 have reported a matter 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 have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had 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 have made 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.

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 29, 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 the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

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

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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

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(3)(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 2018, 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 Health and Care NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Phil Jones

Phil Jones
Director
for and on behalf of Grant Thornton UK LLP

The Colmore Building
Colmore Plaza
Birmingham
B4 6AT

24 May 2018

STATEMENT OF COMPREHENSIVE INCOME

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	170,600	166,755
Other operating income	4	8,927	6,771
Operating expenses	5.1	(167,727)	(178,183)
Operating surplus/(deficit) from continuing operations		**11,800**	**(4,657)**
Finance income	10	46	34
Finance expenses	11.1	(130)	(151)
PDC dividends payable		(2,122)	(2,334)
Net finance costs		**(2,206)**	**(2,451)**
Other gains / (losses)	12	(17)	0
Surplus / (deficit) for the year		**9,577**	**(7,108)**
Other comprehensive income Will not be reclassified to income and expenditure:			
Impairments and reversals taken to the revaluation reserve	6	2,085	(11,087)
Net gain on revaluation of property plant and equipment	14.1	351	1,378
Total comprehensive income / (expense) for the period		**12,013**	**(16,817)**
Adjusted financial performance for the year			
Surplus / (deficit) for the year		9,577	(7,108)
Impairments	6	(2,303)	12,182
Adjustments in respect of donated gov't grant asset reserve elimination		17	15
Adjusted retained surplus		**7,291**	**5,089**

The Trust's reported NHS financial performance position is derived from its retained surplus, but adjusted for the following:
a) Impairments to non-current assets 2017/18 are based upon the annual valuation of the Trust's estate.
b) Depreciation on donated assets.

The notes on pages 75 to 115 form part of this account.

STATEMENT OF FINANCIAL POSITION

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	774	613
Property, plant and equipment	14.1	87,268	78,115
Total non-current assets		**88,042**	**78,728**
Current assets			
Inventories	16	483	558
Trade and other receivables	17.1	7,347	6,365
Cash and cash equivalents	18	17,015	14,018
Total current assets		**24,845**	**20,941**
Current liabilities			
Trade and other payables	19.1	(17,210)	(17,250)
Borrowings	21	(164)	(464)
Provisions	22	(628)	(294)
Other liabilities	20	(129)	(87)
Total current liabilities		**(18,131)**	**(18,095)**
Total assets less current liabilities		**94,756**	**81,574**
Non-current liabilities			
Borrowings	21	(2,597)	(2,761)
Provisions	22	(1,941)	(2,314)
Total non-current liabilities		**(4,538)**	**(5,075)**
Total assets employed		**90,218**	**76,499**
Financed by:			
Public dividend capital		37,342	35,636
Revaluation reserve		7,414	5,134
Income and expenditure reserve		45,462	35,729
Total taxpayers' equity		**90,218**	**76,499**

The notes on pages 75 to 115 form part of these accounts.

The financial statements on pages 71 to 74 were approved by the Audit Committee under the delegated authority of the Trust Board on 24 May 2018 and signed on its behalf by:

Name Sarah Dugan
Position Chief Executive
Date 24th May 2018

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2018

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017	**35,636**	**5,134**	**0**	**35,729**	**76,499**
Surplus for the year	0	0	0	9,577	**9,577**
Other transfers between reserves*	0	(156)	0	156	**0**
Impairments	0	2,085	0	0	**2,085**
Revaluations	0	351	0	0	**351**
Public dividend capital received	1,706	0	0	0	**1,706**
Taxpayers' equity at 31 March 2018	**37,342**	**7,414**	**0**	**45,462**	**90,218**

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2017

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016	**35,636**	**14,949**	**26**	**42,705**	**93,316**
Deficit for the year	0	0	0	(7,108)	**(7,108)**
Other transfers between reserves	0	(106)	(26)	132	**0**
Impairments	0	(11,087)	0	0	**(11,087)**
Revaluations	0	1,378	0	0	**1,378**
Taxpayers' equity at 31 March 2017	**35,636**	**5,134**	**0**	**35,729**	**76,499**

* Transfers between reserves relates to backlog depreciation (£156k).

Information on reserves:

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge (3.5%) reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as PDC dividend.

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

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

STATEMENT OF CASH FLOWS

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		11,800	(4,657)
Non-cash income and expense:			
Depreciation and amortisation	5.1	2,913	1,963
Net impairments	6	(2,303)	12,182
(Increase) / decrease in receivables and other assets		(1,213)	(2,000)
(Increase) / decrease in inventories		75	(27)
Increase / (decrease) in payables and other liabilities		(1,138)	2,935
Increase / (decrease) in provisions		(48)	(369)
Net cash generated from operating activities		**10,086**	**10,027**
Cash flows from investing activities			
Interest received	10	46	34
Purchase of intangible assets		(272)	0
Purchase of property, plant, equipment and investment property		(6,093)	(5,711)
Net cash used in investing activities		**(6,319)**	**(5,677)**
Cash flows from financing activities			
Public dividend capital received		1,706	0
Movement on loans from the Department of Health and Social Care		(464)	(764)
Other capital receipts *		28	726
Other interest paid		(121)	(125)
PDC dividend paid		(1,919)	(2,565)
Net cash used in financing activities		**(770)**	**(2,728)**
Increase in cash and cash equivalents		**2,997**	**1,622**
Cash and cash equivalents brought forward at 1 April		**14,018**	**12,396**
Cash and cash equivalents at 31 March	18	**17,015**	**14,018**

* Relates to the in-year receipt of prior year's capital receivables.

NOTES TO THE ACCOUNTS

NOTE 1 – ACCOUNTING POLICIES AND OTHER INFORMATION

Note 1.1 – Basis of preparation
The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 – Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 – Going concern
IAS1 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.

The Trust Board has considered its ability to continue as a going concern and is satisfied that it has sustainable service and financial plans that have been appropriately risk assessed; and having taken into account the income and associated cash flow secured under contracts and down side scenarios, it's content that no disclosures are required to be made. The financial statements for 2017/18 have therefore been prepared on this basis.

Note 1.2 – Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- Determining the appropriate asset lives for the Trust's buildings following a professional review undertaken by professionally qualified chartered surveyors;

- Determining the appropriate method of valuation of the Trust's property assets and in particular when and how to apply the Modern Equivalent Asset method of valuation. The Trust has elected to value the Estate at 1 April 2017 on an alternative site basis. The key assumptions applied in using this approach are set out in note 15.

Note 1.2.1 – Sources of estimation uncertainty

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

- The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure 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 discount rates as determined by H M Treasury.

Note 1.3 – Interests in other entities

The Trust does not have any subsidiaries or any equity interests in associates or joint ventures. The Trust has considered the impact of IFRS 10 regarding the consolidation of Charitable Funds and determined that this is not required in respect of Worcestershire Health and Care NHS Trust Charitable Funds (Charity number 1060335) on the grounds of immateriality.

Note 1.4 – Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. The Trust has no revenue relating to partially completed spells.

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

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

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

The Trust has a workshop at Shrub Hill, Worcester. This workshop provides activities in a supported setting for those moving towards college, employment or volunteering. These activities produce revenue for the Trust from the sale of goods.

1.4.1 – 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.

Note 1.5 – Expenditure on employee benefits

Note 1.5.1 – 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.

Note 1.5.2 – 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. There, 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.

Note 1.5.3 – Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Note 1.6 – Expenditure on other goods and services

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

Note 1.7 – Property, plant and equipment

Note 1.7.1 – Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year

- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.7.2 – Measurement

Valuation

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

All assets are measured subsequently at valuation. Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value in existing use at the date of revaluation less any impairment.

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

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and where it would meet the location requirements of the service being provided, an alternative site can be valued. This method has been applied to the valuations associated with all of the Trust's sites as at 1 April 2017.

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 economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

An increase in an asset's valuation due to an increase in general market prices is a separate event and does not represent a reversal of a previous economic benefit/service potential impairment. Therefore this is accounted for as a revaluation gain rather than a reversal of a past economic benefit impairment.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure

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

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

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

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

the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

Note 1.7.3 – Derecognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

Note 1.7.4 – Donated and grant funded assets

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

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

Note 1.7.5 – Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

The Trust has no PFI or LIFT schemes.

Note 1.7.6 – Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The Trust uses the following standard asset lives for each class of asset. For buildings, the Trust uses the asset life advised by professional qualified valuers. The fair value of land is determined by market value for existing use:

Short life engineering plant and equipment	5 years
Medium life engineering plant and equipment	10 years
Long life engineering plant and equipment	15 years
Vehicles	7 years
Furniture	10 years
Office and IT equipment	7 years
Soft furnishings	7 years
Short life medical and other equipment	5 years
Medium life medical equipment	10 years
Long life medical equipment	15 years
Mainframe-type IT installations	8 years

Finance-leased assets (including land) are depreciated over the shorter of the useful economic 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.

Note 1.8 – Intangible assets

Note 1.8.1 – Recognition

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

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

Expenditure on research is not capitalised.

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

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

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

Note 1.8.2 – Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains, 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".

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

Note 1.8.3 – Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. Trusts intangible assets are soley software licences which have a useful economic life between 5 – 10 years.

Note 1.9 – Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.10 – Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure. The Trust does not have any investment properties.

Note 1.11 – 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.

Note 1.12 – Carbon Reduction Commitment

The Trust's emissions are below the threshold levels for participation in the Scheme and therefore the Trust has made no accounting entries in relation to it.

Note 1.13 – Financial instruments and financial liabilities

Recognition

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

De-recognition

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

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

Classification and measurement

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

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

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

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

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

Loans and receivables

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

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

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

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

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date. The Trust does not have any financial assets.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

The Trust has no outstanding borrowings or financial liabilities other than with NHS Pensions and the Department of Health and Social Care.

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices where possible, otherwise by the following valuation techniques:

- The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.
- If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.
- Loans from the Department of Health and Social Care are recognised at historic cost.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

Note 1.14 – Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 – The trust as lessee

Finance leases
The Trust does not hold any Finance leases.

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

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

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

Note 1.14.2 – The trust as lessor

Finance leases
The Trust does not hold any Finance leases.

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

Note 1.15 – Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk- adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs – NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution, who, 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 22.1 but is not recognised in the Trust's accounts.

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

Note 1.16 – 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 23 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 23, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 – Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) 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 Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 – Value added tax

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

Note 1.19 – Corporation tax

The Trust is exempt from corporation tax.

Note 1.20 – Foreign exchange

The functional and presentational currency of the Trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date. Monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Note 1.21 – Third party assets

the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.22 – Losses and special payments

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

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

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

Note 1.23 – 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.

The Trust has an internal 'gifts and hospitality' register and can confirm that the Trust has not received any gifts of a material nature for the year ending 2017/18.

Note 1.24 – Transfers of functions to or from other NHS bodies or local government bodies

The Trust has had no transfer of function to or from other NHS or local government bodies in the year.

Note 1.25 – Early adoption of standards, amendments and interpretations

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

Note 1.26 – Standards, amendments and interpretations in issue but not yet effective or adopted

The following table presents a list of recently issued accounting standards and amendments which have not yet been adopted within the FReM, and are therefore not applicable to DH group accounts in 2017/18:

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. It is not anticipated that this will impact upon the Trust.
- IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. It is not anticipated that this will impact upon the Trust.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

NOTE 2 – OPERATING SEGMENTS

Worcestershire Health and Care NHS Trust operates within one healthcare segment. Whilst income and expenditure is reported upon by Service Delivery Units for internal monitoring purposes, Corporate overheads and assets are reported to the Chief Executive on a Trust wide basis.

NOTE 3 – OPERATING INCOME FROM PATIENT CARE ACTIVITIES

Note 3.1 – Income from patient care activities (by nature)

	2017/18 £000	2016/17 £000
Acute services		
First outpatient income	872	940
Follow up outpatient income	1,085	1,499
A & E income	2,234	1,975
Mental Health services		
Cost and volume contract income	788	860
Block contract income	65,692	63,776
Clinical partnerships providing mandatory services (including S75 agreements)	2,065	2,098
Community services		
Community services income from CCGs and NHS England	79,120	76,337
Income from other sources	17,327	17,678
All services		
Private patient income	0	0
Other clinical income	1,417	1,592
Total income from activities	**170,600**	**166,755**

Note 3.2 – Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	3,215	3,107
Clinical commissioning groups	134,953	131,642
Other NHS providers	11,258	10,026
Local authorities	20,664	21,568
Non-NHS: private patients	0	0
Non-NHS: overseas patients (chargeable to patient)	40	0
NHS injury scheme	109	127
Non NHS: other *	361	285
Total income from activities	**170,600**	**166,755**
Of which:		
Related to continuing operations	170,600	166,755
Related to discontinued operations	0	0

* Other income includes: Clinical Research Network Income (£104k); Hydrotherapy Pool Income (£68k); Care & Repair SLA (£64k); Tissue Viability Income (£18k); and other immaterial items.

Note 3.3 – Overseas visitors

Relating to patients charged directly by the provider:	2017/18 £000	2016/17 £000
Income recognised this year	40	0
Cash payments received in-year	39	0
Amounts added to provision for impairment of receivables	1	0

NOTE 4 – OTHER OPERATING INCOME

	2017/18 £000	2016/17 £000
Education and training	3,185	2,600
Non-patient care services to other bodies	1,430	1,352
Sustainability and transformation fund income *	3,478	2,054
Rental revenue from operating leases	34	62
Other income **	800	703
Total other operating income	**8,927**	**6,771**
Of which:		
Related to continuing operations	8,927	6,771
Related to discontinued operations	0	0

* Allocation of centrally held STF for the achievement of targets set by NHS England.
** Key individual items within other operating income include: car parking (£162k), catering (£93k), and IT recharges (£35k).

NOTE 5.1 – OPERATING EXPENSES

	2017/18 £000	2016/17 £000
Purchase of healthcare from non-NHS and non-DHSC bodies *	2,399	1,515
Staff and executive directors costs	133,708	133,040
Remuneration of non-executive directors	61	65
Supplies and services – clinical (excluding drugs costs)	8,582	8,328
Supplies and services – general	3,191	3,534
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,087	2,112
Establishment	5,739	5,120
Premises	4,730	4,338
Transport (including patient travel)	2,669	2,654
Depreciation on property, plant and equipment	2,802	1,872
Amortisation on intangible assets	111	91
Net impairments	(2,303)	12,182
Increase/(decrease) in provision for impairment of receivables	(9)	7
Change in provisions discount rates	28	225
Audit fees payable to the external auditor: **		
audit services – statutory audit	58	62
other external auditor remuneration	41	12
Internal audit costs	104	95
Clinical negligence	545	450
Legal fees	67	49
Insurance	133	183
Education and training ***	962	361
Rentals under operating leases	1,815	1,728
Hospitality	17	11
Losses, ex gratia & special payments	6	0
Other	184	149
Total	**167,727**	**178,183**
Of which:		
Related to continuing operations	167,727	178,183
Related to discontinued operations	0	0

* The increase in purchase of healthcare from non-NHS bodies is due to the full year effect of Birmingham Health Consortium delivering IAPT services.
** Amounts payable for audit fees are inclusive of VAT.
*** The increase in education and training expenditure was due to additional Health Education England income for the Nurse Associate Training programme (£400k) and Apprenticeship Hub (£85k).

Note 5.2 – Other auditor remuneration

Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	0	0
2. Audit-related assurance services	41	12
3. Taxation compliance services	0	0
4. All taxation advisory services not falling within item 3 above	0	0
5. Internal audit services	0	0
6. All assurance services not falling within items 1 to 5	0	0
7. Corporate finance transaction services not falling within items 1 to 6 above	0	0
8. Other non-audit services not falling within items 2 to 7 above	0	0
Total	**41**	**12**

Note 5.3 – Limitation on auditor's liability

There was a £2m limitation on auditor's liability for external audit work carried out for the financial year 2017/18 (2016/17 no limitation).

NOTE 6 – IMPAIRMENT OF ASSETS

Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price due to revaluation	(2,303)	12,182
Total net impairments charged to operating surplus / deficit	**(2,303)**	**12,182**
Impairments charged to the revaluation reserve	(2,085)	11,087
Total net impairments	**(4,388)**	**23,269**

Impairment reversals and valuations recognised during 2017/18 resulted from the annual asset revaluation of land and buildings to reflect movements in values during the financial year. An independent valuer provided valuations as at 1 April 2017 resulting in a total net upward revaluation of £4,740k, of which;

- £2,303k has been credited against the Statement of Comprehensive Income (SoCI) in respect of net impairment reversals;
- £2,086k for an increase to the revaluation reserves for impairments; and
- £351k for an upward revaluation to the revaluation reserve.

NOTE 7 – EMPLOYEE BENEFITS

Salaries and wages	100,409	97,188
Social security costs	9,100	9,115
Apprenticeship levy	472	0
Employer's contributions to NHS pensions	13,017	13,126
Pension cost - other	13	17
Temporary staff (including bank and agency)	10,783	13,731
Total gross staff costs	**133,794**	**133,177**
Recoveries in respect of seconded staff	0	0
Total staff costs	**133,794**	**133,177**
Of which		
Costs capitalised as part of assets	86	137

Note 7.1 – Retirements due to ill-health

Number of persons retired early on ill-health grounds	3	3
	£000	**£000**
Total additional pensions liabilities accrued in the year	220	139

The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

NOTE 8 – PENSION COSTS

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017,

updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

c) Other pension schemes

From 1 August 2013 the Trust opened an additional pension scheme with the National Employment Savings Trust (NEST). The number of employees in the scheme as at 31 March 2018 is less than 30 and the Trust has made Employer contributions of 1% of relevant pay, with the total contributions in 2017-18 being less than £4,000. Details of this scheme can be found on the NEST website which can be accessed at www.nestpensions.org.uk.

Three employees of the Trust are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The contribution rate set out in the initial report has been applied. A review as part of the 2016 actuarial valuation was implemented with a new rate effective from April 2017. The changes to the rate is not material in comparison to the NHS pension scheme. Further information is available at www.lgpsmember.org.

NOTE 9 – OPERATING LEASES

Note 9.1 – Worcestershire Health and Care NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Worcestershire Health and Care NHS Trust is the lessor.

Operating lease revenue		
Minimum lease receipts	34	62
Total	**34**	**62**
	31 March 2018 £000	**31 March 2017 £000**
Future minimum lease receipts due:		
- not later than one year;	6	17
- later than one year and not later than five years;	12	18
Total	**18**	**35**

Note 9.2 – Worcestershire Health and Care NHS Trust as a lessee

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

The Trust has entered into lease arrangements for the lease of properties with individual landlords and lease cars managed by GMP Drivercare Limited. The Trust has no option to purchase the leased buildings or goods at the end of the term of the contract.

	2017/18 £000	**2016/17 £000**
Operating lease expense		
Minimum lease payments	1,815	1,728
Total	**1,815**	**1,728**
	31 March 2018 £000	**31 March 2017 £000**
Future minimum lease payments due:		
- not later than one year;	1,073	1,121
- later than one year and not later than five years;	3,861	3,348
- later than five years.	6,247	6,322
Total	**11,181**	**10,791**
Future minimum sublease payments to be received	0	0

NOTE 10 – FINANCE INCOME

Finance income represents interest received on assets and investments in the period.

	2017/18 £000	2016/17 £000
Interest on bank accounts	46	34
Total	**46**	**34**

NOTE 11.1 – FINANCE EXPENDITURE

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health and Social Care	116	124
Interest on late payment of commercial debt	5	0
Total interest expense	**121**	**124**
Unwinding of discount on provisions	9	27
Total finance costs	**130**	**151**

Note 11.2 – The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18 £000	2016/17 £000
Total liability accruing in year under this legislation as a result of late payments	5	0
Amounts included within interest payable arising from claims made under this legislation	5	0

NOTE 12 – OTHER GAINS / (LOSSES)

	2017/18 £000	2016/17 £000
Losses on disposal of assets	(17)	0
Total other gains / (losses)	**(17)**	**0**

NOTE 13 – INTANGIBLE ASSETS – SOFTWARE LICENCES

	2017/18 £000	2016/17 £000
Valuation / gross cost at 1 April	**946**	**789**
Additions	272	157
Gross cost at 31 March	**1,218**	**946**
Amortisation at 1 April	**333**	**242**
Provided during the year	111	91
Amortisation at 31 March	**444**	**333**
Net book value at 31 March	**774**	**613**
Net book value at 1 April	**613**	**547**

NOTE 14.1 – PROPERTY, PLANT AND EQUIPMENT – 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017	**13,765**	**56,422**	**0**	**3,574**	**183**	**12,310**	**1,803**	**88,057**
Transfers by absorption	0	0	0	0	0	0	0	**0**
Additions	0	1,756	3,534	194	0	1,599	150	**7,233**
Impairments	0	(307)	0	0	0	0	0	**(307)**
Reversals of impairments	0	2,392	0	0	0	0	0	**2,392**
Revaluations	0	1,639	0	0	0	0	0	**1,639**
Reclassifications	0	(40)	40	0	0	0	0	**0**
Disposals / derecognition	0	0	0	(22)	0	0	0	**(22)**
Valuation/gross cost at 31 March 2018	**13,765**	**61,862**	**3,574**	**3,746**	**183**	**13,909**	**1,953**	**98,992**
Accumulated depreciation at 1 April 2017	**0**	**1,113**	**0**	**1,855**	**183**	**5,808**	**983**	**9,942**
Provided during the year	0	1,336	0	240	0	1,098	128	**2,802**
Impairments	0	70	0	0	0	0	0	**70**
Reversals of impairments	0	(2,373)	0	0	0	0	0	**(2,373)**
Revaluations	0	1,288	0	0	0	0	0	**1,288**
Disposals / derecognition	0	-	0	(5)	0	0	0	**(5)**
Accumulated depreciation at 31 March 2018	**0**	**1,434**	**0**	**2,090**	**183**	**6,906**	**1,111**	**11,724**
Net book value at 31 March 2018	**13,765**	**60,428**	**3,574**	**1,656**	**0**	**7,003**	**842**	**87,268**
Net book value at 1 April 2017	**13,765**	**55,309**	**0**	**1,719**	**0**	**6,502**	**820**	**78,115**

Note 14.2 – Property, plant and equipment financing – 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned – purchased	13,753	59,597	3,574	1,656	0	7,003	842	**86,425**
Owned – donated	12	831	0	0	0	0	0	**843**
NBV total at 31 March 2018	**13,765**	**60,428**	**3,574**	**1,656**	**0**	**7,003**	**842**	**87,268**

Note 14.3 – Property, plant and equipment – 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016	**15,414**	**74,944**	**3,022**	**3,320**	**183**	**7,510**	**1,715**	**106,108**
Additions	0	1,303	0	254	0	2,195	88	**3,840**
Impairments	(1,156)	(9,931)	0	0	0	0	0	**(11,087)**
Revaluations	(493)	(10,311)	0	0	0	0	0	**(10,804)**
Reclassifications	0	417	(3,022)	0	0	2,605	0	**0**
Valuation/gross cost at 31 March 2017	**13,765**	**56,422**	**0**	**3,574**	**183**	**12,310**	**1,803**	**88,057**
Accumulated depreciation at 1 April 2016	**0**	**0**	**0**	**1,628**	**183**	**5,406**	**853**	**8,070**
Provided during the year	0	1,113	0	227	0	402	130	**1,872**
Impairments	771	11,411	0	0	0	0	0	**12,182**
Revaluations	(771)	(11,411)	0	0	0	0	0	**(12,182)**
Accumulated depreciation at 31 March 2017	**0**	**1,113**	**0**	**1,855**	**183**	**5,808**	**983**	**9,942**
Net book value at 31 March 2017	**13,765**	**55,309**	**0**	**1,719**	**0**	**6,502**	**820**	**78,115**
Net book value at 1 April 2016	**15,414**	**74,944**	**3,022**	**1,692**	**0**	**2,104**	**862**	**98,038**

Note 14.4 – Property, plant and equipment financing – 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	13,753	54,530	0	1,719	0	6,502	820	**77,324**
Owned - donated	12	779	0	0	0	0	0	**791**
NBV total at 31 March 2017	**13,765**	**55,309**	**0**	**1,719**	**0**	**6,502**	**820**	**78,115**

NOTE 15 – REVALUATIONS OF PROPERTY, PLANT AND EQUIPMENT

At the 1 April 2017 the Trust revalued its assets following an annual review having regard to IFRS as applied to the UK public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Professional Standards 2014. The valuation was carried out by an independent valuer; Cushman & Wakefield Debenham Tie Leung Limited.

Public sector bodies are required to apply the revaluation model set out in IAS 16 as interpreted by HM Treasury's Financial Reporting Manual (FReM) and value capital assets at fair value. Fair value is defined in IFRS 13 as the amount for which an asset or liability could be exchanged in an orderly transaction between market participants at the measurement date, though the FReM restricts the situations when IFRS 13 would apply for NHS assets. Most NHS assets will therefore be held at their current value in existing use value.

For non-specialised operational assets, this equates in practice to Existing Use Value (EUV).

For specialised operational assets, if there is no market-based evidence of fair value because of the specialised nature of the property and the item is rarely sold, except as part of a continuing business, fair value is estimated using 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 valuation takes into account that the modern equivalent reprovision of the existing service would be from fewer locations. The functional obsolescence attributed to the buildings and the size of the "alternative" sites required for the modern equivalent assets takes this into account.

If an asset is re-classified as a non-current asset held for sale, then it is valued in accordance with IFRS 5. As at 31 March 2018, the Trust did not possess any non-current assets held for sale.

Change in asset lives

During the financial year, the Trust reviewed its assets in use and their respective asset lives which continue to be appropriate.

NOTE 16 – INVENTORIES

	31 March 2018 £000	31 March 2017 £000
Drugs	74	83
Consumables	139	147
Other	270	328
Total inventories	**483**	**558**

Inventories recognised in expenses for the year were £384k (2016/17: £371k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

NOTE 17.1 – TRADE RECEIVABLES AND OTHER RECEIVABLES

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	2,719	3,788
Capital receivables (including accrued capital related income)	0	28
Accrued income	3,535	1,415
Provision for impaired receivables	(97)	(116)
Prepayments	803	644
PDC dividend receivable	4	207
VAT receivable	383	399
Total current trade and other receivables	**7,347**	**6,365**
Of which receivables from NHS and DHSC group bodies:		
Current	4,436	3,984
Non-current	0	0

Note 17.2 – Provision for impairment of receivables

	2017/18 £000	2016/17 £000
At 1 April as previously stated	**116**	**112**
Increase in provision	0	7
Amounts utilised	(10)	(3)
Unused amounts reversed	(9)	–
At 31 March	**97**	**116**

The Trust's provision for impairment of receivables is calculated as 25% of Non NHS debtors greater than 30 days, 50% for Non-NHS debtors over 60 days and 75% for Non-NHS debtors greater than 90 days. This provision is based upon historic evidence on the recoverability of debt. Some debts have also been specifically provided for. A provision is made in respect of receivables relating to the NHS Injury Cost Recovery Scheme calculated at 22.84% of all outstanding debts as at 31 March 2018.

Note 17.3 – Credit quality of financial assets

Ageing of impaired financial assets	2017/18 Trade and other receivables £000	2016/17 Trade and other receivables £000
0 - 30 days	14	22
30-60 Days	1	11
60-90 days	4	15
90- 180 days	1	4
Over 180 days	77	64
Total	**97**	**116**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	62	322
30-60 Days	48	141
60-90 days	10	67
90- 180 days	18	71
Over 180 days	213	139
Total	**351**	**740**

Trust policy requires customers to pay in accordance with agreed payment terms. Depending on the customer segment, Trust settlement terms are generally 15 to 30 days from date of invoice. Any recovery risk associated with trade receivables has been provided for in the balance sheet with the exception of NHS debts which are not to be impaired.

Local Authority and NHS organisations comprise the vast majority of the unimpaired debt.

NOTE 18 – CASH AND CASH EQUIVALENTS MOVEMENTS

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

	2017/18 £000	2016/17 £000
At 1 April	**14,018**	**12,396**
Net change in year	2,997	1,622
At 31 March	**17,015**	**14,018**
Broken down into:		
Cash at commercial banks and in hand	17	23
Cash with the Government Banking Service	16,998	13,995
Total cash and cash equivalents	**17,015**	**14,018**

Note 18.1 – Third party assets held by the trust

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.

	31 March 2018 £000	31 March 2017 £000
Monies on deposit	13	1
Total third party assets	**13**	**1**

NOTE 19.1 – TRADE AND OTHER PAYABLES

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	3,726	2,669
Capital payables	2,369	1,229
Accruals	7,116	7,602
Social security costs	1,317	2,653
Other taxes payable	933	1,309
Accrued interest on loans	5	5
Other payables	1,744	1,783
Total current trade and other payables	**17,210**	**17,250**
Of which payables from NHS and DHSC group bodies:		
Current	2,594	2,292
Non-current	0	0

Note 19.2 – Early retirements in NHS payables above

The other payables note above includes amounts in relation to early retirements as set out below:	31 March 2018 £000	31 March 2017 £000
– to buy out the liability for early retirements over 5 years	0	0
– outstanding pension contributions	1,744	1,783

NOTE 20 – OTHER LIABILITIES

Note 20 Other liabilities	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	129	87
Total other current liabilities	**129**	**87**

NOTE 21 – BORROWINGS

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Social Care	164	464
Total current borrowings	**164**	**464**
Non-current		
Loans from the Department of Health and Social Care	2,597	2,761
Total non-current borrowings	**2,597**	**2,761**
Total borrowings	**2,761**	**3,225**

The Trust's outstanding loans as at 31 March 2018 comprise of:

Loan (£1,937k) for the financing of capital expenditure. Length of borrowing from 15 December 2009 to 15 September 2034. The rate of interest is determined by reference to the National Loan Fund rate on the day the Loan Facility Agreement was issued (4.12%). The first repayment £39k was paid on 15th March 2010 and the final repayment is due on 15 September 2034.

Loan (£2,132k) for the financing of capital expenditure. Length of borrowing from 15 December 2010 to 15 September 2035. The rate of interest is determined by reference to the National Loan Fund rate on the day the Loan Facility Agreement was issued (3.85%). The first repayment £43k was paid on 15th March 2011 and the final repayment is due on 15 September 2035.

The Trust may, if it gives the Lender not less than fourteen days prior notice, prepay the whole or any part of the loan on the September repayment date in any financial year.

NOTE 22 – PROVISIONS FOR LIABILITIES AND CHARGES ANALYSIS

	Pensions – early departure costs £000	Legal claims £000	Other £000	Total £000
At 1 April 2017	**737**	**156**	**1,715**	**2,608**
Change in the discount rate	5	0	23	**28**
Arising during the year	41	86	35	**162**
Utilised during the year	(66)	(26)	(67)	**(159)**
Reversed unused	(59)	(20)	0	**(79)**
Unwinding of discount	1	0	8	**9**
At 31 March 2018	**659**	**196**	**1,714**	**2,569**
Expected timing of cash flows:				
- not later than one year;	67	196	365	**628**
- later than one year and not later than five years;	269	0	275	**544**
- later than five years.	323	0	1,074	**1,397**
Total	**659**	**196**	**1,714**	**2,569**

The provisions covered by this note fall into four main categories:

- **Early Departure costs** – provision to cover the costs of early retirements of staff which took place in previous years, but for which the Trust continues to make payment to the NHS Pensions Agency on a quarterly basis. The Trust will continue to pay amounts in respect of these for the remainder of the individuals' lives, which have been estimated using national mortality figures;

- **Legal claims** – provision for the costs of public and employer liability cases, for which the Trust is covered by NHS Resolution. The Trust is liable for the excess amounts. The value of these provisions has been estimated by NHS Resolution, using its estimates of the probability of winning the cases involved. The Trust has also provided for the expected costs of other legal action not covered by NHS Resolution;

- **Other** – provisions for individuals who receive personal injury benefit from the Department of Work and Pensions, which are recharged to the Trust on a quarterly basis. The Trust will continue to pay amounts in respect of these for the remainder of the individuals' lives, which have been estimated using national mortality figures; and

- **Other** – The Trust has also made provision for dilapidation charges that are expected in future years for rented properties to be vacated under the Estates Strategy Review.

Note 22.1 – Clinical negligence liabilities

At 31 March 2018, £2,680k was included within NHS Resolution's provisions in respect of clinical negligence liabilities of Worcestershire Health and Care NHS Trust (31 March 2017: £5,023k).

NOTE 23 – CONTINGENT ASSETS AND LIABILITIES

	31 March 2018 £000	31 March 2017 £000
Net value of contingent assets	**0**	**0**
Value of contingent liabilities		
NHS Resolution legal claims *	(19)	(42)
Other **	(650)	(650)
Gross value of contingent liabilities	**(669)**	**(692)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(669)**	**(692)**

* The provision is calculated by reference to the excess amount the Trust could be liable to pay and a probability factor applied by NHS Resolution. The difference between the provision and the excess amount is the contingent liability.

** Contingent liability of £650k relates to a grant received from HF Trust Limited in May 2000. The grant relates to the funding of capital costs for St Jules Thorne House, Malvern and the Hydrotherapy Pool, Malvern. The Trust has a head lease with the Development Trust for the lease of land, the term of the lease is for 20 years until 4 September 2020 for a peppercorn rent. The Development Trust leases the building via an under lease to the Trust again for the same terms as the head lease. The grant shall be repayable to The Development Trust if any one or more of a number of specified events occur on or before 4 September 2020. The Health Service is required to ensure that the facilities are used for the purpose they were built for during the 20 year term.

NOTE 24 – CONTRACTUAL CAPITAL COMMITMENTS

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	1,125	907
Total	**1,125**	**907**

The capital commitments as at 31 March 2018 relates to work on IT projects and various estate schemes. The capital commitments as at 31 March 2017 relates to work on IT infrastructure.

NOTE 25 – FINANCIAL INSTRUMENTS

Note 25.1 – Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Clinical Commissioning Groups and the way those Groups 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. Trust 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 31 March 2018 are in receivables from customers, as disclosed in note 17.1, trade and other receivables.

Liquidity Risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups and NHS England, 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.

Market Risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. 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. As the interest rates are fixed the Trust does not have any exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Foreign Currency Risk

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

Note 25.2 – Carrying values of financial assets

	Loans and receivables	Total book value
	£000	£000
Assets as at 31 March 2018		
Trade and other receivables excluding non financial assets	6,211	**6,211**
Cash and cash equivalents at bank and in hand	17,015	**17,015**
Total at 31 March 2018	**23,226**	**23,226**

	Loans and receivables	Total book value
	£000	£000
Assets as at 31 March 2017		
Trade and other receivables excluding non financial assets	5,438	**5,438**
Cash and cash equivalents at bank and in hand	14,018	**14,018**
Total at 31 March 2017	**19,456**	**19,456**

Note 25.3 – Carrying value of financial liabilities

	Other financial liabilities	Total book value
	£000	£000
Liabilities as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	2,761	**2,761**
Trade and other payables excluding non financial liabilities	13,215	**13,215**
Total at 31 March 2018	**15,976**	**15,976**

	Other financial liabilities	Total book value
	£000	£000
Liabilities as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	3,225	**3,225**
Trade and other payables excluding non financial liabilities	13,283	**13,283**
Total at 31 March 2017	**16,508**	**16,508**

Note 25.4 – Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	13,379	13,747
In more than one year but not more than two years	164	164
In more than two years but not more than five years	492	492
In more than five years	1,941	2,105
Total	**15,976**	**16,508**

NOTE 26 – LOSSES AND SPECIAL PAYMENTS

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	2	0	2	0
Bad debts and claims abandoned	48	10	38	4
Stores losses and damage to property	38	5	13	3
Total losses	**88**	**15**	**53**	**7**
Special payments				
Ex-gratia payments	8	3	27	13
Total special payments	**8**	**3**	**27**	**13**
Total losses and special payments	**96**	**18**	**80**	**20**

NOTE 27 – RELATED PARTY TRANSACTIONS

Note 27.1 – Details of related party transactions with individuals:

	Payments to Related Party	Receipts from Related	Amounts owed to Related	Amounts due from Related
	£000	£000	£000	£000
Age UK Herefordshire and Worcestershire (spouse of Trust Chairman is Head of Finance of this related party) –				
these figures fell below £500.	**0**	**0**	**0**	**0**

Note 27.2 – Details of related party transactions as a corporate trustee:

Worcestershire Health and Care NHS Trust is a corporate trustee of Worcestershire Health and Care NHS Trust Charitable Funds (Charity No. 1060335). The Trust has received revenue payments from this Charity, which are summarised below:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Recharge of goods on Charity's behalf	0	34	0	0
Administration fee	0	38	0	0
Total related party transactions	**0**	**72**	**0**	**0**

Note 27.3 – Details of related party transactions – Department of Health and Social Care:

The Department of Health and Social Care is regarded as a related party. During the year Worcestershire Health and Care 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. The entities where these transactions were at least £500,000 in value for the year are:

Birmingham Women's and Children's Hospitals NHS Foundation Trust
Health Education England
NHS Birmingham South and Central CCG
NHS England
NHS Redditch and Bromsgrove CCG
NHS Resolution
NHS South Warwickshire CCG
NHS South Worcestershire CCG
NHS Wyre Forest CCG
Worcestershire Acute Hospitals NHS Trust

Note 27.4 – Details of related party transactions – other government departments:

In addition, the Trust has had a number of material transactions, a total of at least £100,000 in value in year, with other government departments and other central and local government bodies. These transactions have been with:

Bromsgrove District Council
Herefordshire Council
HM Revenue & Customs
Malvern Hills District Council
NHS Pensions Scheme
NHS Professionals
Worcester City Council
Worcestershire County Council
Wychavon District Council

NOTE 28 – EVENTS AFTER THE REPORTING DATE

There are no events that have occurred that need to be reported after the end of the reporting date.

NOTE 29 – BETTER PAYMENT PRACTICE CODE

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	28,159	73,623	28,006	68,335
Total non-NHS trade invoices paid within target	27,728	72,993	27,511	66,907
Percentage of non-NHS trade invoices paid within target	**98.5%**	**99.1%**	**98.2%**	**97.9%**
NHS Payables				
Total NHS trade invoices paid in the year	438	9,626	426	8,558
Total NHS trade invoices paid within target	425	9,509	407	8,343
Percentage of NHS trade invoices paid within target	**97.0%**	**98.8%**	**95.5%**	**97.5%**

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

NOTE 30 – EXTERNAL FINANCING

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

	2017/18 £000	2016/17 £000
Cash flow financing	(1,727)	(1,660)
Other capital receipts	(28)	(726)
External financing requirement	**(1,755)**	**(2,386)**
External financing limit (EFL)	5,741	(1,879)
Under spend against EFL	**7,496**	**507**

NOTE 31 – CAPITAL RESOURCE LIMIT

	2017/18 £000	2016/17 £000
Gross capital expenditure	7,505	3,997
Less: Disposals	(17)	0
Charge against Capital Resource Limit	**7,488**	**3,997**
Capital Resource Limit (CRL)	7,506	3,997
Under / (over) spend against CRL	**18**	**0**

NOTE 32 – BREAKEVEN DUTY FINANCIAL PERFORMANCE

	2017/18 £000
Adjusted financial performance surplus (control total basis)	7,291
Remove impairments scoring to Departmental Expenditure Limit	0
Add back income for impact of 2016/17 post-accounts STF reallocation	0
Add back non-cash element of On-SoFP pension scheme charges	0
IFRIC 12 breakeven adjustment	0
Breakeven duty financial performance surplus	**7,291**

NOTE 33 – 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
Breakeven duty in-year financial performance	N/A	N/A	1,500	2,522	2,920	2,828	3,566	5,089	7,291
Breakeven duty cumulative position	N/A	N/A	1,500	4,022	6,942	9,770	13,336	18,425	25,716
Operating income	N/A	N/A	171,083	170,835	172,314	171,461	172,346	173,526	179,527
Cumulative breakeven position as a percentage of operating income	**0.00%**	**0.00%**	**0.88%**	**2.35%**	**4.03%**	**5.70%**	**7.74%**	**10.62%**	**14.32%**

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. The Department considers that 2009/10, being the first year of International Financial Reporting Standards (IFRS) implementation is a suitable point from which the breakeven duty should now be assessed.

Worcestershire Health and Care NHS Trust was established on 1 July 2011, therefore the breakeven duty commenced during 2011/12.

The Department of Health and Social Care, HM Treasury and the National Audit Office previously agreed that the breakeven duty will be assumed to have been met if the breakeven cumulative net deficit is less than or equal to 0.5% of the turnover of the reporting year.

Worcestershire Health and Care NHS Trust has achieved the breakeven duty year on year, since its formation in July 2011.

A&E (Accident & Emergency)
The emergency departments of hospitals that deal with people who need emergency or life threatening treatment because of sudden illness or injury. Sometimes these services are referred to as casualty departments.

Acute services
Medical and surgical interventions usually provided in hospital. The Trust only provided these services up to 30th June 2011, after which date these services were transferred to the local acute Trust.

AMH
Adult Mental Health.

AWOL
Absent Without Leave.

BAF
Board Assurance Framework.

BPPC
Better Payment Practice Code.

Capital
Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles, etc. In the NHS, expenditure on an item is classified as capital if it is in excess of £5,000.

Capital charges
Capital charges are a way of recognising the costs of ownership and use of capital assets and comprise depreciation and interest/target return on capital. Capital charges are funded through a circular flow of money between HM Treasury, the Department of Health, primary care trusts and NHS trusts.

Care Quality Commission (CQC)
The Care Quality commission use expert assessors to determine annual ratings for NHS Bodies on the quality of the services they operate.

CAS
The Central Alerting System is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS.

C-diff
Clostridium difficile

Clinical Commissioning Groups (CCGs)
Clinical Commissioning Groups CCGs will from 1.4.2013 commission the majority of health services, including emergency care, elective hospital care, maternity services, and community and mental health services. Each of the 8,000 GP practices in England is now part of a CCG. There are 211 CCGs altogether, commissioning care for an average of 226,000 people each. There are three CCGs in Worcestershire.

Corporate Governance
The system and rules of delegation by which organisations are directed and controlled.

CPA
The Care Programme Approach is the process by which all service users and carers' needs are assessed in secondary mental health services.

FFT
The Friends and Family Test asks patients and staff how likely is that they would recommend a ward/department to friends and family if they needed similar care or treatment.

HoNOS
Health of the Nation Outcome Scales. The use of HoNOS is recommended by the English National Service Framework for Mental Health and by the working group to the Department of Health on outcome indicators for severe mental illnesses.

I&E
Income and Expenditure.

IAPT
Improving Access to Psychological Therapies is a National Health Service (England) initiative in to improve access to psychological therapies.

ICU
Intensive Care Unit.

In-patient
A person admitted on to a hospital ward for treatment.

International Financial Reporting Standard (IFRS) and International Accounting Standards (IAS)
Issued by the International Accounting Standards Board, financial reporting standards govern the accounting treatment and accounting policies adopted by organisations. Generally these standards apply to NHS organisations.

MH
Mental Health.

MRSA
Methicillin-resistant Staphylococcus aureus.

NED
Non Executive Director

NEST
National Employment Savings Trust this is a defined contribution occupational pension scheme backed by the government.

NHS England
Formally established as the NHS Commissioning Board on 1 October 2012, NHS England is an independent body at arm's length to the Government.

NHS Foundation Trusts
NHS hospitals that are run as independent, public benefit corporations, which are both controlled and run locally.

NHS Improvement
NHS Improvement, the operational name for the organisation which brings together Monitor and the Trust Development Authority.

NHS Trusts
NHS trusts are hospitals, community health services, mental health services and ambulance services which are managed by their own boards of directors. NHS trusts are part of the NHS and provide services based on the requirements of patients as represented by primary care trusts and GPs.

NICE
The 'National Institute for Health and Care Excellence' provides national guidance and advice to improve health and social care.

Outpatient
A person treated in a hospital but not admitted on to a ward.

PALS
The Patient Advice and Liaison Service offers confidential advice, support and information on health-related matters.

PDC
Public Dividend Capital

Performance indicator
Measures of achievement in particular areas used to assess the performance of an organisation.

PLACE
The Patient Led assements of care environment (Formally know as PEAT – Patient Environment Action) inspections every year and comprise a team of health professionals along with an independent patient representative. The team assess each hospital they visit in terms of cleanliness, hygiene, privacy, dignity, patient information, food quality and service.

Provisions
Provisions are made when an expense is probable but there is uncertainty about how much or when payment will be required, e.g. estimates for clinical negligence liabilities. An estimate of the likely expense is charged to the Trust's Operating Cost Statement as soon as the issue comes to light, although actual cash payment may not be made for many years, or in some cases never. The expense is matched by a balance sheet provision entry showing the potential liability of the organisation.

Revenue
Revenue is expenditure other than capital, for example, staff salaries and drug budgets. Also known as current expenditure.

RTT
Referral to Treatment Time.

Secondary care
Specialised medical services and commonplace hospital care, including outpatient and in-patient services. Access is often via referral from primary care services.

STP
Sustainability and Transformation Partnership.

VTE
Venous Thromboembolism.

WTE
Whole Time Equivalent

YTD
Year To Date.

NHS
Worcestershire Health and Care
NHS Trust

Do you have a concern, complaint or comment?

We always value feedback from you about the care you receive and you may be contacted to comment on the service. However, if you wish to make a compliment, comment or complaint please contact:

Patient Relations Team,
Worcestershire Health and Care Trust,
Isaac Maddox House,
Shrub Hill Road,
Worcester,
WR4 9RW

Tel: 01905 681517
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