NHS
Worcestershire Health and Care
NHS Trust

ANNUAL REPORT
2018/19



www.hacw.nhs.uk

Working together **for outstanding care**

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OVERVIEW OF OUR TRUST 2018/19

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 overview section of the Annual Report provides a short summary of the organisation, the context and environment within which we work and assurance around the sustainability of the Trust to continue providing healthcare services to our population.

We are partnership focussed and this is recognised in our vision statement, '**Working Together for Outstanding Care'**, which is underpinned by a core set of values which describe the principles around which all staff are asked to work. Working Together doesn't just mean with partner organisations; we are committed to co-production with patients, carers and families at all levels to ensure what we provide meets the needs of our wider community, and we also work in partnership with staff to support them to provide the best care they can every day.

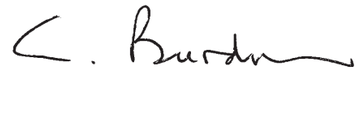
2018/19 has been a year of innovation across the organisation. Through our status as a Global Digital Exemplar we have continued to push the boundaries of how IT and digital solutions can support front line staff to provide the best care we can to our patients, families and carers. We continue to develop our EVIE system which is enabling our community staff, acute clinicians and GPs access to a patient's up to date care record which is a real breakthrough in how we share information and work collaboratively.

We are supporting staff at work through new initiatives such as digital dictation software which is freeing up more time for clinical staff to spend with patients; and we are also revolutionising how we can support young people with their mental health and wellbeing through a new online resource and app called BESTIE. This has been developed and designed for young people by young people and is already earning national and international recognition. It promises to transform how we use digital solutions to support young people and we are really excited by its potential.

Of course all of this is underpinned by our unwavering commitment to ensuring we get the basics right so patients and their families have a really positive experience every time they come into contact with us. We have continued to work together with our staff, with patients, carers, the wider community and with our partners to deliver safe and effective care both within our own portfolio but also as part of our local Sustainability and Transformation Partnership (STP), and we have again met all our financial targets including reducing the amount we spend on temporary staffing and achieving a year-end surplus which supports us to make further improvements to our estate and clinic environments.

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.



Chairman, Chris Burdon

Chief Executive, Sarah Dugan

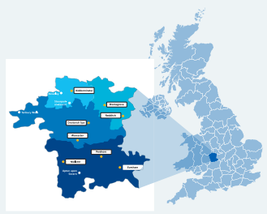
ABOUT THE TRUST

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 occupational therapy, physiotherapy and dementia care. We also run the county's community hospitals, recovery units, and inpatient wards for those recovering from mental health conditions. **Visit www.hacw.nhs.uk for a full list of services.**

Rated Good by the Care Quality Commission (CQC)

Our services are provided from over 100 sites

We employ around 4,000 staff



Population of Worcestershire is around 560,000

28,000 patient contacts every week

81 different services

Key stats:
Our services:

We organise our services into the following Service Delivery Units (SDUs):

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

OUR VISION

OUR VISION

Working together for **outstanding care**

OUR VALUES

COURAGEOUS AMBITIOUS RESPONSIVE EMPOWERING SUPPORTIVE

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

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 ACHIEVEMENTS IN 2018/19

Shortlisted in the 'Creating a Supportive Staff Culture' HSJ Award

More people self-referring for mental health support following the launch of our Now We're Talking campaign

Our Dementia Assessment and Support Team awarded national accreditation

Met all financial targets, including year-end surplus

Children's Speech & Language service win national Giving Voice award

Launched BESTIE, transforming the way we support young peoples' mental health

Service supporting people with mental health difficulties to get back into work awarded 'Centre of Excellence' status

Officially opened the county's specialist Stroke Rehabilitation Ward in Evesham

Signed the Time to Change Employer Pledge to end mental health discrimination in the workplace

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.**

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

Worcestershire Health and Care NHS Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

After making enquiries, the Directors have a reasonable expectation that we have adequate resources to continue in operational existence for the foreseeable future. NHSI's Single Oversight Framework oversees and supports Trusts in improving financial sustainability, efficiency and compliance with controls within the financial sector. Using these measures we have the lowest level of risk with the Use of Resources rating being at the best possible level both in overall terms and for liquidity.

The Board of Directors approved the NHSI Operational Plan which identified that for the next financial year (2019/20) the Trust will deliver a £1.956m surplus (agreed control total set by NHSI) after delivery of a £3.2m savings programme which has been agreed by the Trust Board and is embedded in the budget. The Trust will again be reporting the best possible Use of Resources rating. The Directors have assumed that the financial impact of the increase in employer's pension contributions being consulted on nationally will be funded. The Trust has an agreed and signed contract in place with its main commissioner for 2019/20. The Trust has assessed the risks in achieving the 2019/20 financial plan and, in particular, the cost improvement programme. The Trust has a proven track record of achievement of challenging efficiencies programmes, it has delivered recurrent savings and surplus control totals year-on-year since its formation in July 2011. The Trust has the appropriate financial and operational risk management processes in place to support its operational plans.

On a quarterly basis the Trust's Finance and Performance Committee receives the organisation's future Long Term Financial Model (LTFM), working capital positions, reporting processes and overall finances.

For the reasons stated, the Directors continue to adopt the going concern basis in preparing the accounts.

PERFORMANCE ANALYSIS

Performance Review

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 2019.

Finance		
	Target £m	Achieved £m
Bottom line I&E position – Forecast compared to plan	3,4	5.0
Bottom line I&E position – Year to date actual compared to plan	3.4	5.0
Efficiency YTD actual compared to plan (delivered)	3.5	3.5
Actual efficiency recurring compared to plan – Forecast compared to plan	3.5	3.5
Forecast underlying surplus/deficit compared to plan	3.4	5.0
Forecast year end charge to capital resource limit (Capital Spend)	9.3	9.3
Is the Trust forecasting permanent PDC for – liquidity purposes	No	No
Agency Spend – Year to date actual compared to plan	6.0	4.8

Workforce		
	Target	Achieved
Trust sickness rate – monthly position	≤ 4.0%	4.7%
Staff appraisals	95.0%	94.9%
Mandatory training	90.0%	92.3%
Agency as a % of employee benefit spend	-	3.7%
Workforce WTE	-	3,036
Turnover rate (12 month rolling) from September 2018	12.5%	13.2%
Vacancy rate	-	9.0%

Quantitative Performance		
	Target	Achieved
RTT waiting times incomplete pathways	92.0%	98.8%
RTT over 52 week waiters	0	0
Proportion of patients spending less than 4 hours in A&E	95.0%	100.0%
Referral to IAPT will be treated within 6 weeks of referral	75.0%	96.4%
Referral to IAPT will be treated within 18 weeks of referral	95.0%	100.0%
Early Intervention: 1st episode of psychosis treated within 2 weeks	53.0%	100.0%
IAPT – Patients receiving psychological therapies (Q4 trajectory and position)	4.8%	Q4 5.0%
IAPT – Patients who complete treatment moving to recovery	50.0%	50.3%
Patients on CPA who had a CPA review within the last 12 months	95.0%	95.0%
Patients on CPA receiving follow-up contact within 7 days of discharge	95.0%	98.0%
Inappropriate out-of-area placements for Mental Health Services (total number of bed days)	0	22
Delayed Transfers of Care – Mental Health	≤ 3.5%	0.3%
Delayed Transfers of Care – Community Hospitals	≤ 3.5%	9.1%
Mental Health Clustering	95.0%	93.3%
Mental Health Clustering Reviews	95.0%	86.7%
Data Quality Maturity Index (DQMI) – MHSDS dataset score	95.0%	99.2%

Quality Performance		
	Target	Achieved
Incidence of C.diff (Monthly Trajectory 10, Full Year Target ≤ 10)	≤ 10	1 YTD
Incidents of MRSA	0	0
Never Event incidence	0	0
VTE Risk Assessment	95.0%	96.6%
Safety Thermometer – % of patients free from harm	95.0%	93.8%
% of incidents categorised as resulting in moderate, severe harm or death	<= 7.7%	1.3%
Admissions to Adult Mental Health for patients under 16	0	0
Number of prone restraints	0	0
Single Sex Accommodation Breaches	0	0
Inpatient scores from Friends & Family Test – % positive	-	96.0%
Staff FFT response Rate	-	Q2 22.7%
Staff FFT Percentage recommended work	-	Q2 57.4%
Staff FFT Percentage recommended care	-	Q2 75.9%
Number of avoidable grade 3 & 4 pressure ulcers	0	0
Number of complaints	-	21
Number of complaints upheld by the Ombudsman	0	0

Performance Overview

For several years the performance of NHS Trusts has been assessed by NHS Improvement (NHSI) against the requirements of the Single Oversight Framework.

The Framework is based on the allocation of NHS Trusts into segments, which are driven jointly by performance against key 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 is currently allocated to Segment 1 by NHSI, the highest level that can be achieved. The performance of the Trust against the NHSI Single Oversight Framework for March 2019 can be found 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 more comprehensive 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 considered at Team and Service Delivery Unit level, as well as at Board Committees and the Trust Board.

As with previous years, there are indicators that are challenging to achieve, with patients experiencing delays in their discharge from hospital being one the most significant problems. The rise in the number of frail elderly patients often with multiple long-terms conditions being treated within the community hospitals means that there is a cohort of patients who are unable to return home and require some form specialist nursing or residential care home placement. There is limited availability of such homes to accommodate these patients and as a result, they stay in hospital longer than intended. Countywide work involving Worcestershire County Council, Worcestershire Acute Hospitals NHS Trust and the three Worcestershire Clinical Commissioning Groups is in place to try to develop solutions and to improve the position for our patients. It must be stressed however that these problems are being experienced nationally and are not unique to Worcestershire.

A particular success story has been the improvements that have been made with the Improving Access to Psychological Therapies service. Each year, the Trust is set an increasing target for the number of people with conditions such as anxiety and depression accessing the service. Following an extensive re-design programme, the service not only achieved the higher levels of access, but also maintained performance against the waiting time standards and recovery rates for patients being discharged from treatment.

NHS Improvement Single Oversight Framework: Quality of Care Monitoring Metrics 2018/19

Safe	Target	Mar-19
Clostridium Difficile – variance from plan	≤ 0	-9
Clostridium Difficile – incident rate (March trajectory less than or equal to 10)	≤ 10	1 YTD
Incidence of MRSA	0	0 YTD
Never Event – count	0	0
Patient Safety Alerts outstanding	0	0
VTE Risk Assessment	95.0%	96.6%
Admissions to adult facilities of patients who are under 16 years of age (Number)	0	0
Effective	**Target**	**Mar-19**
% of clients in settled accommodation	60.0%	64.6%
% clients in employment	10.0%	12.6%
CPA follow up within 7 days of discharge	95.0%	98.0%
Caring	**Target**	**Mar-19**
Staff FFT Percentage Recommended – Care	-	Q2 75.9%
Inpatient Scores from Friends and Family Test – % Positive	-	96.0%
FFT – Minor Injury Units	85.0%	97.0%
FFT – Mental Health	85.0%	86.0%
FFT – Community	85.0%	96.0%
Written Complaints – rate	-	21
Mixed Sex Accommodation Breaches (number)	0	0
Well-led – (renamed Organisational health)	**Target**	**Mar-19**
Proportion of temporary staff	£6.0m	£4.8m
Aggressive cost reduction plans	£3.5m	£3.5m
Trust level total sickness rate	≤ 4.0%	4.7%
Staff turnover rate (Rolling 12 months from September 2018)	12.5%	13.2%

NHS Improvement Single Oversight Framework: Finance and Use of Resources 2018/19

Finance and Use of Resources	Target	Mar-19
Liquidity rating	1	1
Capital service cover rating	1	2
I & E margin rating	1	1
I & E margin: distance from financial plan	1	2
Agency rating	1	1
Overall risk rating	**1**	**1**

NHS Improvement Single Oversight Framework: Operational Performance Metrics 2018/19

Governance Risk	Threshold	Mar-19
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92.0%	98.8%
A&E: maximum waiting time of four hours from arrival to admission/transfer/ discharge	95.0%	100.0%
Out of area placements for mental health services (number of days)	0	22
Inappropriate out of area placements for mental health services (number of days)	0	22
Early Intervention in Psychosis: 1st episode of psychosis treated with a NICE approved care package within 2 weeks	53.0%	100.0%
Improving access to psychological therapies (IAPT):		
Proportion of people completeing treatment who move to recovery	50.0%	50.3%
Referral to the IAPT programme will be treated within 6 weeks of referral	75.0%	96.4%
6 weeks 3-month rolling position as per Single Oversight Framework		91.4%
Referral to the IAPT programme will be treated within 18 weeks of referral	95.0%	100.0%
18 weeks 3-month rolling position as per Single Oversight Framework		99.4%
Data Quality Maturity Index (DQMI) - MHSDS dataset score	95.0%	99.2%

Financial Overview

Revenue

For 2018/19, 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 £176.6m (£179.5m last year). The reduction in revenue primarily related to the 'Forward Thinking Birmingham' contract which ceased on 31 March 2018.

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 2019 is a surplus of £5.2m (2017/18 £9.6m). 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 £5.0m (2017/18 £7.3m). This is the surplus which the Trust is monitored by NHSI.

Capital

In 2018/19 the Trust used internally generated funds from depreciation, brought forward revenue surpluses and Public Dividend Capital (PDC) funding to cover a capital programme of £9.3m. The Trust spent its 2018/19 Capital Resource Limit, which was approved by NHSI.

The Trust's main areas of expenditure were: £3.8m on Information Technology (which included the Global Digital Exemplar, WiFi and Health Service Lead Investment programmes – whereby the Trust received PDC funding for these); £3.6m implementing its estates strategy, £0.7m on backlog maintenance and £0.5m on equipment. Other areas of substantial expenditure included £0.4m on PLACE and investment in Anti-ligature £0.2m.

Working Capital

The Trust has taken active measures to secure its working capital and cash liquidity with a year-end cash balance of £19.6m, £9.1m in excess of its External Financial Limit (EFL). This exceeds the 10 days minimum operating cash recommended by NHSI. This over-delivery is allowable by NHS Improvement. The Trust made early payments to clear its outstanding loans with the Department of Health and Social Care.

Financial statutory and non-statutory targets

Target	Achieved	Explanation
Surplus (£3.4m)	✔	Achieved a year end surplus of £5.0m
Remain within the Capital Resource Limit (£9.3m)	✔	The Trust spent its capital resource limit £9.3m
Remain within the External Financial Limit (£9.1m)	✔	The Trust under-spent against its limit by £9.1m (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 99%
Efficiencies (£3.5m)	✔	£3.5m 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; as 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 as sustainable lifestyles with more active travel and less energy intensive diets result in healthier lifestyles.

The Trust emitted 22,172 tonnes of CO^2 equivalents (TCO^2e) a year (based on 2013/14 baseline) with a reduction target of 15,964 tonnes CO^2e by 2020/21. In 2018/19 the Trust emitted 20,413 TCO^2e against a target of 18,292 TCO^2e. The Trust did not reach its target due to increased travel and procurement emissions. Overall, the electricity's carbon emissions dropped by 333 TCO^2e. The following projects were implemented in 2018/19:

- Installation of LED lighting throughout the Trust premises (Princess of Wales Community Hospital)
- Continued maintenance upgrades (boiler upgrades, 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 3 years through LASER's 4 year framework and are in the early stages of energy procurement an exercise for energy contracts from 2020 onwards. This is to ensure tariff charges are competitive as the energy market is constantly changing. The Trust still has energy contracts in place with the following energy suppliers up until September 2020:

- 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, with the Trust deciding to explore the market in 2017/18. In 2018/19 Bright Sourced was nominated as the broker to complete a tendering exercise for a water services contract.

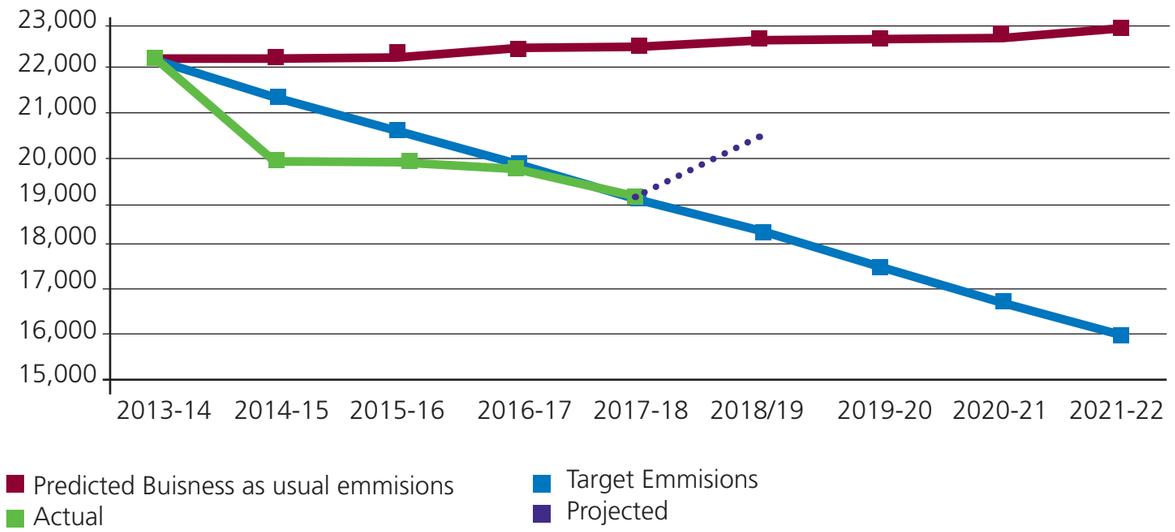
Travel

Table 1: Travel Data

Business Travel	Units	2017/18	2018/19
Travel – BM non-owned/grey fleet & public transport	m	4,374,965	4,660,489
Overall Cost	£	2,432,686	2,591,451
Grey Fleet Carbon Emissions	TCO^2e	1,581	1,661

The data shows in 2018/19 shows we have increased our business travel carbon emissions by 80 tonnes. This may be attributed to greater travel as a result of staff relocation.

Figure 1: Carbon Dioxide Emissions resulting from Trust operations



The green line in the graph illustrates that the Trust has decreased its emissions (actual) against both the 'Do Nothing' and 'Target emissions' lines. At the end of the 2017/18 financial year we calculated that the CO^2 emissions had decreased to 19,170 tonnes against the trajectory target of 19,068 tonnes. The graph also shows the estimated 2018/19 year end position well below the target for 2017/18. As stated previously this has increased due to an increase in travel and procurement.

Table 2: Carbon Emissions from Energy

Resource		2015/16	2016/17	2017/18	2018/19
Gas	Use (kWh)	13,486,050	14,335,484	14,508,285	14,328,785
	tCO2e	2,829	3,000	3,032	3,038
Oil	Use (kWh)	43,937	33,126	44,373	44,942
	tCO2e	14	11	14	15
Coal	Use (kWh)	0	0	0	0
	tCO2e	0	0	0	0
Electricity	Use (kWh)	2,487,313	5,643,729	3,703,592	3,547,928
	tCO2e	1,540	3,245	1,914	1,581
Green Electricity	Use (kWh)	3,454,644	43,845	1,541,729	1,921,980
	tCO2e	2,140	0	776	837
Total Energy CO2e		**6,524**	**6,255**	**5,736**	**5,471**
Total Energy Spend		**£ 1,269,853**	**£ 1,238,547**	**£ 1,129,328**	**£ 1,428,020**

The table above illustrates that our measured energy carbon emissions has decreased since last year but increased in cost. This is due to a significant price rises by all energy suppliers as a result of:

- low gas storage levels
- cold snaps
- increasing cost of transporting fuels to meet demand
- economic and political unrest in different regions of the world (playing a role in pushing up oil prices over the past 24 months)

Table 3: Water consumption

Water		2017/18	2018/19
Mains Water	m^3	58,276	54,990
	tCO^2e	53	50
Water & Sewage Spend		£252,795	£260,379

Our water consumption has decreased in comparison to 2017/18; this is solely due to detecting meter reader failures at some Trust premises.

Table 4: Waste production

Waste		2015/16	2016/17	2017/18	2018/19
Recycling	(tonnes)	197.00	191.00	278.75	187.27
	tCO2e	4.14	3.82	5.85	4.07
Other recovery	(tonnes)	2.00	311.00	245.86	444.74
	tCO2e	0.04	6.22	5.16	9.68
High Temp disposal	(tonnes)	47.00	0.00	220.88	52.95
	tCO2e	10.34	0.00	48.59	11.65
Landfill	(tonnes)	371.00	142.00	5.76	0.00
	tCO2e	90.68	34.71	1.79	0.00
Total Waste (tonnes)		**617.00**	**644.00**	**751.25**	**684.96**
% Recycled or Re-used		**32%**	**30%**	**37%**	**27%**
Total Waste tCO2e		**105.20**	**44.75**	**61.40**	**25.40**

Our waste production has reduced in 2018/19. This is due to waste in classification changes in ERIC.

Some of the Trust's 2018/19 data is estimated based on ERIC data.

Non-financial information

Anti-bribery policies

The Trust collaborates closely with other organisations to deliver high quality care for our patients. These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely, but there is a risk that conflicts of interest may arise. As an organisation we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

Our Conflicts of Interest Policy sets out the process by which the Trust manages any potential or actual conflicts of interests in accordance with up to date guidance. This includes the requirement for staff to declare any gifts, hospitality, relevant personal interests and non-NHS work. This process is overseen by the Audit Committee.

The aim of our Counter Fraud, Bribery and Corruption Policy is to increase staff awareness of the issue of fraud within the Trust, to provide guidance to staff about what to do if they have suspicions of fraud and to set out the Trust's approach in investigating allegations of fraud and pursuing sanctions against and redress from those who participate in fraudulent or corrupt activity.

ACCOUNTABILITY REPORT

CORPORATE GOVERNANCE REPORT

Directors Report

Chris Burdon, Chairman
Chris took up his appointment on 1 July 2011 having been Chairman designate since February 2011. Chris was appointed as NED with NHS Worcestershire in December 2008 and chaired their provider services Board. Following an early career in metallurgical research, 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. He Chairs Remuneration Committee and attends Quality and Safety, Workforce and Finance and Performance Committee in an ex officio capacity.

Sarah Dugan, Chief Executive
Sarah took up post on 1 July 2011. Sarah previously worked for NHS Dudley as Chief Executive. Sarah is a Registered General nurse, Children's nurse and Public Health nurse. She has held a wide range of senior positions with community and mental health service providers and in commissioning organisations. She attends Quality and Safety, Workforce and Finance and Performance Committee in an ex officio capacity.

Michelle Clarke, Director of Nursing and Quality
Michelle Clarke took up post in April 2016 following a secondment from January to March 2016 from Wye Valley NHS Trust where she worked since August 2011 as Director of Nursing and Quality. Prior to this Michelle worked in various posts linked to professional development, service improvement, education and leadership. Michelle has previously been Managing Director for Warwickshire Community Health Services. She has extensive knowledge of community health care and has a District Nursing background. Michelle qualified as a nurse in 1988 and obtained her Masters in Health Sciences in early 2000. She attends Quality and Safety Committee and Workforce Committee.

John Devapriam, Medical Director
John Devapriam is National Professional Advisor for Learning Disability for the independent regulator, the Care Quality Commission, and chairs the Quality Network for Learning Disabilities for the Royal College of Psychiatrists. He joined the Trust in April 2019 from Leicestershire Partnerships NHS Trust where he was Consultant Psychiatrist in Learning Disabilities and Clinical Director for the Adult Mental Health and Learning Disability directorate. He became a Fellow of the Royal College of Psychiatrists in 2015. He attends Quality and Safety Committee, Workforce Committee and Mental Health Legislation Committee.

Stephen Collman, Chief Operating Officer
Stephen was our Chief Operating officer having previously been the Deputy Director of Service Delivery with the Trust from August 2011. He was responsible for the day today running of the Service Delivery Units operations and management teams and workforce/HR department teams. Stephen qualified as a mental health nurse in 1990. He has held a number of management posts in mental health and community services. Stephen left the Trust February 2019. He was a member of Quality and Safety Committee, Workforce Committee and Finance and Performance Committee.

Ros Alstead, Interim Chief Operating Officer
Ros is a registered general nurse and mental health nurse by background and has held a number of Executive Director leadership roles covering service improvement, nursing and general management and was most recently Executive Director of Nursing and Clinical Standards at Oxford Health Foundation Trust. Ros is a visiting professor of health and life sciences at Oxford Brookes University and was awarded an OBE for services to nursing in 2017. She also lives in Worcestershire and is really passionate about supporting local services. Ros joined the Trust in January 2019. She attended Quality and Safety Committee, Workforce Committee and Finance and Performance Committee.

Robert Mackie, Director of Finance and Deputy Chief Executive
Robert took up post with the Trust on 1 July 2011 as Director of Finance. He is a Member of the Finance & Performance Committee and also attends Audit Committtee. He previously worked for the NHS Walsall, initially as Director of Resources from October 2008 and then from November 2010 as Interim Chief Executive. Robert is qualified accountant and joined the NHS with the 1998 cohort of the national financial management training scheme, having previously worked in general management within the private sector.

Sue Harris, Director of Strategy and Partnerships
Sue was appointed in May 2012. Sue is a member of the Finance & Performance Committee and her Directorate responsibilities include strategy and business development, business planning, the Programme Management Office, marketing and communication, patient self-management and community engagement. Prior to a secondment to the Strategic Health Authority in 2011, Sue was, from 2009, Lead Commissioner for mental health services in Worcestershire. Prior to this role, she was a national director for Turning Point, a leading social enterprise, Sue has over 20 years of business development experience in the health and social care field across a range of sectors.

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. She qualified as a solicitor in 1994 working in local authorities in Warrington, Gloucestershire and Birmingham, undertaking a broad range of legal work. She moved into the NHS in 2007 working in a specialist Mental Health Trust. She is responsible for corporate governance in the Trust. She is a member of Quality and Safety Committee, Mental Health Legislation Committee and attends Audit Committee.

Rick Roberts, Non Executive Director
Rick was a NED with the Trust since 1 April 2014, having previously served as a NED (Designate) from 1 November 2013. He chaired the Quality & Safety Committee and was a member of Audit Committee, Remuneration Committee and Mental Health Legislation Committee. 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. Previous appointments include Clinical Director of the Birmingham Dental Hospital and Consultant in Oral Surgery. Rick left the Trust in March 2019.

Steve Peak, Non Executive Director
Steve has been a NED since June 2015. He is the Chair of the Finance and Performance Committee and a member of Remuneration Committee and Audit Committee. He previously lectured for Keele University and is Sales and Business Development Director for Vanguard Healthcare Solutions. Over the past 25 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 joined the Board in September 2016 and is a Chartered Accountant and has held a series of senior executive positions in the financial services sector. This has included three years with the Financial Services Authority before taking up the position of Director of Legal and Compliance with a global private equity firm. Stephen is also an accomplished musician, and for 10 years was Master of Music at the Chapels Royal, HM Tower of London. He chairs Audit Committee and Charitable Funds Committee and is a member of Quality and Safety Committee.

Jamie Morris, Non Executive Director
Jamie joined the Board in November 2016 and is a retired senior executive who has held roles in various public and private sector organisations, most recently as an Executive Director at Walsall Metropolitan Council, where he had responsibility for a wide range of front line services. Before that he was Assistant Chief Executive at Birmingham City Council and a Management Consultant with Deloitte advising local and central government on a variety of issues. He chairs Workforce Committee and is a member of Finance and Performance Committee and Mental Health Legislation Committee.

Tessa Norris, Associate Non Executive Director
Tessa joined the Board 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 is a member of the Workforce Committee and Quality and Safety Committee.

Martin Charters, Non Executive Director
Martin joined the Trust in May 2018 and is a trained Chartered Accountant with experience in senior finance roles within the NHS. However his more recent experience has been focused on clinical service transformation, the alignment of culture, values and behaviours across systems, and ensuring effective governance. Recent examples include working with the Stockport Together Vanguard Programme focused on the development of integrated physical, mental and social care, and with St George's Hospital on the complete redesign of outpatient services. He chairs Mental Health Legislation Committee and is a member of Finance and Performance Committee.

Martin Papadatos, Associate Non Executive Director
Martin joined the Trust in May 2018. He brings experience from being the Chief Operating Officer for Commercial Banking Europe at Lloyds Banking Group. Martin is also a Financial Analyst and holds a PhD degree in business strategy from the University of Cambridge. His research at the university focused on board of directors and how they make decisions. Prior to joining Lloyds he was a consultant at the Boston Consulting Group and Deloitte. He is a member of Quality and Safety Committee and Audit 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 the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

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

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

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

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

Chief Executive, Sarah Dugan
Date: 23 May 2019

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board

Chief Executive, Sarah Dugan
Date: 23 May 2019

Director of Finance, Robert Mackie
Date: 23 May 2019

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 2019 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. All of the above committees review key risks each meeting and consider any changes that ought to be escalated to Trust Board's attention. The Mental Health Legislation Committee receives reports on all complaints and incidents and inspections arising out of the Trust's usage of the Mental Health Act and reports onwards to Trust Board.

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 runs 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 meeting. 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.

In addition, there is a monthly review of risks within each Director's portfolios with a residual score of 10, as well as the Committees reviewing risks within their portfolios each meeting with residual scores of 12 or above. The Trust Board receives all risks with residual risks of 15 or above at each public meeting.

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.

Cost Improvement plans are subject to a rigorous process in which, a detailed quality impact assessment is approved by the Director of Nursing and Quality and/or Medical Director.

Risk management continues to be promoted and embedded throughout the Trust. During 2018/19 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 April to March 2018/19

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 2018/19. Alongside the assurance framework, additional support has been 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 2019:

Risk	Mitigation	Outcome
SO 2/3/4 – 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 • Safety thermometer • Wide ranging governance arrangements • Serious incidents process • Revalidation of medical staff and 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

Risk	Mitigation	Outcome
SO 1/4 – 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
SO 1/3/4 – 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 engagement and where appropriate consultation • Processes in place to address plans in dedicated workstreams with governance processes embedded	• Governance Structure being agreed and overseen by NHS England • STP based on public engagement and national priorities. • 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 • Staff Health and Well Being Programme	• 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

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.

The Quality and Safety Committee is 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 detailed analysis of quality within the scope of financial and performance influences, allowing for a shared understanding of key risks, mitigations and achievements. A highlight presentation is provided each month from the Integrated Governance meeting to the Quality and Safety Committee.

In addition to this a monthly Clinical Quality Improvement Forum focuses on shared learning. The Forum uses additional intelligence from related governance sources such as complaints and compliments, clinical audit and patient experience feedback to recognise key successes and identify where improvements can be shared and replicated.

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 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 key metrics where performance is falling short of target.

All Cost Improvement Programmes or new service developments undergo a Quality Impact Assessment. These are presented by the project lead to a Quality 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/or the Medical Director who require assurance that all quality and safety considerations have been fully assessed. Each project will then have indicators identified to monitor longer term effects on the quality of services.

Our governance arrangement for learning from deaths reflects the principles of the National Quality Board's guidance. Our Mortality Surveillance Group, chaired by the Deputy 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 and safety of care.

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

participates in local Sudden Unexpected Deaths in Childhood (SUDIC) processes, participating in reviews following child deaths in Worcestershire.

The Trust's web-based monitoring tool for staffing levels, allows senior managers and the Director of Nursing and Quality to have access to real time staffing level information and ensures that there are strong controls around safe staffing. An in-depth review of staffing data is undertaken every 6 months and is reported to Trust Board. 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 at every public Board meeting. 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 narrative comments about individual staff who 'go the extra mile' for patients and carers. Where individual staff members are named in any positive feedback, 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.

Our 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 (PALS), 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. We are active participants in the NHS Improvement's 'Quality Service Improvement and Redesign' (QSIR) programme. We are now able to utilise the skills of staff trained in quality improvement methodology to support a wide variety of improvement initiatives such as restraint reduction, insulin incident analysis, as well as process mapping and demand and capacity exercises for teams that are undergoing transformation. This added expertise leads to greater project efficiency and enhanced project outcomes. In April 2018 three Quality Initiatives were identified for the year ahead, after consultation by Trust Board. These were also our 2018/19 Quality Account priorities:

- Dementia
- Parity
- Workforce.

Each Quality Initiative is aligned with the Trust's Strategic Priorities and has an identified project lead and project coordinator. The project plans are reviewed by the Quality and Safety Committee to ensure agreed milestones are on track.

Arrangements for assurance on Clinical Audit

We have a 3 year rolling audit programme 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 2018/19 Clinical Audit plans were agreed by the Service Delivery Units in early 2018, 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. The report 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 2018/19.

We are embedding the NHS Improvement 'Just Culture' guide to help managers determine appropriate steps to be taken when a member of staff is involved in an incident. The guide helps to facilitate a consistent and fair approach and underpins our commitment to supporting staff who have been involved in an incident.

Each Serious Incident undergoes a Root Cause Analysis investigation 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. 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.

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 policy for Being Open and the Duty of Candour. Bespoke individual Duty of Candour training sessions are also held with clinical teams using examples of real cases to promote reflective discussion.

External Review of the quality of services provided

When the CCG undertake an announced inspection of services we accompany the visiting team with staff from similar teams in the Trust to act as peer reviewers. This supports the promotion of shared learning between clinical teams and Service

Between 1st April 2018 and 31st March 2019, 13 services took part in a peer review with the CCG.

Date	Location/Service for Peer Review
21/06/2018	Podiatry Diabetic Team
12/07/2018	Droitwich Integrated Team
01/08/2018	Community Stoke Therapists, Evesham Community Hospital
15/08/2018	Home Treatment Team
18/09/2018	CAMH Redditch and Bromsgrove
01/10/2018	Hadley inpatient Unit
05/10/2018	Musculoskeletal Physiotherapy (South)
10/10/2018	Worcester City Inpatient Unit
14/11/2018	Learning Disability CAMHS Seaford Court, Malvern
03/11/2018	Enhanced Primary Care Mental Health Service
04/02/2019	Osborne Court Learning Disability Respite Service
21/02/2019	Complex Dementia and OAMH CMHT, North
14/02/2019	Starting Well Children Service, Wychavon

Overall the peer review visits have reported positive findings. Action plans are drawn up and agreed by the reviewers themselves and are then signed off by the staff in each service. Actions are monitored by the governance teams in the SDU until all actions have been completed.

Care Quality Commission

The CQC have undertaken 5 unannounced Mental Health Act monitoring inspections:

Date of inspection	Service inspected by CQC	Key findings
26/04/2018	New Haven - two older adult mental health wards - Woodlands Ward and Meadow Ward.	A positive report. An action plan has addressed areas identified for improvement relating to detained patients having their rights explained in a timely manner, care plans reflecting any blanket restrictions and improving signage on bedroom doors.
14/08/2018	Athelon – an older adult mental health ward	It was noted patients felt they were being well looked after and that staff were kind. Actions relate to ensuring the patient's capacity to consent to admission, treatment and sharing information is recorded as well as advice to patients of their legal status under the MHA.
12/11/2018	Hillcrest – an adult mental health ward	Patients said that staff were friendly and helpful. There was clear information about patient medications. The ward was described as pleasant. Actions related to ensuring the involvement and support for patients in discharge planning and providing gluten-free meal choices.
07/12/2018	Cromwell House – a community based adult mental health inpatient unit.	Patients said they had a great deal of freedom in preparation for discharge and described staff as caring and approachable. Actions related to ensuring the recording of consent discussions and recording patient views in care planning and community meetings.
28/01/2019	Holt Ward – an adult mental health ward	Report not received at the time of drafting this statement.

All such reports and the accompanying action plans are reviewed by our Mental Health Legislation Committee.

Trust Board operates in accordance with the Trust's Establishment Order, Standing Orders, Scheme of Delegation and Standing Financial Instructions. The Trust Board 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

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	Chief Operating Officer*	Michelle Clarke, Director of Nursing and Quality*	John Devapriam 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 Brexit	Operational Management of Services Service Transformation Integrated Service Delivery Service Improvement and Productivity Emergency Planning	Patient Safety Clinical Strategy Safeguarding Professional Standards Training & Development Organisational Development Infection Prevention and Control Health and safety Security Management Complaints Workforce/HR	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) Marketing Communications Programme Management Office Community Engagement	Board/ Corporate Support Corporate Governance and Risk Assurance Framework Legal Services Mental Health Act Lead Board Development Information Governance

*June – Dec 2018 Stephen Collman was seconded to another Trust and Michelle Clarke acted as Interim Chief Operating Officer in addition to her substantive role, Stephen Collman returned to the Trust in December 2018 and left in February 2019. Ros Alstead has been interim Chief Operating Officer for the remainder of the reporting period including a handover period.

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 consider the Well Led Framework throughout the reporting period. An external Well Led review is anticipated in the year 2019/20.

Annually, Non-Executive Director membership of Board committees is reviewed by the Chairman and changes were last implemented with effect in August 2018. A recruitment exercise was undertaken in the final quarter of the previous financial year and a new Non-Executive Director, Martin Charters and Associate Non-Executive Director, Martin Papadatos commenced with the Trust in May 2018.

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 and Professional Standards Authority's standards for members of NHS boards. 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. Further an annual audit is undertaken to ensure that the Trust complies with the Fit and Proper Person Regulations.
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 2018 the Trust Board conducted an evaluation of their effectiveness, which included outputs from the effectiveness reviews of the main Board Committees. The effectiveness evaluation is 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 2018 – 31 March 2019

Meeting	Number held	Chris Burdon □	Stephen Tilton	Rick Roberts	Steve Peak	Jamie Morris	Tessa Norris	Sarah Dugan □	John Devapriam	Stephen Collman *	Michelle Clarke	Robert Mackie	Sue Harris	Gill Harrad	Martin Papadatos	Martin Charters	Ros Alstead **
Trust Board	6	6	5	5	6	4	6	6	6	5	6	5	6	6	4	5	1
Board Development	5	5	4	4	4	4	5	5	4	3	5	5	5	5	4	4	1
Audit Committee	5		3	3	4			1				4		5	2		
Quality & Safety Committee	11	2	7	10		1▲	10	4	6	3	9			9	1▲		2
Finance & Performance Committee	11	11			9	10		1	1	3	1	10	6			4	3
Charitable Funds Committee	4	4	3							1	1	3					1
Remuneration Committee	3	3		3	3			3						3			
Workforce Committee	6	3			4▲	6	6	1	4	2	6				3		1
Mental Health Legislation Cttee	4	3	3	4		2	3		1					4		2	

□ Attends Finance and Performance Committee, Quality and Safety Committee and Workforce Committee in an Ex Officio capacity
▲ Observing
* Stephen Collman, Chief Operating Officer left post February 2019 and seconded June-Dec 18
** Ros Alstead, Interim Chief Operating Officer commenced in post in February 2019
Martin Charters and Martin Papadatos were appointed May 2018 and allocated to committees in October 2018

The Board considers the balance, completeness and composition of membership annually and takes the outcome into account when recruiting new members. Rick Roberts left the Trust on 31 March 2019 and a recruitment process is being undertaken to replace him.

Balance, Completeness and Appropriateness of the Board membership 1 April 2018 – 31 March 2019

	Chris Burdon (Chairman)	Sarah Dugan (Chief Executive)	Stephen Tilton	Rick Roberts	Steve Peak	Jamie Morris	Tessa Norris	John Devapriam	Stephen Collman+	Michelle Clarke	Robert Mackie	Sue Harris	Gill Harrad	Martin Papadatos	Martin Charters	Ros Alstead #
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	M	M	F	M	F	F	M	M	F
Individual's Appraisal undertaken by NHS Improvement	✔															
Individuals' Appraisals undertaken or objectives set by Chairman		✔	✔	✔	✔	✔	✔							✔	✔	
Individuals' Appraisals undertaken by Chief Executive								✔	✔	✔	✔	✔	✔			

Ros Alstead became a voting member in February 2018
+Stephen Collman left the Trust in February 2018

On a monthly basis quality and outcome dashboards are reviewed at the Integrated Governance meeting and anything untoward is escalated to Quality and Safety Committee and Workforce Committee and in the public Board meeting which is held bi-monthly. This is triangulated with safe staffing data through e rostering, fill rates, care hours per patient day, compliance with essential and mandatory training, and care sensitive indicators, for example, pressure ulcers, falls with harm, number of prone restraints as well as Friends and Family test response rate and place to recommend from both patients and staff .

When the Trust is implementing new roles these are subject to quality impact assessment, this has recently occurred relating to the employment of 27 nursing associates.

Six monthly safe staffing reviews are undertaken and submitted to Trust Board with involvement of workforce teams, finance and staff using the Safer Nursing Care Tool where appropriate. A more recent review has been presented to Trust Board in relation to all AHP and Nursing workforce in all service areas

not just inpatient areas, further work is now going to be undertaken to include the medical workforce. Our workforce plan is updated annually and discussed in public.

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

The trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. https://www.hacw.nhs.uk/our-services/freedom-of-information/publication-scheme/lists-and-registers/

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. All policies are subject to an equality impact assessment and any significant service changes are subject to both quality and equality impact assessments.

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

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 2018/19 financial year. In the reporting period, seventeen reviews have been undertaken during this period, of which: one has been given full assurance; ten have been given either level A or significant assurance on the Trust's controls; five were given moderate assurance; and one was recorded as an advisory review.

Full assurance:
- Treasury Management

Level A/significant assurance:
- Board Assurance Framework
- Charitable Funds
- Cost Improvement Programme
- Financial Management
- Financial Systems and Payroll
- Income & Debtors
- Pharmacy – National Alerts
- Procurement
- Site visits
- Well Led

Moderate assurance:
- Data Quality
- Do Not Attempt Resuscitation
- Job planning
- Sickness Management (Medical Staff)

Advisory review:
- Data Security Standards Compliance

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.

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 General Data Protection Regulation (GDPR) / Data Protection Act 2018, 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 (IG) works closely with, and offers advice to, the Caldicott Guardian.

As required under the 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 appropriate training for the role. The Trust's GDPR implementation plan has finished and all critical milestones were achieved on time. The Trust demonstrates compliance with the GDPR by completing the NHS Digital Data Security and Protection Toolkit (formerly the Information Governance Toolkit).

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.

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 and 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 derives its authority from the Information Governance Steering Group and is chaired by the Caldicott Guardian; there is representation from each service delivery unit and key corporate functions of the Trust. Quarterly reports are provided to the Information Governance Steering Group.

The NHS Digital Data Security and Protection Toolkit is based upon the 10 x data security standards identified in the National Data Guardian (NDG) Review. The Trust has gathered supporting evidence and submitted its end of year Toolkit return. The Trust has developed a comprehensive Improvement Plan to address any areas where development is needed. This Plan has been signed off by the SIRO and has been reviewed and approved by NHS Digital. The Trust status is 'standards not fully met – plan agreed'.

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 data security awareness training.
All new staff and volunteers are required to attend Trust induction which includes raising awareness of information governance issues.

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 reportable serious data security breaches are reported to the Information Commissioner's Officer or Department of Health and Social Care as necessary and are published on the Trust's website and in the Trust's Annual Report. This includes cyber incidents. There have been no serious data security breaches 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 Digital Data Security and Protection Toolkit.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust's Quality Account complies with the Department of Health and Social Care 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 comments to certify we have provided a fair representation. We respond to this consultation and amend 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.

In terms of the accuracy of data, 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.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee 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 internal control issues that have been identified in the reporting period.

Name: Sarah Dugan
Position: Chief Executive
Date: 23rd May 2019

Community Engagement and Patient Involvement

The last twelve months has seen the Engagement Team working more closely with the Trust Communications Team whilst retaining core independent functions, particularly around more complex engagement projects, co-production and volunteering. Areas of more integrated working have included engagement support around the Now We're Talking campaign, to include a stand at the Victorian Fayre where we, alongside our partners, engaged with the community around mental wellbeing. The team have also undertaken engagement work with partners and networks to seek wider support around the aims of the project. Another area where we have worked in a more integrated way has been around the resurrection of community education events. The first of these events was held in March 2019, around the subject of anxiety and depression. It afforded the opportunity to engage with a number of stakeholders around self-help techniques and the Healthy Minds offer. The event was also attended by a number of partners who through a market place were likewise able to connect with some of the community around their services. The events will now take place on a quarterly basis, each focusing on a different topic.

The team has very much been working to support wider system work, particularly around the Sustainability and Transformation Partnership and the Long Term Plan. Involvement and support has been on many projects and areas throughout the year, but some more recent key areas of work have been around creating three patient and stakeholder groups to support the work of the fourteen Neighbourhood Teams, and advising on and undertaking the engagement required for the system wide Clinical Sustainability Strategy project. More latterly, the team have been advising on the engagement required by the Integrated Care for Older People's workstream and advising on the engagement work required around the Long Term Plan. This has included a review of the plan, the development of some key engagement questions, the creation of an engagement plan, and the creation of a 'plan on a page'. Work is currently being undertaken to identify pieces of work that are required by the individual workstreams – that is, the key areas and groups where the workstreams must undertake engagement as outlined in the plan.

Much work has been undertaken around co-production. This has included a refresh of the Trust Strategic Approach to Co-production and focused work to understand what the strategy means for mental health services. All of these pieces of work saw the team engaging with Trust staff and patient groups through a series of workshops to gather views, which helped shape the developing documents. A system wide event in the summer of 2018 was arranged to launch the refreshed strategy and develop more interest in the approach by showcasing work being undertaken across the system. The Strategy action plan was informed by all of this engagement and much work has already been done in this regard – for example, a co-production portal has been created, which will form part of the Your Conversation website, and work has been done to review and improve the Trust approach to co-production in recruitment and selection processes, to include a refresh of the guidelines and staff and patient training programme, and the recruitment of many more patients and carers who can inform these processes. A module on co-production is also now included at induction; in preceptorship training; in MAPA training; in team leader development programmes and in Apprenticeship programmes. Also generic staff training has been developed and piloted with the Orchard Service, and work is on-going around how to work with each SDU to embed the approach.

The team support a number of patient and youth panels and groups, all of whom have been involved in a range of projects throughout the year. The Community Engagement Panel has recruited a number of new members to join established members and topics considered throughout the year have included Stroke services; the development of a Podiatry service website; the development of a new Healthy Minds website; supporting the Parity of Esteem initiative; and offering advice around bereavement packs. Most members are also members of a range of other groups to include Clinical Audit and Effectiveness; the Equality Advisory Group; the Stroke Family Education Group; and the GDE working group. In addition, members have advised on and supported the development of bespoke patient groups for services; have co-delivered training to staff; and have been involved in the recruitment and selection of senior leads and Directors.

Similarly, the Youth Board have been engaged with a number of projects throughout the year. One key piece of work has been the development of a CAMHS App for young people called 'Bestie'. This has been a co-produced piece of work involving members of Youth Board, young people who are currently accessing CAMHS, clinicians and technicians. The members have also been working to develop the sexual health services website; improve staff awareness of the need to increase young peoples' participation in services; and support the recruitment and selection of new staff.

The Equality Advisory Group is now well established and members offer representation from the nine protected characteristics to inform all equality work undertaken by the Trust – including around service developments and changes, new and refreshed policies and the Equality Delivery Standard (EDS). During the course of the year the group have advised on the Podiatry service redesign; Occupational Therapy services; the Sexual Health service change of premises; intensive home visits for the Starting Well Service; EDS standards in particular areas, and a range of policies to include the developing Transgender Policy and the refreshed Community Engagement Strategy. The Engagement Team are working closely with Equalities colleagues to develop an Equality Report that will sit alongside the Trust Operational Plan and all SDU plans to ensure best practice is followed around equalities work.

Finally, the Team supports the Trust's seventy volunteers who are employed in a range of areas – both clinical and corporate. Roles include hospital radio; chaplains; ward assistants; gardeners and many others. Work is currently being undertaken with SDU leads to explore the appetite for more volunteers and roles that would be most supportive to teams.

MODERN SLAVERY ACT 2015 – TRANSPARENCY IN SUPPLY CHAINS

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.

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 2018/19 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 remuneration table (audited)

Name and Title	Date Started	Date Left	2018/19									2017/18								
			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	£'000s	£'000s	£'000s	£'000s	£'000s				£'000s	£'000s	£'000s	£'000s	£'000s	£'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	Nil	Nil	Nil	Nil	Nil	Nil				0 - 5	Nil	Nil	Nil	Nil	Nil			
James Morris, Non Executive Director			5 - 10	Nil	Nil	Nil	Nil	5 - 10				5 - 10	Nil	Nil	Nil	Nil	5 - 10			
Martin Charters, Non Executive Director	May-18		5 - 10	Nil	Nil	Nil	Nil	5 - 10				Nil	Nil	Nil	Nil	Nil	Nil			
Martin Papadatos, Associate Non Executive Director	May-18		5 - 10	Nil	Nil	Nil	Nil	5 - 10				Nil	Nil	Nil	Nil	Nil	Nil			
Richard Roberts, Non Executive Director		Mar-19	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				5 - 10	Nil	Nil	Nil	Nil	5 - 10			
Tessa Norris, Associate Non Executive Director	Jan-18		5 - 10	Nil	Nil	Nil	Nil	5 - 10				0 - 5	Nil	Nil	Nil	Nil	0 - 5			

Name and Title	Date Started	Date Left	2018/19						2017/18					
			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
Sarah Dugan, Chief Executive			145 - 150	Nil	10 - 15	Nil	Nil	160 - 165	140 - 145	Nil	10 - 15	Nil	30 - 32.5	185 - 190
Andrew Sant, Medical Director *		Feb 18	Nil	Nil	Nil	Nil	Nil	Nil	95 - 100	Nil	0 - 5	Nil	0 - 2.5	105 - 110
David Lewis, Interim Medical Director	Feb-18	Apr-18	10 - 15	0	Nil	Nil	2.5 - 5.0	10 - 15	20 - 25	1	Nil	Nil	2.5 - 5	25 - 30
John Devapriam, Medical Director **	Apr -8		175 - 180	8	Nil	Nil	55 - 57.5	230 - 235	Nil	Nil	Nil	Nil	Nil	Nil
Robert Mackie, Director of Finance and Deputy Chief Executive***			135 - 140	Nil	5 - 10	Nil	7.5 - 10	150 - 155	125 - 130	Nil	0 - 5	Nil	40 - 42.5	170 - 175
Stephen Collman, Chief Operating Officer ****		Feb-19	95 - 100	Nil	5 - 10	Nil	62.5 - 65	165 - 170	95 - 100	Nil	0 - 5	Nil	65 - 67.5	170 - 175
Rosalind Alstead, Interim Chief Operating Officer	Feb-19		15 - 20	Nil	Nil	Nil	Nil	15 - 20	Nil	Nil	Nil	Nil	Nil	Nil
Michelle Clarke, Director of Nursing and Quality			115 - 120	Nil	5 - 10	Nil	75 - 77.5	195 - 200	95 - 100	Nil	0 - 5	Nil	25 - 27.5	130 - 135

Name and Title	Date Started	Date Left	2018/19						2017/18					
			Director of Finance	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
Susan Harris, Director of Strategy and Partnerships			105 - 110	Nil	5 - 10	Nil	10 - 12.5	125 - 130	95 - 100	Nil	0 - 5	Nil	22.5 - 25	125 - 130
Gill Harrad, Company Secretary			100 - 105	Nil	5 - 10	Nil	25 - 27.5	130 - 135	95 - 100	Nil	0 - 5	Nil	25 - 27.5	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 in 2017/18.

**The figure for Dr John Devapriam includes remuneration paid in respect of their national clinical excellence award and clinical work done (amounting to £80,585 in total) as well as directorship duties.

*** The figure for Robert Mackie includes an allowance for his role as Deputy CEO.

**** Stephen Collman was seconded to Worcestershire Acute Hospitals NHS Trust from 1st July and returned on the 17th December 2018. However, the figures presented represent his total remuneration for the period up to the date he left the Trust.

Pensions Entitlement table (audited)

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			0 - 2.5	0 - 2.5*	55 - 60	155 - 160	1,099	123	1221	0
John Devapriam, Medical Director	30 April 2018		2.5 - 5	2.5 - 5	30 - 35	70 - 75	383	108	491	0
David Lewis, Interim Medical Director		04 May 2018	0 - 2.5	0 - 2.5	35 - 40	90 - 95	634	110	745	0
Robert Mackie, Director of Finance and Deputy Chief Executive			0 - 2.5	0 - 2.5*	35 - 40	90 - 95	629	94	724	0
Stephen Collman, Chief Operating Officer		10 Feb 2019	2.5 - 5	5 - 7.5	35 - 40	85 - 90	504	138	642	0
Michelle Clarke, Director of Nursing and Quality			2.5 - 5	5 - 7.5	40 - 45	105 - 110	685	158	842	0
Susan Harris, Director of Strategy and Partnerships			0 - 2.5	0	30 - 35	0	334	72	406	0
Gill Harrad, Company Secretary			0 - 2.5	0 - 2.5	30 - 35	80 - 85	527	96	623	0

* In accordance with the Group Accounting Manual (GAM), negative figures are noted as zero.

Compensation on early retirement or for loss of office (audited)

The Trust has made no payments or provisions for compensation on early retirement or for loss of office during the financial year.

Payments to past directors (audited)

The Trust has made no payments to past directors during the financial year.

Fair Pay Disclosure (audited)

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 2018/19 was £190k-£195k (2017/18, £155k-£160k). This was 7.2 times (2017/18, 6.2 times) the median remuneration of the workforce, which was £26k (2017/18, £26k).

As the median remuneration of the workforce has remained constant, the increase in the highest paid director/median remuneration ratio is due to the new medical director receiving a higher clinical excellence award than the previous incumbent.

In 2018/19, no employees (one in 2017/18) received remuneration in excess of the highest-paid director/member.

STAFF REPORT

Inclusion – Equality and Diversity

We are committed to greater equality in healthcare for the communities we serve, ensuring that everyone has access to the healthcare they need, while treating people with respect, dignity and fairness.

Key to a successful organisation is strong leadership characterised by a well-led environment in which the workforce are valued for their diversity and contribution through their experience, knowledge and skills. Every person working for the Trust has a personal responsibility for implementing and promoting Equality, Diversity & Inclusion.

We seek to create an environment that is inclusive and supportive for everyone and deliver a health service culture in Worcestershire in which:

- diversity is valued and respected – an approach that embraces both visible and non-visible difference;
- the community works together effectively in an atmosphere of trust, harmony and respect;
- discrimination and prejudice are challenged;
- both direct and indirect discrimination (including associative and perceptive discrimination), harassment and victimisation will not be tolerated.

Below are examples of initiatives that have contributed to the inclusion agenda in 2018/19:

Inclusion Strategy 2018-2022

Our Inclusion Strategy, launched in 2018, 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/**

AccessAble

Worcestershire Health and Care NHS Trust in partnership with AccessAble have produced a series of online accessibility guides for the Trust sites listed opposite.

An individual can access these guides to find out more about the buildings and sites before making a physical visit.

The accessibility guides are detailed, taking into account many different types of access needs, because what is accessible for one person may not be for another. The guides are based on 100% facts, figures and photographs and include information on everything from parking and availability of lifts and ramps, to toilet accessibility, lighting levels and availability of hearing loops. Each department, ward or service on sites also has its own accessibility guide so an individual can find out all the key information they need to know for the particular area they are visiting.

These guides are designed to enable patients, carers, staff and other visitors and in particular people with a disability or other access needs to plan and prepare effectively, so that they can access our Trust sites with confidence.

AccessAble
Your Accessibility Guide

Online access guides are available for the following Trust sites:

- Church View
- Cromwell House
- Elgar Unit
- Evesham Community Hospital
- Hill Crest
- Keith Winter House
- Kidderminster Health Centre
- Lucy Baldwin Building
- Malvern Community Hospital
- New Brook
- New Haven
- Osborne Court
- Pershore Community Hospital
- Princess of Wales Community Hospital
- The Robertson Centre
- Tenbury Community Hospital
- Worcester City Inpatient Unit
- Wulstan Unit

The Trust's online accessibility guides can be found at: **https://www.accessable.co.uk/ organisations/worcestershire-health-and-care-nhs-trust.** Alternatively, information can be accessed via the AccessAble app both on IOS and Android devices.

Disability Confident

Disability Confident is a government-run scheme to help organisations successfully employ and retain disabled people and those with health conditions. The Trust has Disability Confident Employer status (Level 2) – this 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.

disability confident EMPLOYER

It also means that we demonstrate our commitment to supporting and retaining our existing employees who have a disability, or who become disabled during their employment, by:

- ensuring there are no barriers to the development and progression of disabled staff;
- supporting employees to manage their disabilities;
- valuing and listening to feedback from disabled staff.

Equality Impact Analysis (EIA)

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 this year and updated 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. The Trust seeks to integrate and work with our partners, including for example Worcestershire County Council, with social care, acute services, voluntary organisations, our commissioners and communities. We recognise that working in collaboration is the best way to deliver the aims of our Sustainability and Transformation Partnership (STP) plan and Equality, Diversity and Inclusion initiatives are no exception. In conjunction with our partners we undertake and identify areas where we can work together and agree a uniform approach, EIA is an example of this practice.

Staff Networks

The aim of the Trust is to establish a number of staff networks, addressing specific issues. Each network will be self-organised feeding into the Trust's Inclusion Strategy to improve the working lives of staff and enhance patient care.

A Black and Asian Minority Ethnic (BAME) Staff Network was the first network to be established. The purpose of the network is to:

- be a campaigning voice on BAME issues within the Trust and discuss issues affecting BAME staff with key decision makers within the Trust;
- influence and make responses to employment strategies, policies, procedures and practices in relation to race equality;
- review the Trust progress in its statutory obligations regarding its duty under the Equality Act 2010, Public Sector Equality Duty and National Standard such as the Workforce Race Equality Standard (WRES);
- support, encourage and actively promote the professional and career development of BAME staff;
- support the WHAC in recruitment and retention of a diverse workforce which reflects the community it services.

The network will enhance the quality of service to BAME communities by assisting Worcestershire Health & Care NHS Trust (WHCT) in delivering better services for all and implementing the WRES report recommendations and action plan. The BAME Staff Network is empowered to challenge and contribute to any activity within the Trust regarding BAME staff.

Following the formation of the BAME Staff Network a newly formed Lesbian, Gay, Bisexual, Transgender (LGBT) + Staff Network has also been established. The purpose and structure is similar to the BAME Staff Network. The next Staff Network to be established will be for people with disabilities and it is anticipated they will be integral to the recommendations and action plan of the Workforce Disability Equality Standard (WDES) which comes into existence in 2019.

Transgender Staff – Guidelines

For many people their innate sense of being their gender matches their birth sex and they do not have any questions over their gender identity. This is not the case for everyone. 'Trans' is an umbrella term that acknowledges each trans person's experience is unique and there are few absolutes. The Trust seeks to ensure that no trans person is treated less favourably than any other member staff and the individual's right to self-identify their gender is respected. During the year 'Transgender Staff – Guidelines' were developed in conjunction with trans and non-binary communities in Worcestershire and are in the final stages of our governance assurance before being agreed. It is anticipated that once implemented 'Transgender Patients – Guidelines' will be developed (and will be inclusive of service users and carers).

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

All of the above have 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 action 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 make 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 nonstatutory 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 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.

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 Becky Lane, Patient Relations Manager as the new Freedom to Speak Up Guardian in February 2018 and communicated this appointment across the Trust along with the established intranet page. Increasing staff awareness of the role is ongoing. Staff are encouraged to contact Becky 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 2019.

Band	Number
Personal Salary	7
Trust Non Executive Director	8
Grand Total	15

Staff composition

This is based on executive and Non Executive directors in post as at 31st March 2019.

Gender	Number
Female	6
Male	9
Grand Total	15

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 WTE 2018	Adjusted WTE days lost to Cabinet Office definitions	Average Sick Days per WTE	WTE-Days Available	WTE-Days recorded Sickness Absence
3,007.42	32,187.61	10.70	1,097,708	52,215

Average number of employees (audited)

This is based on ESR 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	8,649	74	4,962	39	13,611	113
Administration and estates	18,583	568	2,052	63	20,635	631
Healthcare assistants and other supporting staff	20,920	792	4,585	143	25,505	935
Nursing, midwifery and health visiting staff	44,421	1,001	4,360	79	48,781	1,080
Nursing, midwifery and health visiting learners	300	12	50	2	350	14
Scientific, therapeutic and technical staff	18,645	394	2,546	49	21,191	443
Social care staff	590	16	0	0	590	16
Healthcare science staff	17	0	0	0	17	0
Total	**112,125**	**2,857**	**18,555**	**375**	**130,680**	**3,232**

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 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	23
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	2
for between 3 and 4 years at the time of reporting	4
for 4 or more years at the time of reporting	14

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 2018 and March 2019, 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	2
Of which:	
No. assessed as caught by IR35	2
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 2018 and 31 March 2019:

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.	17

Consultancy expenditure

The Trust did not incur any consultancy expenditure in 2018/19.

Reporting of compensation schemes – exit packages 2018/19

The Trust did not make any severance payments or provide any exit packages, during this financial year.

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 2017/18

The Trust did not make any severance payments or provide any exit packages during the previous financial year.

Exit packages: other (non-compulsory) departure payments (audited)

	2018/19		2017/18	
	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	-	-	-	-
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	-	-	-	-
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

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 2019. The Annual Report and Accounts (ARA) document is available on request from the Director of Finance at 2 Kings Court, Charles Hastings Way, Worcester, WR5 1JR (Tel. 01905 681321).

As in previous years the auditor's report on the full annual report and accounts for 2018/19 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 a robust 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 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion the financial statements:

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

Basis for opinion

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

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

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

Matters on which we are required to report by exception

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

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

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

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 28, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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 2019.

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

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

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

Report on other legal and regulatory requirements – Certificate

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

Use of our report

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

Phil Jones

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

Birmingham

23 May 2019

STATEMENT OF COMPREHENSIVE INCOME

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	167,178	170,600
Other operating income	4	9,375	8,927
Operating expenses	6.1	(168,993)	(167,727)
Operating surplus from continuing operations		**7,560**	**11,800**
Finance income	11	141	46
Finance expenditure	12	(110)	(130)
PDC dividends payable		(2,347)	(2,122)
Net finance costs:		**(2,316)**	**(2,206)**
Other gains / (losses)	13	0	(17)
Surplus for the year		**5,244**	**9,577**
Other comprehensive income Will not be reclassified to income and expenditure:			
Impairments	7	859	2,085
Revaluations		491	351
Total other comprehensive income		**1,350**	**2,436**
Total comprehensive income for the period		**6,594**	**12,013**
Adjusted financial performance (control total basis):			
Surplus for the period		5,244	9,577
Remove net impairments not scoring to the Departmental Expenditure Limit		(274)	(2,303)
Remove I&E impact of capital grants and donations		17	17
Adjusted financial performance surplus		**4,987**	**7,291**

The notes on pages 73 to 111 form part of these accounts.

STATEMENT OF FINANCIAL POSITION

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets:			
Intangible assets	14	643	774
Property, plant and equipment	15	94,964	87,268
Total non-current assets		**95,607**	**88,042**
Current assets:			
Inventories	17	420	483
Receivables	18	8,093	7,347
Cash and cash equivalents	19	19,574	17,015
Total current assets		**28,087**	**24,845**
Current liabilities:			
Trade and other payables	20	(21,204)	(17,210)
Borrowings	22	0	(164)
Provisions	23	(954)	(628)
Other liabilities	21	(34)	(129)
Total current liabilities		**(22,192)**	**(18,131)**
Total assets less current liabilities		101,502	94,756
Non-current liabilities:			
Borrowings	22	0	(2,597)
Provisions	23	(2,370)	(1,941)
Total non-currentliabilities		**(2,370)**	**(4,538)**
Total assets employed		99,132	90,218
Financed by:			
Public dividend capital		39,662	37,342
Revaluation reserve		8,600	7,414
Income and expenditure reserve		50,870	45,462
Total taxpayers' equity		**99,132**	**90,218**

The notes on pages 73 to 111 form part of these accounts.

The financial statements on pages 68 to 72 were approved by the Audit Committee under the delegated authority of the Trust Board on 23 May 2019 and signed on its behalf by:

Name: Sarah Dugan
Position: Chief Executive
Date: 23rd May 2019

STATEMENT OF CHANGES IN EQUITY

for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2018	**37,342**	**7,414**	**45,462**	**90,218**
Surplus for the year	0	0	5,244	5,244
Other transfers between reserves	0	(164)	164	0
Impairments	0	859	0	859
Revaluations	0	491	0	491
Public dividend capital received	2,320	0	0	2,320
Taxpayers' equity at 31 March 2019	**39,662**	**8,600**	**50,870**	**99,132**

STATEMENT OF CHANGES IN EQUITY

for the year ended 31 March 2018

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

Information on reserves

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

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

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

STATEMENT OF CASH FLOWS

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities:			
Operating surplus		7,560	11,800
Non-cash income and expense:			
Depreciation and amortisation	6.1	3,379	2,913
Net impairments	7	(274)	(2,303)
(Increase) / decrease in receivables and other assets		(667)	(1,213)
(Increase) / decrease in inventories		63	75
Increase / (decrease) in payables and other liabilities		3,052	(1,138)
Increase / (decrease) in provisions		751	(48)
Net cash generated from operating activities		**13,864**	**10,086**
Cash flows from investing activities:			
Interest received		141	46
Purchase of intangible assets		0	(272)
Purchase of property, plant, equipment and investment property		(8,468)	(6,093)
Net cash generated used in investing activities		**(8,327)**	**(6,319)**
Cash flows from financing activities:			
Public dividend capital received		2,320	1,706
Movement on loans from the Department of Health and Social Care*		(2,761)	(464)
Other capital receipts		0	28
Interest on loans		(111)	(121)
PDC dividend paid		(2,426)	(1,919)
Net cash generated used in financing activities		**(2,978)**	**(770)**
Increase in cash and cash equivalents		**2,559**	**2,997**
Cash and cash equivalents at 1 April		**17,015**	**14,018**
Cash and cash equivalents at 31 March	19.1	**19,574**	**17,015**

* The movement on loans from the Department of Health and Social Care is a result of the Trust repaying all of its outstanding loans on 4 March 2019.

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

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 1.2 – 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 2018/19 have therefore been prepared on this basis.

Note 1.3 – Consolidation

The Trust does not have any subsidiaries or any equity interests in associates joint ventures or joint operations. 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 1.4.1 – Revenue from contracts with customers

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

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

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. The Trust has no revenue relating to partially completed spells.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and de-recognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty. The Trust has received no penalties during 2018/19.

The Trust receives income from Commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

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

1.4.2 - 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

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. Therefore, the schemes are accounted for as though they are defined contribution schemes.

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

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

National Employment Savings Trust
Every employer in the UK has to offer their staff a workplace pension scheme. From 1 August 2013 the Trust opened an additional pension scheme with the National Employment Savings Trust (NEST). The Trust's pension cost contributions are charged to operating expenses as and when they become due.

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, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful 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. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying 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.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

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 the assets 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.

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 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 – De-recognition

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

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

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 useful 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 lives of property, plant and equipment

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

Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;

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

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

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.

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

Note 1.8.3 – Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The Trust's intangible assets are solely software licences which have a useful 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

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 scheme (CRC)

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 assets and financial liabilities

Note 1.13.1 – Recognition

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

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Note 1.13.2 – Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income.

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

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

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

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

Financial assets measured at fair value through other comprehensive income
Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On de-recognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value through income and expenditure
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

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

Note 1.13.3 – De-recognition

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

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

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 23.2 but is not recognised in the Trust's accounts.

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

Note 1.16 – 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 where an inflow of economic benefits is probable. The Trust has no contingent assets.

Contingent liabilities are not recognised, but are disclosed in note 24, 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;
(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 of the annual accounts' audit.

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.

Note 1.21 – Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in note 19.2 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 27) 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 2018/19.

Note 1.24 – Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (note 1.25) 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 key assumptions applied in using this approach are set out in note 16.

Note 1.25 – 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.
- Following the Trust's professional revaluation as at 31 December 2018, amended guidance was published by the RICS relating to the assessment of remaining useful lives for depreciation accounting purposes and which is effective from January 2019. The amendments will not have any significant impact on value, however they will result in shortened remaining useful lives and potentially an increase in depreciation. The Trust has assessed the impact resulting from these changes and have concluded that this amendment will not have a material effect and therefore has not been accounted for within these Financial Statements.

Note 1.26 – 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 1.27 – Early adoption of standards, amendments and interpretations

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

Note 1.28 – 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 Department of Health and Social Care group accounts in 2018/19:

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 23 Uncertainty over Income Tax Treatments
Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating segments

The 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

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1.

Note 3.1 Income from patient care activities (by nature)

	2018/19 £000	2017/18 £000
Acute services:		
First outpatient income	740	872
Follow up outpatient income	1,050	1,085
A & E income	2,486	2,234
Mental health services:		
Cost and volume contract income	768	788
Block contract income *	58,914	65,692
Clinical partnerships providing mandatory services (including S75 agreements)	1,973	2,065
Community services:		
Community services income from CCGs and NHS England	81,315	79,120
Income from other sources (e.g. local authorities)	16,194	17,327
All services:		
Private patient income	0	0
Agenda for Change (AfC) pay award central funding from DoHSC	2,239	0
Other clinical income	1,499	1,417
Total income from activities	**167,178**	**170,600**

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

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	3,028	3,215
Clinical Commissioning Groups	137,698	134,953
Department of Health and Social Care – AfC pay award funding	2,239	0
Other NHS providers *	3,372	11,258
Local Authorities	20,232	20,664
Non-NHS: overseas patients (chargeable to patient)	0	40
Injury cost recovery scheme	181	109
Non NHS: other **	428	361
Total income from activities relating to continuing operations	**167,178**	**170,600**

* Block contract/Other NHS providers income has reduced in 2018/19 following the cessation of the Forward Thinking Birmingham contract from Birmingham Women's and Children's NHS Foundation Trust on 31 March 2018.
** Other non-NHS income includes Paediatric Services (£174k), Occupational Therapy (£186k) and Palliative Care (£33k).

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

	2018/19 £000	2017/18 £000
Income recognised this year	0	40
Cash payments received in-year	0	39
Amounts added to provision for impairment of receivables	0	1
Amounts written off in-year	0	0

Note 4 – Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Education and training (excluding notional apprenticeship levy income)	3,593	3,165
Non-patient care services to other bodies	1,490	1,430
Provider sustainability fund (PSF) *	3,306	3,478
Other contract income **	819	800
Other non-contract operating income:		
Education and training – notional income from apprenticeship fund	117	20
Rental revenue from operating leases	50	34
Total other operating income relating to continuing operations	**9,375**	**8,927**

* Allocation of centrally held PSF for the achievement of targets set by NHS England.
** Key areas of income include: car parking (£176k); catering (£87k) and other sundry revenue streams.

Note 5 Additional information on revenue from contracts with customers recognised in the period

	2018/19 £000
Release of deferred IFRS 15 income	105

Note 6.1 – Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from non-NHS and non-DHSC bodies *	775	2,399
Staff and executive directors costs	130,682	133,708
Remuneration of Non Executive directors	74	61
Supplies and services – clinical (excluding drugs costs) **	9,225	8,582
Supplies and services – general **	2,751	3,191
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,058	2,087
Establishment **	7,461	5,739
Premises ***	5,677	4,730
Transport (including patient travel)	2,668	2,669
Depreciation on property, plant and equipment	3,248	2,802
Amortisation on intangible assets	131	111
Net impairments	(274)	(2,303)
Movement in credit loss allowance: contract receivables/contract assets	78	0
Movement in credit loss allowance: all other receivables and investments	0	(9)
Increase/(decrease) in other provisions	33	0
Change in provisions discount rate	(34)	28
Audit fees payable to the external auditor:		
audit services – statutory audit	58	58
other auditor remuneration (external auditor only)	11	41
Internal audit costs	104	104
Clinical negligence	696	545
Legal fees	45	67
Insurance	138	133
Education and training	1,382	962
Rentals under operating leases	1,761	1,815
Hospitality	15	17
Losses, ex gratia & special payments	6	6
Other	224	184
Total relating to continuing operations	**168,993**	**167,727**

* The reduction in purchase of healthcare from non-NHS bodies is due to the cessation of the Forward Thinking Birmingham contract.
** This expenditure has been reclassified in 2018/19 due to the refinement of costs within the Trust's SLAs. There has also been increased costs in relation to the GDE programme, lockable ward feasibility scheme, and fees incurred relating to the renewal of the Computacenter contract.
*** Premises expenditure has increased due to the provision for dilapidations on Trust properties.

Note 6.2 – Other auditor remuneration

	2018/19 £000	2017/18 £000
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	11	41
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	**11**	**41**

Note 6.3 – Limitation on auditor's liability

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

Note 7 – Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus resulting from changes in market price	(274)	(2,303)
Impairments charged to the revaluation reserve	(859)	(2,085)
Total net impairments	**(1,133)**	**(4,388)**

Impairment reversals and valuations recognised during 2018/19 resulted from the annual asset revaluation of the Trust's land and buildings to reflect movements in values during the financial year. An independent valuer provided valuations as at 31 December 2018 resulting in a total net upward revaluation of £1,624k, of which;

- £274k has been credited against the Statement of Comprehensive Income (SoCI) in respect of net impairment reversals;
- £859k for an increase to the revaluation reserves for impairments; and
- £491k for an upward revaluation to the revaluation reserve.

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	97,838	100,409
Social security costs	8,975	9,100
Apprenticeship levy	466	472
Employer's contributions to NHS pensions	13,018	13,017
Pension costs - NEST and Local Government pension schemes	16	13
Temporary staff - bank and agency costs	10,886	10,783
Total staff costs	**131,199**	**133,794**
Of which		
Costs capitalised as part of non-current assets *	517	86

* The costs capitalised as part of non-current assets was for the Global Digital Exemplar IT capital programme.

Note 8.1 – Retirements due to ill-health

During 2018/19 there were 2 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £26k (£220k in 2017/18).

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

Note 9 – NHS 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 for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the

previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

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

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

Note 10 – Operating leases

Note 10.1 – Worcestershire Health and Care NHS Trust as a lessor

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

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	50	34
Total	**50**	**34**
	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
not later than one year;	6	6
later than one year and not later than five years;	6	12
Total	**12**	**18**

Note 10.2 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.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	1,761	1,815
Total	**1,761**	**1,815**
	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
not later than one year	1,007	1,073
later than one year and not later than five years*	5,051	3,861
later than five years *	9,427	6,247
Total	**15,485**	**11,181**

* The increase in lease payments greater than one year is the result of the Trust relocating its Headquarters (long term lease). The previous site was on a short-term basis (rolling three months) and therefore was not reflected in its future minimum lease payments.

Note 11 – Finance income

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

	2018/19 £000	2017/18 £000
Interest on bank accounts	141	46
Total finance income	**141**	**46**

Note 12.1 – Finance expenditure

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

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	106	116
Interest on late payment of commercial debt	0	5
Total interest expense	**106**	**121**
Unwinding of discount on provisions	4	9
Total finance costs	**110**	**130**

Note 12.2 – The late payment of commercial debts (interest) Act 1998/Public Contract Regulations 2015

	2018/19 £000	2017/18 £000
Total liability accruing in year under this legislation as a result of late payments	0	5
Amounts included within interest payable arising from claims under this legislation	0	5

Note 13 Other gains/(losses)

	2018/19 £000	2017/18 £000
Losses on disposal of assets	0	(17)
Total losses on disposal of assets	**0**	**(17)**

Note 14 - Intangible assets – Software licences

	2018/19 £000	2017/18 £000
Valuation/gross cost at 1 April	**1,218**	**946**
Additions	0	272
Gross cost at 31 March	**1,218**	**1,218**
Amortisation at 1 April	**444**	**333**
Provided during the year	131	111
Amortisation at 31 March	**575**	**444**
Net book value at 1 April	**774**	**613**
Net book value at 31 March	**643**	**774**

Note 15.1 Property, plant and equipment – 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018	**13,765**	**61,862**	**3,574**	**3,746**	**183**	**13,909**	**1,953**	**98,992**
Additions	0	2,019	4,559	106	0	2,478	158	9,320
Impairments	0	(1,118)	0	0	0	0	0	(1,118)
Reversals of impairments	203	1,774	0	0	0	0	0	1,977
Revaluations	222	(1,162)	(289)	0	0	0	0	(1,229)
Reclassifications	0	1,504	(3,726)	0	0	2,222	0	0
Valuation/gross cost at 31 March 2019	**14,190**	**64,879**	**4,118**	**3,852**	**183**	**18,609**	**2,111**	**107,942**
Accumulated depreciation at 1 April 2018	**0**	**1,434**	**0**	**2,090**	**183**	**6,906**	**1,111**	**11,724**
Provided during the year	0	1,435	0	219	0	1,455	139	3,248
Impairments	0	457	289	0	0	0	0	746
Reversals of impairments	(222)	(798)	0	0	0	0	0	(1,020)
Revaluations	222	(1,653)	(289)	0	0	0	0	(1,720)
Accumulated depreciation at 31 March 2019	0	875	0	2,309	183	8,361	1,250	12,978
Net book value at 1 April 2018	**13,765**	**60,428**	**3,574**	**1,656**	**0**	**7,003**	**842**	**87,268**
Net book value at 31 March 2019	**14,190**	**64,004**	**4,118**	**1,543**	**0**	**10,248**	**861**	**94,964**

Note 15.2 Property, plant and equipment financing – 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned – purchased	14,178	63,190	4,118	1,543	0	10,248	861	94,138
Owned – donated	12	814	0	0	0	0	0	826
Net book value at 31 March 2019	**14,190**	**64,004**	**4,118**	**1,543**	**0**	**10,248**	**861**	**94,964**

Note 15.3 – 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**
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 / de-recognition	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/de-recognition	0	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 1 April 2017	**13,765**	**55,309**	**0**	**1,719**	**0**	**6,502**	**820**	**78,115**
Net book value at 31 March 2018	**13,765**	**60,428**	**3,574**	**1,656**	**0**	**7,003**	**842**	**87,268**

Note 15.4 – 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
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
Net book value at 31 March 2018	**13,765**	**60,428**	**3,574**	**1,656**	**0**	**7,003**	**842**	**87,268**

Note 16 – Revaluations of property, plant and equipment

At the 31 December 2018 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 2019, the Trust did not have 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 17 – Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	82	74
Consumables	138	139
Other	200	270
Total inventories	**420**	**483**

Inventories recognised in expenses for the year were £388k (2017/18: £384k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 18.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	7,039	0
Trade receivables*	0	2,719
Accrued income*	0	3,535
Allowance for impaired contract receivables/assets*	(127)	0
Allowance for other impaired receivables	0	(97)
Prepayments (non-PFI)	603	803
PDC dividend receivable	83	4
VAT receivable	495	383
Total current trade and other receivables	**8,093**	**7,347**
Of which receivables from NHS and DHSC group bodies:	**5,590**	**4,436**

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

Note 18.2 – Allowances for credit losses (doubtful debts) 2018/19

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April 2018	0	97
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	97	(97)
New allowances arising	78	0
Utilisation of allowances (write offs)	(48)	0
Allowances as at 31 March 2019	**127**	**0**

The Trust's provision for doubtful debts is calculated on non-NHS debtors as less than 30 days, 2%; greater than 30 days 6%; greater than 60 days 14%; and 34% for debtors over 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 21.89% of all outstanding debts as at 31 March 2019.

Note 19.1 – Cash and cash equivalents movements

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

	2018/19 £000	2017/18 £000
At 1 April	17,015	14,018
Net change in year	**2,559**	**2,997**
At 31 March	**19,574**	**17,015**
Broken down into:		
Cash at commercial banks and in hand	15	17
Cash with the Government Banking Service	19,559	16,998
Total cash and cash equivalents	**19,574**	**17,015**

Note 19.2 – 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 2019 £000	31 March 2018 £000
Monies on deposit	2	13
Total third party assets	**2**	**13**

Note 20.1 – Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current trade and other payables		
Trade payables	3,162	3,726
Capital payables	3,221	2,369
Accruals	10,842	7,116
Social security costs	1,314	1,317
Other taxes payable	937	933
Accrued interest on loans*	0	5
Other payables	1,728	1,744
Total current trade and other payables	**21,204**	**17,210**
Of which payables from NHS and DHSC group bodies	**3,823**	**2,547**

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note. IFRS 9 is applied without restatement therefore comparatives have not been restated. The Trust has no outstanding loans at the end of the period.

Note 20.2 – Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2019 £000	31 March 2018 £000
To buy out the liability for early retirements over 5 years	0	0

Note 21 – Other liabilities

	31 March 2019 £000	31 March 2018 £000
Other current liabilities:		
Deferred income	34	129
Total other current liabilities	**34**	**129**

Note 22 – Borrowings

	31 March 2019 £000	31 March 2018 £000
Current borrowings		
Loans from the Department of Health and Social Care *	0	164
Total current borrowings	**0**	**164**
Non-current borrowings		
Loans from the Department of Health and Social Care *	0	2,597
Total non-current borrowings	**0**	**2,597**

* During the financial year, the Trust repaid all of its outstanding loans.

Note 22.1 – Reconciliation of liabilities arising from financing activities

	31 March 2019 £000
Carrying value of Loans from DoHSC at 1 April 2018	2,761
Cash movements:	
Financing cash flows – payments and receipts of principal	(2,761)
Financing cash flows – payments of interest	(111)
Non-cash movements:	
Impact of implementing IFRS 9 on 1 April 2018	5
Application of effective interest rate	106
Carrying value at 31 March 2019	**0**

Note 23.1 – Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits* £000	Legal claims £000	Other £000	Total £000
At 1 April 2018	**659**	**1,418**	**196**	**296**	**2,569**
Change in the discount rate	(6)	(28)	0	0	(34)
Arising during the year	40	227	222	760	1,249
Utilised during the year	(65)	(86)	(41)	0	(192)
Reversed unused	(20)	(214)	(38)	0	(272)
Unwinding of discount	2	4	0	(2)	4
At 31 March 2019	**610**	**1,321**	**339**	**1,054**	**3,324**
Expected timing of cash flows:					
- not later than one year;	66	69	38	781	954
- later than one year and not later than five years;	262	272	301	273	1,108
- later than five years.	282	980	0	0	1,262
Total	**610**	**1,321**	**339**	**1,054**	**3,324**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions.

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.

- **Injury benefits**
  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.

- **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**
  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 23.2 – Clinical negligence liabilities

At 31 March 2019, £1,740k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Worcestershire Health and Care NHS Trust (31 March 2018: £2,680k).

Note 24 – Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities:		
NHS Resolution legal claims	(32)	(19)
Other	(650)	(650)
Gross value of contingent liabilities	**(682)**	**(669)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(682)**	**(669)**

* 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 the 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 25 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment *	3,175	1,125
Intangible assets	0	0
Total contractual capital commitments	**3,175**	**1,125**

* The capital commitments relate to work on IT projects and various estate schemes.

Note 26 Financial instruments

Note 26.1 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 2019 are in receivables from customers, as disclosed in note 18.2, 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. At 31 March 2019, the Trust no longer held any loans.

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 26.2 Carrying values of financial assets

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

Carrying values of financial assets as at 31 March 2019 under IFRS 9	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	6,543	0	0	6,543
Cash and cash equivalents at bank and in hand	19,574	0	0	19,574
Total at 31 March 2019	**26,117**	**0**	**0**	**26,117**

Carrying values of financial assets as at 31 March 2018 under IAS 39	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Trade and other receivables excluding non financial assets	6,211	0	0	0	6,211
Cash and cash equivalents at bank and in hand	17,015	0	0	0	17,015
Total at 31 March 2018	**23,226**	**0**	**0**	**0**	**23,226**

Note 26.3 Carrying value of financial liabilities

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

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Trade and other payables excluding non financial liabilities	17,218	0	17,218
Total at 31 March 2019	**17,218**	**0**	**17,218**

Carrying values of financial liabilities as at 31 March 2018 under IAS 39	Other financial liabilities £000	Held at fair value through the I&E £000	Total book value £000
Loans from the Department of Health and Social Care	2,761	0	2,761
Trade and other payables excluding non financial liabilities	13,215	0	13,215
Total at 31 March 2018	**15,976**	**0**	**15,976**

Note 26.4 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	17,218	13,379
In more than one year but not more than two years *	0	164
In more than two years but not more than five years *	0	492
In more than five years *	0	1,941
Total	**17,218**	**15,976**

* The Trust repaid its outstanding loans during the financial year.

Note 27 – Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses:				
Cash losses	1	0	2	0
Bad debts and claims abandoned	73	48	48	10
Stores losses and damage to property	26	6	38	5
Total losses	**100**	**54**	**88**	**15**
Special payments:				
Ex-gratia payments	18	4	8	3
Total special payments	**18**	**4**	**8**	**3**
Total losses and special payments	**118**	**58**	**96**	**18**

Note 28.1 – Initial application of IFRS 9

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

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

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £5k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £43k.

Note 28.2 – Initial application of IFRS 15

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

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

The Trust has not made any adjustments to its accounts in respect of IFRS 15 as there were no material amounts identified.

Note 29 – Related parties

29.1 – Details of related party transactions with individuals:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Age UK Herefordshire and Worcestershire (spouse of Trust Chairman is Head of Finance of this related party)	1	0	0	0
Care Quality Commission (Medical Director is a National Professional Advisor of this related party)	122	0	0	0
Total related party transactions with individuals	**123**	**0**	**0**	**0**

29.2 – 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	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Recharge of goods on Charity's behalf	0	131	4	16
Administration fee	0	23	0	8
Total related party transactions	**0**	**154**	**4**	**24**

29.3 – 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:

- Department of Health and Social Care
- Health Education England
- NHS Birmingham and Solihull CCG
- NHS England
- NHS Redditch and Bromsgrove CCG
- NHS Resolution
- NHS South Worcestershire CCG
- NHS Wyre Forest CCG
- Worcestershire Acute Hospitals NHS Trust

29.4 – 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
- Worcester City Council
- Worcestershire County Council
- Wychavon District Council

Note 30 – Events after the reporting date

Following the Trust's professional revaluation as at 31 December 2018, amended guidance was published by the RICS relating to the assessment of remaining useful lives for depreciation accounting purposes and which is effective from January 2019. The amendment will not have any significant impact on value, however they will result in shortened remaining useful lives, potentially with an increase in depreciation. The Trust has assessed the potential impact from these changes and estimate this to be in the range of £350k to £620k.

Note 31 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables:				
Total non-NHS trade invoices paid in the year	26,925	72,686	28,157	73,623
Total non-NHS trade invoices paid within target	26,420	71,629	27,726	72,992
Percentage of non-NHS trade invoices paid within target	**98.1%**	**98.5%**	**98.5%**	**99.1%**
NHS Payables:				
Total NHS trade invoices paid in the year	464	7,748	438	9,626
Total NHS trade invoices paid within target	457	7,694	425	9,509
Percentage of NHS trade invoices paid within target	**98.5%**	**99.3%**	**97.0%**	**98.8%**

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

Note 32 External financing

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

	2018/19 £000	2017/18 £000
Cash flow financing	(3,000)	(1,727)
Other capital receipts	0	(28)
External financing requirement	**(3,000)**	**(1,755)**
External financing limit (EFL)	6,068	5,741
Under spend against EFL	**9,068**	**7,496**

Note 33 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	9,320	7,505
Less: Disposals	0	(17)
Charge against Capital Resource Limit	**9,320**	**7,488**
Capital Resource Limit	9,332	7,506
Under spend against CRL	**12**	**18**

Note 34 – Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus (control total basis)	4,987
Breakeven duty financial performance surplus	**4,987**

Note 35 Breakeven duty rolling assessment

	2009 /10 £000	2010/ 11 £000	2011 /12 £000	2012 /13 £000	2013 /14 £000	2014 /15 £000	2015 /16 £000	2016 /17 £000	2017 /18 £000	2018 /19 £000
Breakeven duty in-year financial performance	-	-	1,500	2,522	2,920	2,828	3,566	5,089	7,291	4,987
Breakeven duty cumulative position	-	-	1,500	4,022	6,942	9,770	13,336	18,425	25,716	30,703
Operating income	-	-	171,083	170,835	172,314	171,461	172,346	173,526	179,527	176,553
Cumulative breakeven position as a percentage of operating income	**0.0%**	**0.0%**	**0.9%**	**2.4%**	**4.0%**	**5.7%**	**7.7%**	**10.6%**	**14.3%**	**17.4%**

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.

GLOSSARY

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 inpatient 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.

Do you need to know about accessibility?
Read our detailed guides at
www.AccessAble.co.uk

AccessAble
Your Accessibility Guide

Do you get stressed, anxious or have low mood?

Visit www.nowweretalking.nhs.uk

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