



NHS

Worcestershire
Acute Hospitals
NHS Trust



Annual Report 2019/20



Putting Patients First

Acknowledgements and feedback

Acknowledgements

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

Feedback

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

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Welcome from the Chief Executive and Chairman



Matthew Hopkins
Chief Executive



Sir David Nicholson
Chairman

Welcome to Worcestershire Acute Hospitals NHS Trust's 2019/20 Annual Report.

At the time of writing this introduction to the 2019/20 Annual Report, it is a time like no other. Our hospitals, and the wider NHS, are in the midst of dealing with the biggest challenge we have ever faced. The COVID-19 pandemic affects every aspect of life for our staff, patients and the public.

For those on the frontline in particular, it is an unprecedented, unparalleled and unrelenting situation. We are confident though, that the progress we have made as an organisation over the past 12 months has, in some part, helped to ensure our hospitals are as equipped and are as ready as we can be to cope with the additional pressures that coronavirus continues to bring.

In spite of significant operational and financial pressures, there has been continuing progress

on our overall Trust strategy. We have published our Digital Strategy and Communications and Engagement Strategy. These are important foundations which support the developments set out in our Clinical Services Strategy - the cornerstone of our transformation plans into next year and beyond.

Our '4ward' culture programme has also continued to embed and develop, with the CQC noting that 'culture had positively changed' and that there had been a 'year-on-year improvements across all 11 of the themed areas in the national NHS Staff Survey.'

In support of the urgent care pathway, we opened 99 additional beds across Worcestershire Royal and the Alexandra Hospitals, and launched the Onward Care Team, with the support of our health and social care partners. Furthermore, we have renewed our focus

on our emergency care improvement plan, known as HomeFirst Worcestershire – including launching a new surgical assessment pathway at Worcestershire Royal.

In addition, there have been many awards, accreditations and a myriad of other service improvements, many of which were recognised in our CQC report published in September. Most notably, our overall rating was lifted from 'Inadequate' to 'Requires Improvement,' and not forgetting the fantastic achievement at Kidderminster with a 'Good' overall rating.

We want to pay tribute to all of our staff and volunteers who have played a part in these achievements, and who continue to show bravery, resolve and determination day in, day out to confront the enormous challenge we are currently facing.

In particular, we must highlight the extraordinary, compassionate care for our patients who, at the very time they need the love and support of their nearest and dearest most, are unable to directly receive it. I must also thank our local communities, whose kindness and generosity at this time continues to both overwhelm us and spur us on in equal measure.

We don't yet know what the future holds, but we are determined to work together with our health and social care partners to ensure that we emerge from this pandemic a stronger organisation that can move '4ward' with pride, safe in the knowledge that we did our upmost to confront this challenge and continued to put our patients first.



Matthew Hopkins
Chief Executive



David Nicholson
Chairman



Performance Report

Performance Overview

What we do

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

We provide a wide range of services to a population of more than 590,000 people in Worcestershire as well as caring for patients from surrounding counties and further afield.

In 2019/20 we provided care to more than 244,912 different Worcestershire patients

– that is 41% of the Worcestershire population receiving care at one of our hospitals.

We saw 670 patients per day, including:

- ▶ 161,011 A&E attendances (WRH, ALX and KTC)
- ▶ 158,589 Inpatients
- ▶ 623,538 Outpatients
- ▶ 5,137 births (i.e. individual babies)
- ▶ 5,043 deliveries (i.e. mothers giving birth)

We employ nearly 6,000 people and more than 400 local people volunteer with us helping to deliver care. We have an annual turnover of

over £443 million. The Trust provides a range of Acute Services for the people of Worcestershire. This includes general surgery, general medicine, oncology, emergency care and women and children services. There are a range of support services as well including diagnostics and pharmacy. A list of the services provided can be found on our website www.worcsacute.nhs.uk/services

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

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

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



A YEAR IN NUMBERS

2019/2020



97,066
Walk-in patients
(A&E)



54,845
Patients arriving by
ambulance



158,589
Inpatients



623,538
Outpatients



5,137
Births



4,109
Emergency
Operations



23,620
Elective
Operations



2,063
Trauma
Operations



6.4 days
Average length
of stay



893,100
Number of meals served

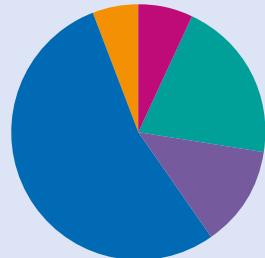


1,448,060
Number of sheets
laundered



£49.8m
Value of prescriptions
issued

Diagnostics



Staff



Total Staff
5,566



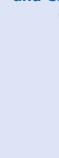
Nurses



Doctors and Consultants



Allied Health Professionals



Midwives and Midwifery Support Workers



Other Support Staff*



Volunteers

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

Performance Summary

Description	Indicator	2019/20 Target	Year End	Period
Quality				
Mortality	HSMR – Hospital Standardised Mortality Ratio	<=100	102.47 (as expected)	Rolling 12 months to November 2019
	SHMI – Summary Hospital Mortality Indicator	<=1	1.06 (as expected)	Rolling 12 months to November 2019
Infection Control	Clostridium Difficile	<=59	61	April 2019 - March 2020
	MRSA	0	0	April 2019 - March 2020
Prevention	VTE - Venous Thromboembolism Risk Assessment	>=95%	94.56%	April 2019 - March 2020
Patient Experience	Mixed Sex Accommodation Breaches	0	603	April 2019 - March 2020
Operational				
Cancer	62 days: Wait for first treatment from urgent GP referral: All Cancers (unadjusted)	>=85%	69.16%	April 2019 - March 2020
	31 days: Wait for first treatment: All Cancers	>=96%	97.25%	April 2019 - March 2020
	2 Week Wait: All Cancer Two Week Wait (suspected Cancer)	>=93%	85.97%	April 2019 - March 2020
	2 Week Wait: Wait for symptomatic breast patients (Cancer not initially suspected)	>=93%	47.62%	April 2019 - March 2020
18 Weeks Waiting Time	RTT - Referral to Treatment: Incomplete - 92% in 18 weeks	>=92%	78.75%	March 2020
Diagnostic Waiting Time	6 week Diagnostic Waits (% of breaches on the waiting list)	<=1%	5.71%	March 2020
A&E Waiting Time	4 Hour Waits (%) - Trust inc MIU	>=95%	77.90%	April 2019 - March 2020

Description	Indicator	2019/20 Target	Year End	Period
Stroke	80% of patients spend 90% of time in a Stroke Ward	>=80%	73.60%	April 2019 - March 2020
	Direct admission (via A&E) to Stroke Ward	>=90%	48.00%	April 2019 - March 2020
	TIA - Transient Ischaemic Attack - High Risk Patients seen within 24 hours	>=70%	62.00%	April 2019 - March 2020
	CT scan within 24 hours of arrival	>=80%	46.70%	April 2019 - March 2020
Patient Experience				
Friends and Family Test	Acute Wards (% recommend)	-	95.35%	April 2019 - March 2020
	Acute Wards (Response Rate %)	>=30%	33.30%	April 2019 - March 2020
	A&E (% recommend)	-	82.29%	April 2019 - March 2020
	A&E (Response Rate %)	>=20%	14.06%	April 2019 - March 2020
	Maternity (% recommend)	-	98.15%	April 2019 - March 2020
	Maternity (Response Rate %)	>=30%	27.66%	April 2019 - March 2020

Performance Analysis

Performance Measurement

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

Our priorities for 2019/20 were aligned to our new strategic objectives and delivered through actions in relation to:

- ▶ Strategy
- ▶ Operational Performance
- ▶ Quality
- ▶ Finance
- ▶ People and Culture

Care Quality Commission

Following the publication of the most recent Trustwide inspection report in September 2019, the overall quality rating for the Trust was upgraded from "Inadequate" to "Requires Improvement".

Between 14th and 29th May 2019, the CQC visited the Trust to inspect six Core Services; Urgent Care (including Minor Injuries Unit), Medical Care, Surgery, Children & Young People, Outpatients and Diagnostics. A review of the "Well-Led" domain was also conducted.

CQC Inspection Report published 20 September 2019:

Ratings for the whole Trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement  Sept 2019	Good  Sept 2019	Good  Sept 2019	Requires improvement  Sept 2019	Requires improvement  Sept 2019	Requires improvement  Sept 2019

The inspection report published in September 2019 identified and rated the following as outstanding:

- ▶ Diagnostic Imaging at the Alexandra General Hospital "Outstanding" for the "Caring" domain.

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

- ▶ Medicines' Management
- ▶ Infection Prevention and Control
- ▶ Incident Reporting
- ▶ Sharing learning across the Trust
- ▶ Divisional and Local Leadership
- ▶ Engagement in the Trust's improvement journey
- ▶ Complaints Management
- ▶ Compassionate and caring staff

The September 2019 inspection report saw an improvement in the overall quality rating, and the Trust is rated "Requires Improvement".

Overall, the Trust continues to be rated Good" in the "Caring" domain, and "Requires Improvement" in the "Well-Led" domain. The ratings for "Safe" and "Responsive" improved to "Requires Improvement", and the rating for "Effective" improved to "Good".

Ratings for the acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Worcestershire Royal Hospital	Requires improvement 	Good 	Good 	Requires improvement 	Requires improvement 	Requires improvement
	Sept 2019	Sept 2019	Sept 2019	Sept 2019	Sept 2019	Sept 2019
Alexandra Hospital	Requires improvement 	Requires improvement 	Good 	Requires improvement 	Good 	Requires improvement
	Sept 2019	Sept 2019	Sept 2019	Sept 2019	Sept 2019	Sept 2019
Kidderminster Hospital and Treatment Centre	Good 	Good 	Good 	Requires improvement 	Good 	Good
	Sept 2019	Sept 2019	Sept 2019	Sept 2019	Sept 2019	Sept 2019
Evesham Community Hospital	Requires improvement 	Good 	Good 	Requires improvement 	Requires improvement 	Requires improvement
	Sept 2019	Sept 2019	Sept 2019	Sept 2019	Sept 2019	Sept 2019
Overall trust	Requires improvement 	Good 	Good 	Requires improvement 	Requires improvement 	Requires improvement
	Sept 2019	Sept 2019	Sept 2019	Sept 2019	Sept 2019	Sept 2019

In December 2019, The Urgent and Emergency Core Services at Worcestershire Royal Hospital and the Alexandra General Hospital were inspected as part of an unannounced focused Inspection. The CQC identified that further improvement was required to ensure timely ambulance handovers, patient assessment and speciality review.

Although no safety concerns were raised during the on-site inspections, Urgent & Emergency Core service ratings were downgraded from "Requires Improvement" to "Inadequate" for "Safe",

"Responsive" and "Well-Led", and the Trust was issued with a Section 31 Conditions Notice for both sites. The overall Trust ratings received in the September 2019 Inspection Report remain unchanged.

Following the CQC inspection, the Trust has implemented further safety, quality and risk assessment and assurance tools in response to CQC's concerns. At the time of writing this report, the Trust's Urgent and Emergency Services were working to satisfy the Section 31 Conditions.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Worcestershire Royal Hospital	Inadequate 	Good 	Requires improvement 	Inadequate 	Inadequate 	Inadequate
Alexandra General Hospital	Inadequate 	Requires improvement 	Requires improvement 	Inadequate 	Inadequate 	Inadequate

Performance Management Framework

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

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

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

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

Performance tracking is based on these general principles:

- High quality care and patient safety is the over-riding goal
- Transparency of performance metrics and reporting
- Decisions are based on transparent quality (determined by the Data Quality Kitemark), timely and reliable information built on clinical leadership of data quality
- Information is shown in trends; using SPC charts where appropriate
- Clear targets are set reflecting national and local priorities

- Targets provide a balanced view of performance across the Single Oversight Framework themes
- Key performance indicators are established, with clear links to drivers so that changes be understood, and subject to continual review.

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

Delivery of Operational Performance Standards

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

High levels of emergency demand, and the lack of available capacity and flow within the Trust and within the wider health and social care system continued to present significant challenges in 2019/20. Coupled with the significant impact of COVID-19 in February and March 2020, these have been key limiting factors to the Trust achieving best possible operational performance and quality of care. Workforce capacity has been a major contributing factor to the deterioration in operational performance, particularly in relation to high numbers of consultant vacancies.

Consequently, the four key national standards in relation to Emergency Access, Referral to Treatment (RTT), 62 day Cancer waiting time and Diagnostics have not been met during 2019/20. Plans to improve performance are highly dependent on the ability to recruit consultants, the availability of beds and delivery of planned productivity improvements and how government policy influences hospital activity in 2020/21.

Development of specialty level improvement trajectories for the key national performance

standards based on demand and capacity modelling will provide clear actions and performance requirements against which divisions will be held to account through the Performance Management Group.

The summary of our performance in 2019/20 can be seen within the Performance Summary section, page 9 and is described in more detail below.

Emergency Access Standard

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

Performance for the Emergency Access Standard has not met the national target of 95% for more than 5 years and in 2019/20 only 77.90% of patients were admitted, transferred or discharged within 4 hours. This is a slight deterioration in performance from the previous year (75.93% in 2018/19). However, this decrease in performance should be seen in the context of 2,449 more patients attending our Accident and Emergency departments this year. The lack of availability of inpatient beds was one of the main causes of delay in the patient pathway. The lack of bed availability, particularly during winter, also resulted in 934 patients waiting more than 12 hours in the A&E departments from the point at which a decision had been made to admit them; a significant increase from 535 in 2018/19. The focus is on supporting the timely discharge of patients through the implementation of national best practice and closer working with partner organisations across the county. The Trust accessed external help and support from the NHS Emergency Care Intensive Support Team.

Referral to Treatment (RTT)

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

Due to the impact of COVID-19, the decision was taken to cancel outpatient appointments and elective surgery in March 2020, the Trust has not met the 92% standard in 2019/20. In March 2020 78.67% of patients were within 18 weeks of referral compared to 80.77% the previous March. There have been 9 month end breaches of patients waiting for longer than 52 weeks during 2019/20 and the Trust continued to focus on reducing the number of patients waiting longer than 40 weeks; 155 reported in March 2020 down from 357 reported at March 2019, but was down to 70 at the end of February 2020. Plans to address performance in 2020/21 have yet to be agreed due to the uncertainty of the length of time COVID-19 will impact on health services.

Cancer

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

Over the year 69.16% of patients had commenced treatment within 62 days. This is a slight decrease from the previous year which saw 72.02% of patients commencing treatment within 62 days. There has been a slight decrease in the number of patients treated, 2120 in 2019/20 compared to 2130 in 2018/19. Performance against this standard continued to be impacted by increased referrals resulting from national awareness cancer campaigns, emergency pressures and medical staffing gaps across a number of specialties. Delays in diagnostic tests are also impacting performance against this standard.

Diagnostics

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

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



Matthew Hopkins

Chief Executive

Date: 22nd June 2020

Financial Performance in 2019/20 - finance

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

The Trust has reported an Operational Financial Performance excluding Provider Sustainability Fund (PSF), Financial Recovery Fund (FRF) and Marginal Rate Emergency Threshold (MRET)

funding and impairments, deficit of £(81.5)m against a comparable plan target of £(82.8)m for the 2019/20 financial year. This is in line with the forecast outturn. The Trust did not sign up to its 2019/20 Control Total of £(64.6)m pre PSF, FRF and MRET funding as based on the assumptions and information available at the time it was not considered deliverable. Work has continued in-year, internally and externally with our system partners to improve overall financial performance. In 2019/20 the Trust received £0.5m of Special Measures funding to support improvement initiatives. The Trust additionally received £0.5m of 2018/19 Provider Sustainability Fund (PSF) which was awarded after the closure of the 2018/19 accounts and so is reported in 2019/20.

There are other below the line adjustments for Capital Donations; Grants; and Impairments, as detailed below, which are included in the overall Income and Expenditure position.

Financial Position - Income and Expenditure	Actual 2019/20 £000s	Actual 2018/19 £000s
Operational (Adjusted) Financial performance surplus/(deficit) excluding PSF, FRF, MRET funding and impairments	(81,466)	(73,712)
<i>Adjust Provider Sustainability Funding (PSF)</i>		4,922
Performance against Control Total/Plan adjusted to include PSF	(81,466)	(68,790)
<i>Adjust Remove impact of prior year PSF post accounts reallocation</i>	493	
<i>Adjust Remove capital donations/grants I&E impact</i>	(70)	(86)
<i>Adjust I&E impairments/(reversals)</i>	(7,288)	(6,828)
<i>Surplus/(deficit) for the year including PSF, FRF and MRET funding and after Impairments</i>	(88,331)	(75,704)

The Trust achieved £12.0m of nominal gross Cost Improvement Programme savings during the year, which have a further £1.0m of full year effect benefit into 2020/21. The recurrent effect of this year's programme secured £11.2m to improve the Trust's underlying position.

The Trust has met its original planned deficit in 2019/20, although it was not able to achieve the stretch target deficit of £(73.7)m. During the year the Trust has received £65.5m revenue cash support from the DHSC to be able to maintain the payment of creditors through the year. The Trust also received capital loans of £7.7m and Public Dividend Capital (PDC) of £4.6m making the total new borrowings of £77.8m in 2019/20. The Trust repaid £1.87m revenue loans and £4.6m capital loans in 2019/20. An improved cash flow, despite the increased deficit, has led to an improvement in Better Payment Performance in 2019/20 compared to 2018/19. In 2019/20, the Trust achieved 96% by number (80% in 2018/19) and 90% of value (76% in 2018/19).

The Trust has invested £13.7m of capital resources in 2019/20 in line with its Capital Resource Limit. This was funded from: internally generated funds; capital loan funding; Urgent and Emergency Care PDC; Health System Led Investment (HSLI) PDC and Cyber Security Schemes PDC. Schemes included major developments such as the ASR Aconbury East ward scheme; cyber security; replacement of clinical equipment; improvements in IT systems/infrastructure; and maintenance of the estate.

Looking forward to 2020/21 and beyond

The Trust still has a challenging financial outlook entering 2020/21. In light of the COVID-19 response, the planning cycle has been paused and the Trust is operating under the revised national funding regime for the period to end July 2020. Under this regime, the Trust is funded based on the expected cost base.

At the point the planning cycle was paused, the Trust had not concluded contract negotiation with its main commissioners, nor had it formally indicated acceptance of the Financial Improvement Trajectory of £(60.5)m excluding FRF and MRET. Discussions between the STP and the regional and national team were ongoing to agree an acceptable system financial plan. In March 2020, the Trust Board received an update on the Annual Plan which projected a deficit in 2020/21 of £(78.9)m (pre FRF/MRET) after inclusion of £14.5m of efficiency improvements. The 2020/21 financial plan will need to be refreshed when national guidance for the remainder of 2020/21 is clear.

The NHS faces continued pressure with substantial challenges driven by an ageing population; increases in the prevalence of long-term conditions; and rising costs and public expectations within a challenging financial environment. In order to respond to these significant challenges health and social care providers across Herefordshire and Worcestershire are working towards a longer term vision for a truly integrated health and social care system and transforming the way in which services are delivered aligned with the ambitions of the NHS Long Term Plan. The shared focus is the move towards Integrated Care Systems, which will need to demonstrate a system-wide sustainable return to financial balance.

The Trust's internal capital resources remain limited in 2020/21 and beyond, although the conversion of historic interim capital loans to PDC from April 2020, and the capital loan already secured for the most urgent schemes across 2019/20 and 2020/21, provides security of our ability to meet the most pressing priorities. It is likely that further capital loan applications may be required to fund critical and urgent schemes in future years. From 2020/21, capital resources will be collectively overseen within the local system.

The Trust Board will consider, and then submit for national approval, the Full Business Case for the Acute Service Reconfiguration in May 2020, and in doing so will access the £11.4m of capital allocated for the scheme in 2020/21 and the balance of the required funding in subsequent years.

An application for Sustainability and Transformation Plan (STP) funding was successful and consequently we are finalising the Full Business Case to secure £4.0m of PDC across 2020/21 and 2021/22 to fund the Breast Service Improvement scheme.

The Trust faces a range of risks and operates in a challenging financial environment. In March 2020 the Board made an assessment of the risks, opportunities and uncertainties faced and considers itself to be a going concern in line with published guidance. The published accounts are therefore produced on a going concern basis. There is clear evidence of continued provision of services being planned by NHSI, Commissioners and within the Trust. The primary risk to the Trust remaining as a going concern is the underlying financial deficit and resultant cash shortfall to discharge our liabilities. In 2019/20 we accessed £65.5m of revenue support for the deficit position. The continued breach in the achievement of the breakeven duty resulted in the s30 referral by the external auditor to the Secretary of State. The 2020/21 financial plan (prior to COVID-19) continues to be based on a material deficit (£78.9m after inclusion of £14.5m efficiencies). The conversion of historic revenue and capital interim loan funding to PDC from April 2020 will reduce the risk associated with the going concern assessment, albeit the in-year position is not materially improved as a result of PDC dividend payments replacing interest charges.

As a result of COVID-19, interim arrangements for contracting and payment were put in place nationally. The Trust is now being paid under

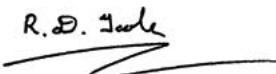
these arrangements with suspension of local contracting and funding through a nationally calculated block payment, designed to result in a break even position. The board assessment of going concern has not materially changed: there remains an expectation of continued provision of services during 2020/21.

Better Payments

The Better Payments Practice Code (BPPC) targets NHS bodies with paying all non-NHS trade creditors within 30 days of the receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

The increase in the Trust's deficit in 2018/19, above the original planned level has resulted in a tight cash flow and impacts payments to creditors within the required Better Payment Practise Code (BPPC) target. An improved Cash flow despite the increased deficit arising from the Trust's financial position has led to an improvement in performance in 2018/19 compared to 2017/18. The Trust performance in 2017/18 was 64% by number and 65% of value, against the national target of 95%. The Trust achieved 80% and 76% respectively in 2018/19. The Trust's cash position will remain challenging in 2019/20 with another deficit forecast but plans have been put in place to manage liquidity.

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



Robert D Toolé
Chief Finance Officer

BPPC Target Performance : 95%	Number	£000
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	101,681	232,317
Total Non-NHS Trade Invoices Paid Within Target	98,244	216,409
% of Non-NHS Invoices Paid Within Target	96.62%	93.15%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,936	16,513
Total NHS Trade Invoices Paid Within Target	2,221	7,741
% of NHS Invoices Paid Within Target	75.65%	46.88%
Total Payables		
Total Invoices Paid in the Year	104,617	248,830
Total Invoices Paid Within Target	100,465	224,150
% of Invoices Paid Within Target	96.03%	90.08%

Herefordshire and Worcestershire Sustainability and Transformation Partnership (STP)

The vision across the STP footprint of Herefordshire and Worcestershire is that “*Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people*”.

The NHS Long Term Plan was published in January 2019, followed by an implementation framework published in June 2019. In November 2019, the Herefordshire and Worcestershire STP submitted a refreshed 5 year STP plan in line with the priorities identified in the NHS Long Term Plan. This included a system perspective on annual activity and financial planning that has been carried forward into 2020/21 annual operational plans at organisational and aggregate system level.

As part of the framework for implementation of the NHS Long Term Plan, STPs will continue to evolve towards Integrated Care Systems (ICS). The Herefordshire and Worcestershire STP has established an Integrated Care System Executive forum that draws on membership from the constituent organisations and sectors across the STP, that is tasked with developing the local ICS and identifying the priority areas of focus for integrated care.

Worcestershire Acute Hospitals NHS Trust is represented at the ICS Executive forum, the STP Partnership Board and is involved in a range of programmes supporting the STP transformation priorities.

In 2019, the Trust published its strategy for clinical services to 2025. The strategy is based on three strategy ‘pillars’: integrated care, urgent and emergency care and acute and specialised planned care. The Clinical Services Strategy is aligned with

both the ambitions in the NHS Long Term Plan and the local Herefordshire and Worcestershire STP plan whilst also providing important future direction for Trust services and the staff that deliver them.

Acute Services Review (ASR)

In July 2017, following an extensive development and consultation process on the Future of Acute Hospital Services in Worcestershire programme (FoAHSW), the Governing Bodies of Worcestershire’s three Clinical Commissioning Groups (CCGs) formally stated their support for the clinical model designed to bring stability and certainty to the local acute health service through the reconfiguration of services between the Alexandra Hospital (AH), Redditch and the Worcestershire Royal Infirmary (WRH), Worcester.

Delivery of the clinical model is supported by a capital business case and capital development at both WRH and AH, totalling c£30m. An outline business case for the capital development was approved in January 2018 and STP wave one capital funding was allocated in July 2018, subject to full business case approval. The full business case will be completed in spring 2020, following a lengthy procurement process covering the six separate schemes across the two sites.

During the first half of 2018, the Trust was able to access £11m in capital PDC and loans to allow work to begin (pre FBC) on the construction of a link bridge between the main Worcestershire Royal Hospital building and the Aconbury East ward block building on the former Newtown Road Hospital site. The link bridge opened in January 2019 and the refurbishment of the Aconbury East building is well advanced with the last of four new wards opening in May 2020, providing 79 additional acute beds. This development has provided much needed additional general and acute bed capacity at the Worcestershire Royal Hospital site to support both the centralisation of services and ongoing capacity issues at the Trust.



Engaging with our stakeholders

Developing our relationships with our partner organisations has continued throughout 2019/20.

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

We also continue to work closely with a wide range of external agencies, including the Health Overview and Scrutiny Committee and HealthWatch – as well as regional and national organisations that monitor and assess the Trust, including the Care Quality Commission.

The Trust has continued to build relationships with a wide range of stakeholders including our local MPs and other elected representatives.

Working together with our patients, carers, volunteers and the public - Together We Are Patient Experience

Over the last 12 months we have continued to increase opportunities for people to work with us to improve patient care and the patient experience. Our commitment to listen and bring about change from what we are hearing is now possible at every level. Every month our Trust Board meetings have begun with a patient or staff story which provides a direct connection with our staff, patients and carers and the opportunity to connect first hand; and our Trust has worked closely with our Patient Public Forum members to understand what matters most to



Visual notes from the Volunteer Strategy Engagement Day.

our patients through meetings, consultations and hundreds of volunteer led audits informed by our CQC 'Must' and 'Should Dos'. We have worked with the Patient Public Forum to develop a new model of engagement which supports their involvement with governance and representation at all levels on Committees and steering groups. The Patient Public Forum was actively involved in the development of the Clinical Services Strategy, creating Top Tips for Engagement to support staff across the Trust to effectively engage and collaborate with stakeholders. Members also attended two engagement events alongside local healthcare providers, Trust staff, volunteers and community representatives.

In the summer of 2019, we launched our first hospital youth forum, for young people aged 14-24 with an interest in health. The group meets every month and works in partnership with our Trust. In the last 6 months the group has developed quality improvement projects in response to parent, carer and young patient survey feedback focusing on food tasting, Wi-fi connection and the clinical environment.

During 2019 we launched **Together We Are Patient Experience** – a movement for positive change and engagement which brings together Patient Experience Champions twice every three months, to explore and share ideas and solutions. We have recruited, trained and supported more than 100 champions from across our hospitals to really understand that patient experience



Poster recruiting members for our first Hospital Youth Forum.

is “everybody’s business” empowering staff to bring about change from everyday feedback. A core component of the movement is to make it clear that Patient Experience Champions have “permission” to bring about positive change.

Our champions are role models and have led on projects that have been instrumental in enabling a greater number of our patients, friends and families to regularly share their feedback and demonstrate that we are a listening Trust. We have measured this through the increased number of Friends and Family Test responses received month on month throughout the year.

You can spot our champions who have attended the full training programme wearing our smiley Patient Experience Champion badges on our wards and in our clinics!

In Patient Experience Week April 2019 (#Expo of Care) we relaxed visiting hours and developed a Visitor’s Charter with public focus groups and staff feedback. We also developed posters and awareness to welcome carers across our hospitals and we launched a film and tools for staff to promote our Patient Experience Champions programme. During this week our tweets were seen more than 23,000 times locally and nationally and this simple way of messaging, stood as a positive action against negative press which was a concern shared by the public during our Quality Account consultations the previous year.

We relocated our bereavement service at Worcestershire Royal Hospital to a quieter location on the same site in response to face to face and questionnaire feedback. We created a photographic and art competition open to the public and staff to improve the new waiting and meeting rooms and received over 200 entries in the first stage and over 887 votes to select the favourite images.

Volunteers were involved throughout the process and the office has been designed following active consultation with office staff, the dementia team and members of the public visiting the service.

We have continued to gather feedback throughout the year using national and local surveys, the daily Friends and Family Test, online mechanisms, on-going informal conversations, discussions with families and visitors and more formal consultations and events. All feedback is shared with the relevant departments who are supported to develop action plans and bring about change and share the compliments. The majority of feedback received at the Trust remains positive and the focus in 2020-2021 will be to increase how this is shared.

2019-2020 has been our year of the volunteer with significant focus on infrastructure and strategic development. Completion of a new database and app enabled the Trust to recruit 86% more volunteers from April-July than in previous months and paved the way for a new way of working.

More than 100 volunteers came together at two engagement workshops in October which were open to any volunteer supporting the Trust and included volunteers from the Royal Voluntary Service, Age UK, Alzheimer’s Society, The League of Friends, and Sight Concern. The purpose of the events was to explore key experiences, ideas, issues and solutions to begin to design a future strategy together. November public consultations led by volunteers and Trust staff ensured all stakeholders were included in development of the volunteers’ strategy. 76 volunteers and staff came together at two December events to look at the themes and discuss priorities.

We have the ambition to grow, develop and raise the profile of volunteering at the Trust and our process to design this strategy has been about inclusivity and continued conversation throughout the development process; starting as we mean to continue forwards, valuing the contribution of volunteers alongside paid professionals.

We are excited to launch our strategy publicly in 2020.

Accountability Report

Corporate Governance Report

Directors' Report

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

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

In 2019/20 the Board met in public on 11 occasions, with meetings covering all three of our main sites. In the period covered by this annual report, the Board was part of the NHS E/I sponsored *Learning from Improvement*. Four sessions were held during the year. Other Board development sessions included work on the Clinical Services Strategy, risk management and the strategic direction of the Trust.

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

The Trust Board

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

- **Paul Brennan**, Chief Operating Officer /Deputy CEO
- **Anita Day**, Non-Executive Director
- **Mike Hallissey**, Chief Medical Officer *from July 2019*
- **Matthew Hopkins**, Chief Executive
- **Graham James**, Acting Chief Medical Officer, *May-July 2019*
- **Suneil Kapadia**, Chief Medical Officer *until May 2019*

- **Dame Julie Moore**, Non-Executive Director
- **Vicky Morris**, Chief Nursing Officer
- **Sir David Nicholson**, Chairman
- **Robert Toole**, Interim Chief Finance Officer, Chief Finance Officer *from September 2019*
- **Bill Tunnicliffe**, Non-Executive Director
- **Steve Williams**, Non-Executive Director
- **Mark Yates**, Non-Executive Director

Non-voting members of Trust Board

- **Richard Haynes**, Director of Communications and Engagement
- **Colin Horwath**, Associate Non-Executive Director
- **Helen Lewis (Vikki)**, Chief Digital Officer *from January 2020*
- **Dame Julie Moore**, Non-Executive Director
- **Tina Ricketts**, Director of People and Culture
- **Richard Oosterom**, Associate Non-Executive Director
- **Kimara Sharpe**, Company Secretary
- **Sarah Smith**, Director of Strategy and Planning

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

Non-Executive Directors

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

Clinical Engagement in decision making

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

The Trust Management Executive meets monthly to discuss the operational direction of the Trust. This Group, chaired by the Chief Executive, consists of the Board Executive Directors, the Divisional Medical Directors and other key senior staff from throughout the organisation.

Governance

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

Audit and Assurance Committee has reviewed Finance and Performance, People and Culture and Quality Governance Committees. Audit and Assurance Committee has undertaken a self-assessment in accordance with guidance in the Audit Committee handbook.

The Board has been developing its approach to risk management with the approval of its risk appetite in January 2020. From April 2020, the Board and committee agendas will be structured around the key risks, as identified by the Board Assurance Framework and the Corporate Risk Register, both of which are linked to the Annual Plan objectives.

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

The **Finance and Performance Committee's** purpose is to give the Board assurance on the management of the financial and corporate performance of the Trust and to monitor and support the financial planning and budget setting process. The Committee is chaired by Richard Oosterom.

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

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

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

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

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

Full details of membership of the Trust Committees can be found on page 45 in the Annual Governance Statement section.

Personal Data Incidents 2019/20

Details of Information Governance related incidents can be found on page 43 in the Annual Governance Statement.

Cyber security preparedness

The risk around cyber security is currently sitting on the corporate risk register, supported by a robust Cyber Security Action Plan. This plan is monitored by the Information Technology Security and Risk forum, which in turn reports in Information Governance Steering Group. The Cyber Security Action Plan is sensitive in nature, but full assurance is provided on the detail through these meetings.

An NHS Digital sponsored review of the Trusts Cyber Operational and Resilience reported back to the Trust in 2019. The review covered technical infrastructure security, procurement, communications and policy. The procurement recommendations take into account partners, suppliers and third parties and set out to deal with standardising cyber security within current contracts, and setting clear processes in place for cyber in terms of future procurement.

Statement on disclosure to auditors

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



Matthew Hopkins
Chief Executive

Date: 22nd June 2020

Annual Governance Statement 2019/20

1. Introduction

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

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

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

During 2019/20 we undertook an option appraisal to determine our future formal partnership arrangements for oncology, head and neck and urology services. We are working with University Hospitals Birmingham to formalise a working relationship.

The Trust is an active partner in the System Wide Command and Control, set up to manage the COVID-19 pandemic. This includes daily Gold and Silver Command meetings and the local system resilience forum. These meetings are in addition to the internal incident response to the pandemic.

The Trust has been monitored and assessed by a wide range of external agencies. These have included the three local Clinical Commissioning Groups (merged into one from 1 April 2020), Cancer Peer Review, Royal Colleges, Health Education West Midlands, NHS England/Improvement (NHS E/I), the Care Quality Commission (CQC), NHS Resolution and the Health and Safety Executive. This is not an exhaustive list of organisations that monitor and assess the Trust for assurance purposes. The Trust is also monitored by Healthwatch and the Worcestershire Overview and Scrutiny Committee.

I have regular contact with NHS E/I through a range of groups, individual, informal and formal meetings. Effective relationships are also in place with the executive team for the three Worcestershire clinical commissioning groups. All Executive Directors are fully engaged in the relevant networks, including nursing, medical, finance, operations and human resources. I hold regular meetings with the six County MPs and with the Worcestershire County Council Cabinet Member for Adult Social Care and the Chair of that Council's Overview and Scrutiny Committee.

As at 31 March 2020 the Trust's adjusted financial performance deficit excluding PSF, FRF and MRET funding and impairments for 2019/20

was £(81.5)m against a £(82.8)m planned deficit and its cumulative deficit against the break-even duty was £(349.8)m. The Trust did not sign up to the Control Total in 2019/20 (£(64.6)m pre PSF, FRF and MRET funding) and was therefore not eligible to earn any 2019/20 Provider Sustainability Fund income amounting to £26.9m, although a final payment of £0.5m relating to 2018/19 performance was received during the year.

The Trust delivered marginally better than its submitted financial plan, although it was unable to reduce the deficit to its internal stretch target of £(73.7)m as efficiency improvements did not deliver above the originally identified level. The position against submitted financial plan is largely driven by income margin growth; slippage in planned business case expenditure, and reduced costs related to the provision of additional bed capacity.

The Trust has met its statutory duties of External Funding Limit and Capital Resources Limit. However the Trust has not complied with its statutory Break Even Duty required by the National Health Service Act 2006. Grant Thornton, the Trust's external auditors, issued a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in March 2020 due to the Trust's failure to comply with the Break Even Duty.

The Annual Plan for 2019/20, Building for the future, was approved by the Board at its June 2019 meeting setting out a different way of working. This Plan detailed the revised Strategic Objectives for the Trust and launched the 'pyramid' for Putting Patients First. The Annual Plan for 2020/21 was approved by the Board in March 2020. Performance against objectives will be monitored and actions identified through a number of channels:

- Approval of annual budget by the Trust Board.
- Detailed Monthly review by the Finance and Performance Committee on key performance indicators covering finance and activity

- Monthly reporting to the Quality Governance Committee on patient safety and quality
- Bimonthly reporting to the People and Culture Committee on human resource performance indicators
- Reporting by the Committees to the Trust Board at each meeting
- Monthly review of the delivery of Cost Improvement Plans by the Finance and Performance Committee to ensure that savings targets are being met.
- Monthly divisional performance meetings
- Monthly Trust Management Executive meetings where key operational decisions are made
- Divisional Board and Governance meetings

During the first half of 2018, the Trust was able to access £11m in capital PDC and loans to allow work to begin (pre Full Business Case) on the construction of a link bridge between the main Worcestershire Royal Hospital building and the Aconbury East ward block building on the former Newtown Road Hospital site. The link bridge opened in January 2019 and the refurbishment of the Aconbury East building is well advanced with the last of four new wards opening in May 2020, providing 79 additional acute beds. This development has provided much needed additional G&A bed capacity at the WRH site to support both the centralisation of services and ongoing capacity issues at the Trust. The Full Business Case is to be presented to the Trust Board in May 2020.

I will now outline the key areas of responsibility and control in more detail.

2. Quality

We have been in the Trust Quality Special Measures regime since December 2015. The Trust improved its overall CQC rating to requires improvement in September 2019, following a planned inspection in May/June 2019 (see overall rating below).

At the time of publication, the CQC recommended that the Trust came out of quality special measures. However, NHS E/I Provider Oversight Committee did not uphold this recommendation pending evidence of a sustained improvement in performance and quality and evidence of a system-wide improvement approach. NHS E/I has continued to provide support in assigning an Intensive Support Director to the Trust, allocating special measures funding to pump prime quality and performance improvement initiatives and earmarking funds for the appointment of a System Intensive Support Director.

Until December 2019, we had no conditions on our CQC registration. Following an unannounced inspection of our emergency departments in December 2019, the Trust had the following section 31 conditions placed on its registration:

► **Regulation 12 (2) (a) (b) (i)**

The trust must ensure that ambulance handovers are timely and effective.

► **Regulation 12 (2) (a) (b) (i)**

The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments.

► **Regulation 12 (2) (a) (b) (i)**

The trust must ensure that patients receive medical and specialty reviews in a timely manner.

► **Regulation 12 (c)**

The trust must ensure that consultant and nurse cover in the department meets national

guidelines. Trainee consultants must not be classed as 'consultants' on the staffing rota.

► **Regulation 12 (2) (a) (b) (i)**

Fully implement the trust wide actions to reduce overcrowding in the department.

► **Regulation 10 (1)**

The trust must ensure that the privacy and dignity of patients receiving care and treatment in the emergency department is maintained at all times.

Additionally, the Trust has been mandated to report fortnightly to the CQC in relation to effective management of patients, environmental risk assessments and paediatric staffing levels.

The report relating to the unannounced visit was published on 13 February 2020 and the overall rating for the emergency departments was reduced to inadequate.

As this was a partial inspection, not all domains were reviewed and our overall rating of requires improvement, was not altered. The altered ratings are shown below:

The Trust is otherwise fully compliant with the registration requirements of the Care Quality Commission. Our registration details have been checked and meet the statutory requirements.

Following the Trust-Wide inspection and Well-Led review carried out by the CQC in 2019, the Trust retained its overall rating of "Requires Improvement" for the Well-Led domain, and the CQC noted that the Trust was continuing to establish an experienced Executive Team with a comprehensive knowledge of Trust priorities and challenges facing the Trust, and the "skills, abilities and commitment to provide high-quality services".

The improvements in leadership across the Trust were reflected in the improved ratings by site, which saw Worcestershire Royal Hospital (WRH) improving from "Inadequate" to "Requires

Improvement”, and the Alexandra General Hospital (AGH) and Kidderminster Hospital and Treatment Centre (KTC) increasing by two ratings, moving up from “Inadequate” to “Good” in the Well-Led domain.

Improvements were seen in the Well-Led domain for individual Core Services as follows:

- ▶ Urgent and Emergency Services improved from “Inadequate” to “Requires Improvement” at WRH, AGH and KTC
- ▶ Medical Care improved from “Requires Improvement” to “Good” at WRH, AGH and KTC
- ▶ Surgery increased by two ratings from “Inadequate” to “Good” at WRH, AGH and KTC, (the rating decreased to “Requires Improvement” at Evesham Community Hospital)
- ▶ Services for Children and Young People improved from “Requires Improvement” to “Good” at WRH
- ▶ Outpatient Services increased by two ratings from “Inadequate” to “Good” at WRH, AGH and KTC
- ▶ Diagnostic Imaging Services improved from “Requires Improvement” to “Good” at KTC, and retained the rating of “Requires Improvement” at WRH and AGH

The report also stated that the Board and the Senior Leadership Team had a clear vision and values which are at the centre of all work within the organisation, ensuring that a patient-centred culture is embedded, and continuing the commitment to providing development opportunities for managers throughout the organisation.

2.1 Quality Improvement Strategy

Our Quality Improvement Strategy and associated plans, presented to the Trust Board in March 2018, have been monitored through the Quality Governance Committee and the Trust Management Executive (chaired by myself) and reported to the Trust Board. Divisional implementation plans are in place to support implementation and ensure a golden thread from Board to Ward. A key action for 2020/21 is the development of another three-year Quality Improvement Strategy and we have been undertaking engagement events during 2019/20 in preparation for this work.

2.2 Quality Governance

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

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

CGG is supported by the Divisional Governance Forums and specialist groups covering areas such as infection prevention control, clinical effectiveness and safeguarding. Attendance by the clinicians is excellent and they present their quality exception reports, key risks and mitigations through the corrective action statements.

The Trust Management Executive (TME) has been operational for the whole of 2019/20. Membership includes the Executive Team, the Divisional Directors, the Chief Pharmacist, Director of Estates and the Head of Allied Health Professionals. This monthly meeting is our operational decision making forum and discusses and approves key items before they are presented to the relevant Committee for assurance.

The CGG reports every month to the Trust Management Executive and through the Integrated Quality Report, to the Quality Governance Committee for assurance.

2.3 Learning from Deaths

During 2019/20, The Trust commissioned an external review into the elevated mortality indicators and this was published in November 2019. Despite the high mortality indicators most of the 225 deaths reviewed were due to irreversible disease and contrary to other comparative reviews the frequency of avoidable factors was low which reflects well on the staff caring for an elderly frail population. No specific cases required escalation.

However, a number of concerns in care were identified which included: prolonged lengths of stay; nutrition and hydration; extended stays in ED while waiting for an appropriate inpatient bed; multiple handovers of patients between clinicians; delays in escalation and lack of recognition of end of life care. As the review did not raise any significant concerns with failures of care, it was agreed to focus on the review of cases from January 2019 where learning would be most applicable to current practice. Therefore any outstanding reviews prior to this will not be pursued. Additional medical examiner capacity is being identified and the aim is to provide real time review which will support both families and junior medical staff.

Clinical engagement with the mortality reviews had been suboptimal and there had been too much focus on process. Meaningful learning

from deaths was therefore compromised. From the beginning of 2020/21, we now have a full complement of medical examiners and we are reviewing deaths in a timely manner. We will maintain this position throughout 2020/21.

We continue to report quarterly to the Trust Board on the learning from deaths.

2.3.1 Regulation 28 letters

During the year, the Trust received one Regulation 28 letter (a report to prevent future deaths) from the Coroner. This concerned record keeping. We have reviewed our discharge records and in particular the information given to patients on discharge to reflect the coroners' findings.

2.4 Quality impact assessments

The process for undertaking Quality Impact Assessments has been revised during 2019/20. Quality impact assessments (including equality and diversity) are undertaken for all developments and cost improvement plans that could have an impact on quality. These are reported to the TME and Quality Governance Committee and to the Audit and Assurance Committee for assurance on the process undertaken. We have plans to truncate the Quality Impact Assessment process during the COVID-19 pandemic.

2.5 Research and Development

We recognise that R&D is integral to a successful Trust. We will be reinvigorating our strategy during 2020-21. We have appointed a new lead for R&D and participation in R&D based activity continues to rise. The Trust is progressing in line with its targets, increasing overall recruitment of patients into trials from 1082 to 1206 increasing the number of principal investigators (PI) by 10 in the last 12 months. A third target was increasing the number of specialities participating in R&D to 18 which has been achieved as we are currently recruiting into 22 Clinical Research Network defined specialities. All of the commercial research

studies closing this year have recruited to time and target. Of the non-commercial research, 81.8% of studies closed so far this year have recruited to time and target. The forecast for the end of the year is that 87.5% of studies will recruit to time and target. The team were shortlisted as a national centre for Commercial trial development which demonstrates the increasing skill set in the department.

2.6 Annual Quality Account

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

The Quality Governance Committee assures the Trust Board in relation to the quality account and is overseeing the production of the 2019/20 Quality Account. The quality priorities have been developed following consultation with our staff and patients and were agreed at the February 2020 meeting of the Committee. Comments have been sought from partners to ensure a balanced view. There is no requirement for a quality accounts audit opinion this year.

2.7 Management of risk

2.7.1 The risk and control framework

Risk Management is embedded within the organisation including throughout our Committee structure. We are undertaking further work to ensure that our Board and Committees focus on areas with the highest level of risk and are our greatest priorities. In March 2020 the Board agreed a statement of risk appetite for the Trust to aid the quantification of risks.

We have an incident reporting and feedback system and risk management is included within all job descriptions, including both training and the processes for the assessment of risk as well as the reporting and investigation of incidents.

2.7.2 Internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Worcestershire Acute Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Worcestershire Acute Hospitals NHS Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

2.7.3 Capacity to handle risk

I have designated the following posts as executive leads:

- ▶ **Clinical risk management**
Chief Nursing Officer
- ▶ **Clinical governance**
Chief Nursing Officer
- ▶ **Medical education, audit and effectiveness and research and development**
Chief Medical Officer
- ▶ **Patient safety, medicines optimisation, learning from deaths and medical revalidation**
Chief Medical Officer
- ▶ **Information governance**
Chief Finance Officer
- ▶ **Financial risk and anti-fraud**
Chief Finance Officer
- ▶ **Corporate governance**
Company Secretary
- ▶ **Data Protection Officer**
Company Secretary

2.7.4 Risk Management Strategy

The Risk Management Strategy (RMS) is an integral part of the Trust's approach to continuous quality improvement and is intended to support and assist us in delivering our key objectives as well as meeting the requirements contained within the NHS Constitution. A revised RMS was presented to and approved by the Board in January 2020. Risk appetite statements were also approved and during 2020/21 the Trust will be embedding the use of the statements. There is continuous review of the risk registers and the Board Assurance Framework shows clear links to the risks on the corporate risk register.

The Audit and Assurance Committee gives assurance on the implementation of the Risk Management Strategy.

2.7.5 Identification of risks

The Trust identifies risks from a range of internal, external, proactive and reactive sources. The stages involved in risk management are defined in the Trust Risk Management Strategy as follows:

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

2.7.6 Staff Awareness

Staff continue to be made aware of their risk management responsibilities as part of the induction process, and existing staff are required to attend a mandatory annual update in respect of risk management. Training needs of staff in relation to risk management are assessed through a formal training needs analysis process with staff receiving training appropriate to their authority and duties. The role of individual staff in managing risk is also supported by a framework of policies and procedures which promote learning from experience and sharing of good practice.

Specific training targeted at Executive Directors, Non-Executive Directors and Managers has been undertaken.

2.7.7 Incident reporting

Our e-based reporting system, Datix, has been rolled out throughout the organisation so that incidents can be input at source and in real time and data can be interrogated through ward, team and locality processes, thus encouraging local ownership and accountability for incident management. The Trust has an on-going training programme around Datix and how to register incidents, risks and complaints that is open to all staff from Board to Ward on both a classroom-based approach and 1-2-1 intensive training.

2.7.8 Corporate Risk Register

The Trust has a Corporate Risk Register in place which outlines the key corporate risks for the organisation and action identified to mitigate these risks. This register has been formed from the risks identified within clinical divisions and corporate services, Trust Committees and through other risk identification activities. The key clinical risks relate to:

- Infection Prevention and Control
- Patient Flow
- Sterile Services

There has been a focus on infection control throughout the year and whilst the Trust has not met its targets for key infection numbers, assurance on the systems and processes has been gained through the NHSE/I inspection regime and in October 2019, the Trust was rated green. A review of surgical instruments by an external provider identified concerns over practice in Sterile Services. As a result there has been a review of all surgical instruments and implementation of a replacement programme. In addition an external review of current practice in Sterile Services has resulted in the development of a rectification plan which is being implemented.

2.7.9 Risk Management Governance

The Risk Management Group has matured during 2019/20 and assurance has been obtained at the Audit and Assurance Committee in respect of its working. The Risk Management Group approves risks for inclusion onto the Corporate Risk

Register High rated risks are presented to the Risk Management Group which then recommends risks for inclusion within the Corporate Risk Register to TME. In relation to clinical risks, the Trust Management Executive oversees the mitigations for each risk and the Quality Governance Committee receives reports for assurance. The Finance and Performance Committee oversees mitigations for the finance and operational performance risks and the People and Culture Committee oversees mitigations for the staff risks. Outcomes are assessed at the Risk Management Group where the risk rating is determined and changed, according to the progress of the mitigations.

2.7.10 Serious incidents and never events

Serious incidents and never events are thoroughly investigated and improvements made at local and corporate levels to reduce the likelihood of re-occurrence. There were 83 confirmed serious incidents reported between 1 April 2019 and 31 March 2020 (compared to 102 the previous year). Of these 83, 16 are under investigation and are still within the timescales for submission. This number includes 8 cases being investigated by the HSIB (Healthcare Safety Investigation Branch). Of the 59 that have been submitted to Commissioners, 100% were submitted within the national timescale of 60 days. Four cases (in addition to the 59) were submitted late but they had been investigated by the HSIB and so were outside our control. By 31 March 2020, we had 0 serious incidents overdue which compares to 1 in March 2019.

A fundamental part of embedding a safety culture is ensuring robust identification and management of incidents and ensuring learning is shared at an

organisational level. The Trust has weekly multi-disciplinary Serious Incident (SI) Learning and Review meetings chaired by the Chief Medical Officer. All incidents are categorised for level of harm by the divisional governance teams using a checklist and escalated to the SI group accordingly. The group reviews the root cause analyses of all SIs and assess whether any deaths are as a consequence of the event, were avoidable or not through the mortality review process. They also consider Initial Case Reviews (ICRs) for all new incidents which Divisions have categorised the outcome as moderate harm or above, and those which may require external notification. In addition, the group assesses compliance with Duty of Candour, whether the terms of reference are appropriate, and that an investigating officer has been allocated. Each meeting concludes with a lesson of the week for wider learning across the Trust. Once a month, cases with important learning which affect multiple divisions are presented at the start of the meeting which is open to all staff to attend.

There were 8 never events reported in the Trust between 1 April 2019 and 31 March 2020, two related to retained foreign objects (ophthalmology ports and surgical swab), and six related to wrong site surgery. This resulted in minor (6) and moderate (2) harm to the patients; an apology and explanation was given to all patients as part of Duty of Candour. Learning from the incidents to date highlighted that;

- ▶ Advances in technology may result in changes to procedural techniques that require the reassessment of a procedure/task against existing policies or guidelines in place to ensure the continued safety of patient care;
- ▶ The impact of not having a medical illustration service or sufficient photography equipment on specialties where it is considered best practice to ensure high-quality medical photography as an essential part in the recording, surveillance and storage of images for clinical decision making, and;

- The importance of accurate descriptions using anatomical terms as an essential component for communicating surgical sites to colleagues who are expected to carry out procedures but are not present at the time of consultation and action has been taken to address this.

A quarterly report from the group is submitted to the Clinical Governance Group and then to the Trust Management Executive followed by the Quality Governance Committee which then assures the Board.

2.7.11 Complaints

We have also committed to ensuring that we do not delay in responding to complaints and investigating serious incidents. By 31 March 2020, we had 15 complaints overdue which compares to 17 in March 2019.

2.7.12 Learning lessons

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

- Incidents
- Patients' Advice and Liaison Service (PALS)
- Complaints and compliments
- Friends and Family Test
- Litigation Claims
- Clinical Audit and Clinical Outcome Reviews
- Clinical Incident Reports, reviews and analysis including serious incidents and never events
- Morbidity and Mortality data (HSMR/SHMI)
- External Reports (for example the National Confidential Enquiry into Peri-operative Death, reports from the Royal Colleges)

- Patient and Staff surveys
- Internal quality inspections
- Huddles
- Mortality reviews
- Duty of Candour
- Quality performance metrics
- Board Executive safety walk rounds
- Health Education West Midlands – visits and inspections
- External reviews by the CQC, NHSE/I, Royal Colleges and Clinical Commissioning Group.

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

As well as this, a 'lesson of the week' is communicated via the weekly brief and some lessons communicated have been in relation to: rebooking outpatient appointments, supernumerary /supervised practice for all doctors new to the NHS, MRSA swabbing of patients post admission, those with chronic wounds and those with indwelling catheters and allergic reactions vs side effect/intolerance.

All lessons of the week are on the Trust's intranet site and accessible via the front page.

2.7.13 COVID-19

We have responded promptly to the significant change in circumstances of the COVID-19 pandemic by invoking the Major Incident Plan. The Command and Control structure is now embedded with Bronze, Silver and Gold meeting seven days a week. The Bronze Commander is

the Director of Strategy and Planning, Silver is the Chief Nurse and Gold is the Deputy Chief Executive. We have an active risk register in place specifically for COVID-19 with a risk being placed on the Board Assurance Framework. We are aware that with the cancellation of routine surgery and delays to some cancer screening, harm may well take place to some patients. We are developing a robust approach to the harm review process specifically for use within the pandemic.

The Board agreed in March 2020 that for the foreseeable future Board and Committee (including Trust Management Executive) meetings be held virtually using a recognised video conference platform with a focussed agenda. As specified by NHS England, our Trust Board meetings will not be open to the public. There is a notice on our website letting the public know that we will be undertaking virtual meetings in April and May 2020, and papers will be published as normal. HealthWatch Worcestershire will be invited to participate in virtual meetings.

The meeting attendance is reduced to enable key operational leaders to focus on immediate incident response matters, although each meeting is quorate. The agendas for Committees have focused on assurance of the impact of COVID-19 on the business of the Trust, as well as elements of the normal assurance or performance management work plan of the Committees. Minutes and actions are produced as normal together with a summary of the key issues for the Trust Board. A log will be kept of items deferred from the normal agendas and these will be considered with the lead Executive Director when the incident is scaled down. The Chairs of these meetings remain as identified on the extant terms of reference and the scheme of delegation remains.

3. Safety & leadership walkabouts

Safety and leadership walkabouts by the Executive Management Team and Non-Executive Directors were in place during 2019/20 prior to the onset of the COVID-19 pandemic. The process is undergoing a Plan Do Study Act (PDSA) cycle and will be implemented as soon as safety and leadership walkabouts are re-introduced in 2020/21 with the introduction of a real time electronic application being used to record visits. This approach will be reviewed before the end of 2020/21.

4. Board Assurance Framework

We recognise the importance of a robust Board Assurance Framework (BAF) and as such, it is received four times a year by the TME, each committee and the Trust board (May, July, November, March). The Audit and Assurance Committee reviews the process and controls for each Board submission. The BAF was revised in January 2020 to reflect the annual plan priorities for 2020/21 and the revised BAF was approved by the Board in March 2020. An extra BAF risk on COVID-19 was approved following the Trust Board in March 2020.

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

Priority/risk	Summary of controls/mitigations*
Priority 1. Deliver safe, high quality compassionate patient care	
IF we do not have in place robust clinical governance for the delivery of high quality compassionate care THEN we may fail to consistently deliver what matters to patients RESULTING IN negative impact on patient experience (including safety & outcomes) with the potential for further regulatory sanctions.	Development of a framework for clinical governance.
IF we do not deliver the Quality Improvement Strategy (incorporating the CQC 'must and should' dos) THEN we may fail to deliver sustained change RESULTING IN required improvements not being delivered for patient care and reputational damage.	Ongoing sustained implementation of the Quality Improvement Strategy including a refreshed strategy and year 2 divisional plans. Publication of Quality Account.
IF we do not deliver the statutory requirements under the Health and Social Care Act (Hygiene code) THEN there is a risk that patient safety may be adversely affected RESULTING IN poor patient experience and inconsistent/varying patient outcomes.	Ongoing sustained implementation of the Quality Improvement Strategy including a refreshed strategy and year 2 divisional plans. Publication of Quality Account.
IF we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning THEN we will fail the national quality and performance standards RESULTING IN a negative patient experience and a failure to exit special measures and to attain STF funding.	Development of an Urgent Care Improvement Plan.
IF we do not have effective IT systems which are used optimally THEN we will be unable to utilise the systems for the benefit of patients RESULTING IN poorly coordinated care for patients and a poor patient experience.	Development of a Digital Strategy.
If COVID -19 manifests itself as is modelled by the Government, then there is a serious risk that the safety of patients will be compromised due to the lack of medical and nursing staff and equipment to enable treatment of the most seriously ill resulting in excess deaths.	Major incident control plan.
Priority 2. Design healthcare around the needs of our patients, with our partners	
IF there is a lack of a strategic plan which balances demand and capacity across the county THEN there will be delays to patient treatment RESULTING IN a major impact on the Trust's ability to deliver safe, effective and efficient care to patients.	Development of the winter plan and system plan.

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

* the full controls, mitigations and assurances can be reviewed in the Board Assurance Framework approved at the Trust Board in May 2019 & March 2020.

5. Quality Performance Data

During 2019 we commissioned an external review of our data quality. MBT (an organisation specialising in this areas of work) reviewed our data quality and whilst they were able to assure that the technical data quality was very good, they ascertained that the Trust was not using the data to its full potential. A set of recommendations will be completed by the Autumn 2020. We are committed to continuous improvement in data quality. We support a culture of valuing high quality data and strive to ensure all data is accurate, valid, reliable, timely, relevant and complete. Identified risks and relevant mitigation measures are included in the risk register. Work continues to ensure the completeness and validity of all data entry, analysis and reporting.

To support this, and to triangulate learning and evidence of compliance, we undertake quality audits. These audits provide regular information at a ward level as to adherence to key clinical assessments and patient documentation completeness, in addition to information regarding environmental standards. The quality audits identify areas of good practice and highlight where further training or support is required.

The Safety and Quality Information Dashboard (SQuID) continues to evolve and is utilised within the Trust. The system is a Ward to Board system which highlights performance around quality and safety, and when we are not where expected to be, what is being done about it. It incorporates all our agreed key quality metrics, and is aligned to risks, gaps in controls and corrective actions. This can be viewed by all and is used as part of the Trust's process to provide Ward to Board assurance. Critically, over the last financial year, significant work has taken place to align SQUID with the new Pathway to Platinum (P2P) (ward accreditation scheme), to support the quantitative element of P2P with robust reporting. Ward metrics under the P2P scheme are available for review by all our staff and used to help identify

high performing wards and exemplars, and wards which need additional support.

5.1 Waiting time elective data

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

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

5.2 Data Quality Steering Group (DQSG)

Our clinically led Data Quality Steering Group meets bi monthly and has oversight of our data quality log. It continues to support the improvement in the recording of all patient data at source in line with the 'Right First Time' policy. Work is ongoing with clinical staff to improve the timeliness and quality of the Electronic Discharge Summary (EDS) and real time Admissions Discharges and Transfers (ADTs), and with clerical staff to ensure the correct GP is recorded at source. Our Informatics led Ward Clerk forum which brings together our ward clerks and helps support 'getting it right first time' at the front line.

We operate a Data Quality Kitemark for key data items, highlighting known issues within the six domains as defined in the Data Quality Framework (accuracy, validity, reliability, timeliness, relevance and completeness).

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

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

6. People and Culture

The Trust is in year three of its People and Culture Strategy which is structured around three themes – an engaged, skilled and supported workforce. Metrics in all areas except for staff sickness have improved during the year. We will be developing the Strategy for 2020-23 in the early part of 2020/21. Progress relating to the People and Culture Strategy is reported through the Trust Management Executive for action and the People and Culture Committee for assurance.

The People and Culture Committee has oversight of the short, medium and long-term workforce strategies on behalf of the Board. The Committee meets bi-monthly and receives regular updates on progress against the Trust's people and culture strategy and strategic workforce plan.

In addition, key workforce metrics including establishment, vacancy rates and bank and agency usage are reported through the monthly Integrated Performance Report.

Compliance with the "Developing Workforce Safeguards" is overseen by the Chief Nursing Officer with monthly safer staffing reports submitted to either the People & Culture Committee (on the months that it meets) or

directly to the Board. Regular acuity audits using recognised evidence based tools are undertaken to inform the Trust's staffing models. The Trust has also adopted the safer staffing module on Allocate to ensure daily oversight of staffing levels.

6.1 Mandatory training

Our systems and processes in relation to the monitoring of mandatory training have much improved during 2019/20. Staff are able to undertake a large part of mandatory training through e-learning and can attend any of the Trust's libraries for support. The monitoring of mandatory training levels takes place through the performance management system and is monitored via the Trust Management Executive and the People and Culture Committee. There has been significant improvement in both the data quality and mandatory training levels attained by all staff across all subject areas.

6.2 Culture

We have undertaken considerable work as a Board to define the culture we wish to nurture and to be ambassadors for our 4ward behaviours. We monitors our culture through the triangulation of the NHS staff survey results and themes raised through the Freedom to Speak Up Guardian, HR casework, Occupational Health and staff engagement events. This analysis had confirmed that there is further work to do to improve our culture with actions being identified to address the root causes. We will continue to ensure that we demonstrate our 4 signature behaviours at every opportunity.

6.3 Staff survey

The 2019 national staff survey results showed improvements overall. The survey has 11 sections containing over 90 questions, with the results summarised in the table below.

6.4 Leadership development

A full programme of leadership and management development is in place with over 830 colleagues having participated in a programme during 2019. The latest staff survey results evidence the impact these programmes are having within the Trust.

6.5 Strategic workforce plan

The first iteration of our strategic workforce plan was issued in October 2019 and has been further developed as part of the annual planning round. We are working with the STP to develop a system strategic workforce plan as we recognise that workforce is a key element to the success of our Clinical Services Strategy and there are finite staff who work within the Worcestershire footprint.

6.6 Recruitment

We have had a successful international nurse recruitment drive which will result in over 100 additional registered nursing staff employed by the Trust by March 2020. We are actively recruiting to clinical fellow and physician associates posts and we are reviewing the roles of the clinical nurse specialists to determine how they can support further support the medical workforce.

6.7 Safe Staffing

Senior nursing staff review record our staffing levels at every shift make sure we continue to provide the best care and treatment for our patients. Following reviews of nurse and midwifery staffing reports to Board have confirmed that the Trust in March 2020 has an establishment that affirms safe staffing across ward areas.

6.8 Freedom to Speak Up

Our new Freedom to Speak Up Guardian, appointed in February 2020, is working to take the role forward and recruit more local champions. There are regular reports to the People and Culture Committee and Trust Board on her work and the Audit and Assurance Committee have a role in

reviewing the systems and processes in place to ensure staff have every opportunity to discuss workplace attitudes.

6.9 Pension Scheme

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.

6.10 Equality, diversity, human rights

Control measures are in place to ensure that all our obligations under equality, diversity and human rights legislation are complied with. We have published both our equal pay report and our equality and diversity annual report.

7. Digital

The Board approved the Digital Strategy in June 2019. The objective of the Digital Strategy is to improve patients' health and well-being outcomes. It has three main areas of focus: remediation of failing IT infrastructure, and rolling out a Digital Care Record (DCR) across the Trust, and enabling innovative and effective digital enhancements to improve ways of working. The Digital Care Record Business Case was approved by the Trust Board in January 2020. This important step towards digital transformation further demonstrates the organisations focus and dedication to the digital element of Putting Patients First. The DCR will take three years to implement, and initial financial benefits are expected in year three.

We continue to ensure clear read-across to the aspirations in the STP Digital Strategy, to ensure consistency with STP level digital plans. The STP priority around a Local Health Care Record, along with the information sharing agenda is fully supported by the Trust. The NHS Long Term Plan has also been taken into account in the latest iteration of the Strategy, allowing the Trust's Digital Strategy to run co-terminously with the timescales set out in the Digital Chapter of the Long Term Plan.

7.1 Cybersecurity

The Trust received an external report on cybersecurity preparedness and is currently working to resource the requirements to ensure that we meet the national standards. The report (official secret) was considered by the Audit and Assurance Committee. Work is progressing well on the different domains of this report (policy and strategy, procurement, communications and technical remediation) with the limiting factors being capital funding to remediate aging infrastructure.

7.2 Information Governance

We place a high priority on the secure handling and accurate recording of personal identifiable information (PII) on behalf of our patients and staff. All staff are provided with an IG awareness session at induction. Our staff are aware of their responsibilities in relation to handling personal information in a confidential and secure manner through completion of the national Data Security Awareness training. As at February 2020, 86% of staff had completed their annual training and there is an action plan in place to improve the compliance rate by March.

There are regular articles in relation to IG and data security placed in the Trust's Weekly Brief and on the PC home screens. A newsletter is planned to go out to all staff in the early part of 2020/21 and will include all the latest news and guidance for staff. Following an incident in June 2019 which

the Trust reported to the Information Commissions Office (ICO), the Trust has run an extensive 'no excuse' campaign to inform staff that there is no excuse for accessing anyone's records unless they have a legitimate reason and are directly involved in that person's care. In February 2020 the Trust has reported a misplaced handover sheet to the ICO which had been handed in by a member of the public. There is a policy in place for the safe keeping of handover sheets and all new staff are instructed at induction on how to keep their handover sheets secure. This is also reiterated at the junior doctors forums, included in the Trust's Weekly Brief and there will be a reminder on the PC home screens in the near future. The Trust reported two data security incidents to Senior Information Risk Owner (SIRO) who approved the reporting to the Information Commissioners Office (ICO). There has been one disciplinary associated with data security.

All new systems and projects have a Data Protection Impact Assessment (DPIA) completed and where required data sharing or processing agreements are completed. Following the completion of the data mapping project which has identified all of the flows of personally identifiable data, internally and externally to other organisations, the Trust is now in a position to ensure data sharing agreements are in place where required.

Our Board has completed Cyber Security awareness training and specialist training has been provided to support the roles of the Senior Information Risk Owner (SIRO), the Data Protection Officer (DPO), the Caldicott Guardian and the Senior Information Asset Owners (IAO). The Trust has been working with Cyber specialists from NHS Digital who have provided the Trust with recommendations to further enhance its security posture along with the implementation of Cyber Essential requirements. The Governance structure around IG and cyber security is being strengthened and formalised through delegating system level information risk ownership to relevant information asset owners across the Trust. A meeting will be

convened to include those involved, at which roles, responsibilities and structures as well as interfaces with IG and IT will be explained.

The Information Governance Steering Group (IGSG) acts as a subcommittee of the Trust Management Executive (TME) and is set up to ensure the Trust has effective policies and management arrangements covering all aspects of Information Governance in line with the Trust's overarching Information Governance Policy. IGSG has three subcommittees; an IT Security and Risk Forum which brings together operational IT staff, the Data Protection Officer and the Caldicott Guardian to determine the data security risks, including cybersecurity; The Data Quality Steering Group (DQSG) provides assurance to IGSG that the Trust is fulfilling its duties to accurately record all patient activity on a timely basis, and to ensure that the Trust has a single set of Trust-wide effective policies and management arrangements covering all aspects of data quality. The Health Records Group (HRG) provides assurance to IGSC on the capture and usability of clinical information; the quality, availability and storage of clinical documentation as well as supporting the development and implementation of the Digital Care Record (DCR).

Due to COVID-19 the submission of the 2019/20 the Data Security and Protection Toolkit has been delayed until 30 September 2020.

8. Patient, Public Involvement

The Trust works closely with public stakeholders to involve them in understanding and supporting the management of risks that impact upon them. Stakeholders are able to influence the Trust in a number of ways, including patient involvement groups and public involvement in the activities of the Trust. In addition, the Chief Executive and Chairman meet the local MPs regularly. The Trust has directly engaged public stakeholders in the risk management process through the Patient and Public Forum and through PALS. In

addition a patient and public forum member sits on the Quality Governance Committee. Public involvement also occurs through the Trust complaints procedure and summaries of complaints are reviewed at the Patient and Public Involvement Forum. There is an opportunity for questions from the public following each Trust Board meeting held in public. We have reviewed our quality priorities as part of the Quality Account and have actively sought views from patients and the public in this review.

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

9. Counter Fraud

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

In order to reduce economic crime against the NHS, it is necessary to take a multi-faceted approach that is both proactive and reactive. The Trust's Local Counter Fraud Specialist (LCFS) follows the four key principles, in accordance with the NHS counter fraud strategy. These are

designed to minimise the incidence of economic crime against the NHS and to deal effectively with those who commit crime.

The four key principles are:

- ▶ **Strategic Governance** - this sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.
- ▶ **Inform and involve** those who work for, or use the NHS, about economic crime and how to tackle it. NHS staff and the public should be informed and involved to increase everyone's understanding of the impact of economic crime against the NHS. This takes place through communications and promotion such as face to face counter fraud presentations, public awareness campaigns and media management. Working relationships with stakeholders are strengthened and maintained through active engagement.
- ▶ **Prevent and deter** economic crime in the NHS to take away the opportunity for crime to occur or to re-occur and discourage those individuals who may be tempted to commit economic crime. Successes are publicised internally during counter fraud presentations and using other media opportunities so that the risk and consequences of detection are clear to potential offenders. Those individuals who are not deterred should be prevented from committing economic crime by robust systems, which will be put in place in line with policy, standards and guidance.
- ▶ **Hold to account** those who have committed economic crime against the NHS. The Trust's LCFS is a professionally accredited investigator and is qualified to the required standards. Once allegations of suspected economic crime are received by the Trust, the LCFS must ensure that investigations are undertaken to satisfy national legislation. The Trust

encourages the prosecution of offenders, and where appropriate refers offenders to their professional bodies for disciplinary sanction. Economic crimes must be detected and investigated, suspects prosecuted where appropriate, and other methods of redress sought where possible. Where necessary and appropriate, economic crime, investigation and prosecution will take place locally wherever possible. Nevertheless the LCFS also works in partnership with the police and other crime prevention agencies to take investigations forward to criminal prosecution.

10. Governance

10.1 The Trust Board

The Board of Worcestershire Acute Hospitals NHS Trust sets the strategic direction for the Trust. The Trust is committed to setting high standards and the whole Board has signed up to the Nolan principles, requiring honesty and integrity in all matters.

The Non-Executive Directors (NEDs) bring a wealth of experience to the Trust Board, from private sector commercial business to management within a large public sector organisation. We have two Associate Non-Executive Directors supporting the work of the Board, specifically governance and finance/information technology.

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

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

The national emergency of COVID-19 meant that the Board needed to reconsider its way of working from the end of March 2020. It was determined that Board meetings would be

held virtually without the public (government social isolation requirements constitute 'special reasons' ref 001559 NHS publication) for at least the months of April and May 2020. Committee meeting agendas would be shortened with limited attendance, but at all times would be quorate during the major incident. I have held weekly virtual meetings with the Chair and the non-executive directors and the Chairman continues to have a regular presence on both main hospital sites. We have followed the guidance within the Russell and Reynolds paper Performance in a Crisis as well as the HFMA paper, NEDs and COVID-19.

In 2019/20 the Board met in public on 11 occasions, with meetings covering all three of our main sites. In the period covered by this annual report, the Board also held development sessions covering a wide range of topics including an in depth review of the Digital Care Record Business Case, the Digital Strategy, risk appetite and setting the strategic direction for the Trust. Additionally, the Board took part in Learning for Improvement, an NHS E/I sponsored development programme consisting of four seminars: organising for improvement, measurement for improvement, cultures and behaviours for improvement and governing for improvement.

The voting members of Trust Board during 2019/20 were as follows:

- **Paul Brennan**, Chief Operating Officer /Deputy CEO
- **Anita Day**, Non-Executive Director
- **Mike Hallissey**, Chief Medical Officer, *from July 2019*
- **Matthew Hopkins**, Chief Executive
- **Graham James**, Interim Chief Medical Officer – May 2019 – June 2019
- **Suneil Kapadia**, Chief Medical Officer *until May 2019*

- **Dame Julie Moore**, Non-Executive Director
- **Vicky Morris**, Chief Nursing Officer
- **Sir David Nicholson**, Chairman
- **Robert Toole**, Interim Chief Finance Officer *from 14 March 2019*, Chief Finance Officer *from September 2019*
- **Bill Tunnicliffe**, Non-Executive Director
- **Steve Williams**, Non-Executive Director
- **Mark Yates**, Non-Executive Director

Non-voting members of Trust Board

- **Richard Haynes**, Director of Communications and Engagement
- **Colin Horwath**, Associate Non-Executive Director
- **Helen Lewis (Vikki)**, Chief Digital Officer *from 27 January 2020*
- **Tina Ricketts**, Director of People and Culture
- **Richard Oosterom**, Associate Non-Executive Director
- **Kimara Sharpe**, Company Secretary
- **Sarah Smith**, Director of Strategy and Planning

At all meetings there were more Non-Executive Director voting members present than Executive Director voting members.

10.1.2 Public Board attendance

(maximum number of meetings – 11. Attendance is shown relative to the number of meetings that could have been attended)

		Attended
David Nicholson	Chairman	11/11
Matthew Hopkins	Chief Executive	10/11
Paul Brennan	Chief Operating Officer/Deputy CEO	10/11
Anita Day	Non-executive director	11/11
Mike Hallissey	Chief Medical Officer	7/8
Richard Haynes	Director of Communications	10/10*
Colin Horwath	Associate Non-Executive Director	10/11
Graham James	Interim CMO	2/2
Suneil Kapadia	Chief Medical Officer	1/1
Helen Lewis (Vikki)	Chief Digital Officer	1/3
Julie Moore	Associate Non-Executive Director	10/11
Vicky Morris	Chief Nursing Officer	8/10*
Richard Oosterom	Associate Non-Executive Director	9/11
Tina Ricketts	Director of People and Culture	10/11
Kimara Sharpe	Company Secretary	10/11
Sarah Smith	Director of Strategy and Planning	9/11
Robert Toole	Chief Finance Officer	11/11
Bill Tunnicliffe	Non-executive director	9/11
Steve Williams	Non-executive director	11/11
Mark Yates	Non-executive director	9/11

* due to a visit from the Secretary of State, these Directors were unable to attend one meeting.

10.2 Committees

All Committees of the Trust Board are chaired by a Non-Executive Director to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. This structure ensures that the performance of the organisation is fully scrutinised. The Committee structure supports the necessary

control mechanisms throughout the Trust. The Committees have met regularly throughout the year and each report to the Board following their meetings.

During 2019/20, the Trust Board had the following Committees:

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

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

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

Quality Governance
Learning from deaths Quality Improvement Strategy oversight Infection prevention and control Ward accreditation Deep dives Serious Incidents Complaints
Audit and Assurance
Review of effectiveness of Quality Governance/Finance and Performance/People and Culture Board Assurance Framework Data quality Local Security Management Specialist Anti-Fraud Internal Audit Reports

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

10.2.1 Audit and Assurance Committee

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

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

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

Chairman	Steve Williams	7/7
Non-Executive Director	Anita Day	6/7
Non-Executive Director	Mark Yates	7/7

10.2.2 Charitable Funds Committee

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

(maximum number of meetings – 4. Attendance is shown relative to the number of meetings that could have been attended)

Chairman	Mark Yates	4/4
Non-Executive Director	Anita Day	4/4
Non-Executive Director	Steve Williams	4/4

10.2.3 Finance and Performance Committee

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

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

Chairman	Richard Oosterom	10/12
Non-Executive Director	Steve Williams	12/12
Associate Non-Executive Director	Colin Horwath	12/12
Director of People and Culture	Tina Ricketts	10/11
Chief Medical Officer	Suneil Kapadia/ Mike Hallissey	8/11
Chief Nursing Officer	Vicky Morris	6/11
Chief Executive	Matthew Hopkins	7/12
Chief Operating Officer	Paul Brennan	9/11
Chief Finance Officer	Robert Toole	11/12
Director of Strategy and Planning	Sarah Smith	11/12
Chief Digital Officer	Helen Lewis (Vikki)	3/3

10.2.4 Quality Governance Committee

Purpose: The Quality Governance Committee:

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

The Quality Governance Committee is key to the assurance to the Trust Board in respect of the Quality Improvement. Membership and attendance at the QGC is shown below. The QGC also has regular attendance by a patient forum representative, HealthWatch and the CCGs.

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

Chairman	Bill Tunnicliffe	10/12
Chief Operating Officer	Paul Brennan	3/11
Chief Executive	Matthew Hopkins	8/11
Chief Medical Officer	Suneil Kapadia/ Mike Hallissey	11/11
Non-executive Director	Julie Moore	9/12
Chief Nursing Officer	Vicky Morris	8/12
Non-Executive Director	Mark Yates	10/12

10.2.5 Remuneration and Terms of Service Committee

Purpose: The Remuneration and Terms of Service Committee reviews the structure, size and composition of the Board and making recommendations for changes where appropriate.

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

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

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

Chairman	Sir David Nicholson	7/7
Non-Executive Director	Mark Yates	7/7
Non-Executive Director	Steve Williams	7/7

10.2.6 People and Culture Committee

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

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

Chairman	Mark Yates	7/7
Non-Executive Director	Anita Day	7/7
Chief Executive	Matthew Hopkins	5/7
Director of People and Culture	Tina Ricketts	7/7
Associate Non-Executive Director	Richard Oosterom	5/7
Director of Communications	Richard Haynes	4/6
Chief Medical Officer	Suneil Kapadia	1/1
Chief Nursing Officer	Vicky Morris	6/6
Chief Finance Officer	Robert Toole	3/6

10.3 Declaration of interests

The Trust has published an up-to-date register of interests, including gifts and hospitality, for decision-making staff (defined by the Trust as Executive Directors, Consultants and other staff on Band 8d and above) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. This is available on the Trust website at www.worcsacute.nhs.uk/our-trust/our-board

10.4 Provider licence conditions

The Trust considered its compliance with conditions FT4 and G6 of the provider licence (as at 31 March 2020) at the Board meeting in May 2020. These are set out below. This will be published on the website by 31 May 2020 as required by NHS Improvement.

Condition FT4

	Corporate Governance Statement	2020
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Not confirmed
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	Confirmed
3	<p>The Board is satisfied that the Licensee has established and implements:</p> <ul style="list-style-type: none"> (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation. 	Confirmed Confirmed Confirmed Confirmed
4	<p>The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:</p> <ul style="list-style-type: none"> (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements. 	Not confirmed Confirmed Confirmed Confirmed Not confirmed Confirmed Confirmed Confirmed Confirmed Confirmed Confirmed Confirmed

	Corporate Governance Statement	2020
5	<p>The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:</p> <ul style="list-style-type: none"> (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. 	Confirmed
6	<p>The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.</p>	Confirmed

Condition G6

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Not compliant

10.5 Climate Change

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

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

11.1 Finance

The External Auditor has indicated that he intends to issue a qualified Value for Money (VfM) Conclusion for 2019/20. Similarly, the Head of Internal Audit's limited assurance opinion indicates that there are caveats to his opinion with respect to the Trust's use of resources. In May 2019, the CQC Use of Resources (UOR) assessment, in relation to 2018/19 resulted in a UOR rating of Inadequate. The report concluded that: operational performance was below national standard and national average; workforce costs were high; there is significant scope to improve efficiency in the Trust's support services; and the financial position over recent years has been on a worsening trend.

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

- ▶ Approval of annual budget by the Trust Board.
- ▶ Detailed monthly review by the Finance and Performance Committee on key performance indicators covering finance and activity.
- ▶ Monthly oversight of the delivery of Cost Improvement Plans by the Finance and Performance Committee to ensure that savings targets are being met.
- ▶ Monthly Trust Management Executive meetings where key operational decisions are made.
- ▶ Monthly Divisional performance review meetings.
- ▶ Regular Budget Holder meetings.

The Trust reported a deficit excluding PSF, FRF and MRET funding and impairments for 2019/20 of £(81.5)m against a deficit plan of £(82.8)m for the year ended 31 March 2020. The Trust aspired to achieve a stretch deficit of £(73.7)m which was not achieved in-year. The Trust achieved efficiency savings of £12.0m against a £13.7m target. Of these savings, with the inclusion of £1.0m of full year effect benefit, £11.2m was achieved recurrently.

The financial deficit position for 2019/20 has required the Trust to access £65.5m of cash support from the DHSC to be able to maintain the payment of creditors through the year. The Trust also received capital loans of £7.7m and Public Dividend Capital (PDC) of £4.6m making the total new borrowings of £77.8m in 2019/20.

The Trust outsources elements of its transactional financial services to a third party supplier.

Assurance on the effective operation of the control environment is gained through measures including independent Auditor reports. In May 2020, the Trust received the supplier's Finance and Accounting ISAE3402 report, covering Finance and Accounting and associated general IT controls for the period 1 April 2019 to 31 March 2020. The audit did not identify any exceptions in respect of all twenty one control objectives, however, unfortunately due to COVID-19 and the closure of the supplier's India offices the auditors were unable to test a small number of controls for the period February 2020 to March 2020 and as a result a qualified opinion was issued. We have reviewed the audit report and are satisfied that no material control weaknesses were identified.

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

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

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

As part of the annual accounts review, the Trust's efficiency and effectiveness of its use of resources in delivering clinical services are assessed by its External Auditors and the auditor's qualified Value for Money Conclusion is published with the Trust's 2019/20 accounts.

11.2 Auditors

11.2.1 External Audit

The External Auditor has indicated that he intends to issue a qualified Value for Money (VfM) Conclusion for 2019/20. This is due to the Trust's financial deficit, performance management metrics, the CQC inspection and the Trust remaining in Special Measures. The qualified VfM Conclusion means that External Audit will not be providing assurance on effective use of resources for the year 2019/20. Similarly, the Head of Internal Audit's limited assurance opinion indicates that there are caveats to his opinion with respect to the Trust's use of resources.

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

11.2.2 Internal audit

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

The Head of Internal Audit Opinion for 2019/20 is as follows:

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

Commission (CQC), following inspection at that time. We acknowledge that the Trust has delivered improvements that have been reported in subsequent inspection (reported September 2019), which saw the Trust's overall CQC rating improve to Requires Improvement, within which use of resources was rated inadequate and the Trust continue to operate under licence conditions. In addition to remaining under Special Measures, the Trust has highlighted other significant internal control issues within its Annual Governance Statement, which includes its ongoing, serious underlying financial deficit.

The assurance levels provided for all assurance reviews undertaken (*denotes those at draft report stage) is summarised below:

Significant

- ▶ Financial Systems
- ▶ Data Quality
- ▶ Governance Arrangements*
- ▶ Budget Setting, Monitoring and Reporting Processes*

Moderate

- ▶ Trust Access Policy
- ▶ Job Planning*
- ▶ Bank and Agency Staffing*
- ▶ Financial Sustainability and Outcomes*

Limited

- ▶ None

12. Compliance with key national targets and standards

The Trust is committed to delivering all national and contractual targets and standards. On 31 March 2020, the Trust was non-compliant with the following key targets:

- ▶ Emergency Access Targets
- ▶ 18 weeks referral to treatment
 - incomplete pathways
- ▶ Cancer performance (62 days)
- ▶ Diagnostics waiting time
- ▶ C-Diff, MSSA and MRSA

13. Review of effectiveness

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

The Assurance Framework provides me with evidence that the effectiveness of controls put in place to manage the risks to the organisation achieving its principle objectives have been reviewed. The Assurance Framework will be reviewed in 2020/21 to ensure that it aligns with the strategic objectives of the Trust.

I am supported by the Executive Team, consisting of the Executive Directors. The Divisional Structure ensures that the Trust is clinically led. This restructuring of the Divisions in early 2020 to strengthen accountability within the Trust enables me to ensure that clinical leadership and management arrangements are in place supported

by robust and clear governance and accountability processes. During 2019, I have reviewed the directors' portfolios and clarified responsibilities. I have also appointed a Chief Digital Officer who has overall accountability for information governance and information technology. This post is the Senior Information Risk Owner (SIRO). The Chief Operating Officer is now accountable for the estates and facilities function. The change in portfolios means that the Chief Finance Officer can concentrate on Finance and Performance.

NHS Improvement appointed an Intensive Support Director to support us in turning around our performance. This post has been in place throughout 2019/20.

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

14. Conclusion

I consider that we have had six significant issues during the year 2019/20 as detailed below.

ISSUE 1

The Trust has remained in Quality Special Measures for the whole year 2019/20. This means that the Trust has enhanced oversight from NHS England/Improvement. The Trust agreed to a Statement of Undertakings (May 2019), progress with which was discussed at the Trust Board (meeting in public) in January 2020. This issue was on our Board Assurance Framework for 2019/20 (risk 2) and is on the BAF for 2020/21 (risk 4).

Following the CQC planned inspection in the summer 2019, the Trust was rated Requires Improvement overall. Previously it had been rated inadequate. The CQC recommended the Trust be removed from Quality Special Measures once

robust support from health partners was in place and the Trust achieved a sustained improvement in performance and quality.

As part of the CQC winter inspections, the Trust was visited on 16 December. Following this visit, the following conditions were imposed on the Trust's registration with the CQC:

► **Regulation 12 (2) (a) (b) (i)**

The trust must ensure that ambulance handovers are timely and effective.

► **Regulation 12 (2) (a) (b) (i)**

The trust must ensure that all patients are assessed in a timely manner and ensure that patients receive assessment and treatment in appropriate environments.

► **Regulation 12 (2) (a) (b) (i)**

The trust must ensure that patients receive medical and specialty reviews in a timely manner.

► **Regulation 12 (c)**

The trust must ensure that consultant and nurse cover in the department meets national guidelines. Trainee consultants must not be classed as 'consultants' on the staffing rota.

► **Regulation 12 (2) (a) (b) (i)**

Fully implement the trust wide actions to reduce overcrowding in the department.

► **Regulation 10 (1)**

The trust must ensure that the privacy and dignity of patients receiving care and treatment in the emergency department is maintained at all times.

In response to the notices, we took a number of immediate actions including

► Increased staffing in a range of areas across the emergency departments.

► Implementation of a Dynamic Trigger Tool (DTT).

- Daily safety/ escalation calls to Clinical Commissioning Group and NHSE/I.
- Quality Assurance Visits by CNO, DCNO's and Quality Improvement matron.

ISSUE 2

Key to the Trust being able to provide services in a timely manner is to ensure that there is flow through the hospitals which will enable patients arriving at the emergency departments to be admitted on a timely basis. The Trust has struggled to maintain flow during 2019/20 and developed the HomeFirst Worcestershire programme to improve the safety, efficiency and performance of the urgent and emergency care pathways at the Trust, focusing primarily on the elements of the pathway that are within our control.

The HFW Programme Board (chaired by the CEO) drives the implementation of the six work streams and the headline measures of improvement:

- Implementation of SAFER and Red2Green
- Reduction in Long Length of Stay
- Same Day Emergency Care (SDEC) and Primary care streaming
- Clinical Site Management
- Internal Professional Standards
- Implementation of a Frailty sensitive approach to care including Hospital Acquired Functional Decline (HAFD)

Key metrics have been developed to determine progress with the Programme and these are monitored through the Trust Management Executive and the Finance and Performance Committee, as well as Trust Board.

The Quality Governance Committee will be reviewing metrics in relation to the quality and safety aspects of the Programme and the People

and Culture Committee will start reviewing specific workforce indicators in 2020/21.

The System Improvement Board was developed during 2019/20 to hold system partners to account in relation to flow and discharge of patients. An Onward Care Team is in place (from February 2020) which is managed by the Health and Care Trust but attends ward rounds with both hospitals. An extra 33 beds have been opened within the Trust during 2019/20 and additional experienced consultants have been employed to ensure timely assessment within the emergency department. The Trust has also benefited from external support from ECIST (the emergency care intensive support team).

There was a system to Board meeting in January with NHS E/I. Assurance was given in respect of the system commitment to supporting the Trust in ensuring better flow through the hospitals.

The issue of patient flow was on the BAF for 2019/20 (risk 4) and is on the 2020/21 BAF (risks 1&5).

ISSUE 3

The Trust ended financial year 2019/20 with a deficit better than the submitted plan and forecast outturn but adverse to the internally set stretch target. The non-achievement of the stretch target deficit is driven by an inability to increase identification and in-year delivery of further CIP, as a result of continued requirement for additional capacity and workforce pressures.

A focussed piece of work was undertaken by the external auditors in January 2019 due to the deteriorating financial position in 2018/19. Eight issues were identified which the Trust acted upon and have monitored at subcommittee level, most recently in February 2020. The issues related to: deliverability of financial planning and cost improvement assumptions; ensuring cost improvements were embedded in start point budgets; developing a Board approved Medium Term Financial Plan; and ensuring key risks to

financial delivery and the impact of mitigating actions are understood by the Finance and Performance Committee and clearly reported to Board. The Trust did not sign up to its 2019/20 Control Total of £(64.6)m pre PSF, FRF and MRET funding as based on the assumptions and information available at the time it was not considered deliverable.

Whilst the Trust has met the submitted plan, the on-going deficit position remains a significant risk. Through the development of the Integrated Care System approach, a system finance forum meets regularly to ensure a collective approach to financial sustainability. Work has continued in year as a Trust and within the system to improve the system overall financial performance.

ISSUE 4

The Trust continues to have significant challenges in delivering key national standards. These include the 4-hour Emergency Access Target, 18 weeks referral to treatment – incomplete pathways and 62-day cancer performance standard. There was one patient who was waiting over 52 weeks for their first definitive as at 31st March 2020 and 155 waiting over 40 weeks, down from 357 as at 31st March 2019. In 2019/20 there were 9 reported breaches where patients were waiting longer than 52 weeks to receive their first definitive treatment on the RTT pathway, compared to 6 breaches in 2018/19. We have not achieved 3 of the 4 key infection prevention year end performance trajectories; namely C-Diff, MSSA and MRSA.

ISSUE 5

A significant element of the Trust's IT infrastructure is ageing to the point of obsolescence. This represents a risk to the current systems being used by the Trust in terms of performance, cybersecurity and even of system failure.

The ageing IT hardware is impacting on the Trust's ambition to improve patient care and clinical practice through the use of digital services such as the Digital Care Record and electronic prescribing.

The lack of investment in IT infrastructure has resulted in legacy technology debt which now needs to be resolved. The Trust recognises that the risk is no longer acceptable and is making capital available to remedy the worst components. The Trust also recognises that with increasing use of modern digital technologies the underlying technical infrastructure must be kept at an optimum level of operational effectiveness.

This will require ongoing investment in the core critical infrastructure to ensure resilient, secure digital platforms to meet the needs of improving the experience of both patients and staff through the deployment of digital technologies including the digital care record to build a long term sustainable future.

During the year, we approved the Digital Strategy and the business case for the Digital Care Record. 2020/21 will see the first year of the implementation of the digital care record.

The risks have been identified and monitored through the Board Assurance Framework for 2019/20 (risk 7&8) and 2020/21 (risks 6&8).

ISSUE 6

COVID-19 is the worst public health crisis for a generation. The Trust is following national guidance during this time and has invoked the major incident plan. The risk appears on the Board Assurance Framework and within the Corporate Risk Register, both rated as a 25.



Matthew Hopkins
Chief Executive

Date: 22nd June 2020



Members of the colorectal nursing team who were chosen as national finalists in the Nursing Times Awards.

Developments and highlights from 2019/20



Cardiac Physiologist,
Amanda Hayden



Consultant Radiologist,
Dr Ashim Lahiri

April 2019

- **Cardiac Physiologist, Amanda Hayden receives international recognition** after being asked to present about a life-saving heart case performed in Worcester, at the World Cardiology Conference in America.
- **Consultant Radiologist, Dr Ashim Lahiri receives 'Frank Farr Award'** by the regional West Midlands Association of Radiologists, in recognition of his 'exemplary commitment and contribution to training Radiologists in the West Midlands'.

June 2019

- **The catering team at the Alexandra Hospital receive a national prize for the quality and sustainability of food they produce.** The Soil Association's 'Food For Life Served Here' award is a widely respected acknowledgement of raising standards for food quality and sustainability in both public and private sector catering.
- **A 'Cake and Shake' scheme is put in place on Ward 12 at the Alexandra Hospital.** The daily slice of cake and a milkshake helps frail and elderly patients recover more quickly.
- **Maternity Bereavement team become national finalists in the NHS Parliamentary Awards.**

July 2019

- **The colorectal nursing team are chosen as national finalists in the cancer nursing category in the Nursing Times Awards.** The team were selected for the improvements they have made following the successful pilot of a new telephone triage system which has helped reduce waiting times for patients with suspected bowel cancer.
- **Julia Rhodes (pictured left) received the prestigious Society of Radiographers' Silver Medal award** after nominations from across the region.

August 2019

- **The national Infection Prevention Society (IPS) Awards chooses Sue Arthur among the finalists in the link practitioner of the year category.** Sue had recently received an internal award recognising her efforts and leadership to achieve high standards of infection prevention, improving patient safety and providing the best care for patients.



Members of the catering team at the Alexandra Hospital.



Staff on Ward 12 at the Alexandra Hospital delivering their 'Cake and Shake' round.



Lead Radiographer,
Julia Rhodes



Ward Housekeeper,
Sue Arthur.



September 2019

- The team running the Bowel cancer screening programme in Herefordshire and Worcestershire celebrates 10 years of helping to detect cancer earlier. The programme has proved to be a resounding success screening over 402,000 patients since its launch.
- Bereavement support midwife Ashlea Gormley is nominated for Midwife of the Year in the annual Butterfly Awards, which celebrates the survivors and champions of baby loss.
- The Trust's overall rating is lifted from 'Inadequate' to 'Requires Improvement' in a CQC report. The report showed improved ratings in 41 out of 79 categories rated, including double rating uplifts in 9 areas.



October 2019

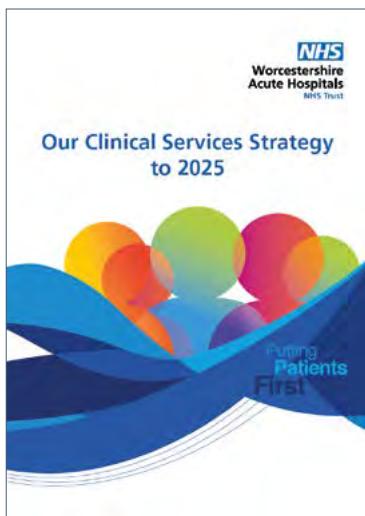
- The Trust holds its first 'pyramid week' - a chance to collectively remind colleagues of our purpose, vision and strategic objectives and celebrate how we are working towards delivery of these through our improvement plans, supporting strategies and 4ward behaviours to ensure we are always Putting Patients First.



- A new process to support people to get the care they would want in a medical emergency is introduced across healthcare settings in Worcestershire. The Recommended Summary Plan for Emergency Care and Treatment, or ReSPECT, creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.
- Endoscopy services awarded national accreditation by the Joint Advisory Group (JAG) of the Royal College of Physicians and British Society of Gastroenterology after a rigorous assessment process.

November 2019

- The Trust's Clinical Services Strategy is signed off. The strategy determines how and where our services will be delivered over the next five years.



- A £4.2million investment in endoscopy means that patients having endoscopy procedures for gastrointestinal, respiratory or urology-related conditions will receive more advanced investigations, including high-definition cameras and top-of-the-range optical technology – all of which allow for clearer examination of patients.

December 2019

- A new surgical assessment pathway is launched at Worcester. The aim of the new dedicated assessment areas in the Surgical Clinical Decision Unit (SCDU), is to help our number one priority of improving patient flow by enabling patients to be assessed by a surgical registrar, with a view to referring them to one of our daily clinics for continued investigation and advice if they do not need admission to a bed.
- Team Ruby and Team Sapphire – Continuity of Carer midwives from Worcestershire Acute Hospitals NHS Trust – are nominated for Team of the Year in the RCM Awards 2020. The roll out of the continuity of carer model – which aims to ensure that more mums-to-be see their named midwife, or a midwife from a small team, right through their pregnancy journey including birth – aim to ensure most pregnant women receive their care this way by 2021.



January 2020

- Patients, families and carers affected by cancer benefit from a new monthly programme of health and wellbeing events across Worcestershire aimed at encouraging a positive approach to moving forward after diagnosis. The events offer a 'one stop shop', providing advice and information across a range of topics.



- New mums who are separated from their babies immediately after birth are given iPads to help them bond with their child via a live video link. Babies that suffer complications or premature babies are often sent straight to a neonatal unit so they can receive specialist care, meaning that new mums can often spend hours, without being able to hold or bond with their new-born baby.
- Consultant Anaesthetist, Dr Satinder Dalay was awarded the highest honour by the Association of Anaesthetists at their 2020 meeting.

► Procurement Team (pictured left) receive national accreditation by Department of Health and Social Care.

February 2020

► Nurses and social care staff start working together to help ensure that hospital patients who are fit to go home, get there in a safe and timely way. The Onward Care Team (pictured above) ensure discharge from hospital is timely and effective, in turn reducing delays for people accessing urgent or emergency care.

► Two new, additional wards open at Worcestershire Royal Hospital, providing an extra 33 beds.

March 2020

► Kelly Bill, a Clinical Scientist from Worcestershire Royal Hospital, is shortlisted for the national Healthcare Scientist of the Year award. She was nominated by her colleagues after introducing a ground-breaking new way of assessing patients in the Neurophysiology department in Worcester.

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

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

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

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 entity's auditors are aware of that information.

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



Matthew Hopkins
Chief Executive

Date: 22nd June 2020

Statement of directors' responsibilities in respect of the accounts

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

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

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in

the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

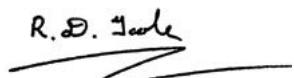
The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

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

By order of the Board.



Matthew Hopkins
Chief Executive



Robert D Toole
Chief Finance Officer

Date: 22nd June 2020

Date: 22nd June 2020

Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for Worcestershire Acute Hospitals NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2019/20 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:
 - the financial records maintained by the NHS Trust,
 - accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and,
 - the template accounting policies for NHS Trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.
2. I certify that the TAC schedules are internally consistent and that there are two validation errors which have been accepted by NHSI and Auditors.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.



Robert D Toole
Chief Finance Officer

Date: 22nd June 2020

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Trust is required to submit to NHS Improvement.
2. I have reviewed the schedules and agree the statements made by the Chief Finance Officer above.



Matthew Hopkins
Chief Executive

Date: 22nd June 2020



Staff Report - Creating a Great Place to Work

The Trust's **People and Culture** strategy, agreed by the Trust Board in November 2017, acts as the framework to ensure the Trust's workforce is safely configured and empowered to provide high quality care. It undertakes to assure the board that the workforce is engaged, skilled and supported, working in a culture shaped by our 4 signature behaviours.

The 4ward Programme



4ward is the 'way we do things around here' at the Trust which has now been embedded since October 2017. 4ward is a long-term, far-reaching initiative which aims to help colleagues across our Trust work more effectively together in a spirit of mutual support and respect as we tackle the challenges we face and make the most of the opportunities that the future will bring.

For colleagues across the organisation, 4ward is how we will deliver the best possible care for our patients ensuring they have the best experience and that we are always putting them first in everything that we do. 4ward helps to create a great culture, one which encourages innovation, new ideas and supports colleagues.

At the heart of 4ward are four signature behaviours. Our aim is to have all our staff positively demonstrating these behaviours and working together to achieve our shared goals.

The behaviours are:

-  Do what we say we will do
-  No delays, every day
-  We listen, we learn, we lead
-  Work together, celebrate together

Look back

4ward has helped us to achieve a number of improvements across our organisation over the last two years as colleagues work together to face some of our challenges. Some examples of these improvements are as follows:

CQC report

4ward helped us to deliver an improved CQC position during our inspection in May and June 2019 with the organisation moving from inadequate to overall ratings of requires improvement and a good rating for Kidderminster Treatment Centre. CQC mentioned 4wards impact a number of times within their report including:



"The culture had positively changed, with team working collaboratively to achieve a common goal."



"We also saw examples of where long-standing attitudinal issues in some areas were addressed immediately by the leadership team."



"We saw that all strategies, planned processes and documents reflected the signature behaviours and staff articulated and demonstrated them."



"The 4ward programme was embedded with staff aware of the signature behaviours' and evidencing them in all processes."

Reference as at 30.01.20: <https://www.cqc.org.uk/provider/RWP/reports>.

Staff Survey Results 2019

Our final response rate for the 2019 survey was 39% (2,331) colleagues.

We saw year-on-year improvements across all 11 of the themed areas, with our Trust ranking average or better than average for equality, diversion and inclusion; quality of care; team working; offering a safe working environment; and staff morale.

These latest results give us much cause for optimism, and reflect the hard work that has been taking place over the last few months as part of our People and Culture Strategy and 4ward – both of which aim to create a more positive, supportive working environment.

Our focus now is on improving the experience of all our staff. We will be undertaking a full review of the staff survey results against our People and Culture Strategy and drawing up an action plan in partnership with each division and our staff, as well as sharing more information about what is being done in response to feedback from colleagues.

4ward Advocates

We currently have 400 4ward advocates working across the organisation and championing the 4ward behaviours. Some of our most successful 4ward advocate initiatives are explained in more detail below:

Pyramid Launch

The launch in 2019 of our Putting Patients First strategy 'pyramid' puts our 4ward behaviours at the heart of our vision for the future of the Trust, enhancing opportunities for our advocates to actively support the delivery of our strategic objectives. 4ward advocates helped to launch our new strategy, were engaged during the development stages and helped to socialise it with colleagues across the organisation.



Happy Cafés

The launch of Happy Cafés took place in October 2019 at Worcestershire Royal Hospital, Kidderminster Treatment Centre and the Alexandra Hospital. In the spirit of our 4ward behaviour 'Work together, celebrate together' and in line with our People & Culture Strategy and 'Best People' strategic objective, a 4ward advocate proposed the idea of the Trust launching a Happy Café for staff in partnership with Action for Happiness (<https://www.actionforhappiness.org/>).

A Happy Café (pictured above) is a place where those seeking happier lives for themselves and others can connect with each other over a coffee and learn science-based skills for enhancing psychological wellbeing. Happy cafés provide a safe space for colleagues to focus on their health and wellbeing whilst promoting mindfulness.

#ThankYouThursday

4ward advocates continue to support our #ThankYouThursday initiative which encourages colleagues to thank those around them for excellent practice and for demonstrating our 4ward behaviours. 4ward advocates also linked this initiative to World Mental Health Day and World Kindness Day.

Some of the other successes of 4ward advocates include:

- ▶ A fortnight-long celebration across all sites of '2 years of 4ward' in October 2019.
- ▶ A cohort of 400 Advocates and advocate development programme to support these colleagues in becoming local cultural leaders.
- ▶ Over 1000 #Thank You Thursdays issued over the last year.



- Celebration of #WorldMentalHealthDay and #WorldKindnessDay for the first time in the Trust's history.
- Successful launch and embedding of Trustwide Happy Cafés (Health and wellbeing cafés held for colleagues across the organisation).
- Helped to create, share and celebrate our award-winning Staff Facebook Group www.facebook.com/groups/WorcsAcuteStaff/
- 4ward behaviour boards on every single ward linking 4ward behaviours to #PuttingPatientsFirst and encouraging 4ward language to be embedded at all levels.
- Patient engagement including a patient 'we do this by' and audit tool developed to see how 4ward is impacting our patients' experience.
- Greater levels of staff engagement.
- Improved staff survey results.
- Greater community engagement as 4ward advocates bridge the gap with local homeless shelters, food banks and local businesses.
- An improved recruitment and retention position.
- Evidence of improvement for most recent CQC inspection this summer.
- The first-ever BIG #ThankYouThursday from our Executive Team was awarded to our 4ward advocates.
- Another 50 4ward showcases published in Worcestershire Weekly.

Communication

All staff have access to information through a number of different communication channels. Our Chief Executive provides a weekly email update to all staff, and weekly staff e-bulletin; 'Worcestershire Weekly' shares key information about Trust initiatives and news.

We also publish comprehensive news updates, policies and other information of relevance and interest to staff on the Trust intranet and award-winning staff Facebook group.

There are a number of other Trust forums, such as our Senior Leaders Brief and Meet the Chief Sessions which act as an opportunity for leaders and staff to learn more and ask questions on policy and performance issues.

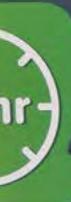
We work in partnership with Staff Side colleagues through the formal Joint Negotiation and Consultative Committee, which meets monthly. In addition, we encourage participation from Staff Side representatives, and staff at all levels from across the Trust, to take a role within our People and Culture Committee Group including, 4ward Culture Change Group.

Freedom to Speak Up Themes

The following table provides an overview of the concerns raised through the Freedom to Speak up Guardian in 2019. There were 79 instances raised although some were group reports so the number of staff affected will be more than 79. From the table it can be seen that 113 of the cases relate to poor attitudes and behaviours.

Summary of concerns raised to the Freedom to Speak Up Guardian in 2019:

Total number of speak up incidences	79
Total number of speak up incidences reported anonymously	5
Total number of speak up incidences where there was a bullying or harassment element	113 where attitudes and behaviours was a theme
Total number of speak up incidences where there was a patient safety or quality element	1 quality; 15 patient experience
Total number of speak up incidences where there was a perception of detriment to the reporter	None recorded



Our Workforce

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

The Trust launched its Recruitment and Retention Plan in February 2018 and submits a Recruitment and Retention Assurance Report to People and Culture Committee quarterly. The recruitment and retention of our staff remains a key priority and focus has been given to the challenging areas this year, of doctors and nurses.

Significant reductions in vacancy numbers and staff turnover have been achieved in both staff groups following various campaigns which have included showcasing the Trust as an employer of choice through social media campaigns, targeted local recruitment within specialist areas, open days and an overseas recruitment project for doctors.

However, there are a number of service changes that have taken place this year that have increased our workforce by 246 FTE due to recruitment to vacancies and opening of additional wards to respond to capacity and flow issues.

Snapshot of key workforce indicators:

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Trendline
Cumulative Sickness Absence Rate	4.09%	4.35%	4.27%	4.17%	4.20%	4.72%	
Actual staff in post in full-time equivalent (FTE)	5079.14	5083	5106.18	5199.57	5316.38	5566.85	
Headcount staff in post	5959	5935	5951	6055	6207	6453	
Mandatory Training Compliance	78%	76%	89%	89%	84%**	89%	
Appraisal Completion %	78%	80%	76%	65%	77%	81%	
Staff Turnover	10.42%	12.97%	12.57%	11.04%	12.30%	11.12%	

** Drop in compliance in 2018/19 is due to breaking mandatory training down into levels rather than reporting at base level.

Sickness Absence

In the last year the cumulative absence rate has deteriorated slightly by 0.50% to 4.72%. We monitor our sickness rates against the national and peer median via the Model Hospital.

Our sickness was better than the national average on Model Hospital in September 2019 which is the most up to date comparison data. Our sickness was 4.23% on Model Hospital compared to national average of 4.35% which demonstrates that we are not an outlier:

Staff Sickness	2016-17	2017-18	2018-19	2019-20	Trendline
Total FTE Days lost	80,277	76,071	80,266	88,100	
Total staff (headcount)	5,951	6,055	6,207	6,453	
Average number of working days lost	13.48	12.56	12.93	13.65	

Absence due to Covid-19

In addition to sickness absence the Trust has experienced other absence due to self-isolation, social distancing and shielding which have been dealt with as paid medical suspension in line with national guidance. These absences range from 7 days for symptomatic staff, 14 days for those with a family member symptomatic and 12 weeks for shielding.

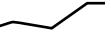
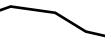
As at 31st March 2020 the absence levels related to Covid 19 medical suspensions were as follows:

Staff Group	Total
Add Prof Scientific and Technic	28
Additional Clinical Services	237
Administrative and Clerical	197
Allied Health Professionals	96
Estates and Ancillary	65
Healthcare Scientists	26
Medical and Dental	74
Nursing and Midwifery Registered	291
GP Trainees	34
Grand Total	1048

Staff Turnover

We have been closely monitoring overall Trust turnover since it started steadily increasing in July 2015 peaking at 13.03% in November 2016. Our overall staff turnover has been reducing since July 2015 to 11.12% in March 2020 which is within Trust target of 12% despite the increase in establishment.

Our breakdown of staff by staff group as at 31st March 2020 is as follows:

Workforce profile	FTE					Trendline
	31 March 2016	31 March 2017	31 March 2018	31 March 2019	31 March 2020	
Additional Prof. Scientific and Technic.	169.96	179.43	174	191.32	193.42	
Additional Clinical Services	942.48	950.72	977.43	995.04	1,050.37	
Administrative and Clerical	913.58	957.75	966.76	995.65	1,043.24	
Allied Health Professionals	339.21	332.92	344.64	363.15	356.21	
Estates and Ancillary	256.12	246.11	259.68	278.94	293.55	
Healthcare Scientists	175.17	176.75	178.88	178.88	174.43	
Medical and Dental	590.93	553.15	581.88	606.82	653.25	
Nursing and Midwifery Registered	1,673.65	1,678.35	1,692.29	1,697.58	1,800.38	
Students	19	29	24	9.00	2	
Grand Total	5,080.09	5,104.18	5,199.57	5,316.38	5,566.85	

Our profile of Senior Managers as at 31st March 2020 was as follows:

Senior Managers Profile as at 31 March 2020						
Staff Category	Band 8	Band 9	Consultant	Trust Board	Total	
Trust Board (Female)				6		6
Trust Board (Male)				9		9
Senior Manager (Female)	78	3	7			88
Senior Manager (Male)	20	1	25			46
Grand Total	98	4	32	15	149	

Vacancies

The Trust has relied on a high percentage of agency workers to address additional capacity due to the opening of additional wards. The breakdown of staff as at 31st March 2020 was as follows:

Substantive/Bank/Agency as at Month 12 (Source - Finance ADI)	Funded WTE	Contracted WTE	Vacant WTE	Worked WTE
Agency	3.4	0	3.4	298.64
Bank	68.29	0	68.29	409.24
Substantive	6017.98	5634.98	383	5571.89
Grand Total	6089.67	5634.98	454.69	6279.77

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

From the staff on our payroll on ESR as at 31st March 2020 we had the following assignment categories:

Assignment Category	Sum of FTE	Sum of Employee Headcount
Fixed Term Temp	486.32	526
Locum	2.13	3
Permanent	5078.40	5924
Grand Total	5566.85	6453

The total staff costs for 2019/20, excluding remuneration of non-executive directors are:

Staff Cost 2019/20	Permanent £'000	Other £'000	Total £'000
Salaries and Wages	206,009	0	206,009
Social Security Costs	20,373	1,543	21,916
Apprenticeship Levy	1,056	0	1,056
NHS Pension Costs	35,923	937	36,860
Other Pension Costs	0	62	62
Temporary Staff	0	49,228	49,228
Less: recoveries in respect of outward secondments (where treated net).	0	0	0
Total Staff Costs	263,361	51,770	315,131

(Audited)

The analysis of average WTE employed are below by category:

Average number of employees (WTE basis 2019/20)	Permanent Number	Other Number	Total Number
Medical and dental	634	104	738
Ambulance staff	1	-	1
Administration and estates	1,047	9	1,056
Healthcare assistants and other support staff	1,263	179	1,442
Nursing, midwifery and health visiting staff	1,727	331	2,058
Nursing, midwifery and health visiting learners	7	-	7
Scientific, therapeutic and technical staff	569	22	591
Healthcare science staff	194	-	194
Social care staff	-	-	0
Other	-	-	0
Total Average Numbers	5,442	645	6,087

(Audited)

Health and Wellbeing

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

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

Occupational Health record the reasons (from the staff member's perspective) of what is contributing to their work related stress. Of 146 cases recorded to March 31st 2020, 42 (29%) were due to workload, 28 (19%) were due to investigations or being performance managed, 24 (16%) were due to relationship issues with manager, 15 (10%) were due to working relationships with colleagues and 11 (7%) were due to working hours. 12 (8%) were a combination of above.

The Occupational Health Team have worked with our Counselling provider to offer a wide range of emotional support as part of our COVID-19 response.

Staff Appraisals

The Trust believes appraisals are vital in valuing staff and all staff should have an appraisal every year. The Trust's appraisal rate for non-medical staff as at 31 March 2020 improved to 81% from 77% last year and 65% the previous year. However this is still short of our target against a Model Hospital average of 83%.

Appraisal was to be linked to pay progression for new managers and staff from 2020 and for all staff from 2021 which will be a key driver in improving our appraisal rates. This has been put on hold nationally for 2020 as part of the national COVID-19 response.

Electronic Staff Record – Self Service

The Trust rolled out ESR Employee Self Service in October 2017. This enables all staff to view the information that is recorded about them on the payroll system and to update their own personal information. It also enables them to view their training compliance via a Competency Matrix which is RAG rated and sends them reminders four months before their training is due to expire.

ESR Employee Self Service continues to be a key tool in improving our training and appraisal compliance. We have also rolled out electronic payslips in 2019/20 to reduce IG risks and provide staff with up to date information at all times.

Employee Policies

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

Equality and Diversity

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

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

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

We have published our Workforce Race Equality Scheme (WRES) data on the national portal and on our intranet and website. As at 31st March 2020 the ethnic breakdown of our staff was as follows:

Headcount by Ethnicity as at 31 March 2020			
Ethnicity	Female	Male	Total
Asian or Asian British	505	232	737
Black or Black British	79	31	110
Mixed Race	43	23	66
Not Stated / Undisclosed	35	9	44
Other	78	40	118
White	4589	789	5378
Grand Total	5329	1124	6453

Gender Pay Gap

In accordance with the Equality Act 2010 (Gender Pay Gap Information Regulations 2017), the Trust has undertaken a gender pay gap review for 31 March 2017, 31 March 2018 and 31 March 2019. The results have been uploaded into the designated government portal and on the Trust's website.

As at 31st March 2019, the Trust had 6186 employees of which 5084 (82.203%) were female and 1101 (17.80%) were male. This ratio is not reflected in certain occupational categories.

Average Mean Hourly Rates as at 31 March 2019	
Gender	Avg. Hourly Rate
Male	£23.4880
Female	£15.7669
Difference	£7.7211
Pay Gap %	32.87%

It is noted that in including all staff, this information is skewed by the numbers of male employees in senior medical posts and particularly bank/agency doctor posts. 66.6% of our consultant workforce are male. When we remove all doctors (including agency/bank doctors) from

the calculation the gender pay gap shows a small pay difference of 0.85% in favour of males. This is a slight change from last year where the difference was 1.15% in a more favourable position for females.

Average Mean Hourly Rates as at 31 March 2019 (excluding doctors)	
Gender	Avg. Hourly Rate
Male	£15.0132
Female	£14.8858
Difference	£0.1273
Pay Gap %	0.85%

Remuneration Report

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

Role of the Remuneration Committee

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

Membership of the Remuneration Committee

The membership of the Trust's Remuneration Committee comprises of two Non-Executive Directors, plus the Chairman.

- ▶ Chairman Sir David Nicholson commenced from 14th May 2018 until the present date.

Non-Executive Directors:

- ▶ Mr Mark Yates
- ▶ Mr Stephen Williams

Senior Manager's Remuneration Policy

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

All Executive Directors are on permanent contracts. Notice and termination payments are made in accordance with NHS Improvement guidance and contracts of employment.

New Executive Directors were appointed this year: Mike Hallisey (Chief Medical Officer); and Helen Lewis (Vikki) (Chief Digital Officer). Suneil Kapadia (Chief Medical Officer) resigned in May 2019.

Robert Toole, Chief Finance Officer was appointed substantively in September 2019. Prior to this he was in post on an interim basis.

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

		2019/2020								2018/2019											
		Salary and fees		All taxable benefits		All pension-related benefits		Total		Salary and fees		All taxable benefits		All pension-related benefits		Total					
		£000s (in bands of £5k)		£s (nearest £100)		£000s (in bands of £2.5k)		£000s (bands of £5k)		£000s (in bands of £5k)		£s (nearest £100)		£000s (in bands of £2.5k)		£000s (bands of £5k)					
Job title (and period of office if relevant)		35	-	40	0		-	35	-	40	35	-	40	0		-	35	-	40		
David Nicholson	Trust Chairman	35	-	40	0		-	35	-	40	35	-	40	0		-	35	-	40		
Matthew Hopkins	Chief Executive	210	-	215	500		-	210	-	215	40	-	45	0		-	40	-	45		
Paul Brennan	Chief Operating Officer & Deputy Chief Executive	170	-	175	0		-	170	-	175	75	-	80	0		-	75	-	80		
Mike Hallisey	Chief Medical Officer - from 25.06.19 (secondment)	75	-	80	0		-	75	-	80	-	-	-	0		-	-	-	-		
Suneil Kapadia	Chief Medical Officer - to 07.05.19	15	-	20	0		-	15	-	20	185	-	190	0		-	185	-	190		
Victoria Morris	Chief Nursing Officer	125	-	130	0	7.5	-	10	135	-	140	125	-	130	0		-	125	-	130	
Robert D Toole	Chief Finance Officer	150	-	155	1,800	27.5	-	30	180	-	185	5	-	10	0		-	5	-	10	
Jill Robinson	Director of Finance (seconded)	70	-	75	0	37.5	-	40	110	-	115	140	-	145	200	22.5	-	25.0	160	-	165
Sarah Smith	Director of Strategy & Planning	105	-	110	0	27.5	-	30	135	-	140	95	-	100	0	115.0	-	117.5	210	-	215
Richard Haynes	Director of Communications & Engagement	100	-	105	0	22.5	-	25	125	-	130	95	-	100	100	65.0	-	67.5	160	-	165
Tina Ricketts	Director of People & Culture	120	-	125	200	22.5	-	25	145	-	150	110	-	115	100	60	-	62.5	170	-	175
Helen Lewis (known as Vikki)	Chief Digital Officer - from 27.01.2020	20	-	25	0	67.5	-	70	90	-	95	-	-	-	0		-	-	-	-	-

(Audited)

NOTES

- All taxable benefits relate to cars and the benefits in kind are based on the HMRC guidance.
 - Pension related benefits have been calculated in line with the 2019/20 Group Accounting Manual 2019/20.
 - There are no performance pay, long-term performance pay or bonuses for the directors in either 2018/19 or 2019/20.
- **Chair**
Sir D. Nicholson remains as the Chair
- **Chief Executive**
Mr M. Hopkins remains as the Chief Executive
- **Chief Finance Officer**
Mr R. D Toole remains as the Chief Finance Officer.
- **Chief Operating Officer**
Mr P. Brennan remains as the Chief Operating Officer.
- **Chief Nursing Officer**
Ms V. Morris remains as the Chief Nursing Officer.
- **Chief Medical Officer**
Mr M Hallisey commenced as the Chief Medical Officer on 25 June 2019.
- **Chief Digital Officer**
Ms H Lewis commenced as the Chief Digital Officer on 27 January 2020.

Non-Executive Directors

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

Job title (and period of office if relevant)		2019/20							2018/19												
		Salary and fees			All taxable benefits	All pension-related benefits			Total	Salary and fees			All taxable benefits	All pension-related benefits							
		£000s (in bands of £5k)		£s (nearest £100)	£000s (in bands of £2.5k)			£000s (bands of £5k)	£000s (in bands of £5k)		£s (nearest £100)	£000s (in bands of £2.5k)			£000s (bands of £5k)						
Job title (and period of office if relevant)																					
Anita Day	Non Executive Director	5	-	10	1,200		-		5	-	10	0	-	5	1,000		-		0	-	5
William Tunnicliffe	Non Executive Director	5	-	10	0		-		5	-	10	5	-	10	0		-		5	-	10
Steven Williams	Non Executive Director	5	-	10	2,300		-		5	-	10	5	-	10	700		-		5	-	10
Mark Yates	Non Executive Director	5	-	10	700		-		5	-	10	5	-	10	800		-		5	-	10
Colin Horwath	Non Executive Director	5	-	10	1,200		-		5	-	10	0	-	5	0		-		0	-	5
Julie Moore	Non Executive Director	5	-	10	0		-		5	-	10	0	-	5	0		-		0	-	5
Richard Oosterom	Non Executive Director	10	-	15	0		-		10	-	15	5	-	10	0		-		5	-	10

(Audited)

NOTES

- All taxable benefits relate to cars and the benefits in kind are based on the HMRC guidance.

Pension Benefits

Pension related benefits represent the benefit in year from participating in the NHS Pension Scheme, including any previous posts held in the Trust prior to becoming a Very Senior Manager (Board Member). The amount is calculated by taking the full pension due to the Director upon retirement if they were to retire at 31 March 2020 and deducting the equivalent value from the amount due at 31 March 2019.

This includes lump sum and annual pension entitlement and uses a factor of 20 for grossing up purposes in accordance with the HMRC method (derived from section 229 of the Finance Act 2004). Where no figures are calculated for 2019/20 the Director was either not a Director at the beginning of the year or is not a member of the NHS Pension Scheme.

Salary and Pension Entitlements of Senior Managers – Pension Benefits

	Real Increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension age at pension age at 31 March 2020	Lump sum at pension age related to accrued pension at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 01 April 2019	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Matthew Hopkins	0	0	0	0	0	0	0	0
Jill Robinson	0-2.5	0-2.5	25-30	0-5	429	395	34	10.37
Victoria Morris	0-2.5	2.5-5	45-50	140-145	1,034	1,003	31	18.81
Tina Ricketts	0-2.5	0	25-30	55-60	511	491	20	17.15
Sarah Smith	0-2.5	5-7.5	35-40	115-120	915	862	53	15.01
Richard Haynes	0-2.5	0	15-20	35-40	313	298	15	14.58
Paul Brennan	0	0	55-60	165-170	1,310	1,853	0	17.62
Helen Lewis (known as Vikki)	0-2.5	0-2.5	20-25	50-55	456	395	61	3.11
Robert D Toole	2.5-5	2.5-5	25-30	65-70	593	563	30	21.57

(Audited)

Notes

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member as a particular point in time. The CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme.

The Real increase in CETV takes into account the increase in accrued pension due to inflation, contributions paid by the employee.

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

The table on page 83 details the current pension benefits of the Trust's senior managers. As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of Non Executives. Where the Executive Director in post at 31 March 2020 is not a member of the NHS Pension Scheme, there are no pension benefits to be disclosed.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the Scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that

the individual has accrued as a consequence of their total membership of the NHS Pension Scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the Scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement (a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design).

During the year, the Government announced that public sector pension schemes will be required to provide the same indexation in payment on part of a public service scheme pensions known as the Guaranteed Minimum Pension (GMP) as applied to the remainder of the pension i.e. the non GMP. Previously the GMP did not receive full indexation. This means that with effect from August 2019 the method used by NHS Pensions to calculate CETV values was updated. So the method in force at 31 March 2020 is different to the method used to calculate the value at 31 March 2019. The real increase in CETV will therefore be impacted (and will in effect include any increase in CETV due to the change in GMP methodology).

Exit Packages

The figures disclosed below relate to exit packages agreed in the year. The actual date of departure might be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period.

The data here is therefore presented on a different basis to other staff cost and expenditure notes in the accounts. A single Exit Package can be made up of several components, each of which is counted separately in this note.

Exit Package Cost Band (including any special payment element)	Number of Compulsory Redundancies	Cost of Compulsory Redundancies	Number of Other Departures Agreed	Cost of Other Departures Agreed	Total Number of Exit Packages	Total Cost of Exit Packages	Number of Departures Where Special Payments Have Been Made	Costs of Special Payment Element included in Exit Packages
		£		£		£		£
Less than £10,000			5	4,580				
£10,000 to £25,000			1	15,000				
£25,001 to £50,000			1	30,833				
£50,001 to £100,000								
£100,001 to £150,000			1	120,773				
£150,001 to £200,000								
> £200,000								
Totals			8	171,187				

(Audited)

No non-contractual payments were made to employees where the payment value was more than 12 months' of their annual salary. The Remuneration Report includes disclosure of exit payments made to individuals named in that report.

Exit Package - disclosures (excluding compulsory redundancies)	Number of Exit Package Agreements	Total Value of Agreements £
Voluntary Redundancies including Early Retirement Contractual Costs	1	1,964
Mutually Agreed Resignations (MARS) Contractual Costs	0	0
Early Retirements in the Efficiency of the Service Contractual Costs	1	30,833
Contractual Payments in Lieu of Notice	4	2,616
Exit Payments Following Employment Tribunals or Court Orders	2	135,773
Non-Contractual Payments Requiring HM Treasury Approval	0	0
Totals	8	171,187

(Audited)

Off Payroll Engagements

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

Audit around its IR35 processes and received "full assurance".

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

Off-payroll engagements longer than 6 months: For all payroll engagements as at 31 March 2020, for more than £245 per day and that last longer than six months.	Number of engagements
Number of existing engagements as at 31 March 2020	4
Number that have existed for less than one year at a time of reporting	2
Number that have existed for between one and two years at a time of reporting	0
Number that have existed for between two and three years at a time of reporting	1
Number that have existed for between three and four years at a time of reporting	1

New off-payroll engagements: All new payroll engagements, or those that have reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months.	Number of engagements
Number of new engagements, or those that reached six months duration between 1 April 2019 and 31 March 2020	3
Of which:	
▶ Number assessed as within the scope of IR35	
▶ Number assessed as not within the scope of IR35	3
▶ Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	
▶ Number of engagements reassessed for consistency/assurance purposes during the year	
▶ Number of engagements that saw a change to IR35 status following the consistency review	

Fair Pay Disclosure (Audited)

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

The banded remuneration of the highest paid Director at Worcestershire Acute Hospitals NHS Trust in the financial year 2019/20 was between £210k–215K. This was 8.2 times the median remuneration of the workforce, which was £26,220.

In 2018/19 the banded remuneration highest paid Director was £185-190k which was 7.7 times the median remuneration of £28,050. There has been a change to the most highly paid Director as they have been in post for the full financial year.

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

During the year 2 employees received remuneration in excess of the highest paid director. In 2018/19 6 employees received remuneration in excess of the highest paid director.

Remuneration ranged from £5,338 and £209,300 for 2019/20. The range of remuneration for 2018/19 was between £4,100 and £237,300.



Grant Thornton

The Annual Audit Letter for Worcestershire Acute Hospitals NHS Trust

Year ended 31 March 2020

14 July 2020



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A Reports issued and fees

Executive Summary

Purpose

Our Annual Audit Letter (Letter) summarises the key findings arising from the work that we have carried out at Worcestershire Acute Hospitals NHS Trust (the Trust) for the year ended 31 March 2020.

This Letter is intended to provide a commentary on the results of our work to the Trust and external stakeholders, and to highlight issues that we wish to draw to the attention of the public. In preparing this Letter, we have followed the National Audit Office (NAO)'s Code of Audit Practice and Auditor Guidance Note (AGN) 07 – 'Auditor Reporting'. We reported the detailed findings from our audit work to the Trust's Audit and Assurance Committee as those charged with governance in our Audit Findings Report on 15 June 2020.

Our work

Materiality	We determined materiality for the audit of the Trust's financial statements to be £7.0 million, which is 1.5% of the Trust's gross revenue expenditure.
Financial Statements opinion	<p>We gave a qualified opinion on the Trust's financial statements on 22 June 2020.</p> <ul style="list-style-type: none">• We qualified the audit opinion due to a limitation of scope as due to the Covid19 pandemic we were unable to attend the planned stocktakes at year end• We included a going concern material uncertainty paragraph in our report on the Trust's financial statements to draw attention to the note which explains the basis on which the Trust has determined that it is still a going concern.• We included an emphasis of matter paragraph in our report on the uncertainty over asset valuations as at 31 March 2020 due to the pandemic.
NHS Group consolidation template (WGA)	We also reported on the consistency of the financial statements consolidation template provided to the National Audit Office with the audited financial statements. We concluded that these were consistent.
Use of statutory powers	We referred a matter to the Secretary of State, as required by section 30 of the Act, on 2 April 2020 because the Trust had taken a course of action that has led to a breach of the Trust's breakeven duty for the three-year period ending 31 March 2020.

Respective responsibilities

We have carried out our audit in accordance with the NAO's Code of Audit Practice, which reflects the requirements of the Local Audit and Accountability Act 2014 (the Act). Our key responsibilities are to:

- give an opinion on the Trust's financial statements (section two)
- assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion) (section three).

In our audit of the Trust's financial statements, we comply with International Standards on Auditing (UK) (ISAs) and other guidance issued by the NAO.

Executive Summary

Value for Money arrangements	We were not satisfied that the Trust put in place proper arrangements to ensure economy, efficiency and effectiveness in its use of resources because of the matters we identified in respect of operational performance and CQC assessment, and the management of the Trust's finances. We therefore issued an adverse value for money conclusion in our audit report to the Directors of the Trust on 22 June 2020.
Quality Accounts	Due to the Covid-19 pandemic, the Department of Health and Social Care suspended the requirement for the Trust's Quality Accounts to be certified.
Certificate	We certified that we had completed the audit of the financial statements of Worcestershire Acute Hospitals NHS Trust in accordance with the requirements of the Code of Audit Practice on 22 June 2020.

Executive Summary

NHS

#ThankYouNHS

Working with the Trust

This has been a year like no other for all of us and for the Trust as a healthcare provider. Trust staff have been on the front-line in the national effort to contain and manage the pandemic and save lives. This has reminded us how lucky we are to have the NHS and what a fantastic and dedicated workforce Worcestershire Acute Hospitals NHS Trust has. We thank you for your commitment to and care for all patients you treat.

Before the pandemic hit the Trust was continuing to respond to both the patient care and financial challenges it was facing. The improvement in the Care Quality Commission (CQC) rating to 'requires improvement' was encouraging and recognised that the Trust's leadership was moving the organisation in the right direction. However, system wide pressures remained, not least the management of emergency care patient flows. These were brought into sharp focus by the CQC's findings of its unannounced visits to the Trust's Emergency Departments. The Trust has both increased its bed capacity and is working with its partners to improve this situation.

The Trust financial challenge remains severe. Although the Trust delivered a financial outcome in 2019/20 within its budget, the annual deficit was over £80 million and cash support in excess of £60 million was required to keep the Trust solvent. Understanding the scale and nature of the Trust's structural deficit and implementing a plan to reduce the annual deficit to this level is in our view a key priority for the Trust Board.

Our overall value for money conclusion, whilst recognising the positive steps the Trust is making is again an 'adverse' qualification. The Trust needs to make further demonstrable improvements in both its operational performance and financial management.

Delivering the annual report and accounts for audit during at the height of the national lock down put more pressure on the Trust's Finance Team. Extended deadlines for completion of the annual report and accounts and audit were set by the DHSC to reflect the increased challenges producing and auditing accounts remotely and the new risks associated with Covid19.

The quality of the working papers to support the balances in the accounts was good in many areas and the Trust team were responsive to our requests for information. However, our work took more time to complete, due to the challenges of remote working, and the quality of the evidence that was supplied to support some of our sample testing.

In previous years our audit opinion has drawn attention to the going concern "material uncertainty" disclosure in the Trust's accounts. As a result of the uncertainties in the property market due to the pandemic there was also a "material uncertainty" disclosure relating to the valuation of land and buildings in the accounts. We drew attention to both of these material uncertainties in our audit opinion.

The Trust was unable to fully complete stock takes in all areas and we were unable to gain our planned audit assurance over the inventory balance in the accounts. We concluded that it was necessary to issue a qualified limitation of scope audit opinion. This was due to uncertainty over the completeness of the inventory reported in the accounts. It is not indicative of any governance or control failures in the Trust's management of its inventory. NHS England and NHS Improvement have confirmed that there will be no adverse consequences as a result of this.

We would like to record our appreciation for the assistance and co-operation provided to us during our audit by the Trust's staff during these extraordinary times.

Grant Thornton UK LLP
July 2020

Audit of the Financial Statements

Our audit approach

Materiality

In our audit of the Trust's financial statements, we use the concept of materiality to determine the nature, timing and extent of our work, and in evaluating the results of our work. We define materiality as the size of the misstatement in the financial statements that would lead a reasonably knowledgeable person to change or influence their economic decisions.

We determined materiality for the audit of the Trust's financial statements to be £7.0 million, which is 1.5% of the Trust's gross revenue expenditure. We used this benchmark as, in our view, users of the Trust's financial statements are most interested in where the Trust has spent its revenue in the year.

We also set a lower level of specific materiality for senior officer remuneration of £100,000 and £200,000 for the Cash Equivalent Transfer Value of senior officer pensions.

We set a lower threshold of £300,000, above which we reported errors to the Audit and Assurance Committee in our Audit Findings Report.

The scope of our audit

Our audit involves obtaining sufficient evidence about the amounts and disclosures in the financial statements to give reasonable assurance that they are free from material misstatement, whether caused by fraud or error. This includes assessing whether:

- the accounting policies are appropriate, have been consistently applied and adequately disclosed;
- the significant accounting estimates made by management are reasonable; and
- the overall presentation of the financial statements gives a true and fair view.

We also read the remainder of the Annual Report to check it is consistent with our understanding of the Trust and with the financial statements included in the Annual Report on which we gave our opinion.

We carry out our audit in accordance with ISAs (UK) and the NAO Code of Audit Practice. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based.

We identified key risks and set out overleaf the work we performed in response to these risks and the results of this work.

Audit of the Financial Statements

Significant Audit Risks

These are the significant risks which had the greatest impact on our overall strategy and where we focused more of our work.

Risks reported in our audit plan and audit findings report	How we responded to the risk
<p>Covid19</p> <p>In our audit plan addendum we noted our expectation that the Covid19 pandemic would have an impact on the production and audit of the financial statements for the year ended 31 March 2020, including but not limited to:</p> <ul style="list-style-type: none">• remote working arrangements and redeployment of staff to critical front line duties impacting on the quality and timing of the production of the financial statements, and the evidence we can obtain through physical observation• the volatility of financial and property markets increasing the uncertainty of assumptions applied by management to asset valuation and receivable recovery estimates, and the reliability of evidence we can obtain to corroborate management estimates• financial uncertainty requiring management to reconsider financial forecasts supporting their going concern assessment and whether material uncertainties have arisen; and• disclosures revisions within the financial statements to reflect the unprecedented situation and its impact on the preparation of the financial statements as at 31 March 2020 in accordance with IAS1.	<p>As part of our audit work we:</p> <ul style="list-style-type: none">• evaluated the adequacy of the disclosures in the financial statements that arose in light of the Covid-19 pandemic• evaluated whether sufficient audit evidence could be obtained in the absence of physical verification of assets through remote technology• evaluated whether sufficient audit evidence could be obtained to corroborate significant management estimates such as asset valuations and recovery of receivable balances• evaluated management's assumptions that underpinned financial forecasts and the impact on management's going concern assessment• discussed with management any potential implications for our audit report where we were unable to obtain sufficient audit evidence. <p>Auditor findings</p> <p>The main areas of the accounts impacted by COVID -19 were:</p> <ul style="list-style-type: none">• Inventories (stock): we were unable to attend sufficient stock takes to provide the planned assurance over the accuracy and completeness of stock• Property, plant and equipment: the valuer included reference to material valuation uncertainty in relation to his valuations due to the uncertainty in the current property market.• Going concern: reflecting the Trust's financial deficit, the lack of secure plans to achieve a balanced budget and the uncertainty around funding arrangements for much of 2020/21 and the following year. <p>These matters were referred to in our audit opinion.</p>

Audit of the Financial Statements

Risks reported in our audit plan and audit findings report	How we responded to the risk
<p>Going concern material uncertainty disclosures</p> <p>It has been a challenging year due to the impact of the Covid-19 pandemic on the Trust. This has included the need to free up capacity resulting in the cancellation of planned treatments, staff sickness absence, and a high influx of patients with Covid-19 in addition to the Trust's normal patient care responsibilities. With the outbreak of the pandemic the NHS implemented changes to funding arrangements and confirmed that trusts' expenditure will be supported, including additional funding for specific Covid-19 related additional costs. Funding arrangements were confirmed for the first four months of 2020/21 but not for the remainder of the year.</p> <p>The Trust is facing significant financial challenges and has reported a (£81.5m) deficit position for 2019/20, with further budget deficits forecast for 2020/21 and 2021/22. The Trust forecast a deficit of (£78.9m) in its annual plan for 2020/21 (before the interim financial arrangements were put in place) and the draft medium term financial plan confirms that annual deficits will continue for the foreseeable future. It therefore seems probable that the Trust will require further cash support in 2020/21 and 2021/22 to pay its expenses in these years.</p> <p>The source and amount of support is not confirmed although NHS England and NHS Improvement have assured provider trusts that access to distressed revenue financing will continue to be available under the new capital and cash regime.</p> <p>We identified the adequacy of disclosures relating to material uncertainties that may cast doubt on the Trust's ability to continue as a going concern in the financial statements as a significant risk.</p>	<p>As part of our audit work we considered management's assessment process for confirming that the Trust is a going concern and its disclosure of a "going concern" "material uncertainty" in note 1.2 of the accounts.</p> <ul style="list-style-type: none">Management prepared a going concern assessment which was presented to the Trust's Finance and Performance (F&P) Committee in February 2020, and Trust Board in March 2020. An assessment was also made by management in the 'informing the risk assessment' audit planning document presented to the March 2020 Audit and Assurance Committee. A draft medium term financial plan (MTFP) has been prepared and considered by the F&P committee in December 2019.We reviewed managements assessment and the cash flow forecast prepared up to June 2021, and considered the key assumptions of both.We carried out a detailed review of the Trust's outturn and underlying financial challenges as part of our value for money conclusion work.We also reviewed the going concern disclosure in the draft accounts and suggested changes which were made in the final version of the accounts. <p>Auditor findings</p> <p>We agreed that there is a going concern material uncertainty and draw attention to this in our audit opinion. Our opinion is not modified in respect of this matter.</p>

Audit of the Financial Statements

Risks reported in our audit plan and audit findings report	How we responded to the risk
<p>Income from contract variations and other operating revenue</p> <p>Trusts are facing significant external pressure to restrain budget overspends and meet financial targets, coupled with increasing patient demand and cost pressures. In this environment, we considered whether there was a material fraud risk in the recognition of revenue streams.</p> <p>We concluded that there was a low risk of material fraud in:</p> <ul style="list-style-type: none"> • the block contract income element of patient care revenues; and • education and training income. <p>We focused our attention on the variable elements of patient care income and other operating revenue. We identified the occurrence and accuracy of these income streams and the existence of associated receivable balances as a significant risk of material misstatement.</p>	<p>As part of our audit work we:</p> <ul style="list-style-type: none"> • evaluated the Trust's accounting policy for recognition of income from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2019/20. • updated our understanding of the Trust's system for accounting for income from patient care activities and evaluated the design of the associated controls. • reviewed all significant signed contracts with commissioners and schedules of variations, and confirmed annual amounts and payment mechanisms to the signed contracts. • tested a sample of contract variations and agreed these back to supporting evidence, ensuring that the income belonged to the Trust, had been recorded in the correct financial year and any judgements made by management were reasonable. • considered the DHSC mismatch report and investigated unmatched revenue and receivable balances over the NAO £0.3m threshold. <p>Auditor findings</p> <p>No significant matters arose from our work.</p>
<p>Management override of internal controls</p> <p>Management override controls is a risk requiring special audit consideration.</p> <p>The Trust faces external pressures to meet the agreed targets, and this could potentially place management under undue pressure in terms of how they report performance.</p>	<p>As part of our audit work we tested journal postings in the Trust's ledger. In particular we:</p> <ul style="list-style-type: none"> • evaluated the design effectiveness of management controls over journals • analysed the journals listing and determined our criteria for selecting high risk journals • tested high risk journals made during the year and at the accounts production stage for appropriateness and corroboration. <p>We also:</p> <ul style="list-style-type: none"> • gained an understanding of the accounting estimates and critical judgements applied by management and considered their reasonableness • evaluated the rationale for any changes in accounting policies, estimates or significant unusual transactions. <p>Auditor findings</p> <p>No significant matters arose from our work.</p>

Audit of the Financial Statements

Risks reported in our audit plan audit findings report	How we responded to the risk
<p>Valuation of Property, plant and equipment</p> <p>Revaluation of property, plant and equipment should be 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. Additionally, the valuation is a material and significant estimate made by management in the accounts.</p> <p>We identified land and buildings revaluations and impairments as a risk requiring special audit consideration.</p>	<p>As part of our work we:</p> <ul style="list-style-type: none">evaluated management's processes and assumptions for the calculation of the valuation estimate, the instructions issued to the valuation experts and the scope of their workevaluated the competence, capabilities and objectivity of the valuation expertwrote to the valuer to confirm the basis on which the valuations were carried outused our own valuation expert and challenged the information and assumptions used by the valuer to assess the completeness and consistency of the valuationtested a sample of revaluations made during the year to ensure they had been input correctly into the Trust's asset registerconsidered the impact of uncertainty in the property market due to the Covid-19 pandemic, how the valuer had taken this into account and the disclosure in the accounts. <p>Auditor findings</p> <p>We noted that whilst the Trust provided accurate Gross Internal Area information to the valuer it was not specified how much of this area was used by each department within the hospitals (the valuation can differ based on the purpose of a particular area of each hospital). We did some simple sensitivity analysis of the impact of this approach and concluded that the maximum impact would be a misstatement of the valuation by £927k.</p> <p>The valuer concluded that the valuation was subject to material uncertainty due to the unknown impact of the Covid-19 pandemic on the property market. This material uncertainty is referred to in note 1.33 of the accounts and we have made reference to this in our audit opinion. Our opinion is not modified in respect of this matter.</p>

Audit of the Financial Statements

Other Risks and Issues

These are new issues and risks which were identified during the course of the audit that were not previously communicated in the Audit Plan.

Risks and issues reported in our audit findings report	How we responded to the risk or issue
Inventory As a result of the Covid-19 restrictions and Major Incident status, the Trust was unable to fully complete stock takes in all areas and made reasonable adjustment to assess stock balances at year-end. We attended the stock takes in pharmacy at the Worcestershire Royal Hospital on 10 March and the Alexandra Hospital on 6 March. We were not able to attend the stocktake at Worcestershire Royal Hospital theatres due to the impact of Covid-19. At our stock attendances we noted difference to records and stock counts which were subsequently adjusted for.	We were able to gain sufficient assurance over the accuracy and completeness of inventory for £2.7m of the £8.9m balance. At the time of drafting our audit findings report we were considering whether there was a risk that the untested £6.2m balance was understated and could be in excess of £7.0m (our materiality level). We noted that £2.2m the 'general stock' carrying value was rolled forward from 2018/19 and an error in the 2018/19 balance means there is no comparative for the £0.6m of 'ward drugs'. Auditor findings Following discussions with management and consideration by our national consistency panel we concluded that it was necessary to issue a qualified limitation of scope audit opinion. This was due to uncertainty over the completeness of the inventory reported in the accounts. It is not indicative of any governance or control failures in the Trust's management of its inventory. NHS England and NHS Improvement have written to all providers to confirm that "There will be no adverse consequences from an NHS England and NHS Improvement oversight perspective for trusts with a qualified opinion resulting from limitation of scope on inventory."
IFRS 16 Leases implementation Although the implementation of IFRS 16, the new leasing standard, has been delayed to 1 April 2021, the Trust still needed to include disclosure in the 2019/2020 financial statements. As a minimum the following needed to be disclosed; the title of the standard, the date of initial application and the nature of the changes in accounting policy for leases.	We considered the paper the Trust produced to assess IFRS16 implementation and concluded that the approach adopted was reasonable. The deferral of implementation is referenced in the accounts (note 1.31) with the conclusion that it is not possible to make an accurate financial assessment of the impact of the standard due to the delay in implementation. Auditor findings The Trust's 2019/20 accounts include the required disclosures

Audit of the Financial Statements

Audit opinion

We gave a qualified due to limitation of scope on stock opinion on the Trust's financial statements on 22 June 2020.

Preparation of the financial statements

The Trust presented us with draft financial statements in accordance with the revised national deadline and pandemic lockdown restrictions. A good set of working papers was provided to support the draft accounts. The finance team responded promptly and efficiently to our queries remotely during the course of the audit. There were however some areas where further improvements are required which we have brought to management's attention.

Issues arising from the audit of the financial statements

We reported the key issues from our audit to the Trust's Audit and Assurance Committee on 15 June 2020. These are summarised in this Annual Audit Letter.

Annual Report, including the Annual Governance Statement

We are also required to review the Trust's Annual Report, including the Annual Governance Statement. It provided these on a timely basis with the draft financial statements with supporting evidence.

We reviewed the Annual Report and completed our audit testing on the auditable elements of the Report. We also reviewed and commented on the draft Annual Governance Statement.

Whole of Government Accounts (WGA)

We issued a group return to the National Audit Office in respect of Whole of Government Accounts, which did not identify any issues for the group auditor to consider.

Other statutory powers

We are also required to refer certain matters to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. On 2 April 2020 we reported to the Secretary of State that Trust had breached its financial duty to breakeven taking one year with another.

Certificate of closure of the audit

We certified that we have completed the audit of the financial statements of Worcestershire Acute Hospitals NHS Trust in accordance with the requirements of the Code of Audit Practice on 22 June 2020.

Value for Money conclusion

Background

We carried out our review in accordance with the NAO Code of Audit Practice, following the guidance issued by the NAO in April 2020 which specified the criterion for auditors to evaluate:

In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people.

Key findings

Our main considerations were:

- Financial performance in 2019/20 and its financial planning for 2020/21 and beyond before the impact of the Covid19 pandemic.
- Progress made with our 2018/19 financial planning recommendations.
- Outcomes of Care Quality Commission (CQC) reviews of the Trust during 2019/20 and the Trust's response
- Performance against the four key national standards, Emergency Access, Diagnostics Six Week Waits, Referral to Treatment (RTT) in 18 Weeks and All Cancer 62 Day Waits.

We noted overall that the Trust was making progress with its improvement agenda before the Covid-19 pandemic. Moving from an 'inadequate' CQC rating to 'requires improvement' was an important achievement.

The Trust continued to struggle with capacity issues in both of its Emergency Departments and it was both disappointing and concerning that following an unannounced CQC visit in December they were both assessed as 'inadequate' and an enforcement notice was issued. The additional capacity generated by the capital investment in the Worcestershire Royal Hospital site and the partnership leadership through the "Home First Worcestershire" programme are designed to alleviate these pressures.

Overall performance indicated by the four key national standards was mixed. The Trust did not achieve its agreed trajectory for any of these standards at the end of 2019/20, but clearly since February 2020 the pandemic has impacted on this. During the year there were significant improvements against the Diagnostics Six Week Waits and RTT in 18 Weeks standard.

The Trust continued to manage a major financial challenge. Although the overall financial delivery was within the (£82.8)m planned deficit, the "stretch target" set by the Board was not achieved.

Based on the planning assumptions included in the 2020/21 Annual Plan a deficit of (£78.9)m is forecast and it is clear that without financial support the Trust will continue to have annual deficits. Understanding the scale and nature of the Trust's structural deficit and reducing the level of dependence on bank and agency staff are in our view key priorities for the Trust's financial planning and management.

Critical Business Continuity

We considered the arrangements to maintain critical business continuity during the Covid-19 pandemic as reported to the April 2020 Board meeting. This included revisions to governance arrangements, the Trust's operational response and the temporary revised financial controls in place. The Trust has taken clear actions to maintain business continuity during the Covid-19 Pandemic.

Overall Value for Money conclusion

Because of the significance of the matters we identified in our work, we were not satisfied that the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2020.

Value for Money conclusion

Value for Money Risks

Risks identified in our audit plan and audit findings report	Findings and conclusions
<p>Informed decision-making: operational performance and CQC assessment</p> <p>In our audit plan we said that the Trust was assessed as "requires improvement" in the CQCs report published in September 2019. Following an unannounced visit in December 2019 the Trust's emergency department was rated as "inadequate". We also said that delivery of key national targets is a continuing challenge for the Trust. Particular concerns exist in urgent care and patient flow.</p>	<p>Care Quality Commission Assessment</p> <p>The Trust's latest inspection report was published on the 20 September 2019 following an inspection visit in May and a well-led visit in June 2019. It also included a Use of Resources assessment for the first time. The overall rating was an improvement on the previous two inspections, moving the Trust up to requires improvement. CQC made a recommendation that the Trust should be taken out of Special measures, although at this current time the Trust remains in special measures.</p> <p>The Trust was rated as good for the effective and caring domains and requires improvement for the safe, responsive and well-led domains. It is pleasing to note that the inspection report also highlighted outstanding practice in diagnostic imaging at the Alexandra Hospital.</p> <p>Areas for improvement included four regulations breaches in urgent and emergency services, surgery, maternity, and end of life care services.</p> <p>In December 2019, the CQC carried out unannounced visits to the Trust's Emergency Departments at the Worcestershire Royal Hospital and the Alexandra Hospital. They concluded that both departments were inadequate and issued an enforcement notice. This reflected the concerns on the time taken to assess people on arrival, the adequacy of risk assessments and the impact of overcrowding. It was however also noted that staff are professional and caring and leaders and staff are committed to improvements to keep patients safe and improve the patient experience.</p> <p>Responding to Care Quality Commission Assessment</p> <p>During 2019/20 the Trust responded to the issues raised by the CQC's assessments with the central aim of improving patient care and the patient experience. The completion of the Aconbury link bridge on Worcestershire Royal Hospital site enabled the opening of much needed additional acute capacity.</p> <p>The Trust has also worked with its partners to develop the "Home First Worcestershire" programme. The aim of the programme is to improve the safety, efficiency and performance of the urgent and emergency care pathways. Although this is helping to ensure a system-wide to patient flow issues the findings of the CQC unannounced visit clearly indicated that further improvements are urgently needed.</p> <p>Trust leadership are giving priority to providing a clear organisational direction and has published the Clinical Services Strategy to 2025. It states a clear commitment to "lead the delivery of comprehensive integrated healthcare in Worcestershire providing the best possible patient experience and outcomes."</p>

Value for Money conclusion

Value for Money Risks

Risks identified in our audit plan and audit findings report	Findings and conclusions
<p>Informed decision-making: operational performance and CQC assessment</p> <p>In our audit plan we said that the Trust was assessed as "requires improvement" in the CQCs report published in September 2019. Following an unannounced visit in December 2019 the Trust's emergency department was rated as "inadequate". We also said that delivery of key national targets is a continuing challenge for the Trust. Particular concerns exist in urgent care and patient flow.</p>	<p>Performance against national targets</p> <p>We considered the Trust's performance against the four key national standards, Emergency Access, Diagnostics Six Week Waits, Referral to Treatment (RTT) in 18 Weeks and All Cancer 62 Day Waits. For all of these standards monthly trajectories were agreed with NHS Improvement at the start of 2019/20. The Trust did not achieve planned trajectory for any of these national standards in February or March 2020. There were, however, significant improvements in performance during the year against the Diagnostics Six Week Waits and RTT in 18 Weeks standard.</p> <p>Auditor conclusions</p> <p>Overall, the Trust has demonstrated improvements that are reflected in its improved CQC rating and it has responded positively to the issues raised in CQC assessments. The outcome of the unannounced emergency department visits was disappointing and reflects the continuing need to improve both patient flows and the physical environments in both of the Trust's emergency departments.</p> <p>There is now a clear improvement plan for the Trust, centred on the Clinical Services Strategy to 2025 with clear milestones to achieve.</p> <p>Responding to Covid-19 has stress tested many of the Trust's arrangements and it has had to be highly adaptive whilst staff have been working under extreme pressure. Nationally the pandemic has resulted in decreases in patients presenting at hospitals for non-Covid-19 related illnesses. There is however an expectation that as the pandemic passes, numbers will again increase. The Trust leadership has identified a clear focus on both the "Restoration" and "Recovery" phases and the opportunities for transformation on care delivery.</p> <p>The Trust's performance against national standards continued to be below the required level throughout 2019/20. It is however encouraging to see improvements against two of the four standards and longer-term capacity and patient flow measures should help to deliver improvements in the Emergency Access standard. Performance against the cancer waiting metrics needs to improve.</p> <p>The Covid-19 pandemic has resulted in a national decrease in people presenting at hospitals for non-Covid-19 related illness. There is however an expectation that as the pandemic passes, numbers will again increase, and the Trust will face challenges in improving its performance against national standards</p>

Value for Money conclusion

Value for Money Risks

Risks identified in our audit plan and audit findings report	Findings and conclusions
<p>Sustainable resource deployment: Management of Trust Finances</p> <p>We said in our audit plan that the Trust continues to face very significant financial challenges. The Trust did not agree with the NHSI control total set for 2019/20. The Trust set a financial plan with a year-end deficit of £(82.8) m. We noted that the Trust was reporting against, and managing the financial position in line with this plan. We also said that a timetable for producing a three-year financial plan was expected to be provided by the Director of Finance in December 2019 and that the Trust had been assessed as inadequate in its Use of Resources assessment.</p> <p>We said we would review the arrangements for managing and reporting financial resources. We also said we would review progress with our 2018/19 recommendations and how the Trust is responding to the issues raised in its Use of Resources Assessment.</p>	<p>Managing and reporting financial resources: 2019/20</p> <p>The Trust committed to delivering a deficit of no more than £(82.8)million with a "stretch target" of £(73.7)million. The Trust did not sign up to the regulator's control total of £(64.4)m (excluding PSF, FRF and MRET funding) as the Board concluded that this was not deliverable.</p> <p>The year-end financial position was a £(81.5)m deficit, a £1.3m favourable variance against plan, but a £(7.8)m adverse variance against the stretch target. There was additional cost impact in March due to the Trust's response to managing the Covid-19 pandemic. The main reasons identified by the Trust for not achieving the stretch target were that:</p> <ul style="list-style-type: none">• demand in emergency care pathways was significantly in excess of the system plan leading to premium costs for additional staffing with only marginal recovery of income; and• -insufficient identification and delivery of recurrent productivity and efficiency improvement schemes. <p>Overall income was £10.0 million more than originally planned (prior to inclusion of notional income to reflect the nationally paid additional pension contributions). The favourable variance was largely due to the national approach to 2019/20 contract settlements and reimbursements in response to the Covid-19 pandemic.</p> <p>Total pay costs including bank and agency were very close to plan overall. The full year agency staffing spending exceeded the agency cost ceiling by £12.0 million. Non- pay expenditure exceeded the original plan by £6.7m.</p> <p>The Trust delivered cost and efficiency savings totalling £12.0 million. The 2019/20 financial plan included a savings requirement of £13.7m, although the Board set a more challenging target of £22.5 million.</p> <p>The Trust continued to rely on additional cash support from the DHSC to maintain its financial liquidity enabling it to meet its pay bill and pay its creditors. During 2019/20 the net additional revenue cash support was £63.6 million.</p>

Value for Money conclusion

Value for Money Risks

Risks identified in our audit plan and audit findings report	Findings and conclusions
<p>Sustainable resource deployment: Management of Trust Finances</p> <p>We said in our audit plan that the Trust continues to face very significant financial challenges. The Trust did not agree with the NHSI control total set for 2019/20. The Trust set a financial plan with a year-end deficit of £(82.8) m. We noted that the Trust was reporting against, and managing the financial position in line with this plan. We also said that a timetable for producing a three-year financial plan was expected to be provided by the Director of Finance in December 2019 and that the Trust had been assessed as inadequate in its Use of Resources assessment.</p> <p>We said we would review the arrangements for managing and reporting financial resources. We also said we would review progress with our 2018/19 recommendations and how the Trust is responding to the issues raised in its Use of Resources Assessment.</p>	<p>Financial Planning 2020/21 and the Medium-Term Financial Plan</p> <p>As part of the national response to the Covid-19 pandemic the national financial planning exercise for 2020/21 was suspended and at the time of drafting this was still the case. NHS England and NHS Improvement also simplified funding arrangements for at least the first four months of 2020/21. It also made clear that the additional costs of dealing with the pandemic would be funded. The Trust's financial planning assumptions for 2020/21 have therefore been largely superseded by the impact of the pandemic and at the time of drafting it was not clear whether and for how long these arrangements would be extended.</p> <p>The Trust's draft Annual Plan for 2020/21 was considered by the Board at its March 2020 meeting. Continued growth in activity is assumed, particularly in A&E attendances and outpatients. It is recognised that workforce efficiencies are key to financial delivery. Based on the planning assumptions included in the Annual Plan a deficit of £(78.9) million is forecast for 2020/21.</p> <p>The draft Medium-Term Financial Plan (MTFP) covers the period to 2023/24. The overall aim of the MTFP is to reduce the annual deficit to no more than the level of the structural deficit. It was intended to do more work on analysing and understanding the structural deficit in the last quarter of 2019/20 but was curtailed due to the Covid-19 pandemic.</p> <p>It is noted in the draft MTFP that the Trust has been issued with a Financial Improvement Trajectory that requires the delivery of a £(35.6) million deficit in 2023/24. The draft MTFP identifies two other trajectories, the 'Modelled Deficit' with 2.5% efficiencies that would deliver a 2023/24 deficit of £(68.0) million and a 'Stretch 3.5% Efficiency' that would deliver a 2023/24 deficit of £(44.9) million. The deficit forecast in the 2020/21 Annual Plan is in line with the 'Modelled Deficit'. Prior to the suspension of the planning cycle, the Trust had been working with system partners to model the system financial position against the system Financial Improvement Trajectory.</p>

Value for Money conclusion

Value for Money Risks

Risks identified in our audit plan and audit findings report	Findings and conclusions
<p>Sustainable resource deployment: Management of Trust Finances</p> <p>We said in our audit plan that the Trust continues to face very significant financial challenges. The Trust did not agree with the NHSI control total set for 2019/20. The Trust set a financial plan with a year-end deficit of £(82.8) m. We noted that the Trust was reporting against, and managing the financial position in line with this plan. We also said that a timetable for producing a three-year financial plan was expected to be provided by the Director of Finance in December 2019 and that the Trust had been assessed as inadequate in its Use of Resources assessment.</p> <p>We said we would review the arrangements for managing and reporting financial resources. We also said we would review progress with our 2018/19 recommendations and how the Trust is responding to the issues raised in its Use of Resources Assessment.</p>	<p>Auditor conclusion</p> <p>The Trust continues to face a fundamental financial issue with the scale of its deficit. The Board recognised at the outset of the year that it was important to work to a realistic financial target but was also clear that a more challenging target should be delivered. Although it is disappointing that the Trust was not on course to deliver this stretch target before the financial impact of the response to Covid-19, the agreed financial plan was delivered.</p> <p>The Trust's Use of Resources Assessment highlighted key improvement areas that the Trust has continued to maintain a focus on. It has further developed its partnership working and has moved forward with its strategic planning. There are however continuing significant issues that need to be addressed including high workforce costs and below average operational performance.</p> <p>The Trust has responded positively to our 2018/19 financial planning recommendations and it is pleasing to note the progress made. There are still big challenges for the Trust and its partners in moving to a sustainable financial position.</p> <p>It is clear from both the draft Annual Plan 2020/21 and the draft MTFP that the Trust's financial challenges will continue for the foreseeable future. It does, however, remain to be seen what impact the national response to the Covid-19 pandemic will have on the Trust's future finances. The underlying key dynamics to achieve financial sustainability remain. Understanding the scale and nature of the Trust's structural deficit and reducing the level of dependence on bank and agency staff are central to this.</p>

A. Reports issued and fees

We confirm below our final reports issued and fees charged for the audit.

Reports issued

Report	Date issued
Audit Plan	14 Jan 2020 (draft) 10 March 2020 (final)
Audit Plan Update	12 May 2020
Audit Findings Report	15 June 2020
Annual Audit Letter	14 July 2020

Fees

	Planned £	Actual fees 2018/19 fees £	2018/19 fees £
Statutory audit			
- Audit contract	40,000	40,000	40,000
- Fee variation	5,000	5,000	10,000
- Additional fee due to remote working/ Covid19 impact		6,000	
Sub-total	45,000	51,000	50,000
Charitable fund	2,000	2,000	2,000
Total fees	47,000	53,000	52,000

Fees for non-audit services

Service	Fees £
Audit related services	Nil
- None (Quality Accounts audit not required £6,000 proposed fee)	
Non-Audit related services	Nil
- None	

Non- audit services

- For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust. The table above summarises all non-audit services which were identified.
- We have considered whether non-audit services might be perceived as a threat to our independence as the Trust's auditor and have ensured that appropriate safeguards are put in place.

Trust's Annual General Meeting

The date and venue of the Annual General Meeting of Worcestershire Acute Hospitals NHS Trust has yet to be agreed, due to the current COVID-19 outbreak.

Further information can be obtained by writing to:

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

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

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



www.worcsacute.nhs.uk



Published: September 2020



Putting Patients First

Worcestershire Acute Hospitals NHS Trust

Annual accounts for the year ended 31 March 2020

Statement of Comprehensive Income

		2019/20	2018/19
	Note	£000	£000
Operating income from patient care activities	3	416,176	381,078
Other operating income	4	27,546	30,888
Operating expenses	7, 9	(514,924)	(472,151)
Operating surplus/(deficit) from continuing operations		(71,202)	(60,185)
Finance income	12	191	134
Finance expenses	13.1	(17,349)	(15,693)
Net finance costs		(17,158)	(15,559)
Other gains / (losses)	14	29	40
Surplus / (deficit) for the year		(88,331)	(75,704)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(2,217)	13,694
Revaluations		791	7,109
Total comprehensive income / (expense) for the period		(89,757)	(54,901)
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(88,331)	(75,704)
Remove net impairments not scoring to the Departmental expenditure limit		7,288	6,828
Remove (gains) / losses on transfers by absorption		-	-
Remove I&E impact of capital grants and donations		70	86
Remove 2018/19 post audit PSF reallocation (2019/20 only)		(493)	-
Adjusted financial performance surplus / (deficit)		(81,466)	(68,790)

The Trust deficit of £(88.331)m includes the exceptional items of £(7.288)m for asset impairments and transfers, which along with the donated asset impact of £70k. These items are due to the Trust requirement to report its assets at the current fair value over the appropriate life of the asset. This is a non cash technical adjustment. The adjusted financial deficit (against which our performance is measured) is £(81.466)m after these adjustments.

Financial Position - Income & Expenditure	Actual 2019/20 £000s	Actual 2018/19 £000s
Operational (Adjusted) financial performance surplus/(deficit) excluding PSF, FRF, MRET funding and Impairments	(81,466)	(73,712)
Adjust Provider Sustainability Funding (PSF)	4,922	
Performance Against Control Total / Plan adjusted to include PSF	(81,466)	(68,790)
Adjust Remove impact of prior year PSF post accounts reallocation	493	
Adjust Remove capital donations/grants I&E impact	(70)	(86)
Adjust I&E impairments/(reversals)	(7,288)	(6,828)
Surplus/(deficit) for the year including PSF, FRF and MRET funding and after Impairments	(88,331)	(75,704)

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	15.1	3,103	2,574
Property, plant and equipment	16.3	282,384	289,447
Receivables	19.1	2,766	2,987
Total non-current assets		288,253	295,008
Current assets			
Inventories	18	8,914	8,759
Receivables	19.1	35,125	28,927
Non-current assets for sale and assets in disposal groups	20	400	400
Cash and cash equivalents	21	2,017	2,002
Total current assets		46,456	40,088
Current liabilities			
Trade and other payables	22	(53,547)	(35,028)
Borrowings	24.1	(328,354)	(114,919)
Provisions	25.1	(2,071)	(784)
Other liabilities	23	(2,609)	(3,603)
Total current liabilities		(386,581)	(154,334)
Total assets less current liabilities		(51,872)	180,762
Non-current liabilities			
Borrowings	24.1	(71,362)	(219,384)
Provisions	25.1	(2,882)	(2,802)
Other liabilities	23	(3,278)	(2,840)
Total non-current liabilities		(77,522)	(225,026)
Total assets employed		(129,394)	(44,264)
Financed by			
Public dividend capital		195,884	191,257
Revaluation reserve		85,407	88,846
Other reserves		(861)	(861)
Income and expenditure reserve		(409,824)	(323,506)
Total taxpayers' equity		(129,394)	(44,264)

The notes on pages 7 to 53 form part of these accounts.

The financial statements on pages 2 to 6 were approved by the Board on 15th June 2020 and signed on its behalf by



Matthew Hopkins
Chief Executive
22nd June 2020

Position
Date

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	191,257	88,846	(861)	(323,506)	(44,264)
Surplus/(deficit) for the year	-	-	-	(88,331)	(88,331)
Other transfers between reserves	-	(2,013)	-	2,013	-
Impairments	-	(2,217)	-	-	(2,217)
Revaluations	-	791	-	-	791
Public dividend capital received	4,627	-	-	-	4,627
Taxpayers' and others' equity at 31 March 2020	195,884	85,407	(861)	(409,824)	(129,394)

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	187,347	69,238	(861)	(247,023)	8,701
Prior period adjustment	-	100	-	(100)	-
Taxpayers' and others' equity at 1 April 2018 - restated	187,347	69,338	(861)	(247,123)	8,701
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	(1,974)	(1,974)
Surplus/(deficit) for the year	-	-	-	(75,704)	(75,704)
Other transfers between reserves	-	(1,295)	-	1,295	-
Impairments	-	13,694	-	-	13,694
Revaluations	-	7,109	-	-	7,109
Public dividend capital received	3,910	-	-	-	3,910
Taxpayers' and others' equity at 31 March 2019	191,257	88,846	(861)	(323,506)	(44,264)

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 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.

Financial assets reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Other reserves

The Other reserves reflects the difference between the value of the fixed assets taken over by the Trust at inception and the corresponding figure in its originating debts.

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(71,202)	(60,185)
Non-cash income and expense:			
Depreciation and amortisation	7.1	11,512	10,475
Net impairments	8	7,288	6,828
Amortisation of PFI deferred credit	4	(674)	(650)
(Increase) / decrease in receivables and other assets		(5,230)	(708)
(Increase) / decrease in inventories		(155)	1,359
Increase / (decrease) in payables and other liabilities		18,884	1,154
Increase / (decrease) in provisions		1,417	(248)
Net cash flows from / (used in) operating activities		<u>(38,160)</u>	<u>(41,975)</u>
Cash flows from investing activities			
Interest received	12	191	134
Purchase of intangible assets		(1,703)	(960)
Purchase of PPE and investment property		(13,053)	(21,161)
Sales of PPE and investment property		41	39
Net cash flows from / (used in) investing activities		<u>(14,524)</u>	<u>(21,948)</u>
Cash flows from financing activities			
Public dividend capital received		4,627	3,910
Movement on loans from DHSC		66,646	77,379
Capital element of PFI, LIFT and other service concession payments		(1,782)	(2,106)
Interest on loans		(4,901)	(3,183)
Interest paid on PFI, LIFT and other service concession obligations		(11,891)	(12,188)
PDC dividend (paid) / refunded		-	5
Cash flows from (used in) other financing activities		-	-
Net cash flows from / (used in) financing activities		<u>52,699</u>	<u>63,817</u>
Increase / (decrease) in cash and cash equivalents		<u>15</u>	<u>(106)</u>
Cash and cash equivalents at 1 April - brought forward		<u>2,002</u>	<u>2,107</u>
Prior period adjustments		-	-
Cash and cash equivalents at 1 April - restated		<u>2,002</u>	<u>2,107</u>
Unrealised gains / (losses) on foreign exchange		-	1
Cash and cash equivalents at 31 March	21	<u>2,017</u>	<u>2,002</u>

Notes to the Accounts

Note 1 Accounting policies and other information

1. Accounting policies and other information

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Going concern

These accounts have been prepared on a going concern basis.

NHS Trusts are required to prepare their accounts in accordance with the relevant accounting rules, which are set out in the International Accounting Standards (IFRSs) and interpreted by the DHSC Annual Reporting Manual (GAM). IFRS1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern.

Key considerations in assessing the Trust as a going concern

The Board has considered the overall financial position of the Trust. This has included the financial position against the agreed plan, the level of support already received, future cash flows, feedback from the ongoing engagement of NHS Improvement, the contractual position with commissioners, the 2019/20 CIP programme, financial plans, executive leadership and CQC inspections.

The Trust deficit of £(88.331)m includes the exceptional items of £(7.288)m for asset impairments and transfers, which along with the donated asset impact of £70k. These items are due to the Trust requirement to report its assets at the current fair value over the appropriate life of the asset. This is a non cash technical adjustment. The adjusted financial deficit (against which our performance is measured) is £(81.466)m after these adjustments.

The Trust has taken out a £326.3m of revenue loans over recent years (£65.5m) million in 2019/20 and signalled in its annual plan for 2020/21 that it will require further cash support in 2020/21 in line with the planned deficit of £(78.9) million. Of the existing loans, £107.7 million was due for repayment in 2019/20 relating to revenue loans; however £105.9m was agreed to be deferred until 2020/21. A further £4.622m relating to the capital loans was repaid

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £326.343m, interim loan principal of £324.892m and interest accrual of £1.451m as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

Prior to the Covid-19 pandemic, the Board prepared and agreed the 2020/21 annual plan, which included productivity and efficiency improvements of £14.5 million. The Trust signalled in this annual plan that it will require further cash support in 2020/21 in line with the planned deficit of £(78.9) million. Despite the extinguishment of interim revenue and capital loans and their replacement with PDC, plus the impact of temporary funding arrangements to July 2020 due to Covid-19, the Trust still expects that it will require further cash support from DHSC in 2020/21. DHSC has not confirmed that this will be available, however in additional guidance on the new capital and cash regime (April 2020), DHSC has confirmed that temporary revenue support arrangements will continue, in order to support providers with demonstrable cash needs.

During the final weeks of the financial year, the Trust has been significantly impacted, as for the wider NHS, by COVID-19. This resulted in significantly changed activity levels and resource profiles. The Trust received funding in 2019/20 to mitigate the impact of costs incurred on COVID-19. Nationally, normal contractual processes have been suspended until end July 2020 at the earliest, and Providers are being funded through a block arrangement designed to mitigate the full costs during the period. This measure provides increased certainty to Providers and supports the assessment of Going Concern. Whilst the interim arrangements are in place, additional cash support is not anticipated to be required.

Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the DHSC Group Accounting Manual 2019-20, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. Although COVID-19 has resulted in an interim contracting and payment approach, the assessment by the Board that there is an expectation of continuation in the provision of services remains valid and the interim arrangements provide greater certainty of cash flow in the short term. The Board has endorsed the preparation of the accounts on a going concern basis. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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.

Education and Training Income

Education and Training income (note 4) relates to the Learning and Developments Agreement (LDA) of £11.911m. The Trust contracts with the LDA who provides all education training and learning activity commissioned by Health Education England from the Multi – professional Education and Training Levy (MPET) funding.

It establishes a framework for the delivery of practise learning and teaching to support the workforce development.

The agreement includes training for medical and dental students, non-medical professional and vocational students, postgraduate training for doctors, learning beyond registration, learning before registration and education and training infrastructure.

1.4 Revenue from NHS contracts

Income in respect of services provided is recognised when and to the extent that performance occurs and is measured at the fair value of the consideration receivable.

The main source of income for the Trust is contracts with commissioners for health care services. 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. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

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

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

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

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred. Accounting policy for maternity pathway income is in line with IFRS15 where income is recognised over the period of the patient pathway, and a deferred income amount calculated at the year end.

1.5 NHS injury cost recovery scheme

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

1.6 Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

The Trust, working with wider system partners was unable to sign up to its control total target in 2019/20 and therefore was ineligible to access PSF/FRF funding.

Note in respect of 2018/19 however, the Trust received as a Post Balance Sheet Event £493k of late disbursement of 2018/19 PSF during the year.

1.7 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. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

1.8 Apprenticeship service income

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 from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.9 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care 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 scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The 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.

The Trust has accounted for the increase in the 2019-20 employer pension contributions increase 6.3% to 20.6%

The contribution rates have increased from 6.3% to 20.6% where the difference is being funded by DHSC and that the full amount of the cost is included in the employee costs and the DHSC funding included in operating income.

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

1.10 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 1.11 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

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.

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.

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

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

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

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

HM Treasury currently adopts a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust engaged a professional property adviser to undertake a desktop valuation in 2019/20 following a full revaluation in 2018/19.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

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

Depreciation

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

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	2	81
Dwellings	48	55
Plant & machinery	1	50
Transport equipment	4	8
Information technology	3	9
Furniture & fittings	5	10

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

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.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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.

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

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's *FReM*, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

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

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

In 2013 the PFI provider was found to be in default of the service agreement due to building defects. A settlement was reached between the Trust and the PFI provider in June 2016. The Deed of Variation included two broad elements, a lump sum compensation payment and alterations to future service charges. The lump sum payment of £7.3m was credited to other operating revenue. In 2016/17 the Trust recognised the revenue coming from future service price alterations in other operating revenue. The Trust looked at the reduction in future service provider margins that would not have been agreed without the building defects. The contractual value was used as the basis for the calculation allowing both for cost of capital adjustments and future service price increases based on predicted RPI changes. The gain on the alteration to future service charges was recognised in other operating revenues to be consistent with the recognition of the lump sum compensation payment. This gain reduced the PFI liability as the settlement related to the compensation for the building defects. By adopting this accounting treatment annual Unitary Payments from 2018/19 do not reflect the full value of the service received. The service element of the Unitary Payment is therefore adjusted by an amount equivalent to the full value of the service received and the PFI liability is increased. This adjustment will 'unwind' the 2016/17 revenue recognition over the remaining life of the PFI contract.

Note 1.13 Intangible assets

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 where it meets the requirements set out in IAS 38:

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

Software

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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value 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.

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.

Useful lives of intangible assets

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

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

Note 1.14 Inventories

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

The Trust's inventory balance of £8.9m is material to the Trust's accounts. The Trust is satisfied that its inventory balance is presented fairly in all material respects: the Trust has well-established stocktake procedures which are regularly reviewed. However the restrictions on movement in the United Kingdom in March 2020 meant that the Trust has experienced constraints in accessing stock information and as such has made reasonable adjustment. The Trust's auditor was unable to fully attend the relevant year-end inventory counts, and the auditor has been unable to gain sufficient audit evidence from alternative procedures. The auditor has therefore been unable to complete the procedures required by auditing standards, and is required to issue a qualified opinion. We are aware that a number of trusts in the country are affected by the same issue in 2019/20 and we understand NHS Improvement will disclose the extent to which this has impacted the sector in its consolidated provider accounts when published later in 2020. The auditor's opinion on the financial statements remains unmodified in all other respects.

Note 1.15 Cash and cash equivalents

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

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

Note 1.16 Carbon Reduction Commitment scheme (CRC)

The Climate Change Levy (CCL) has replaced the Carbon Reduction Commitment (CRC) Energy Efficiency scheme. Any fees associated with the CCL are accounted for as an operating expense.

Note 1.17 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract 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 ONS.

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, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

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

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

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

Financial assets are classified as subsequently measured at amortised cost
Financial liabilities classified as subsequently measured at amortised cost

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

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

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

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

Derecognition

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

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

Note 1.18 Leases

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

The trust as a lessee

Finance leases

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

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

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position 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.

The trust as a lessor

Finance leases

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

Operating leases

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

Note 1.19 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 HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

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

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Note 1.20 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 25.2 but is not recognised in the Trust's accounts.

Note 1.21 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 1.22 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, 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 1.23 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.

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 public dividend capital 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 and grant funded assets,
- (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- (iii) any PDC dividend balance receivable or payable.

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

Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS capital and cash regime from 1st April 2020. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

Note 1.24 Value added tax

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

Note 1.25 Corporation tax

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

Note 1.26 Foreign exchange

The functional and presentational currency of the trust is sterling.

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

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.27 Third party assets

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

Note 1.28 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.

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

Note 1.29 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.

Note 1.30 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.31 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust has not disclosed the estimated financial impact of applying IFRS 16 in 2020/21 due to the levels of uncertainty involved in forecasting a year into the future. It is expected that the revenue impact of the implementation of IFRS 16 will be immaterial.

Note 1.32 Critical judgements in applying accounting policies

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

1.32.1 PFI

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Note 1.33 Sources of estimation uncertainty

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

Valuation of Property, Plant and Equipment

- Valuation of property, plant and equipment (see note 16.1) is based upon an assessment undertaken by professional property valuers which by its nature includes an element of subjectivity.
- The Trust engaged a professional property adviser to undertake a desktop revaluation in 2019/20 after having a full revaluation in 2018/19.
- The valuation exercise was carried out between December 2019 and March 2020 with a valuation date of 31 March 2020. All property inspections were completed in advance of the COVID 19 lockdown. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The valuer considers that they can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.
- The valuation report recommends that given the unknown future impact that COVID-19 might have on the real estate market, the valuation of the Trust is kept under frequent review. 96.8% of the value of the Trust property assets is in respect of specialised properties, and therefore valued on a Depreciated Replacement Cost basis. The valuation for such assets, with the exception of the Land component, is based on comparable build cost information published by the RICS Building Cost Information Service (BCIS), up to and including the valuation date of 31 March 2020. Whilst these published build costs remain 'provisional' and therefore subject to fluctuation, it is not anticipated that there would be a significant change. It is possible that the COVID-19 pandemic will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

The PPE valuation would need to change by more than 3% for it to become material uncertainty.

Note 2 Operating Segments

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

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

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

(a) the nature of the products and services:

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

(b) the nature of the production processes:

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

(c) the type or class of customer for their products and services:

The Trust's customers are similar across all services in that they are ill/vulnerable people – whilst certain patient groups may be more susceptible to different healthcare needs, most services are provided to customers of all ages, gender etc.

(d) the methods used to distribute their products or provide their services:

The majority of services are delivered to customers through attendance at hospital as outpatients, day cases or inpatients.

(e) if applicable, the nature of the regulatory environment:

The regulatory environment in which the Trust's services are provided is NHS healthcare.

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

Financial Performance Reporting

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

Income Sources

Key information on the Trust's sources of income is as follows:

- Clinical Commissioning Groups (CCGs) from which £330 million (£307.9 million in 2018/19) was received; and
- NHS England from which £70.1 million (£64.2 million in 2018/19) was received.

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

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

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

Note 3.1 Income from patient care activities (by nature)	2019/20 £000	2018/19 £000
Elective income	66,326	60,377
Non elective income	143,762	123,983
First outpatient income	28,046	26,941
Follow up outpatient income	24,281	20,985
A & E income	25,856	21,755
High cost drugs income from commissioners (excluding pass-through costs)	37,129	36,168
Other NHS clinical income	77,449	86,282
Private patient income	401	456
Agenda for Change pay award central funding*	-	3,927
Additional pension contribution central funding**	11,207	-
Other clinical income	1,719	204
Total income from activities	416,176	381,078

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Of the total income figure, contracted income in 2019 is £392.6m (£363.3m 2018/19) and non contract income is £23.5m (£17.8m 2018/19).

Note 3.2 Income from patient care activities (by source)	2019/20 £000	2018/19 £000
Income from patient care activities received from:		
NHS England	81,285	64,206
Clinical commissioning groups	329,979	307,872
Department of Health and Social Care	-	3,927
Other NHS providers	2,443	2,324
NHS other	204	204
Non-NHS: private patients	345	389
Non-NHS: overseas patients (chargeable to patient)	56	67
Injury cost recovery scheme	1,129	1,308
Non NHS: other	735	781
Total income from activities	416,176	381,078
Of which:		
Related to continuing operations	416,176	381,078

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)	2019/20 £000	2018/19 £000
Income recognised this year	56	67
Cash payments received in-year	21	25
Amounts added to provision for impairment of receivables	-	10
Amounts written off in-year	15	-

Note 4 Other operating income	2019/20			2018/19		
	Contract income £000	Non- contract income £000	Total £000	Contract income £000	Non- contract income £000	Total £000
Research and development	1,036	-	1,036	910	-	910
Education and training	12,237	-	12,237	12,041	-	12,041
Non-patient care services to other bodies	6,572	-	6,572	7,708	-	7,708
Provider sustainability fund (PSF)	493	-	493	4,922	-	4,922
Charitable and other contributions to expenditure		254	254		340	340
Rental revenue from operating leases		114	114		42	42
Amortisation of PFI deferred income / credits		674	674		650	650
Other income	6,166	-	6,166	4,167	108	4,275
Total other operating income	26,504	1,042	27,546	29,748	1,140	30,888

The income in 2019/20 includes £0.493m relates to an adjustment for 2018/19 post accounts STE reallocation.

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

Education and Training is mainly from the Learning and Developments Agreement (LDA) £11.9m. Note 1.3

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period	2019/20	2018/19
	£000	£000

Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,977	1,974
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	3,139	2,518

Note 5.2 Transaction price allocated to remaining performance obligations	31 March	31 March
	2020	2019
	£000	£000
within one year	-	*
Total revenue allocated to remaining performance obligations	-	-

The Trust has excluded these details in 2019/20 as our health care contracts are for a duration of under one year. In addition the partial completed spells excluded. The 2018/19 details have therefore been amended to reflect the guidance *

Note 6 Fees and charges

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

	2019/20	2018/19
	£000	£000
Income	2,435	2,479
Full cost	(2,251)	(1,974)
Surplus / (deficit)	184	505

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

Note 7.1 Operating expenses

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	4,440	5,313
Purchase of healthcare from non-NHS and non-DHSC bodies	4,328	1,960
Staff and executive directors costs	314,915	282,327
Remuneration of non-executive directors	103	83
Supplies and services - clinical (excluding drugs costs)	44,808	43,951
Supplies and services - general	17,753	17,736
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	46,555	44,477
Inventories written down	228	336
Consultancy costs	450	1,904
Establishment	5,649	4,125
Premises	13,165	15,184
Transport (including patient travel)	1,504	1,790
Depreciation on property, plant and equipment	10,630	9,253
Amortisation on intangible assets	882	1,222
Net impairments	7,288	6,828
Movement in credit loss allowance: contract receivables / contract assets	468	350
Increase/(decrease) in other provisions	-	426
Change in provisions discount rate(s)	(59)	-
Audit fees payable to the external auditor		
audit services- statutory audit	61	68
other auditor remuneration (external auditor only)	-	-
Internal audit costs	67	75
Clinical negligence	13,361	14,117
Legal fees	295	291
Insurance	214	257
Education and training	905	800
Rentals under operating leases	4,413	3,156
Redundancy	2	9
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	20,724	16,034
Other	1,775	79
Total	514,924	472,151
Of which:		
Related to continuing operations	514,924	472,151

Note 7.2 Other auditor remuneration	2019/20 £000	2018/19 £000
<i>Other auditor remuneration paid to the external auditor:</i>		
Audit-related assurance services	-	-
Total	-	-

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2018/19: £1m).

Note 8 Impairment of assets	2019/20 £000	2018/19 £000
<i>Net impairments charged to operating surplus / deficit resulting from:</i>		
Changes in market price	7,288	6,828
Total net impairments charged to operating surplus / deficit	7,288	6,828
Impairments charged to the revaluation reserve	2,217	(13,694)
Total net impairments	9,505	(6,866)

The Trust engaged a professional property advisor to undertake a desk top revaluation in 2019/20, following a full revaluation in 2018/19. All land and buildings have been assessed for physical depreciation and obsolescence which has resulted in changes in valuation of the Trusts assets. Any buildings assets which reduced in value were impaired to either the revaluation reserve or to I&E.

Note 9 Employee benefits	2019/20	2018/19
	Total £000	Total £000
Salaries and wages	206,009	192,653
Social security costs	21,916	19,020
Apprenticeship levy	1,056	1,001
Employer's contributions to NHS pensions	36,860	23,395
Pension cost - other	62	34
Termination benefits	-	71
Temporary staff (including agency)	49,228	46,269
Total staff costs	315,131	282,443
Of which		
Costs capitalised as part of assets	216	116

During 2019/20 there were 6 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £783k (£254k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care 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 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 to 20.6%, and the Scheme Regulations were amended accordingly.

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 11 Operating leases

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

Note 11.1 Worcestershire Acute Hospitals NHS Trust as a lessor

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

The Trust receives operating rental income from leasing of accommodation space at KTC.

	2019/20 £000	2018/19 £000
Operating lease revenue		
Minimum lease receipts	114	42

	31 March 2020 £000	31 March 2019 £000
Total	<u>114</u>	<u>42</u>

Future minimum lease receipts due:

- not later than one year;	114	
- of which buildings	114	42
- of which other	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	<u>114</u>	<u>42</u>

Note 11.2 Worcestershire Acute Hospitals NHS Trust as a lessee

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

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

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	4,413	3,156

	31 March 2020 £000	31 March 2019 £000
Total	<u>4,413</u>	<u>3,156</u>

Future minimum lease payments due:

- not later than one year;	108	
- of which land	108	-
- of which buildings	1,008	1,377
- of which other	2,292	1,532
- later than one year and not later than five years;	430	-
- of which land	430	-
- of which buildings	3,113	3,067
- of which other	2,800	2,654
- later than five years.	2,959	-
- of which land	2,959	-
- of which buildings	17,739	18,506
- of which other	89	-
Total	<u>30,538</u>	<u>27,136</u>

Note 12 Finance income

	2019/20 £000	2018/19 £000
Interest on bank accounts	191	134
Total finance income	191	134

Finance income represents interest received on assets and investments in the period.
The Trust benefited from the timing of the capital receipts in advance of capital payables during 2019/20.

Note 13.1 Finance expenditure

	2019/20 £000	2018/19 £000
Interest expense:		
Loans from the Department of Health and Social Care	5,450	3,457
Interest on late payment of commercial debt	-	44
Main finance costs on PFI and LIFT schemes obligations	5,595	5,774
Contingent finance costs on PFI and LIFT scheme obligations	6,295	6,415
Total interest expense	17,340	15,690
Unwinding of discount on provisions	9	3
Total finance costs	17,349	15,693

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

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20 £000	2018/19 £000
Amounts included within interest payable arising from claims made under this legislation	-	44

The Trust has not incurred any late payment interest charges in 2019/20.

Note 14 Other gains / (losses)

	2019/20 £000	2018/19 £000
Gains on disposal of assets	41	39
Losses on disposal of assets	(12)	-
Total gains / (losses) on disposal of assets	29	39
Gains / (losses) on foreign exchange	-	1
Total other gains / (losses)	29	40

Note 15.1 Intangible assets - 2019/20

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 - brought forward	7,818	2,507	1,024	11,349
Additions	246	-	1,165	1,411
Valuation / gross cost at 31 March 2020	8,064	2,507	2,189	12,760
Amortisation at 1 April 2019 - brought forward	6,725	2,050	-	8,775
Provided during the year	643	239	-	882
Amortisation at 31 March 2020	7,368	2,289	-	9,657
Net book value at 31 March 2020	696	218	2,189	3,103
Net book value at 1 April 2019	1,093	457	1,024	2,574

Note 15.2 Intangible assets - 2018/19

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

Note 16.1 Property, plant and equipment - 2019/20									
	Land £000	Buildings excluding dwellings £000	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 2019 - brought forward	40,015	222,627	901	11,691	42,957	302	23,140	136	341,769
Valuation/gross cost at start of period as FT	-	-	-	-	-	-	-	-	-
Additions	-	6,123	-	4,006	2,088	-	76	-	12,293
Impairments	-	(10,833)	-	-	-	-	-	-	(10,833)
Reversals of impairments	-	1,316	12	-	-	-	-	-	1,328
Revaluations	-	(5,361)	(29)	-	-	-	-	-	(5,390)
Reclassifications	-	8,680	-	(8,680)	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(210)	-	-	-	(210)
Valuation/gross cost at 31 March 2020	40,015	222,552	884	7,017	44,835	302	23,216	136	338,957
Accumulated depreciation at 1 April 2019 - brought forward	-	444	-	-	33,249	302	18,204	123	52,322
Depreciation at start of period as FT	-	-	-	-	-	-	-	-	-
Provided during the year	-	6,392	29	-	2,308	-	1,896	5	10,630
Revaluations	-	(6,152)	(29)	-	-	-	-	-	(6,181)
Disposals / derecognition	-	-	-	-	(198)	-	-	-	(198)
Accumulated depreciation at 31 March 2020	-	684	-	-	35,359	302	20,100	128	56,573
Net book value at 31 March 2020	40,015	221,868	884	7,017	9,476	-	3,116	8	282,384
Net book value at 1 April 2019	40,015	222,183	901	11,691	9,708	-	4,936	13	289,447
Note 16.2 Property, plant and equipment - 2018/19									
	Land £000	Buildings excluding dwellings £000	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 - as previously stated	37,316	207,275	893	4,654	44,146	302	22,771	133	317,490
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2018 - restated	37,316	207,275	893	4,654	44,146	302	22,771	133	317,490
Valuation / gross cost at start of period as FT	-	-	-	-	-	-	-	-	-
Additions	-	6,098	-	9,453	769	-	591	3	16,914
Impairments	-	(13,884)	(4)	-	-	-	-	-	(13,888)
Reversals of impairments	896	19,824	34	-	-	-	-	-	20,754
Revaluations	1,821	808	(22)	-	-	-	-	-	2,607
Reclassifications	(18)	2,506	-	(2,416)	-	-	-	-	72
Disposals / derecognition	-	-	-	-	(1,958)	-	(222)	-	(2,180)
Valuation/gross cost at 31 March 2019	40,015	222,627	901	11,691	42,957	302	23,140	136	341,769
Accumulated depreciation at 1 April 2018 - as previously stated	18	181	-	-	32,727	302	16,432	109	49,769
Provided during the year	-	4,743	22	-	2,480	-	1,994	14	9,253
Revaluations	-	(4,480)	(22)	-	-	-	-	-	(4,502)
Reclassifications	(18)	-	-	-	-	-	-	-	(18)
Disposals / derecognition	-	-	-	-	(1,958)	-	(222)	-	(2,180)
Accumulated depreciation at 31 March 2019	-	444	-	-	33,249	302	18,204	123	52,322
Net book value at 31 March 2019	40,015	222,183	901	11,691	9,708	-	4,936	13	289,447
Net book value at 1 April 2018	37,298	207,094	893	4,654	11,419	-	6,339	24	267,721

Note 16.3 Property, plant and equipment financing - 2019/20									
	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2020									
Owned - purchased	40,015	137,134	884	7,017	4,435	-	3,005	8	192,498
On-SoFP PFI contracts and other service concession arrangements	-	84,495	-	-	5,041	-	-	-	89,536
Owned - donated	-	239	-	-	-	-	111	-	350
NBV total at 31 March 2020	40,015	221,868	884	7,017	9,476	-	3,116	8	282,384

Note 16.4 Property, plant and equipment financing - 2018/19									
	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019									
Owned - purchased	40,015	134,255	901	11,691	4,887	-	4,936	13	196,698
On-SoFP PFI contracts and other service concession arrangements	-	87,685	-	-	4,821	-	-	-	92,506
Owned - donated	-	243	-	-	-	-	-	-	243
NBV total at 31 March 2019	40,015	222,183	901	11,691	9,708	-	4,936	13	289,447

Note 17 Revaluations of property, plant and equipment

A desk top valuation of the Trust's land and buildings was undertaken by Cushman and Wakefield (RICS Registered Valuers), as at 31st March 2020, as part of the five year agreement with them.

The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the DHSC and HM Treasury.

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

In line with HM Treasury guidance, the revaluation as at 31st March 2020 was based on the 'Modern Equivalent Asset' approach to valuation.

The Trust commissioned a full revaluation in 2018/19. The Valuers reviewed the Trusts asset base including a condition survey. Each site is defined as the "property asset" with the 3 significant components defined as land, buildings and external works.

Note 18 Inventories	31 March	31 March
	2020	2019
	£000	£000
Drugs	3,712	3,421
Work In progress	90	90
Consumables	5,087	5,223
Energy	25	25
Total inventories	8,914	8,759

Inventories recognised in expenses for the year were £50,274k (2018/19: £49,657k). Write-down of inventories recognised as expenses for the year were £228k (2018/19: £336k).

Note 19.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	15,248	21,847
Allowance for impaired contract receivables / assets	(1,972)	(1,999)
Deposits and advances	(130)	1
Prepayments (non-PFI)	2,275	1,940
PFI lifecycle prepayments	5,427	4,680
VAT receivable	2,532	1,391
Other receivables	11,745	1,067
Total current receivables	<u>35,125</u>	<u>28,927</u>
Non-current		
Contract assets	2,766	2,987
Total non-current receivables	<u>2,766</u>	<u>2,987</u>
Of which receivable from NHS and DHSC group bodies:		
Current	6,447	18,454

Note 19.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	1,999	-	-	1,746
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			1,746	(1,746)
New allowances arising	468	-	350	-
Utilisation of allowances (write offs)	(495)	-	(97)	-
Allowances as at 31 Mar 2020	1,972	-	1,999	-

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

Injury cost recovery income: subject to a provision for credit losses of 21.79% (21.89% 2018/19) as per DHSC guidance.

Non-NHS receivables that are over 3 months old: subject to a provision for credit losses of 100%

Non-NHS receivables less than 3 months old: individually assessed and an appropriate provision made

NHS receivables: individually assessed and an appropriate provision made (taking account of the NHS agreement of balances exercise)

Note 19.3 Exposure to credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

Note 20 Non-current assets held for sale and assets in disposal groups

	2019/20 £000	2018/19 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	400	400
Prior period adjustment	-	-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	400	400
NBV of non-current assets for sale and assets in disposal groups at 31 March	400	400

Note 21 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.

	2019/20 £000	2018/19 £000
At 1 April	2,002	2,107
Net change in year	15	(105)
At 31 March	2,017	2,002
Broken down into:		
Cash at commercial banks and in hand	127	51
Cash with the Government Banking Service	1,890	1,951
Total cash and cash equivalents as in SoFP	2,017	2,002

Note 22 Trade and other payables	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	10,954	14,409
Capital payables	2,661	2,880
Accruals	37,511	17,318
Receipts in advance and payments on account	160	-
Social security costs	149	92
Other taxes payable	39	95
Other payables	2,073	234
Total current trade and other payables	53,547	35,028
Of which payables from NHS and DHSC group bodies:		
Current	4,857	10,088

Note 23 Other liabilities	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	2,609	2,953
Deferred PFI credits / income	-	650
Total other current liabilities	2,609	3,603
Non-current		
Deferred PFI credits / income	3,278	2,840
Total other non-current liabilities	3,278	2,840

Trust Deferred Income Contract Liabilities include the maternity pathway deferred element where the provision of service will continue into 2020/21.

Note 24.1 Borrowings	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	326,343	113,136
Obligations under PFI, LIFT or other service concession contracts	2,011	1,783
Total current borrowings	328,354	114,919
Non-current		
Loans from DHSC	13,929	159,941
Obligations under PFI, LIFT or other service concession contracts	57,433	59,443
Total non-current borrowings	71,362	219,384

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £326m are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2019	273,077	61,226	334,303
Cash movements:			
Financing cash flows - payments and receipts of principal	66,646	(1,782)	64,864
Financing cash flows - payments of interest	(4,901)	(5,595)	(10,496)
Non-cash movements:			
Application of effective interest rate	5,450	5,595	11,045
Other changes	-	-	-
Carrying value at 31 March 2020	340,272	59,444	399,716

Note 24.3 Reconciliation of liabilities arising from financing activities - 2018/19

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

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure			
	costs £000	Legal claims £000	Other £000	Total £000
At 1 April 2019	3,015	181	390	3,586
Change in the discount rate	(59)	-	-	(59)
Arising during the year	354	82	1,781	2,217
Utilised during the year	(211)	(22)	(299)	(532)
Reversed unused	(57)	(120)	(91)	(268)
Unwinding of discount	9	-	-	9
At 31 March 2020	3,051	121	1,781	4,953
Expected timing of cash flows:				
- not later than one year;	212	121	1,738	2,071
- later than one year and not later than five years;	847	-	-	847
- later than five years.	1,992	-	43	2,035
Total	3,051	121	1,781	4,953

Early departure costs are pensions relating to former staff are based upon actuarial estimates and are reviewed annually.

Payments are made quarterly to the NHS Pensions Agency in respect of the Trust's liability.

Legal claims relate to employers'/third party liability claims. Cost estimates and timings are based on information held by the Legal Services team who work closely with the NHS Litigation Authority.

Other provisions include exit costs for major contract.

Note 25.2 Clinical negligence liabilities

At 31 March 2020, £121k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Worcestershire Acute Hospitals NHS Trust (31 March 2019: £181k).

Note 26 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	(34)	(27)
Gross value of contingent liabilities	<u>(34)</u>	<u>(27)</u>
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	<u><u>(34)</u></u>	<u><u>(27)</u></u>

Note 27 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2020 £000	31 March 2019 £000
not later than 1 year	10,993	9,283
after 1 year and not later than 5 years	10,936	11,757
paid thereafter	592	-
Total	<u><u>22,521</u></u>	<u><u>21,040</u></u>

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

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

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

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

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	98,857	106,235
Of which liabilities are due		
- not later than one year;	7,411	7,378
- later than one year and not later than five years;	33,367	32,263
- later than five years.	58,079	66,594
Finance charges allocated to future periods	(39,413)	(45,009)
Net PFI, LIFT or other service concession arrangement obligation	59,444	61,226
- not later than one year;	2,011	1,783
- later than one year and not later than five years;	14,581	12,240
- later than five years.	42,852	47,203

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	424,651	483,919
Of which payments are due:		
- not later than one year;	31,408	32,521
- later than one year and not later than five years;	133,817	138,553
- later than five years.	259,426	312,845

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2019/20 £000	2018/19 £000
Unitary payment payable to service concession operator	36,247	31,302
Consisting of:		
- Interest charge	5,595	5,774
- Repayment of balance sheet obligation	1,783	2,106
- Service element and other charges to operating expenditure	20,724	16,034
- Capital lifecycle maintenance	1,850	973
- Contingent rent	6,295	6,415
Total amount paid to service concession operator	36,247	31,302

Revenue lifecycle costs are included in the service element of the unitary payments.

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

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

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

Credit Risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

Currency risk

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

Interest Rate risk

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

The Trust also borrows from government to support the financial deficit and ensure sufficient cash flow to maintain day to day operations. The interest rate on these loans remained fixed during 2019/20.

Note 29.2 Carrying values of financial assets

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
	Carrying values of financial assets as at 31 March 2020			
Trade and other receivables excluding non financial assets	27,657	-	-	27,657
Cash and cash equivalents	2,017	-	-	2,017
Total at 31 March 2020	29,674	-	-	29,674

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
	Carrying values of financial assets as at 31 March 2019			
Trade and other receivables excluding non financial assets	23,902	-	-	23,902
Cash and cash equivalents	2,002	-	-	2,002
Total at 31 March 2019	25,904	-	-	25,904

Note 29.3 Carrying values of financial liabilities

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
	Carrying values of financial liabilities as at 31 March 2020		
Loans from the Department of Health and Social Care	340,272	-	340,272
Obligations under PFI, LIFT and other service concession contracts	59,444	-	59,444
Trade and other payables excluding non financial liabilities	53,199	-	53,199
Total at 31 March 2020	452,915	-	452,915

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
	Carrying values of financial liabilities as at 31 March 2019		
Loans from the Department of Health and Social Care	273,077	-	273,077
Obligations under PFI, LIFT and other service concession contracts	61,226	-	61,226
Trade and other payables excluding non financial liabilities	34,841	-	34,841
Total at 31 March 2019	369,144	-	369,144

Note 29.4 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	381,553	149,760
In more than one year but not more than two years	4,388	64,460
In more than two years but not more than five years	15,433	91,002
In more than five years	51,541	63,922
Total	452,915	369,144

NHSE&I agreed to defer £105.9m of the £107.7m existing loans due for repayment in 2019/20 relating to revenue loans to 2020/21. The total amount due for repayment in 2020/21 has been subsequently increased to include all of the interim loans for both capital and revenue following the announcement of the reforms to the NHS cash and capital regimes. As a result, the Trust borrowing shows a requirement to repay the principal of £324.9 million in 2020/21 for revenue and capital loans in accordance with the guidance from DHSC.

Note 30 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	1	0	-	-
Bad debts and claims abandoned	350	204	126	44
Stores losses and damage to property	12	253	12	337
Total losses	363	456	138	381
Special payments				
Ex-gratia payments	42	17	75	92
Total special payments	42	17	75	92
Total losses and special payments	405	474	213	473

Note 31 Related parties

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

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

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

The Trust has also received revenue and capital payments from Worcestershire Acute Hospitals Charity amounting to £515,186k (£527,622 in 2018/19). All of these payments relate to expenditure made by the Trust on behalf of the Worcestershire Acute Hospitals Charity. As at 31 March 2020, Worcestershire Acute Hospitals Charity owed the Trust £100,082. The Trust Board is Corporate Trustee of the Trust's Charitable Funds. The summary financial statements of the funds held on Trust are included in the annual report and accounts.

Note 32 Prior Period adjustments

The accounts includes a Prior Period Adjustment to the transfer between reserves of £100k to restate the opening balance of the revaluation reserve.

Note 33 Events after the reporting date

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £326m as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

Note 34 Better Payment Practice code	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	101,681	232,318	102,230	226,631
Total non-NHS trade invoices paid within target	98,244	216,409	82,637	176,310
Percentage of non-NHS trade invoices paid within target	<u>96.6%</u>	<u>93.2%</u>	<u>80.8%</u>	<u>77.8%</u>
NHS Payables				
Total NHS trade invoices paid in the year	2,936	16,513	3,029	12,136
Total NHS trade invoices paid within target	2,221	7,741	1,823	4,626
Percentage of NHS trade invoices paid within target	<u>75.6%</u>	<u>46.9%</u>	<u>60.2%</u>	<u>38.1%</u>

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 35 External financing limit	2019/20 £000	2018/19 £000
Cash flow financing	69,476	79,289
External financing requirement	69,476	79,289
External financing limit (EFL)	69,491	79,359
Under / (over) spend against EFL	15	70

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

Note 36 Capital Resource Limit	2019/20 £000	2018/19 £000
Gross capital expenditure	13,704	18,092
Less: Disposals	(12)	-
Charge against Capital Resource Limit	13,692	18,092
Capital Resource Limit	16,343	18,970
Under / (over) spend against CRL	2,651	878

As a result of the operational impact of COVID-19, the Trust was unable to complete all of its planned capital schemes, resulting in an underspend against the CRL. The Trust is working with the National Team to ensure that its planned capital programme can be completed in 2020/21.

Note 37 Breakeven duty financial performance	2019/20 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(81,466)
Add back income for impact of 2018/19 post-accounts PSF reallocation	493
Breakeven duty financial performance surplus / (deficit)	(80,844)

Note 38 Breakeven duty rolling assessment

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

	1997/98 to 2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000
Breakeven duty in-year financial performance		3,135	287	88	17	(14,191)
Breakeven duty cumulative position	(21,854)	(18,719)	(18,432)	(18,344)	(18,327)	(32,518)
Operating income		312,889	321,829	336,594	348,763	346,029
Cumulative breakeven position as a percentage of operating income		(6.0%)	(5.7%)	(5.4%)	(5.3%)	(9.4%)

	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000
Breakeven duty in-year financial performance	(25,918)	(59,831)	(28,748)	(52,562)	(68,790)	(80,844)
Breakeven duty cumulative position	(58,436)	(118,267)	(147,015)	(199,577)	(268,367)	(349,211)
Operating income	364,656	368,981	403,348	400,918	411,966	443,722
Cumulative breakeven position as a percentage of operating income		(16.0%)	(32.1%)	(36.4%)	(49.8%)	(65.1%)
						(78.7%)

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

Report on the Audit of the Financial Statements

Qualified opinion

We have audited the financial statements of Worcestershire Acute Hospitals NHS Trust (the 'Trust') for the year ended 31 March 2020, 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 2019 to 2020.

In our opinion, except for the possible effects of the matter described in the basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 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 2019 to 2020; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

Due to the national lockdown arising from the Covid-19 pandemic we did not fully observe the counting of physical inventories at the end of the year. We were unable to obtain sufficient appropriate audit evidence regarding the inventory quantities held at 31 March 2020, which have a carrying amount in the Statement of Financial Position of £8.914 million, by performing other audit procedures. Related balances such as drug costs and supplies and services may be materially misstated for the same reason.

Consequently, we were unable to determine whether any adjustment to these amounts were necessary. In addition, were any adjustment to these amounts to be required, the Annual Report would also need to be amended.

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 qualified opinion.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Directors and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's future operational arrangements. However,

no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which indicates that the Trust incurred a deficit of £88.331 million during the year ended 31 March 2020. As stated in note 1.2, the Trust has taken out a number of revenue loans over recent years (£65.5 million in 2019/20). On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21, existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Note 1.2 also states that nationally, normal contractual processes have been suspended until end July 2020 at the earliest, and providers are being funded through a block arrangement designed to mitigate the full costs during the period. Whilst the interim arrangements are in place, additional cash support is not anticipated to be required. Prior to the Covid-19 pandemic, the Board prepared and agreed the 2020/21 annual plan, which included productivity and efficiency improvements of £14.5 million. The Trust signalled in this annual plan that it will require further cash support in 2020/21 in line with the planned deficit of £78.9 million. Despite the extinguishment of interim revenue and capital loans and their replacement with PDC, plus the impact of temporary funding arrangements due to Covid-19, the Trust still expects that it will require further cash support from DHSC in 2020/21. DHSC has not confirmed that this will be available.

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

Emphasis of Matter – effects of Covid-19 on the valuation of land and buildings

We draw attention to Note 1.33 of the financial statements, which describes the effects of the Covid-19 pandemic on the valuation of land and buildings as at 31 March 2020. The valuation exercise was carried out between December 2019 and March 2020 with a valuation date of 31 March 2020. As, disclosed in Note 1.33 to the financial statements, in applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The valuer considers that they can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. Our opinion is not modified in respect of this matter.

Other information

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

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

As described in the basis for qualified opinion section of our report, we were unable to obtain sufficient appropriate audit evidence regarding the inventory quantities, which have a carrying amount in the Statement of Financial Position of £8.914 million at 31 March 2020, and related balances. Accordingly, we are unable to conclude whether or not the other information is materially misstated with respect to this matter.

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 in April 2015 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 2019 to 2020 and the requirements of the National Health Service Act 2006; and
- except for the possible effects of the matter described in the basis for qualified opinion section of our report, based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

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

We have nothing to report in respect of the above matters except on 28 March 2019 we referred a matter to the Secretary of State under section 30(a) of the Local Audit and Accountability Act in relation to the Trust not setting a budget for the year ended 31 March 2020 and not having a formal plan to achieve cumulative financial balance. On 2 April 2020 we referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to the Trust's ongoing breach of its break-even duty for the three-year period ending 31 March 2020.

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

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

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

Adverse conclusion

On the basis of our work, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects Worcestershire Acute Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for adverse conclusion

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

- For 2019/20 the Trust delivered an adjusted financial deficit of £81.5 million after excluding valuation impairments of £7.3 million, which was within its planned deficit of £82.8 million.
- The Trust delivered cost and efficiency savings totalling £12.0 million. The 2019/20 financial plan included a savings requirement of £13.7m, although the Board set a more challenging target of £22.5 million.
- The Trust's adjusted retained cumulative deficit is £349.3 million at 31 March 2020 and it does not yet have a financial recovery plan in place to achieve an in-year break-even position.

These matters identify weaknesses in the Trust's arrangements for setting and agreeing a sustainable budget and delivery of that budget.

- The Care Quality Commission (CQC) made unannounced visits to the Trust's Emergency Departments in December 2019 and subsequently rated them as "inadequate" and issued statutory improvement notices.
- The CQC published a Use of Resources report for the Trust in September 2019, which assessed whether the Trust was using its resources productively to maximise patient benefit. The CQC rated the Trust as "inadequate" in this assessment.
- The Trust remains in "Special Measures" which started in November 2015 due to concerns over quality and patient care.
- The Trust's performance against national standards continued to be below the required level throughout 2019/20. Planned performance improvement trajectories were not achieved for Emergency Access, Diagnostics Six Week Waits, Referral to Treatment in 18 Weeks and All Cancer 62 Day Waits.

These matters identify weaknesses in the Trust's arrangements for responding to service delivery issues raised by regulators.

These matters are evidence of weaknesses in proper arrangements for sustainable resource deployment and informed decision making in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions, planning, organising and developing the

workforce effectively to deliver strategic priorities and for understanding and using appropriate and reliable financial and performance information to support informed decision making and performance management including where relevant, business cases supporting significant investment decisions.

Responsibilities of the Accountable Officer

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 April 2020, 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 2020, and to report by exception where we are not satisfied.

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

Report on other legal and regulatory requirements – Certificate

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

Use of our report

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

Richard Percival

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

Birmingham
22 June 2020