Putting Patients First

4ward

NHS

Worcestershire Acute Hospitals

NHS Trust

ANNUAL REPORT 2020/21

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 Chair and Chief Executive

Sir David Nicholson

Chair

Matthew Hopkins

Chief Executive

Welcome to Worcestershire Acute Hospitals NHS Trust's 2020/21 Annual Report.

We now know that the unprecedented, unparalleled and unrelenting situation which our hospitals, and the wider NHS, found ourselves in this time last year was to continue for many months.

The Covid-19 pandemic has touched every aspect of life for our staff, patients and the public and forced us all to live and work differently. In spite of the incredible challenges, our staff – with support from our amazing volunteers, the Armed Forces and our local community- have worked tirelessly and innovatively, finding new and different ways of working to continue to put patients first.

At the height of the pandemic we were operating six Intensive Care Units instead of our usual two – made possible only due to the hard work and dedication of Trust staff, many of whom were redeployed to work in this unfamiliar and challenging environment. Out of more than 400,000 outpatient clinics that were held, well over 150,000 took place either via telephone or video call to ensure patients were still able to access their continuing care; a drive through children's diabetes clinic was established to enable vital blood sugar level tests to continue in safety; chemotherapy treatment was temporarily relocated from the Alexandra Hospital to the Covid-safe Kidderminster Treatment Centre; and a series of health and wellbeing events for cancer patients were turned into an online resource to be accessed at any time.

At the same time our staff and patients were directly involved in a clinical trial for dexamethasone, which can help save the lives of patients who are seriously ill with Coronavirus; and Herefordshire and Worcestershire's Covid-19

vaccination programme got underway at the Alexandra Hospital.

To enable our staff to continue to provide the best for our patients, ensuring they make time for their own physical and mental health and wellbeing has also been a priority, and we are grateful for the generous support of our communities whose fundraising and volunteering enabled us to further boost our extensive health and wellbeing support offer in a range of ways, including pop up Wellbeing Shops, and dedicated areas where colleagues could go for some respite.

But while, our staff and services have responded amazingly well over the past year, this has inevitably meant that many people have had to wait longer than we or they would like for their treatment as non-urgent operations and routine diagnostic work were suspended to cope with the increased numbers of seriously ill patients.

Now, as the numbers of Covid-19 patients continues to reduce, we are firmly focussed on the task ahead and the need to balance being prepared for any resurgence in Covid and accepting that it will impact on our ways of working for some time, while also restarting our services in a planned way.

Being lifted out of quality special measures by NHS England and NHS Improvement in September after almost five years was certainly cause for celebration, and we continue to make great strides in our person-centred approach for patients, their carers and families, widening opportunities for the public to share feedback to inform quality improvement.

It important to us as a Trust to create an inclusive environment for everyone who experiences our hospitals from our patients to our staff and a concerted focus on health inequalities, diversity and inclusion has never been more important. Our teams have worked hard to focus on inclusion and in particular our staff networks, LGBT+ and our recently formed Black, Asian, Minority Ethnic (BAME) Network have focussed on improving the experience of minority groups so that colleagues have confidence to be themselves at work regardless of their protected characteristics.

As we head into 2021/22 we are looking 4ward to the opportunities for us to further accelerate innovation and service transformation, not just within our Trust but across our Integrated Care System (ICS) as we work in even closer partnership with health and care colleagues, local communities and partners across Worcestershire and Herefordshire in the future.

Sir David Nicholson
Chair

Matthew Hopkins
Chief Executive

2020/21 A year like no other

Thank you to the children at Lyppard Grange Primary School for making our imaging staff smile everyday when they see this fabulous masterpiece.

Mayor of Worcester City Council Allah Ditta and fellow trustees were on hand to deliver vital equipment to hospital chiefs.

The eyes have it

One of our very artistic colleagues redefined PPE as 'Portrait Painting Exhibition!'

Jo Keeley, who works for our Abdominal Aortic Aneurysm (AAA) Screening Programme, has been using her free time out of work to paint portraits of our staff with their masks on for an online exhibition. Jo's already painted more than 300 colleagues, with over 100 more paintings in the pipeline. The portraits have impressed so much that the George Marshall Medical Museum has created an online exhibition to showcase Jo's paintings. You can see the full exhibition online at: medicalmuseum.org. uk/eye-contact

Community support is uplifting

Coronavirus has touched all of our lives in one way or another, but our teams wouldn't have been able to do the jobs they've been doing without the help, support and well wishes from our local community. The support from the public and local businesses has provided a much needed morale boost for our staff when at work or when travelling to or from our hospitals as they face the challenges that the Covid19 outbreak has brought.

Support for Covid-19 survivors

Critical Care Consultants, Outreach Nurses, Physiotherapists and Occupational Therapists are offering support and advice to patients who have survived Covid-19.

Patients who have been on ventilators or continuous positive airway pressure therapy (CPAP), machines that help an individual with their breathing are invited to attend virtual video follow up clinics after they have left hospital. Each clinic provides survivors with support and guidance from a wide range of medical professionals to help each patient return to full physical and mental health.

As well as follow up clinics, staff have introduced virtual support groups that allow patients who have been discharged from an intensive care unit to talk to others who have also gone through that same experience.

Health and wellbeing services moved online to support people affected by cancer

Cancer patients across Worcestershire can now access online wellbeing support.

In partnership with Macmillan Cancer support and Move More Worcestershire, the Cancer Services Team had planned to hold a series of Health and Wellbeing Events over the course of the year, offering support with self-management for people affected by cancer.

However, due to the Coronavirus outbreak and for the safety of patients, the live events could no longer take place. Staff have worked together to create a series of videos that can be accessed at any time, with the aim of providing those affected by cancer, their families and carers with advice and information.

The videos provide advice and guidance on a variety of topics including; dietary advice, keeping active and coping with fatigue, and relaxation and mindfulness techniques. The videos and guidance can be found on www.worcsacute.nhs.uk/health-and-wellbeing

County Covid-19 research helps provide international medicine breakthrough

Our staff have worked with hundreds of patients to participate in clinical trials.

Our hospitals are participating in a number of National Institute for Health Research supported, urgent public health studies and audits investigating potential treatments and providing vital information to improve our knowledge of Covid-19.

One clinical trial that our staff and patients have been directly involved in was the first in the world to successfully find a drug – dexamethasone – which can help save the lives of patients who are seriously ill with Coronavirus.

Emma Rowan, Research Operations Lead at the Trust said: *"The government has been clear that*

it is research that offers us hope to end the pandemic and it has been critical to their response. We are a crucial part of this nationally coordinated effort and are currently prioritising Covid-19 research to create the capacity to support as many of these important trials as possible. "

More than 200 student nurses and midwives provide vital support to hospital patients

Student nurses and midwives have provided care and comfort to patients and vital support to hospital staff across the Alexandra and Worcestershire Royal Hospitals during the Coronavirus pandemic.

One hundred and eighty-four student nurses and 38 midwives from the University of Worcester opted for a six month paid placement on the frontline, with many more continuing with their course-related placements in hospitals and care settings, volunteering in their communities or supporting people in other ways.

Keeping patients and loved ones in touch during the pandemic

Ensuring patients and their loved ones have been able to keep in touch has been vital at a time when visiting our hospitals has been restricted to keep patients and staff as safe as possible.

Kind-hearted staff put a number of solutions in place to support people to keep in contact as much as they can. Thanks to the generous donation of over 130 iPads, Virtual Visiting has allowed patients to have vital contact with their nearest and dearest via Facetime and Skype.

Patients' families and friends have also been invited to send letters and small gifts from home to bring cheer to their loved ones while they are in hospital. Patients in Covid wards are given a small knitted heart, and their relatives receive the matching pair to remind them that, even though they are not able to be with each other, their loved is in safe hands and is not alone.

A generous donation of over 130 iPads has allowed patients to have vital virtual contact with their friends and family.

County vaccination programme gets off the ground at the Alexandra Hospital

Consultant Colorectal Surgeon Pamela Sivathondan (pictured above) became the first member of healthcare staff in the county to be vaccinated when the Herefordshire and Worcestershire Covid 19 Vaccination Programme got underway at the Alexandra Hospital on December 15.

Tweeting at the time, Pamela said: *"Absolutely thrilled to be the 1st. Congrats and thank you to @worcsacutenhs for all the hard work in getting this to frontline staff. 1st step towards normality and just hoping all my colleagues get vaccinated soon."*

An innovative new system transforms Ophthalmology services across Worcestershire

Richard Evans, Associate Nurse Practitioner using the new OpenEyes system

A new web based electronic patient record system is now in use across Worcestershire's hospitals, reducing the need for patients to visit hospital for their procedures.

The new digital system OpenEyes is a secure open source electronic patient record system that allows health professionals to share information electronically across health care providers across Worcestershire.

OpenEyes enables clinical staff to record data in real-time, eliminating the use of paper. The new system is also designed to be used in any Ophthalmic setting across Worcestershire, meaning a patient's information will be instantly available to authorised and authenticated users regardless of time and location.

Quality and safety improvements lift Trust out of special measures

There were celebrations in September when the Trust was lifted out of quality special measures by NHS England and NHS Improvement after almost five years.

Matthew Hopkins, Chief Executive, said: *"This is fantastic news for colleagues across our Trust who have worked so hard to put our patients first and provide the safest, highest quality care they can.*

"It is recognition of the progress we have made, and is another very important step forward on our improvement journey, following on from last year's greatly improved CQC ratings and the way we have risen to the unprecedented challenges of the Covid-19 pandemic.

"There is still much we have to do, and many more challenges to overcome, but this announcement is a huge vote of confidence in our ability to make sure that every patient coming through the doors of our hospitals gets the best, safest, most compassionate care."

New unit helps keep A&E waits shorter

Our brand-new Ambulatory Emergency Care (AEC) opened at Worcestershire Royal Hospital in February.

The unit (pictured above) treats patients who need urgent care but are not sick enough to need to be admitted to a hospital bed. This helps keep our A&E waiting times shorter for others who need serious or life-saving care.

Multi-million pound redevelopment plan for Worcestershire Royal Hospital's Urgent and Emergency Care

Plans to transform urgent and emergency care services at Worcestershire Royal Hospital could see a relocation and expansion of the hospital's Emergency Department and the creation of an 'emergency village' hosting a wide range of diagnostic and treatment services.

The plans are being drawn up following the offer of an additional £15 million central funding to Worcestershire Acute Hospitals NHS Trust, to deliver improvements in urgent care facilities at the Trust's Worcester site.

The Trust aims to use the funding to deliver an improved patient experience for patients receiving care from the Emergency Department (ED) and other urgent care services as well as providing clinical teams with a much better working environment.

The expansion of urgent care facilities will further contribute to the improvements being led by local health and care organisations to reduce waiting times, improve ambulance handovers and also introduce new and innovative models of care in and out of hospital.

The preferred location for the new development is in the refurbished Aconbury East block, using two currently unoccupied floors, with an additional ground floor extension.

Subject to planning approval, building work is due to start on the new development before the end of April 2021, with the aim of a phased opening of the new unit starting in spring 2022.

Worcestershire nurses shortlisted for three national nursing awards

Nurses from Worcestershire's hospitals celebrated after being shortlisted as national finalists in three different categories for the prestigious Nursing Times Awards 2020.

The Frailty Team based at Alexandra Hospital in Redditch were chosen in the Care of Older People category after setting up a specialist Frailty Assessment Unit and inpatient wards designed specifically for people living with Frailty. The service provides Comprehensive Geriatric Assessment for thousands of patients over-65, which prevents hundreds of these patients from being unnecessarily admitted to hospital each year.

Worcestershire's Community Neonatal Service was chosen as a finalist in the Nursing in the Community category, after the team implemented a new seven-day neonatal community outreach service in the county.

Specialist nurses from Worcestershire were also shortlisted for an award for their work alongside Bangor University in the Infection Prevention and Control category. The team worked together with university lecturers to develop a custom-made online learning course for other nurses and healthcare practitioners on Infection Prevention and Control

Innovative maternity app gives mums real-time information about their pregnancy

Pregnant women across Worcestershire are now able to access a real-time summary of their maternity notes at their fingertips.

An innovative maternity app, 'BadgerNet', has replaced paper records, and supports women from their first contact in antenatal care through to the delivery of their baby and postnatal care.

It also means information can be shared directly with expectant mums from the maternity system, and they can also add personalised information – such as plans and preferences for birth – which can be discussed with their midwife.

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 595,786 people in Worcestershire as well as caring for patients from surrounding counties and further afield.

In 2020/21 we provided care to more than 242,643 different Worcestershire patients – that is 40% of the Worcestershire population receiving care at one of our hospitals.

We saw 664 patients per day, including:

- 128,473 A&E attendances (WRH, ALX and KTC)
- 118,114 Inpatients
- 458,225 Outpatients
- 4,863 births
- 4,950 babies

We employ nearly 6,800 people and more than 567 local people volunteer with us helping to deliver care. In 2020/21 we had an annual turnover of over £559 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 20/21

2,723
COVID INPATIENTS

11.2
DAYS IN HOSPITAL
(FOR COVID PATIENTS)

1,996
PATIENTS
DISCHARGED

287,961
OUTPATIENTS
(FACE TO FACE)

170,264
OUTPATIENTS
(VIRTUAL AND TELEPHONE)

74,134
WALK-IN PATIENTS (A&E)

53,608
PATIENTS ARRIVING
BY AMBULANCE

118,114
INPATIENTS

4,950
BIRTHS

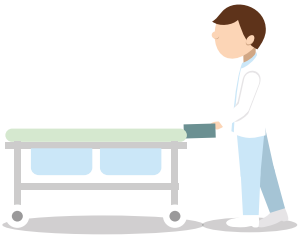
3,612
EMERGENCY
OPERATIONS

8,744
ELECTIVE
OPERATIONS

1,265
TRAUMA
OPERATIONS

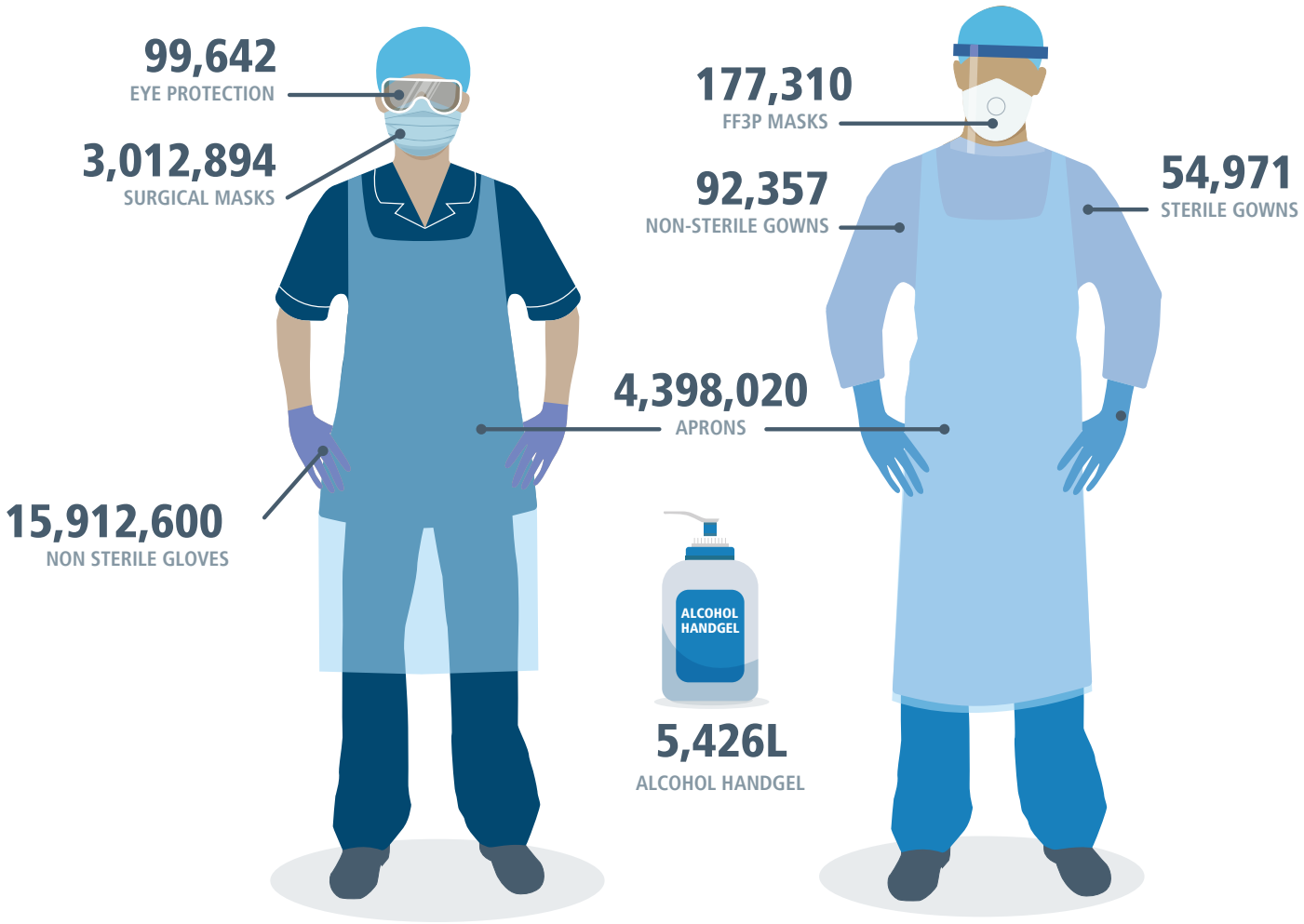
5.6 days
AVERAGE LENGTH
OF STAY

535,177
NUMBER OF MEALS
SERVED

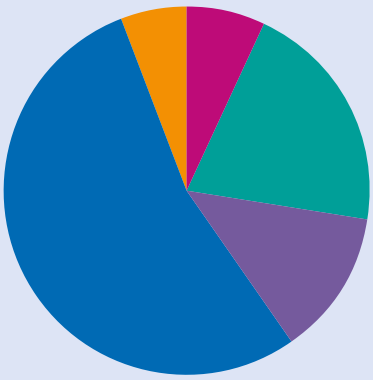


913,798
NUMBER OF SHEETS
LAUNDERED

£48.3M
VALUE OF PRESCRIPTIONS
ISSUED



Diagnostics



- MRI scans - **15,955**
- Non-obstetric ultrasound scans - **48,089**
- CT scans - **50,511**
- Plain film X-Rays - **277,165**
- Endoscopies - **11,420**

Staff

Registered Nurses and Midwives
2,149

Total Staff
6,748

Doctors and Consultants
713

HCAs, Helpers and Assistants
1,304

OTHER CLINICAL STAFF AND ALLIED HEALTH PROFESSIONALS
854

OTHER NON-CLINICAL SUPPORT STAFF
1,728

VOLUNTEERS
423

Covid Numbers

The following tables summarise the total number of Covid inpatients treated (incl. those that are still inpatients), their combined length of stay (i.e. total bed days), the numbers discharged (treated) and those who died (in hospital). They also show the crude mortality rate and average length of stay.

Combined (since 23 March 2020)

Site	Total no. inpatients	Combined Length of Stay (LOS)	Discharged (treated)	Died (in hospital)	Combined discharges	Crude mortality rate	Average LOS (treated)	Average LOS (died)
ALX	1,325	16,011	921	394	1,315	30.0%	11.7	12.4
WRH	1,422	16,255	1,104	304	1,408	21.6%	11.0	12.3
Trust	2,747	32,266	2,025	698	2,723	25.6%	11.3	12.4

The following two tables outline the same data for wave 1 and wave 2 (separately).

Wave 1 (23 March – 22 September 2020)

Site	Total no. inpatients	Combined Length of Stay (LOS)	Discharged (treated)	Died (in hospital)	Combined discharges	Crude mortality rate	Average LOS (treated)	Average LOS (died)
ALX	401	4,631	258	143	401	35.7%	11.8	11.1
WRH	360	4,004	260	100	360	27.8%	11.3	10.7
Trust	761	8,635	518	243	761	31.9%	11.6	10.9

Wave 2 (23 September 2020 – 31 March 2021)

Site	Total no. inpatients	Combined Length of Stay (LOS)	Discharged (treated)	Died (in hospital)	Combined discharges	Crude mortality rate	Average LOS (treated)	Average LOS (died)
ALX	924	11,380	663	251	914	27.5%	11.7	13.1
WRH	1,062	12,251	884	204	1,048	19.5%	11.0	13.1
Trust	1,986	23,631	1,547	455	1,962	23.2%	11.3	13.1

Performance Summary

Description	Indicator	2020/21 Target	Year End	Period
Quality				
Mortality	HSMR – Hospital Standardised Mortality Ratio	<=100	99.08 (as expected)	Rolling 12 months to March 2021
	SHMI – Summary Hospital Mortality Indicator	<=1	1.0210 (as expected)	Rolling 12 months to January 2021
Infection Control	Clostridium Difficile	<=53	59	April 2020 - March 2021
	MRSA	0	2	April 2020 - March 2021
Prevention	VTE - Venous Thromboembolism Risk Assessment	>=95%	96.71%	April 2020 - March 2021
Patient Experience	Mixed Sex Accommodation Breaches	0	13	April 2020 - March 2021
Operational				
Cancer	62 days: Wait for first treatment from urgent GP referral: All Cancers (unadjusted)	>=85%	68.97%	April 2020 - March 2021
	31 days: Wait for first treatment: All Cancers	>=96%	95.49%	April 2020 - March 2021
	2 Week Wait: All Cancer Two Week Wait (suspected Cancer)	>=93%	81.70%	April 2020 - March 2021
	2 Week Wait: Wait for symptomatic breast patients (Cancer not initially suspected)	>=93%	42.97%	April 2020 - March 2021
18 Weeks Waiting Time	RTT - Referral to Treatment: Incomplete - 92% in 18 weeks	>=92%	52.89%	March 2021
Diagnostic Waiting Time	6+ week Diagnostic Waits (% of breaches on the waiting list)	<=1%	50.67%	March 2021
A&E Waiting Time	4 Hour Waits (%) - Trust inc. MIU	>=95%	84.13%	April 2020 - March 2021

Description	Indicator	2020/21 Target	Year End	Period
Stroke	80% of patients spend 90% of time in a Stroke Ward	>=80%	77.20%	April 2020 - March 2021
	Direct admission (via A&E) to Stroke Ward	>=90%	48.91%	April 2020 - March 2021
	TIA - Transient Ischaemic Attack - High Risk Patients seen within 24 hours	>=70%	92.03%	April 2020 - March 2021
	CT scan within 24 hours of arrival	>=80%	46.60%	April 2020 - March 2021
Patient Experience				
Friends and Family Test	Acute Wards (% recommend)	-	96.35%	April 2020 - March 2021
	Acute Wards (Response Rate %)	>=30%	29.67%	April 2020 - March 2021
	A&E (% recommend)	-	86.60%	April 2020 - March 2021
	A&E (Response Rate %)	>=20%	19.49%	April 2020 - March 2021
	Maternity (% recommend)	-	97.53%	April 2020 - March 2021
	Maternity (Response Rate %)	>=30%	14.69%	April 2020 - March 2021

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 2020/21 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 (CQC)

Since July 2015 there have been nine announced inspections undertaken by the Care Quality Commission (CQC); a number of unannounced Core Service inspections, three focused inspections of our Urgent Care Services, and a focused inspection of our Maternity Services.

The Trust's Emergency Departments were inspected as part of the CQC's focused winter programme in December 2019. Following this inspection, the CQC issued Section 31 Conditions Notices for the Worcestershire Royal Hospital and Alexandra General Hospital Emergency Departments.

In partnership with NHSI/E, CCG and WMAS, safety, quality, risk assessment and assurance tools and processes have been implemented and embedded across the service. Oversight of the continuous improvement has been monitored via the Trust's internal governance structure and the Homefirst Worcestershire Board.

The Trust has continued to satisfy the conditions, submitting fortnightly reporting to the CQC. In February 2021, the Trust applied for the Section 31 Conditions to be removed from the Emergency Departments and, at the time of writing this report, the Trust was awaiting an outcome decision.

On 24th September 2020, the NHS National Director of Improvement confirmed that the Trust has been lifted out of quality special measures after almost five years. He also congratulated the Trust on our excellent progress and hard work, particularly in improving our Urgent and Emergency Care performance.

Throughout 2020, and as part of the Covid-19 response, CQC implemented a Transitional Monitoring Approach. Under this model, the Trust has completed self-assessments in the following areas:

- Trust-wide focused infection control Board Assurance Framework
- System-wide responses for the Provider Collaboration Reviews, focused on Urgent Care across Herefordshire and Worcestershire
- Project Reset in Emergency Medicine, Patient FIRST

During 2020/21, the CQC conducted one unannounced inspection at Worcestershire Acute Hospitals NHS Trust. On 9 December 2020, the CQC conducted an on-site focused inspection of the Maternity Core Service at Worcestershire Royal Hospital.

Following the inspection, the Maternity service's overall rating went down from Good to Requires Improvement. The service was rated as Good for being effective and Requires Improvement for being safe and well-led. The service's previous ratings for caring and responsive remained as Good.

The inspection report, published in on 19 February 2021, positively identified that:

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The service had enough medical staff with the right qualifications, skills and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of women's care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, not all records were up-to-date.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women and babies. They supported each other to provide good care.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The CQC identified that further improvements were required within Maternity to ensure:

- Effective monitoring and oversight of staffing
- Monitoring risks, issues and patient outcomes
- Incident reporting and sharing learning
- Engaging with staff to make improvements in a timely way
- Training compliance post Covid-19 pandemic response
- Governance processes – staff roles, accessible information

The Trust has maintained its overall quality rating of "Requires Improvement".

The Trust continues to be rated positively "Good" in the "Effective" and "Caring" domains, and "Requires Improvement" in the "Safe", "Responsive" and "Well-Led" domains.

CQC Inspection Report published 19 February 2021:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires improvement Feb 2021	Good Feb 2021	Good Sept 2019	Good Sept 2019	Requires improvement Feb 2021	Requires improvement Feb 2021

Ratings for the whole Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall Trust	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

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
Alexandra Hospital	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Kidderminster Hospital and Treatment Centre	Good	Good	Good	Requires Improvement	Good	Good
Evesham Community Hospital	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall Trust	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Performance Management Framework

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

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

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

The divisional performance matrix aligns metrics to these five themes whilst ensuring that all of the annual priorities have been accounted for.

Performance is monitored against the targets set out in the Single Oversight Framework or against agreed improvement trajectories. In all other cases targets or improvement trajectories are agreed with Divisions.

Performance tracking is based on these general principles:

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

Over the course of 2020/21, the Performance Management Framework was superseded by an incident command structure which was established to provide operational, tactical and strategic governance and decision making in response to the Covid-19 pandemic. During this time, and especially when the Trust was at its highest escalation levels, meetings classed as non-essential were stood down in order to create capacity for staff to focus on the care of patients and hospital management. Between wave 1 and 2, meetings to support the restoration of services were prioritised, led by the Restoration Oversight Group and its sub-committees. As we anticipate returning to business as usual during 2021/22, the Performance Management Framework will be updated in-line with the Trust's clinical and operational objectives.

Delivery of Operational Performance Standards and the impact of Covid-19

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

However, it has to be recognised that Covid-19 significantly changed our capability to achieve operational standards in 2020/21 and this will continue to be the case, for some waiting time

standards, for the foreseeable future as we restore services and increase our capacity in-line with government ambition and policy. While the majority of urgent care and activity was maintained through 2020/21, elective care was disrupted. Cancer patients were prioritised and treatments continued, however there was a reduction in clinic capacity and the complexities of managing straight to test pathways meant that patients waited longer than the operational standards require. During the year, the Trust also had to suspend routine and non-urgent diagnostics to provide the capacity for urgent diagnostics.

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 2020/21. Plans to improve performance are highly dependent on the availability of beds, the capacity to respond to the unknown, unmet, demand that will result from the anticipated increased levels of GP referrals and the treatments required, and delivery of service restoration.

The summary of performance can be seen within the Performance Summary section, page 17 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 6 years. With 84.13% of patients admitted, transferred or discharged within 4 hours, the EAS performance has increased in 2020/21 by 10.96 percentage points compared to the 2019/20 performance of 75.82%. For context, 23,168 fewer patients attended A&E this year due to the Covid-19 pandemic even though the Government's message was that the 'NHS is open for business, and for people to seek emergency support as soon as they need it'. The principal reason for the performance level remained the lack of bed availability caused by delays in discharging patients following completion of their hospital based treatment. Although bed capacity at peak times of the pandemic was limited; cohorting wards to ensure patients were treated appropriately, the number of patients waiting more than 12 hours in the A&E Departments from the point at which a decision had been made to admit them reduced from 934 in 2019/20 to 79 in 2020/21.

Referral to Treatment (RTT)

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

Due to the impact of the Covid-19 pandemic where at points during the year decisions were taken to cancel outpatient appointments, diagnostic tests and elective surgery, the Trust has not met the 92% standard in 2020/21. At the end of March 2021 52.89% of patients were within 18 weeks of referral compared to 78.75% the previous March. The size of the waiting list has grown from 35,394 at the end of March 2020 to 46,513 at the end of March 2021. Over the course of the year, activity levels fluctuated, however they were not at 2019/20 levels due to the on-going restrictions in place to keep our staff and patients safe. The number of patients over 52 weeks for their treatment has increased month on month throughout 2020/21, starting at 1 in March-20 and rising to 6,515 at the end of March 2021.

Cancer

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

Over the year 68.97% of patients have commenced treatment within 62 days. This is a slight decrease from the previous year which saw 69.02% of patients commencing treatment within the required timescales. There has been a decrease in the number of patients treated; 1,900 in 2020/21 compared to 2,127 in 2019/20. Our capacity to see and treat cancer patients was impacted by the Trust's response to the Covid-19 pandemic and the necessary introduction of additional infection prevention and control measures to protect patients and staff. However, the Trust used the independent sector to enable as many cancer patients as possible to undergo surgery in a timely way.

Diagnostics

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

The Diagnostics standard has not been met in 2020/21 with 50.67% of patients waiting more than 6 weeks at the end of March 2021. The previous year's performance in 2019/20 did not hit the standard with 5.71% of patients waiting more than 6 weeks. At points during the year, the Trust had to suspend routine and non-urgent diagnostics to provide the capacity for urgent diagnostics; and in order to create additional intensive care beds at the Alexandra Hospital during the wave 2 peak, the Trust created surge capacity using the endoscopy unit. The delay in patients receiving diagnostic tests is having an adverse impact on the time elapsed before cancer treatment commences.

Matthew Hopkins
Chief Executive

Date: 9 June 2021

Financial Performance in 2020/21 – Finance

The Trust has three key financial duties and has achieved compliance with the Capital Resource Limit and External Financing Limit. It has achieved an in year Income and Expenditure surplus position (subject to audit) under the National Financial Framework established during Covid-19. It should be noted, though, that it has not achieved the Statutory Breakeven duty. This 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 not been able to meet this in recent years and as required under statute, our external auditors formally notify the Department of Health and Social Care (DHSC) annually.

The Trust has reported an Adjusted Financial Performance surplus (including Top-Up funding, excluding impairments and the impact of donated assets) of £6.7m against the allocated funding for the 2020/21 financial year. This represents a positive performance against the originally planned deficit, and is broadly in line with the forecast financial outturn considering the impact of the COVID wave 2 during quarter four; key variations in notification of national support (including annual leave support); and resolution of system inter NHS balances.

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 2020/21 £000s	Actual 2019/20 £000s
Operational (Adjusted) financial performance surplus/(deficit) including PSF, FRF, MRET and Top-up funding, excluding Impairments	6,652	(81,466)
Adjust Remove impact of prior year PSF post accounts reallocation	0	493
Adjust Remove capital donations/grants I&E impact	847	(70)
Adjust I&E impairments/(reversals)	(6,553)	(7,288)
Adjust Remove net impact of DHSC centrally procured inventories	385	
Surplus/(deficit) for the year including PSF, FRF and MRET and Top-Up funding and after Impairments	1,331	(88,331)

A number of productivity and efficiency schemes were delivered in year, totalling £10.9m, though the impact of the pandemic meant the originally identified level of £14.6m was not fully met. £9.3m of the delivered savings were achieved recurrently.

Prior to the change in financial regime the Trust requested and received £7.7m of interim revenue support PDC in April 2020. No further interim revenue borrowing was requested as a result of the in-year position.

The Department of Health and Social Care converted historic interim revenue and capital loans totalling £324.4m to Public Dividend Capital (PDC) in September 2020. This reduced the interest liability although offsetting PDC dividends are now payable. The Trust also received

£20.8m of capital PDC to support targeted capital schemes, largely related to previously identified high risk backlog; supporting the Covid response; and enabling restoration of activity. Total new borrowings in 2020/21 are £28.5m.

An improved cash flow, has supported an improvement in Better Payment Performance in 2020/21 compared to 2019/20. In 2020/21, the Trust achieved 97% by number (96% in 2019/20) and 94% of value (90% in 2019/20).

The Trust has invested £26.5m of capital resources in 2020/21 in line with its Capital Resource Limit. This was funded from: internally generated funds; interim capital PDC funding; Urgent and Emergency Care PDC; Critical Infrastructure Risk PDC; and other national funding streams including supporting the Covid response.

Schemes included major developments such as the commencement of a new Urgent and Emergency Care unit in the Aconbury redevelopment; IT network infrastructure improvements; cyber security; replacement of clinical equipment including end of life diagnostic equipment; critical backlog maintenance of the estate; and developments such as the breast services redevelopments and the Garden Suite Chemotherapy facility at the Kidderminster Treatment Centre.

Looking forward to 2021/22 and beyond

The Trust still has a challenging financial outlook entering 2021/22 with a high underlying cost base compared to peer multi-site hospital Trusts.

In light of the Covid-19 response, the planning cycle has been revised and the interim national funding regime seen in 2020/21 largely rolled forward into the first half of 2021/22. Planning for the second half of 2021/22 is ongoing, based on a return to funding allocations in place prior to the pandemic.

The revised planning cycle incorporates greater ICS planning and co-ordination with a focus on increasing capacity to meet the needs of patients. This is focused especially on those with delayed treatment caused by the Covid-19 Pandemic. The aim is to determine and meet increased patient demand and activity within a nationally determined funding allowance aligned to an acceptable system operational financial plan. The Herefordshire & Worcestershire system is expected to deliver a break even position in the first half of 2021/22. The 2021/22 Trust Annual plan will be refreshed when national guidance and trajectories for the remainder of 2021/22 are finalised.

The NHS faces continued pressure with substantial challenges further impacted by Covid-19 and driven by an ageing population; increases in the prevalence of long-term conditions; and rising costs and public expectations within an even more economically challenging financial environment.

In order to respond to these challenges health and social care partners across Herefordshire and Worcestershire through the newly established Integrated Care System (ICS) 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 in the NHS Long Term Plan. The shared focus is the need to demonstrate and deliver a system-wide sustainable return to financial balance.

The Trust capital resources now form part of an overall system capital envelope. This is collectively prioritised against the most urgent schemes and has been agreed for 2021/22.

The system internally generated capital resources remain limited, and there is recognition that interim support funding over and above internally generated cash will be required. In addition to the system capital envelope, the Trust is planning to continue to progress nationally funded capital schemes including the breast services scheme, ASR scheme and the Urgent and Emergency Care scheme.

The Trust faces a range of risks and operates in a challenging financial environment. In March 2021 the Board made an assessment of the risks, opportunities and uncertainties it faces and considers itself to be a going concern in line with published guidance. The published accounts are therefore produced on a going concern basis. As a result of Covid-19, interim arrangements for contracting and payment were put in and remain in place nationally. There is clear evidence of continued provision of services being planned by NHSE/I, Commissioners and within the Trust.

The primary risk to the Trust remaining as a going concern is the underlying cost base and structural deficit and the resultant cash shortfall (under the suspended PbR regime) to be able to discharge our liabilities. Despite a surplus position in 2020/21 there is a continuing breach in the achievement of the Breakeven duty which the external auditor will be required to refer as a s30 referral to the Secretary of State. The conversion of historic revenue and capital interim loan funding to PDC from April 2020 and the Financial Framework in 2020/21 and into the first half of 2021/22 has reduced the risk associated with the going concern assessment.

Better Payments

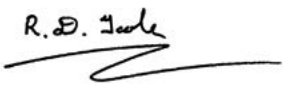
The Better Payments Practice Code (BPPC) targets NHS Bodies with paying Creditors within 30 days of receipt of goods or an undisputed invoice (whichever is later) unless payment terms have been agreed. The Trust does however pay all invoices within 7 days or as soon as they are authorised for payment.

The move to a surplus position in 2020/2021, coupled with the change in financial regime during Covid has resulted in an improved cash flow. This had a slight benefit to payments to creditors within the required BPPC target. The Trust performance in 2019/2020 was 96% by number and 90% by value. The Trust improved achieving 97% and 94% respectively in 2020/2021.

The Trust's cash position will be closely monitored in 2021/2022 with an underlying deficit remaining; plans have been put in place to manage liquidity.

BPPC Target Performance : 95%	Number	£000
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	86,534	238,913
Total Non-NHS Trade Invoices Paid Within Target	84,111	230,673
% of Non-NHS Invoices Paid Within Target	97.2%	96.55%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,155	17,161
Total NHS Trade Invoices Paid Within Target	1,619	9,687
% of NHS Invoices Paid Within Target	75.13%	56.45%
Total Payables		
Total Invoices Paid in the Year	88,689	256,074
Total Invoices Paid Within Target	85,730	240,360
% of Invoices Paid Within Target	96.66%	93.86%

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



Robert D Toole
Chief Finance Officer

Date: 9 June 2021

Herefordshire and Worcestershire Integrated Care System (ICS)

The vision across the Herefordshire and Worcestershire Sustainability & Transformation Partnership (STP) footprint of Herefordshire and Worcestershire has been broadened in line with development of the ICS partnership, linked to the wider determinants of health:

> "Our residents will have healthy, fulfilling lives and feel safe"

Underpinned by a core purpose to:

> "recover from the economic, health and wellbeing impacts of Covid-19"

Consistent with the framework outlined in the NHS Long Term Plan, published in January 2019, the STP has evolved into the Integrated Care System. Herefordshire and Worcestershire were designated as an ICS in late Spring 2021.

A White Paper was published in early 2021 confirming the intention to create a NHS ICS statutory board and NHS Health & Care Partnership board for each ICS. Development of the ICS and identifying priority areas of focus is overseen by the ICS Executive forum, which draws membership from the constituent organisations and sectors across the ICS. Worcestershire Acute Hospitals NHS trust is represented at the ICS Executive forum, with executive leadership of system forums and other programmes of work as part of the agreed ICS development plan. The importance of Worcestershire as the place to oversee and deliver services as a provider collaborative remains key.

Following the publication of the Trust Clinical Services Strategy in 2019, a refresh was undertaken during the year to reflect progress against year one objectives emerging from the Response phase (Wave 1) to Covid-19. The strategy is based on three strategy 'pillars': integrated care, urgent and emergency care, and acute and specialised planned care and remains consistent with the ambitions of the NHS Long Term Plan and the local Herefordshire and Worcestershire ICS plan.

In July 2020/21 NHSE/I published planning guidance for Restoration and Recovery of services following the first wave of Covid-19. A separate People Plan was also published with the expectation of an integrated ICS system plan submission. This included a recovery plan for delivery of elective and cancer services, and a half year activity and financial plan which included additional planning assumptions to address health inequalities and staff wellbeing. This system approach has been carried forward into planning for 2021/22 annual operational plans at organisational and system level.

Acute Services Review (ASR)

Reconfiguring the Alexandra Hospital's theatre and endoscopy services, and a Paediatric Assessment Unit at Worcestershire Royal Hospital, in accordance with the clinical model laid out in the Acute Services Review business case has been affected by the Covid-19 pandemic during 2020/21.

The major theatre refurbishment that underpinned the creation of surgical centres of excellence at the Alexandra Hospital, required a period of shut-down for engineering works for up to five months. This has not yet taken place, primarily because all possible theatre capacity was needed during the Covid-19 pandemic to sustain treatment for people who needed urgent surgical care, including those with cancer. During the pandemic, our usual theatre usage rates were constrained by additional control of

infection measures, reducing the numbers of patients we were able to treat each day. Further, the alternative capacity we had planned to use whilst the Alexandra theatres were off-line during refurbishment was no longer available as private hospitals firstly supported urgent NHS care and then turned their attention to catching up with their own pandemic-imposed waiting lists.

At the close of 2020/21, the Trust does not foresee being able to refurbish the Alexandra Hospital's theatres and is, instead, exploring alternative solutions, including a new, replacement, theatre suite.

Creation of surgical centres of excellence will continue and will make the Trust more resilient as it further separates routine planned surgery, for which a Covid-free environment is required, from emergency surgery.

Re-provision of modernised and enlarged Endoscopy facilities at the Alexandra Hospital will go ahead during 2021/22.

At the Worcestershire Royal Hospital site, during 2020/21, the remaining beds in the Aconbury East ward block were opened as planned and were fully utilised within the Trust's pandemic response, including provision of additional, temporary ICU capacity, allowing the main ICU to treat Covid positive patients.

Engaging with our community and stakeholders: working together in partnership

It is important to us as a Trust to continue to create an inclusive and listening environment for everyone who experiences our hospitals. At a time when the global Covid-19 pandemic has impacted across the local community and global population, our focus has been to ensure that we can maintain and even progress our stakeholder engagement and to embrace creative approaches to support this. We were faced with difficult decisions throughout the year and at the forefront of our approach was how we could ensure that our measures could support as positive a patient and carer experience as possible.

Responding to the pandemic and working together with our community in new ways:

We took the difficult decision at the start of the pandemic to restrict patient visiting, to compassionate visiting; our approach alongside this was to connect as many patients with families and friends as possible using a variety of measures including **Letters from Home**, **Knitted Hearts** and **Virtual Visiting**.


4ward

NHS Worcestershire Acute Hospitals NHS Trust

Keeping in touch with your loved one

We know how hard it is for you not to be able to visit your loved one in hospital during the Covid-19 pandemic. We are doing all we can to support people to keep in contact as much as possible. And when you cannot be there, we will be there, so that everyone in our hospitals has someone to turn to.

Phone
Patients can make free calls on the Hospedia bedside units. You might like to call or Facetime your loved one too - we have free wifi to help with this.

Video Call
If you know a patient who doesn't have a mobile phone, we can help you arrange a video call to stay in touch via Facetime or Zoom. Please contact the ward directly or our Patient Services team on **0300 123 1732** or email wah-tr.PET@nhs.net

Letters from Home
You can send letters, messages or photographs to our dedicated email inbox WAH-tr.Lettersfromhome@nhs.net If you would like our staff to read them out for you, just let us know. Please remember to include your loved one's full name, date of birth and address if known, which hospital they are in and the name of the ward. Relatives and friends can find more information on our website www.worcsacute.nhs.uk

Hearts in Hand
All patients on our Covid wards will be given a small knitted heart to hold. The 'matching pair' to that heart will be sent home to their relative so that they know that even though they are not able to be here, we are and their loved one is not alone. For further details please contact Alison.robinson34@nhs.net

We are here to support you

Our Patient and Relative Support Helpline is here to listen. You can call them on **0300 303 3544.**

Our support line offers 24/7 emotional support and a listening ear to patients in our hospitals, or for their relatives. It is a confidential service which we hope can give comfort where it's needed.

PALS Team
If you have a concern or need extra help with getting a response, you can call our PALS team on **0300 123 1732** Monday - Friday.

Online
You can share your feedback with us directly at any time. Email Patient Services at wah-tr.PET@nhs.net, Tweet us @WorcsAcuteNHS, message us on Facebook or leave a comment or review at NHS.UK

A poster sharing ways that people can connect with loved ones

Pictured left: Alison Davis with some of the supplies donated for the Staff Wellbeing stores. Right: Hundreds of prayer squares, dementia twiddle muffs and masks were donated by volunteer sewers and knitters.

We supported **Virtual Visiting**, via online communication platforms, which was supported by a donation of iPads which we shared across all of our wards. We also focused on wellbeing for patients and families with a series of early supportive measures which included a **Patient and Relative Emotional Support** helpline, managed by the Chaplaincy team and staff wellbeing which was supported by new Volunteering roles to open **WellBeing stores** to co-ordinate public donations of food and gifts.

We also developed initiatives in response to feedback received from the public which was shared online, through our Patient Advice and Liaison service and/or our Friends and Family test, this included a new **Family Liaison Hub** service with a dedicated telephone line and support staff as an important link for families. We recruited bubbles of Volunteers throughout the year to create a **Property Delivery Service** for family and friends to bring in small essential items for patients.

Throughout 2020/21, the service supported more than 4000 parcels to be delivered to patients. These Volunteers worked in a Covid-secure way and also supported with Wayfinding to give our patients and carers an extra friendly smile and reassurance when entering our hospitals. Our approach throughout the year ensured that our services could be responsive in an evolving, unprecedented and challenging environment

#WeAreVolunteering – delivering on our strategy in new ways and integrating with our partners

In response to hundreds of queries and offers of help received at the start of the outbreak, we set up a new microsite, the "App of Help" to focus public support.

Our app received nearly 1000 visits in the first few months of operation and provided a way for us to manage donations, offers of volunteering support and to signpost people to other organisations, to offer their support across the local received nearly 1000 visits in the first few months of operation and provided a way for us to manage donations, offers of volunteering support and to signpost people to other organisations, to offer their support across the local community.

The Volunteer Strategy #WeAreVolunteering was "soft" launched in July 2020 with a **Volunteer Virtual Engagement Programme**.

5 virtual engagement projects were offered to volunteers in the absence of their volunteering duties which were designed around the main themes from our volunteer consultation workshops and events in 2019-20.

112 volunteers actively engaged in the soft launch of the new Volunteer strategy.

The 5 Virtual Projects:

- **Value and Appreciate:** a survey approach to inform the co-design of new uniforms and approaches
- **Effective Communication - Adopt a Volunteer:** supporting volunteer and staff expectations
- **Making it Easier to Volunteer:** developing a Volunteer Handbook
- **Integrated Volunteer Newsletter:** editorial Volunteers creating a new Quarterly newsletter with the Worcestershire Health and Care Trust
- **Make it Easier to Volunteer:** developing a locally integrated training offer

We shared progress across the 5 Projects in our Virtual Engagement Programme, with our Volunteers in our December Volunteer Newsletter.

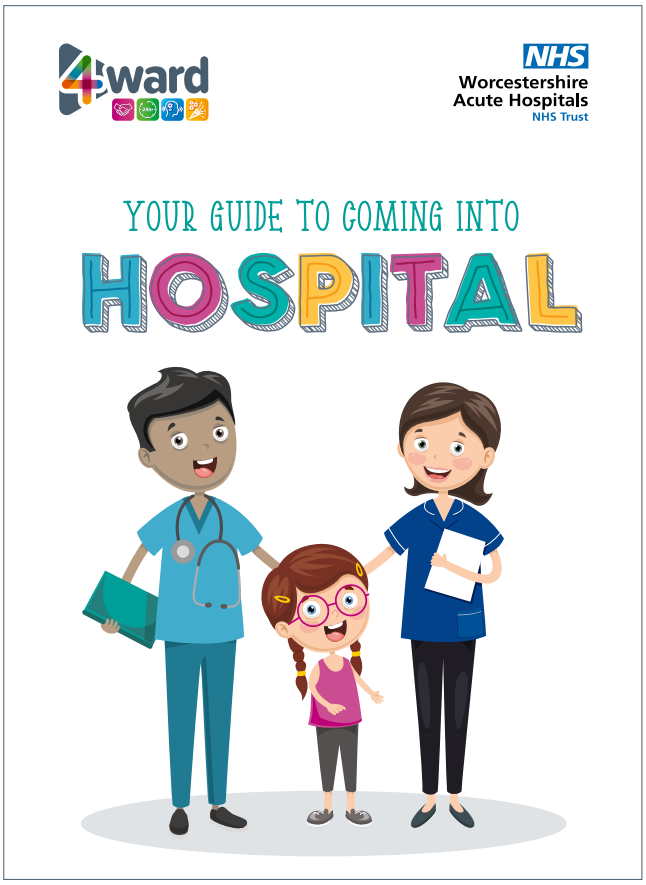
Our Keeping in Touch with Our Volunteers Programme

Throughout 2020-21 we have created new ways to ensure that our Volunteers "at home" were included in our work and our thoughts. Alongside this we created new Volunteer roles and opportunities in our hospitals for Volunteers who were still able to come onto site. We ran a recruitment programme throughout the year and welcomed a range of new ways to communicate which included **"Blogging"** and **"Vlogging"**, a **Keeping in Touch** email and telephone programme to support Volunteer wellbeing and a new quarterly integrated **Volunteer newsletter** with the Worcestershire Health and Care Trust.

We celebrated our Volunteers in "Volunteer Week" in June 2020 with a series of "one a day" blogs sharing the stories of our Volunteers' experiences during Covid-19, in their words. Our tweets were "seen" 10,495 times and more than 1000 people interacted with our tweets by messaging us, replying, "liking" and "re-tweeting". We also sent a thank you card to all of our volunteers by email and in the post.

We have worked in new ways, meeting with our Patient Representatives on the Patient Public Forum and our Hospital Youth Forum using virtual communication platforms throughout the year; we established a Patient, Carer, Public Engagement steering group to bring together our staff and local voluntary representatives including Worcestershire Carers and Healthwatch to discuss experiences of care, set against the backdrop of our Quality Improvement Strategy and we continued to enable patients to connect with family, friends and volunteers in a number of ways underpinned by the support of our volunteers and staff.

We worked with Patient Representatives to ensure that our messaging to the public during the pandemic was clear as possible, creating new leaflets, posters and letters and we listened to concerns shared through our Patient Stories and Patient Advice and Liaison Service (PALS) to create new services to support families to communicate during a time of restricted visiting (compassionate visiting).



A guide for children who are coming into hospital.

Personal Stories

As part of our commitment to understanding and learning from the patient and carer experience, we have continued to demonstrate our commitment to strengthen the patient voice at Board level and to work together by listening to feedback and ideas.

During 2020-21, we welcomed 12 patient stories at the beginning of our Trust Board meetings and we have shared some of these stories in our Equality and Diversity Annual Report and our Quality Account Annual Report. Experiences of care across our hospitals is heard and listened to at every level from Divisional meetings, steering groups, Committees and our Children's Board meetings. We continue to speak with our patients and their carers, friends and family at our annual Quality Account consultations to inform our Quality Priorities for the coming year – we also include feedback from annual patient surveys, our Friends and Family Test, via online platforms, from formal complaints and concerns and compliments shared by the public.

Copies of the Equality and Diversity Annual Report and the Quality Account can be found on our website: www.worcsacute.nhs.uk

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 2020/21 the Board met in public on 11 occasions. All meetings were held virtually due to the Covid-19 pandemic and live streamed via YouTube. The video was also posted on our website for the following month. Board development sessions included work on the annual plan, finances, mental health act, cybersecurity and dementia.

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 2020/21 were as follows:

- **Waqar Azmi**, Non-Executive Director *from 1 January 2021*
- **Paul Brennan**, Chief Operating Officer/ Deputy CEO
- **Anita Day**, Non-Executive Director
- **Paula Gardner**, Chief Nursing Officer *from 15 March 2021*
- **Mike Hallissey**, Chief Medical Officer
- **Matthew Hopkins**, Chief Executive
- **Dame Julie Moore**, Non-Executive Director
- **Vicky Morris**, Chief Nursing Officer *until 31 July 2020 and from 1 September 2020 until 31 March 2021*
- **Sir David Nicholson**, Chair
- **Robert Toole**, Chief Finance Officer
- **Bill Tunnicliffe**, Non-Executive Director
- **Steve Williams**, Non-Executive Director *until 31 December 2020*
- **Mark Yates**, Non-Executive Director *until 31 March 2021*

Non-voting members of Trust Board

- **Richard Haynes**, Director of Communications and Engagement
- **Colin Horwath**, Associate Non-Executive Director
- **Vikki Lewis**, Chief Digital Officer
- **Jo Newton**, Director of Strategy and Planning *from 27 April 2020*
- **Richard Oosterom**, Associate Non-Executive Director
- **Rebecca O'Connor,** Company Secretary *from 1st March 2021*
- **Tina Ricketts,** Director of People and Culture
- **Kimara Sharpe**, Company Secretary *until 31 December 2020*
- **Sarah Smith**, Director of Strategy and Planning *until 30 June 2020*
- **Sharon Thompson**, Associate Non-Executive Director *from January 2021*

Details of all the Board members and their declaration of interests can be viewed on the Trust's website 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 Directors and other key senior staff from throughout the organisation.

Governance

The governance 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. This was refined by the work of the Governance Task and Finish group which approved updated templates for the oversight and management of BAF risks, strengthening the utilisation of the BAF by Committees.

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

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

The **Audit and Assurance Committee's** role is to critically review the governance and assurance processes upon which the Trust Board places reliance, ensuring that the organisation operates effectively and meets its strategic objectives. The Audit and Assurance committee works closely with the External and Internal Auditors. The process for managing the Board Assurance Framework is presented to the Committee on a regular basis. It also receives regular reports from the Freedom to Speak Up Guardian, Data Quality Champion, Local Anti-Fraud Specialist and Local Security Management Specialist. The Trust currently complies fully with the National Strategy to combat and reduce NHS fraud. The Committee was chaired by Steve Williams until 31 December and Anita Day from 1 January.

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 58 in the Annual Governance Statement section.

Personal Data Incidents 2020/21

Details of Information Governance related incidents can be found on page 54 in the Annual Governance Statement.

Cybersecurity 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 Trust's Cyber Operational and Resilience reported back to the Trust in 2019. The Audit and Assurance Committee have received a progress report in this financial year on the Cyber Action plan.

The Trust updated its Modern Slavery Statement in April 2021 setting out its approach to compliance with the Act; this available at https://www.worcsacute.nhs.uk/our-hospitals/at-hospital/keeping-you-safe/safeguarding-adults

The Trust has approved capital investment in the updating of critical infrastructure which will support the strengthening of the cyber posture and a reduction in the vulnerability vector these investments are fully aligned to the cyber action plan and Corporate Risk Register and Board Assurance Framework.

The Digital Clinical Reference Group and other key clinical leaders and Divisional Directors have participated in cyber awareness training to educate and support the workforce in the changing profile and nature of cyber threats that face the NHS. There is a planned Board development session taking place during quarter 2 of 2021/2022 on cyber security awareness this session will be facilitated by external subject matter experts.

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: 9 June 2021

Annual Governance Statement 2020-21

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) as we move towards an Integrated Care System, 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 have also joined the Worcestershire Alliance as we develop the PLACE agenda, and 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. On 31 March 2021 the Trust moved to Alert Level 3, and to Phase 8 of the Command and Control governance structure with Gold Command meeting weekly and Silver Command meeting twice weekly.

The Trust has been monitored and assessed by a wide range of external agencies. These have included the local Clinical Commissioning Group (following their merger 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 Health 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 of Hereford and Worcester Clinical Commissioning Group. 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 Health Overview and Scrutiny Committee.

As at 31 March 2021, the Trust's adjusted financial performance surplus including top-up funding but excluding impairments and the impact of donated assets was £6.7m. This represents a positive performance against the £(7.3)m planned deficit recognised by NHSE/I in 2020/21 under the Covid-19 financial architecture.

The Trust's Annual Plan for 2020/21, developed under a Payment by Results model prior to the impact of Covid-19 and the changes to the financial regime, was a planned deficit of £(78.9) m (excluding funding from the Financial Recovery Fund). As a result of Covid-19, an interim national financial regime was introduced, providing fixed funding envelopes and top up funding to mitigate the impact of materially changed activity profiles, and enable providers to meet the additional costs associated with the pandemic response.

The positive improvement to the Covid-19 planned deficit is primarily driven by slower than anticipated elective recovery (and associated marginal costs) as a result of the impact of wave 2 during quarter 4, coupled with additional national funding streams not known at the time of setting the plan. A number of productivity and efficiency schemes were delivered in year, though the impact of the pandemic meant the originally identified level was not fully met.

Despite the positive performance against the Covid-19 planned deficit, the Trust's underlying financial position remains a material deficit. The Trust's cumulative deficit against the break-even duty stands at £(342.6)m at the 31st March 2021.

The Trust has met its statutory duties of External Funding Limit and Capital Resources Limit. Though the Trust has delivered an in year Income and Expenditure (I&E) surplus, the cumulative deficit position means that the Trust has not complied with its statutory Break Even Duty required by the National Health Service Act 2006 as this requires break even over a rolling 3 year period. Grant Thornton, the Trust's external auditors, are expected to issue a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 due to the Trust's failure to comply with the Break Even Duty.

The Annual Plan for 2020/21 was approved by the Board in March 2020. Performance against objectives was 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 Productivity and Efficiency 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

In the light of the Covid-19 pandemic, a revised Annual Plan for 2020/21 was approved by the Trust Board in both June and November 2020, to re-prioritise activity in the response to Waves 1 and

2 of the Covid-19 pandemic respectively. Annual Planning guidance for 2021/22 was published late March 2021 to develop a half year plan in line with NHSE/ I Recovery of services.

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

2. Quality

Worcestershire Acute Hospitals NHS Trust was placed in Quality Special Measures in November 2015. Following the publication of the September 2019 CQC Inspection report, the Trust improved its overall CQC rating to Requires Improvement, and it was recommended that the Trust was removed from Special Measures.

Since July 2015 there have been nine announced inspections undertaken by the Care Quality Commission (CQC); a number of unannounced Core Service inspections, three focused inspections of our Urgent Care Services, and a focused inspection of our Maternity Services.

The Trust's Emergency Departments were inspected as part of the CQC's focused winter programme in December 2019. Following this inspection, the CQC issued Section 31 Conditions Notices for the Worcestershire Royal Hospital and Alexandra General Hospital Emergency Departments.

In partnership with NHSI/E, CCG and WMAS, safety, quality, risk assessment and assurance tools and processes have been implemented and embedded across the service. Oversight of the continuous improvement has been monitored via the Trust's internal governance structure and the Homefirst Worcestershire Board.

The Trust has continued to satisfy the conditions, submitting fortnightly reporting to the CQC. In February 2021, the Trust applied for the Section 31 Conditions to be removed from the Emergency Departments.

Throughout 2020, and as part of the Covid-19 response, CQC implemented a Transitional Monitoring Approach. Under this model, the Trust has completed self-assessments in the following areas:

- Trust-wide focused infection control Board Assurance Framework
- System-wide responses for the Provider Collaboration Reviews, focused on Urgent Care across Herefordshire and Worcestershire
- Project Reset in Emergency Medicine, Patient FIRST

On 24 September 2020, the NHS National Director of Improvement confirmed that the Trust has been lifted out of quality special measures after almost five years. He also congratulated the Trust on our excellent progress and hard work, particularly in improving our Urgent and Emergency Care performance.

During 2020/21, the CQC conducted one unannounced inspection at Worcestershire Acute Hospitals NHS Trust. On 9 December 2020, the CQC conducted an on-site focused inspection of the Maternity Core Service at Worcestershire Royal Hospital.

Following the inspection, the Maternity service's overall rating reduced from Good to Requires Improvement. The service was rated as Good for being effective and Requires Improvement for being safe and well-led. The service's previous ratings for caring and responsive remained as Good.

Maternity Services, Worcestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires improvement Feb 2021	Good Feb 2021	Good June 2018	Good June 2018	Requires improvement Feb 2021	Requires improvement Feb 2021

The inspection report, published in on 19 February 2021, positively identified that:

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The service had enough medical staff with the right qualifications, skills and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff kept detailed records of women's care and treatment. Records were clear, stored securely and easily available to all staff providing care. However, not all records were up-to-date.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit women and babies. They supported each other to provide good care.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The CQC identified that further improvements were required within Maternity to ensure:

- Effective monitoring and oversight of staffing
- Monitoring risks, issues and patient outcomes
- Incident reporting and sharing learning
- Engaging with staff to make improvements in a timely way
- Training compliance post Covid-19 pandemic response

- Governance processes – staff roles, accessible information

The Trust has maintained its overall quality rating of "Requires Improvement".

The Trust continues to be rated positively "Good" in the "Effective" and "Caring" domains, and "Requires Improvement" in the "Safe", "Responsive" and "Well-Led" domains.

To ensure that continued focus remains on all CQC Regulated Activity and in particular, areas where the Trust must take action to either:

- Bring services into line with legal requirements (Must Do's) and/or
- Take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in the future, or to improve the service (Should Do's)

The Trust utilises an in-house designed system for core service monitoring called the Regulatory Activity Improvement Tool (RAIT). The process and tool:

- Allows the Divisions to monitor and demonstrate progress and improvement against the Must and Should Do's aligned their Core Services.
- Enables the Divisions to provide additional accessible assurance through to Clinical Governance Group (CGG) and Quality Governance Committee (QGC).
- Supports the Divisions in completion of their self-assessments.
- Assists the Divisions in preparing for their next CQC Inspection.

Due to the success of RAIT, the Trust has recently developed local tools to support Divisions in their measurement against the CQC's Key Lines of Enquiries (KLOEs).

Essentially, the KLOE tool will work to the same process as that of the RAIT tool, however, the KLOE tool will focus on pre-inspection phase by supporting and encouraging the Divisions to assess their processes and systems continuously, allowing the Trust to better understand our areas of outstanding performance, areas of improvement and any areas for focus.

Currently the tools and process rely on the use of a combination of Excel spreadsheets, PowerPoint and shared folders to update on progress. This system is labour intensive and requires a considerable amount of manual check and chase to understand current status.

The Quality Hub are working with the Business Intelligence team to create an App style tool for both RAIT and KLOEs that are simplistic in use and will provide the Divisions with real time analytics.

2.1 Quality Improvement Strategy

Our Quality Improvement Strategy (2018-21) has been monitored through the Quality Governance Committee and the Trust Management Executive, reporting to the Trust Board. Divisional implementation plans are in place to support implementation and ensure a golden thread from Board to Ward.

The Trust Board has approved a rollover of the quality priorities from year three into year 4. The enablers in the implementation and delivery will be through the accreditation programme known as path to platinum, quality improvement training, HomeFirst board and volunteer strategy. Key learning from Covid-19 pandemic alongside engagement with patients, relatives, staff and public has also been incorporated and a focus on delivering the fundamentals of care programme and healing ward environment and are key actions for 2021/22.

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.

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 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 2020/21. 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 Performance 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 which 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. The factors identified have formed part of work streams to enhance the delivery of care. A project led by one of the Deputy Chief Nursing Officers has focused on nutrition and hydration which will remain a key metric for next year. The other issues identified remain part of the work streams in Home First Worcestershire and are part of the System wide approach to improving delivery of 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 have not been 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.

As overall mortality remains in line with national bench marking via HMSR and SHMI, there are no concerns around specific aspects of care

and therefore the areas of focus continue to be driven by incident reporting and SI investigation. As the Structure Judgement Reviews increase in frequency, they will form a further area to identify areas which require focus.

Clinical engagement with the mortality reviews had been suboptimal during Covid due to time pressures related to the pandemic. The Medical Examiners have focused on the review of all Covid deaths. Meaningful learning from deaths over the whole cohort was therefore compromised.

From the end of 2020/21, we have recruited the baseline number of medical examiners and we are now able to support the certification of all deaths and we aim to implement Structured Judgement Reviews in appropriate cases. We will seek to recruit Medical Examiners Officers by the end of this year to further support the Medical examiners and improve responsiveness and continue to recruit in the Medical Examiners role to enhance the learning from deaths that the process supports. .

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 no Regulation 28 letters (a report to prevent future deaths) from the Coroner.

2.4 Quality impact assessments

The process for undertaking Quality Impact Assessments was revised during 2019/20. Quality impact assessments (including equality and diversity) are undertaken for all developments, in particular the measures required to protect patients and staff related to the restoration of activity, 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.

2.5 Research and Development (R&D)

We recognise that R&D is integral to a successful Trust. The Trust research strategy was reinvigorated and is underway for 2021-22, with progress being made along many of its strategic and operational objectives. This includes the development of digital software which was nominated for a regional award.

The pandemic has changed the way research is delivered this year, with the Government making it clear research was pivotal to its response. As such, most national research was paused to prioritise interventional and observational studies to increase our understanding of the new virus and develop effective treatments.

As a result, the Trust was able to recruit 11.8% of all Covid-19 admissions into the RECOVERY trial, and has been recognised regionally and nationally for its outstanding contribution. In just three months the study recruited 10,000 patients in the UK, and identified that dexamethasone, a cheap and widely available drug could reduce deaths by a third. This changed practice globally overnight.

Despite these challenges, overall recruitment was increased to 1469 patients. This included 465 patients who were recruited into interventional studies, of which 374 were in REMAP CAP and RECOVERY, the two interventional Covid-19 studies.

Other specialties have continued their recruitment this year, including Haematology and Oncology.

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 2020/21 Quality Account. The quality priorities have been developed following consultation with our staff, patients and stakeholders and were agreed at the February 2021 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.

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 2021 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.
- Digital risk – Chief Digital 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. 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:

- Clarifying objectives
- Identifying risks to objectives
- Assessing and scoring the risk
- Identifying controls and their effectiveness
- Identifying and record actions to mitigate risks
- Escalation and de-escalation of risks.

2.7.6 Staff Awareness

Staff are made aware of their risk management responsibilities as part of the induction process. 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 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 risks relate to:

- Patient flow and service capacity
- IT systems and security
- Asset management
- Workforce

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. The focus of infection prevention and control activity over the year has been on the prevention and management of Covid-19. This has been managed robustly through our Incident Command Structure, which has provided oversight on all aspects of our response. This includes the local processes we have needed to develop in response to changing national guidance, the challenges of variable personal protective equipment supply early in the pandemic, and management of outbreaks and healthcare-associated Covid-19 infection.

In addition to Covid-19 we have continued to focus work on two key risks: reducing *Staphylococcus aureus bacteraemia* (MSSA and MRSA), and antimicrobial stewardship. Our Trust Management Executive (TME) and our Quality Governance Committee (QGC) have continued to receive monthly updates on these important issues in order to ensure oversight and scrutiny on our programmes of work. We are presently reviewing our annual programme for 2021-22 with focus on these issues, with approval of the programme via our Trust Infection Prevention and Control Committee, Trust Management Executive and then Quality Governance Committee.

2.7.8 Risk Management Governance

The Risk Management Group has continually matured during 2020/21 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 that are

not able to be mitigated to an acceptable level 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. The Finance and Performance Committee overseas mitigations for the finance and digital and operational performance risks and the People and Culture Committee overseas mitigations for the staff risks.

2.7.9 Covid-19 Risk Management

There is a risk management process specifically for risks related to Covid-19, which involves a dedicated risk register for tactical, strategic and operational elements of Covid-19 management. Risks are discussed via the Covid-19 governance structure, with updates provided by nominated risk leads across clinical and non-clinical areas. The process ensures that there are actions, controls, assurances in place and that gaps in controls and/or assurances have appropriate actions identified to mitigate the risk as well as ensuring there is evidence to support completion. The process is monitored within the command and control structure, which includes a framework for escalating risks from operational to Trust Management Executive, the senior clinical and managerial group in the Trust, which is accountable to the Board. Reports on the management of Covid-19 risks are a standing agenda item on the Risk Management Group.

2.7.10 Serious incidents and never events

Occasionally things go wrong and we have system designed for reporting and learning from such events. During 2020-21 we reported 186 serious incidents (SIs) through the serious incident system (STEIS). This number includes 2 cases being investigated by the HSIB (Healthcare Safety Investigation Branch). In the same period we reported no never events. Each of these incidents have been subjected to a rigorous root cause analysis investigation resulting in an action plan being developed to address system or process concerns; implementation is then followed up and monitored. These incident investigation reports are used to learn and bring about improvements in the care we deliver.

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) Review and Learning meetings chaired by the Chief Medical Officer. The group reviews the completed investigation reports into all SIs, and considers whether all aspects of the SI have been examined and addressed. They also consider incidents which may meet the criteria of a serious incident, determining the level of investigation to be conducted and agreeing those which may require external notification. In addition, the group explores the terms of reference for the investigation. Where identified, the group assesses opportunities to share learning from serious incidents across the Trust via a lesson of the week.

A quarterly report on patient safety 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

The Trust is committed to ensuring we do not delay in responding to complaints and investigating serious incidents. The effect of coronavirus on the number of formal complaints received alongside a national pause of the complaints process, has determined that improvements achieved in the previous two years could not be maintained. However, taking this into account, the Trust sustained an improved performance in the latter half of the financial year, finishing in March 2021 with 7 complaints overdue compared to 16 at a comparable time in 2019-2020.

2.7.12 Learning lessons

The Trust continues to learn lessons in a variety of ways, including but not limited to, the following sources:

- Incidents
- Serious incidents and never events
- Patients' Advice and Liaison Service (PALS)
- Complaints and compliments
- Friends and Family Test
- Litigation Claims
- Clinical Audit and Clinical Outcome Reviews
- 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
- 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.

In addition, the lesson of the week, which shares learning from serious incidents, is included in the Weekly staff newsletter.

Some lessons shared during this period have related to: monitoring adequate nutrition and why weight matters, clarifying the procedure for collecting and receiving blood units, identifying Orthostatic (postural) hypotension, using nebulisers alongside prescribed oxygen requirements and understanding possible spinal shock syndrome/autonomic dysreflexia in patients with paraplegia. Lessons of the week are available 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 Incident Command and Control structure has been operating since late March 2020, with Strategic, Tactical and Operational (Gold, Silver and Bronze) meetings leading the oversight of our Covid-19 response. The Bronze Commander is the Director of Finance, Silver is the Chief Nursing Officer and Gold is the Deputy Chief Executive.

The Command governance structure reports into the Trust's Business as Usual governance structure through Trust Management Executive (TME), and the Gold Commander has given frequent and detailed updates on the Covid-19 situation at Board meetings.

The frequency of the command governance has been flexed depending on the National and Trust Alert levels; ensuring that appropriate governance remains in place to deal with incident related decision making. During the peak of each wave, whilst the Trust was at the highest Alert Level, business as usual governance was stood down to allow time to focus on the response to Covid-19.

The Command and Control governance included a sharp focus on intelligence led decision making, risk management, and links into the ICS (particularly around the Vaccination Programme). The governance structure further ensured that patient safety and quality were integral to the decision making, implementing assurances such as a Star Chamber to discuss clinical prioritisation of surgical cases during Wave 2, and a Quality Impact Assessment Panel to support the restart of services post Wave 1.

A comprehensive evaluation of the Wave 1 Covid-19 response was undertaken in the form of a Trust wide After Action Review, and a series of debriefs. Evidence was compiled and analysed and a post-debrief action plan was developed, which included themes around leadership,

communications, workforce, mental health and wellbeing, BAME and high risk staff. This learning contributed directly to the second wave response.

A further Wave 2 After Action Review, and a full Pandemic Learning Review are underway as the Trust transitions back into full business as usual governance during Quarter 1 2021/22.

The Board agreed in March 2020 that for the foreseeable future Board and Committee 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 and papers will be published as normal.

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. Committee workplans are currently under review to take account of items deferred from the normal agendas and these will be considered with the lead Executive Director and Committee Chair. 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 Safety Walkaround schedule continues to be shared with the Clinical Commissioning Group and with members of the Patient and Public Forum, to encourage external oversight and scrutiny, and invite them to support the assurance processes.

Safety Walkarounds were deferred at the onset of the pandemic, and the process has undergone a Plan Do Study Act (PDSA) cycle to ensure Executive and Non-Executive Director engagement with clinical areas could continue whilst adhering to guidelines regarding visitors to clinical areas.

A revised combined physical and virtual Safety Walkaround process was developed during June 2020, and a trial of the revised process was conducted during July 2020. Further revisions were made to the process, and, between July - November 2020, seven Safety Walkarounds took place using the revised process.

The combined physical and virtual Safety Walkaround process will remain in place until such a time it is deemed appropriate and safe to visit clinical areas as a group.

4. Board Assurance Framework

We recognise the importance of a robust Board Assurance Framework (BAF) and as such, it is received by the TME, Committee and the Trust Board. The Audit and Assurance Committee reviews the process and controls for each Board submission.

The Trust's Risk Management Strategy includes agreed levels of risk appetite against the key governance domains (i.e. safety, effectiveness, innovation, financial position and partnership), with the risk appetite for each risk being defined. The Trust has developed the BAF in year and refined its approach in the use and management of risk appetite, taking account of the impact of the Covid-19 pandemic.

A Board seminar was held in March 2021 outlining the proposed utilisation of the BAF and risk appetite at Committee level, leading to broader discussion regarding application of risk appetite by Committee and this will be embedded further during 2021/22.

In light of the current de-escalation of Covid-19, Committees are reviewing their BAF risks and the risk appetite aligned to the same. This will culminate in a wholescale review of the BAF in its entirety in early 2021/22.

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:

Risk	Objective	Risk Appetite
If we do not have an effective phase 3 restoration plan or if the magnitude of the 2nd/3rd wave is too great, and we have a second/third peak of Covid-19 cases then we will be unable to maintain the safety of emergency and elective patients, resulting in compromised staff and patient safety and potentially excess mortality and morbidity	Best Services for Local People	High
If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes.	Best experience of care Best outcomes for our patients	Moderate
If we do not have assurance on the technology estate lifecycle maintenance and asset management then we could be open to a cybersecurity attack or technology failure resulting in possible loss of service.	Best Services for Local People	High
If we fail to effectively engage our patients, our staff, the public and other key stakeholders in the redesign and transformation of services then it will adversely affect implementation of our Clinical Services Strategy in full resulting in a detrimental impact on patient experience and a loss of public and regulatory confidence in the Trust.	Best Services for Local People	Moderate
If we fail to address the drivers of the underlying deficit then we will not achieve financial sustainability (as measured through achievement as a minimum of the structural level of deficit) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures.	Best use of resources	Low
If we fail to implement Home First Worcestershire as scheduled then there will be an impact on our ability to see, treat and discharge patients in a timely way which may result in patient harm and curtails urgent elective activity.	Best experience of care Best outcomes for our patients	Low
If we do not have a sustainable fit for purpose diverse and flexible workforce, we will not be able to provide safe and effective services resulting in a poor patient experience.	Best People	Moderate

Risk	Objective	Risk Appetite
If we fail to sustain the positive change in organisational culture, then we may fail to attract and retain sufficiently qualified, skilled and experienced staff to sustain the delivery of safe, effective high quality compassionate treatment and care.	Best People	Moderate
If the Worcestershire Health and Care System is not able to resolve the mismatch between demand and capacity for urgent and emergency care, then there will be delays to patient treatment, resulting in a significant impact on the Trust's ability to deliver safe, effective and efficient care to patients.	Best Services for Local People	High
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.	Best services for local people Best experience Best use of resources Best people	Moderate
If we do not have in place robust systems and processes to ensure improvement of quality and safety, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes.	Best experience of care and Best outcomes for our patients	Low
If we are not able to secure capital financing then we will not be able to maintain and modernise our estate, infrastructure, and facilities; equipment and digital technology resulting in a risk of business continuity and delivery of safe, effective and efficient care.	Best use of resources	Low

5. Quality Performance Data

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.

We have taken the Covid-19 incident period as an opportunity to progress the development of a holistic Patient Tracking List (PTL), which we have been striving towards for some time. The principle being that any patient awaiting any treatment in the Trust will be visible in one PTL, which will enable different views depending on your interest. Existing logic has been reviewed, which has enabled understanding of how issues are generated and the data warehouse tables have been rewritten.

We are making more transparent the system constraints and user errors that create issues, so that these can be considered as part of the OASIS re-implementation and the new Digital Care Record; and can be incorporated into the RTT training plan. This is a very complex undertaking, but we are on track to have the holistic PTL in place for the start of the next financial year.

In response to the management of the Covid-19 incident which commenced in March 2020, much of resource available for data quality management

was re-focused to manage Covid related data and more recently the restoration of services.

To ensure the accuracy of critical data sent to external agencies for management of the pandemic at national and regional level the Data Quality team became responsible for reporting deaths to the Covid-19 Patient Notification System (CPNS), management of the central government Shielded patient database for the Trust and contributed towards the delivery of daily reporting through the incident control governance process.

Digital Update

As part of the Digital Division the Data Quality team are requesting involvement in the implementation of all new systems; and are expecting to contribute significantly to the development of the Digital Care Record and the re-implementation of our patient administration system – OASIS. In preparation for the re-implementation the Data Quality Team and the Business Intelligence section within Information are working together on Data Integrity project. A portal is under construction to help identify areas of concern and will allow investigation and transparency ready for the DCR project. The portal is looking at the integrity between the same information being held on all the systems that Demographic data is entered, alongside the completeness of what data is being collected. The project has begun to look at differences between OASIS (Source), Bluespier and ICE concentrating on NHS Number, Date of Birth and Ethnicity, with Death Date collection being the next phase, whilst comparing against National Codes and how these are mapped to our internal systems.

Safety Alerts

The lack of governance for safety alerts recorded on our clinical systems had been identified as a contributory factor for several patient safety incidents that had been recorded on the Datix in the past few years. The Clinical lead for Data Quality has overseen a programme of work that will data cleanse the current list of safety alerts that are available, gain assurance that alerts are recorded once and transferred across all clinical systems, and has implemented a robust governance process for the creation, review and removal of alerts on patient records

The Safety alerts work is drawing to a close with communication sent out in October 2020 to alert staff to the new governance policy that can be found on the Intranet. The policy holds a new request form that will now need to be completed for any new alert or an alert removal. This will be reviewed at the Health Records Group to decide the outcome and a live register of alerts will be held by the Health Records Manager to prevent duplication.

Embedding best Practice

A task and finish group was formed to address the lack of governance around changing patients key demographic detail and to establish measures are in place to ensure lessons are learned from the any incidents arising from changes that have not been actioned appropriately.

A new governance process was produced by the Data Quality and Health Records Manager to address correct process when searching for a patient in the first instance, mandating that searches begin on static demographic detail, NHS Number or Date of Birth – if an NHS Number is not available then the search should begin with the patients date of birth as this detail will never change. A report has been devised to allow the Data Quality Team to investigate any changes and check them against the SPINE to ensure they are legitimate changes. It provides a view of the past 3 days and allows contact with the user to discuss. When an error is highlighted the user will be issued with the governance process and receive refresher training to ensure the correct procedure is now being followed. This piece of work was supported by the Chief Executive's brief on 13 November 2020 which re-emphasised the importance of this piece of work.

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)

As with many activities, the Covid-19 incident has impacted our ability to progress business as usual tasks. Unfortunately there has been no formal meeting of this group due to the Covid-19 incident taking priority; however the restart of these will commence as soon as practicable.

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 and while work continues to promote this the team has been involved in projects that support Trust initiatives such as Homefirst and SHREWD.

These continuing improvements to our collection of patient data are identifying processes and areas that need support. In the past year the Lead has also overseen a poster campaign to provide a visual prompt to clinicians on the importance and correct way to complete an Electronic Discharge Summary (EDS) The poster features one of our own FY2 doctors to keep the message personal and to encourage best practice amongst our colleagues.

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. 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 Strategy was reviewed in 2020 with the production of a new Strategic Framework with 11 pillars.

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 2020/21.

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 Results 2020

The results of the latest national NHS Staff Survey were published on 11th March 2021. Our final response rate for the 2020 survey was 46% (2,950 colleagues) compared to 39% last year. This is better than the median response rate for Acute Trusts of 45%.

We are now at the national average level for all 10 of the themed areas. In summary:

- We have improved in 6 areas (Health and Wellbeing, Support from immediate managers, Morale, Bullying and Harassment, Safety Culture, Staff Engagement
- Stayed the same in 3 themes (ED&I, Quality of Care, Violence)
- Only 1 theme (team working) has deteriorated from last year which arguably is to be expected due to the number of staff homeworking and higher levels of absence due to the Covid-19 pandemic

These latest results give us much cause for optimism, and reflect the hard work that has been taking place over the last three years 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 to make WAHT an exemplar/ employer of choice. We are currently reviewing the staff survey results against our People and Culture Strategy and drawing up an action plan in partnership with each division

6.4 Leadership development

A full programme of leadership and management development is in place with over 830 colleagues having participated in a programme. 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

The recruitment and retention of our staff remains a key priority and we are proud that significant reductions in vacancy numbers and staff turnover have been sustained despite the Pandemic across most staff groups.

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 2021 has an establishment that affirms safe staffing across ward areas.

6.8 Freedom to Speak Up

Our 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. During 2020/21 we have raised the profile of FTSU with the appointment of our new Guardian and launch of our FTSU Portal so that staff can access support via one click.

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.

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 initiatives and Equality and Inclusion networks.

7. Digital

The key objectives identified in the digital strategy, approved in June 2019, have been operationalised throughout 2020/2021. The introduction of digital enhancements such as remote working and patient monitoring capability are underpinned by a step change improvement in digital infrastructure.

The development of a robust capital programme aligned to the corporate risk register is in place and year 1 delivery is underway to remediate and upgrade the critical IT assets across the three hospitals sites.

The digital care record programme which is an important cornerstone to the digital maturity of the Trust has been pushed back to allow the Trust to focus on meeting the Covid response.

During quarter 4 of this financial year this programme has been re-energised with the first step on this multi-year programme being the requirement to upgrade the Patient Administration System.

The Trust has been identified as a digital aspirant and supported with seed funding to develop a

business case to accelerate the introduction and adoption of digital technologies to support new and transformational models of care across the ICS.

7.1 Cybersecurity

Following the 2019 external NHS Digital report on cybersecurity preparedness, the Audit and Assurance Committee have received progress reports in the financial year on progress across the different domains (policy and strategy, procurement, communications and technical remediation). The Trust has approved capital investments to remediate the aged IT infrastructure and this investment is aligned to the priorities identified in the report and the corporate risk register.

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. 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 31 March 2021, 88.32% of staff had completed their annual training and there is an action plan in place to improve the compliance rate by June 2021.

There are articles in relation to Information Governance 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 2021 and will include all the latest news and guidance for staff.

The Trust has reported two incidents to the Information Commissioners Office (ICO) during the last calendar year; In July 2020 a spreadsheet containing staff personal information was sent out in error to all of those staff. The e-mail was recalled, the staff were all informed and a communication sent out Trustwide to remind staff to review all emails before sending. Following an incident in January 2021 which involved a staff member accessing multiple patients records, an extensive 'no excuse' campaign has taken place 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 persons care. The Information Governance Manager reports all potential incidents to the Senior Information Risk Owner (SIRO) for review and decisions regarding internal or external reporting to the ICO.

All new systems and projects have a Data Protection Impact Assessment (DPIA) completed where required data sharing or processing agreements are completed. There have been numerous DPIAs completed in response to system or process changes to support the Trust's response to Covid. These DPIAs will be reviewed after June for systems which remain in place for the longer term. 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.

The Board has completed Cyber Security awareness training in 2020 and is due a refresher in 2021. 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 specialist 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 (IAOs) across the Trust. IAOs have all signed a

letter of delegation and are completing their training. Two IAOs are members of the Information Governance Steering Group (IGSG).

The Information Governance Steering Group 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 IGSG 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 Data Security and Protection Toolkit for 20/21 has been delayed until 30 June 2021.

8. Patient, Public Involvement

The Trust works closely with public stakeholders to actively engage and involve them in decision making and reviews. Stakeholders are able to influence the Trust in a number of ways, including through the formal mechanisms of patient representative groups and specific focus groups. The Chief Executive and Chair meet the local MPs regularly and have also met with the Patient Public Forum (PPF) for example. PPF members actively engage with and are engaged at all levels of governance including actively sitting on Divisional Committees, Trustwide Committees including Quality Governance Committee and Clinical Governance and steering groups. Public representatives are also engaged with the Trust's Children's Board. Public involvement has developed through Quality Review projects with the Patient Public Forum specifically focusing on the review of formal complaint responses and the Patient Advice and Liaison process. The PPF have continued to carry out audits throughout 2020-21 and have embraced technology to support this.

Patient Stories are shared at the Trust Board monthly meetings with space for discussion and exploration of learning from experiences; there is also an opportunity for questions from the public following each Trust Board meeting held in public. Co-design is pivotal to the way that the Trust engages and creates new initiatives and one example is the way that volunteers and community groups have been actively engaged with to continue to develop the Volunteer Strategy #WeAreVolunteering. This strategy was initially developed with volunteers and staff at a series of workshops and throughout 2020-21, a series of virtual engagement programmes has ensured the Trust's ability to continue to provide volunteering experiences in a responsive way to public and staff feedback arising from the pandemic, whilst continuing to create a solid foundation for the volunteering offer going forward.

We have continued to review our quality priorities as part of the Quality Account and have again 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 three Associate Non-Executive Directors supporting the work of the Board.

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.

As a result of Covid-19, Board meetings were held virtually without the public (government social isolation requirements constitute 'special reasons' ref 001559 NHS publication) during 2020/21 and broadcast live via the Trust's Youtube channel. Committee meeting agendas were shortened and at times of necessity met 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 Chair 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 2020/21 the Board met in public on 11 occasions. In the period covered by this annual report, the Board also held development sessions covering a wide range of topics including urgent care, finance, mental health, equalities, risk appetite, restoration and recovery.

The voting members of Trust Board during 2020/21 were as follows:

- **Waqar Azmi**, Non-Executive Director *from 1 January 2021*
- **Paul Brennan**, Chief Operating Officer /Deputy CEO
- **Anita Day**, Non-Executive Director
- **Jackie Edwards**, Chief Nursing Officer, *1 August 2020 to 31 August 2020*
- **Paula Gardner**, Chief Nursing Officer *from 15 March 2021*
- **Mike Hallissey**, Chief Medical Officer
- **Matthew Hopkins**, Chief Executive
- **Dame Julie Moore**, Non-Executive Director
- **Vicky Morris**, Chief Nursing Officer *until 31 July 2020 and from 1 September 2020 until 31 March 2021*
- **Sir David Nicholson**, Chair
- **Robert Toole**, Chief Finance Officer
- **Bill Tunnicliffe**, Non-Executive Director
- **Steve Williams**, Non-Executive Director *until 31 December 2020*
- **Mark Yates**, Non-Executive Director *until 31 March 2021*

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
- **Tina Ricketts**, Director of People and Culture
- **Richard Oosterom**, Associate Non-Executive Director
- **Kimara Sharpe**, Company Secretary *until 31 December 2020*
- **Rebecca O'Connor**, Company Secretary *from 1 March 2021*
- **Sarah Smith**, Director of Strategy and Planning *until 30 June 2020*
- **Jo Newton**, Director of Strategy and Planning *from 27 April 2020*
- **Sharon Thompson**, Associate Non-Executive Director *from 1 January 2021*

At all meetings there were more Non-Executive Director voting members present then 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	Chair	11/11
Matthew Hopkins	Chief Executive	11/11
Waqar Azmi	Non-Executive Director	3/3
Paul Brennan	Chief Operating Officer/Deputy CEO	10/11
Anita Day	Non-executive director	10/11
Mike Hallissey	Chief Medical Officer	10/11
Richard Haynes	Director of Communications	11/11
Colin Horwath	Associate Non-Executive Director	11/11
Helen Lewis (Vikki)	Chief Digital Officer	9/11
Julie Moore	Associate Non-Executive Director	11/11
Vicky Morris	Chief Nursing Officer	10/11
Rebecca O'Connor	Company Secretary	1/1
Richard Oosterom	Associate Non-Executive Director	8/11
Tina Ricketts	Director of People and Culture	10/11
Kimara Sharpe	Company Secretary	8/8
Sarah Smith	Director of Strategy and Planning	1/1
Sharon Thompson	Associate Non-Executive Director	3/3
Robert Toole	Chief Finance Officer	11/11
Bill Tunnicliffe	Non-Executive Director	8/11
Steve Williams	Non-Executive Director	7/8
Mark Yates	Non-Executive Director	11/11

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 2020/21, 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)

Chair until 31 Dec 2020	Steve Williams	5/5
Non-Executive Director Chair from 1 Jan 2021	Anita Day	7/7
Non-Executive Director	Mark Yates	7/7
Non-Executive Director from 1 Jan 2021	Colin Horwath	2/2

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

Chair	Mark Yates	6/6
Non-Executive Director to 31 Dec 2021	Steve Williams	4/4
Non-Executive Director from 1 Jan 2021 to 31 March 2021	Julie Moore	2/2
Associate Non-Executive Director from 1 Jan 2021	Sharon Thompson	0/2

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)

Chair	Richard Oosterom	12/12
Non-Executive Director until 31 Dec 2020	Steve Williams	8/9
Associate Non-Executive Director	Colin Horwath	11/12
Director of People and Culture	Tina Ricketts	8/12
Chief Medical Officer	Mike Hallissey	9/12
Chief Nursing Officer to 31 March 2021	Vicky Morris	5/10

Chief Nursing Officer from 15 March 2021	Paula Gardner	1/1
Chief Executive	Matthew Hopkins	10/12
Chief Operating Officer	Paul Brennan	9/12
Chief Finance Officer	Robert Toole	12/12
Director of Strategy and Planning	Sarah Smith	1/1
Director of Strategy and Planning	Jo Newton	10/12
Chief Digital Officer	Helen Lewis (Vikki)	10/12
Non-Executive Director from 1 Jan 2021	Waqar Azmi	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)

Chair	Bill Tunnicliffe	10/12
Chief Operating Officer	Paul Brennan	6/12
Chief Executive	Matthew Hopkins	10/12
Chief Medical Officer	Mike Hallissey	10/12
Non-executive Director	Julie Moore	11/12
Chief Nursing Officer to 31 March 2021	Vicky Morris	9/11
Chief Nursing Officer 1-31 August 2020	Jackie Edwards	1/1
Chief Nursing Officer from 15 March 2021	Paula Gardner	1/1
Non-Executive Director until 31 Dec 2020	Mark Yates	9/9
Associate Non-Executive Director from 1 Jan 2021	Richard Oosterom	3/3
Associate Non-Executive Director from 1 Jan 2021	Sharon Thompson	3/3

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)

Chair	Sir David Nicholson	7/7
Non-Executive Director until 31 March 2021	Mark Yates	7/7
Non-Executive Director until 31 Dec 2020	Steve Williams	7/7
Non-Executive Director from 1 Jan 2021	Anita Day	0/0

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

Chair to 21 March 2021	Mark Yates	6/6
Non-Executive Director to 31 Dec 2020	Anita Day	4/4
Chief Executive	Matthew Hopkins	6/6
Director of People and Culture	Tina Ricketts	6/6
Associate Non-Executive Director until 31 Dec 2020	Richard Oosterom	4/4
Director of Communications	Richard Haynes	6/6
Chief Medical Officer	Mike Hallissey	4/6
Chief Nursing Officer to 31 March 2021	Vicky Morris	3/6
Chief Nursing Officer 1-31 August 2020	Jackie Edwards	1/1
Chief Nursing Officer from 15 August	Paula Gardner	1/1
Chief Finance Officer	Robert Toole	3/6
Associate Non-Executive Director from 1 Jan 2021	Colin Horwath	2/2
Non-Executive Director from 1 Jan 2021	Bill Tunnicliffe	1/2

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 https://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 2021. These are set out below. This will be published on the website by 31 May 2021 as required by NHS Improvement.

Condition T4

	Corporate Governance Statement	2021
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	The Board is satisfied that the Licensee has established and implements:	Confirmed
	(a) Effective board and committee structures;	Confirmed
	(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	Confirmed
	(c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:	Not confirmed
	(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	Confirmed
	(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	Confirmed
	(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;	Confirmed
	(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);	Not confirmed
	(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	Confirmed
	(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	Confirmed
	(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	Confirmed
	(h) To ensure compliance with all applicable legal requirements.	Confirmed

	Corporate Governance Statement	2021
5	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: (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	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.	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.

The Trust declares that it is not compliant with condition G6.

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 Trust has an underlying financial deficit, with a current CQC Use of Resources (UOR) assessment rating of Inadequate. The External Auditor Value for Money (VfM) Assessment process has changed and no longer generates a binary conclusion. We are expecting their assessment of the Trust's efficiency and effectiveness of its use of resources in delivering clinical services to result in recommendations relating to Financial Sustainability.

The Trust's Annual Plan for 2020/21, developed under a Payment by Results model prior to the impact of Covid-19 and the changes to the financial regime, was a planned deficit of £(78.9)m (excluding funding from the Financial Recovery Fund). Whilst this was not in line with the nationally set Financial Improvement Trajectories, it did reflect a stabilisation of the deficit.

As a result of Covid-19, an interim national financial regime was introduced, providing fixed funding envelopes and top up funding to mitigate the impact of materially changed activity profiles, and enable providers to meet the additional costs associated with the pandemic response. This resulted in a Covid-19 deficit plan of £(7.3)m.

As at 31 March 2021 the Trust's adjusted financial performance surplus including Top-Up funding but excluding impairments and the impact of donated assets was £6.7m. This represents a positive performance against the £(7.3)m planned deficit recognised by NHSE I in 2020/21 under the Covid-19 financial architecture.

The positive improvement to the Covid-19 planned deficit is primarily driven by slower than anticipated elective recovery (and associated marginal costs) as a result of the impact of Covid wave 2 during quarter 4, coupled with additional national funding streams not known at the time of setting the plan. A number of productivity and efficiency schemes were delivered in year, totalling £10.9m, though the impact of the pandemic meant the originally identified level of £14.6m was not fully met. £9.4m of the delivered savings were achieved recurrently.

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

- Approval of annual budget (and in year material changes) 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 and financial performance reviewed.
- Monthly Divisional performance review meetings *(partially suspended in 2020/21 due to Covid response)*
- Regular Budget Holder meetings.
- Monthly ICS Finance Forum where review of the financial performance and forecast performance of the system is overseen

During 2020/21, the Covid-19 financial regime was designed to ensure cash was made available in advance to support prompt payments. The Trust requested and received £7.7m of interim revenue support PDC in April 2020, requested prior to the change in regime. No further interim revenue borrowing was requested as a result of the in-year surplus position. The Department of Health and Social Care converted historic interim revenue and capital loans totalling £324.4m to Public Dividend Capital (PDC) in September 2020, reducing the interest liability though PDC dividends are now payable. The Trust also received £20.8m of capital PDC to support targeted capital schemes, largely related to previously identified high risk backlog, supporting the Covid response and enabling restoration of activity. Total new borrowings in 2020/21 are £28.5m.

The Trust outsources elements of its transactional financial services and employment services (Payroll) to a third party supplier. Assurance on the effective operation of the control environment is gained through measures including independent Auditor reports. In April 2021, the Trust received the supplier's Finance and Accounting and Employment Services ISAE3402 reports. These covered Finance and Accounting and associated general IT controls, and Employment Services controls for the period 1 April 2020 to 31 March 2021.

The Finance and Accounting audit identified an exception in one out of 23 control objectives and a qualified opinion was issued. The service auditor advises that in all material respects, except for the matter identified the controls were suitably designed and have operated effectively during the period. We have reviewed the audit report and management response and are satisfied that no material control weaknesses were identified.

The Employment Services audit identified exceptions in four out of thirteen control objectives and a qualified opinion was issued. The service auditor advises that in all material respects, except for the matters identified the controls were suitably designed and have operated effectively during the period. We have reviewed the audit report and management response and are satisfied that no material control weaknesses were identified. One of the four control exceptions related to timeliness of investigation of overpayments. This was as a result of the redeployment of the overpayments team to payroll as part of the Covid response early in the reporting period. The Trust did escalate its concerns with timeliness of management of overpayments to the third party supplier during the period, and continues to monitor that performance is improving.

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. As a result of the pandemic, the annual planning process for 2021/22 has been nationally delayed and remains in progress at the time of writing. 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. This process also takes account of the overall system

financial position, published Financial Improvement Trajectories, and any other national targets.

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. This process has been strengthened during 2020/21 with further development of the process, and specific focus on benefits realisation, including system benefit.

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

11.2 Auditors

11.2.1 External Audit

The External Auditor Value for Money (VfM) Assessment process has changed and no longer generates a binary conclusion. We are expecting their assessment of the Trust's efficiency and effectiveness of its use of resources in delivering clinical services to result in recommendations relating to Financial Sustainability. This is primarily due to the Trust's underlying financial deficit and performance management metrics.

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 Committee also monitors progress with implementation of agreed actions.

The Head of Internal Audit Opinion for 2020/21 is as follows:

My overall opinion is that Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

It is my view that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2020/21 Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation. 2021

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

Full

- BAF

Significant

- Health & Safety Follow Up
- Financial Assurance Review* (Creditors, Debtors, Financial Ledger, Treasury Management & Contracted Out Payroll)
- Financial Management & Reporting Arrangements*

Moderate / 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 2021, the Trust was non-compliant with the following key targets:

- Emergency Access Targets
- 18 weeks referral to treatment – incomplete pathways
- Cancer waiting times
- Diagnostics waiting times
- 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 2020/21, I have reviewed the directors' portfolios and clarified responsibilities. Following the former post holder's retirement, in March 2021 I appointed a new Chief Nursing Officer. A new Director of Strategy & Planning has been appointed to replace the outgoing retiring director, with a greater emphasis on system working.

NHS Improvement appointed a System Support Director to support sustained quality and performance improvement. This post has been in place since September 2020 following lifting of quality special measures.

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 2020/21 as detailed below.

Issue 1

During May and June 2019, the CQC conducted core-service inspections across six services, and a review of the Trustwide Well-led domain. Following the publication of the inspection report

in September 2019, the CQC recommended that the Trust was removed from Quality Special Measures.

On 14 January 2020 a risk summit was chaired by the Regional Medical Director, NHS Midlands, to review System-wide perspective. A further risk summit follow-up session was held on 8 April 2020, chaired by the Medical Director, North Midlands, which focused on System-wide follow-up feedback and ongoing oversight and assurance arrangements. Both risk summit sessions included participation from the Clinical Commissioning Group, West Midlands Ambulance Service, NHSE/I, Health Education England, Healthwatch, Local Authority, General Medical Council (GMC), Nursing and Midwifery Council (NMC) and the Care Quality Commission (CQC) .

On 24 September 2020, the NHS National Director of Improvement confirmed that the Trust has been lifted out of quality special measures after almost five years. He also congratulated the Trust on our excellent progress and hard work, particularly in improving our Urgent and Emergency Care performance.

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 seen and treated in a more timely manner and, where necessary, admitted on a timely basis. The Trust struggled to maintain flow during 2019/20 and developed the Home First Worcestershire (HFW) 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.

Throughout 2020/21, the further refinements were made to HFW to change the governance structure, establish executive lead work streams and identify key priorities within those work streams.

HFW is now a CEO Chaired programme with four work streams:

1. Acute Front Door
2. Acute Patient Flow
3. Clinical Site Management
4. Frailty

Each work stream has a clear improvement plan with actions, timescales and owners. Each action also has a series of metrics expected to be impacted upon as a direct result of that action.

HFW has a dashboard used to ensure that the actions are delivering the desired outcomes and also assist in identifying any new challenges. Along with the actions, these metrics are monitored through the Trust Management Executive and the Finance and Performance Committee, as well as Trust Board.

The progress made in HFW and the improvements delivered are a direct result of the team working approach, our key principles, the Executive oversight and the diligence of our staff.

As a result of the improvements made via HFW, WAHT are now in the top 20% of trusts for their G&A bed occupancy performance, total time in A&E performance and A&E left without being seen performance. DTOCs are in the top third in the country too. Whist 4 hour performance has shifted from being consistently one of the worst in the midlands to being right in the middle of the pack nationally.

HFW reports directly into the system-wide A&E Delivery Board (AEDB). In addition to the work streams overseen by HFW, the AEDB also oversees the pre-hospital and post-acute work led by system partners.

According to Public View Ltd - a performance monitoring and benchmarking service for NHS leaders - WAHT are the second most improved Trust in the country.

Issue 3

The Trust was able to deliver a £6.7m adjusted financial surplus in 2020/21, a better performance than both the Covid-19 planned deficit and the Trust 2020/21 Annual Plan deficit. However, this surplus was primarily secured through the interim Covid-19 financial regime which provided additional block and Top-Up funding to meet the cost of responding to the pandemic. The Trust underlying financial position remains a material deficit, requiring ongoing action and focus on financial sustainability to mitigate this risk. Through the developing ICS, a collective approach is taken to financial sustainability and best use of system resource. Work continues within the Trust and the system to improve overall Use of Resources and productivity.

Issue 4

The Trust faced significant challenges in delivering key national standards whilst managing the Covid-19 pandemic. These included the 4-hour Emergency Access Target, 18 weeks referral to treatment – incomplete pathways, cancer waiting time standards and diagnostic waiting times.

There were 6,515 patients who were waiting over 52 weeks for their first definitive as at 31th March 21 and of those 1,394 have been waiting over 70 weeks. 19,740 patients have been seen on a two week wait pathway by a specialist, but capacity issues, social distancing, diagnostic pathways and patient choice impacted the number of patients seen within two weeks. 1,900 cancer patients received their first treatment in 2020/21 as the Trust committed to diagnosing and treating patients; however, there is a backlog of 208 untreated patients who have been waiting 62+ days, 96 of whom have been waiting over 104 days.

Diagnostic pathways were significantly impacted by the pandemic, with many routine tests having to be cancelled. 5,609 patients were waiting over 6 weeks for their diagnostic test as at 31th March 2021. 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 which may impact business continuity. The Trust has commenced a multi year programme of infrastructure modernisation this investment will upgrade the IT infrastructure.

However due to the complexity of infrastructure replacement and updating this will take place over next 3 years and therefore there will be an incremental improvement of the cyber security position of the Trust over this period.

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.

2020/21 has been the first year of delivery of the digital strategy which has been accelerated in parts to support the Trust's response to Covid and other aspects have been re prioritised.

Issue 6

The Covid-19 pandemic has demanded a significant focus from all Trust staff during 2020/21, impinging on achievement of both national and Trust Annual Plan priorities. The pandemic has affected the Trust's capacity to treat patients, resulting in extended waiting times for elective patients and growth in waiting lists which will require significant time and resource to resolve. Our workforce has been significantly affected by the pace and challenges of work during both

waves of the pandemic, the period of restoration mid 20202/21, and concerns about their own health and that of their loved ones. Key strategic priorities for 2020/21 were paused at various points due to the pandemic due to restrictions and workforce capacity.

Matthew Hopkins
Chief Executive

Date: 9 June 2021

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

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

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, 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: 9 June 2021

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

Date: 9 June 2021

Robert D Toole
Chief Finance Officer

Date: 10 June 2021

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 2020/21 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: 9 June 2021

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

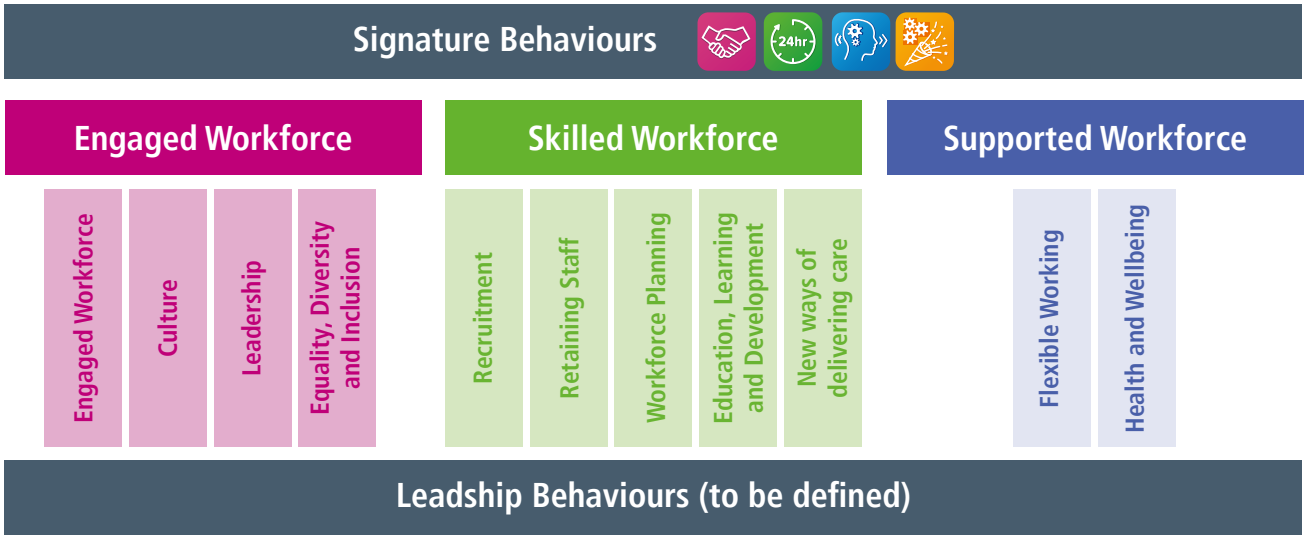
Date: 9 June 2021

Staff Report - Creating a Great Place to Work

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

The Strategy was reviewed in 2020 with the production of a new Strategic Framework with 11 pillars:

People and Culture Strategic Framework for the period 1 January 2021 to 31 December 2023



The People and Culture Directorate has been reconfigured to align itself with the pillars with the creation of new Assistant Director Posts covering Learning Academy, HR Strategy and Corporate HR.

The 4ward Programme – Our Values and behaviours

Putting Patients First

4ward

4ward sits at the heart of our #PuttingPatientsFirst strategy and is the 'how' to how we will deliver both our strategic objectives and our vision. For staff across the organisation, 4ward is how we will deliver the best possible care and best services for our patients, and that we are always putting them first in everything that we do.

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.

Our focus going 4ward is twofold. We want to transform our culture whilst at the same time improving our performance across the whole of Trust, particularly around our wide-ranging quality improvement programme, improving the flow for patients, our preparations for winter and our efforts to achieve financial stability.

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

Building on from the foundations of our cultural improvement journey which we began in 2017 at Worcestershire Acute Hospitals NHS Trust with our 4ward programme we have seen the benefits of our 4ward culture in terms of our response to wave 1 and 2 of the coronavirus pandemic.

During this period it continued to be a priority for us as an organisation to display our 4ward behaviours which focus around team working, being accountable, creating innovation and completing work with no delays.

We saw this through our no delays response to the pandemic, our deployment of colleagues across the organisation, cross team working in order to put our patients first and provide the best possible patient care as well as the re-start and re-set of the NHS post first wave of the pandemic.

Our growing team of 4ward advocates (front line culture change agents) came together with renewed focus on supporting colleagues' wellbeing. Introducing "WAHT's Wellbeing Academy" a virtual wellbeing space from colleagues for colleagues which provided opportunities for holistic wellbeing for example advocates led exercise classes, mindfulness sessions, cookalongs, live content around nutrition, hydration and sleep. All of this utilised the skills that as healthcare workers they already had.

The 4ward advocate team also supported high levels of staff engagement by providing a two way dialogue from ward to board in regards to morale,

showcasing of achievements and also feedback any concerns or issues that were being raised during the new way of working that the pandemic created.

Some of our 4ward advocates became mental health first aiders, others supporting wellbeing groups, others supported care packages for clinical teams, whilst other advocates worked on increasing our digital capacity, suggesting ideas for memorials and single improvement methodology.

4ward advocates also understood that in order to further progress our cultural improvement work further engagement was required around our equality and diversity agenda. Therefore advocates supported colleagues within our BAME, LGBTQ, Faith and Disability Networks and in partnership created the first ever WAHT Culture Month in October 2020 which celebrated 3 years of 4ward and also showcased the various elements and successes of our cultural improvement journey.

4ward advocates had sessions with Board members throughout the pandemic ensuring that the key messages from all colleagues at all levels were being heard in line with our 'listen, learn, lead' behaviour.

Finally, our 4ward advocates supported the National Staff Survey walking all departments to ensure colleagues understood what the survey was and why it was important to complete. This year WAHT achieved its highest participation rate in recent years as well as the best survey results indicating another year of improvement in both staff experience and engagement.

#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.

#WellbeingWednesday

During the Covid pandemic we have relaunched #WellbeingWednesday and tied this into a Pinwheel on the intranet of all of the health and wellbeing support available to staff.

Staff Facebook Page

The WAHT Staff Facebook page is used by staff to share Thank you's and messages of support to colleagues and develop a feeling of community – particularly helpful for those staff who have been required to shield or work from home during the pandemic.

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. During the Covid Pandemic there is also a regular Coronavirus Briefing incorporating the latest information and policy decisions agreed through Command and Control.

There are a number of other Trust gatherings, such as our Senior Leadership Group which act as an opportunity for leaders to be consulted on policy and performance issues. Staff are invited to "Meet the Chief" sessions so that their voice can be heard.

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 initiatives and Equality and Inclusion networks.

Staff Survey Results 2020

The results of the latest national NHS Staff Survey were published on 11th March 2021. Our final response rate for the 2020 survey was 46% (2,950 colleagues) compared to 39% last year. This is better than the median response rate for Acute Trusts of 45%.

We are now at the national average level for all 10 of the themed areas. In summary:

- We have improved in 6 areas (Health and Wellbeing, Support from immediate managers, Morale, Bullying and Harassment, Safety Culture, Staff Engagement)
- Stayed the same in 3 themes (ED&I, Quality of Care, Violence)
- Only 1 theme (team working) has deteriorated from last year which arguably is to be expected due to the number of staff homeworking and higher levels of absence due to the Covid-19 pandemic

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

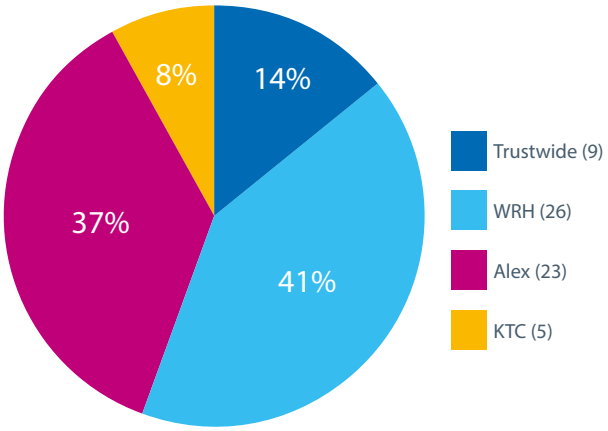
Our focus now is on improving the experience of all our staff to make WAHT an exemplar/ employer of choice. We are currently reviewing the staff survey results against our People and Culture Strategy and drawing up an action plan in partnership with each division.

Freedom to Speak Up (FTSU) Themes

During 2020 we have raised the profile of FTSU with the appointment of our new Guardian and launch of our FTSU Portal so that staff can access support via one click.

The Guardian is supported by a network of 45 FTSU champions across site.

FTSU Cases by Site



The following table provides an overview of the concerns raised through the Freedom to Speak up Guardian in 2020. The majority of the cases raised cover the themes of inappropriate behaviour and attitudes including bullying and harassment. The advent of the portal has also seen an increase in anonymous concerns, the majority being around bullying and harassment and Covid 19/infection control.

Summary of concerns raised to the Freedom to Speak Up Guardian in 2020/21:

Total number of speak up incidences	63
Total number of speak up incidences reported anonymously	13
Total number of speak up incidences where there was a bullying or harassment element	21
Total number of speak up incidences where there was a patient safety or quality element	11
Total number of speak up incidences where there was a perception of detriment to the reporter	0

Themes of concerns raised to FTSU in 2020/21:

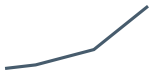
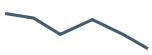
Theme	Number of times issue raised
Bullying and harassment	21
Staff levels	3
Attitudes and behaviours	24
Policy and Procedures	13
Quality and Safety	11
Other	5
Grand Total	**63 cases (some with multiple issues)**

Our Workforce

During 2020 the Trust welcomed the news that our Regulators had recognised significant improvements in safety and quality of patient care, and praised staff for their hard work and dedication. After almost five years the Trust was lifted out of quality special measures by NHS England and NHS Improvement which is a significant achievement due to the dedication and hard work of our staff.

The recruitment and retention of our staff remains a key priority and we are proud that significant reductions in our overall vacancy numbers and staff turnover have been sustained despite the Pandemic. Our substantive vacancy rate has improved by 2.35% this year and turnover has improved by 1.62%.

Snapshot of key workforce indicators

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Trendline
Cumulative Sickness Absence Rate	4.35%	4.27%	4.17%	4.20%	4.72%	4.96%	
Actual staff in post in full-time equivalent (FTE)	5083	5106.18	5199.57	5316.38	5566.85	5827.25	
Headcount staff in post	5935	5951	6055	6207	6453	6748	
Mandatory Training Compliance	76%	89%	89%	84%**	89%	90%	
Appraisal Completion %	80%	76%	65%	77%	81%	79%	
Staff Turnover	12.97%	12.57%	11.04%	12.30%	11.12%	9.50%	

** 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 by 0.24% to 4.96%. We monitor our sickness rates against the national and peer median via the Model Hospital. Our sickness was slightly higher than the national average on Model Hospital in December 2020 which is the most up to date comparison data. Our sickness was 5.25% on Model Hospital (Quartile 3) compared to national average of 5.17%. Sickness rates are 0.24% higher than the same period last year which will be primarily due to Covid Sickness and a subsequent increase in stress and anxiety (S10).

Staff Sickness	2016-17	2017-18	2018-19	2019-20	2020-21	Trendline
Total FTE Days lost	80,277	76,071	80,266	88,100	99,853	
Total staff (headcount)	5,951	6,055	6,207	6,453	6,748	
Average number of working days lost	13.48	12.56	12.93	13.65	14.80	

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 are usually for 10 days for symptomatic staff or those with a family member symptomatic or contacted by "Test and Trace". As at 31st March 2021 we had 109 staff who were required on medical advice to shield in Wave 2, plus a further 76 Shielding but doing their full duties from home.

As at 31st March 2021 the absence levels related to Covid-19 medical suspensions were significantly reduced from 1048 reported last year at the start of the pandemic:

Absences due to Covid Self Isolation	Staff Group	Covid Absences
Covid Household Member Symptoms	Additional Clinical Services	6
Covid Household Member Symptoms	Administrative and Clerical	2
Covid Household Member Symptoms	Nursing and Midwifery Registered	7
Covid Lateral Flow Test Isolation	Nursing and Midwifery Registered	1
Covid Track and Trace	Administrative and Clerical	1
Covid Track and Trace	Nursing and Midwifery Registered	1
Total		**18**

Staff Turnover

Our overall staff turnover has been reducing year on year since July 2015 from 12.97% to 9.5% in March 2021. This is well within Trust target of 11% despite an increase in establishment of 111 wte since the same period last year. We are pleased that our turnover has reduced by 1.62% from the same period last year which is an indicator of a happier workforce. We are performing well against the Model Hospital average (Quartile 2). Our breakdown of staff by staff group as at 31st March 2021 is as follows:

Workforce profile	FTE					
Staff group	31 March 2017	31 March 2018	31 March 2019	31 March 2020	31 March 2021	Trendline
Additional Prof. Scientific and Technic.	179.43	174	191.32	193.42	203.88	
Additional Clinical Services	950.72	977.43	995.04	1,050.37	1,085.12	
Administrative and Clerical	957.75	966.76	995.65	1,043.24	1,094.74	
Allied Health Professionals	332.92	344.64	363.15	356.21	373.53	
Estates and Ancillary	246.11	259.68	278.94	293.55	304.64	
Healthcare Scientists	176.75	178.88	178.88	174.43	167	
Medical and Dental	553.15	581.88	606.82	653.25	675.62	
Nursing and Midwifery Registered	1,678.35	1,692.29	1,697.58	1,800.38	1,870.73	
Students	29	24	9.00	2	52	
Grand Total	**5,104.18**	**5,199.57**	**5,316.38**	**5,566.85**	**5,827.25**	

Our profile of Senior Managers (Band 8 and above) by gender as at 31st March 2021 is as follows:

Senior Managers Profile as at 31 March 2021				
Staff Category	Band 8	Band 9	Trust Board	Total
Trust Board (Female)			10	10
Trust Board (Male)			10	10
Senior Manager (Female)	210	6	1	217
Senior Manager (Male)	59	2	1	62
Grand Total	**269**	**8**	**22**	**299**

Vacancies

The Trust has continued to rely on a high percentage of agency workers to address additional capacity due to the opening of additional wards and response to the Covid pandemic. The breakdown of staff as at 31 March 2021 is as follows:

Substantive/Bank/Agency as at M12 ADI	Funded WTE	Contracted WTE	Vacant WTE	Worked WTE
Agency	110			237
Bank	110			413
Substantive	6129	5883	246	5771
Grand Total	**6349**	**5883**	**246**	**6421**

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 31 March 2021 we had the following assignment categories:

Assignment Category as at 31 March 2021	FTE	Employee Headcount
Non-Executive Director/Chair	0	8
Fixed Term Temp Locum	582.56	641
Permanent	5,244.69	6114
Grand Total	**5,827.25**	**6763**

The total staff costs for 2020/21, excluding remuneration of non-executive directors are:

Staff Cost 2020/21	Permanent £'000	Other £'000	Total £'000
Salaries and Wages	228,590	0	228,590
Social Security Costs	22,191	1,392	23,583
Apprenticeship Levy	1,135	0	1,135
NHS Pension Costs	38,894	835	39,729
Other Pension Costs	0	56	56
Temporary Staff	0	43,097	43,097
Less: recoveries in respect of outward secondments (where treated net).	0	0	0
Total Staff Costs	**290,810**	**45,380**	**336,190**

(Audited)

The analysis of average WTE employed as at 31 March 2021 are below by category:

Number of employees as at 31 March 2021 (WTE)	Permanent	Fixed Term	Locum	Grand Total
Add Prof Scientific and Technic	191.07	12.81		203.88
Additional Clinical Services	1046.59	38.53		1085.12
Administrative and Clerical	1023.39	71.35		1094.74
Allied Health Professionals	368.84	4.68		373.53
Estates and Ancillary	297.36	7.29		304.64
Healthcare Scientists	162.00	5.00		167.00
Medical and Dental	315.70	358.79	1.1	675.62
Nursing and Midwifery Registered	1838.74	31.99		1870.73
Students	1.00	51.00		52.00
Grand Total	**5,244.69**	**581.43**	**1.13**	**5827.25**

(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.

During the pandemic our Occupational Health team have been supporting the organisation by providing staff COVID swab results and supporting the implementation and professional review of Covid-19 risk assessments.

Occupational Health record the reasons (from the staff member's perspective) of what is contributing to their work related stress. Cases have increased from 146 last year to 241 this year with 50% being Covid related as follows:

Work Related Stress OH Appointments		
Covid related issues (including redeployment, uncertainty over where asked to work, fears due to risk)	120	50%
Relationship issues with colleagues	27	11%
Relationship issues with manager	9	4%
Workload	39	16%
Working hours	8	3%
Investigation/Incident at work/Performance Management	18	7%
Combination of above	20	8%
Grand Total	241	

The Occupational Health Team has worked with our Counselling provider to offer a wide range of emotional support as part of our Covid-19 response. The Intranet has been updated to include a Health and Wellbeing Pinwheel which provides a raft of information for staff.

Our Health and Wellbeing plan was approved in March 2021 and is based on the following:

- Creating a culture of wellness through a holistic approach to Health and Wellbeing
- Psychological pyramid – ensuring staff have information, advice, and guidance to self-help with specialist advice and support in place for those in crisis
- Wellbeing conversations – giving all staff the opportunity for reflective practice and to discuss their holistic health and wellbeing

Health and Wellbeing Pinwheel

Staff Appraisals

The Trust believes appraisals are vital in valuing staff and all staff should have an appraisal every year. However, there has been some dispensation given for appraisals during the Pandemic. The Trusts appraisal rate for non-medical staff as at 31 March 2021 deteriorated to 79% from 81% last year and 77% the previous year. This is short of our target against a Model Hospital average of 85% and will be a focus for managers as we move into the Recovery and Restoration phase following the pandemic.

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

Covid-19 response and is due to be reinstated from 1 April 2021.

Electronic Staff Record (ESR) – 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 and maintaining our training compliance. Throughout the Pandemic we have maintained high levels of Mandatory Training Compliance at around 89%. The current compliance at the end of March 2021 is 90% which meets our target and equals the Model Hospital average.

During the latter part of 2020/21 we have introduced new competencies on ESR for a number of Essential to Role topics such as Frailty, Dementia, Sepsis, ReSpect and MCA and DoLs. Compliance is currently 81% across all these topics and improvement is rapid once a topic is rolled out due to automated reminders and remote access via mobiles.

E-Rostering

The Trust purchased a suite of rostering solutions from Allocate Software as recommended in the Carter Report. Previously E-Rostering was limited to Nurses but in 2020 we have rolled out Medics Rostering and Locum on Duty which facilitates early booking of locum shifts via bank staff in the first instance with a view to reducing premium agency costs.

We also implemented the Incident Management module on HealthRoster to enable all of our absence for all staff groups to be recorded on the system and interfaced to payroll. During the latter months of the year we have been rolling out Employee On Line (EOL) for the booking of all absence via mobile into HealthRoster. With effect from 1st April HealthRoster will be the only route for booking and recording all absence which will enable full transparency and triangulation of our absence data.

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 and Trust Board.

Equality and Diversity

We continue to make great strides in our cultural change journey to create a place where all colleagues have a voice, have equal opportunity and are supported to reach their full potential.

At a time when the global Covid-19 pandemic continues to have an impact on all colleagues across Worcestershire Acute Hospitals NHS Trust – and on some staff groups more than others – a concerted focus on health inequalities, diversity and inclusion has never been more important.

The last 12 months, with the start of Black Lives Matter movement, have also brought to the fore an important reminder of the inequalities experienced by some colleagues on a daily basis.

It is against this backdrop that our teams have worked hard to focus on inclusion and ensure that our 4ward behaviours are embedded in every day practice across the Trust.

In particular, our staff networks, LGBT+ and our recently formed Black, Asian, Minority Ethnic (BAME) Network - have focussed on improving the experience of minority groups so that colleagues have confidence to be themselves at work regardless of their protected characteristics.

Our priorities set out in section 4 of this report align with our People and Culture Strategy, as well as the Workforce Race Equality Standard (WRES), and Workforce Disability Equality Standard (WDES). Improving the experience of all of our staff is a key aim of our People and Culture Strategy, which itself is aligned to the wider objectives laid out in our Trust Strategy pyramid and our overall purpose of Putting Patients First.

Our 4ward behaviours continue to guide us, and we remain committed to positively reinforcing these to continue to influence the culture in which we all work and ensure it is one of understanding, kindness and inclusivity, especially as we continue to experience the impact of the global pandemic

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 for all and treatment which respects diversity and dignity.

We offer guaranteed interviews to all applicants under the "two ticks" scheme if they 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) and Workforce Disability Equality Scheme (WDES) data on the national portal and on our intranet and website. As at 31 March 2021 the ethnic breakdown of our staff was as follows:

Headcount by Ethnicity as at 31 March 2021			
Ethnicity	**Female**	**Male**	**Total**
Asian or Asian British	563	244	807
Black or Black British	86	41	127
Mixed Race	51	26	77
Not Stated / Undisclosed	34	9	43
Other	87	48	135
White	4743	816	5559
Grand Total	**5564**	**1184**	**6748**

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 each year up to 31 March 2019. The results have been uploaded into the designated government portal and on the Trust's website.

Due to the continuing impact of the Coronavirus (COVID 19) pandemic, the Equality and Human Rights Commission (EHRC) announced that employers will have an additional six months after the current deadline to report their gender pay gap information. Our 2020 Gender Pay Gap Report will therefore be published by 5 October 2021.

Finance - 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 Chair 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 Chair.

- Chair Sir David Nicholson commenced from 14 May 2018 until the present date.

Non-Executive Directors:

- Mr Mark Yates until 31 March 2021
- Mr Stephen Williams until 31 December 2020
- Ms Anita Day from 1 January 2021

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: Joanna Newton (Director of Strategy & Planning); and Paula Gardner (Chief Nursing Officer). Sarah Smith (Director of Strategy & Planning) resigned on 30 June 2020 and Victoria Morris resigned on 31 March 2021.

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

		2020/2021									2019/2020								
		Salary and fees			All taxable benefits	All pension-related benefits			Total			Salary and fees			All taxable benefits	All pension-related benefits			Total		
		£000s			£s	£000s			£000s			£000s			£s	£000s			£000s		
Job title (and period of office if relevant)		(in bands of £5k)			(nearest £100)	(in bands of £2.5k)			(bands of £5k)			(in bands of £5k)			(nearest £100)	(in bands of £2.5k)			(bands of £5k)		
David Nicholson	Trust Chair	35	-	40	0		-		35	-	40	35	-	40	0		-		35	-	40
Matthew Hopkins	Chief Executive	210	-	215	1,200		-		210	-	215	210	-	215	3,300		-		210	-	215
Paul Brennan	Chief Operating Officer & Deputy Chief Executive	185	-	190	0		-		185	-	190	170	-	175	0		-		170	-	175
Mike Hallisey	Chief Medical Officer (on secondment fro University Hospital B'ham, invoiced)	100	-	105	0		-		100	-	105	75	-	80	0		-		75	-	80
Victoria Morris	Chief Nursing Officer - to 31 March 2021	100	-	105	0		-		100	-	105	125	-	130	0	7.5	-	10.0	135	-	140
Robert D Toole	Chief Finance Officer	150	-	155	4,000	35.0	-	37.5	190	-	195	150	-	155	1,800	27.5	-	30.0	180	-	185
Sarah Smith	Director of Strategy & Planning - to 30 June 2020	20	-	25	0	2.5	-	5	25	-	30	105	-	110	0	27.5	-	30.0	135	-	140
Joanna Newton	Director of Strategy & Planning - from 27 April 2020	110	-	115	0	25.0	-	27.5	135	-	140		-			-	-	-	-	-	-
Richard Haynes	Director of Communications & Engagement	100	-	105	0	25.0	-	27.5	125	-	130	100	-	105	0	22.5	-	25.0	125	-	130
Tina Ricketts	Director of People & Culture	125	-	130	0	62.5	-	65	190	-	195	120	-	125	200	23	-	25.0	145	-	150
Helen Lewis (known as Vikki)	Chief Digital Officer	120	-	125	0	125.0	-	127.5	245	-	250	20	-	25	0	67.5	-	70.0	90	-	95
Paula Gardner	Chief Nursing Officer from 15 March 2021	5	-	10	0		-		5	-	10		-		0		-			-	

(Audited)

NOTES

- All taxable benefits relate to cars and the benefits in kind are based on the HMRC guidance.
- The taxable benefits for the Chief Executive for 2019/20 have been restated to £3,300 (£500 in 2019/20 Annual Report) due to taxable relocation expenses of £2,800 not being reported.
- Pension related benefits have been calculated in line with the 2020/21 Group Accounting Manual.
- There are no performance pay, long-term performance pay or bonuses for the directors in either 2019/20 or 2020/21.
- **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 remains as Chief Medical Officer.
- **Chief Digital Officer**
  Ms H Lewis remains as Chief Digital Officer.
- **Chief Nursing Officer**
  Ms P Gardner commenced as Chief Nursing Officer on 15 March 2021

Non-Executive Directors

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

		2020/21									2019/20								
		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)																					
Anita Day	Non Executive Director	10	-	15	0		-		10	-	15	5	-	10	1,200		-		5	-	10
William Tunnicliffe	Non Executive Director	10	-	15	0		-		10	-	15	5	-	10	0		-		5	-	10
Stephen Williams	Non Executive Director to 31 December 2020	5	-	10	100		-		5	-	10	5	-	10	2,300		-		5	-	10
Mark Yates	Non Executive Director to 31 March 2021	10	-	15	200		-		10	-	15	5	-	10	700		-		5	-	10
Colin Horwath	Non Executive Director	10	-	15	0		-		10	-	15	5	-	10	1,200		-		5	-	10
Julie Moore	Non Executive Director	10	-	15	0		-		10	-	15	5	-	10	0		-		5	-	10
Richard Oosterom	Non Executive Director	10	-	15	0		-		10	-	15	10	-	15	0		-		10	-	15
Waqar Azmi	Non Executive Director from 1 January 2021	0	-	5	0		-		0	-	5				0		-				
Sharon Thompson	Non Executive Director from 1 January 2021	0	-	5	0		-		0	-	5				0		-				

(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 2021 and deducting the equivalent value from the amount due at 31 March 2021. 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 2020/21 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 2021	Lump sum at pension age related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 31 March 2021	Cash Equivalent Transfer Value at 01 April 2020	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
Victoria Morris	0	0	45 - 50	145 - 150	0	1,072	0	6.17
Tina Ricketts	2.5 - 5	2.5 - 5	30 - 35	60 - 65	595	538	58	13.12
Sarah Smith	0 - 2.5	0 - 2.5	35 - 40	115 - 120	970	945	26	3.00
Richard Haynes	0 - 2.5	0	15 -20	35 - 40	353	333	20	14.43
Paul Brennan	0	0	0	0	0	1,343	0	0
Helen Lewis (known as Vikki)	5 - 7.5	12.5 - 15	30 - 35	60 - 65	582	467	115	17.43
Joanna Newton	0 - 2.5	0	5 - 10	0	84	69	15	16.17
Robert D Toole	2.5 - 5	0	30 - 35	65 - 70	675	640	36	21.79

(Audited)

Notes

Paula Gardner joined the Trust on 15 March 2021, and therefore no Pension Benefits information available.

Victoria Morris) – pension paid up to 31 July 2020, which is reflected in the figures above.

Tina Ricketts opted out of the pension on 1 January 2021, pension benefits have been prorated to reflect this.

Sarah Smith and Joanna Newton – pension benefits have been prorated to reflect days employed by the Trust in the year to 31 March 2021.

Paul Brennan opted out of the pension on 1 January 2020, which was not reported in the Annual Report 2019/20.

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

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

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

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

The table above details the current pension benefits of the Trust's senior managers. As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of Non Executives. Where the Executive Director in post at 31 March 2021 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.

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	0	0	0	0	0	0	0	0
£10,000 to £25,000	0	0	0	0	0	0	0	0
£25,001 to £50,000	0	0	1	34,305	0	0	0	0
£50,001 to £100,000	2	162,006	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0	0	0
> £200,000	0	0	0	0	0	0	0	0
Totals	**2**	**162,006**	**1**	**34,305**	**0**	**0**	**0**	**0**

(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.

Other Exit Package - disclosures (excluding compulsory redundancies)	Number of Exit Package Agreements	Total Value of Agreements £
Voluntary Redundancies including Early Retirement Contractual Costs	0	0
Mutually Agreed Resignations (MARS) Contractual Costs	0	0
Early Retirements in the Efficiency of the Service Contractual Costs	0	0
Contractual Payments in Lieu of Notice	1	34,305
Exit Payments Following Employment Tribunals or Court Orders	0	0
Non-Contractual Payments Requiring HM Treasury Approval	0	0

(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".

Off-payroll engagements longer than 6 months: For all payroll engagements as at 31 March 2021, for more than £245 per day and that last longer than six months.	Number of engagements
Number of existing engagements as at 31 March 2021	5
Number that have existed for less than one year at a time of reporting	1
Number that have existed for between one and two years at a time of reporting	4
Number that have existed for between two and three years at a time of reporting	0
Number that have existed for between three and four years at a time of reporting	0

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.

New off-payroll engagements: All new payroll engagements, or those that have reached six months in duration, between 1 April 2020 and 31 March 2021, 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 2020 and 31 March 2021	0
Of which:	
▶ Number assessed as within the scope of IR35	
▶ Number assessed as not within the scope of IR35	
▶ 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 2020/21 was between £210k–215K. This was 7 times the median remuneration of the workforce, which was £30,615.

In 2019/20 the banded remuneration highest paid Director was £210-215k which was 8.2 times the median remuneration of £26,220. 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, no employees received remuneration in excess of the highest paid director. In 2019/20 2 employees received remuneration in excess of the highest paid director.

Remuneration ranged from £5,338 and £211,458 for 2020/21. The range of remuneration for 2019/20 was between £5,338 and £209,300.

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

Report on the Audit of the Financial Statements

Qualified opinion on financial statements

We have audited the financial statements of Worcestershire Acute Hospitals NHS Trust (the 'Trust') for the year ended 31 March 2021, 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 accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

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 2021 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; 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 in March 2020, we were not able to observe the counting of the physical inventories at 31 March 2020 or satisfy ourselves by alternative means concerning the inventory quantities held at that date, which had a carrying amount in the Statement of Financial Position of £8.914 million. Consequently, we were unable to determine whether any adjustment to this amount at 31 March 2020 was necessary or whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. 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.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated

with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Directors with respect to going concern are described in the 'Responsibilities of the Directors and Those Charged with Governance for the financial statements' section of this report.

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 satisfy ourselves concerning the inventory quantities of £8.914 million held as 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 2020 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, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, 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 7 June 2021 we referred a matter to the Secretary of State under Section 30 (b) of the Local Audit and Accountability Act in relation to the Trust's ongoing breach of its break-even duty for the three-year period ending 31 March 2021.

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

As explained in the Statement of directors' responsibilities in respect of the accounts, 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting

standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).

- We enquired of management and the Audit and Assurance committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management and the Audit and Assurance committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and revenue recognition. We determined that the principal risks were in relation to:
  - journal entries, including manual and year-end postings
  - the significant accounting estimates in the financial statements, including those related to the valuation of property, plant and equipment, accruals and provisions.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large and unusual items;
  - challenging assumptions and judgements made by management in its significant accounting estimates;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the breach of the Trust's break-even duty for the three-year period ending 31 March 2021, the potential for fraud in income and expenditure recognition, and the significant accounting estimates.
- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation
    - NHS Improvement's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances,

expected financial statement disclosures and business risks that may result in risks of material misstatement.

- the Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Worcestershire Acute Hospitals NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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.

Julie Masci

Julie Masci, Key Audit Partner

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

Bristol

15 June 2021

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

In our auditor's report issued on 15 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 15 June 2021 we reported that, 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 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

The Basis for qualified opinion section of our opinion was as follows:

Due to the national lockdown arising from the Covid-19 pandemic in March 2020, we were not able to observe the counting of the physical inventories at 31 March 2020 or satisfy ourselves by alternative means concerning the inventory quantities held at that date, which had a carrying amount in the Statement of Financial Position of £8.914 million. Consequently, we were unable to determine whether any adjustment to this amount at 31 March 2020 was necessary or whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter except on 17 September 2021 we identified three significant weaknesses in the Trust's arrangements for improving economy, efficiency, and effectiveness:

- The Trust's estates costs are high in relation to similar Trusts and are a factor driving the Trust's deficit. However there is currently no approved estates strategy to drive more effective use of property assets. We recommended that the Trust should develop its estates strategy and strengthen the Trust's PFI contract management to secure improved value from the arrangements.
- The Trust has high bank and agency costs which are factors behind the Trust's deficit. However the Trust does not have a sustainable workforce model or human resources strategy. We recommended that the Trust should accelerate the work on understanding the drivers of the high cost of its workforce and dependency on bank and agency nursing, which should then drive a workforce strategy developed in conjunction with system partners.
- There are inadequacies in some of the Trust's information systems and benchmarking data is not being used effectively to provide reliable management information for decision making. We recommended that the Trust should continue to implement a range of actions to improve the quality of its clinical, performance and service data and to make better use of benchmarking data.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Worcestershire Acute Hospitals NHS Trust for the year ended 31 March 2021 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.

Julie Masci

Julie Masci, Key Audit Partner

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

Bristol

20 September 2021

Trust's Annual General Meeting

The Annual General Meeting will take place virtually from 2pm on Thursday 8 July. This meeting will be Live Streamed on our YouTube Channel.

www.youtube.com/worcestershireacute

Further information can be obtained by writing to:

Rebecca O'Connor
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.

Worcestershire Acute Hospitals NHS Trust

Annual accounts for the year ended 31 March 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	488,127	416,176
Other operating income	4	70,876	27,546
Operating expenses	6, 8	(540,126)	(514,924)
Operating surplus/(deficit) from continuing operations		**18,877**	**(71,202)**
Finance income	11	7	191
Finance expenses	12	(11,854)	(17,349)
PDC dividends payable		(5,728)	-
Net finance costs		**(17,575)**	**(17,158)**
Other gains / (losses)	13	29	29
Surplus / (deficit) for the year		**1,331**	**(88,331)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(2,094)	(2,217)
Revaluations	17	5,332	791
Total comprehensive income / (expense) for the period		**4,569**	**(89,757)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		1,331	(88,331)
Remove net impairments not scoring to the Departmental expenditure limit		6,553	7,288
Remove I&E impact of capital grants and donations		(847)	70
Remove 2018/19 post audit PSF reallocation (2019/20 only)			(493)
Remove net impact of inventories received from DHSC group bodies for COVID response		(385)	
Adjusted financial performance surplus / (deficit)		**6,652**	**(81,466)**

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, surplus of £6.652m against the allocated funding for the 2020/21 financial year. This is broadly in line with the forecast financial outturn considering key variations in notification of annual leave support and resolution of system inter NHS balances. 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 & Expenditure	Actual 2020/21 £'000s	Actual 2019/20 £'000s
Operational (Adjusted) financial performance surplus/(deficit) including PSF, FRF, MRET and Top-Up funding, excluding Impairments	6,652	(81,466)
Adjust Remove impact of prior year PSF post accounts reallocation	0	493
Adjust Remove capital donations/grants I&E impact	847	(70)
Adjust I&E impairments/(reversals)	(6,553)	(7,288)
Adjust Remove net impact of DHSC centrally procured inventories	385	
Surplus/(deficit) for the year including PSF, FRF, MRET and Top-Up funding and after Impairments	1,331	(88,331)

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	4,287	3,103
Property, plant and equipment	15	294,208	282,384
Receivables	19	1,559	2,766
Total non-current assets		**300,054**	**288,253**
Current assets			
Inventories	18	8,428	8,914
Receivables	19	21,490	23,918
Non-current assets for sale and assets in disposal groups	20	400	400
Cash and cash equivalents	21	41,527	2,017
Total current assets		**71,845**	**35,249**
Current liabilities			
Trade and other payables	22	(60,455)	(42,340)
Borrowings	24	(4,101)	(328,354)
Provisions	25	(5,313)	(2,071)
Other liabilities	23	(431)	(2,609)
Total current liabilities		**(70,300)**	**(375,374)**
Total assets less current liabilities		**301,599**	**(51,872)**
Non-current liabilities			
Borrowings	24	(66,345)	(71,362)
Provisions	25	(2,927)	(2,882)
Other liabilities	23	(4,249)	(3,278)
Total non-current liabilities		**(73,521)**	**(77,522)**
Total assets employed		**228,078**	**(129,394)**
Financed by			
Public dividend capital		548,787	195,884
Revaluation reserve		86,722	85,407
Other reserves		(861)	(861)
Income and expenditure reserve		(406,570)	(409,824)
Total taxpayers' equity		**228,078**	**(129,394)**

The notes on pages 7 to 54 form part of these accounts.

Name Matthew Hopkins
Position Chief Executive
Date 9th June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**195,884**	**85,407**	**(861)**	**(409,824)**	**(129,394)**
Surplus/(deficit) for the year	-	-	-	1,331	**1,331**
Impairments	-	(2,094)	-	-	**(2,094)**
Revaluations	-	5,332	-	-	**5,332**
Transfer to retained earnings on disposal of assets	-	(1,923)	-	1,923	**-**
Public dividend capital received	352,903	-	-	-	**352,903**
Taxpayers' and others' equity at 31 March 2021	**548,787**	**86,722**	**(861)**	**(406,570)**	**228,078**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£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)**

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.

Income and expenditure reserve
The balance of this reserve is made up from the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		18,877	(71,202)
Non-cash income and expense:			
Depreciation and amortisation	6.1	11,068	11,512
Net impairments	7	6,553	7,288
Income recognised in respect of capital donations	4	(968)	-
Amortisation of PFI deferred credit		(507)	(674)
(Increase) / decrease in receivables and other assets		4,346	(5,230)
(Increase) / decrease in inventories		486	(155)
Increase / (decrease) in payables and other liabilities		16,285	18,884
Increase / (decrease) in provisions		3,315	1,417
Net cash flows from / (used in) operating activities		**59,455**	**(38,160)**
Cash flows from investing activities			
Interest received	11	7	191
Purchase of intangible assets		(1,719)	(1,703)
Purchase of PPE and investment property		(24,250)	(13,053)
Sales of PPE and investment property		63	41
Net cash flows from / (used in) investing activities		**(25,899)**	**(14,524)**
Cash flows from financing activities			
Public dividend capital received		352,903	4,627
Movement on loans from DHSC		(325,823)	66,646
Capital element of PFI, LIFT and other service concession payments		(2,011)	(1,782)
Interest on loans		(1,784)	(4,901)
Interest paid on PFI, LIFT and other service concession obligations		(11,535)	(11,891)
PDC dividend (paid) / refunded		(5,796)	-
Net cash flows from / (used in) financing activities		**5,954**	**52,699**
Increase / (decrease) in cash and cash equivalents		**39,510**	**15**
Cash and cash equivalents at 1 April - brought forward		**2,017**	**2,002**
Cash and cash equivalents at 31 March	21	**41,527**	**2,017**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 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.

Accounting convention

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

Note 1.2 Going concern

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.

In March 2021 the Board made an assessment of the risks, opportunities and uncertainties it faces and considers itself to be a going concern in line with published guidance. The trust surplus of £6.652m includes the exceptional items of £(6.553)m for asset impairments (due to the trust requirement to report its assets at the current fair value over the appropriate life of the asset which is a non cash technical adjustment), the net impact of the DHSC centrally procured inventories £385k, along with the donated asset impact of £847k. The adjusted financial surplus (against which our performance is measured) is £1.331m after these adjustments.

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 totalling £324.4m were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The Trust also received £20.8m of capital PDC to support targeted capital schemes, largely related to previously identified high risk backlog, supporting the COVID-19 response and enabling restoration of activity. Total new borrowings in 2020/21 are £28.5m.

In light of the COVID-19 response, the planning cycle has been revised and the interim funding regime seen in 2020/21 largely rolled forward into the first half of 2021/22. The trust, with system partners is finalising its operational and financial plan for the period April to September 2021 within which there continues to be an assumed provision of service, and a focus on restoration of elective activity impacted by COVID-19. Planning for the second half of 2021/22 is ongoing, based on a return to funding allocations in place prior to the pandemic and continued focus on restoration of services. The 2021/22 Trust Annual plan will be refreshed when national guidance and trajectories for the remainder of 2021/22 are finalised. DHSC has confirmed that temporary revenue support arrangements will continue, in order to support providers with demonstrable cash needs.

Note 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 for 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. It 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 £12.97m. 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 (MPET) levy funding.
It establishes a framework for the delivery of practice 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.

COVID-19 Additional Income

In addition to the nationally determined block contract income through commissioners, an interim top up funding regime was introduced to ensure the costs of the COVID-19 pandemic were funded appropriately. Note 3.1 also refers.

Note 1.4 Other forms of income

Grants and donations

Government grants are income from government bodies, other than 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 grant 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.

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.

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 for Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 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.

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's 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 into 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 accounted for the increase in pension contribution at 20.6% from the 1st April 2019. The rates have been agreed from the 1st April 2019 to 31st March 2023 at 20.6% of pensionable pay for both the 1995-2008 pension scheme and the 2015 pension scheme. The employers contribution is set through a scheme valuation which is carried out every four years, where the 2016 valuation identified the need to increase the employer contribution from 14.3% to 20.6% from 1st April 2019.

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

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

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

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

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 up to date asset of equivalent capacity that meets 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.

Valuation guidance issued by the Royal Institution 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.

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 and 2021/21, following a full revaluation in 2018/19.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, 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 remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction 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.

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 expenditure.

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 the criteria in IFRS 5 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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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 this 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.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the Coronavirus pandemic. As defined in the GAM, the trust applies the principle of Donated Asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Note 1.8 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'.

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

Useful lives of property, plant and equipment

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

	Min life	Max life
	Years	Years
Buildings, excluding dwellings	2	81
Dwellings	48	64
Plant & machinery	1	50
Transport equipment	4	8
Information technology	5	41
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.

Note 1.9 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.

Software

Software which is integral to the operation of hardware, for example 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, for example 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. Revaluation gains, losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value, 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 1.10 Inventories

Inventories (excluding drugs) are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value due to the typically high turnover of stocks.

Drugs inventories are valued using the weighted average cost method.

The trust's inventory balance of £8.4m 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 and were further improved in 2020/21 with the introduction of a digital app to aid data collection. In the prior period, the impact of the pandemic meant that the trust experienced constraints in accessing stock information and made reasonable adjustment. The auditor was unable to gain sufficient assurance through testing procedures and issued a Limitation of Scope. Though the impact of COVID-19 continues to be prevalent, trust staff were able to complete the stock counts, the trust's auditor was able to fully attend the relevant year-end inventory counts and the balances as at 31st March 2021 and have been appropriately tested.

In 2020/21, the trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 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, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

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

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

• Financial assets are classified as subsequently measured at amortised cost.

• Financial liabilities are 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, 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 both 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 1.13 Leases

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

The trust as 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 as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

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 1.14 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 2021:

		Nominal rate
Short-term	Up to 5 years	0.02%
Medium-term	After 5 years up to 10 years	0.18%
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 2021:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
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 0.95% in real terms.

Note 1.15 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 1.16 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 1.17 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 1.18 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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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 have been extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

Note 1.19 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 1.20 Corporation tax

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

Note 1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.22 Foreign exchange

The functional and presentational currency of the trust is pound 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 1.23 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, where held they are discolosed in a seperate note to the accounts.
In 2020/21 and the prior year comparator no such balances were held by the trust.

Note 1.24 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 1.25 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 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases is set to 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 2022. The standard provides a single accounting model for the recognition and measurement of leases, 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 on a lease-by-lease basis, which allows a lessee to exclude direct costs from the measurement of a right of use asset. 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 from IAS 17.

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 2022, 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 defined by HM Treasury. Currently this rate is 0.91% 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. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, 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 implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

From 1 April 2022, the principles of IFRS 16 will also be applied to the trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Note 1.28 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:

Note 1.28.1 PFI

Valuation guidance issued by the Royal Institution 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 1.28.2 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 15) 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 2020/21 after having a full revaluation in 2018/19.

• The valuation exercise was carried out between December 2020 and March 2021 with a valuation date of 31 March 2021 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 the valuation is not subject to a 'material valuation uncertainty' in the valuation report. The valuer considers that at the valuation date property markets are mostly functioning again, with transaction volumes and other relevant evidence at levels where an adequate quantum of market evidence exists upon which to base opinions of value. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. 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 2021. Whilst these published build costs remain 'provisional' and therefore subject to fluctuation, it is not anticipated that there would be a significant change.

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 35 relating to breakeven performance.

Income Sources

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

- Clinical Commissioning Groups (CCGs) from which £394.9 million (£330 million in 2019/20) was received of which £9m related to System COVID-19 and £43.8m to Top up Payments; and

- NHS England from which £128.9 million (£70.1 million in 2019/20) was received of which £7.4m related to COVID-19 expenditure incurred (or revenue lost due to the pandemic) and £37.6m to Top up Payments.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	2020/21 £000	2019/20 £000
Block contract / system envelope income*	431,823	361,209
High cost drugs income from commissioners (excluding pass-through costs)	39,450	37,129
Other NHS clinical income	4,489	4,511
Private patient income	272	401
Additional pension contribution central funding**	12,093	11,207
Other clinical income	-	1,719
Total income from activities	**488,127**	**416,176**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have 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.

Note 3.2 Income from patient care activities (by source)		
	2020/21	2019/20
Income from patient care activities received from:	**£000**	**£000**
NHS England	88,493	81,285
Clinical commissioning groups	394,873	329,979
Other NHS providers	2,592	2,443
NHS other	204	204
Non-NHS: private patients	224	345
Non-NHS: overseas patients (chargeable to patient)	48	56
Injury cost recovery scheme	972	1,129
Non NHS: other	721	735
Total income from activities	**488,127**	**416,176**
Of which:		
Related to continuing operations	488,127	416,176

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)	2020/21 £000	2019/20 £000
Income recognised this year	48	56
Cash payments received in-year	53	21
Amounts written off in-year	28	15

Note 4 Other operating income	2020/21			2019/20		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	914	-	**914**	1,036	-	**1,036**
Education and training	12,990	-	**12,990**	12,237	-	**12,237**
Non-patient care services to other bodies	7,413		**7,413**	6,572		**6,572**
Provider sustainability fund (2019/20 only)			**-**	493		**493**
Reimbursement and top up funding	40,411		**40,411**			**-**
Receipt of capital grants and donations		968	**968**		-	**-**
Charitable and other contributions to expenditure		7,195	**7,195**		254	**254**
Rental revenue from operating leases		117	**117**		114	**114**
Amortisation of PFI deferred income / credits		507	**507**		674	**674**
Other income	361	-	**361**	6,166	-	**6,166**
Total other operating income	**62,089**	**8,787**	**70,876**	**26,504**	**1,042**	**27,546**
Of which:						
Related to continuing operations			70,876			27,546

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) £12.9m. Note 1.3

Receipts of capital grants and donations (£968k) relates to the donated property, plant and equipment assets from DHSC as part of the coronavirus pandemic response in 2020/21.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	-	1,977
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	3,139

As per national NHSE/I guidance all partially completed spells £3.139m and maternity pathway payments £1.977m relating to 2019-20 have been reversed and transacted in cash with the relevant commissioner. Therefore no liability or obligation has been recognised in the Financial Year 2020/21.

Note 5.2 Transaction price allocated to remaining performance obligations Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2021 £000	31 March 2020 £000
within one year	-	-
after one year, not later than five years		
after five years		
Total revenue allocated to remaining performance obligations	**-**	**-**

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

Note 5.3 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.

	2020/21 £000	2019/20 £000
Income	74	2,435
Full cost	(2,492)	(2,251)
Surplus / (deficit)	**(2,418)**	**184**

The income and full costs relate to the trust car parking which are included in Other Income note 4.

Income has reduced in 2020/21 due to the COVID-19 pandemic and free parking for all staff and patients.

Note 6.1 Operating expenses	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,131	4,440
Purchase of healthcare from non-NHS and non-DHSC bodies	3,635	4,328
Staff and executive directors costs	335,891	314,915
Remuneration of non-executive directors	134	103
Supplies and services - clinical (excluding drugs costs)	44,252	44,808
Supplies and services - general	21,773	17,753
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	47,655	46,555
Inventories written down	323	228
Consultancy costs	318	450
Establishment	2,811	5,649
Premises	14,898	13,165
Transport (including patient travel)	1,095	1,504
Depreciation on property, plant and equipment	10,533	10,630
Amortisation on intangible assets	535	882
Net impairments	6,553	7,288
Movement in credit loss allowance: contract receivables / contract assets	1,347	468
Change in provisions discount rate(s)	368	(59)
Audit fees payable to the external auditor		
audit services- statutory audit	83	61
Internal audit costs	77	67
Clinical negligence	14,807	13,361
Legal fees	364	295
Insurance	300	214
Education and training	531	905
Rentals under operating leases	3,569	4,413
Redundancy	-	2
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	20,752	20,724
Other	2,391	1,775
Total	**540,126**	**514,924**
Of which:		
Related to continuing operations	540,126	514,924

Note 6.2 Other auditor remuneration	2020/21 £000	2019/20 £000

Other auditor remuneration paid to the external auditor:

There has been no other remuneration paid to the external auditor in either 2019/20 or 2020/21.

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2019/20: £1 million).

Note 7 Impairment of assets	2020/21 £000	2019/20 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	6,553	7,288
Total net impairments charged to operating surplus / deficit	**6,553**	**7,288**
Impairments charged to the revaluation reserve	2,094	2,217
Total net impairments	**8,647**	**9,505**

The trust engaged a professional property advisor to undertake a desk top revaluation in 2020/21, 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 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	228,590	206,009
Social security costs	23,583	21,916
Apprenticeship levy	1,135	1,056
Employer's contributions to NHS pensions	39,729	36,860
Pension cost - other	56	62
Temporary staff (including agency)	43,097	49,228
Total gross staff costs	**336,190**	**315,131**
Of which		
Costs capitalised as part of assets	299	216

Note 8.1 Retirements due to ill-health

During 2020/21 there were 7 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £175k (£783k in 2019/20).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Note 10 Operating leases

Note 10.1 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.

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	117	114
Total	**117**	**114**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year;	117	114
Total	**117**	**114**

Note 10.2 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.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	3,569	4,413
Total	**3,569**	**4,413**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	2,169	3,408
- later than one year and not later than five years;	5,302	6,343
- later than five years.	19,824	20,787
Total	**27,295**	**30,538**
Future minimum sublease payments to be received	-	-

Note 11 Finance income	2020/21 £000	2019/20 £000
Interest on bank accounts	7	191
Total finance income	**7**	**191**

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

Note 12.1 Finance expenditure	2020/21 £000	2019/20 £000
Interest expense:		
Loans from the Department of Health and Social Care	348	5,450
Main finance costs on PFI and LIFT schemes obligations	5,399	5,595
Contingent finance costs on PFI and LIFT scheme obligations	6,135	6,295
Total interest expense	**11,882**	**17,340**
Unwinding of discount on provisions	(28)	9
Total finance costs	**11,854**	**17,349**

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

Any future financial support for revenue will be in the form of PDC funding which increases the PDC Dividend charge. There will be no further requirement for revenue loans going forward.
As the loans have converted to PDC there is a corresponding reduction in interest payable on loans

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015	2020/21 £000	2019/20 £000
Total liability accruing in year under this legislation as a result of late payments	-	-

The trust has not incurred any late payment interest charges in 2019/20 nor 2020/21

Note 13 Other gains / (losses)	2020/21 £000	2019/20 £000
Gains on disposal of assets	63	41
Losses on disposal of assets	(34)	(12)
Total gains / (losses) on disposal of assets	**29**	**29**
Total other gains / (losses)	**29**	**29**

Note 14 Intangible assets - 2020/21	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**8,064**	**2,507**	**2,189**	**12,760**
Additions	618	507	594	**1,719**
Reclassifications	1,529	561	(2,090)	**-**
Valuation / gross cost at 31 March 2021	**10,211**	**3,575**	**693**	**14,479**
Amortisation at 1 April 2020 - brought forward	**7,368**	**2,289**	**-**	**9,657**
Provided during the year	388	147	-	**535**
Amortisation at 31 March 2021	**7,756**	**2,436**	**-**	**10,192**
Net book value at 31 March 2021	**2,455**	**1,139**	**693**	**4,287**
Net book value at 1 April 2020	**696**	**218**	**2,189**	**3,103**

Note 14.1 Intangible assets - 2019/20	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**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 - as previously stated	**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 15.1 Property, plant and equipment - 2020/21	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 2020 - brought forward	**40,015**	**222,552**	**884**	**7,017**	**44,835**	**302**	**23,216**	**136**	**338,957**
Additions	-	2,741	14	8,420	9,721	-	4,809	1	**25,706**
Impairments	(500)	(12,343)	(41)	-	-	-	-	-	**(12,884)**
Reversals of impairments	201	4,036	-	-	-	-	-	-	**4,237**
Revaluations	-	(1,263)	(30)	146	-	-	-	-	**(1,147)**
Reclassifications	-	6,425	-	(7,449)	823	-	201	-	**-**
Disposals / derecognition	-	-	-	-	(398)	-	(12,309)	-	**(12,707)**
Valuation/gross cost at 31 March 2021	**39,716**	**222,148**	**827**	**8,134**	**54,981**	**302**	**15,917**	**137**	**342,162**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**684**	**-**	**-**	**35,359**	**302**	**20,100**	**128**	**56,573**
Provided during the year	-	6,518	30	-	2,286	-	1,697	2	**10,533**
Revaluations	-	(6,449)	(30)	-	-	-	-	-	**(6,479)**
Disposals / derecognition	-	-	-	-	(398)	-	(12,275)	-	**(12,673)**
Accumulated depreciation at 31 March 2021	**-**	**753**	**-**	**-**	**37,247**	**302**	**9,522**	**130**	**47,954**
Net book value at 31 March 2021	**39,716**	**221,395**	**827**	**8,134**	**17,734**	**-**	**6,395**	**7**	**294,208**
Net book value at 1 April 2020	**40,015**	**221,868**	**884**	**7,017**	**9,476**	**-**	**3,116**	**8**	**282,384**

Note 15.2 Property, plant and equipment - 2019/20	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**40,015**	**222,627**	**901**	**11,691**	**42,957**	**302**	**23,140**	**136**	**341,769**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2019 - restated	**40,015**	**222,627**	**901**	**11,691**	**42,957**	**302**	**23,140**	**136**	**341,769**
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 - as previously stated	**-**	**444**	**-**	**-**	**33,249**	**302**	**18,204**	**123**	**52,322**
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 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	39,716	136,221	827	8,134	10,758	6,395	7	**202,058**
On-SoFP PFI contracts and other service concession arrangements	-	84,946	-	-	6,060	-	-	**91,006**
Owned - donated/granted	-	228	-	-	916	-	-	**1,144**
NBV total at 31 March 2021	**39,716**	**221,395**	**827**	**8,134**	**17,734**	**6,395**	**7**	**294,208**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 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/granted	-	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 Donations of property, plant and equipment

The trust has received £968k of donated property, plant and equipment assets from DHSC as part of the coronavirus pandemic response in 2020/21. These have depreciated during the year to give a Net Book Value of £916k as at 31st March 2021.

Where the funder provides cash, rather than physical assets, any difference between the cash provided and the fair value of the assets acquired should also be disclosed.

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 2021, as part of the five year agreement with them.

The valuations were carried out in accordance with the Royal Institution 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 2021 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 2021 £000	31 March 2020 £000
Drugs	3,474	3,712
Work In progress	103	90
Consumables	4,829	5,087
Energy	22	25
Other	-	-
Total inventories	**8,428**	**8,914**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £53,009k (2019/20: £50,274k). Write-down of inventories recognised as expenses for the year were £323k (2019/20: £228k).

Through learning from response to the COVID-19 pandemic, the trust is seeking to modernise its inventory management practices including the acquisition of a modern inventory management system. The trust, through its annual plan expects to introduce modern practices and systems during 2021/22 which will improve visibility of slow moving, change of use or obsolete inventory. Given the current limited visibility of slow moving and obsolete inventory; the relatively low level of historic inventory write-downs; and the anticipated improvements in inventory management, it has been deemed prudent to make a provision equivalent to 25% of core inventory items (£0.67m) to account for anticipated losses. (Note 25.1)

In response to the COVID-19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £6,839k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19.1 Receivables	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	8,165	15,248
Allowance for impaired contract receivables / assets	(1,551)	(1,972)
Deposits and advances	714	(130)
Prepayments (non-PFI)	3,785	2,275
PFI lifecycle prepayments	6,070	5,427
PDC dividend receivable	68	-
VAT receivable	3,858	2,532
Other receivables	381	538
Total current receivables	**21,490**	**23,918**
Non-current		
Contract receivables	1,559	2,766
Total non-current receivables	**1,559**	**2,766**
Of which receivable from NHS and DHSC group bodies:		
Current	6,241	6,447
Non-current	35	-

Non-Current Contract Receivables relates to the NHS Injury Cost Recovery Scheme, whereby the Trust accounts for expected income.
During 2020/21 the Trust reviewed all outstanding cases up to and including 2017/18 as advised by the Compensation Recovery Unit which resulted in the expected income reduction.

Note 19.2 Allowances for credit losses	2020/21 Contract receivables and contract assets £000	2019/20 Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	**1,972**	**1,999**
New allowances arising	1,347	468
Utilisation of allowances (write offs)	(1,768)	(495)
Allowances as at 31 Mar 2021	**1,551**	**1,972**

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

Injury cost recovery income: subject to a provision for credit losses of 22.43% (21.79% 2019/20) as per DHSC guidance for 2020/21 receivables. The Trust has used the following allowance for older receivables - 2019/20 - 2017/18 50% and 100% for any prior debt due to updated guidance from the Compensation Recovery Unit (CRU)

Non-NHS receivables that are over 3 months old, are subject to a provision for credit losses of 100%

Non-NHS receivables less than 3 months old have been individually assessed and an appropriate provision made based on the information available and the assessed risk to the income.

NHS receivables: individually assessed and an appropriate risk based provision made.

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 2021 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	2020/21 £000	2019/20 £000
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.

	2020/21 £000	2019/20 £000
At 1 April	**2,017**	**2,002**
Net change in year	39,510	15
At 31 March	**41,527**	**2,017**
Broken down into:		
Cash at commercial banks and in hand	47	127
Cash with the Government Banking Service	41,480	1,890
Total cash and cash equivalents as in SoCF	**41,527**	**2,017**

As a part of the COVID-19 regime the trust received sufficient cash to ensure the organisations could make payments to other organisations as part of the COVID-19 pandemic requirements

Note 22 Trade and other payables	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	14,002	10,954
Capital payables	3,791	2,661
Accruals	32,471	26,774
Receipts in advance and payments on account	181	160
Social security costs	3,215	149
Other taxes payable	2,887	39
Other payables	3,908	1,603
Total current trade and other payables	**60,455**	**42,340**
Of which payables from NHS and DHSC group bodies:		
Current	3,326	4,857
Non-current	-	-

Note 23 Other liabilities	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	431	2,609
Total other current liabilities	**431**	**2,609**
Non-current		
Deferred PFI credits / income	4,249	3,278
Total other non-current liabilities	**4,249**	**3,278**

In 2019/20 the trust had deferred income relating to the maternity pathway payment framework. Due to the changes in the funding regime in 2020/21, maternity pathway payments were suspended, and there is no deferred income at the year end.

Note 24.1 Borrowings	31 March 2021 £000	31 March 2020 £000
Current		
Bank overdrafts	-	-
Loans from DHSC	1,461	326,343
Obligations under PFI, LIFT or other service concession contracts	2,640	2,011
Total current borrowings	**4,101**	**328,354**
Non-current		
Loans from DHSC	11,552	13,929
Obligations under PFI, LIFT or other service concession contracts	54,793	57,433
Total non-current borrowings	**66,345**	**71,362**

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 have been extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2020/21	Loans from DHSC	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2020	**340,272**	**59,444**	**399,716**
Cash movements:			
Financing cash flows - payments and receipts of principal	(325,823)	(2,011)	**(327,834)**
Financing cash flows - payments of interest	(1,784)	(5,399)	**(7,183)**
Non-cash movements:			
Application of effective interest rate	348	5,399	**5,747**
Carrying value at 31 March 2021	**13,013**	**57,433**	**70,446**

Note 24.3 Reconciliation of liabilities arising from financing activities - 2019/20	Loans from DHSC	PFI and LIFT schemes	Total
	£000	£000	£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**
Carrying value at 31 March 2020	**340,272**	**59,444**	**399,716**

Note 25.1 Provisions for liabilities and charges analysis	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2020	**3,051**	**121**	**1,781**	**4,953**
Change in the discount rate	362	-	6	**368**
Arising during the year	52	57	3,604	**3,713**
Utilised during the year	(205)	(28)	-	**(233)**
Reversed unused	(135)	(45)	(353)	**(533)**
Unwinding of discount	(28)	-	-	**(28)**
At 31 March 2021	**3,097**	**105**	**5,038**	**8,240**
Expected timing of cash flows:				
- not later than one year;	205	105	**5,003**	**5,313**
- later than one year and not later than five years;	820	-	**35**	**855**
- later than five years.	2,072	-	**-**	**2,072**
Total	**3,097**	**105**	**5,038**	**8,240**

Early departure costs or 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 Resolution.

Other provisions include exit costs for major contracts, potential tax liabilities and International Nurses quarantine costs.

Other provisions also includes slow moving, change of use or obsolete inventory: Through learning from response to the COVID-19 pandemic, the trust is seeking to modernise its inventory management practices including the acquisition of a modern inventory management system. The trust, through its annual plan expects to introduce modern practices and systems during 2021/22 which will improve visibility of slow moving, change of use or obsolete inventory. Given the current limited visibility of slow moving and obsolete inventory; the relatively low level of historic inventory write-downs; and the anticipated improvements in inventory management, it has been deemed prudent to make a provision equivalent to 25% of core inventory items (£0.67m) to account for anticipated losses.

Note 25.2 Clinical negligence liabilities

At 31 March 2021, £209,416k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Worcestershire Acute Hospitals NHS Trust (31 March 2020: £174,524k).

Note 26 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(33)	(34)
Gross value of contingent liabilities	**(33)**	**(34)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(33)**	**(34)**
Net value of contingent assets	**-**	**-**

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 2021 £000	31 March 2020 £000
not later than 1 year	8,226	10,993
after 1 year and not later than 5 years	17,676	10,936
paid thereafter	1,279	592
Total	**27,181**	**22,521**

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

The information below is required by the Department of Heath for inclusion in the national statutory accounts. The Trust has commitments to the PFI scheme covering the redevelopment of the Worcestershire Royal 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 2021 £000	31 March 2020 £000
Gross PFI, LIFT or other service concession liabilities	**91,447**	**98,857**
Of which liabilities are due		
- not later than one year;	7,824	7,411
- later than one year and not later than five years;	34,058	33,367
- later than five years.	49,565	58,079
Finance charges allocated to future periods	(34,014)	(39,413)
Net PFI, LIFT or other service concession arrangement obligation	**57,433**	**59,444**
- not later than one year;	2,640	2,011
- later than one year and not later than five years;	16,706	14,581
- later than five years.	38,087	42,852

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 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**391,134**	**424,651**
Of which payments are due:		
- not later than one year;	32,037	31,408
- later than one year and not later than five years;	136,496	133,817
- later than five years.	222,601	259,426

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:

	2020/21 £000	2019/20 £000
Unitary payment payable to service concession operator	**37,601**	**36,247**
Consisting of:		
- Interest charge	5,399	5,595
- Repayment of balance sheet obligation	2,011	1,783
- Service element and other charges to operating expenditure	20,752	20,724
- Capital lifecycle maintenance	3,304	1,850
- Contingent rent	6,135	6,295
Total amount paid to service concession operator	**37,601**	**36,247**

Note 29 Financial instruments

Note 29.1 Financial risk management

The 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 2021 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. Where funding is provided though loans, 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. Following changes to the national financing regime, funding is primarily now provided as Public Dividend Capital, attracting a nationally set dividend payment of 3.5% on net relevant assets. The Trust therefore has low exposure to interest rate fluctuations.

The trust also borrows from government where relevant to support any financial deficit and ensure sufficient cash flow to maintain day to day operations. Since April 2020 any new interim revenue support is provided as Public Dividend Capital and attracts a nationally set dividend payment of 3.5% on net relevant assets.

Note 29.2 Carrying values of financial assets				
Carrying values of financial assets as at 31 March 2021	**Held at amortised cost**	**Held at fair value through I&E**	**Held at fair value through OCI**	**Total book value**
	£000	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	8,554	-	-	**8,554**
Cash and cash equivalents	41,527	-	-	**41,527**
Total at 31 March 2021	**50,081**	**-**	**-**	**50,081**

Carrying values of financial assets as at 31 March 2020	**Held at amortised cost**	**Held at fair value through I&E**	**Held at fair value through OCI**	**Total book value**
	£000	**£000**	**£000**	**£000**
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**

The trust achieved an in year surplus position, and received sufficient cash through the COVID-19 regime to ensure timely payments to other organisations. The change in regime has resulted in an improved cash balance.

Note 29.3 Carrying values of financial liabilities			
Carrying values of financial liabilities as at 31 March 2021	**Held at amortised cost**	**Held at fair value through I&E**	**Total book value**
	£000	**£000**	**£000**
Loans from the Department of Health and Social Care	13,013	-	**13,013**
Obligations under PFI, LIFT and other service concession contracts	57,433	-	**57,433**
Trade and other payables excluding non financial liabilities	54,172	-	**54,172**
Total at 31 March 2021	**124,618**	**-**	**124,618**

Carrying values of financial liabilities as at 31 March 2020	**Held at amortised cost**	**Held at fair value through I&E**	**Total book value**
	£000	**£000**	**£000**
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**

Note 29.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021 £000	31 March 2020 restated* £000
In one year or less	63,770	387,309
In more than one year but not more than five years	38,659	39,723
In more than five years	58,972	68,391
Total	**161,401**	**495,423**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

During the year the trust received £7.7m revenue cash support from the DHSC which was requested prior to the notification of the change in funding regime. The trust also received Public Dividend Capital (PDC) of £20.8m making the total new borrowings of £28.5m in 2020/21. Revenue and capital loans amounting to £324.4m were converted to PDC in year as part of national arrangements. The trust also repaid capital loans of £1.4m in 2020/21. An improved cash flow has led to an improvement in Better Payment Performance in 2020/21 compared to 2019/20.

Note 30 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	2	-	1	0
Bad debts and claims abandoned	179	320	350	204
Stores losses and damage to property	12	250	12	253
Total losses	**193**	**570**	**363**	**456**
Special payments				
Compensation under court order or legally binding arbitration award	1	34	-	-
Ex-gratia payments	27	21	42	17
Total special payments	**28**	**55**	**42**	**17**
Total losses and special payments	**221**	**625**	**405**	**474**

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:

Related parties may include but are not limited to:

- NHS England
- NHS Herefordshire and Worcestershire CCG
- NHS South Warwickshire CCG
- Herefordshire and Worcestershire Health and Care NHS Trust
- NHS Resolution
- Local Authorities
- NHS Business Services Authority

The trust has also received revenue and capital payments from Worcestershire Acute Hospitals Charity amounting to £365,658 (£515,186 in 2019/2020). All of these payments relate to expenditure made by the trust on behalf of the Worcestershire Acute Hospitals Charity. As at 31 March 2021, Worcestershire Acute Hospitals Charity owed the Trust £78,129. 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 Better Payment Practice code	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	86,534	238,913	101,681	232,318
Total non-NHS trade invoices paid within target	84,111	230,673	98,244	216,409
Percentage of non-NHS trade invoices paid within target	97.2%	96.6%	96.6%	93.2%
NHS Payables				
Total NHS trade invoices paid in the year	2,155	17,161	2,936	16,513
Total NHS trade invoices paid within target	1,619	9,687	2,221	7,741
Percentage of NHS trade invoices paid within target	75.1%	56.4%	75.6%	46.9%

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 33 External financing limit

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

	2020/21 £000	2019/20 £000
Cash flow financing	(14,441)	69,476
Finance leases taken out in year		
Other capital receipts		
External financing requirement	**(14,441)**	**69,476**
External financing limit (EFL)	(13,922)	69,491
Under / (over) spend against EFL	**519**	**15**

Note 34 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	27,425	13,704
Less: Disposals	(34)	(12)
Less: Donated and granted capital additions	(968)	-
Charge against Capital Resource Limit	**26,423**	**13,692**
Capital Resource Limit	30,434	16,343
Under / (over) spend against CRL	**4,011**	**2,651**

Note 35 Breakeven duty financial performance

	2020/21 £000
Adjusted financial performance surplus / (deficit) (control total basis)	6,652
Breakeven duty financial performance surplus / (deficit)	**6,652**

Note 36 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 assume to be the first year of International Financial Reporting Standards (IFRS) implementation is a suitable point from which the breakeven duty should now be assessed. (NHS Improvement April 2018 Publication code: CG 57/18)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		3,135	287	88	17	(14,191)	(25,918)
Breakeven duty cumulative position	(21,854)	(18,719)	(18,432)	(18,344)	(18,327)	(32,518)	(58,436)
Operating income		312,889	321,829	336,594	348,763	346,029	364,656
Cumulative breakeven position as a percentage of operating income		(6.0%)	(5.7%)	(5.4%)	(5.3%)	(9.4%)	(16.0%)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(59,831)	(28,748)	(52,562)	(68,790)	(80,844)	6,652
Breakeven duty cumulative position	(118,267)	(147,015)	(199,577)	(268,367)	(349,211)	(342,559)
Operating income	368,981	403,348	400,918	411,966	443,722	559,003
Cumulative breakeven position as a percentage of operating income	(32.1%)	(36.4%)	(49.8%)	(65.1%)	(78.7%)	(61.3%)

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