

ANNUAL REPORT 2021/22



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 this report and make suggestions for the content of future reports to the Communications Department:

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A Welcome from our Chair and Chief Executive

Welcome to Worcestershire Acute Hospitals NHS Trust's 2021/22 Annual Report.

As life outside of our hospitals and the wider NHS has started to slowly move towards a new post-pandemic 'normal', our dedicated and hard-working teams have continued to deal with unprecedented demand on our services that Covid has both directly and indirectly brought.

More than 2,100 patients with Covid were cared for in our hospitals in the last 12 months, while demand for urgent and emergency care has been at its highest ever levels with 166,904 patients seeking care from our Emergency Departments.

But in spite of the challenges that this has presented, work has continued in parallel and at pace with our wider reset and recovery programme to support our efforts to put our patients first, deliver the highest quality care possible and reduce waiting lists which have grown during the Covid pandemic.

This includes introducing additional, temporary, operating theatre capacity and diagnostic capacity, with a new permanent Community Diagnostic Centre (CDC) opening at the Kidderminster Hospital and Treatment Centre - an important part of our work to improve access for our patients to a range of important procedures which are an essential part of the early diagnosis and timely treatment of some potentially serious conditions, including many forms of cancer.

Building work has also continued on our new multi-million pound Urgent and Emergency Care facilities at Worcestershire Royal Hospital



Sir David Nicholson

Chair



Matthew Hopkins

Chief Executive

which will see a relocation and expansion of the Emergency Department and a wide range of diagnostic treatment services when they open towards the end of 2022. This will help to reduce waiting times, improve ambulance handovers as well as provide improved facilities for our clinical colleagues.

New innovative ways of working have also been launched, including our award-winning #CallMe campaign which sees patients called by their chosen name which can often be different to the official name on their medical notes; and a growing focus on sustainable ways of working as we play our part in delivering a net zero NHS by 2040.

The Board also remain committed to establishing a culture of inclusion and respect towards our patients, relatives, carers, staff and the wider public, and ensuring our health and wellbeing offer for our colleagues continues to develop.

As we move into 2022 we look forward to continuing to working with our health and social care partners and playing our part in the emerging Herefordshire and Worcestershire Integrated Care System, while focussing on a number of important developments which will support us in our continuing journey to become an outstanding Trust.

This includes the introduction of robot-assisted surgery at the Alexandra Hospital - part of a wider programme of investment to create a centre for surgical excellence at the Alexandra Hospital - as well as the roll out of our hugely important Digital Care Record which will transform the way we manage patient information to support further improvements

in quality, safety and efficiency, and the launch of our 4ward Improvement System designed to support and promote a culture of continuous improvement across all our services to ensure we continue Putting Patients First.



Sir David Nicholson
Chair



Matthew Hopkins
Chief Executive

Look back at 2021/2022

Trust shortlisted for two HSJ Awards



Worcestershire Acute Hospitals NHS Trust was shortlisted for two awards in the HSJ Awards 2021, recognising outstanding contributions to healthcare in what has been an exceptional and challenging period for the NHS.

The Trust was a finalist in the Freedom to Speak Up (FTSU) Organisation of the Year Award for its work to make speaking up as easy as possible for staff, and the Workforce Initiative of the Year Award for a new nurse-led approach in ophthalmology which reduces the time each patient spends in the clinic, and aims to improve the patient experience.

Caring for our colleagues while Putting Patients First

Ensuring all colleagues have access to health and wellbeing support remained high on the Trust agenda in 2021/22.

The health and wellbeing ‘pinwheel’ – where colleagues can access a range of information that includes psychological, physical, social and financial advice alongside civility and respect guidance, equality, diversity and inclusion information, and Covid support – was completely refreshed to make it easier to find relevant support and advice.



Consultant Anaesthetist Dr Sally Millett was recruited as the Trust’s Health and Wellbeing Guardian in May, Wellbeing Conversations were launched in September, to give all colleagues the opportunity to have a regular, supportive conversation with their manager, team leader or another trained colleague about how they are, and over 60 colleagues received Mental Health First Aid training.

A #CaringForMe campaign which launched across the Trust in November highlighted the numerous health and wellbeing support initiatives on offer and uses real case studies from colleagues who have benefited from these.

Our Clinical Psychologists for Staff Health and Wellbeing continue to provide much valued support to teams and individuals, alongside monthly wellbeing webinars and a wellbeing slot on Trust induction.

Green schemes across Trust lead the way in battling climate change

Two new green schemes have been launched across the Trust in the battle against climate change.

The Radiotherapy team at the Worcestershire Oncology Centre worked with Worcestershire Acute Hospitals Charity to fund reusable, biodegradable water bottles for patients undergoing pelvic radiotherapy treatment.

The bottles were introduced to help support patients in drinking the correct amount of fluid for their radiotherapy treatment and to drastically reduce the use of single use plastic in the Oncology department.

The Theatres department and wider teams across the Trust have also been working together to tackle climate change by using alternative anaesthetic gases to lessen their environmental impact.

Across the NHS, anaesthetic gases are commonly used as a part of everyday surgeries, when putting patients to sleep and managing pain. These gases alone are responsible for over two per cent of all NHS emissions.

Consultant Anaesthetist Dr Paul Southall and colleagues have been using alternative surgical anaesthesia options to reduce the use of one type of anaesthetic gas in particular – desflurane – which is one of the most harmful for our environment.

Their work means desflurane made up just 4.8 per cent of anaesthetic gases used at Worcestershire's hospitals in the last 12 months, down from to 30% in 2014/15 - the biggest



Therapy Radiographer Richard Cormie with Worcestershire Oncology patient Richard Stark

decrease amongst hospital Trusts in the West Midlands, and one of the top performers compared to hospital Trusts nationally.

Remembering lives lost



'Memorial Tree' artwork was installed at each of our three main sites to commemorate lives lost during the Covid pandemic and to provide colleagues, patients and visitors with a focal point for reflection and remembrance. The artwork was funded by the Worcestershire Acute Hospitals Charity. The Charity is also working in partnership with the Trust on larger permanent memorial installations.

Pictured is Nicky Langford, Community Fundraising Officer, with the memorial tree at Worcestershire Royal Hospital. For more information on the charity please visit www.wahcharity.org

Drive-through service for Cardiology patients in Worcestershire



Cardiac Physiologists going through checks with patient, Mr Adlington

Patients across Worcestershire with pacemakers and implantable cardiac loop recorders can now be seen via a drive-through cardiac clinic at Worcestershire Royal Hospital.

Patients with pacemakers need to have their device checked regularly, usually at least once a year, but because of restrictions due to Covid-19, it has been difficult for the Cardiology team to see patients face-to-face in a hospital setting.

Via the drive-through clinic the Cardiology team can see more patients for their yearly checks, and it also frees up capacity within the cardio-pulmonary department for other cardio-pulmonary investigations to take place within the hospital.

83-year-old patient, John Adlington said: *“The drive through clinic is ideal. You don’t have to worry about parking and, importantly with the worry of Coronavirus, you feel more secure and the check-up is done in no time.”*

State-of-the-art mobile operating theatre opened at Alexandra Hospital



A new mobile operating theatre opened at the Alexandra Hospital in Redditch in September 2021, providing an additional 200 patients a month with a range of planned procedures including breast surgery, minor vascular, upper and lower GI surgery, urology, and gynaecology operations and minor orthopaedic work.

The theatre provided an anaesthetic room, operating theatre, two-bed first-stage recovery area, staff changing room, and utility areas. A specially-constructed corridor and ramps join the main body of the hospital to the unit and ensure a seamless journey for patients.

The additional theatre formed an important part of our wider reset and recovery programme that is in place to help hospital and wider health services continue to keep putting patients first despite the continuing impact of the Covid pandemic.

Patient and Public Involvement

Patient engagement is central to the delivery of a quality healthcare service because this approach enables patients to be partners in their own care, to be informed and to support overall patient outcomes and experience. Patient and public participation and involvement is important to us because it is essential in helping our Trust realise the purpose of "Putting Patients First". This is about how we work together with our local communities to understand, celebrate and improve the patient and carer experience across our hospitals.

We have had to work in new ways against the constraints of a continued pandemic and this has presented both challenges and opportunities with the ways we engage with stakeholders in our local population.

We have continued to work alongside our Patient and Public Forum, a group of patient representatives who actively contribute to a wide range of service improvements. The Patient and Public Forum have engaged with us using online tools which has facilitated public representation at Trust Committees and steering groups. This has supported us to gather different perspectives, gain a representative view and draw on a variety of volunteer skills and experiences to help shape and influence our services.

The Patient and Public Forum has also met bi-monthly at dedicated meetings which focus on a joint agenda between forum members and the Trust. At these meetings there is opportunity for wider discussion and involvement in Trust initiatives with staff at all levels including Matrons, Managers and the Chief Executive Officer.

We have continued to share Patient and Staff stories at the monthly Trust Board meetings which are broadcast publicly; stories of staff, patients and/or carers' experiences through our healthcare system enable us to really understand the patient journey "first-hand" and examine opportunity for improvement alongside showcasing good practice and celebrating innovation.

Our Trust objectives are about best experience of care and best outcomes and embedded within this are our core values about patient respect, dignity and quality of care. One example of transformation to support our objectives is an initiative developed by the Trust in response to patient experience and interactions. #CallMe was developed with our patients, patient representatives and wider volunteers; ensuring that we are communicating with our patients using their preferred name is a vital and valuable step in providing truly person-centred care and supports the development of a strong and dignified relationship with our patients.

Throughout the year we have created new responsive "Pandemic" roles for volunteers to provide a proactive and reactive approach to support our patients, carers, families and staff; we have developed new local community partnerships, developed our networks across the county and local area and continued to provide a variety of ways for people to feedback about their experiences.

We have provided a snapshot of our work below.



Working with and listening to patients and carers

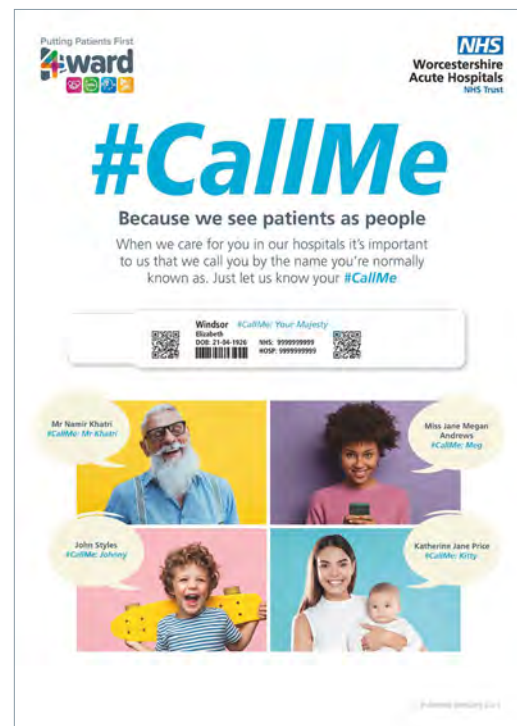
Patient Experience and Engagement snapshot: #CallMe

We engaged with patients, patient representatives and volunteers to develop and launch #CallMe which aims to ensure patients are called by their preferred name.

We launched #CallMe as a new initiative in Patient Experience Week on 27 April 2021 across our hospitals.

Winner of the prestigious 2021 British Medical Journal Awards, winning "Digital Innovation Team of the Year", #CallMe was led by a small team and is about respect to our patients and compassionate care for individuals. It also enables communication with vulnerable patient groups.

We showcased our #CallMe initiative nationally in an NHS England/Improvement webinar to



Heads of Patient Experience and it has been received positively by patients, carers, staff, volunteers and the wider public right from the start.

“**It’s amazing to be a small part of a project which could literally mean the world to some people!**”

Young patient

“**It really is an amazingly thoughtful idea and thank you for doing this.**”

Patient parent

Putting all patients first:

#CallMe demonstrates how a simple, clinically led and patient focused digital innovation can profoundly improve patient experience and the overall experience of care, not just in our hospitals but, it is hoped, across the NHS and even outside the UK.

Being addressed by your preferred name can reassure patients and have profound ability to put patients at ease during what can be a stressful time and ensure all of our patients feel included in their care.

We are proud of what we have developed.

Our #CallMe initiative, supported by our patients and patient representatives and developed by our staff won the prestigious 2021 British Medical Journal Digital Innovation Team of the Year award and has received significant interest from other Trusts across the country.

#CallMe was spearheaded by Worcestershire Acute Hospitals NHS Trust Consultant

Anaesthetist, Dr Michael McCabe. It sees an additional section added to patients’ hospital identification wrist bracelets and name stickers, which can be completed with their preferred term of address, which will follow that patient throughout their stay in hospital.

Dr McCabe said: *“In hospital patients are identified in many ways – NHS number, date of birth, hospital number and name. The default is for patients to be addressed by their recorded forename, despite the fact that up to a third of patients prefer to be addressed differently.*

“The introduction of #CallMe is very simple, but it’s really important. We hope that it will give comfort and reassurance to patients that we respect their identity by addressing them with their preferred name and not assuming that they are most comfortable using their formal birth forename.”

“**#CallMe is a simple, discreet and inexpensive way of helping us all to deliver the quality of service that we aspire to, but have not always achieved, especially in relation to diversity.**”

Member of the Patient and Public Forum

New Accessibility Guides launched with and for patients, carers and visitors

Worcestershire Acute Hospitals NHS Trust has worked with AccessAble and patient representatives to create detailed accessibility guides to facilities, wards, and departments at Worcestershire Royal Hospital, Alexandra Hospital, and Kidderminster Hospital and Treatment Centre.

The guides include facts, figures and photographs to help patients, carers, visitors and staff plan their journeys to and around our hospitals, covering everything from parking facilities and hearing loops, to walking distances and accessible toilets.

Each accessibility guide has been checked in person, on site, by trained surveyors to ensure everyone’s different, yet equally important accessibility needs are met.

You can view our Accessibility Guides at www.worcsacute.nhs.uk/accessable

We have included more about our community engagement later in our report.

Engaging with our community and stakeholders: continuing to work together in partnership

We have continued to collaborate and actively engage in lots of different ways with our local community throughout 2021-2022. It is important to us that we build on the inclusive approaches that we have begun to adopt

and that we demonstrate we are listening to feedback from people who experience our hospitals.

The global Covid-19 pandemic has continued to impact across our services, which has presented us with challenges and difficult decisions and our focus continues to be about how we provide as positive an experience as possible for our patients and their carers families and friends.

Working with and listening to our local community

We are keen to reach out further each year to our patients, carers, their family and friends.

We aim to give our local community a voice that we will listen to and that will inform the work that we do, to meet the needs of our local population.

We do this in a variety of ways including the Friends and Family Test and regular CQC Patient Experience surveys. We also create our own surveys and below is a snapshot of just one of the ways we have supported our local community to have a voice:

The Big Quality Conversation feedback survey

We ran our first “mixed mode” paper and online digital survey from April-June 2021 to understand what is important to our patients and carers.

- The survey was viewed **1,906 times**.
- In total we received **474 responses** from the public.

We used the feedback to inform our priorities for the Quality and Safety Strategy 2022-2025 - to ensure they align with patient and carer needs.

- ▶ We launched our second “mixed mode” survey in February 2022 – we are aiming for greater engagement and will again be focusing on safety, effectiveness and experiences of care at our hospitals.
- ▶ We have increased our partnership working with local health care and education providers and voluntary/ community organizations to help us reach as many people as possible so that we can understand a wide variety of patient, carer and family experiences at our hospitals.

Putting Patients First
ward

NHS
Worcestershire
Acute Hospitals
NHS Trust

THE BIG QUALITY CONVERSATION

Join the conversation to **share your experiences**
in our hospitals and **help us plan for the future**

How effective was the care/treatment you received?

Help us to improve our services

100% Anonymous

How safe did you feel in our care?

Your feedback is important to us

Help us understand best practice

Voice your opinion

Visit: surveyhero.com/c/ke9egvcj
Opens: February 2022 Closes: March 2022

Published January 2022

Working with and listening to Carers



We have developed a series of pledges and signed a formal Commitment to Carers along with other health organisations across the county. To support this we have progressed our partnership with the Worcestershire Association of Carers. We have also joined local community groups to continue the conversation and our active engagement.

Snapshot:

We developed a joint messaging and engagement campaign with the Worcestershire Association of Carers to mark Carer's Rights Day in November 2021. Called "**Who is a Carer**", the campaign aimed to raise awareness that anyone can be a carer and everyone can support carers. We reached out to carers, the local community and to staff in different ways to highlight where people can go for support and to "start the conversation".

We have a series of joint face to face and virtual "Carers Café Conversations" events planned for 2022-23 to continue that conversation and to further develop our ability to engage with carers across the local community.

We are exploring different ways to communicate with the local community and as part of this, we have created a new volunteering role – our first ever **Poet in Residence!**

We have commissioned a series of poems this year including a special poem created for Carer's Rights day:

After Care

*So, what happens to me now?
I've been relieved, stood down,
Told my life's again my own,
But - I can't remember what that means....*

*For fourteen years we've been inseparable,
But with me being invisible;
A carer, always there, no matter where.
I did it gladly, that's a fact
"Till death do us part" and all ever-changing
But it became too much
I fell out of touch
With friends, family-
I forgot just what it was to be me,
Alone, on my own.
Now my race is run, the baton passed on-
Now I find I don't know anyone.*

*So what's next? Who's there for
A carer with no-one to care for?*

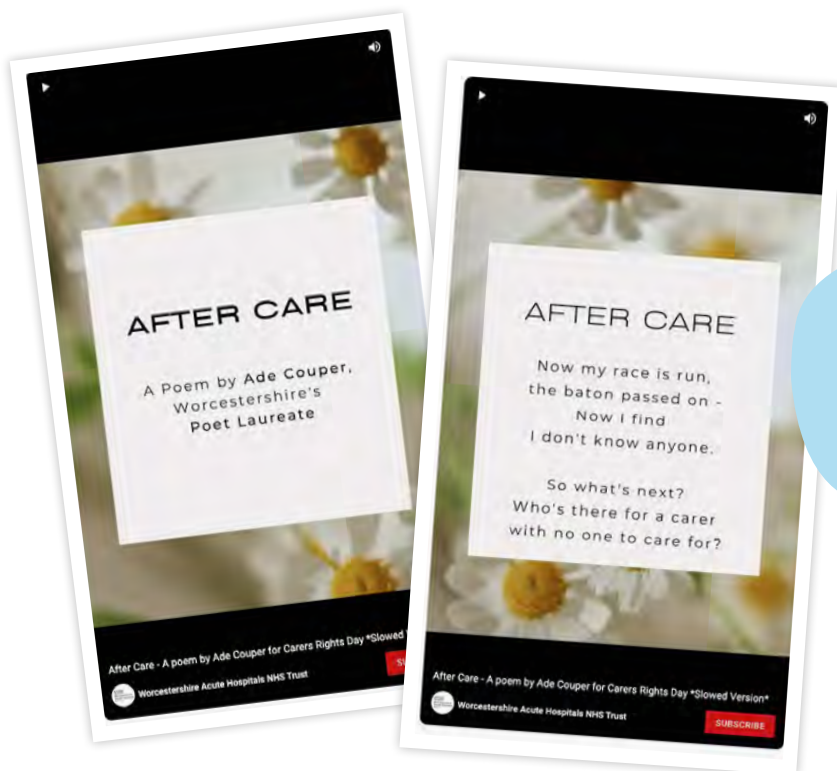


Our Poet in Residence, Ade Couper, pictured left, wrote a poem for Carer's Right's day called "After Care".

Ade is a member of Worcester Lit Fest and we are excited about joint plans for the future.

Our Communications team turned Ade's words into a short film which was launched on social media and which we shared with staff across our Trust.

**Watch the film on Youtube here:
www.youtube.com/shorts/wsCu-1l4EhQ**



7,949 people saw our posts on Twitter and Facebook for #CarersRightsDay.



Working with and listening to patient representatives:

“ What stands out for me about the past year is that we have continued as a group to contribute to the Trust's intensive and tireless scrutiny of individual cases of infection and prevention processes in light of that learning.

We have also supported the development of staff networks set up by the Trust to further support and understand the lived experience of equality and diversity issues. ”

Alan Richens, Vice-Chair of the Patient and Public Forum

We have continued to work with our Patient and Public Forum who are patient representatives. They have supported us throughout 2021-2022 by:

- ▶ Advising us as an equal member of Trust committees at all levels of governance from steering groups to Quality and Clinical Governance Committees. They also engage with Divisional Board meetings.
- ▶ Meeting with our Senior Leaders and Trust Board members including our Chief Executive Officer, our Chief Nursing Officer, many of our Directors and Non-Executive Directors.

- ▶ Helping us to shape and drive 4ward on our Single Improvement Methodology–member engagement at key steps from the tender process through to project delivery to secure the best provider for our Trust to support us on our improvement journey.
- ▶ Unannounced Visits to assess “quality” and safety on our wards – this included patient interviews via ipad.
- ▶ Interviewing new staff.
- ▶ Active engagement in the design of the new Urgent Care facility at Worcestershire Royal Hospital.
- ▶ Developing our partnership with AccessAble by reviewing and testing draft accessibility guides, advising us on “usability”, ease of navigation and access, including a specific focus on patients who are visually impaired.
- ▶ Giving feedback on patient leaflets.
- ▶ Scrutiny and appraisal of our Quality Account.
- ▶ Active participation in our Digital and Clinical Strategy development, Freedom to Speak Up and a Quality Review on our Formal Complaints processes.
- ▶ The group has actively contributed to our Integrated Volunteer newsletter with the Herefordshire and Worcestershire Health and Care Trust.

The group continues to monitor the local media and have widened their local community networks to further gauge public opinion about hospital experiences.

Scrutiny and appraisal of our Quality Account.



Active participation in our Digital and Clinical Strategy development, Freedom to Speak Up and a Quality Review on our Formal Complaints processes.



Active engagement in the design of the new Urgent Care facility at Worcestershire Royal Hospital.



Interviewing new staff.



PATIENT AND PUBLIC FORUM
2021/2022

Developing our partnership with AccessAble

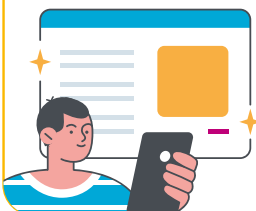


Helping us to shape and drive 4ward on our Single Improvement Methodology

Meeting with our Senior Leaders and Trust Board members



The group has contributed to our Volunteer newsletter



Unannounced Visits to assess "quality" and safety on our wards – this included patient interviews via ipad.



Advising us as an equal member of Trust committees.



Giving feedback on patient leaflets.



The forum has been engaging with local councillors, Healthwatch and chairs of local voluntary groups – this supports the group to bring relevant questions to the Trust and reflect back to the community. New members have continued to be recruited into the forum.

“ We are pleased that despite the restrictions imposed by Covid-19 we have been able to contribute in so many ways to support the Trust and represent the patients of Worcestershire. ”

Rosemary Smart, Chair of the Patient and Public Forum.

We have also worked with advisory and peer support groups – these groups include the Hospital Youth Forum, Worcestershire Breast Unit Support Group and Worcestershire Maternity Voices Partnership. We also regularly meet with Healthwatch, the health and social care champion.

Increasing access for our local community

Our Trust Vision, **“Putting Patients First”** is about individualised person-centred care, it is about ensuring that our services are accessible to and meet the needs of all of our patients, carers and visitors. We know everyone’s accessibility needs are different, which is why having detailed, accurate information is important to us.

We launched our Accessibility Guides online in February 2022

We worked in partnership with AccessAble to create Detailed Access Guides to facilities, wards, and departments across our hospital sites. These guides are available to anyone to help prepare people in making choices when they come into our hospitals. These guides take the chance out of going out.



The guides can be accessed via our Trust website, the AccessAble website or via an App to use on mobile phones.

The guides are made up of facts, figures and photographs to help patients, visitors and staff plan their journeys to and around our hospitals, covering everything from parking facilities and hearing loops, to walking distances and accessible toilets. But more than this, the guides look at ‘access’ and ‘disability’ from different perspectives. The guides cover mobility impairment, learning disability, sensory impairment, dementia and mental health.

The Accessible Information Standard requires us to follow specific and consistent approaches to support the information and communication needs of patients and carers who have a disability, impairment or sensory loss.

Our partnership with AccessAble underpins our ability to support all of our patients and carers with navigating around our hospitals, but more than this, it really underpins our ability to empower our patients.



Our volunteers delivered a significant number of crumpets! We co-designed with our volunteers a brand new uniform and received 100% positive feedback

Working with and transforming our work with Volunteers: #WeAreVolunteering

We developed a focus on Pandemic Response volunteer roles in 2021-2022, alongside a new way of working. These roles include:

- ▶ We launched new Pharmacy Pandemic Volunteers to reduce the time that patients have to wait for their medicines, primarily in the Discharge Lounge. This supports an improved patient experience with a faster discharge process.
- ▶ Wayfinder (meet and greet) volunteers supported our Patient Comfort and Gift Delivery Service which we first launched in May 2020. It was established to enable loved ones to bring in patient gifts during visiting restrictions and to reduce pressure on ward staff. Volunteers are predicted to have delivered **14,000 patient gift items** from January 2021 to March 2022!



Our volunteers gave us 4,600 hours of their time from 1 April 2021 to 31 January 2022!



- ▶ Patient Experience Volunteers have supported in the Emergency Department specifically with comforting patients.

Our volunteers have supported with delivery of key comfort packs and important items to support the patient and staff experience. In 2021-2022 this included:

- ▶ Over 7,000 patient property parcels!
- ▶ 27,000 crumpets!
- ▶ 78 staff welfare packs
- ▶ 70 Christmas ward chocolate deliveries
- ▶ They packed 870 Christmas gifts for every inpatient on Christmas day!
- ▶ Big Quality Conversation survey posters, #CallMe posters and fundraising leaflets were delivered to every ward across our hospitals



Our series of video logs and blogs were showcased as a Trust ward showcase.

“ The best part of volunteering at the hospital is feeling part of the Worcestershire Acute Hospitals NHS Trust family and the appreciation I receive. ”

Ben, Volunteer.



We worked with the Herefordshire and Worcestershire Health and Care Trust to re-brand the quarterly Volunteering and Engagement newsletter and we launched an accessible new look.



Thank you - for Volunteers Week in June 2021 we sent over **430 e-certificates** and **40 postal certificates** to say thank you to our Volunteers.

14, 598 members of the public interacted with our “Thank You” message to Volunteers across our social media platforms!





Our volunteers have supported the hospital charity in many ways across our hospitals - even our Volunteers who are currently not on site helped to build the Charity's contact list!

To support all volunteers to be part of the integrated caring team we launched a pilot project "Adopt a Volunteer" in August 2021 which included a new co-designed Volunteer Charter. Feedback has been **100% positive** from volunteers and staff engaging in this work.

Our next steps will be to ensure that our Volunteer and Staff Charter is embedded when we can bring more Volunteers back onto our hospital sites.

My Story "in my words"

We have continued to provide the opportunity to increase our understanding of the patient, carer and staff experience at our Trust.

Each month, we provide space to share patient, carer, volunteer and staff stories at the beginning of our Trust Board meetings. This provides a rich opportunity for our Trust Board which is a group of Executive Directors and Non-Executive Directors, to experience first-hand, individual patient, carer and staff stories in "their own words".

Our Patient Stories take place at the very beginning of our Trust Board meetings and offer a space to reflect, celebrate and explore *together* where we can develop solutions and champion innovation. We share stories in different ways

– from interviews, to digital storytelling, to attending in person (virtual). Conversations can result in reflections on the day, support with ensuring that Trust Board meetings begin with "Putting Patients First" and can also be continued after the Trust Board meetings with actions developed as a result.

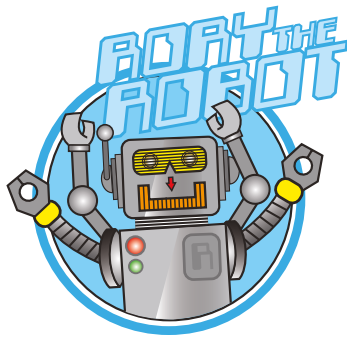
It is important to us that we provide a rich variety of ways for people to feedback about their experiences.

Developing an understanding of how people experience our hospitals is vital to ensure that we can continue our journey and the process of continual improvement.

We analyse patient and carer feedback at Divisional level and in quarterly detailed reports, which are discussed at our Clinical Governance Group, Engagement groups and our Quality and Governance Committee. We also publish a variety of reports which analyse and highlight our learning and improvements from patient and carer feedback. These include our Annual Quality Account, Annual Complaints and Patient Advice and Liaison Report and our Inclusion, Diversity, Accessibility and Equality report.

All our reports can be found on our website: www.worcsacute.nhs.uk/our-trust/corporate-information

Plans for state of the art robot-assisted surgery in Worcestershire take a significant step forward



Plans to offer patients in Worcestershire improved access to state of the art robot-assisted surgery have taken a significant step forward.

The installation of a surgical robot at the Alexandra Hospital, Redditch, is part of a wider programme of investment in the future of the Alexandra as a surgical centre of excellence.

The robot will be a further addition to the range of high quality elective (planned) surgical services already provided there for patients from across Worcestershire and beyond.

Senior clinicians aim to begin providing robot assisted surgery at the Alexandra later in 2022, after the Board of Worcestershire Acute Hospitals NHS Trust backed their updated business plan for the new service.

Thanks to the generosity of local supporters, a fundraising appeal in aid of robotic surgery had already raised around £500,000, before plans for the development were paused during the Covid-19 pandemic.

A detailed implementation plan covering the installation of the robot, as well as the building

work, recruitment and training needed to get the service up and running is now being finalised, with an investment of around £3.6 million.

The first procedure to be offered by the new service will be robot-assisted prostate surgery for men with prostate cancer.

New displays to help young cancer patients



Rosa Hooks, Teenage Cancer Trust TYA Clinical Liaison Nurse Specialist; Paris Khan, Staff Nurse; Lisa Rowberry, Interim Lead Cancer Nurse; Lucy Eaton, a patient from the unit; and Jackie Eaton, Lucy's mother.

Teenagers and young adults aged 13-24 being treated for cancer across Worcestershire are now benefiting from newly decorated and enhanced treatment spaces at Worcestershire Royal Hospital.

Worcestershire Acute Hospitals NHS Trust and charity Teenage Cancer Trust have worked in partnership to upgrade treatment areas within the Rowan chemotherapy suite and Laurel 3, one of the cancer inpatient wards.

The works – which involved teenagers and young adults in the design process - are part of

an ongoing relationship with Teenage Cancer Trust, which sees cancer services in the hospital supported by a dedicated Teenage Cancer Trust Teenage and Young Adult (TYA) Clinical Liaison Nurse Specialist, a post funded by the charity.

The Teenage and Young Adult (TYA) service based at Worcestershire Royal Hospital ensures that patients aged 13-24 with a confirmed cancer diagnosis can receive age-appropriate support alongside their standard cancer treatment.

Money for digital transformation supports improvements in maternity care in Worcestershire

Maternity services in Worcestershire have been awarded £340,000 of funding from the national Digital Maternity Fund to further improve digital maternity services.

Worcestershire Acute Hospitals NHS Trust is one of many NHS Trusts across the country which has benefited from funding which will help to deliver an enhanced experience for maternity service users and staff by improving infrastructure, technology systems and connectivity.

Digital tools are one of the ways the Trust is improving safety, reporting, and sharing information with women and their families so they can feel more supported throughout their pregnancy and maternity journey.

In Worcestershire, the money will be used to implement a fetal medicine reporting system called Viewpoint which will enable medical images to be measured and annotated digitally, inserted into medical reports and used for diagnostic purposes. It will also enable a home

blood pressure monitoring system to be put in place, where pregnant women can monitor and record their blood pressure results via a smart phone app and receive tailored advice from clinical staff.

Breast patients benefit from £5 million worth of improvements across breast imaging services



From left to right: Dr Maria Carrillo, Consultant Breast Radiologist; Michelle Day, Radiographer / Clinical Trainer; Tracey Clarke, Radiographer; Davina Grey, Radiographer / Clinical Trainer.

Breast patients across Herefordshire and Worcestershire are benefiting from £5 million worth of improvements across breast imaging services.

The improvements include a brand new breast imaging unit at the Alexandra Hospital, Redditch which opened in February. The new purpose-built extension, which replaces the previous mobile breast imaging unit, incorporates two dedicated rooms for breast mammography and ultrasound scans. It is located close to the breast surgery clinics to allow a seamless and accessible pathway for patients.

Work is nearing completion on the newly extended Worcestershire Breast Unit at Worcestershire Royal Hospital, which will incorporate additional screening and ultrasound facilities. The expansion of services will enable more screenings to take place meaning patients awaiting diagnostic tests can be seen quicker, and also provide space for more support services run by the Worcestershire Breast Unit Haven charity.

In addition to these works to improve breast facilities across Worcestershire Acute Hospitals NHS Trust, three brand new mobile screening vans have also been funded to ensure new and improved screening technology is available and accessible to the eligible breast screening population across Herefordshire and Worcestershire. One of the vans will be permanently located at the Princess of Wales Community Hospital, Bromsgrove, with the other two vans replacing the previous vans which travel between Evesham, Malvern, Hereford, Tenbury, Bromyard, Ross-on-Wye and Leominster.

New diagnostic facilities open at the Alexandra and Kidderminster Hospitals



A new Community Diagnostic Centre (CDC) at the Kidderminster Hospital and treatment Centre will offer an expanded endoscopy service, an additional CT scanner and additional ultrasound room for patients from across Worcestershire.

The new Community Diagnostic Centre, is part of the Government's £350 million investment across the UK into community based diagnostic centres, which will provide earlier scans and diagnoses for patients through better capacity to provide more imaging facilities to enable faster access to the full range of diagnostic tests.

Paul Brennan, Chief Operating Officer at Worcestershire Acute Hospitals NHS Trust, said: *"This is an important part of our work to improve access for our patients to a range of important procedures which are an essential part of the early diagnosis and timely treatment of some potentially serious conditions, including many forms of cancer."*

"The new facility at Kidderminster is part of a wider programme of improvements to diagnostic facilities at all our hospital sites which will support our efforts to put our patients first, deliver the highest quality care possible and reduce waiting lists which have grown during the Covid pandemic."

Whilst the new facilities were being built patients were able to benefit from temporary mobile endoscopy and CT units at Kidderminster Hospital which started working in October 2021.

At the Alexandra Hospital in Redditch a mobile MRI scanner was delivered in January 2022 followed by a mobile CT scanner in February – both were in place for three months in addition to the permanent MRI and CT scanners already in place.

Covid-19 vaccination clinics for pregnant women are a success



Brooke Roper receiving her Covid-19 vaccine from Alexis Greenwood.

Weekly drop-in Covid vaccination clinics for pregnant women were rolled out at the Alexandra Hospital in Redditch and Worcestershire Royal Hospital following the success of clinics at Kidderminster Hospital's Maternity Hub.

The clinics are available for pregnant women, women who have recently given birth, breastfeeding women and partners.

They are in addition to the walk-in clinics already available across the county which anyone can use. It is hoped the convenience of being able to have the vaccine while at an existing antenatal clinic will further improve uptake.

Justine Jeffery, Director of Midwifery at Worcestershire Acute Hospitals NHS Trust, said: "Covid-19 rates are currently higher in Worcestershire than England's average rate and can be serious for pregnant women. It is so important to have both doses of the vaccine and these vaccination clinics will further encourage pregnant women and women who have recently given birth to get their jabs."

The former England rugby star now tackling busy Emergency Department



A former England rugby star is now helping try to save lives in the Emergency Department at Worcestershire Royal Hospital.

Having won almost everything there is to win in the Women's game during a trophy-laden career, Dr Karen Jones is now working as an Emergency Medicine Consultant helping tackle emergency health problems in A&E.

Despite swapping her scrum cap for her stethoscope, Karen hasn't cut her ties with the sport as she continues to work part-time as the Club Doctor for Premiership Rugby side, Gloucester.

The former back-row joined Worcestershire Royal Hospital in July 2021 to be closer to home and because of the exciting plans for a brand-new, expanded Emergency Department at the hospital, which is expected to open before the end of 2022.

"I feel lucky to be part of the team at Worcestershire Royal. It's a challenging time but I feel very fortunate to work alongside such a lovely, caring medical and nursing team who work so hard and really care about their patients", said Karen.

"I've lived in Worcester for a long time so it's great to be working at my local hospital, and it's an exciting time to join with the plans for the new, expanded department in the near future."

Herefordshire and Worcestershire Integrated Care System (ICS)

The vision across the Herefordshire and Worcestershire Sustainability and 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. ”

Our Herefordshire and Worcestershire STP was designated as an Integrated Care System (ICS) in late Spring 2021. The Health and Care Bill continues to proceed through legislation which has delayed statutory changes until 2022/3.

During 2021/22 operating models for the new ICB and Place based Worcestershire Executive Committee have been developed, supported by designate appointment to new roles as part of the proposed governance and accountability framework.

Worcestershire Acute Hospitals NHS Trust is represented at the ICS Executive forum, with

executive leadership of system forums and other programmes of work. We continue to champion the voice of Worcestershire providers in shaping and delivering services as part of a provider collaborative at Place. Consistent with the ICS plan and our Clinical Services Strategy we have extended the remit of our HomeFirst programme from a trust to a system lens.

Development of our Three Year Plan has been punctuated with three planning rounds in 21/22 as NHSEI nationally and locally has sought to reset elective recovery in the face of the continued Covid-19 pandemic. The NHS Elective Recovery Plan published in February 2022 underlined the need to focus on reducing our waiting lists for elective and cancer care whilst increasing capacity for diagnostic testing.

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 2021/22.

The first phase in creation of surgical centres of excellence at the Alexandra Hospital has taken place with the relocation of the inpatient trauma service back to Worcester and elective care centred on the Redditch site, supported by an enhanced care unit.

At the close of 2021/22, the Trust has committed to introducing robotic surgery at The Alexandra Hospital, whilst being confident that a solution for a new replacement, theatre suite is in reach.

Additional capital support throughout the year has allowed investment in a new community diagnostics hub at Kidderminster Treatment Centre, additional CT scanning capacity has been secured at Worcestershire Royal. On the same site, a new Medical Assessment Unit is due to open at the close of 21/22, with the new Urgent and Emergency Centre located on the Aconbury East block due to open later in 2022.



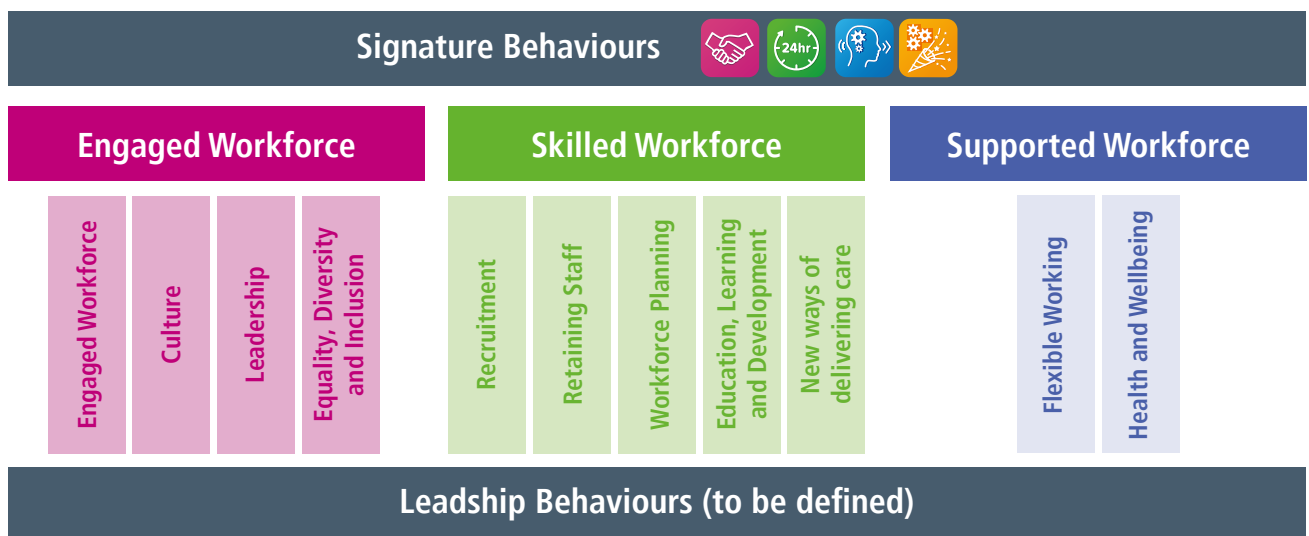
Staff Report - Creating a Great Place to Work

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 4ward behaviours.

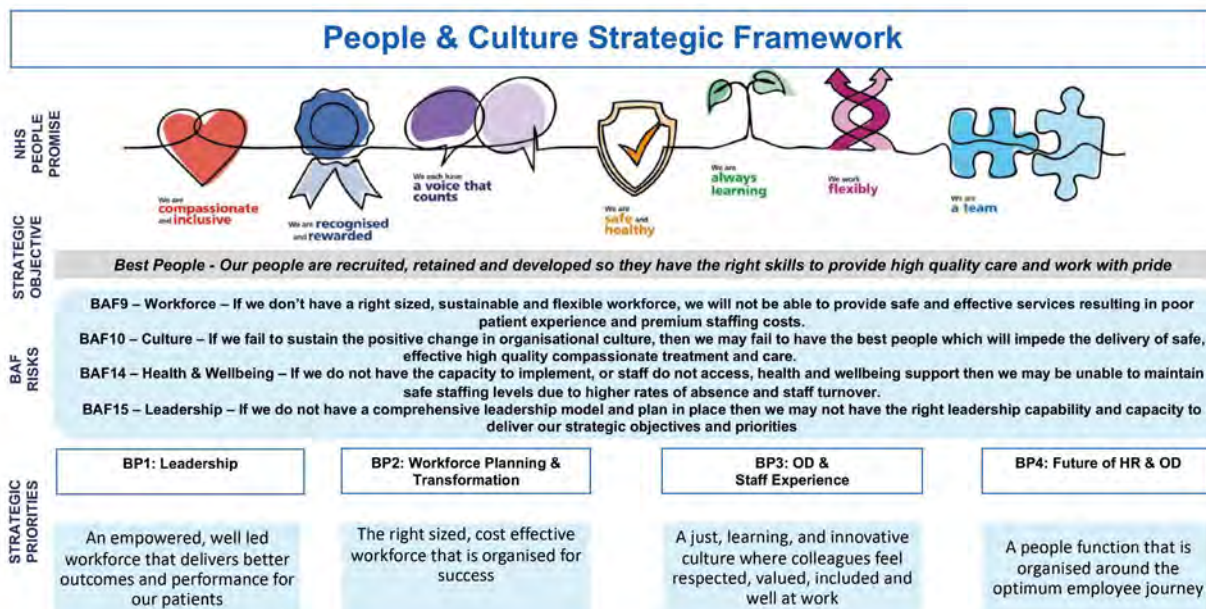
The Strategy was reviewed in 2021 with the production of a revised Strategic Framework with 11 pillars:

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



Strategic Priorities

Our strategic priorities have been reviewed in 2021/22 and focused around 4 key priorities – Leadership, Workforce Planning and Transformation, Staff Experience and Future of HR and OD:



The 4ward Programme – Our values and behaviours

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.

At the heart of 4ward are our four signature behaviours which are now well embedded with our staff, having been launched in 2017.

#ThankYouThursday

4ward Advocates continue to support our #ThankYouThursday initiative which encourages colleagues to thank those around them for

Putting Patients First

4ward

Our 4ward behaviours are:

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

excellent practice and for demonstrating our 4ward behaviours. These #Thankyous are either shared via a e-postcard directly to the individual or via the Staff Facebook Page, and are popular and well embedded in the organisation.



Health and Wellbeing Pinwheel

Thank you Day

In recognition of their hard work throughout the pandemic all substantive staff who were employed prior to 1 April 2021 were awarded an additional Thank you Day (7.5 hours pro rata) to be taken at any time before 31st March 2023.

#WellbeingWednesday

During the Covid pandemic we have launched #WellbeingWednesdays and refreshed our Health and Wellbeing Pinwheel which segments our health and wellbeing support into seven areas, encouraging our people to take a holistic approach to their personal health and wellbeing.

Wellbeing Conversations

The Trust has launched Wellbeing Conversations which are recorded via a bespoke "How Are You Really?" App. This initiative encourages staff to hold an informal Wellbeing Conversation with their manager, or a trained facilitator of their choice to ensure that they are affording time

to consider their own health and wellbeing. A training programme which is available online for managers, facilitators and staff enables participants to get the most out of the programme.

Staff Facebook Page

Our Trust Staff Facebook page is used by staff to ask questions, share Thank yous, messages of support to colleagues, share health and wellbeing tips, and develop a feeling of community – particularly helpful for those staff who have been working from home during the pandemic.

Other Communication Channels

All staff have access to information through various 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. A Coronavirus Briefing incorporating the latest information and policy decisions agreed through Command and Control is distributed weekly by email.

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 across the Trust, to take a role within our People and Culture initiatives and Equality and Inclusion networks.

Equality and Diversity

The Trust recognises that a diverse workforce (that is represented across all levels) brings a range of experiences, ideas and creativity essential for delivering high quality, safe healthcare.

As part of our Trust’s People and Culture Strategy, we have established a trio of dynamic staff Inclusion networks [BAME, LGBTQ+ and Staff Disability]. These Networks are chaired by staff that have scheduled protected time for this activity and have an identified executive and non-executive sponsor. Our Networks provide a supportive environment for both staff and managers to raise issues, and take advice to make informed, evidence based decisions within their areas of responsibility.

Whilst there is still more to do, we are prioritising representation and improving staff experience. This continues to be a collaborative undertaking

with the support of our staff inclusion networks and our IDEA committee.

In the past 12 months our Staff Inclusion Networks have been instrumental in raising awareness of important issues through lived experience articles, which helped us, understand and make positive changes to improve the experience of our own people and that of our patients. Here are some highlights from the past year from our Staff Inclusion Networks:

- ▶ **BAME Network** – Held their first annual conference in 2021 “Let’s Talk Racism” which was attended by over 200 colleagues across the West Midlands, to listen to speakers such as Imran Khan QC the solicitor for the Stephen Lawrence family. The Network has recently elected a new Chairperson who officially started the role in April 2022.
- ▶ **Staff Disability Network** – In December the network took the lead on Disability History month organising awareness events on The Equality Act, Reasonable Adjustments, and Barriers to declaring Disability and Hidden Disabilities. The month culminated with a session from Andy Lewis MBE and Paralympic Triathlon gold medallist entitled Overcoming Adversity.
- ▶ **LGBTQ+ Network** – Have appointed a new Chair, who has already made a huge contribution in the short time they have been in post. The network successfully launched a new project to gain accreditation for the new NHS Rainbow Badge. This involves a review of people polices and staff and experience surveys to assess the experience of LGBTQ+ staff and patients. The LGBTQ+ Network has also been instrumental in improving our training offer to staff to increase awareness and understanding.

To improve the representation of our people across the Trust, we have developed and introduced an Inclusive Recruitment Approach. This is intended to increase the number of BAME, Disabled and LGBT+ applicants as well as improve our selection techniques by making sure that we have interview panels who are better trained and representative. We have initially introduced this new approach for management roles, as we need the greatest change there.

We offer proactive return to work plans, redeployment opportunities, and reasonable adjustments, for staff that have or develop health problems or disabilities during their career.

We are committed to improving education and training for our people. We have continued to develop helpful, supportive guidance and training packages for all colleagues to encourage diverse practice and thinking. These include our Enabling a Proactive and Inclusive Culture (EPIC) Training package looking at Values Discover, Building and Inclusive Culture and Inclusive Dynamic Conversations, and delivery of Equality Impact Assessment champion sessions to improve our policies and procedures capabilities and make better, more inclusive decisions.

We continue to work to demonstrate compassion to one another and to challenge and redress any experience of inappropriate discrimination or unequal treatment as part of our Behavioural charter.

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

This can be found at: <https://www.worcsacute.nhs.uk/our-trust/corporate-information/equality-and-diversity/workforce-race-equality-standard>

As at 31 March 2022 the ethnic breakdown of our staff was as follows:

Headcount by Ethnicity as at 31 March 2022			
Ethnicity	Female	Male	Total
Asian or Asian British	680	269	949
Black or Black British	99	40	139
Mixed Race	63	23	86
Not Stated / Undisclosed	19	6	25
Other	56	41	97
White	4641	821	5462
Grand Total	5589	1217	6806

Gender Pay Gap

The gender pay gap shows the difference between the average (mean or median) earnings of men and women. This is expressed as a percentage of men's earnings e.g. women earn 16% less than men. Used to its full potential, gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation, and how effectively talent is being maximised.

It is a legal requirement for all relevant employers to publish their gender pay report within one year of the 'snapshot' date: this year's date being 31 March 2021.

The Trust's Gender Pay Gap, in summary:

- ▶ The Trust's mean gender pay gap is 31.7%
- ▶ The Trust's median gender pay gap is 16.0%
- ▶ The Trust's mean bonus gender pay gap is 39.68%

- ▶ The Trust’s median bonus gender pay gap is 40.13%
- ▶ The proportion of males receiving a bonus payment is 5.94%
- ▶ The proportion of females receiving a bonus payment is 0.50%

The National median gender pay gap is 15.9% with the average GPG in the NHS being between 10% and 18%. Our pay gap is 16.0% which is 0.1% above the national average.

Staff Survey Results 2021

The results of the latest national NHS Staff Survey were published on 30 March 2022. Our final response rate for the 2021 survey was 43% (2,883 colleagues) compared to 46% last year. This is lower than the median response rate for Acute Trusts of 46% which was disappointing. However, the range nationally is 29.5% to 79.9% so we are not an outlier.

The seven People Promise elements are new for 2021 which means that there is no trend information available. We have scored lower than national average on all seven elements, and our sub-scores are as follows:

People Promise Element	Sub-Scores better than national average	Sub-scores equal to national average	Sub-scores worse than national average
1. We are compassionate and inclusive		Diversity and Equality	Compassionate Culture; Compassionate Leadership; Inclusion
2. We are recognised and rewarded	Level of pay		Recognition for good work from organisation, line manager and colleagues
3. We each have a voice that counts		Raising concerns	Autonomy and control
4. We are safe and healthy		Burnout	Health and safety climate; Negative experiences
5. We are always learning		Appraisals	Development
6. We work flexibly	Flexible working		Support for work-life balance
7. We are a team		Team working	Line management

We have deteriorated from last year, and score lower than national average, on the two additional themes Staff Engagement and Morale made up from the following sub-scores:

People Promise Element	Sub-Scores better than national average	Sub-scores equal to national average	Sub-scores worse than national average
1. Staff Engagement		Motivation	Involvement; advocacy
2. Morale		Stressors	Thinking about leaving; work pressure

The Trust has deteriorated on both the questions relating to recommending the Trust as a place to work or provide treatment, but remains in the middle of the pack.

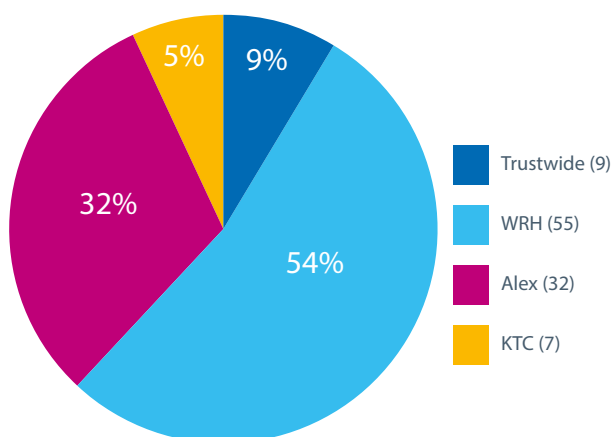
These latest results are disappointing compared to last year but perhaps reflect the impact of a two year pandemic coupled with problematic patient flow which has put the Trust regularly at Level 4 escalation.

Our focus continues to be on improving the experience of all our staff to make WAHT an exemplar/ employer of choice. We are currently reviewing the 2021 staff survey results against our People and Culture Strategy and supporting divisions to draw up their own action plans.

Freedom to Speak Up (FTSU) Themes

During 2021 we have continued to raise the profile of FTSU with regular bulletins from our Guardian and launch of our FTSU Portal so that staff can access support via one click. The Guardian is supported by a network of 52 FTSU champions across our three sites.

FTSU Cases by Site



The following table provides an overview of the concerns raised through the Freedom to Speak up Guardian in 2021. 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 2021/22:

Total number of speak up incidences	103
Total number of speak up incidences reported anonymously	22
Total number of speak up incidences where there was a bullying or harassment element	39
Total number of speak up incidences where there was a patient safety or quality element	16
Total number of speak up incidences where there was a perception of detriment to the reporter	0

Themes of concerns raised to FTSU in 2021/22:

Theme	Number of times issue raised
Bullying and harassment	39
Staff levels	13
Attitudes and behaviours	59
Policy and Procedures	23
Quality and Safety	16
Worker Safety and wellbeing	24
Other	13
Grand Total	103 cases (some with multiple issues)

Our Workforce

The recruitment and retention of our staff remains a key priority and the pandemic is now starting to impact our staff turnover and vacancy numbers. Our substantive vacancy rate has increased by 4.18% to 8.20% this year due to an increase in funded establishment to staff new wards and Covid-19 activity such as pods, vaccination clinics and other national requirements. The majority of the growth was swap out from bank and agency.

Snapshot of key workforce indicators

KPI	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Trendline
Cumulative Sickness Absence Rate	4.27%	4.17%	4.20%	4.72%	4.96%	5.43%	
Actual staff in post in full-time equivalent (FTE)	5106	5200	5316	5567	5827	5881	
Headcount staff in post	5951	6055	6207	6453	6748	6806	
Mandatory Training Compliance	89%	89%	84%**	89%	90%	90%	
Appraisal Completion %	76%	65%	77%	81%	79%	76%	
Staff Turnover	12.57%	11.04%	12.30%	11.12%	9.50%	12.43%	

** 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 0.47% to 5.43%. We monitor our sickness rates against the national and peer median via the Model Hospital. Our sickness was better than the national average on Model Hospital in January 2022 which is the most up to date comparison data. Our sickness was 6.2% on Model Hospital (Quartile 2 (Good) compared to national average of 6.7%. Monthly sickness rates are 1.29% higher than the same period last year which is primarily due to Covid-19 sickness and a subsequent increase in stress and anxiety

(S10). Our sickness rates equate to an average of 16.96 days lost per employee which is the highest on our records and compares to under 13 days per employee pre-pandemic. Some of this increase will be due to the national rules which means that Covid absence is not counted towards triggers and thus is more difficult to manage.

Staff Sickness	2017-18	2018-19	2019-20	2020-21	2021-22	Trendline
Total FTE Days lost	76,071	80,266	88,100	99,853	115,401	
Total staff (headcount)	6,055	6,207	6,453	6,748	6,806	
Average number of working days lost	12.56	12.93	13.65	14.80	16.96	

Absence due to Covid-19

In addition to sickness absence the Trust has experienced other covid related absence for self-isolation following contact with symptomatic people which has to be paid as medical suspension in line with national guidance. These absences are now a minimum of five days for symptomatic staff, earlier in the pandemic isolation was 10 days for staff testing positive or where they had a positive household contact. Staff who were required to isolate or quarantine following a holiday are required to book annual leave or take a period of unpaid leave.

As at 31 March 2022 the absence levels related to Covid-19 medical suspensions were significantly reduced from 1048 reported at the start of the pandemic. From April 2022 Healthcare workers are no longer required to isolate if they have a positive household contact so we should start to see a reduction in these numbers. The rates are similar to the same period last year:

Absences due to Covid Self Isolation on 31 March (Snapshot)	Absences 31 March 2022	Absences 31 March 2021
Covid Household Member Symptoms	30	27
Covid Lateral Flow Test Isolation	65	54
Covid Symptomatic	72	77
Covid Track and Trace	21	17
Grand Total	188	175

Staff Safety during Covid

The Trust has focused much time during 2021/22 on encouraging all staff to complete a Covid Health Risk Assessment so that steps can be taken to mitigate their risk including the issue of PPE to all staff, and the offer of redeployment for those who have a “red” risk. As at 31 March 2022 95% of our staff had an up-to-date risk assessment.

Each workplace is also required to have a Covid Workplace Risk Assessment and managers are required to consider workstations and work patterns to ensure that the 2m social distancing rule was adhered to. All staff on site are required to wear fluid resistant surgical masks as a minimum and those who are patient facing are mask fit tested for FFP3 masks as appropriate.

The Trust has hosted its own vaccination hub to ensure that all staff were offered Covid and Flu vaccination and boosters. As at 31 March 2022 95% of our staff had had at least one Covid

vaccine and 63% had received the flu vaccine. Although the Government changed its policy on vaccination as a Condition of Deployment the Trust has continued to encourage staff to have their vaccines and boosters.

Staff Turnover

Our overall staff turnover has been reducing year on year since July 2015 from 12.97% to 9.5% in March 2021 when staff were not moving jobs during the pandemic. However, this has returned to pre-pandemic levels and is currently at 12.43% which is above our target of 11.5%. This trend appears to be comparable with other Trusts as we are at Quartile 1 (best) for Nursing and Midwifery, Additional Scientific and Technical, Administrative and Clerical and Estates and Ancillary. We are also Quartile 2 (good) for HCAs and Allied Health Professionals. Our Healthcare Scientist and Medical Dental Turnover are cause for concern at Quartile 3 (Latest Model Hospital data is as at December 2021).

Our FTE breakdown by staff group as at 31 March 2022 is as follows:

Workforce profile Staff group	FTE					Trendline
	31 March 2018	31 March 2019	31 March 2020	31 March 2021	31 March 2022	
Additional Prof. Scientific and Technic.	174	191	193	204	145	
Additional Clinical Services	977	995	1050	1085	1075	
Administrative and Clerical	967	996	1043	1095	1100	
Allied Health Professionals	345	363	356	374	438	
Estates and Ancillary	260	279	294	305	313	
Healthcare Scientists	179	179	174	167	163	

Workforce profile	FTE					Trendline
	31 March 2018	31 March 2019	31 March 2020	31 March 2021	31 March 2022	
Medical and Dental	582	607	653	676	689	
Nursing and Midwifery Registered	1692	1698	1800	1871	1958	
Students	24	9	2	52		
Grand Total	5200	5316	5567	5827	5881	

Our profile of Senior Managers (Band 8 and above) by gender as at 31 March 2022 is as follows:

Senior Managers Profile as at 31 March 2022 (Headcount)				
Staff Category	Band 8	Band 9	Trust Board	Total
Trust Board (Female)			9	9
Trust Board (Male)			9	9
Senior Manager (Female)	213	7		220
Senior Manager (Male)	61	3		64
Grand Total	274	10	18	302

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 in response to the Covid-19 pandemic. The breakdown of staff as at 31 March 2022 is as follows:

Substantive/Bank/ Agency as at M12 ADI 2021/22	Funded WTE	Contracted WTE	Vacant WTE	Worked WTE
Agency	32			282
Bank	83	1		449
Substantive	6,463	5,933	530	5,803
Grand Total	6,578	5,934	530	6,535

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 2022, we had the following assignment categories:

Assignment Category as at 31 March 2022	FTE	Employee Headcount
Fixed Term Temp Locum	509.64	544
Permanent	5,371.62	6,262
Grand Total	5,881.26	6,806

The total staff costs for 2021/22, excluding remuneration of Non-Executive Directors are:

Staff Cost 2021/22	Permanent £'000	Other £'000	Total £'000
Salaries and Wages	236,912	0	236,912
Social Security Costs	23,907	1,746	25,653
Apprenticeship Levy	1,217	0	1,217
NHS Pension Costs	41,455	854	42,309
Other Pension Costs	56	0	56
Temporary Staff	0	51,675	51,675
Less: recoveries in respect of outward secondments (where treated net)	0	0	0
Total Staff Costs	303,547	54,275	357,822

The analysis of average WTE employed as at 31 March 2022 are below by category and staff group:

Average number of employees (WTE basis)	Permanent Number	Other Number	2021/22 Total Number	2020/21 Total Number
Medical and dental	690	67	757	681
Ambulance staff	2	-	2	2
Administration and estates	1,097	2	1,099	1,079
Healthcare assistants and other support staff	1,352	6	1,358	1,293
Nursing, midwifery and health visiting staff	1,936	129	2,065	1,827
Nursing, midwifery and health visiting learners	-	-	-	3
Scientific, therapeutic and technical staff	589	20	609	595
Healthcare science staff	165	7	172	251
Total average numbers	5,831	232	6,063	5,731

Health and Wellbeing

Our SEQOHS accredited 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. The service also offers a Stress Awareness course for Managers and vaccination and surveillance programmes such as winter flu and Covid-19 vaccination and a track and trace campaign to keep our staff and patients safe.

During the pandemic our Occupational Health team have been supporting the organisation by providing staff Covid-19 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 in 2019, 241 in 2021 and 286 this year with 15% being Covid-19 related as follows:

Work Related Stress OH appointments			
Covid-19 including compulsory vaccinations in addition to the reasons given last year	43	15%	Decrease
Relationship Issues with colleagues	27	9.5%	Same
Relationship issues with manager	8	3%	Decrease
Workload (inc staffing levels)	75	26%	Increase
Working hours	23	8%	Increase
Working environment	23	8%	Not included in 2021
Investigation/incident at work/ Performance management	44	15%	Increase
Redeployment to other areas	14	5%	Not included in 2021
Not identified in notes	4	1.5%	Not included in 2021
Combination	25	9%	Increase
GRAND TOTAL			Increase of 45

The Occupational Health Team has worked with our outsourced Counselling provider to offer a wide range of emotional support as part of our Covid-19 response. The Intranet is regularly updated and includes 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.

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 2022 was 76% which is the same as the previous year. This is lower than the Model Hospital average of 78%. Appraisal will continue to be a focus for managers as we move through the Recovery and Restoration phase following the pandemic particularly for Admin and Clerical staff who have been impacted by working from home, and Ancillary staff who have increased levels of sickness.

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 and 2021 as part of the national Covid-19 response and is due to be reinstated.

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, access their payslips and pensions statements, 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 90% which is better than the Model Hospital average of 87%. Current compliance as at 31 March 2022 is 90%.

During the latter part of 2020/21 we introduced new competencies on ESR for a number of Essential to Role (E2R) topics such as Frailty, Dementia, Sepsis, ReSPECT and MCA and DoLS. During 2021/22 we have also rolled out e-learning for End of Life Care and have an agreed plan for further topic roll out. Compliance is currently 88% across the board for E2R topics compared to 81% last year.

E-Rostering

The Trust has implemented 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 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 used 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 2021 we rolled out Employee On Line (EOL) for the booking of all absence and shifts via mobile into HealthRoster. With effect from 1st April 2021 HealthRoster became the only route for booking and recording all absence which has improved transparency and triangulation of our absence data. The Rostering Team are now supporting managers across all disciplines to implement full rostering and encouraging both auto-rostering and self-rostering to improve our Flexible Working offer to staff.

Flexible Working

The Trust has achieved Timewise Accreditation this year which is awarded to organisations in recognition of their commitment to increasing opportunities for flexible working for existing staff and new employees.

During 2021/22 we have also launched new functionality on ESR for flexible working requests from staff.

We have a number of flexible working initiatives underway including Location by Vocation which enables non-patient facing staff to work remotely, thus ensuring that our scarce parking resource is available for patients, nurses, doctors and other professional patient facing staff. This initiative has improved attendance rates in particular for admin and clerical staff.

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.

Workforce Key Performance Indicators

We regularly monitor our workforce KPIs at JNCC, People and Culture Committee, Trust Management Executive and Trust Board. During the pandemic key KPIs have also been reported through the Gold Command structure.

Performance Report

Performance Overview

This section of the report provides an analysis of the Trust’s performance, it sets out what the Trust does and our CQC ratings. It shows a summary of our performance against key standards and outlines the Trust’s performance management framework.

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 592,158 people in Worcestershire as well as caring for patients from surrounding counties and further afield.

In 2021/22 we provided care to more than 250,000 different Worcestershire patients – that is 40% of the Worcestershire population receiving care at one of our hospitals.

We saw 692 patients per day, including:

- 166,904 A&E attendances (WRH, ALX and KTC)
- 151,357 Inpatients
- 501,478 Outpatients
- 4,939 births
- 5,010 babies



Covid-19 Numbers

The following table summarises the total number of Covid-19 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) in 2021/22. They also show the crude mortality rate and average length of stay.

Site	Total no. Inpatients	Combined Length of Stay (LOS)	Discharged (treated)	Deceased (in Hospital)	Combined Discharges	Crude Mortality Rate	Average LOS (Treated)	Average LOS (Died)
ALEX	856	10053	735	107	842	12.7%	10.73	14.92
WRH	1271	13383	1121	138	1259	11.0%	9.43	13.68
Trust	2127	23436	1856	245	2101	11.7%	9.95	14.22

Performance Summary

Description	Indicator	2021/22 Target	Year End	Period
Quality				
Mortality	HSMR – Hospital Standardised Mortality Ratio	<=100	102.44 (as expected)	April 2021- March 2022
	SHMI – Summary Hospital Mortality Indicator	<=1	1.0487 (as expected)	February 2021- January 2022
Infection Control	Clostridium Difficile	<=61	91	April 2021- March 2022
	MRSA	0	0	April 2021- March 2022
Prevention	VTE - Venous Thromboembolism Risk Assessment	>=95%	96.34%	April 2021- March 2022
Patient Experience	Mixed Sex Accommodation Breaches	0	352	October 2021 - March 2022

Description	Indicator	2021/22 Target	Year End	Period
Operational				
Cancer	2 Week Wait: All Cancer Two Week Wait (suspected Cancer)	>=93%	63.0%	April 2021-March 2022
	2 Week Wait: Wait for symptomatic breast patients (Cancer not initially suspected)	>=93%	34.3%	April 2021-March 2022
	28 Day Faster Diagnosis	>=75%	64.5%	April 2021-March 2022
	31 days: Wait for first treatment: All Cancers	>=96%	94.0%	April 2021-March 2022
	62 days: Wait for first treatment from urgent GP referral: All Cancers (unadjusted)	>=85%	59.0%	April 2021-March 2022
18 Weeks Waiting Time	RTT - Referral to Treatment: Incomplete - 92% in 18 weeks	>=92%	47.0%	March 2021
Diagnostic Waiting Time	6+ week Diagnostic Waits (% of breaches on the waiting list)	<=1%	27.4%	March 2021
ED Waiting Time	4 Hour Waits (%) - Trust inc MIU	>=95%	72.2%	April 2021-March 2022
Stroke	80% of patients spend 90% of time in a Stroke Ward	>=80%	68.0%	April 2021-March 2022
	Direct admission (via A&E) to Stroke Ward	>=90%	30.5%	April 2021-March 2022
	TIA - Transient Ischaemic Attack - High Risk Patients seen within 24 hours	>=70%	79.5%	April 2021-March 2022
	CT scan within 24 hours of arrival	>=80%	42.1%	April 2021-March 2022

Description	Indicator	2021/22 Target	Year End	Period
Patient Experience				
Friends and Family Test	Acute Wards (% recommend)	-	96.09%	April 2021-March 2022
	Acute Wards (Response Rate %)	>=30%	32.62%	April 2021-March 2022
	A&E (% recommend)	-	76.58%	April 2021-March 2022
	A&E (Response Rate %)	>=20%	17.50%	April 2021-March 2022
	Maternity (% recommend)	-	93.08%	April 2021-March 2022
	Maternity (Response Rate %)	>=30%	9.02%	April 2021-March 2022

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 2021/22 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)

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

Safety, quality, risk assessments and assurance tools and processes have been implemented and embedded across the emergency departments, in partnership with NHSI/E, CCG and WMAS. Oversight of the continuous improvement has been monitored via the Trust's internal governance structure and the HomeFirst Worcestershire Board.

The Trust submitted applications for the Section 31 conditions to be removed from its Emergency Departments in February 2021, and in April 2021, the CQC formally confirmed that all conditions had been removed from both Emergency Departments.

Throughout 2021/22, in response to the Covid-19 requirements, CQC have focused their formal inspection activity on areas of high risk, and implemented a Transitional Monitoring Approach to ensure continued engagement, oversight and assurance.

During 2021/22, the Trust has remained proactively engaged with the CQC, and facilitated a number of monitoring calls such as:

- ▶ Transitional Monitoring Approach – Well-Led
- ▶ Transitional Monitoring Approach – Critical Care

A further one day (on-site) engagement event was held in February 2022 at Worcestershire Royal Hospital which included visits to:

In May 2021, the CQC announced ‘A new strategy for the changing world of health and social care - Our Strategy from 2021’. In support of the new ways of CQC working alongside the Trust, a 2-day (onsite and remote) engagement event took place in November 2021, which included:

- ▶ Emergency Department and tour of new Urgent Care Village construction site.
- ▶ Surgical Same Day Emergency Care (SDEC) Unit.
- ▶ Critical Care.
- ▶ Maternity.
- ▶ Speciality Medicine - Avon 4 ward.

- ▶ Opening session with the Executive Team.
- ▶ CQC meeting with the clinical teams in areas such as the Emergency Departments, Critical Care, Maternity and Outpatients at both Worcestershire Royal and the Alexandra Hospitals.
 - Virtual engagement sessions with Respiratory Teams, Ward 1 (KTC), Radiology, End of Life Care, Clinical Research, Outpatients, International Nurses, Roster Team, #CallMe, Freedom to Speak Up.

Informal feedback from the CQC following both engagement sessions was positive, with many examples of high quality patient care and good leadership. The CQC expressed their gratitude for the welcome they received, the openness and honesty of the colleagues they spoke to and shared their profound admiration for everything that our staff had achieved and are achieving.

It is important to note that CQC are still developing the framework for inspection under their new strategy.

- ▶ Open staff engagement sessions.

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.

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

The Trust's Performance Management and Accountability Framework 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 and against NHSEI's 2021/22 priorities and operational planning guidance which set the priorities to restore services, meet new care demands and reduce the care backlogs that are a direct consequence of the pandemic. In all other cases targets or improvement trajectories are agreed with Divisions.

Performance tracking is based on these general principles:

- ▶ High quality care and patient safety is the over-riding goal.
- ▶ Transparency of performance metrics and reporting.
- ▶ Decisions are based on transparent quality (determined by the Data Quality Kitemark),

timely and reliable information built on clinical leadership of data quality.

- ▶ Information is shown in trends; using SPC charts where appropriate.
- ▶ Clear targets are set reflecting national and local priorities.
- ▶ Targets provide a balanced view of performance across the Single Oversight Framework themes.
- ▶ Key performance indicators are established, with clear links to drivers so that changes can 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 2021/22, the Performance Management Framework continued to be superseded by the Incident Command Structure that was established in 2020/21.

During the year, and especially when the Trust was at its highest escalation levels in its Covid-19 response and level 4 patient flow pressures, 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.

The restoration of services continued to be prioritised, led by the Restoration Oversight Group and its sub-committees. A new Performance Management Framework has been drafted and once approved will be implemented in 2022/23.

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, Covid-19 continued to impact our capability and capacity to achieve operational standards in 2021/22. This is evident in waiting time standards as efforts to restore services and increase capacity in-line with government policy have been offset by the impact on Covid-19 on patients, families and staff across the healthcare system.

A surge in demand following lockdown associated reductions has been particularly noticeable in cancer with two week wait referrals. Urgent care has been under significant pressure with increased attendances across the year. Although we ring-fenced beds at both the Alexandra and Worcestershire Royal Hospital, elective care was disrupted with Covid-19 preventing treatments and appointments, and reducing our capacity for attendances as we maintained appropriate social distancing in our clinical areas.

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. However, unlike in 2020/21, the Trust did not suspend routine and non-urgent diagnostics and in fact was able to increase capacity in key modalities through Community Diagnostic Centre funding to source additional testing equipment.

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 47 and is described in more detail below.

Emergency Access Standard: 95% of patients treated/ admitted from ED within 4 hours of arriving in ED

Performance for the Emergency Access Standard has not met the national target of 95% for more than 7 years. With 72.2% of patients admitted, transferred or discharged within 4 hours, the EAS performance for the year has decreased in 2021/22 by 11.9 percentage points compared to the 2020/21 performance of 84.1%. A more like for like comparison is to 19/20 where the decrease was 3.6 percentage points from 75.8%. For context, 204,358 patients attended a type 1 or type 3 setting in 21/22. This was 6,861 more patients than in 19/20 and 52,462 more than 2020/21. The principal reason for the performance level remains the lack of bed availability caused by delays in discharging patients following completion of their hospital based treatment. Bed capacity at peak times during 21/22 was extremely limited even when attempting to maintain cohorted wards to ensure patients were treated appropriately, and 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 increased from 79 in 2020/21 to 1,248 in 21/22.

Referral to Treatment (validated at Feb-22): 92% of patients to be treated within 18 weeks of referral

The Trust has not met the 92% standard in 2020/21. At the end of March 2022 47.0% of patients were within 18 weeks of referral compared to 52.9% the previous March. The size of the waiting list has grown from 46,513 at the end of March 2021 to 57,151 at the end of March 2022. 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 fluctuated from month to month throughout 2021/22, starting at 6,515 in March 2021 and decreasing to 5,849 at the end of March 2022.

Cancer (validated to Mar-22): 85% of cancer patients to commence treatment within 62 days of referral

Over the year 59.0% of patients commenced treatment within 62 days. This is a decrease from the previous year which saw 68.9% of patients commencing treatment within the required timescales. This is despite an increase in the number of patients treated; 2,228 in 2021/22 compared to 1,901 in 2020/21. 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. An increase in cancer referrals, beyond those experienced in previous

years, put significant pressure on our clinical capacity and the timeliness of cancer pathways resulting in more patients breaching the waiting times standards.

Diagnostics (validated at Feb-22): No more than 1% of patients to wait more than 6 weeks for a diagnostic test

The Diagnostics standard has not been met in 2021/22 with 27.4% of patients waiting more than 6 weeks at the end of March 2021. However, this is an improvement on the previous year's performance in 2020/21 when 50.67% of patients were waiting more than 6 weeks. Delays in patients receiving diagnostic tests do have an adverse impact on the time elapsed before cancer treatment commences as well as other non-cancer treatment pathways.



Matthew Hopkins
Chief Executive

Date: 4 July 2022

Financial Performance in 2021/22

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 nominal Income and Expenditure deficit of (£1.356)m (subject to audit) under the National Financial Framework originally established during the first year of the Covid-19 pandemic and updated through differing allocations over the two 6-month 2021/22 planning periods. It should be noted, though, that it has not achieved the Statutory Break-even duty, which is where the Trust must achieve a cumulative break-even 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 deficit (excluding impairments and the impact of donated assets) of £(1.356)m against the allocated funding for the 2021/22 financial year. This represents a marginally adverse performance against the cumulative two (H1 and H2) six-monthly planning periods' break-even position, though is consistent and indeed c.£0.6m better than the £1.9m forecast financial outturn agreed by the Trust Board considering the continuing impact of Covid-19 during the second half of the year.

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 2021/22 £000s	Actual 2020/21 £000s
Operational (Adjusted) Financial performance surplus/(deficit)	(1,356)	6,652
<i>Adjust</i> Remove I&E impact of capital grants and donations	(151)	(847)
<i>Adjust</i> Remove net impairments not scoring to the Departmental expenditure limit	238	6,553
<i>Adjust</i> Remove net impact of inventories received from DHSC group bodies for Covid-19 response	273	(385)
Surplus / (deficit) for the period	(1,716)	1,331

A number of productivity and efficiency schemes were delivered in line with plan in year, totalling c.£5.4m of which c.£5.2m of the delivered savings were achieved recurrently.

No interim revenue borrowing was requested or received during 2021/22 as a result of the positive in-year cash position.

The Trust received £36.6m 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. This amounts to the total new borrowings in 2021/22.

The improved cash position since the implementation of the Covid-19 funding regime has supported good Better Payment Performance in 2021/22 and 2020/21. In 2021/22, the Trust achieved 95% by number (97% in 2020/21) and 96% of value (94% in 2020/21) a broadly consistent position.

The Trust has invested £51.5m of capital resources in 2021/22 in line with its Capital Resource Limit. This was funded from the Trust's internally generated capital, plus Public Dividend Capital (PDC) from NHSEI, including the PDC for the new Urgent and Emergency Care at Worcestershire Royal Hospital and Community Diagnostic Centre/Hub at the Kidderminster Treatment Centre.

Schemes included major developments such as the commencement of a new Urgent and Emergency Care unit in the Worcestershire Royal Hospital - 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,

community diagnostic hubs and the new clinical assessment unit at Worcester.

Looking forward to 2022/23 and beyond

The Trust still has a challenging financial outlook entering 2022/23 with a high underlying cost base compared to peer multi-site hospital Trusts; this cost base is also impacted by a non-standard contract PFI facility. In light of the Covid-19 response, the planning cycle has been revised and the changing national funding regime seen in 2021/22 largely rolled forward into 2022/23, though with a considerable adjustment to income allocations.

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 2022/23 Trust Annual Plan is currently being finalised with initial figures submitted and processes underway to understand risks around efficiency delivery and activity related income.

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 (with some notable exceptions detailed below) now form part of an overall system capital envelope. This is collectively prioritised against the most urgent schemes and has been agreed for 2022/23.

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 Acute Services Review (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 2022 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. There is clear evidence of continued provision of services being planned by NHSEI, 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 relatively small deficit in 2021/22 following the reported surplus 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 Section 30 referral to the Secretary of State.

Better Payments

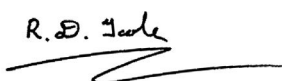
BPPC Target Performance : 95%	Number	£000
Non-NHS Payables		
Total Non-NHS Trade Invoices Paid in the Year	93,207	282,344
Total Non-NHS Trade Invoices Paid Within Target	88,605	271,875
% of Non-NHS Invoices Paid Within Target	95.1%	96.3%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,142	17,228
Total NHS Trade Invoices Paid Within Target	1,779	15,042
% of NHS Invoices Paid Within Target	83.1%	87.3%
Total Payables		
Total Invoices Paid in the Year	95,349	299,572
Total Invoices Paid Within Target	90,384	286,917
% of Invoices Paid Within Target	94.8%	95.8%

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 approved invoices within 7 days or as soon as they are authorised for payment.

The Trust continued to receive cash receipts from the CCGs and NHSE under the revised Covid-19 funding allocation arrangements operating during 2021/22. This enabled sufficient cash flow to not impact payments to creditors within the required BPPC target. In 2021/22, for Non-NHS Payables the Trust achieved 95% by number (97% in 2020/21) and 96% of value (94% in 2020/21) a broadly consistent position.

The Trusts cash position at 31 March 2022 was £59.2m. The cash position will be closely monitored in 2022/23 with a deficit still forecast though plans have been put in place to manage liquidity.

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

A handwritten signature in black ink, appearing to read 'R. D. Toole', with a long horizontal flourish underneath.

Robert D Toole
Chief Finance Officer

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, Vice 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:

- ▶ Ms Anita Day from 1 January 2021 until the present date.
- ▶ Dr Simon Murphy from 1 April 2021 until present date.

Senior Manager's Remuneration Policy

Senior 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 Director appointed this year: Dr Christine Blanshard, (Chief Medical Officer). Mike Hallisey, (Chief Medical Officer) resigned on 31 July 2021. Graham James (acting Chief Medical Officer) 1 August to 6 October 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.

Job title (and period of office if relevant)		2021/22								2020/21											
		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				
		(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)				
Matthew Hopkins	Chief Executive	210	-	215	0		-		210	-	215	210	-	215	1,200		-		210	-	215
Paul Brennan	Chief Operating Officer & Deputy Chief Executive	185	-	190	0		-		185	-	190	185	-	190	0		-		185	-	190
Mike Hallisey	Chief Medical Officer (on secondment from University Hospital B'ham, invoiced)	30	-	35	0		-		30	-	35	100	-	105	0		-		100	-	105
Graham James	Chief Medical Officer (acting 1 Aug - 7 Oct 2021)	35	-	40	0	122.5	-	125	160	-	165		-			-				-	
Robert D Toole	Chief Finance Officer	150	-	155	0	37.5	-	40	190	-	195	150	-	155	4,000	35.0	-	37.5	190	-	195
Joanna Newton	Director of Strategy & Planning	120	-	125	0	27.5	-	30	150	-	155	110	-	115		25.0	-	27.5	135	-	140
Richard Haynes	Director of Communications & Engagement	100	-	105	0	25.0	-	27.5	125	-	130	100	-	105	0	25.0	-	27.5	125	-	130
Tina Ricketts	Director of People & Culture	135	-	140	0		-		135	-	140	125	-	130	0	63	-	65.0	190	-	195
Helen Lewis (known as Vikki)	Chief Digital Officer	120	-	125	0	30.0	-	32.5	150	-	155	120	-	125	0	125.0	-	127.5	245	-	250
Paula Gardner	Chief Nursing Officer	135	-	140	0		-		135	-	140	5	-	10	0		-		5	-	10
Christine Blanshard	Chief Medical Officer (7 October 2021)	90	-	95	0		-		90	-	95		-			-				-	

NOTES

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

Pension related benefits have been calculated in line with the 2021/22 Group Accounting Manual.

There is no performance pay, long-term performance pay or bonuses for the directors in either 2020/21 or 2021/22.

Graham James was Acting Chief Medical Officer for the period 1 August to 6 October 2021. No additional remuneration was received and Mr James continued with the majority of his clinical duties. Please see detailed below the remuneration split by element received:

Basic Pay	£20,839
Additional Elements	<u>£17,144</u>
Total	£37,983

- ▶ **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 P. Gardner remains as Chief Nursing Officer.
- ▶ **Chief Medical Officer**
Dr C. Blanshard commenced as Chief Medical Officer on 7 October 2021
- ▶ **Chief Digital Officer**
Ms H. Lewis remains as Chief Digital Officer.

Non-Executive Directors

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

		2021/22								2020/21											
		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
Anita Day	Vice Chair	20	-	25	1,200		-		20	-	25	10	-	15	0		-		10	-	15
William Tunnicliffe	Non Executive Director	0	-	5	0		-		0	-	5	10	-	15	0		-		10	-	15
Colin Horwath	Non Executive Director	10	-	15	0		-		10	-	15	10	-	15	0		-		10	-	15
Julie Moore	Non Executive Director	10	-	15	0		-		10	-	15	10	-	15	0		-		10	-	15
Richard Oosterom	Associate Non Executive Director	10	-	15	0		-		10	-	15	10	-	15	0		-		10	-	15
Waqar Azmi	Non Executive Director	10	-	15	0		-		10	-	15	0	-	5	0		-		0	-	5
Sharon Thompson	Associate Non Executive Director	10	-	15	0		-		10	-	15	0	-	5	0		-		0	-	5
Simon Murphy	Non Executive Director - from 1 April	10	-	15	0		-		10	-	15		-				-			-	
Susan Sinclair	Associate Non Executive Director - from 14 October 2021	5	-	10	0		-		5	-	10		-				-			-	

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 2022 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 2021/22 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 2022	Lump sum at pension age related to accrued pension at 31 March 2022	Cash Equivalent Transfer Value at 31 March 2022	Cash Equivalent Transfer Value at 01 April 2021	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
Tina Ricketts	0	0	0	0	0	0	0	0
Richard Haynes	0-2.5	0-2.5	20-25	35-40	390	368	22	14.43
Paul Brennan	0	0	0	0	0	0	0	0
Helen Lewis (known as Vikki)	0-2.5	0-2.5	30-35	65-70	632	603	29	17.43
Robert D Toole	2.5-5	0-2.5	35-40	65-70	169	701	0	21.79
Paula Gardner	0	0	0	0	0	0	0	0
Graham James	5-7.5	17.5-20	65-70	205-210	287	1,529	0	21.30
Christine Blanshard	0	0	75-80	235-240	0	2,073	0	13.57
Joanna Newton	0-2.5	0	5-10	0-5	118	101	18	17.43

Notes

Matthew Hopkins, Tina Ricketts, Paul Brennan and Paula Gardner chose not to be covered by the pension arrangements during the reporting year.

Dr Christine Blanshard – pension benefits have been prorated to reflect days employed by the Trust in the year to 31 March 2022. Real increase in pension and lump figures have been reported as zero as they have reduced in value from 2020/21.

Graham James – pension benefits have been included in full as Mr James has been employed in the Trust for the full year, acting up as Acting Chief Medical Officer for the period 1 August to 6 October 2021.

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 2022 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	1	1,600	0	0	0	0
£10,000 to £25,000	0	0	2	31,452	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0	0	0
£50,001 to £100,000	0	0	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	0	0	3	33,052	0	0	0	0

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

Exit Package - disclosures (excluding compulsory redundancies)	Number of Exit Package Agreements	Total Value of Agreements £
Voluntary Redundancies including Early Retirement Contractual Costs	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	2	22,155
Exit Payments Following Employment Tribunals or Court Orders	1	10,897
Non-Contractual Payments Requiring HM Treasury Approval	0	0

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 2022, for more than £245 per day and that last longer than six months.	Number of engagements
Number of existing engagements as at 31 March 2022	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	0
Number that have existed for between two and three years at a time of reporting	2
Number that have existed for between three and four years at a time of reporting	2

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 2021 and 31 March 2022, 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 2021 and 31 March 2022	1
Of which:	
▶ Number assessed as within the scope of IR35	
▶ Number assessed as not within the scope of IR35	1
▶ Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	
▶ Number of engagements reassessed for consistency/assurance purposes during the year	
▶ Number of engagements that saw a change to IR35 status following the consistency review	

Fair Pay Disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in the Trust against the 25th percentile, median and 75th percentile of the remuneration of the Trust's workforce. Remuneration in this context includes salary and allowances, performance related pay and bonuses payable, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For the purposes of this disclosure, the Trust only pays salary and allowances and therefore there is no further breakdown required for the split between total remuneration and salary components (salary and allowances, performance related pay and bonuses payable) as noted above.

Year	25th percentile salary ratio	Median salary ratio	75th percentile salary ratio
2021/22	9:8:1	6.7:1	5.4:1
2020/21	10.1:1	6.9:1	5.6:1

The banded remuneration of the highest paid director/member in the Trust in the financial year 2021/22 was £210,000-£215,000 (2020/21, £210,000-£215,000). The relationship to the remuneration of the Trust's workforce is disclosed in the table below.

2021/22	25th percentile	Median	75th percentile
Salary and Allowances (£)	21,777	31,534	39,467
Pay ratio information	9.8:1	6.7:1	5.4:1

2020/21	25th percentile	Median	75th percentile
Salary and Allowances (£)	21,142	30,615	37,890
Pay ratio information	10.1:1	6.9:1	5.6:1

There has been a reduction from 2020/21 to 2021/22, this is due to the remuneration of the highest paid director/member of the Trust not having a pay increase.

	Percentage change for highest paid director	Percentage change for employee as a whole
Salary and Allowances	0%	4.14%

The above change for employees includes the national 3% National pay increase for AfC and Medical and Dental staff.

In 2021/22, no employees received remuneration in excess of the highest paid director. In 2020/21, no employees received remuneration in excess of the highest paid director.

Remuneration ranged from £5,338 and £211,458 for 2021/22. The range of remuneration for 2020/21 was between £5,338 and £211,458.

Corporate Governance Report

Directors' Report

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. Patient Stories are shared at the Trust Board monthly meetings with space for discussion and exploration of learning from experiences.

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 2021/22 and broadcast live via the Trust's Youtube channel. 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.

In 2021/22 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 inclusion, maternity, finance, digital/cyber, health and wellbeing, risk appetite, three year plan, quality and 4ward Improvement System.

The Trust Board

The voting members of Trust Board during 2021/22 and their attendance are as follows:

Note: *In the following tables attendance shown is relative to the number of meetings that could have been attended. Any executive apologies were covered by deputies.*

Name	Role	Dates	Attendance
Waqar Azmi	Non-Executive Director		9/11
Paul Brennan	Chief Operating Officer/Deputy CEO		10/11
Anita Day	Non-Executive Director		9/11
Christine Blanshard	Chief Medical Officer	from October 2021	5/6
Mike Hallissey	Chief Medical Officer	until July 2021	4/4
Colin Horwath	Non-Executive Director	from October 2021 previously Associate NED	9/11

Name	Role	Dates	Attendance
Matthew Hopkins	Chief Executive		11/11
Dame Julie Moore	Non-Executive Director		10/11
Paula Gardner	Chief Nursing Officer		10/11
Sir David Nicholson	Chair		11/11
Robert Toole	Chief Finance Officer		9/11
Dr Simon Murphy	Non-Executive Director		10/11
Dr Bill Tunnicliffe	Non-Executive Director	until June 2021	1/3

Non-voting members of Trust Board

Name	Role	Dates	Attendance
Richard Haynes	Director of Communications and Engagement		11/11
Colin Horwath	Associate Non-Executive Director	until October 2021	See above
Vikki Lewis	Chief Digital Officer		11/11
Jo Newton	Director of Strategy and Planning		9/11
Richard Oosterom	Associate Non-Executive Director		6/11
Rebecca O'Connor	Company Secretary		11/11
Tina Rickets	Director of People and Culture		11/11
Sue Sinclair	Associate Non-Executive Director	from October 2021	4/5
Sharon Thompson	Associate Non-Executive Director		7/11

Details of all the Board members and their declaration of interests can be viewed on the Trust's website www.worcsacute.nhs.uk/our-trust/our-board

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

The membership of the Audit & Assurance Committee is as follows:

Name	Role	Dates	Attendance
Anita Day	Non-Executive Director	Audit Chair	
Colin Horwath	Non-Executive Director	From October 2021 Previously Associate NED	
Dr Simon Murphy	Non-Executive Director		

Full details of membership of all of the Board's Committees can be found on page 86 in the Annual Governance Statement.

Personal Data Incidents 2021/22

Details of Information Governance related incidents can be found on page 97 in the Annual Governance Statement.

The Trust updated its Modern Slavery Statement in April 2022 setting out its approach to compliance with the Act; this available at <https://www.worcsacute.nhs.uk/publication-2/documents/3029-modern-slavery-statement-april-2022>

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. Annual Governance Statement 2021-22



Matthew Hopkins

Chief Executive

Date: 4 July 2022

Annual Governance Statement 2021-22

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.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Worcestershire Acute Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Worcestershire Acute Hospitals NHS Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

I have designated the following posts as executive leads with regards to the management of risk:

- ▶ **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

4. The risk and control framework

Risk Management is embedded within the Trust including throughout our Committee structure. We are embedding risk and assurance based processes 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.

5. Risk Management Strategy

The Risk Management Strategy 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 fully utilised through the Board Assurance Framework during 2021/22. 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 and has reviewed the efficacy of these arrangements in year.

6. 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

7. Staff Awareness of Risk

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.

8. Corporate Risk Register

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

The key risks relate to:

- ▶ Staffing/Workforce supply
- ▶ Clinical delivery of care (capacity and flow)
- ▶ Asset management

9. Risk Management Governance

The Risk Management Group has continually matured during 2021/22 and the efficacy of the Trust's risks management arrangements have been reviewed by the Audit and Assurance Committee. 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 the Trust Management Executive (TME). In relation to clinical risks, TME oversees the mitigations for each risk with an assurance report to the Quality Governance Committee. The Finance and Performance Committee oversees mitigations for the finance and digital and operational performance risks and the People and Culture Committee oversees mitigations for the staff risks.

10. Data security risks

The Audit and Assurance Committee have received progress reports in the financial year on progress across the different domains of data and cyber security (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.

Cyber security is reported 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. The Audit and Assurance Committee have received a progress report in this financial year on the Cyber Action plan.

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. A Board development session was held in 2021 on cyber security awareness facilitated by external subject matter experts.

There is an escalated focus on information security with the commencement of war on Ukraine by Russia, which has raised the risk level of the BAF and Corporate risks for cyber security, based on intelligence from national sources. The increased threat has led to NHS Digital seeking assurances from Trusts regarding their operational preparedness in the event of a cyber related attack. Updates relating to Business Continuity Plans and operational processes have been provided to NHS Digital for assurance purposes.

11. Covid-19 Risk 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 overseen by 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. The command and control structure having remained in place throughout 2021/22.

12. Board Assurance Framework

The Trust recognises the importance of a robust Board Assurance Framework (BAF) and, as such, it is received by the TME, Committees 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 which has been embedded during 2021/22.

A series of Committee risk workshops were held during the summer of 2021 culminating in a full refresh of the BAF and application of the seven levels of assurance methodology against the strategic risks.

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

Risk	Strategic Objective	Risk Appetite	Current Risk Score	Level of Assurance
If we are unable to increase elective activity, remove long waits and reduce waiting list size in a timely and cost effective manner, then patient outcomes will suffer, patient care will be compromised and/or costs will increase.	Best experience of care and outcomes for our patients	Low	25	5
If we fail to address the drivers of the underlying deficit and fail to respond effectively to the new financial regime (post Covid-19), then we will not achieve financial sustainability (as measured through achievement of the structural level of deficit [to be fully determined]) 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	20	3
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 use of Resources	Low	16	3

Risk	Strategic Objective	Risk Appetite	Current Risk Score	Level of Assurance
If we do not make best use of technology and information to support the delivery of patient care and supporting services, then the Trust will not be able to deliver the best possible patient care in the most efficient and effective way.	Best use of Resources	Low	16	5
If we do not have effective system wide working to enhance patient flow and to ensure patients are managed in the most appropriate environment, then we will not be able to manage the level of urgent care activity and patient experience for patients who are clinically ready for discharge, but have not been, will suffer.	Best Services for Local People	Low	16	4
If we do not ensure that all actions are in place to enable discharge at the point of being ready for clinical discharge then we will adversely impact patient experience and inhibit flow.	Best experience of care and outcomes for our patients	Low	16	4
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 and outcomes for our patients	Low	16	4
If we fail to effectively involve our staff and learn lessons from the management of change and redesign / transformation of services, then it will adversely affect the success of the implementation of our Clinical Services Strategy resulting in missed opportunity to fully capitalise on the benefits of change and adversely impact staff engagement, morale and performance .	Best People	Low	16	5
If we fail to effectively engage and involve our patients, 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	16	4

Risk	Strategic Objective	Risk Appetite	Current Risk Score	Level of Assurance
If we have a poor reputation this will result 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	Moderate	16	4
If we do not have a right sized, sustainable and flexible workforce, we will not be able to provide safe and effective services resulting in poor patient and staff experience and premium staffing costs.	Best People	Moderate	15	4
If we do not have in place robust systems and processes to ensure improvement of quality and safety and to meet the national patient safety strategy, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes.	Best experience of care and outcomes for our patients	Low	12	4
If the Trust fails to capitalise on the benefits of integrated care at Place, System or intra System level then this will result in missed opportunities to improve quality of care, patient experience, efficiency or financial sustainability.	Best Services for Local People	Low	12	3
If we fail to sustain the positive change in organisational culture, then we may fail to have the best people which will impede the delivery of safe, effective high quality compassionate treatment and care.	Best People	Moderate	12	5
If we are not able to secure financing then we will not be able, to address critical infrastructure risks as well as 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	Moderate	12	4
If we do not have a comprehensive leadership model and plan in place then we may not have the right leadership capability and capacity to deliver our strategic objectives and priorities.	Best People	Moderate	12	4
If we do not have the capacity and capacity to implement, or staff do not access, health and wellbeing support then we may be unable to maintain safe staffing levels due to higher rates of absence and staff turnover.	Best People	Moderate	10	5

13. Quality

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

Safety, quality, risk assessments and assurance tools and processes have been implemented and embedded across the emergency departments, in partnership with NHSI/E, CCG and WMAS, and oversight of the continuous improvement has been monitored via the Trust’s internal governance structure and the HomeFirst Worcestershire Board.

The Trust submitted applications for the Section 31 Conditions to be removed from its Emergency Departments in February 2021, and in April 2021, the CQC formally confirmed that all conditions had been removed from both Emergency Departments.

Throughout 2021/22, in response to the Covid-19 requirements, CQC have focused their formal inspection activity on areas of high risk, and implemented a Transitional Monitoring Approach to ensure continued engagement, oversight and assurance.

During 2021/22, the Trust has remained proactively engaged with the CQC, and facilitated a number of monitoring calls such as:

- ▶ Transitional Monitoring Approach – Well-Led
- ▶ Transitional Monitoring Approach – Critical Care

In May 2021, the CQC announced ‘A new strategy for the changing world of health and social care - Our Strategy from 2021’. In support of the new ways of CQC working alongside the Trust, a 2-day (onsite & remote) engagement event took place in November 2021, which included:

- ▶ Opening session with the Executive Team.
- ▶ CQC meeting with the clinical teams in areas such as the Emergency Departments, Critical Care, Maternity and Outpatients at both Worcestershire Royal and the Alexandra Hospitals.
 - Virtual engagement sessions with Respiratory Teams, Ward 1 (KTC), Radiology, End-of-Life Care, Clinical Research, Outpatients, International Nurses, Roster Team, #CallMe, Freedom to Speak Up.
- ▶ Open staff engagement sessions.

A further one day (on-site) engagement event was held in February 2022 at Worcestershire Royal Hospital which included visits to:

- ▶ Emergency Department and tour of new Urgent Care Village construction site.
- ▶ Surgical Same Day Emergency Care (SDEC) Unit
- ▶ Critical Care
- ▶ Maternity
- ▶ Speciality Medicine - Avon 4 ward

Informal feedback from the CQC following both engagement sessions was positive, with many examples of high quality patient care and good leadership. The CQC expressed their gratitude for the welcome they received, the openness and honesty of the colleagues they spoke to and shared their profound admiration for everything that our staff had achieved and are achieving.

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.

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Overall Trust	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

You can find more information about the Trust's CQC ratings and those of our hospitals in the performance analysis section of the Annual Report on page 47.

14. 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 four. 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.

15. 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 2021/22. 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.

16. Serious incidents and never events

Occasionally things go wrong and we have systems designed for reporting and learning from such events. During 2021/22 we reported 141 serious incidents (SIs) through the serious incident system (STEIS). This number includes 8 cases being investigated by the HSIB (Healthcare Safety Investigation Branch). In the same period we reported 9 never events: two related to retained foreign objects (ophthalmology port and guidewire), one related to a wrong implant, one related to a misplaced naso or orogastric tube and five related to wrong site surgery. These resulted in minor (5) harm and no harm (4) to the patients; an apology and explanation was given to all patients as part of Duty of Candour. 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. 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.

17. Complaints

The Trust is committed to ensuring we do not delay in responding to complaints and investigating serious incidents. Following the reduction in formal complaints as a result of Covid-19 in the previous financial year, numbers have returned to normal in 2021/22 and comparable with pre-pandemic years.

The Trust achieved the KPI of >80% complaints responded to within 25 working days in 2021/22 (an improvement on 69% in 2020-21), finishing in March 2022 with 12 complaints overdue, comparable with 11 in March 2021.

18. 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
- ▶ National HSIB reports into patient safety incidents

Learning from the never events to date highlighted the importance of equipment design in making it easy to distinguish between different components at a glance; recognising the impact of the pandemic on delays to routine planned procedures can mean there is a risk that significant anatomical changes may occur that alter the accuracy of the information obtained at the initial consultation, and; the importance of giving consideration to how the standard support mechanisms in place for patient safety are maintained when seeking to prioritise the needs of the individual patient that sit outside of standard arrangements.

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: the importance of valuing differing opinions in multidisciplinary working to keep patients safe, understanding the importance of early identification and management of metastatic spinal cord compression, clarifying the clinical indications to confirm correct nasogastric tube placement, the importance of seeking expert advice on reversing anticoagulant medications, and the importance of prognostic indicators as

early signs of severe illness. Lessons of the week are available on the Trust's intranet site and accessible via the front page.

19. Safety and leadership walkabouts

Safety and leadership walkabouts by the Executive Management Team and Non-Executive Directors were in place prior to the onset of the Covid-19 pandemic. The Safety Walkabouts 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. Following changes to IPC guidance the safety walkabouts are being reinstated.

20. Learning from Deaths

We are committed to continuous learning from deaths and monitor and seek to reduce mortality rates for patients whilst under our care. We have successfully recruited medical examiner officers within the Trust who are working with the Medical Examiner team to care for our bereaved families and carers.

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 Structured Judgement Reviews increase in frequency, they will form a further area to identify opportunities for improvement.

As part of a national initiative, the Trust are recruiting additional Medical Examiners to review community deaths. This will ensure real-time learning from deaths and any issues can be identified and actioned across the divisions in a timely manner. One of our quality priorities

for 2022/23 is to monitor and reduce mortality rates. We will do this by:

- ▶ Relatives to be contacted by medical examiner team and invited to raise concerns
- ▶ Outcomes of mortality reviews will be reported and improvement actions developed
- ▶ Reducing SHMI to remain within the “as expected” range

Recognising End of Life is essential to Learning from Deaths. Our End-Of-Life Care Committee meet frequently to ensure senior, trust-wide leadership is in place. In July 2021 the End of Life care strategy was approved by the Trust Board. This identifies the key areas for development in order to provide high quality end-of-life care. These four areas are:

- ▶ Individualised Patient Care
- ▶ Supporting families and carers
- ▶ Supporting and empowering staff
- ▶ Communication and Information

Together, the Medical Examiner Team and the End-of-Life Care Team will provide essential insights into the care our patients receive and allow continuous learning from deaths.

21. Regulation 28 letters

During the year, the Trust received 1 Regulation 28 letter (a report to prevent future deaths) from the Coroner.

22. Quality impact assessments

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.

23. Clinical Research and Innovation

Clinical research is a driver of quality and effectiveness across the Trust. We prioritise the delivery of national, high-quality studies adopted by the National Institute for Health Research (NIHR), which benefit patients and the NHS.

During 2021-2022 we recruited 2,479 participants into 43 studies (3 commercial) across 11 different clinical specialties, the recruitment for which is shown below. 27 new studies were opened.

The Clinical Research and Innovation strategy is one of the building blocks of our Trust vision of putting patients first. Being delivered in accordance with our 4ward signature behaviours will contribute to our strategic objectives of providing the best services for local people, delivered by the best people.

Our research participants will have the best experience of care, and we will ensure that our research team makes the best use of the resources we are provided with from the NIHR, research funders and charitable funding.

This strategy will raise awareness of and engagement with Research and Innovation at the Board and throughout the Trust and will result in:

- ▶ Increased participation in Clinical Research
- ▶ Increased income and improved efficiency
- ▶ Increased awareness of Clinical Research and Innovation across the Trust
- ▶ Enhanced reputation externally
- ▶ Successful clinical recruitment to hard to recruit to areas

- ▶ Opportunities to create new roles within the Trust's workforce to support delivery of the Clinical Strategy

The strategy was approved by the Trust Board in April 2022 and implementation will be the focus of 2022/23.

24. People and Culture

The People and Culture Strategy (2019 - 22) was structured around three themes – an engaged, skilled and supported workforce. Our key achievements in the last twelve months include:

- a. **Sickness absence** – 0.7% better than acute Trust average. We have performed consistently well with our absence rates during the year
- b. **Nursing vacancies** – reduced by 5.4%
- c. **Job plans** – 15% improvement compared to last year
- d. **Essential to role training** – now at 88% compliance
- e. **Equality and diversity** – we are better than average for colleagues reporting discrimination by colleagues or managers
- f. **Flexible Working** – we are now better than average for colleagues being satisfied with the opportunities for flexible working

Our newly developed People & Culture Strategic Framework (2022 – 2025) sets out how we will support the Trust to achieve its strategic vision and 3 year plans. Our framework is built around the NHS People Promise, our 'Best People' strategic objective, and our People and Culture BAF Risks of Workforce, Culture, Health and Wellbeing, and Leadership.

Our strategic framework has four Strategic Priorities:

1. **Leadership** – An empowered, well led workforce that delivers better outcomes and performance.
2. **Workforce Planning and Transformation** – The right sized, cost effective workforce that is organised for success.
3. **OD and Staff Experience** – A just, learning, and innovative culture where colleagues feel respected, valued, included and well at work.
4. **Future of HR and OD** – A people function that is organised around the optimum employee journey.

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.

25. Mandatory training

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.

26. 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 keep track and monitor 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 4ward behaviours at every opportunity.

27. Staff Survey Results 2021

The results of the latest national NHS Staff Survey were published on 30th March 2022. Our final response rate for the 2021 survey was 43% (2,883 colleagues) compared to 45.8% last year. This compares to the median response rate for Acute Trusts of 46.4%.

We are at national average level for 2 of the survey themes; "We are always learning" and

"We work flexibly". In the other 5 themes we scored 0.1 behind the Acute average.

These latest results, although slightly behind last year, reflect our continued People & Culture work focusing on health and wellbeing, flexible working and inclusive leaders and workplace culture.

Our ambition remains on improving the experience of all our staff to make WAHT an exemplar/ employer of choice.

28. Leadership development

A full programme of leadership and management development is in place. The latest staff survey results evidence the impact these programmes are having within the Trust.

29. Strategic workforce plan

Our strategic workforce plan has been further developed as part of the annual planning round. We are working with the ICS partners to develop a system strategic workforce plan as we recognise that workforce is a key element to the success of our ICS and there are finite staff who work within the Herefordshire and Worcestershire footprint.

30. 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.

31. Safe Staffing

Senior nursing staff review records of staffing levels at every shift and ensure we continue to provide the best care and treatment for

our patients. Following reviews of nurse and midwifery staffing reports to Board, we can confirm that we have an establishment that affirms safe staffing across ward areas.

32. 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. A Freedom to Speak Up Portal has been set up so that staff can access support via one click.

33. 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.

34. 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.

35. Digital

A review of the 2019 Digital Strategy indicated that many of the objectives identified in the strategy have been delivered during 2021/2022.

The capital programme has completed its second year and amongst other key infrastructure upgrade there is a new data network across the Kidderminster and Alexander sites. The Worcester site will be completed during the first quarter of 2022/2023.

The digital care record programme which is an important cornerstone to the digital maturity of the Trust will start in April 2022 following a successful upgrade to the Trust Patient Administration System.

The Trust has secured three years of capital investment following a successful bid to the *NHS Digital Unified Tech Fund Frontline Digitisation* category.

This funding will support the accelerated deployment of the electronic patient record (EPR) across inpatient and outpatient settings and underpin transformational models of care across the ICS.

36. 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. Patient Stories are shared at the Trust Board monthly meetings with space for discussion and exploration of learning from experiences.

Agendas for the Board and its Committees are driven by the BAF and 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. Where necessary, some Committee meetings have been reduced and/or divisional attendance stood down to support the Trust's operational response, but at all times a quorum was maintained.

Minutes and actions of Committee meetings are produced with a summary of the key issues provided to the Trust Board; these templates have been revised in year to provide a clearer view of items of escalation, assurance and are reconciled to the BAF. Committee workplans are under review following the annual review of terms of reference. 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

2021/22 and broadcast live via the Trust's Youtube channel. 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.

In 2021/22 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 inclusion, maternity, finance, digital/cyber, health and wellbeing, risk appetite, three-year plan, quality and 4ward Improvement System.

37. Board Membership and Composition

The voting members of Trust Board during 2021/22 and their attendance are as follows:

Note: In the following tables attendance shown is relative to the number of meetings that could have been attended. Any executive apologies were covered by deputies.

Name	Role	Dates	Attendance
Waqar Azmi	Non-Executive Director		9/11
Paul Brennan	Chief Operating Officer/Deputy CEO		10/11
Anita Day	Non-Executive Director		9/11
Christine Blanshard	Chief Medical Officer	from October 2021	5/6
Mike Hallissey	Chief Medical Officer	until July 2021	4/4
Colin Horwath	Non-Executive Director	from October 2021 previously Associate NED	9/11
Matthew Hopkins	Chief Executive		11/11
Dame Julie Moore	Non-Executive Director		10/11
Paula Gardner	Chief Nursing Officer		10/11
Sir David Nicholson	Chair		11/11
Robert Toole	Chief Finance Officer		9/11
Dr Simon Murphy	Non-Executive Director		10/11
Dr Bill Tunnicliffe	Non-Executive Director	until June 2021	1/3

38. Non-voting members of Trust Board

Name	Role	Dates	Attendance
Richard Haynes	Director of Communications and Engagement		11/11
Colin Horwath	Associate Non-Executive Director	until October 2021	See above
Vikki Lewis	Chief Digital Officer		11/11
Jo Newton	Director of Strategy and Planning		9/11
Richard Oosterom	Associate Non-Executive Director		6/11
Rebecca O'Connor	Company Secretary		11/11
Tina Rickets	Director of People and Culture		11/11
Sue Sinclair	Associate Non-Executive Director	from October 2021	4/5
Sharon Thompson	Associate Non-Executive Director		7/11

39. Board 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. There is an overlap of NEDs across the Board's Committees. 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. These reports highlight the activities of the Committee and draw the Board's attention to areas of escalation.

Terms of Reference for the Committees have been reviewed during the year and approved by the Trust Board.

During 2021/22, the Trust Board had the following Committees:

Committee	Purpose	Chair
Audit and Assurance	Committee critically reviews the governance and assurance processes upon which the Trust Board places reliance, ensuring that the organisation operates effectively and meets its strategic objectives. Committee monitors the effectiveness of internal control systems on behalf of the Board and continues to do so as part of its work programme.	Anita Day
Charitable Funds	Committee manage the Trust's Charitable Funds on behalf of the Trust, as Corporate Trustee.	Colin Horwath
Finance and Performance	To give the Board assurance on management of financial and operational performance of the Trust and to monitor and support the financial planning and budget setting process. The Committee also reviews business cases with a significant financial impact or those referred by the Trust Management Executive and oversees developments in financial systems and reporting.	Richard Oosterom

Committee	Purpose	Chair
People and Culture	<p>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.</p>	Dame Julie Moore
Quality Governance	<p>Committee enables the Board to obtain assurance that the quality of care within the Trust is of the highest possible standard. It ensures there are appropriate clinical governance systems and processes and controls are in place throughout the Trust in order to:</p> <ul style="list-style-type: none"> • 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. 	Dame Julie Moore

Committee	Purpose	Chair
Remuneration	<p>Committee reviews the structure, size and composition of the Board and making recommendations for changes where appropriate. It gives consideration to succession planning for the Chief Executive and Executive Directors.</p> <p>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.</p>	Sir David Nicholson

40. Committee attendance

The attendance for each Board Committee is shown below:

Audit and Assurance Committee

Name	Role	Attendance
Anita Day	Chair	8/8
Simon Murphy	Non-Executive Director	8/8
Colin Horwath	Non-Executive Director	8/8

Charitable Funds Committee

Name	Role	Attendance
Colin Horwath	Chair	6/6
Simon Murphy	Non-Executive Director	6/6
Sharon Thompson	Associate Non-Executive Director	1/6
Richard Haynes	Director of Communications	5/6
Paula Gardner/ Christine Blanshard	Chief Nursing Officer/Chief Medical Officer	3/6
Robert Toole	Chief Finance Officer	4/6

Finance and Performance Committee

Name	Role	Attendance
Richard Oosterom	Chair	11/12
Waqar Azmi	Non-Executive Director	9/12
Colin Horwath	Non-Executive Director	12/12
Tina Ricketts	Director of People and Culture	8/12
Mike Hallissey	Chief Medical Officer until July 2021	4/4
Christine Blanshard	Chief Medical Officer from Sept 2021	3/7
Paula Gardner	Chief Nursing Officer	9/12
Matthew Hopkins	Chief Executive	12/12
Paul Brennan	Chief Operating Officer	12/12
Robert Toole	Chief Finance Officer	10/12
Jo Newton	Director of Strategy and Planning	10/12
Vikki Lewis	Chief Digital Officer	12/12
Simon Murphy	Non-Executive Director	11/12

Quality Governance Committee

The QGC also has regular attendance by a patient forum representative, HealthWatch and the CCGs.

Name	Role	Attendance
Bill Tunnicliffe	Chair until April 2021	0/3
Dame Julie Moore	Chair from May 2021	10/11
Paul Brennan	Chief Operating Officer	3/11
Matthew Hopkins	Chief Executive	9/11
Mike Hallissey	Chief Medical Officer until July 2021	4/4
Christine Blanshard	Chief Medical Officer from Sept 2021	7/7
Paula Gardner	Chief Nursing Officer	7/11
Richard Oosterom	Associate Non-Executive Director	9/11
Sharon Thompson	Associate Non-Executive Director	8/11
Sue Sinclair	Associate Non-Executive Director from Sept 2021	5/5

Remuneration Committee

There is a standing invitation to all Non-Executive Directors to attend Committee meetings in relation to executive appointments.

Name	Role	Attendance
Sir David Nicholson	Chair	6/6
Dr Simon Murphy	Non-Executive Director	5/6
Anita Day	Non-Executive Director	6/6

People and Culture Committee

Name	Role	Attendance
Dame Julie Moore	Chair from July 2021	6/6
Bill Tunnicliffe	Chair until July 2021	0/1
Matthew Hopkins	Chief Executive	4/6
Tina Ricketts	Director of People and Culture	6/6
Richard Haynes	Director of Communications	6/6
Mike Hallissey	Chief Medical Officer until July 2021	0/6
Christine Blanshard	Chief Medical Officer from October 2021	2/3
Paul Gardner	Chief Nursing Officer	6/6
Robert Toole	Chief Finance Officer	4/6
Colin Horwath	Non-Executive Director	5/6
Waqar Azmi	Non-Executive Director	4/6
Sue Sinclair	Associate Non-Executive Director from September 2021	3/3

41. 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>

42. Provider licence conditions

The Trust considered its compliance with conditions FT4 and G6 of the provider licence (as at 31 March 2022) at the Board meeting in May 2022. These are set out below. This will be published on the website by 31 May 2022 as required by NHS Improvement.

Condition FT4

	Corporate Governance Statement	2021/22
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: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed
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;	Not 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);	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		2021/22
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.

43. System Oversight Framework

The NHS System Oversight Framework was introduced in 2021/22, replacing the NHS Oversight Framework for 2019/20. The NHS System Oversight Framework (SOF) applies to all

Integrated Care Systems, Clinical Commissioning Groups (CCGs) and NHS trusts. It reflects an approach to oversight that reinforces system-led delivery of integrated care, in line with the vision set out in the NHS Long Term Plan and the priorities set out in the 2021/22 Operational Planning Guidance.

A series of oversight metrics are aligned to the five national themes of the System Oversight Framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability. The Herefordshire and Worcestershire ICS have a System Oversight Framework in place which is monitored through ICS governance structures. The Trust has been assessed at SOF segment 3.

44. Climate Change

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme.

During 2021/22 the board reviewed and approved a refreshed Green Development Plan covering ten themes, to address the first preparatory phase from 2022-25. Building from good foundations, the plan will further develop and expand delivery of our sustainability agenda in April 2022. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

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 changed in 2020/21 and no longer generates a binary conclusion.

The Trust's Annual Plan for 2021/22, was developed under the revised Covid-19 financial regime, which consisted of 2 separate planning periods of six months each; H1 (April 2021 to September 2021) and H2 (October to March 2022). Differing funding allocations were split across these two periods which effectively continued to provide additional funding to support responding to the pandemic though not matching total costs as there was an expectation that the Covid-19 impact would reduce and additional elective activity would increase. This resulted in a combined position of a break-even

plan. Note however that the Trust received, in line with other Trusts, non-recurrent support from regional funds to support increased elective activity. It also received Herefordshire and Worcestershire Integrated Care System (H&W ICS) funds which gave an expected out-turn of a £(1.9)m deficit for the Trust.

As at 31 March 2022 the Trust's adjusted financial performance surplus including Top-Up funding but excluding impairments and the impact of donated assets was £(1.356)m. This represents a positive performance against the £(1.9)m revised plan deficit agreed by the Trust Board and recognised by H&W ICS in 2020/21 under the Covid-19 financial architecture though nominally adverse to the H1+H2 Break-even Plan.

A number of productivity and efficiency schemes were delivered in year, totalling c.£5.4m in line with the original plan, c.£5.2m 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 2021/22 due to Covid-19 response*)
- ▶ Regular Budget Holder meetings
- ▶ Regular ICS Finance Forum where review of the financial performance and forecast performance of the system is overseen

No interim revenue borrowing was requested or received during 2021/22 as a result of the positive in-year cash position.

The Trust received £36.6m 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. This amounts to the total new borrowings in 2021/22.

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 2022, the Trust received the supplier's Finance and Accounting (F&A) and Employment Services ISAE3402 reports. These covered Finance and Accounting and associated general IT controls, and Employment Services controls for the period 1 April 2021 to 31 March 2022. The overall opinion of PWC was qualified.

For Employment Services the PWC audit identified exceptions in 10 out of 14 control objectives but an unqualified opinion was still able to be 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. The Trust continues to work with

NHS SBS to support the changes made with regards to controls and processes to ensure risks are managed appropriately.

In the case of Finance and Accounting services the audit identified an exception in one out of 27 control objectives and issued a qualified overall opinion as a result. The exception that resulted in the qualification was that PWC were unable to satisfy themselves on the test that "controls exist to provide reasonable assurance that equipment and facilities are protected from damage by fire, flood and other similar environmental hazards and that physical security is adequate".

Management have established that the reason for the failure was that for one instance of scheduled generator testing the equipment did not operate effectively. Further assurance was sought and this confirmed that quarterly testing schedules are in place alongside with regular data back-ups to safeguard client data at all times. In light of these mitigations management consider that the failure constitutes a very low risk to client data and that there is no direct control risk for the Trust.

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 2022/23 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 System 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 continued to be strengthened during 2021/22 with specific focus on benefits realisation, including system benefit. Procedures are in place to ensure all strategic decisions are considered at Executive and Board level.

46. Auditors

External Audit

The External Auditors 2020/21 Value for Money (VfM) assessment of the Trust's efficiency and effectiveness of its use of resources in delivering clinical services resulted in a number of recommendations relating to Financial Sustainability which the Trust has sought to address in 2021/22, as well as to minimise any further recommendations arising with the 2021/22 VfM Audit. The assessment is rigorous especially due to the Trust's underlying financial deficit and performance management metrics.

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. 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 2021/22 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 2021/22 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.

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

Full

- ▶ BAF

Significant

- ▶ Combined Financial Systems and Payroll
- ▶ Financial Governance*
- ▶ Data Quality – Cancer Waits
- ▶ Facilities Timesheets – Follow Up*
- ▶ Workforce *

Moderate

- ▶ PFI – additional hrs/staff costs testing*

Limited

- ▶ Leavers*

47. Compliance with key national targets and standards

The Trust is committed to delivering all national and contractual targets and standards.

At 31 March 2022, 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 and MSSA

48. 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.

As of April 2021, the Government Functional Standard 013: Counter Fraud replaced the previous NHS specific Standards for Fraud, Bribery and Corruption. Together with stakeholders across the UK, the NHSCFA have developed new NHS Requirements to meet the Functional Standard.

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, the Trust's Local Counter Fraud Specialist (LCFS) takes a multi-faceted approach that is both proactive and reactive. The Trust and LCFS will adopt the new components of the Functional Standard and will continue to follow

the four key principles which are recognised 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. All allegations of fraud, bribery and corruption will be investigated professionally and in line with relevant legislation, as per the counter fraud

functional standard (GovS013). 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.

49. 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 PII in a confidential and secure manner through completion of the national Data Security Awareness training. As at 31 March 2021, 92% of staff had completed their annual training and work continues to improve the compliance which includes an escalation process, in order to meet the nationally required target of 95%. Regular guidance is provided and communicated to staff to support the secure handling of PII.

The Board has completed Cyber Security Awareness training in 2021 and staff in specific roles will be completing Cyber Awareness training during 2022. Information Risk 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 (SIAO). The Trust has worked with cyber specialists from NHS Digital who have provided the Trust with recommendations to further enhance its security posture along with the implementation of Cyber Essential requirements. The Governance structure around IG and cyber security has been strengthened and formalised through delegating system level information risk ownership to relevant Senior Information Asset Owners (SIAOs) across the Trust. SIAOs have all signed a letter of delegation, completed their training and will be appointing Information Asset Owners at departmental and system level to further strengthen this important structure. SIAOs are aware of the IG and cyber agenda through attendance 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 Trusts overarching Information Governance Policy. IGSG has three subcommittees; an Information and Technology Security Forum (ITSF) focusing on cyber security risks and compliance with the ICT elements DSPT; the Data Quality Steering Group (DQSG) which 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).

The Trust measures its compliance with the mandated nationally defined standards contained within the Data Security and Protection Toolkit (DSPT). The Trust status is

'Standards Met' and this will remain until the final submission on the 30th June 2022. Work is being completed to provide the required evidence of compliance in order to achieve 'Standards Met' for the 2022/2023 toolkit submission.

It is now business as usual for all new systems and processes have a Data Protection Impact Assessment (DPIA) completed to ensure any information risks are assessed and where possible mitigated. In order to reduce the risk of data breaches a data mapping exercise is taking place to map all flows of Personal Identifiable Information (PII). This information will support the publication of a Register of Processing Activities (ROPA) which along with the Privacy Notice will inform the public who we share information with and how their data is handled.

The Trust has reported two incidents to the Information Commissioners Office (ICO) during the last calendar year; in September 2021, maternity incident reports were included in the published Trust Board papers and contained potentially identifiable information (patients). In October 2021 an incident was reported around a potential breach of confidentiality of downloaded data and inappropriate access to patient records. 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. Following repeat incidents, or those of a serious nature, reports and guidance are provided to reduce the risk of further incidents and ensure lessons are learned.

50. Data Quality

We support a culture of valuing high quality data and strive to ensure all data is accurate, valid, reliable, timely, relevant and complete. Identified risks and relevant mitigation measures are included in the risk register.

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 pandemic which commenced in March 2020, much of resource availability for data quality management was re-focused to manage Covid-19 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.

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 the 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.

51. Digital Update

The Data Quality team are expecting to contribute significantly to the development of the new Sunrise Electronic Patient Record (EPR) 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 the Data Integrity project. A portal is under construction to help identify areas of concern and will allow investigation and transparency ready for the EPR 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.

52. Embedding Best Practice

A Data Quality Steering Group meets bimonthly to review new data quality issues that have arisen, to discuss their impact, identify mitigation and actions. This group has overseen the completion of several projects such as a full review of Safety Alerts, the mandatory Opt Out process for patients not wishing to partake in research and development activities, the resolution of patient records when issues occur such as activity being captured against the incorrect patient and ensuring that sensitive characteristics have a high degree of completion so that health inequalities analysis can take place.

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 continued to engage junior medics in why good data quality is as important as the 'hands on' care provided.

53. 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.

54. Data Quality Steering Group (DQSG)

The Data Quality Steering Group is clinically led, and considers strategic and operational data quality issues for the Trust. It reports into the Information Governance Steering Group (IGSG) and then into Trust Management Executive (TME).

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.

55. 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.

Internal Audit have provided me with assurances on internal controls, risk management and governance systems to the Audit and Assurance Committee and to the Board. Where scope for improvement 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 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 has been comprehensively reviewed during 2021/22 to ensure 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 the Trust is clinically led with robust governance and accountability processes.

56. Conclusion

I consider that the Trust has had six significant issues during the year 2021/22 as detailed below. Covid is not reported individually having impacted on all areas of the Trust throughout the year as described below:

Issue 1 - CQC/Regulatory

The Trust remains registered with the Care Quality Commission (CQC) and the Trust has maintained its overall quality rating of Requires Improvement. We are in Segment 3 of single oversight framework (SOF).

The Trust has not received any formal CQC inspections during 2021/22, we have remained proactively engaged with the CQC, undertaking monitoring calls under the CQC's Transitional Monitoring Approach, and facilitating on-site and virtual engagement events.

The Trust expects a review of its legal undertakings in 2022/23.

Issue 2 – Urgent care

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 2021/22 and broadened the Home First Worcestershire (HFW) programme to focus on safety within the Trust and enhance the efficiency and performance of the urgent and emergency care pathways across the whole system.

The programme now oversees four work streams as follows:

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 the Trust Board.

Issue 3 - Restoration and Recovery/delivery of national standards

The Trust faced significant challenges in delivering key national standards whilst managing the Covid-19 pandemic during the third wave (June 2021 to date). These included the 4-hour Emergency Access Target, 18 weeks referral to treatment – incomplete pathways, cancer waiting time standards and diagnostic waiting times.

However, during 2021/22 improvements were made with the number of patients waiting over 52 weeks for their first definitive treatment reducing from 6,515 in March 2021 to 5,849 in March 2022. Patients waiting over 104 weeks reduced to 344 with 277 of these patients waiting for orthodontic treatment.

The number of patients waiting over 6 weeks for a diagnostic intervention reduced from a peak of 14,181 in August 2021 to 10,039 by March 2022. In addition, during 2021/22 we exceeded our elective activity targets seeing 159,320 new outpatients against a plan of 154,014 and undertaking 84,036 elective procedures against a plan of 83,696. The number of patients waiting beyond 62 day cancer standard increased during the year from 305 in March 2021 to 449 by March 2022.

Issue 4 - Finance

The Trust delivered a £(1.356)m adjusted financial position in 2021/22, adverse to the planned breakeven position. The performance includes the benefit of non-recurrent income received through the Covid-19 2021/22 financial regime. Differing funding allocations were split across periods H1 (April to September) and H2 (October to March). This effectively continued to provide additional funding to support responding to the pandemic though not matching total costs. As such the Trust received, in line with other Trusts, non-recurrent support from regional funds to support increased elective activity. It also received Herefordshire and Worcestershire Integrated System Funds which gave an expected out-turn of a £(1.9)m deficit for the Trust.

The Trust's underlying financial position remains a material deficit, requiring ongoing action and focus on financial sustainability to mitigate this issue. 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 5 - Workforce

Colleague health and wellbeing has been a significant issue for the Trust during 2021/22. The Trust experienced increases in staff absence linked to Covid due to ill health, self isolation and social distancing. Absence levels varied across the year linked to Covid waves and we have seen evidence of workforce fatigue including higher short-term absence, fewer staff wishing to undertake additional shifts and regular feedback from staff on the relentless nature of the Covid pandemic and requirement to reset and recover services. There was also an increase in mental health related sickness absence. A comprehensive wellbeing package is in place for staff and a manager's toolkit has been developed which sets out all of the wellbeing interventions we have in place. Regular communications are issued to staff to remind them of the support available. We have seen challenges in our workforce supply, with an increase in turnover, fewer applicants applying for vacancies and an increase in the number of shifts being unfilled through bank and agency. Additional staff were required to support our Covid-19 operating models, for example increase in adult critical care beds, and the Covid vaccine programmes in an already challenged market place.

Issue 6 - Digital

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 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.

2021/22 has been the second year of delivery of the infrastructure improvements which have been accelerated in part to support the Trust's response to Covid-19 and other aspects have been reprioritised.



Matthew Hopkins

Chief Executive

Date: 4 July 2022

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: 4 July 2022

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.

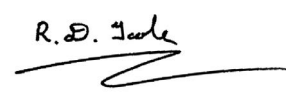
The Directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the Board.



Matthew Hopkins
Chief Executive

Date: 4 July 2022



Robert Toole
Chief Finance Officer

Date: 4 July 2022

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 2021/22 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;
 - ▶ the template accounting policies for NHS Trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.
2. I certify that the TAC schedules are internally consistent and that there is one validation error which has 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 Toole
Chief Finance Officer
Date: 4 July 2022

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: 4 July 2022

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 2022, 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 2021 to 2022.

In our opinion, except for the possible effects on the corresponding figures 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 2022 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 2021 to 2022; 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 £8.9 million. Consequently, we were unable to determine whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021. Our audit opinion on the financial statements for the year ended 31 March 2021 was modified accordingly. Our opinion on the current year's financial statements is also modified because of the possible effect of this matter on the comparability of the current year's figures and the corresponding figures.

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 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 2021 to 2022 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 this 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 £8.9 million held as at 31 March 2020, and whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021. 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 England 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 2021 to 2022; 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 10 June 2022 we referred a matter to the Secretary of State under Section 30 (b) of the Local Audit and Accountability Act 2014 in relation to the Trust's ongoing breach of its break-even duty for the three-year period ending 31 March 2022.

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 2021 to 2022).
- 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, 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 and expenditure recognition.. We determined that the principal risks were in relation to:
 - Large and unusual manual journals and those manual journals with a direct impact on the financial performance of the Trust; and
 - Potential management bias in determining accounting estimates, especially in relation to the calculation of the valuation of the Trust's land and buildings accruals and capital payables.
- 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. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as 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 breakeven duty for the three-year period ending 31 March 2022 as set out in the National Health Service Act 2006, the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to land and buildings, provisions, accruals, depreciation and financial instruments.
- Our 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 England's rules and related guidance; and
 - 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 2022.

We have nothing to report in respect of the above matter except on 30 June 2022 we identified a significant weakness in the Trust’s arrangements for financial sustainability. This was in relation to the Trust reporting a cumulative deficit of £343.6 million in its financial statements at 31 March 2022 and budgeting for a £21 million deficit in 2022/23. We recommended that the Trust work with its partners in the Integrated Care System to develop a robust medium term financial plan that enables it to deliver a recurring breakeven position.

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.

Our work on the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete so we are unable to conclude whether the significant weaknesses reported on 17 September 2021 have been addressed. 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 further significant weaknesses in the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources, they will be reported by exception in a further auditor’s report. 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 2022.

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 December 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 2022 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

8 July 2022

Details of Worcestershire Acute Hospitals NHS Trust's Annual General Meeting will be published on the Trust website once they are confirmed.

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

Worcestershire Acute Hospitals NHS Trust

Annual accounts for the year ended 31 March 2022

Statement of Comprehensive Income

		2021/22	2020/21
	Note	£000	£000
Operating income from patient care activities	3	565,160	488,127
Other operating income	4	31,231	70,876
Operating expenses	6,8	(577,210)	(540,126)
Operating surplus/(deficit) from continuing operations		19,181	18,877
Finance income	11	24	7
Finance expenses	12	(13,027)	(11,854)
PDC dividends payable		(7,455)	(5,728)
Net finance costs		(20,458)	(17,575)
Other gains / (losses)	13	(439)	29
Surplus / (deficit) for the year		(1,716)	1,331
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	10,854	(2,094)
Revaluations	17	8,318	5,332
Total comprehensive income / (expense) for the period		17,456	4,569
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(1,716)	1,331
Remove net impairments not scoring to the Departmental expenditure limit		238	6,553
Remove I&E impact of capital grants and donations		(151)	(847)
Remove net impact of inventories received from DHSC group bodies for COVID response		273	(385)
Adjusted financial performance surplus / (deficit)		(1,356)	6,652

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	14	6,804	4,287
Property, plant and equipment	15	349,769	294,208
Receivables	19	2,307	1,559
Total non-current assets		358,880	300,054
Current assets			
Inventories	18	10,113	8,428
Receivables	19	17,870	21,490
Non-current assets for sale and assets in disposal groups	20	-	400
Cash and cash equivalents	21	59,181	41,527
Total current assets		87,164	71,845
Current liabilities			
Trade and other payables	22	(81,131)	(60,455)
Borrowings	24	(4,880)	(4,101)
Provisions	25	(5,145)	(5,313)
Other liabilities	23	(4,338)	(431)
Total current liabilities		(95,494)	(70,300)
Total assets less current liabilities		350,550	301,599
Non-current liabilities			
Borrowings	24	(61,480)	(66,345)
Provisions	25	(3,047)	(2,927)
Other liabilities	23	(3,866)	(4,249)
Total non-current liabilities		(68,393)	(73,521)
Total assets employed		282,157	228,078
Financed by			
Public dividend capital		585,410	548,787
Revaluation reserve		103,886	86,722
Other reserves		(861)	(861)
Income and expenditure reserve		(406,278)	(406,570)
Total taxpayers' equity		282,157	228,078

The notes on pages 3 to 59 form part of these accounts.



Name	Matthew Hopkins
Position	Chief Executive
Date	4th July 2022

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	548,787	86,722	(861)	(406,570)	228,078
Surplus/(deficit) for the year	-	-	-	(1,716)	(1,716)
Other transfers between reserves	-	(1,970)	-	1,970	-
Impairments	-	10,854	-	-	10,854
Revaluations	-	8,318	-	-	8,318
Transfer to retained earnings on disposal of assets	-	(38)	-	38	-
Public dividend capital received	36,623	-	-	-	36,623
Taxpayers' and others' equity at 31 March 2022	585,410	103,886	(861)	(406,278)	282,157

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

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

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 the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows		2021/22	2020/21
	Note	£000	£000
Cash flows from operating activities			
Operating surplus / (deficit)		19,181	18,877
Non-cash income and expense:			
Depreciation and amortisation	6.1	12,937	11,068
Net impairments	7	238	6,553
Income recognised in respect of capital donations	4	(318)	(968)
Amortisation of PFI deferred credit		(463)	(507)
(Increase) / decrease in receivables and other assets		3,177	4,346
(Increase) / decrease in inventories		(1,685)	486
Increase / (decrease) in payables and other liabilities		15,271	16,285
Increase / (decrease) in provisions		(8)	3,315
Net cash flows from / (used in) operating activities		48,330	59,455
Cash flows from investing activities			
Interest received		24	7
Purchase of intangible assets		(1,996)	(1,719)
Purchase of PPE and investment property		(41,561)	(24,250)
Sales of PPE and investment property		303	63
Net cash flows from / (used in) investing activities		(43,230)	(25,899)
Cash flows from financing activities			
Public dividend capital received		36,623	352,903
Movement on loans from DHSC		(1,446)	(325,823)
Capital element of PFI, LIFT and other service concession payments		(2,638)	(2,011)
Interest on loans		(328)	(1,784)
Interest paid on PFI, LIFT and other service concession obligations		(12,740)	(11,535)
PDC dividend (paid) / refunded		(6,917)	(5,796)
Net cash flows from / (used in) financing activities		12,554	5,954
Increase / (decrease) in cash and cash equivalents		17,654	39,510
Cash and cash equivalents at 1 April - brought forward		41,527	2,017
Cash and cash equivalents at 31 March	21	59,181	41,527

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 2021/22 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.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

In March 2022 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.

In light of the COVID-19 response, the planning cycle has been revised and the interim funding regime first implemented in 2020/21 largely rolled forward into 2021/22. The Trust, with system partners is finalising its operational and financial plan for the year ending 31 March 2023, 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 2022/23 is ongoing, based on funding allocations in place post covid 19 and continued focus on restoration of services. The assessment of the board is that DHSC temporary revenue support arrangements will continue as and when required, 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 of National Statistics (ONS).

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

Education and Training Income

Education and Training income (note 4) relates to the NHS Education Contract of £12.97m. The Trust contracts with the NHS Education 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.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and 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 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

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.

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 assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

The Trust 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, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (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 modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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

Properties in the course of construction for service or administration purposes are carried at cost. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued, adjusted for impairments and depreciation when the assets are complete and 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' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in 'off-Statement of Financial Position' PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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 which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

In 2021/22 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 liability 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 Years	Max life Years
Buildings, excluding dwellings	2	80
Dwellings	48	55
Plant & machinery	-	50
Transport equipment	4	8
Information technology	5	9
Furniture & fittings	7	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, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life 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 £10.1m 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 continue to use the digital app introduced last year to aid data collection. In 2019/20, the impact of the pandemic meant that the Trust and the auditors experienced constraints in accessing stock information and the auditor 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 2022.

In 2020/21 and 2021/22, 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 classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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 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 from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	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 from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

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 27 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.

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 sterling.

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

Note 1.23 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, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

In 2021/22 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 (Note 30).

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 2021/22.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted**IFRS 16 Leases**

IFRS 16 Leases will replace *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

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

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and 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. For 2022, this rate is 0.95%. 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 Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	26,966
Additional lease obligations recognised for existing operating leases	(26,966)
Net impact on net assets on 1 April 2022	-
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(3,788)
Additional finance costs on lease liabilities	(316)
Lease rentals no longer charged to operating expenditure	4,055
Estimated impact on surplus / deficit in 2022/23	(49)
Estimated increase in capital additions for new leases commencing in 2022/23	10,786

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 liability will be remeasured when a change in the index causes a change in future repayments 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. The effect of this has not yet been quantified. Under current accounting guidance this would cause a corresponding charge to expenditure. HM Treasury and DHSC are considering whether this should instead be recognised on transition to IFRS 16 and guidance on this is awaited.

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 2021/22 after having a full revaluation in 2018/19. However, an interim valuation was undertaken to ensure all build rates have been renewed to the current date. Build rates have risen quite considerably since the last full valuation particularly for clinical uses such as wards, theatres, pharmacy and x-ray.

- The valuation exercise was carried out between December 2021 and March 2022 with a valuation date of 31 March 2022. 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. Market participants continue to be affected by details of construction, health and safety, and particularly fire protection, mitigation and means of escape from buildings where people sleep. The Government's proposed legislation is far reaching and will provide a new regime for building regulations compliance. In the light of these circumstances, this valuation has been undertaken in the context of a changing regulatory environment and we would therefore recommend that it is kept under regular review. 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 the importance of the valuation date in recognition of the potential for market conditions to move rapidly in response to changes in the control or future spread of COVID-19.

97.2% 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 2022. Whilst these published build costs remain 'provisional' and therefore subject to fluctuation, it is not anticipated that there would be a significant change.

The DRC approach assumes that the current cost of replacing an asset with its modern equivalent less deductions for physical deterioration and all relevant forms of obsolescence and optimisation, and not a building of identical design, with the same service potential as the existing asset. The modern equivalent may well be smaller than the existing asset, for example due to technological advances in plant and machinery.

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 £470.5 million (£394.9 million in 2020/21) was received and NHS England from which £89.4 million (£128.9 million in 2020/21) was received. Including reimbursement and top-up funding.

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)	2021/22	2020/21
	£000	£000
Block contract / system envelope income	497,880	431,823
High cost drugs income from commissioners (excluding pass-through costs)	46,218	39,450
Other NHS clinical income	2,907	4,489
All services		
Private patient income	173	272
Elective recovery fund	3,043	-
Additional pension contribution central funding*	12,873	12,093
Other clinical income	2,066	-
Total income from activities	565,160	488,127

*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)	2021/22	2020/21
Income from patient care activities received from:	£000	£000
NHS England	89,465	88,493
Clinical commissioning groups	470,549	394,873
Other NHS providers	2,907	2,592
NHS other	-	204
Non-NHS: private patients	167	224
Non-NHS: overseas patients (chargeable to patient)	6	48
Injury cost recovery scheme	1,271	972
Non NHS: other	795	721
Total income from activities	565,160	488,127
Of which:		
Related to continuing operations	565,160	488,127

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)		
	2021/22	2020/21
	£000	£000
Income recognised this year	6	48
Cash payments received in-year	28	53
Amounts written off in-year	10	28

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	900	-	900	914	-	914
Education and training	13,422	-	13,422	12,990	-	12,990
Non-patient care services to other bodies	5,275	-	5,275	7,413	-	7,413
Reimbursement and top up funding	5,140	-	5,140	40,411	-	40,411
Receipt of capital grants and donations	-	318	318	-	968	968
Charitable and other contributions to expenditure	-	1,626	1,626	-	7,195	7,195
Rental revenue from operating leases	-	119	119	-	117	117
Amortisation of PFI deferred income / credits	-	463	463	-	507	507
Other income	3,968	-	3,968	361	-	361
Total other operating income	28,705	2,526	31,231	62,089	8,787	70,876

Of which:

Related to continuing operations			31,231			70,876
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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 NHS Education £13.4m (Note 1.3)

Receipts of capital grants and donations includes £218k relating to the donated property, plant and equipment assets from DHSC as part of the coronavirus pandemic response (Note 16).

Note 5.1 Transaction price allocated to remaining performance obligations

	31 March 2022 £000	31 March 2021 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year		
after one year, not later than five years		
after five years		
Total revenue allocated to remaining performance obligations	<u><u>-</u></u>	<u><u>-</u></u>

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 5.2 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.

	2021/22 £000	2020/21 £000
Income	-	74
Full cost	<u>(1,750)</u>	<u>(2,492)</u>
Surplus / (deficit)	<u><u>(1,750)</u></u>	<u><u>(2,418)</u></u>

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

Income has reduced in 2021/22 due to the COVID-19 pandemic and free parking continued into 2021/22 for all staff, patients and visitors.

Note 6.1 Operating expenses		
	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,104	5,131
Purchase of healthcare from non-NHS and non-DHSC bodies	4,825	3,635
Staff and executive directors costs	357,518	335,891
Remuneration of non-executive directors	164	134
Supplies and services - clinical (excluding drugs costs)	54,414	44,252
Supplies and services - general	24,498	21,773
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	53,194	47,655
Inventories written down	243	323
Consultancy costs	215	318
Establishment	3,430	2,811
Premises	15,396	14,898
Transport (including patient travel)	1,596	1,095
Depreciation on property, plant and equipment	11,913	10,533
Amortisation on intangible assets	1,024	535
Net impairments	238	6,553
Movement in credit loss allowance: contract receivables / contract assets	(181)	1,347
Change in provisions discount rate(s)	103	368
Fees payable to the external auditor		
audit services- statutory audit	126	83
Internal audit costs	90	77
Clinical negligence	16,837	14,807
Legal fees	692	364
Insurance	285	300
Education and training	780	531
Rentals under operating leases	4,680	3,569
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	19,764	20,752
Other	262	2,391
Total	577,210	540,126
Of which:		
Related to continuing operations	577,210	540,126

Note 6.2 Other auditor remuneration	2021/22	2020/21
	£000	£000

Other auditor remuneration paid to the external auditor:

There has been no other remuneration paid to the external auditor in either 2021/22 or 2020/21.

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2020/21: £1 million).

Note 7 Impairment of assets	2021/22	2020/21
	£000	£000

Net impairments charged to operating surplus / deficit resulting from:

Changes in market price	238	6,553
Total net impairments charged to operating surplus / deficit	238	6,553
Impairments charged to the revaluation reserve	(10,854)	2,094
Total net impairments	(10,616)	8,647

The Trust engaged a professional property adviser to undertake a desktop revaluation in 2021/22 after having a full revaluation in 2018/19. However, an interim valuation was undertaken to ensure all build rates have been renewed to the current date. Build rates have risen quite considerably since the last full valuation particularly for clinical uses such as wards, theatres, pharmacy and x-ray. 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 8.1 Employee benefits		
	2021/22	2020/21
	Total	Total
	£000	£000
Salaries and wages	237,285	228,590
Social security costs	25,653	23,583
Apprenticeship levy	1,217	1,135
Employer's contributions to NHS pensions	42,309	39,729
Pension cost - other	56	56
Temporary staff (including agency)	51,302	43,097
Total gross staff costs	357,822	336,190
Of which		
Costs capitalised as part of assets	304	299

Note 8.2 Average number of employees (WTE basis)				
	Permanent	Other	2021/22	2020/21
	Number	Number	Total	Total
			Number	Number
Medical and dental	690	67	757	681
Ambulance staff	2	-	2	2
Administration and estates	1,097	2	1,099	1,079
Healthcare assistants and other support staff	1,352	6	1,358	1,293
Nursing, midwifery and health visiting staff	1,936	129	2,065	1,827
Nursing, midwifery and health visiting learners	-	-	-	3
Scientific, therapeutic and technical staff	589	20	609	595
Healthcare science staff	165	7	172	249
Social care staff	-	-	-	2
Total average numbers	5,831	232	6,063	5,731

Note 8.3 Reporting of compensation schemes - exit packages 2021/22		
	Number of	Total number
	other Agreed	of Exit
	Departures	Packages
Exit package cost band (including any special payment element)		
<£10,000	1	1
£10,000 - £25,000	2	2
Total number of exit packages by type	3	3
Total cost (£)	£33,000	£33,000

Note 8.4 Exit packages: other (non-compulsory) departure payments				
	2021/22		2020/21	
	Payments	Total	Payments	Total
	agreed	value of	agreed	value of
		agreements		agreements
	Number	£000	Number	£000
Contractual payments in lieu of notice	2	22	-	-
Exit payments following Employment Tribunals or court orders	1	11	1	34
Total	3	33	1	34

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially 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.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at <https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports>.

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.

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	119	117
Total	119	117

	31 March 2022 £000	31 March 2021 £000
Future minimum lease receipts due:		
- not later than one year;	119	117
Total	119	117

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.

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	4,680	3,569
Total	4,680	3,569

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	2,109	2,169
- later than one year and not later than five years;	5,066	5,302
- later than five years.	21,956	19,824
Total	29,131	27,295
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	24	7
Total finance income	24	7

Note 12.1 Finance expenditure

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

	2021/22	2020/21
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	327	348
Main finance costs on PFI and LIFT schemes obligations	5,185	5,399
Contingent finance costs on PFI and LIFT scheme obligations	7,555	6,135
Total interest expense	13,067	11,882
Unwinding of discount on provisions	(40)	(28)
Total finance costs	13,027	11,854

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

2021/22	2020/21
£000	£000

The Trust has not incurred any late payment interest charges in 2020/21 nor 2021/22

Note 13 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	273	63
Losses on disposal of assets	(712)	(34)
Total gains / (losses) on disposal of assets	(439)	29
Total other gains / (losses)	(439)	29

Note 14.1 Intangible assets - 2021/22

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2021 - brought forward	10,211	3,575	693	14,479
Additions	1,412	-	2,158	3,570
Reclassifications	609	969	(1,578)	-
Disposals / derecognition	(4,788)	(855)	-	(5,643)
Valuation / gross cost at 31 March 2022	7,444	3,689	1,273	12,406
Amortisation at 1 April 2021 - brought forward	7,756	2,436	-	10,192
Provided during the year	761	263	-	1,024
Disposals / derecognition	(4,775)	(839)	-	(5,614)
Amortisation at 31 March 2022	3,742	1,860	-	5,602
Net book value at 31 March 2022	3,702	1,829	1,273	6,804
Net book value at 1 April 2021	2,455	1,139	693	4,287

Note 14.2 Intangible assets - 2020/21

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2020 - as previously stated	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 - as previously stated	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 15.1 Property, plant and equipment - 2021/22

	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 2021 - brought forward	39,716	222,148	827	8,134	54,981	302	15,917	137	342,162
Additions	-	3,412	-	39,405	5,996	-	182	-	48,995
Impairments	-	(274)	(33)	(4,716)	-	-	-	-	(5,023)
Reversals of impairments	99	15,540	-	-	-	-	-	-	15,639
Revaluations	1,780	38	(29)	-	-	-	-	-	1,789
Reclassifications	-	2,661	-	(3,547)	(646)	-	1,532	-	-
Transfers to / from assets held for sale	-	-	400	-	-	-	-	-	400
Disposals / derecognition	(30)	-	-	-	(10,215)	(38)	(2,008)	(92)	(12,383)
Valuation/gross cost at 31 March 2022	41,565	243,525	1,165	39,276	50,116	264	15,623	45	391,579
Accumulated depreciation at 1 April 2021 - brought forward	-	753	-	-	37,247	302	9,522	130	47,954
Provided during the year	-	6,674	29	-	2,981	-	2,227	2	11,913
Revaluations	-	(6,500)	(29)	-	-	-	-	-	(6,529)
Reclassifications	-	-	-	-	(640)	-	640	-	-
Disposals / derecognition	-	-	-	-	(9,463)	(38)	(1,935)	(92)	(11,528)
Accumulated depreciation at 31 March 2022	-	927	-	-	30,125	264	10,454	40	41,810
Net book value at 31 March 2022	41,565	242,598	1,165	39,276	19,991	-	5,169	5	349,769
Net book value at 1 April 2021	39,716	221,395	827	8,134	17,734	-	6,395	7	294,208

Note 15.2 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 - as previously stated	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 - as previously stated	-	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 15.3 Property, plant and equipment financing - 2021/22

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2022								
Owned - purchased	41,565	148,490	1,165	39,276	13,167	5,169	5	248,837
On-SoFP PFI contracts and other service concession arrangements	-	93,867	-	-	5,803	-	-	99,670
Owned - donated/granted	-	241	-	-	1,021	-	-	1,262
NBV total at 31 March 2022	41,565	242,598	1,165	39,276	19,991	5,169	5	349,769

Note 15.4 Property, plant and equipment financing - 2020/21

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £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 16 Donations of property, plant and equipment

The Trust has received £218k of donated property, plant and equipment assets from DHSC as part of the coronavirus pandemic response in 2021/22 non cash. The Trust also received a cash donation of £100k for the purchase of capital assets.

Where the funder provides cash, rather than physical assets, any difference between the cash provided and the fair value of the assets acquired are disclosed (Note 4).

Note 17 Revaluations of property, plant and equipment

The Trust engaged a professional property adviser Cushman and Wakefield (RCIS Registered Valuers) to undertake a desktop revaluation in 2021/22 after having a full revaluation in 2018/19. However, an interim valuation was undertaken to ensure all build rates have been renewed to the current date. Build rates have risen quite considerably since the last full valuation particularly for clinical uses such as wards, theatres, pharmacy and x-ray.

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 2022 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 2022 £000	31 March 2021 £000
Drugs	4,021	3,474
Work In progress	88	103
Consumables	5,974	4,829
Energy	30	22
Total inventories	<u>10,113</u>	<u>8,428</u>
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £56,887k (2020/21: £53,009k). Write-down of inventories recognised as expenses for the year were £243k (2020/21: £323k).

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 expects to modernise practices from 2022/23 via the new inventory system to 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 (£0.74m) 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 (PPE) and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,434k of items purchased by DHSC (2020/21: £6,839k).

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 2022 £000	31 March 2021 £000
Current		
Contract receivables	5,460	8,165
Allowance for impaired contract receivables / assets	(1,009)	(1,551)
Deposits and advances	61	714
Prepayments (non-PFI)	3,287	3,785
PFI lifecycle prepayments	6,343	6,070
PDC dividend receivable	-	68
VAT receivable	3,299	3,858
Other receivables	429	381
Total current receivables	<u>17,870</u>	<u>21,490</u>
Non-current		
Contract receivables	1,923	1,559
Other receivables	384	-
Total non-current receivables	<u>2,307</u>	<u>1,559</u>
Of which receivable from NHS and DHSC group bodies:		
Current	3,984	6,241
Non-current	384	35

Non-Current Contract Receivables relates to the NHS Injury Cost Recovery Scheme, whereby the Trust accounts for expected income.

Note 19.2 Allowances for credit losses		
	2021/22	2020/21
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	1,551	1,972
New allowances arising	117	1,347
Reversals of allowances	(298)	-
Utilisation of allowances (write offs)	(361)	(1,768)
Allowances as at 31 Mar 2022	1,009	1,551

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

Injury cost recovery income: subject to a provision for credit losses of 23.76% (22.43% 2020/21) as per DHSC guidance for 2021/22 receivables.

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 2022 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

	2021/22	2020/21
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	<u>400</u>	<u>400</u>
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	<u>400</u>	<u>400</u>
Assets no longer classified as held for sale, for reasons other than sale	<u>(400)</u>	<u>-</u>
NBV of non-current assets for sale and assets in disposal groups at 31 March	<u><u>-</u></u>	<u><u>400</u></u>

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.

	2021/22	2020/21
	£000	£000
At 1 April	41,527	2,017
Net change in year	17,654	39,510
At 31 March	59,181	41,527
Broken down into:		
Cash at commercial banks and in hand	194	47
Cash with the Government Banking Service	58,987	41,480
Total cash and cash equivalents as in SoCF	59,181	41,527

Note 22 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	16,624	14,002
Capital payables	12,854	3,791
Accruals	40,170	32,471
Receipts in advance and payments on account	185	181
Social security costs	3,473	3,215
Other taxes payable	3,179	2,887
PDC dividend payable	470	-
Other payables	4,176	3,908
Total current trade and other payables	81,131	60,455
Of which payables from NHS and DHSC group bodies:		
Current	3,181	3,326
Non-current	-	-

Note 23 Other liabilities		
	31 March 2022	31 March 2021
	£000	£000
Current		
Deferred income: contract liabilities	4,338	431
Total other current liabilities	4,338	431
Non-current		
Deferred PFI credits / income	3,866	4,249
Total other non-current liabilities	3,866	4,249

Note 24.1 Borrowings		
	31 March 2022	31 March 2021
	£000	£000
Current		
Loans from DHSC	1,260	1,461
Obligations under PFI, LIFT or other service concession contracts	3,620	2,640
Total current borrowings	4,880	4,101
Non-current		
Loans from DHSC	10,306	11,552
Obligations under PFI, LIFT or other service concession contracts	51,174	54,793
Total non-current borrowings	61,480	66,345

Note 24.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2021	13,013	57,433	70,446
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,446)	(2,638)	(4,084)
Financing cash flows - payments of interest	(328)	(5,186)	(5,514)
Non-cash movements:			
Application of effective interest rate	327	5,185	5,512
Carrying value at 31 March 2022	11,566	54,794	66,360

Note 24.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2020	340,272	59,444	399,716
Prior period adjustment	-	-	-
Carrying value at 1 April 2020 - restated	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 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2021	3,097	105	5,038	8,240
Change in the discount rate	103	-	-	103
Arising during the year	138	46	795	979
Utilised during the year	(181)	(30)	-	(211)
Reversed unused	(273)	(46)	(560)	(879)
Unwinding of discount	(40)	-	-	(40)
At 31 March 2022	2,844	75	5,273	8,192
Expected timing of cash flows:				
- not later than one year;	181	75	4,889	5,145
- later than one year and not later than five years;	724	-	18	742
- later than five years.	1,939	-	366	2,305
Total	2,844	75	5,273	8,192

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 and potential tax liabilities.

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 expects to modernise practices from 2022/23 via the new inventory system to 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 (£0.74m) to account for anticipated losses (Note 25.1).

Note 25.2 Clinical negligence liabilities

At 31 March 2022, £349,181k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Worcestershire Acute Hospitals NHS Trust (31 March 2021: £209,416k).

Note 26 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	(12)	(33)
Gross value of contingent liabilities	<u>(12)</u>	<u>(33)</u>
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	<u>(12)</u>	<u>(33)</u>
Net value of contingent assets	-	-

Note 27 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	10,089	-
Intangible assets	-	-
Total	<u>10,089</u>	<u>-</u>

Note 27 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2022 £000	31 March 2021 £000
not later than 1 year	7,546	8,226
after 1 year and not later than 5 years	14,241	17,676
paid thereafter	944	1,279
Total	<u>22,731</u>	<u>27,181</u>

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

The information below is required by the Department of Health for inclusion in 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 2022 £000	31 March 2021 £000
Gross PFI, LIFT or other service concession liabilities	83,623	91,447
Of which liabilities are due		
- not later than one year;	8,513	7,824
- later than one year and not later than five years;	34,061	34,058
- later than five years.	41,049	49,565
Finance charges allocated to future periods	(28,829)	(34,014)
Net PFI, LIFT or other service concession arrangement obligation	54,794	57,433
- not later than one year;	3,620	2,640
- later than one year and not later than five years;	18,299	16,706
- later than five years.	32,875	38,087

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 2022 £000	31 March 2021 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	376,883	391,134
Of which payments are due:		
- not later than one year;	34,439	32,037
- later than one year and not later than five years;	146,718	136,496
- later than five years.	195,726	222,601

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:

	2021/22	2020/21
	£000	£000
Unitary payment payable to service concession operator	36,585	37,601
Consisting of:		
- Interest charge	5,185	5,399
- Repayment of balance sheet obligation	2,638	2,011
- Service element and other charges to operating expenditure	19,764	20,752
- Capital lifecycle maintenance	1,443	3,304
- Contingent rent	7,555	6,135
Total amount paid to service concession operator	36,585	37,601

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 2022 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 (CCG), 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 through 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 2022	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	6,796	-	-	6,796
Cash and cash equivalents	59,181	-	-	59,181
Total at 31 March 2022	65,977	-	-	65,977

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

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	11,566	-	11,566
Obligations under PFI, LIFT and other service concession contracts	54,794	-	54,794
Trade and other payables excluding non financial liabilities	73,824	-	73,824
Total at 31 March 2022	140,184	-	140,184

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £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

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 2022 £000	31 March 2021 £000
In one year or less	83,885	63,770
In more than one year but not more than five years	37,999	38,659
In more than five years	49,571	58,972
Total	171,455	161,401

Note 30 Losses and special payments

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	3	-	2	-
Bad debts and claims abandoned	77	155	179	320
Stores losses and damage to property	1	243	12	250
Total losses	81	398	193	570
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	34
Ex-gratia payments	47	53	28	11
Total special payments	47	53	29	45
Total losses and special payments	128	451	222	615
Compensation payments received		-		-

Ex-gratia payments excludes overtime corrective payments which the HMT approved on behalf of the employers which relates to 2020/21 (Flowers Case). These payments have been made during 2021/22 for £492k

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:

- Department of Health and Social Care ministers
- Board members of the Trust
- The Department of Health and Social Care
- Other NHS providers
- CCGs and NHS England
- Other health bodies
- Other Government departments
- Local authorities
- NHS charitable funds

- NHS Resolution
- Local Authorities
- NHS Shared Business Services (SBS)
- NHS Business Services Authority

The Trust has also received revenue and capital payments from Worcestershire Acute Hospitals Charity amounting to £413,081 (£365,658 in 2020/2021). All of these payments relate to expenditure made by the Trust on behalf of the Worcestershire Acute Hospitals Charity. As at 31 March 2022, Worcestershire Acute Hospitals Charity owed the Trust £66,083. 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 31.1 Related Party Balances	Receivables	Receivables
	2021/22	2020/21
	£000	£000
Charitable Funds (where not consolidated)	147	126
Total balances with Related parties	147	126

Note 32 Better Payment Practice code	2021/22	2021/22	2020/21	2020/21
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	93,207	282,344	86,534	238,913
Total non-NHS trade invoices paid within target	<u>88,605</u>	<u>271,875</u>	<u>84,111</u>	<u>230,673</u>
Percentage of non-NHS trade invoices paid within target	<u>95.1%</u>	<u>96.3%</u>	<u>97.2%</u>	<u>96.6%</u>
NHS Payables				
Total NHS trade invoices paid in the year	2,142	17,228	2,155	17,161
Total NHS trade invoices paid within target	<u>1,779</u>	<u>15,042</u>	<u>1,619</u>	<u>9,687</u>
Percentage of NHS trade invoices paid within target	<u>83.1%</u>	<u>87.3%</u>	<u>75.1%</u>	<u>56.4%</u>

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

Note 33 External financing limit		
The Trust is given an external financing limit against which it is permitted to underspend		
	2021/22	2020/21
	£000	£000
Cash flow financing	14,885	(14,441)
External financing requirement	<u>14,885</u>	<u>(14,441)</u>
External financing limit (EFL)	14,885	(13,922)
Under / (over) spend against EFL	<u>-</u>	<u>519</u>

Note 34 Capital Resource Limit		
	2021/22	2020/21
	£000	£000
Gross capital expenditure	52,565	27,425
Less: Disposals	(884)	(34)
Less: Donated and granted capital additions	(218)	(968)
Charge against Capital Resource Limit	<u>51,463</u>	<u>26,423</u>
Capital Resource Limit	54,112	30,434
Under / (over) spend against CRL	<u>2,649</u>	<u>4,011</u>

Note 35 Breakeven duty financial performance	
	2021/22
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	(1,356)
IFRIC 12 breakeven adjustment	274
Breakeven duty financial performance surplus / (deficit)	<u>(1,082)</u>

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

	1997/98 to 2008/09	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	2021/22
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(59,831)	(28,748)	(52,562)	(68,790)	(80,844)	6,652	(1,082)
Breakeven duty cumulative position	(118,267)	(147,015)	(199,577)	(268,367)	(349,211)	(342,559)	(343,641)
Operating income	368,981	403,348	400,918	411,966	443,722	559,003	596,391
Cumulative breakeven position as a percentage of operating income	(32.1%)	(36.4%)	(49.8%)	(65.1%)	(78.7%)	(61.3%)	(57.6%)

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