

Public Trust Board & AGM

Tuesday 8 September 2026, 13:00 - 14:30

Teams

Agenda

13:00 - 13:05
5 min
1. Welcome and Apologies for Absence
Information Frances Martin
Apologies received from Glen Burley, Chris Douglas and Hayley Flavell

13:05 - 13:05
0 min
2. Declarations of Interest
Information Frances Martin

13:05 - 13:15
10 min
3. Annual General Meeting
Information

3.1. Minutes of the AGM 24 September 2025
Decision Frances Martin
Trust AGM September 2025 minutes.pdf (5 pages)

3.2. Presentation of Annual Accounts 2025/26
Decision Katie Osmond
Worcestershire Acute Hospitals NHS Trust Annual Report and Accounts 2025-26.pdf (151 pages)

3.3. Presentation of Annual Report 2025/26
Decision Stephen Collman
Annual Report 2025-26 final.pdf (91 pages)

3.4. Questions from the Public
Information Frances Martin
Verbal

13:15 - 13:20
5 min
4. Minutes of Trust Board Meeting held on 14 July 2026
Decision Frances Martin
No actions outstanding
4. Draft Public Trust Board Minutes 14 July 2026.pdf (7 pages)

4.1. Foundation Group Workshop Report
Information Stephen Collman
4.1 - FGBs Workshop Report from the Meeting held on 5 August 2026.pdf (3 pages)

13:20 - 13:25

5 min

5. MD Report

Information

Stephen Collman

📎 5. MD Report - September 2026 - Final.pdf (5 pages)

13:25 - 13:35

10 min

6. Winter Plan

Assurance

Wendy Joberns-Harris

📎 6. Winter Planning Sept 26.pdf (1 pages)

📎 6. WAHT_Winter_Approach_2627_Public.pdf (7 pages)

13:35 - 13:45

10 min

7. Green Plan

Assurance

Julian Berlet

📎 7. Green & Sustainability - Trust Board Sept 26 v2.0.pdf (8 pages)

13:45 - 14:00

15 min

8. Integrated Performance Report

Assurance

Stephen Collman

📎 8. 20260824 - WAHT IPR NOF Metrics Dashboard (up to Jul-26) v2.pdf (3 pages)

📎 8. Trust Board IPR Sep-26 (Jul-26_Data).pdf (25 pages)

8.1. Introduction

Stephen Collman

8.2. Quality & Safety

Jules Walton/Alison Robinson

8.3. Operational Performance

Wendy Joberns-Harris

8.4. Workforce

Alison Koeltgen

8.5. Finance

Katie Osmond

14:00 - 14:10

10 min

9. Quality

9.1. Quality Governance Committee Escalation & Assurance Report

Assurance

Julie Moore

📎 9.1 Quality Governance Committee Escalation & Assurance Report August 2026.pdf (3 pages)

9.2. Nursing Safe Staffing Report

Assurance

Sue Smith

📎 9.2 2026 July 2026 Nursing Safer Staffing Paper.pdf (2 pages)

📎 9.2 August 2026 Nursing Safer Staffing Paper.pdf (19 pages)

9.3. Midwifery Safe Staffing Report

Assurance

Justine Jeffery

📄 9.3 Q1 Safe staffing Report 2026-27.pdf (6 pages)

14:10 - 14:15 10. Finance

5 min

10.1. 2025-26 National Cost Collection - Post Submission Report

Assurance

Katie Osmond

📄 10.1 NCC Board paper - Post-Submission Cover Sheet 2025-26.pdf (1 pages)

📄 10.1 NCC Board paper - Post-Submission 2025-26.pdf (12 pages)

14:15 - 14:20 11. Workforce

5 min

11.1. People & Culture Committee Minutes

Assurance

Karen Martin

📄 11.1 02.06.26 PC Minutes.pdf (7 pages)

14:20 - 14:30 12. Governance & Risk

10 min

12.1. Audit & Assurance Committee Escalation & Assurance Report

Assurance

Colin Horwath

📄 12.1 Audit & Assurance Committee Escalation & Assurance Report 9 July 2026.pdf (2 pages)

12.2. Audit & Assurance Committee Effectiveness Review

Decision

Gwenny Scott

📄 12.2 AAC Annual effectiveness review TB Sept 2026.pdf (20 pages)

14:30 - 14:30 13. Date of Next Meeting

0 min

Information

Frances Martin

13th October 2026

14:30 - 14:30 14. Any Other Business & Questions from the Public

0 min

Information

Frances Martin

14:30 - 14:30 15. Acronyms

0 min

Information

**Annual General Meeting
24 September 2025 at 6pm
Via Microsoft Teams and live streamed on YouTube**

Board Members Present (voting)			
Russell Hardy, Chair	RH	Simon Murphy, Non-Executive Director/Deputy Chair	SM
Karen Martin, Non-Executive Director	KM	Neil Cook, Chief Finance Officer	NC
Dame Julie Moore, Non-Executive Director	JM	Stephen Collman, Acting Chief Executive	SC
Jules Walton, Chief Medical Officer	JW	Hayley Flavell, Chief Nursing Officer	HF
Board Members Present (non-voting)			
Ali Koeltgen, Chief People Officer	AK	Rebecca Brown, Chief Digital Information Officer	RB
Julian Berlet, Chief Clinical Strategy Officer	JB	Michelle Lynch, Associate Non-Executive Director	ML
Chris Douglas, Chief Operating Officer	CD	Catherine Driscoll, Associate Non-Executive Director	CDr
Attending			
Richard Haynes, Director of Communications & Engagement	RH	Gwenny Scott, Company Secretary	GS
Chris Byrne, Healthwatch	CB	Jo Wells, Deputy Company Secretary	JWe
Apologies			
Colin Horwath, Non-Executive Director	CH	Tony Bramley, Non-Executive Director	TB

Ref	Item	Lead	Purpose	Format
1	Welcome and Introduction	RH	Information	Verbal
RH welcomed everyone to the 2024/25 Annual General Meeting of Worcestershire Acute Hospitals NHS Trust, noting that the meeting was being streamed live. Before turning to the formal business, the Chair paid tribute to Mark Yates, former Vice Chair of the Trust, who had sadly passed away in hospital over the preceding weekend. The Chair noted Mark's substantial contribution to Worcestershire Acute over many years, including as a Non-Executive Director and subsequently as Vice Chair, before he went on to become Chair of Herefordshire and Worcestershire Health and Care NHS Trust, having earlier served as Chief Fire Officer for Herefordshire and Worcestershire. The Chair extended condolences to Mark's family on behalf of the Board and thanked him for his enormous contribution to the NHS. RH noted that the Trust had made real progress over the past year, as would be set out in more detail in the presentations on operational, financial and quality performance to follow, and that there remained much still to achieve as part of the Trust's continuing improvement journey. For a short period towards the end of the financial year, the Trust had said goodbye to the Group Chief Executive, Glen Burley, with Stephen Collman stepping up as Acting Chief Executive for Worcestershire Acute Hospitals and Wye Valley NHS Trusts. This had enabled the acceleration of a series of work programmes across Herefordshire and Worcestershire, for the benefit of local healthcare. He also referred to the Government's recently published 10 Year Health Plan, noting this would be discussed further during the Questions and Answers session. It was reported that the Trust had improved from being ranked amongst the bottom 5–10% of NHS acute trusts nationally to being ranked at around the 75th–80th percentile, and stated his ambition for Worcestershire Acute to be amongst the top 25% of all acute hospitals nationally for performance within the next three years. No new declarations of interest were made.				
1.1	Minutes of Annual General Meeting 2024	RH	Approved	Report 1
The minutes of the Annual General Meeting held on 24 September 2024 were confirmed as an accurate record.				
2	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST FORMAL BUSINESS			
2.1	Presentation of Annual Report	SC	Information	Report 2

SC presented the Trust's Annual Report for 2024/25. He explained that he would cover strategic work, a summary of operational performance, key developments and achievements, and a particular focus on the staff survey results and the Trust's new values and behaviours framework. He reminded the meeting that, notwithstanding the volume of data presented, the Trust's focus remained on patients and on colleagues, and echoed the Chair's earlier comments regarding the death of Mark Yates, noting the support available to colleagues across the health and care system at this time.

SC noted that the Trust's original 10-point plan, developed early in its journey as part of the Foundation Group, continued to hold true despite the changing national context..

Turning to operational performance, a mixed picture was described, with the Trust performing well against most cancer targets and showing improvement compared with the previous year across most measures, although not every target had been met. He noted that urgent and emergency care pathways remained the Trust's principal area of continued focus, referencing the Chair's frequent reminder to the Board of the Trust's responsibility both to bring new life into the world safely and to be there reliably for patients when they need care.

A number of achievements and developments were highlighted:

- The new Urology Investigation Unit, which had originated as a clinical team idea and was already improving patient outcomes
- Continued development of the Community Diagnostic Centre at Kidderminster, improving access to diagnostics across Worcestershire
- The Trust's Surgical Hub accreditation for both children's and adult services at Kidderminster – a rare achievement nationally recognised by Professor Tim Briggs
- The Single Point of Access, one of the first of its kind nationally and operated jointly with Herefordshire and Worcestershire Health and Care NHS Trust, enabling GPs, paramedics and other professionals to access advice and direct patients to the right care first time
- Ongoing development of the Emergency Care Hub, including medical and surgical same day emergency care
- The new Cardiology Heart Centre.
- The Trust's achievement of the Gold Award under the Armed Forces Covenant, recognising its commitment to serving personnel, veterans and their families.

The Trust had, for the first time in some time, met a genuinely challenging financial target, and that an even bigger challenge lay ahead in the current year.

The results of the staff survey were presented. Following a lower relative position the previous year, with a particular concern around response rate, the People team had undertaken significant work to promote participation, resulting in a marked increase in response rate and moving the Trust to around or just above the national average. There was ambition to improve further, with a focus on demonstrating to staff that concerns raised through the survey are being acted upon.

SC drew particular attention to the scores reflecting whether colleagues would recommend the Trust as a place to work and as a place to receive treatment, noting these were real indicators of organisational health and that the Trust had been amongst the most improved nationally, while recognising there remained further to go. He noted specific, tangible improvements made in response to staff feedback, including in relation to car parking and food and nutrition.

SC thanked the Board for supporting a ground-up piece of work to reset the Trust's values and behaviours, explaining that these had been developed entirely from what colleagues said the Trust looks like 'at its best', rather than being imposed from the top, and that this work would underpin the Trust's new strategy, with further reporting to come during the following year.

2.2	Presentation of the Annual Accounts and Auditors Report	NC	Information	Report 3
NC presented the Annual Accounts and Auditors' Report for 2024/25. He explained that the Trust had set a cost and productivity improvement programme of £45.1 million for the year – equivalent to 5.6% of turnover, against historic delivery of 2–3% and a national efficiency expectation of around 1–2% – reflecting the very challenging financial context nationally, including a largely block-based national funding model (with the exception of elective services).				

Against a planned deficit of £5.7 million, the Trust delivered a small improvement on plan, reporting a deficit of £5.5 million for the year – £0.2 million better than planned – following delivery of the full £45.1 million cost and productivity improvement programme. Mr Cook thanked colleagues across the organisation for this achievement.

Capital investment during the year totalled £27.4 million, supported by £12.4 million of additional funding secured by the Trust. Key capital schemes included fire safety works at the Alexandra Hospital, remediation of reinforced autoclaved aerated concrete (RAAC) roofing at Kidderminster, investment in frontline digital initiatives, and ongoing building maintenance and equipment replacement programmes.

Overall, the Trust achieved its financial plan for the year, remained within its capital resource limit, and held sufficient cash to remain within its external financing limit, notwithstanding the overall deficit position.

On income and expenditure, it was reported that the Integrated Care Board (ICB) remained the Trust's largest funder, accounting for around 78% of income, the majority on block arrangements, followed by NHS England with further income from education and training and from non-patient care services. On expenditure, staff costs represented the largest area of spend followed by clinical supplies, services and drugs, and expenditure on estates, premises depreciation and PFI costs; the Trust also spent approximately £23 million on its clinical negligence insurance scheme.

The Trust's annual accounts had been submitted on time and had received an unqualified ('clean') audit opinion, giving a true and fair view of the Trust's financial position; the external auditors had described it as amongst the best audits they had undertaken for some time.

On the Value for Money conclusion, NC reported that the Trust had not yet achieved a full pass against the criteria for financial sustainability and improving economy, efficiency and effectiveness, but that this was the second consecutive year of improvement. The number of significant weaknesses identified had reduced to one, relating to the identification and delivery of recurrent savings, with the Trust supported by a Financial Improvement Director and working with system partners on a medium-term financial sustainability programme. On governance, no significant weaknesses were identified, with minor recommendations relating to the publication of gifts and hospitality (since actioned) and to improving staff compliance with policies and procedures. On economy, efficiency and effectiveness, NC reported continuing work and stronger controls to reduce the Trust's reliance on agency staff, with a positive improving trajectory, while acknowledging further work was required.

2.3	Presentation of Quality Accounts	JW	Information	Report 4
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JW presented the Quality Account, explaining that 2024/25 was the final year of the Trust's three-year Quality and Safety Plan, and reminded the meeting that quality in the NHS comprises three components: safe care, clinically effective care, and a positive patient experience. The Trust's Quality Account for 2024/25 was published on the Trust website on 27 June and, following a recommendation from Healthwatch Worcestershire on last year's account, the Trust had for the first time also published a Summary Quality Account, presenting key information in an accessible format for the public.

JW described the Trust's quality improvement roadmap, led through the Nursing, Midwifery and Allied Health Professionals Board established in 2023, highlighting in particular the strengthened Fundamentals of Care Committee, which reports divisionally on how patients' basic care needs are being met and has driven real improvement, and the Care Excellence Accreditation programme, which assesses the quality of care delivered in clinical areas and is being extended into further areas including the Emergency Department, Paediatrics, Gynaecology and Critical Care.

The Trust's overall CQC rating remained 'Requires Improvement', while the Trust continued to be rated 'Good' in the Effective and Caring domains. Under the CQC's new single assessment framework, the Trust's services had been subject to four assessments over the preceding twelve months: Urgent and Emergency Care at Worcestershire Royal Hospital, which identified waiting times as a focus for improvement; Stroke services, where capacity, flow and access to the service were highlighted; Children and Young People's services at Kidderminster, which saw improvement in the Safe, Effective, Responsive and Well-Led domains and resulted in an overall rating of 'Good' across all domains; and Children and Young People's services at the Alexandra Hospital, which saw improvement in the Safe, Effective and Well-Led domains and also resulted in an overall rating of 'Good'. She noted that no domain had decreased in rating across any of the four assessments, while a continued focus on waiting times was required.

JW summarised the Trust's progress against its 2024/25 quality priorities, set across the safe, effective and positive experience domains and evaluated using a combination of data-driven targets and narrative description. While not every target had been met, she reported positive progress and good compliance across most priority areas.

Looking ahead to 2025/26, quality priorities had been reset in collaboration with patients, relatives and carers, through Quality Conversations, and with staff, volunteers and partners, incorporating a wider range of views. Changes for the coming year include the introduction of further data-driven key performance indicators against quality priorities; a particular focus on end-of-life care; the transition of clinical audit and quality improvement into business-as-usual monitoring, reflecting sustained good performance in this area; and closer alignment of priorities and metrics with the Foundation Group and national measures, with continued particular focus on waiting times.

RH placed on record his thanks to Sarah Shingler, Chief Nursing Officer during the year covered by the report, who had since moved to become Managing Director of Wye Valley NHS Trust, and to Hayley Flavell for stepping in on an interim basis as Chief Nursing Officer.

3	Questions and Answers	RH	Information	Verbal
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The Chair advised that four questions had been submitted in advance by the Patient and Public Forum and CB had submitted comments via the chat function.

Question 1 – AGM format: The Patient and Public Forum noted its disappointment that the AGM continued to be held virtually rather than returning to an in-person format, while recognising the Trust's rationale that this provides more equal public access, and asked whether there was evidence to support this.

The Chair responded that, over the previous two years of live-streamed AGMs, the meeting had attracted an average of around 150 viewers via YouTube – a far greater level of access than could realistically be achieved through an in-person meeting. He noted this was of particular benefit to people with disabilities or reduced mobility. While acknowledging that a virtual format loses some of the informal, relationship-building benefit of an in-person meeting, he confirmed his assessment remained that the current format represented the better overall approach.

Question 2 – 10 Year Health Plan: The Forum asked the Trust to describe the short-term impact of the Government's recently published 10 Year Health Plan – which sets a direction of progressively shifting healthcare provision towards community settings and away from acute trusts – for the remainder of this year, and the anticipated impact next year, including whether the Trust had been notified of any reduction to its capital allocation for next year.

SC responded that the Trust had not been notified of any reduction to its capital allocation. He noted that a positive feature of the 10 Year Plan and associated new national frameworks would be a move to multi-year capital allocations, addressing longstanding frustration at capital funding being released in stages through the year rather than confirmed up front. On the 'left shift' of services towards community settings, he highlighted two strands of work: continuing to work with place partners, including Herefordshire and Worcestershire Health and Care NHS Trust and primary care colleagues and working through a shift of some services from tertiary partners closer to Worcestershire, reducing the need for patients to travel.

RH stressed the importance of acute hospitals focusing on delivering acute episodic care, and of the wider health and social care system working more efficiently together over the coming years to minimise patients' length of stay in acute settings, referencing the risk of hospital-acquired functional decline in frail, older patients.

Question 3 – benefits of Foundation Group membership: The Forum asked what patient experience benefit the Trust had gained from being part of the Foundation Group.

SC described two strands of benefit. First, direct support between Foundation Group trusts for fragile services, citing improving stroke services and support from Wye Valley with dermatology, both leading directly to improved patient outcomes. Second, a shared culture of improvement across the Foundation Group Trusts

The Chair added that the core purpose of the Foundation Group is the rapid identification and sharing of best practice, and that this had become increasingly embedded since Worcestershire Acute joined the Group.

Question 4 – executive team stability: The Forum noted that changes within the executive team appeared to happen frequently, despite the Trust previously stating that stability in the executive team was desirable, and asked how the Trust sought to retain its executive team.

SC acknowledged there had been a number of executive changes, but noted these largely reflected retirements and promotions, together with some individuals' personal circumstances. He noted that a number of members of the executive team had long

service with the Trust and lived locally and that recruitment processes were underway to fill current vacancies, including the substantive Chief Nursing Officer post, within the coming weeks.

RH read out and responded to written comments submitted via the chat function by Chris Byrne of Healthwatch Worcestershire, who was unable to join by audio. Mr Byrne thanked the Trust for its presentation and encouraged continued engagement with the public and voluntary sector organisations in the co-production of new solutions; he also raised concern regarding proposals within the 10 Year Health Plan that could see Healthwatch's independent funding removed. RH agreed with these comments, noting that he shared the concern about Healthwatch's independent funding, and confirmed the Trust's commitment to continuing to work with Healthwatch, in whatever form it takes in future, given the importance of an independent voice for citizens and patients.

4	Closing Remarks	RH	Information	Verbal
RH closed the meeting by expressing his hope that members of the public, whether watching live or in future, would take confidence and assurance that the improvement journey at Worcestershire Acute is starting to bear fruit. He emphasised that this progress does not happen by accident, but through the individual and collective effort of everyone working within the organisation, under the direction and leadership of the executive directors.				
He thanked the executive directors for their work, and their families for the support they provide. He also thanked the Non-Executive Directors, both those present and those who had sent apologies, for their role as 'critical friends' to the executive team, using their experience to help drive ever-higher performance.				
The Chair closed the meeting by thanking everyone for their attendance.				

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
ANNUAL REPORT AND ANNUAL ACCOUNTS
2025/26

DRAFT

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
ANNUAL REPORT 2025/26

DRAFT

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DRAFT

Welcome from the Chair

It is my pleasure to present the Annual Report for Worcestershire Acute Hospitals NHS Trust for 2025/26.

Like many NHS organisations, this has been a year characterised by sustained and, at times, exceptional operational pressure. Demand for urgent and emergency care remained consistently high, with ongoing challenges in patient flow, bed occupancy and timely discharge. Regrettably these pressures have had a direct impact on waiting times, patient experience in some areas, and the delivery of key national standards, particularly within emergency care and some cancer pathways. Industrial action has also had an impact, creating disruption and additional complexity for our teams.

Alongside this, the Trust has continued to operate within a challenging financial environment. Despite strengthened financial controls and governance, we did not achieve our planned financial position, reflecting the ongoing cost of maintaining safe capacity, addressing demand, and delivering improvement programmes at pace.

However, it is equally important to recognise the significant achievements made during the year. Within a highly pressured system, our teams have delivered measurable improvements. We have seen progress in elective recovery, with reductions in waiting times and improvements against the 18-week standard, alongside better theatre utilisation and strengthened waiting list management.

In urgent care, although performance has remained challenging, there have been important areas of improvement. Initiatives to improve ambulance handovers, patient triage and flow have delivered tangible benefits at key points in the year and provide a strong foundation for our recovery programme moving forward. We remain committed to improving access and experience in the year ahead.

A particularly important development this year has been the strengthening of our understanding of health inequalities. Our most detailed analysis to date has highlighted clear disparities in access, experience and outcomes for some communities, providing a strong evidence base to inform future action with system partners.

We have also continued to make progress in digital transformation, strengthening our approach to sustainability and reducing our carbon footprint, and advancing collaboration through our membership of the Foundation Group and as a key partner in our Integrated Care System. These partnerships are essential in addressing the complex challenges facing our services and ensuring a sustainable future for healthcare for the Worcestershire population.

Our workforce remains at the heart of everything we do. Despite the sustained pressures, our NHS Staff Survey results demonstrated that staff engagement has continued to improve, and I want to acknowledge the professionalism, compassion and resilience shown by colleagues who continue to demonstrate our shared values: being open and honest, ensuring people feel cared for, and showing respect for everyone. We remain committed to staff wellbeing, development and engagement, recognising that our people are the foundation of our success and have continued to invest in initiatives that support physical and mental health, while also providing opportunities for learning and progression.

Looking ahead, we remain clear about the priorities for the coming year. These include improving urgent and emergency care flow, delivering financial recovery, reducing waiting times further, and continuing to enhance the quality and equity of care for our patients.

I would like to extend my sincere thanks to all our staff, volunteers and partners for their continued dedication and commitment, and our patients and communities for their support and trust. Finally, I would like to thank my fellow Board members for their leadership and support, with particular thanks to my predecessor Russell Hardy for his leadership as Chair of the Trust since 2023, as well as the key role he played in establishing and growing the Foundation Group.

Together, guided by our values and our shared purpose of helping people to live healthier, happier lives, we will continue to learn, improve and move forward with confidence.

Frances Martin

Chair, Worcestershire Acute Hospitals NHS Trust

DRAFT

Performance Report

Performance Overview

The purpose of this section is to describe the Trust's purpose and its performance and the key risks to achievement of its objectives during the year.

Chief Executive Officer's Statement on Performance

I am pleased to introduce our annual performance report, which sets out our performance, achievements and challenges over the last year and reflects the continued commitment of our staff, volunteers and partners to deliver safe, compassionate care for our communities. It has been a year marked by sustained - and at times extreme - demand for Urgent and Emergency Care (UEC), consistently high bed occupancy and length of stay pressures, and the operational and financial consequences of maintaining safe capacity. In that context, I want to acknowledge the professionalism and resilience shown across our services, often in difficult conditions.

Within these pressures, we have made tangible progress. We strengthened elements of front-door delivery, with periods of improved ambulance handovers and triage; we reduced waiting times for planned care in several specialties; we continued to invest in our people and leadership; and we advanced key programmes in quality improvement, research and digital transformation. At the same time, performance has often been fragile, particularly where operational congestion has impacted patient flow, experience and some quality metrics, and we have had ongoing challenges in delivering sustainable financial recovery and productivity, including the delivery of our Cost and Productivity Improvement Plans (CPIP).

Quality and Safety

Quality performance was mixed and closely linked to operational pressures. Positively, mortality remained within expected ranges and the number of patient falls remained below national average. However, numbers of hospital-acquired infections increased, highlighting the fragility of quality metrics during periods of high bed occupancy and use of additional bed capacity. Improvement programmes progressed in antimicrobial stewardship, sepsis care and implementation of Martha's Rule. Complaint management was an area of sustained focus, with reductions in the number of open complaints following targeted work. Patient experience, as reflected by Friends and Family Test results, was strong in some areas but below target in ED and outpatients during high-pressure periods.

Operational Performance

UEC demand remained the dominant performance driver throughout the year, with long waits, high bed occupancy and constraints on patient flow, particularly at Worcestershire Royal Hospital. During the summer and early autumn, there were improvements in ambulance handovers, triage times and long ED waits, supported by changes to streaming processes and collaboration with system partners and NHS England support, which contributed to a shift in escalation status (from Tier 1 to Tier 2) during the year. This performance was more challenged over the winter but the work of our teams during our urgent care sprint towards the end of the financial year started to bear fruit and will form the basis of our Urgent Care Recovery Plans in 2026/27.

Elective performance improved overall, including reductions in waiting times and progress on waiting list management. Cancer performance was consistently challenged, however, by high referral volumes and capacity constraints in some specialties.

Health Inequalities

Our most detailed analysis to date reveals clear inequalities in Worcestershire based on deprivation, with, for example, people from the most deprived areas significantly more likely than those from the least deprived areas both to attend our Emergency Departments and to be admitted as emergencies. This analysis provides the Trust with its strongest baseline to date and will inform targeted action, service improvement and partnership working in 2026/27.

Finance and Productivity

Financial performance reflected the operational volatility of the year. Early performance against the balanced plan was adverse, attributed to additional unfunded capacity and under-delivery of CPIP. Ongoing high UEC demand and continued use of additional bed capacity contributed to a highly challenged position throughout the year. This was reflected in our NHS Oversight Framework status, which improved to segment 3 in quarter 2 but remained at segment 4 for the rest of the year.

Strengthened financial governance arrangements and enhanced grip-and-control measures were put in place; however, our end of year position was an adjusted deficit of (£11)m which was in line with the revised forecast outturn but not within the annual plan agreed with NHSE.

Sustainability

During the year, the Trust continued to strengthen the governance, strategy and risk management arrangements supporting delivery of its Green Plan and wider net zero objectives, with climate change remaining subject to Board oversight and established assurance processes. Total greenhouse gas emissions for the year were 4.6% lower than the 2021/22 baseline, although progress remains below the trajectory required to meet NHS net zero ambitions. We are proud to be one of the first trusts in the country to eliminate the harmful anaesthetic gas desflurane and to be participating in international initiatives in areas such as sterile gown usage.

Workforce

Workforce indicators were broadly stable, though there was increased sickness absence during peak operational pressure. Reducing reliance on temporary staffing remained a consistent priority and challenge and despite strengthened oversight and significant reductions in agency usage, levels remained high in some divisions, driven by the need to staff additional capacity and maintain safe UEC services.

I want to place on record my sincere thanks to our staff for the extraordinary commitment, flexibility and compassion they have shown in continuing to care for patients and supporting one another through these sustained pressures.

Trust's Purpose and Activities

Worcestershire Acute Hospitals NHS Trust was established on 1 January 2000 and provides hospital-based services to a population of over 603,600 people in Worcestershire as well as caring for patients from surrounding counties and further afield.

Services are provided from three main sites:

- Alexandra Hospital in Redditch
- Kidderminster Hospital and Treatment Centre
- Worcestershire Royal Hospital in Worcester

The Trust also provides community-based services in Bromsgrove, Evesham and Malvern.

The Trust has four clinical divisions: Medicine, Surgery, Women's and Children and Specialised Clinical Services.

Foundation Group

The Trust is part of a Foundation Group with South Warwickshire NHS Foundation Trust, George Eliot Hospital NHS Trust and Wye Valley NHS Trust, with a single Chief Executive Officer and, until the end of 2025/26, a single Chair. From 2026/27 the single chair role was split between two new Chairs, each leading two of the Group trusts. All four organisations face similar challenges and have a common strategic vision for how these can be solved. The Foundation Group model retains the identity of each individual trust whilst strengthening the opportunities available to secure a sustainable future for local health services and providing a platform to share best practice and improve whole system patient pathways.

Shared Foundation Group long term strategic objectives and Big Moves



The Big Moves are underpinned by six Strategic Pillars:

- **Quality:** We will improve the experience, outcomes and safety of people accessing our services. We will embed a culture that is open to change and through Quality Priorities we will focus on improvement that will support people to live healthier, happier lives.
- **Workforce:** Our staff are our organisation. The retention, happiness and wellbeing of our workforce is essential. We want the Trust to continue to be an employer of choice, attracting the very best.
- **Productivity:** Making the best use of our limited resources and maximising the benefits of Foundation Group working will help us to be an efficient and effective organisation. We will respond to national programmes and develop a financial and operational strategy that makes us sustainable for future healthcare delivery.
- **Digital:** Digital solutions can enhance services and patient experience. We have an opportunity to use technology and data to transform care and experience for our staff.

- **Sustainability:** We recognise our environmental obligations and we are committed to minimising our impact on the local environment and helping to improve it.
- **Research:** We will create a culture which harnesses and supports research opportunities and improved access to clinical research.

Integrated Care System

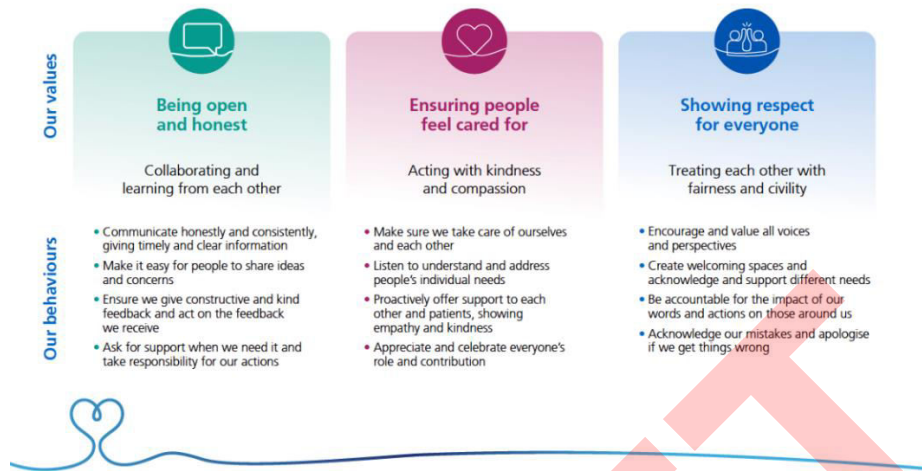
The Trust is part of the Herefordshire and Worcestershire Integrated Care System (ICS). The ICS is responsible for improving health outcomes for the local population, reducing health inequalities and supporting broader social and economic development. The Integrated Care Board (ICB) does this through ensuring effective joined up working with local partners across health, social care, voluntary and community sectors and the allocation of NHS resources to ensure services are in place to deliver the jointly agreed ambitions. During 2025/26, the ICB created a strategic cluster with NHS Coventry and Warwickshire ICB and appointed a shared Chair, Chief Executive and joint non-executive board members.

Trust Vision, Values and Strategy

After engaging with colleagues across and beyond the Trust in 2024/25, a new Trust Strategy for 2025-30 was launched, including purpose, vision, strategic objectives and values that align with the strategies of the NHS, the ICS and the Foundation Group.



Our shared values and behaviours



Performance Appraisal

The performance analysis below describes how in 2025/26 the Trust managed risks to achieving its strategic objectives and performed on key targets and measures.

Taken as a whole, the analysis shows that the Trust met expectations in some important areas, including delivery of the final capital plan, elective recovery against the 18-week standard, theatre utilisation, ambulance handovers under 45 minutes, patient experience, mortality and continued improvement in staff engagement.

However, expectations were not met consistently across financial performance, urgent and emergency care access, some cancer standards, diagnostic waits, sickness absence and aspects of infection prevention and control.

In the main, this reflected sustained demand, discharge and flow pressures, capacity constraints in key specialties, workforce challenges, and the impact of operating within a constrained financial environment.

The report also demonstrates that these issues and risks have been actively managed through strengthened executive and Board oversight, monthly performance and recovery review processes, targeted improvement programmes, specialty-level recovery actions, and continued use of risk management and governance arrangements to monitor delivery, escalation and mitigation.

While these controls have supported improvement in a number of areas, material risks to financial sustainability, operational resilience, access standards, patient flow and infection control remain and require close oversight in 2026/27.

The principal risks to achievement of the Trust's strategic priorities in 2025/26 are set out in the Board Assurance Framework as follows.

Strategic Priority	Principle Risks to Achievement	Changes during the year
People	Health and wellbeing of staff	The risk remained high, reflecting some improvement but missed targets and continued pressures.

	Failure to deliver workforce transformation and achieve a sustainable workforce	The risk remained high reflecting ongoing work to reduce reliance on temporary staff while continuing to meet high demand.
	Failure to sustain a positive change in organisational culture	The risk reduced to moderate ahead of 2025/26 while the new values became embedded.
Patients	Failure to improve urgent and emergency care	The risk remained high throughout the year reflecting continued challenges though performance improved towards the year end.
Collaboration	Failure to improve urgent and emergency care	
Excellence	Failure to develop, modernise and improve information technology through timely delivery of the digital strategy	Good progress was made during the year on delivery of the strategy and the risk reduced to a moderate level.
	Successful cyber-attack on the Trust's systems	The risk remained high throughout the year, reflecting the constantly developing external threat.
Effectiveness	Failure to deliver the Trust's agreed financial plan	The risk remained high throughout the year as the Trust sought to deliver an ambitious plan,
	Fire safety risk at the Alexandra Hospital	The risk reduced during the year as mitigations were implemented and regulatory expectations were met.

These risks will be refreshed for 2026/27 in line with new annual objectives aligned to the overarching Trust Strategy.

Going Concern

International Accounting Standard 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity.

The Trust has a forecast outturn for 2025/26 of £14m deficit, with a stretched ambition to reduce this to £11.6m (as at month 10, January 2026) after receipt of deficit support funding from Herefordshire and Worcestershire ICB of £47.3m. The Trust's final position for 2025/26 was a £11m deficit.

In the 2026/27 plan the Trust forecasts and adjusted financial performance of breakeven positions which includes deficit support funding of £42.194m and CIP target of £57.1119m. This has been agreed in conjunction with the Herefordshire and Worcestershire ICB.

The Directors have carefully considered the principle of going concern. The Trust has agreed contracts with its local commissioners for 2026/27. Services continue to be commissioned in the same manner as in prior years and there are no discontinued operations. The Trust's strategic partnership with the Foundation Group also continues to provide executive leadership and support to the Trust.

The Board has thus concluded that the Trust remains a going concern and the going concern basis has been adopted for the preparation of the accounts. Further details on going concern can be found within the disclosure within the financial statements.

Performance Analysis

This section provides a summary of how we measure performance and manage risk and a detailed integrated performance analysis.

Measuring and Monitoring Performance

The Trust reports each month on a large dataset covering operations, quality, workforce and finance, which is consistent across the Foundation Group, enabling useful comparison and benchmarking. The dataset includes national targets set by NHS England, measures aligned to our annual Trust objectives and other data agreed by the Foundation Group trusts as key measures for Board oversight.

Performance is overseen by the Trust Board and a number of committees, including Quality Governance Committee, Financial Recovery Board and divisional Finance and Performance Executive Committees. Key Performance Indicators (KPI) are included in an Integrated Performance Report (IPR), which is reviewed at each meeting of the Trust Board in public, with all meeting papers published on our website to aid transparency. The IPR comprises data and information about four main areas.

Key Performance Reporting	
Quality	Mortality
	Infections
	Patient Surveys
	Patient feedback
	Clinical incidents
Operations	Urgent care access
	Elective care access
	Cancer services
	Clinic and theatres utilisation (productivity)
Workforce	Sickness absence
	Turnover
	Vacancies and staffing levels
	Staff survey results
Finance	Delivery of financial plan
	Development and implementation of cost and productivity

Every quarter, this information is collated in a single report for the four Trusts of the Foundation Group, which provides useful benchmarking and opportunities for shared learning. Where there is benefit to joint working between the four trusts, this information is discussed by the four Boards together. Areas of Foundation Group focus in 2025/26 included:

- Outpatient services
- Urgent and emergency care impact on mortality and morbidity
- Safe staffing
- Operational planning for winter
- Equality and diversity
- Patient initiated follow-up
- Cancer services
- Home First initiatives

As well as using KPIs to measure performance against specific targets, KPIs also help identify areas of risk, provide assurance about how well risks are being managed or mitigated and inform our annual Trust objectives. This is reflected in our risk register and Board Assurance Framework.

Risk Profile

The Trust faced a range of challenges during the year which were assessed as risks to achievement of the Trust's strategic objectives and delivery of its key priorities. The basis of many of these risks is inherent within the wider NHS while others are particular to the Trust as an individual organisation. Many of these challenges are expected to continue into the coming years, impacting the delivery of the Trust's operational performance improvement priorities. The Trust takes these into account when reviewing its strategy. These include:

- Increased demand in both numbers and acuity at the Trust's 'front door', linked to and helping to drive long waiting lists.
- Challenges in community health and social care impacting the ability to discharge patients from the Trust's acute services when they are ready.
- Private Finance Initiative (PFI) funded hospital estate, which creates a current and future financial pressure. Ensuring an effective transfer of PFI responsibilities and a fully functioning, well managed estate will be a strategic priority for the Trust over the coming years.
- Estate infrastructure issues requiring a high level of financial and people resource to address.
- Workforce pressures in some teams creating 'fragile' services.
- Challenging financial, efficiency and productivity targets, which require careful balancing to ensure core service delivery alongside productivity and quality improvement.

The Trust Board considers its strategic and operational risks regularly through oversight of the Board Assurance Framework, risk register and reports from its committees.

More information on these risks is included within the Annual Governance Statement later in this document.

The impact of these risks and their mitigations is included where relevant in the performance appraisal below.

Financial Performance

Statutory basis

The Trust has fulfilled its responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with the Manual for Accounts and the International Financial Reporting Standards which give a true and fair view in accordance therewith.

Financial Break-even

In 2025/26, the Trust delivered a deficit of (£9)m. Once adjustments for the reversal of impairments and donations are accounted for this equates to an adjusted deficit of (£11)m.

The table below indicates the overall value of the deficit once factors relating to the change in value of tangible assets and other technical adjustments are accounted for.

The Trust break-even duty is calculated based on the retained Surplus/(Deficit) for the year adjusted for asset impairments and revaluations and the impact of donated assets and capital grants received.

In 2025/26 the Trust reported an adjusted deficit of (£11)m which was in line with the revised forecast outturn but not within the annual plan agreed with NHSE.

As part of the 2025/26 audit, the Trust's external auditors, Grant Thornton, concluded that the Charles Hastings Education Centre had not been accounted for appropriately in 2025/26, with an adjustment required back to IFRS 16 lease transition date of 1st April 2022. To align with the audit position and ensure compliance with IAS 8 (Accounting Policies, Changes in Accounting Estimates and Errors), management has agreed to treat this as a prior period adjustment and restate the comparatives accordingly, which is shown in the below table:

Financial Position – Income and Expenditure	Actual 2025/26 £000's	Actual 2024/25 £000's
Operational (Adjusted) financial performance surplus/(deficit)	(11,042)	(5,484)
<i>Adjust Remove I&E impact of capital grants and donations</i>	(619)	(217)
<i>Adjust Remove net impairments not scoring to the Departmental expenditure limit</i>	3,898	1,405
<i>Remove PFI revenue costs on IFRS 16 basis</i>	44,879	44,090
<i>Add back PFI revenue costs on an IAS 17 basis (comparative only)</i>	0	0
<i>Add Prior Period Adjustment</i>	562	0
<i>Add back PFI revenue costs on a UK GAAP basis</i>	(51,009)	(50,222)
<i>Adjust Remove net impact of inventories received from DHSC group bodies for COVID response</i>	0	81
Surplus / (deficit) for the period	(8,753)	(621)

Prior to the Health and Care Act 2022 coming into force, we also had a statutory financial duty to achieve a break-even position on revenue and expenditure taking one year with another. However, our financial performance is now based on agreed financial targets with NHSE. We continue to report on the break-even positions, and the table below shows the cumulative performance against the break-even duty for the last five years.

	2021/22	2022/23	2023/24	2024/25	2025/26
	£'000	£'000	£'000	£'000	£'000
Breakeven duty in-year financial performance	(1,082)	(19,775)	(36,576)	648	(4,912)
Breakeven duty cumulative position	(343,64)	(363,416)	(399,99)	(399,344)	(404,256)
Operating income	596,391	644,967	699,802	807,328	831,752
Cumulative breakeven position as a percentage of operating income	(57.6%)	(56.3%)	(57.2%)	(49.5%)	(48.6%)

NHS trusts also have non-statutory (administrative) duties to meet. These are

- Pay a public dividend capital (PDC) dividend to the DHSC each year.
- Remain within the capital resource limit (CRL)
- Comply with the better payment practice code (BPPC) 178 for the payment of invoices.

Details below for the CRL and BPPC are below:

Capital Resource Limit					
	2021/22	2022/23	2023/24	2024/25	2025/26
	£'000	£'000	£'000	£'000	£'000
Gross capital expenditure	52,565	50,899	48,705	27,361	28,763
Less: Disposals	(884)	(363)	(436)	(773)	(269)
Less: Donated and granted capital additions	(218)	(289)	(371)	(375)	(825)
Charge against Capital Resource Limit	51,463	50,247	47,898	26,213	27,669
Capital Resource Limit	54,112	51,630	47,898	26,213	28,488
Under / (over) spend against CRL	2,649	1,383	-	-	819

Better payment practice code

The trade creditor payment policy of the NHS is to comply with both the Confederation of British Industry (CBI) prompt payment code and the government accounting rules. The Government accounting rules stipulate that, unless otherwise stated, all invoices should be paid within 30 days of receipt of goods or services.

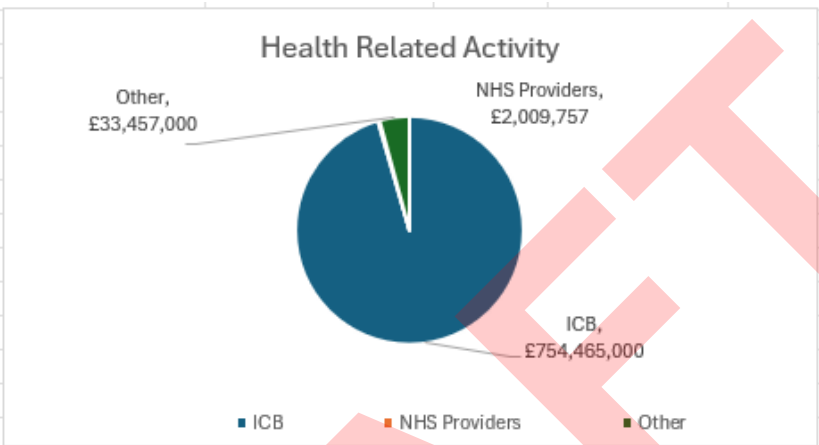
The Trust is measured against a 95% compliance rate target in terms of both value and number of invoices.

Non-NHS Payables	2025/26 Invoice Count	2025/26 £'000	2024/25 Invoice Count	2024/25 £'000	2023/24 Invoice Count	2023/24 £'000
Total non-NHS trade invoices paid in the year	105,864	348,144	104,278	354,177	100,049	357,448
Total non-NHS trade invoices paid within target	92,482	311,083	73,595	276,407	90,391	319,099
Percentage of non-NHS trade invoices paid within target	87.4%	89.4%	70.6%	78.0%	90.3%	89.3%
NHS Payables						
Total NHS trade invoices paid in the year	2,072	23,255	2,218	16,783	2,109	21,234
Total NHS trade invoices paid within target	1,509	13,388	1,107	7,694	1,497	16,186
Percentage of NHS trade invoices paid within target	72.8%	57.6%	49.9%	45.8%	71.0%	76.2%

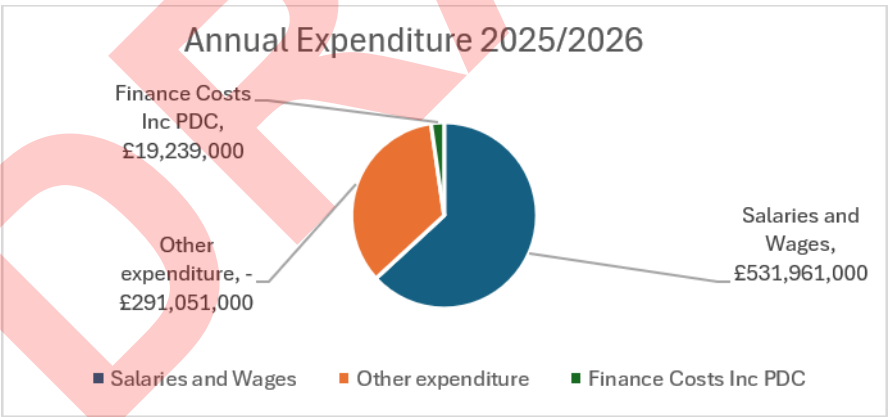
It can be seen in the table above that in invoice volume terms the Trust increased in its performance against the Better Payment Practice Code during 2025/2026. This was aided by changes to processes.

Resources – Income and Expenditure

The Trust generated income of £833.7m which includes £2m finance income during 2025/26. The chart below identifies income received from different sources for health-related activity. The largest share of income is derived from Integrated Care Board (ICB) with the primary source being NHS Herefordshire and Worcestershire ICB.



Annual expenditure incurred in the year totalled £842.3m, which includes £19.2m on finance costs and PDC dividend. Salaries and wages paid to permanent and temporary staff, including those employed through agencies, totalled £532m. Total expenditure on goods and services amounted to £291.1m.



Resources – Capital Expenditure

The Trust spent £28.8m on capital investments during 2025/26 in line with the final plan for the year. The most significant elements within the capital programme were:

2025/26 Capital Expenditure	2025/26 £'000
Clinical Equipment	9.2
Strategic Schemes	1.7
Other Estates Schemes	10.1
Digital	7.2
Lease additions and modifications	0.6
Total Capital Expenditure	28.8

£47.3m of deficit support funding was received due to the planned deficit of the Trust in 2025/26.

The Trust received £15.155m of Public Dividend Capital (PDC) and System Support PDC to support targeted capital schemes, which included £3.0m for the Alexandra Hospital Fire safety scheme and £2.3m for a LINAC (linear accelerator) machine at Worcester Royal Hospital.

The Trust ended the year with a positive cash balance of £7.48m ensuring compliance with its external financing limit.

The current CQC Use of Resources (UOR) assessment rating of the Trust is Inadequate and as such the Trust set up a Financial Recovery Board to meet monthly to oversee the delivery of its overarching financial recovery. Divisions are held to account through monthly executive-led Finance and Performance Executive meetings that are observed by non-executive members of the Board. Finance reports are provided to Board as part of the Trust's Integrated Performance Reports that triangulate quality, finance and performance

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 Executive (FPE) on key performance indicators covering finance and activity.
- Detailed monthly review by the Finance Recovery Board (FRB) on performance against the financial recovery plan.
- Monthly oversight of the delivery of Cost and Productivity Improvement Plans (CPIP) by both the FPE and FRB.
- Monthly Trust Management Board meetings where key operational decisions are made and financial performance reviewed.
- Regular Budget Holder meetings.
- Monthly ICS Finance Committee meetings to review the financial performance and forecasts of system partners and oversee system financial strategy.
- Quarterly ICS level review meetings with NHSE Regional Office.
- Monthly Capital Planning & Delivery Group meetings.

- Monthly Strategic Programme Board meetings.
- Regular CPIP work stream meetings.
- Rapid improvement events and reporting to reflect targeted benefit realisation and improvements.

Pension Liabilities

Within the annual accounts, ongoing employer pension contribution costs are included within employee costs (see Note 9 to the annual accounts for more detail).

Past and present employees are covered by the provisions of the NHS pension scheme. Details of the benefits payable under these provisions can be found on the [NHS Pensions website](#).

Statement of Disclosure for Auditors

Each director knows of no information which would be relevant to the auditors for the purpose 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.

Operational Performance Analysis

NHS Oversight Framework

The NHS Oversight Framework was a new, one-year framework for 2025/26, which is supported by a set of national priorities and other metrics. Organisations’ performance was assessed each quarter during 2025/26 to provide a segment score that determined the level of support or intervention needed by NHS England (NHSE) as follows:

Segment	Description
1	Consistently high performing across all domains, delivering against plans.
2	Good performance across most domains. Specific issues exist.
3	Off track in a range of domains or in financial deficit.
4	Significantly off-track in a range of domains.

All organisations in financial deficit or in receipt of deficit support are limited to a segment score of no greater than 3.

Each quarter, NHSE published data for each organisation, including performance against relevant metrics as well as segment, overall score and rank. The Trust’s overarching performance each quarter was as follows (lower numbers are better):

Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Score	Segment	Rank	Score	Segment	Rank	Score	Segment	Rank	Score	Segment	Rank
2.68	4	110	2.57	3	92	2.79	4	106	2.65	4	109

The Trust continued in financial deficit with deficit support during the year and was challenged on access targets. Although there was an improvement in quarter 2, the position deteriorated at quarter 3 and was reflected in our scores and ranking compared to other acute trusts for the remainder of the year.

The Trust’s performance within each domain was described as follows in the National Oversight Framework quarter 4 results.

Access to services	4 – Low performing
Finance and productivity	4 - Low performing
Effectiveness and experience	3 – Below average
Patient safety	1 – High performing
People and workforce	2 – Above average

National Priorities

The national priorities set for 2025/26 were supported by planning guidance which described how trusts and ICBs should work to achieve the defined measures of success.

Not all the priorities were previously measured by the Trust. Comparative data for previous years is provided where possible.

1. Improve Accident and Emergency waiting times

This priority aligned with the Trust's strategic objectives and was a key area of focus during the year.

The national planning guidance sought to drive improvement through reducing avoidable ambulance dispatches and conveyances, reducing handover delays and improving and standardising urgent care at the front door of the hospital.

a) Percentage of emergency department attendances admitted, transferred or discharged within 4 hours (March results)

Standard	2023/24	2024/25	2025/26
78%	68%	66%	67.26%

b) Percentage of emergency department attendances spending over 12 hours in the department (March results)

2023/24	2024/25	2025/26
Not available	Not available	7.5%

c) Ambulance handovers under 45 minutes (March results)

Standard	2023/24	2024/25	2025/26
80%	Not available*	Not available	83.4%

**The standards previously measured were 30 and 60 minutes.*

The Trust missed the 4-hour target due to a range of pressures including record high levels of demand and congestion throughout the urgent care pathway.

Towards the end of 2025/26, as part of the national urgent care sprint, the Trust implemented an improvement plan focused eliminating corridor care in the Emergency Department (ED) and any ambulance waits over 45 minutes and reducing the overall length of stay in the ED.

Following a successful pilot, the Trust also opened a new Acute Medical Assessment Unit and a new Acute Surgical Assessment Unit.

Due to this work the Trust did see improvements in all emergency access standards in the last few weeks of the year and into 2026/27.

The Urgent and Emergency Care (UEC) Recovery Programme has subsequently been relaunched, focused on discharges from inpatient wards. Improving elective care in this way will help improve emergency access and patient outcomes and experience, as people will be seen and treated earlier, reducing the need for some people to seek acute emergency care.

Implementation of this programme will be overseen by a new Urgent Care Recovery Board.

2. Reduce the time people wait for elective care

The national planning guidance required all providers to deliver this through increased activity levels, effective demand management, driving pathway reform and giving patients choice and control over their care.

Elective care means non-urgent, planned medical procedures that are scheduled in advance. One of the Trust’s key priorities is ensuring patients can access the elective treatment they need in as timely a manner as possible. Prior year performance has been below standard and the Trust’s recovery plans during the year focused on the specialities with the poorest performance.

Performance overall was challenged during the year by a number of factors, such as resident doctor industrial action and adverse weather conditions, both of which required patient appointments to be rearranged.

Key changes made during the year to improve our performance included increasing capacity in our most challenged services, upgrading treatment rooms so we can protect our theatre resources for theatre-only procedures and undertaking an ‘elective sprint’ in quarter 4.

a. Percentage of patients waiting no longer than 18 weeks for elective treatment

Standard	2023/24	2024/25	2025/26
65% by March 2026, with a minimum 5% improvement on 2024/25	54.3%	59.3%	69.9%

b. Percentage of people waiting over 52 weeks for acute care

Standard	2023/24	2024/25	2025/26
<1%	Not available	Not available	1.4%

This standard was not measured in the same way in previous years so a direct comparison is not available. However, from April 2025, performance has improved from 3.57% to 1.4% in March 2026. Although the target was missed and there is more work to do, this is a significant improvement.

3. Reduce the time people wait for elective cancer care

The national focus was on systems working with Cancer Alliances to improve cancer waiting times by maximising care for low-risk patients in non-cancer settings and improving productivity in cancer pathways.

a. Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral

Standard	2023/24	2024/25	2025/26
80%	57.6%	71.1%	74.7%

b. Percentage of patients treated for cancer within 62 days of referral

Standard	2023/24	2024/25	2025/26
75%	71.1%	78.9%	59.8%

While some cancer specialities performed well during the year, there were particular issues in breast and urology in relation to the 28-day standard, and in skin and urology for the 62-day standard.

Recovery plans and support focused on these specialities include:

- Plans to expand operational capacity.
- Robotic process automation solution in Teledermatology
- Support from Wye Valley NHS Trust.
- New low-risk breast pathway.
- Risk stratification at triage to prioritise patients for treatment.

4. Effectiveness and Experience of Care

a) Mortality

The Trust closely monitors rates of mortality and learning from deaths and regularly reports to the Quality Governance Committee and the Board. A key national measure is the Summary Hospital-level Mortality (SHMI), the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die (based on average England figures), given the characteristics of the patients treated.

SHMI is reported each month on a rolling 12-month basis. Data takes time to be analysed nationally and at the time of reporting the most recent data available is for November 2025. Data is sensitive to changes such as coding and inpatient numbers at speciality level.

SHMI is monitored at both Trust and speciality level, which enables more detailed analysis.

The Trust also monitors the ‘crude mortality rate’ – the number of deaths and the percentage of deaths of all inpatient admissions and Emergency Department attendances, which helps identify any potential concerns more quickly.

This, together with detailed reviews of individual deaths, helps provide assurance regarding mortality levels at the Trust.

December 24-November 25	December 23-November 24	November 22-October 23
1.10 (within expected range)	1.05 (within expected range)	1.04 (within expected range)

a) Care Quality Commission Inpatient Survey

The CQC’s annual adult inpatient survey provides useful benchmarking information and a helpful opportunity to triangulate more data about the experience of patients that use our services. The results of the survey are presented to the Quality Governance Committee so they can be considered alongside other information such as complaints, access data and patient feedback.

A key measure taken from the survey is the patient satisfaction rate. The most recent survey for which data is available was undertaken in 2024, the results of which were published in September 2025. The improvement achieved in 2023 was sustained in 2024.

Metric	2022	2023	2024
Overall experience	7.1/10	8.0/10	8.0/10
Compared with other trusts	About the same	About the same	About the same

More information about how we are working to improve patient experience can be found in our annual Quality Account, published on our website: [Annual Reports and Quality Accounts - Worcestershire Acute Hospitals NHS Trust](#).

5. Patient Safety

a. Infection Prevention and Control

The rate of certain infections is monitored closely internally, by the Trust Board and by NHSE.

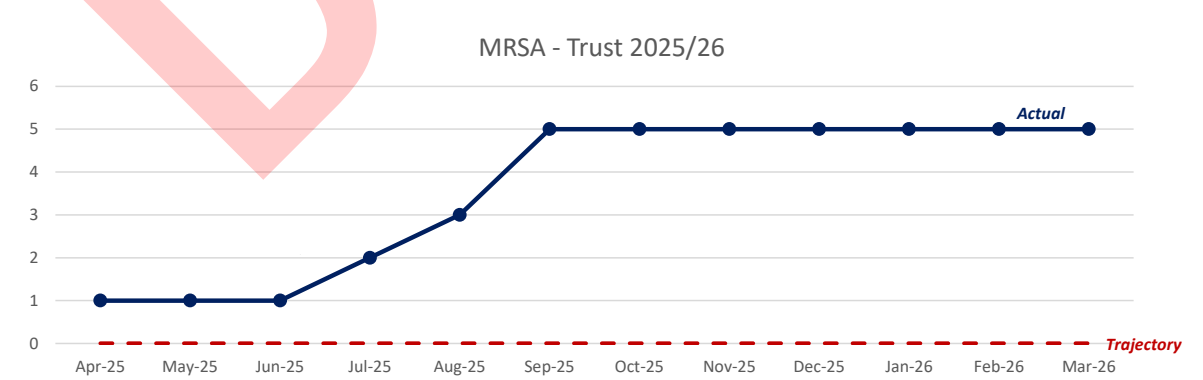
Unfortunately, the number of MRSA cases was above threshold. Each case was reviewed and learning will be reflected in a revised policy.

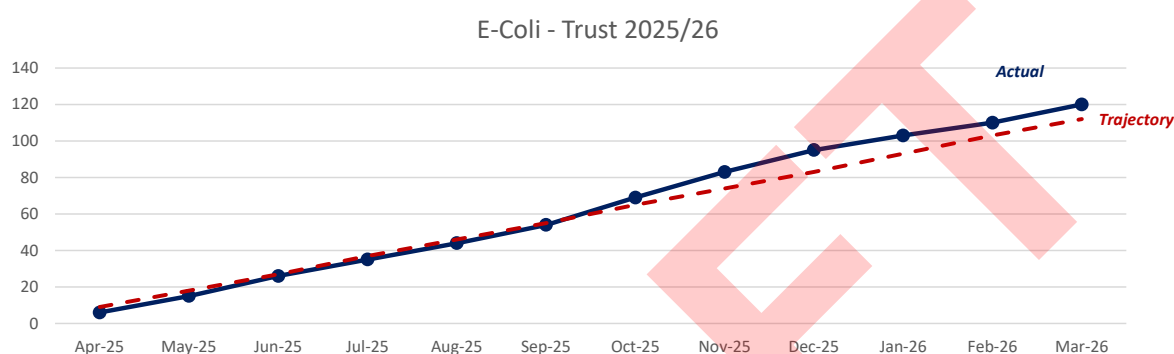
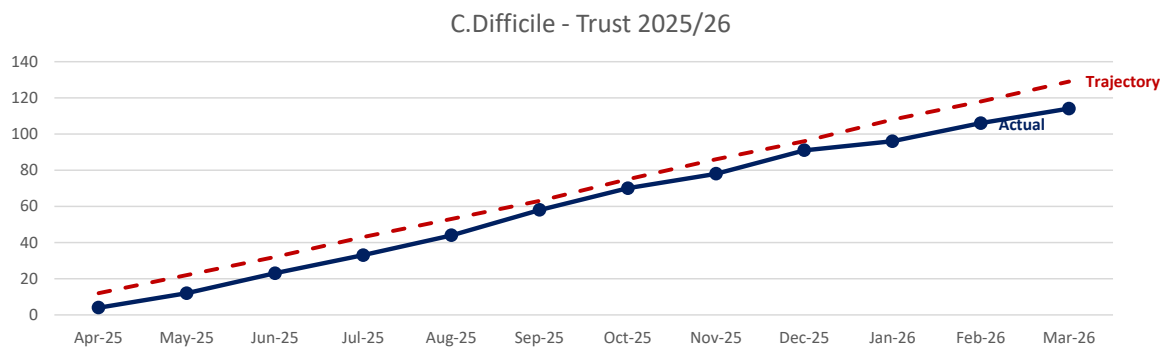
An increase in C-Difficile cases was a common pattern nationally and monitored by the UK Health Security Agency (UKHSA) but the rate improved compared to last year and was below the national threshold.

The number of E-Coli infections was above the national threshold. All cases are reviewed to identify learning and implementation of any changes is carefully monitored. National data indicates that urinary catheter care and timely surgical management of cholecystitis are important and these are therefore a focus for the Trust.

Detailed information about actions we are taking to drive down healthcare acquired infections can be found in the Trust’s annual Quality Account.

Metric	Threshold	2025/26	2024/25	2023/24
MRSA bacteraemia cases	0	5	1	0
Reportable C-Difficile infections	>129	114	137	94
E-Coli bacteraemia infections	>108	120	112	55





b. Staff Survey Raising Concerns Sub-Score

The annual, national NHS Staff Survey provides valuable information not only about staff experience but also the effectiveness of our safety arrangements. This includes questions about raising concerns. The Trust's scores have gradually improved over the last three years and are about average compared to peer organisations.

This is an area of focus for the People and Culture Committee, which receives regular reports from the Freedom to Speak Up Guardian about reactive and proactive work to support people to raise concerns.

Standard	2025	2024	2023
Out of 10	6.47	6.38	6.14

6. People and Workforce

a. Sickness Absence Rate

The Trust Board monitors the staff sickness absence rate closely throughout the year. The Trust target was not met, with varied performance across clinical and corporate divisions. Mitigations and controls included support through occupational health and other wellbeing support, targeted interventions in areas with high sickness absence and support for managers to ensure compliance with policy.

Standard	2025/26	2024/25	2023/24
4%	5.4%	5.1%	5.75%

b. Staff Survey Engagement Theme Score

This important measure provides an indicator of how motivated, involved and committed staff feel, which links directly with the quality of care.

The Trust's engagement score continued the gradual improvement trajectory of the last three years, remaining above the national average.

Standard	2025	2024	2023
Out of 10	7.01	6.90	6.60

Overall, the Trust's staff survey results for 2025 were positive, with overall scores showing improvement across all seven People Promise themes for second year running. There were significant improvements in five areas and all scores in the People Promise themes were above the national average.

People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	7.31	3473	7.36	3861	Not significant
We are recognised and rewarded	5.90	3477	6.03	3863	Significantly higher
We each have a voice that counts	6.67	3444	6.73	3839	Not significant
We are safe and healthy	6.12	3455	6.26	3835	Significantly higher
We are always learning	5.61	3275	5.69	3635	Not significant
We work flexibly	6.43	3453	6.64	3845	Significantly higher
We are a team	6.71	3472	6.81	3861	Significantly higher
Themes					
Staff Engagement	6.82	3478	6.84	3867	Not significant
Morale	5.95	3478	6.13	3872	Significantly higher

Other Performance Measures

The Trust Board monitors many measures of performance against targets and standards relevant to safety, patient experience, patient outcomes, productivity and patient flow. Some of the important measures, including national targets and those linked to Trust, ICB and Foundation Group strategies are as follows.

Measure	Standard	2025/26	2024/25	2023/24
Percentage of people waiting over 6 weeks for a diagnostic procedure or test	5%	24.5%	14.4%	25.8%
Theatre utilisation	85%	85.3%	84%	82.0%
Outpatient appointments not attended (did not attend - DNA - rate)	<4%	4.4%	4.6%	5.0%

Quality Priorities

Each year the Trust publishes a Quality Account which sets out progress on achieving our quality priorities and describes the new priorities we intend to measure the following year. More detail can be found in our Quality Account 2025/26 on our website. Oversight of progress is incorporated in the workplan of the Quality Governance Committee.

Quality Account Priorities Care that is safe	
• Reduce avoidable healthcare acquired infections • Ensure patients experience safe and timely discharge from hospital, with a focus on Hospital Acquired Functional Decline (HAFD) • Ensure a high standard of nutrition and hydration assessment for all patients	

Progress	Further work needed
Partially met national infection thresholds and improved performance on C.difficile. We met targets for MUST (malnutrition universal screening tool) and fluid balance training. There was a reduction in complaints and incidents relating to nutrition and hydration.	We did not meet all our discharge targets. We have embedded principles that support patient flow and reduce HAFD (hospital acquired functional decline) and expect to see improvements in 2026/27. We missed targets for weighing patients on admission and completing MUST assessments. We have expanded our nutritional and dietetics teams and this will support improvement in 2026/27.

Quality Account Priorities Care that is clinically effective	
• Continually learn from deaths and ensure patients in hospital at the end of their lives receive high quality, individualised care • Reduce the time patients are waiting for treatment	

Progress	Further work needed
Mortality rates were 'as expected'. We increased use of the AMBER care bundle for adult patients with an unplanned admission. Achieved target for ambulance handover times. Improved performance on waits under 18 weeks. Reduced the number of people waiting over 52 weeks.	We missed the target for expected adult deaths having an individualised Last Days of Life care plan. Staff will receive training in 2026/27 on caring for patients likely to be in the last year of life. We are working to improve our performance on elective and cancer waiting times.

Quality Account Priorities Care that is a positive experience	
• Ensure all patient, including those requiring reasonable adjustments, receive safe, personalised care and achieve equality of outcomes • Ensure patients, their relatives and carers feel listened to • Continuously learn from patient feedback	

Progress	Further work needed
Met the target for Oliver McGowan training. Delivered plans to engage and partner with stakeholders to support better patient experience Met targets for improving response to PALS (patient advice and liaison service) contacts and complaints. Achieved a 95% recommended rate in the Friends and Family Test (FFT)	We will continue to work with divisions to support achievement of targets for FFT and inpatient survey response rates.

Quality Governance

Information about quality governance is included in the Annual Governance Statement within the Accountability Report later in this document.

Equality, Diversity and Inclusion

Equality of Service Provision

The Public Sector Equality Duty (PSED) under the Equality Act 2010 applies to Worcestershire Acute Hospitals Trust and other public bodies that carry out public functions. It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities. This helps them deliver services that are efficient and effective, accessible to all, and meet the needs of different people. This applies to the Trust as a service provider and employer.

The PSED requires the Trust to have due regard (think about and act) to the: “Need to eliminate discrimination, advance equality of opportunity and foster good relations for people with a protected characteristic when developing its policies, services or when carrying out day-to-day functions and activities”.

In order to meet this duty, all our business cases and policies are required to include an equality impact assessment.

As an NHS provider we are committed to ensuring that our services are accessible to, and meet the diverse needs of, all our patients and visitors. We are committed to working in partnership with colleagues in other NHS organisations, voluntary and community groups and all our key stakeholders to enable us to plan and deliver our services in a way which best meets the needs of everyone in the communities we serve.

Each year we publish information about our compliance with the PSED in an Equality Report. The most recent report can be found on the Trust [website](#). The report includes a review of formal complaints through an equality, diversity and inclusion lens.

In addition to established arrangements, new initiatives to promote equality of service delivery during 2025/26 included:

- Expanded the Chaplaincy service, creating a new multi-faith chaplaincy hub.
- As part of our Allied Health Professionals annual awards, created a new EDI Award to celebrate individuals who have demonstrated a strong commitment to advancing equality, diversity, and inclusion through their everyday work.
- The Patient and Public Forum has shared lived experiences with a focus on health inequalities.
- Continued to access opportunities to raise awareness of initiatives to support people who are D/deaf.
- Specialist Applied Psychology and Cardiac colleagues have worked collaboratively to support patients who have experienced trauma and who find it difficult to access and trust services, to work in partnership and find new ways to be fully engaged in their care.
- Working with AccessAble we now have 155 Detailed Access Guides to our departments, wards and facilities, which are reviewed and updated annually.
- Promoted “On Demand” Interpreting machines and additional digital options.
- Dementia care and enrichment programme.
- Launched the Anti-Racism Charter with an implantation workplan.
- A charity funded programme for International Staff and Students Integration.
- Initiatives to improve the accessibility of the complaints process, including making the service more inclusive for patients using assistive technology, those with visual impairments, and non-native English speakers

- Established new volunteer services:
 - Peony End of Life Volunteer Service: provides support, comfort, and companionship to patients who are on an end-of-life pathway, and those closest to them.
 - Discharge Response Volunteers: an invaluable link between ward staff and Pharmacy teams, helping to speed up the discharge process for patients who are ready to go home.
 - Breastfeeding Friends: support for new mothers and families during their stay in hospital.

Tackling Health Inequalities

1. Understanding our population and service use

Health inequalities are the avoidable, unfair and systematic differences in health outcomes across the population and between different groups within society. Healthcare inequalities relate specifically to differences in access to services, experiences of care and outcomes from healthcare.

Worcestershire has a population of approximately 603,600 people (2021 Census). During 2025/26, the Trust provided services across urgent and emergency care, elective inpatient and day case care, and outpatient services.

Table 1: Population of Worcestershire and Trust activity

Worcestershire census	Non-elective/emergency admissions			Elective inpatient day case activity			Outpatient Activity		
	2019/20	2024/25	2025/26	2019/20	2024/25	2025/26	2019/20	2024/25	2025/26
603,600	62,940	57,220	54,000	93,355	95,040	96,000	581,570	702,450	731,000

This year, the Trust has undertaken detailed analytical work, linking patient-level activity data across all major care settings to the Index of Multiple Deprivation 2025 and to ethnicity data. This section presents the findings of that analysis across five areas: urgent and emergency care, emergency admissions, elective care, outpatient care and cancer diagnosis.

This analysis is now informing the Trust’s strategic planning and its engagement with system partners.

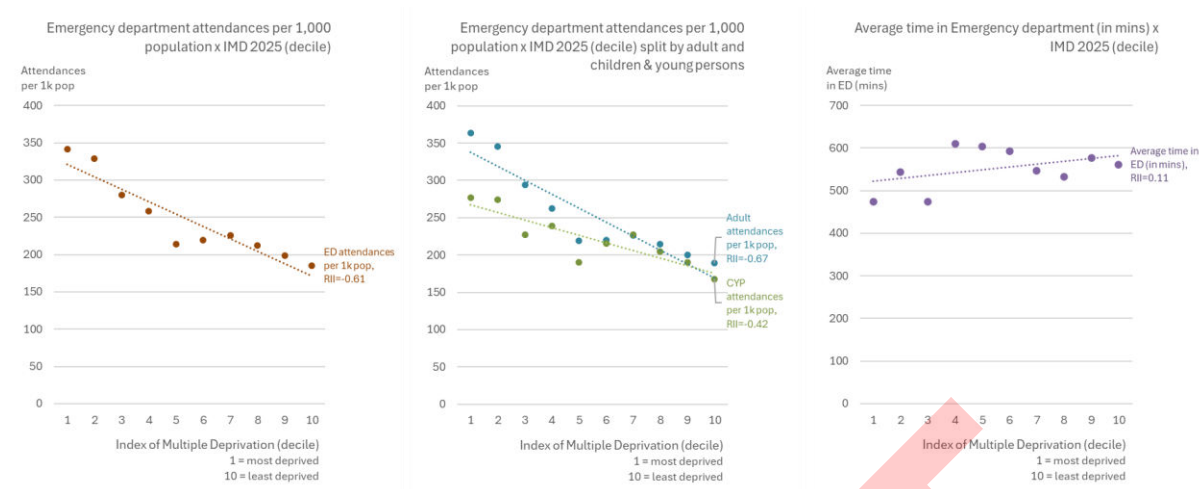
2. About the Index of Multiple Deprivation

The IMD 2025 is a composite measure of deprivation across small geographic areas in England. Decile 1 represents the 10% most deprived areas in England; Decile 10 the least deprived.

Approximately 12% of Worcestershire’s population lives in deciles 1 or 2 compared to 23% in deciles 9 or 10. This means the county is, on balance, less deprived than England as whole, but that a significant minority of our population faces significant disadvantage.

3. Urgent and Emergency Care

Charts 1-3: (1) Emergency Department attendance rate per 1,000 population by IMD2025 decile, (2) adults and children separately, and (3) average time in ED



Observations from Charts 1, 2 and 3:

- Patients from the most deprived areas of Worcestershire are 1.5 times more likely to attend our Emergency Departments than those from the least deprived areas. This is statistically significant (meaning it is very unlikely to be due to chance) and consistent across both sites.
- The gradient is most pronounced for adults, with a similar though less steep pattern observed for children and young people.
- There is no deprivation-related inequality in time spent in the Emergency Department. Patients from all IMD groups are treated within broadly comparable timeframes.

3.1 Emergency Department attendance by ethnicity vs 2021 Census information

Table 2: Proportion of ED attendances by ethnic grouping

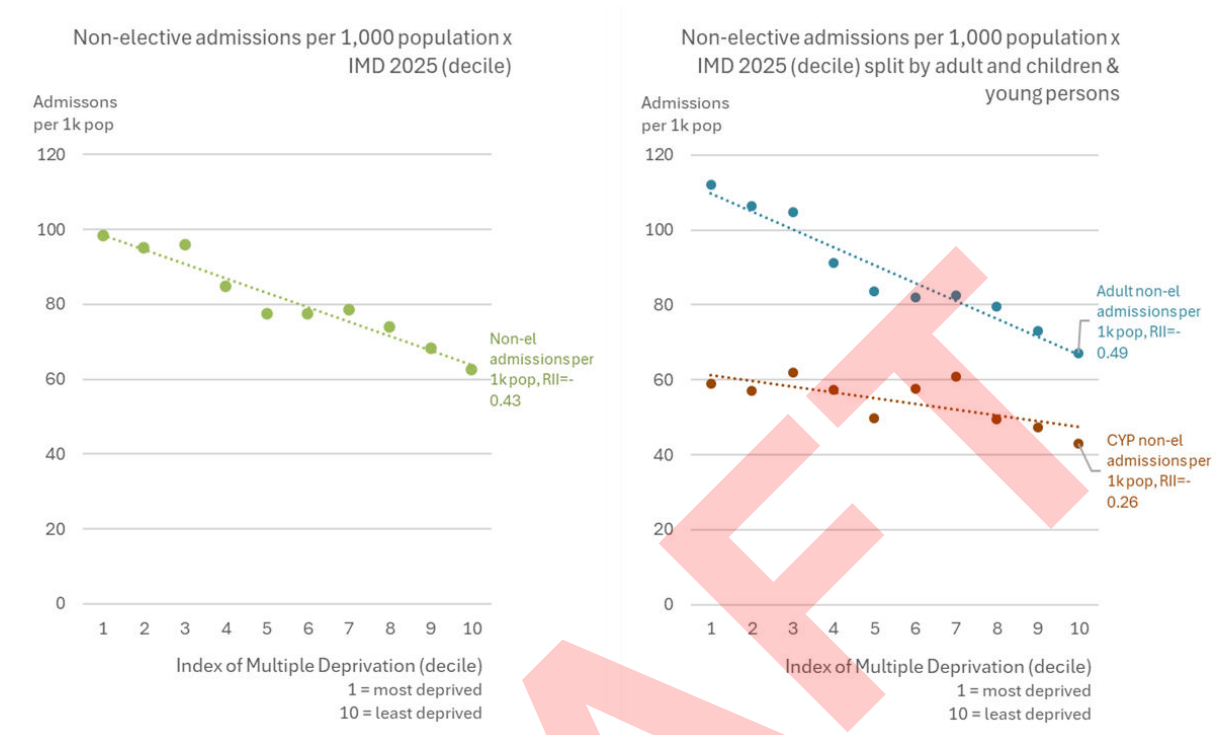
Ethnic group	Emergency department attendances	2021 Census	Difference	Average time in Emergency department (all patients, in minutes)	Average time in Emergency department for admitted patients (in minutes)	Average time in Emergency department for non-admitted patients (in minutes)
Asian	3.7%	3.1%	0.6%	392	756	343
Black	1.0%	0.7%	0.3%	408	712	366
Mixed	1.0%	1.9%	-0.9%	273	472	243
White	88.0%	93.8%	-5.8%	568	978	437
Other	1.0%	0.6%	0.4%	359	778	275
Not known	5.3%			524	968	402
of which not given or patient not medically fit to answer	0.1%					
Avg (all ethnic groups)				552	967	426

Observations from Table 2:

- Recording of patient ethnicity in the Emergency Department is incomplete and robust conclusions about ethnic inequalities in ED access cannot therefore be drawn.
- On available data, there is no clear evidence of differential waiting times by ethnicity.

3.2 Emergency Admissions

Charts 4-5: (4) non-elective admission rate per 1,000 population by IMD decile and (5) adults and children separately



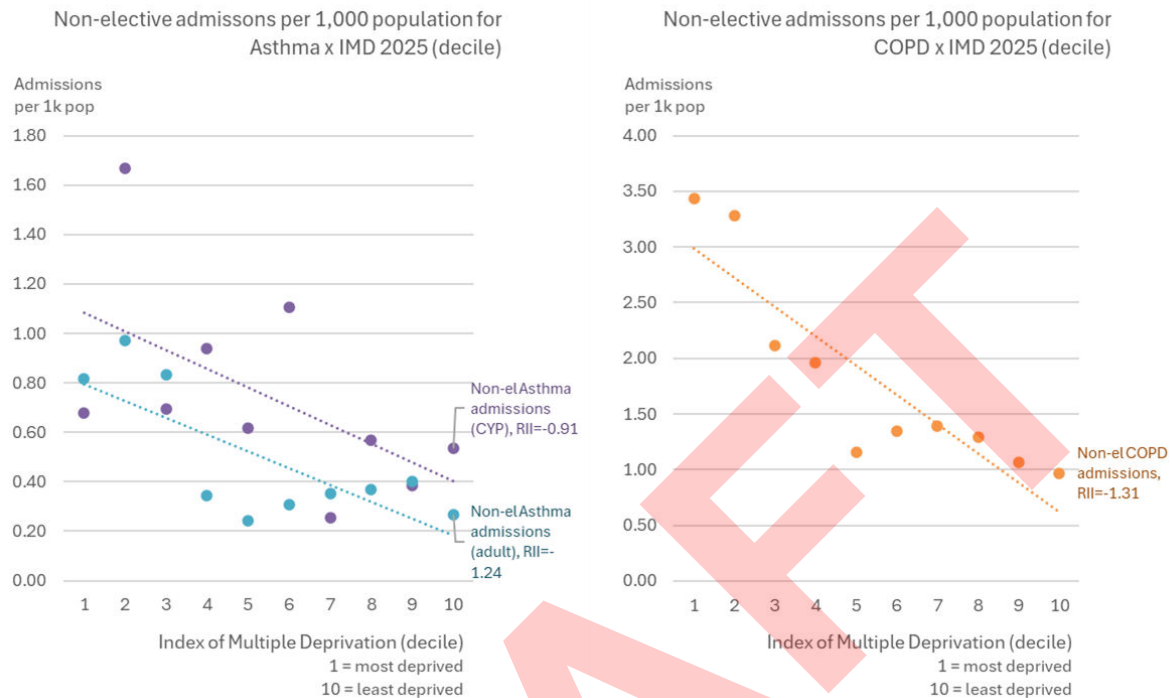
Observations from charts 4 and 5:

- Strong deprivation gradient seen in ED attendances is replicated in non-elective admissions. Patients from more deprived areas are significantly more likely to be admitted as emergencies, and this effect is again more pronounced in adults.
- Patients from the most deprived communities who require emergency admission are, on average, a decade younger than those from the least deprived areas – a clear illustration of the impact of deprivation on health.
- There is no statistically significant difference in average length of stay for adults by deprivation, though children and young people from more deprived areas show a slight tendency toward longer inpatient stays.

3.3 Focus on non-elective admissions for specific conditions:

1. Respiratory disease

Charts 6-7: Non-elective admissions for asthma and COPD by IMD decile

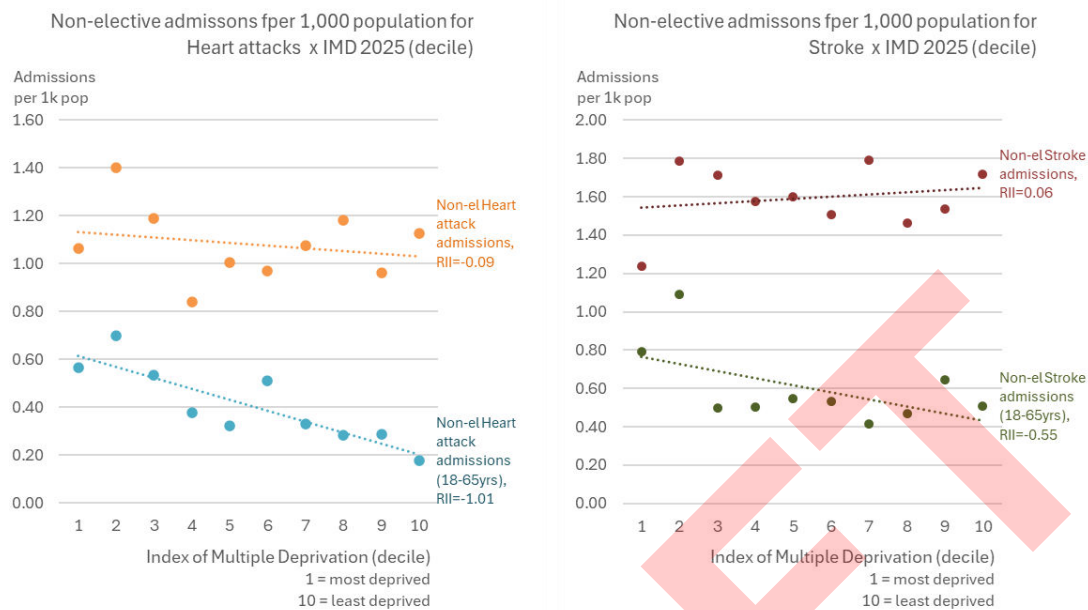


Observations from charts 6 and 7:

- Non-elective admissions for COPD show a strong and statistically significant deprivation gradient. Patients from the most deprived areas are over three times more likely to be admitted with COPD than those from the least deprived areas and tend to be younger at admission.
- For asthma, a similar gradient is observed for both adults and children, though the effect in CYP does not reach statistical significance given smaller sample sizes.

Cardiovascular disease

Charts 8-9: Working-age admission rates for Heart Attack and Stroke by IMD decile

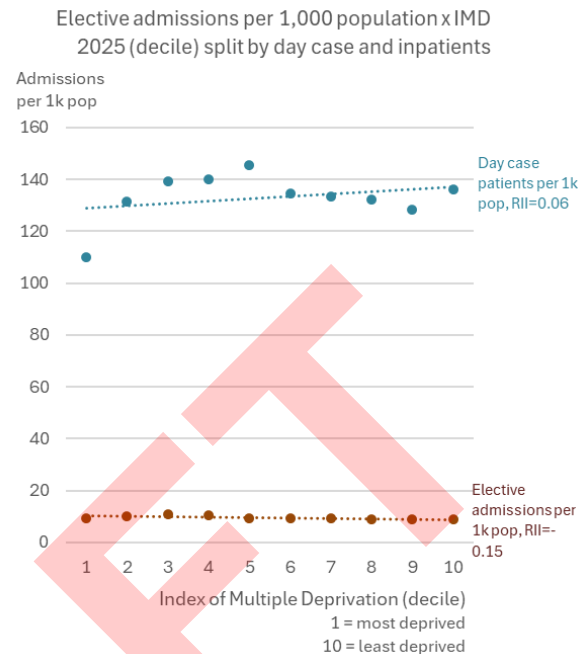
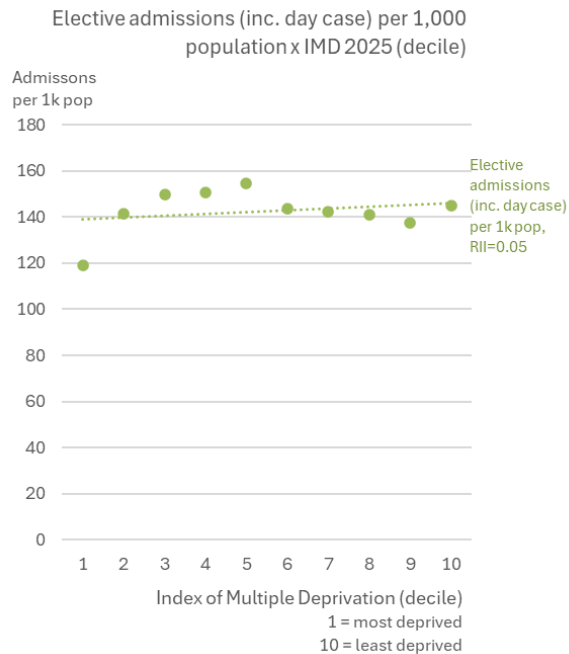


Observations from Charts 8-9:

- When the full age range is considered, admission rates for heart attack and stroke do not show a clear deprivation gradient – a function of the older average age of patients from less deprived areas.
- However, for working-age patients, the picture is markedly different. Working-age patients from the most deprived areas are almost three times more likely to be admitted with a heart attack than people from the least deprived areas of Worcestershire. A similar pattern is seen for stroke.
- This represents a significant premature mortality and morbidity risk concentrated in the most disadvantaged communities in Worcestershire.

4. Elective Care (Inpatient and Day Case)

Charts 10-11: Elective admission rate by IMD decile – all specialties

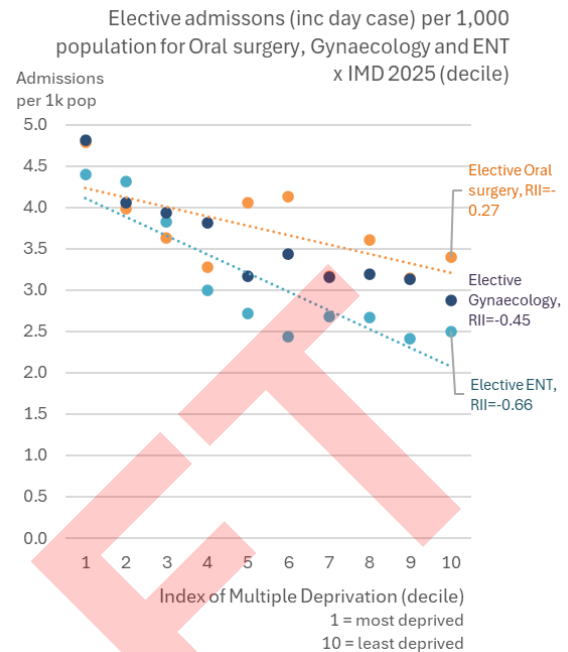
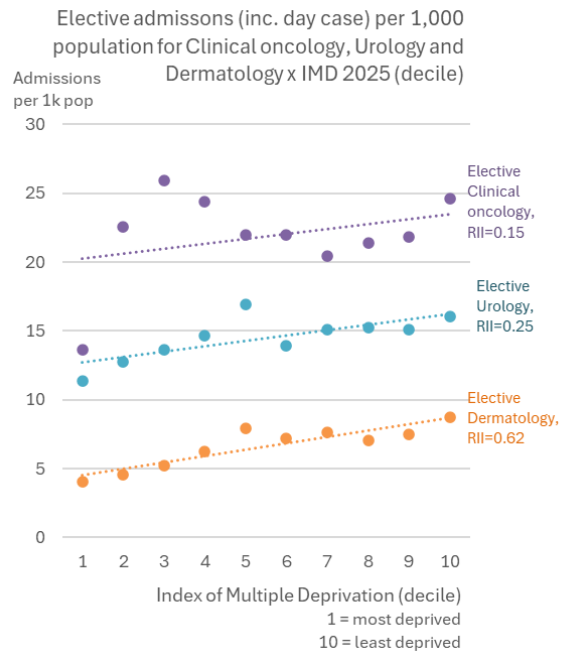


Observations from Charts 10 and 11:

- Overall, elective inpatient and day case activity does not show the deprivation gradient seen in emergency care. On aggregate, patients from all deprivation groups access elective care at broadly comparable rates. This is a reassuring indicator that clinical prioritisation, rather than deprivation, is the primary driver of elective access.
- However, this picture is not consistent across all specialities.

4.1 Elective care specialties

Charts 12-13: Specialties with significant deprivation bias



Observations from Charts 12 and 13:

- Dermatology shows a pronounced and consistent bias towards patients from less deprived areas accessing elective care which is likely to reflect barriers to early help-seeking.
- Clinical Oncology and Urology show a less severe bias in the same direction as above.
- Conversely, Oral Surgery and Gynaecology and ENT show activity weighted towards patients from more deprived areas – a pattern consistent with higher rates of relevant acute need in those communities.
- Ethnicity data quality remains a challenge in elective care with approximately 1 in 10 elective inpatient records not including a valid ethnicity code. Available data suggests some underrepresentation of Asian and Mixed-race patients in elective admissions.

5. Outpatient Care

Chart 14-16: Outpatient activity rate by IMD decile, Obstetrics, Thoracic and Diabetic medicine, and Urology and Dermatology

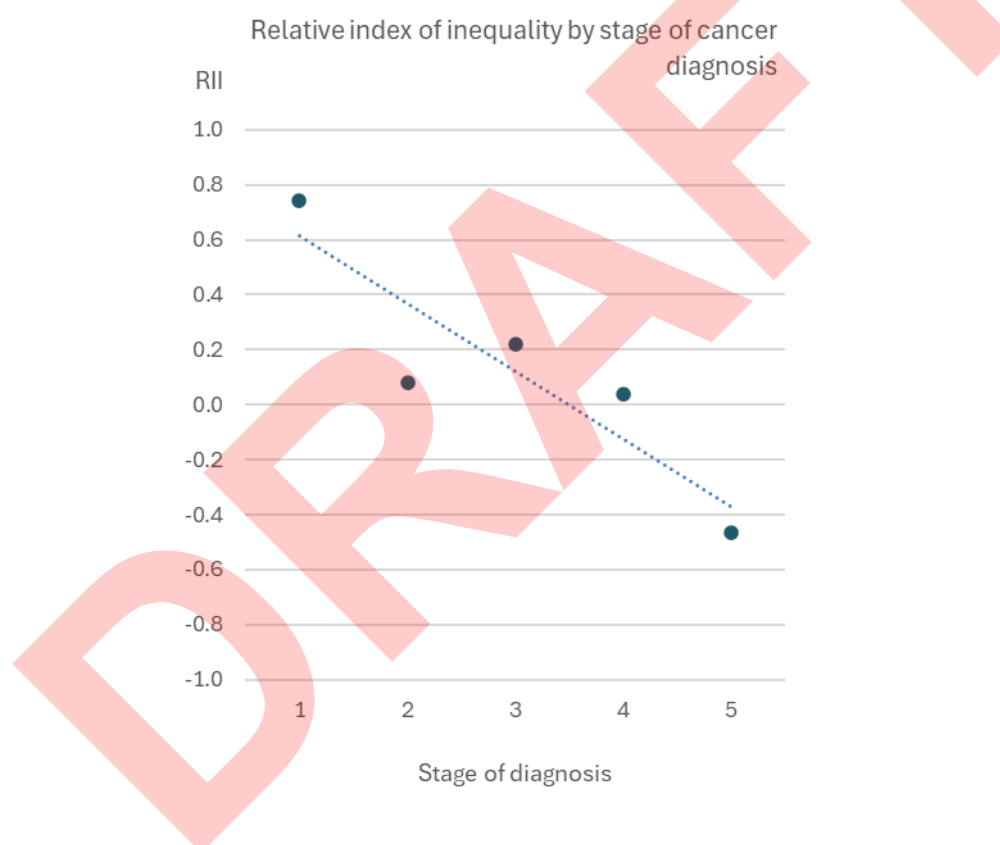


Observations from Charts 14, 15 and 16 show:

- Overall outpatient activity shows a statistically significant deprivation gradient, although less pronounced than in emergency care.
- Obstetrics, Diabetic Medicine and Thoracic Medicine all show higher rates of outpatient activity in more deprived patient groups, reflecting higher population prevalence of the conditions these specialties treat.
- Urology and Dermatology show the reverse, a bias towards patients from less deprived areas, consistent with the elective care findings above.
- Ethnicity recording in outpatients is better than in inpatient settings, but approximately 1 in 12 outpatient records still lacks a valid ethnicity code.

6. Cancer Diagnosis

Chart 17: Stage of cancer diagnosis by IMD decile (data from April 2025 to February 2026)



Observations from Chart 17 show:

- Data shows a consistent trend with patients from less deprived areas being more likely to receive an early (stage 1 or 2) cancer diagnosis while patients from more deprived areas are more likely to be diagnosed at a later stage.
- This later stage diagnosis gradient is more clearly observable for Breast, Colorectal and Urological Cancers.
- Later stage diagnosis is associated with poorer outcomes and higher treatment costs. This finding highlights the importance of upstream action on cancer awareness, screening uptake and GP access in deprived communities.

- Ethnicity data is recorded in only 13% of records in cancer datasets making analysis unreliable.

7. Summary

The analysis represented in this section is the most comprehensive the Trust has undertaken and confirms patterns consistent with the national evidence base on health inequalities.

Acute hospitals occupy a particular position in the health inequalities landscape, seeing the downstream consequences of social disadvantage. We will work with our local health and care system partners to ensure that when patients from deprived communities do need our services, they receive equitable access, experience and outcomes, and that our data meaningfully informs the system's wider prevention and intervention response.

In line with NHS England's *Statement on Information on Health Inequalities*, the Trust has published quantitative and qualitative information within this Annual Report to demonstrate how it is identifying and responding to healthcare inequalities. This year's analysis represents the most comprehensive baseline the Trust has established to date and provides the foundation for a more targeted and evidenced response in 2026/27.

Countering Fraud, Bribery and Corruption

The Counter Fraud Functional Standard (CFFS) was introduced by the Cabinet Office to standardise how fraud is dealt with across government. Since April 2021 the NHS Counter Fraud Authority (NHSCFA) has been required to report to the Cabinet Office in relation to the NHS response to the Functional Standard.

All NHS funded services are required to comply with the Functional Standard. Within the Trust, progress against the requirements of the Functional Standard is overseen by the Trust's Chief Finance Officer and the Audit and Assurance Committee.

The Trust is required to self-assess against the requirements of the Functional Standard annually by completing and submitting the Trust's Counter Fraud Functional Standard Return (CFFSR).

The Trust has a nominated Local Counter Fraud Specialist (LCFS) in place provided by NHS consortium 360 Assurance. The LCFS is responsible for carrying out a range of activities in compliance with the above standards.

The Trust has a Counter Fraud Bribery and Corruption Policy to make sure staff are aware of their responsibilities should they suspect an offence has been committed. When economic crime is suspected, it is fully investigated in line with legislation and can result in criminal, disciplinary and civil sanctions.

Fraud, bribery, and corruption can result in resources being diverted away from their intended purpose. The Trust does not tolerate fraud and works with the LCFS to identify instances of fraud, impose the appropriate level of sanctions where fraud has been committed and reduce the possibility of fraud taking place.

If staff are concerned about fraud within the Trust, they can report direct to the LCFS or can contact the confidential NHS Fraud and Corruption Reporting Line.

The LCFS agrees with the Audit and Assurance Committee an annual plan to deliver this work, which is both proactive and reactive.

Proactive Work

- Review of the Trust's governance arrangements to ensure that anti-crime measures are embedded at all levels.
- Raising awareness of economic crime risks against the NHS, including fraud awareness sessions for staff and the completion of a counter fraud risk assessment.
- Proactive detection exercises based on identification and assessment of fraud risk.
- Reporting to the Trust the outcomes, system weaknesses and losses identified through proactive exercises and recording these on the NHSCFA's fraud case management system.

Reactive Work

- Detecting and investigating economic crime, applying sanctions and seeking redress.

Failure to Prevent Fraud Offence

In September 2025, new legislation was introduced stating that "an organisation is criminally liable if an employee, agent, subsidiary, or other "associated person" commits a specified fraud offence intending to benefit the organisation (or its client)".

The Trust is confident that it complies with the legalisation and is reviewing the requirements of the NHSCFA checklist to ensure that all requirements are in place or steps are taken to address any possible gaps. A link to the CEO's statement on the new legislation can be found on the Trust's [website](#).

Partnership Working

The Trust's key partnerships during the year were with its partners in the Foundation Group and the Integrated Care System.

The Trust engaged as a key partner in the production of the ICB Joint Forward Plan.

The core areas of the plan align with the Trust's strategic priorities which are reflected in our operational and financial plans.

The Trust delivered its capital programme in accordance with the ICS capital resource plans and agreed allocations.

Environmental Matters

As a healthcare provider, the Trust has a duty to protect the health of our natural environment for the benefit and for delivery of sustainable healthcare services in our area. As the largest healthcare services institution in our county, we play an important role beyond the boundaries of our estate for both the population we serve and the wellbeing of the staff we employ.

Our Green Plan sets out our strategies to achieve this and to meet the targets set by NHS England, including reducing emissions we have influence over to net zero by 2040 and for emissions we can influence to net zero by 2045. More information can be found within the Green Plan on our [website](#).

Task force on climate-related financial disclosures (TCFD)

The Department of Health and Social Care Group Accounting Manual (GAM) has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

Where relevant, supporting information is included within this report and the Trust's Green Plan.

The following sections set out how the Trust is managing climate-related risks and opportunities through its governance arrangements, strategic planning, risk management processes and performance monitoring.

Governance Pillar

Board oversight of climate-related issues

One of the Foundation Group Big Moves is to 'lead the NHS on carbon reduction', which includes climate resilience and adaptation. Delivery of this ambition is incorporated in the Trust's organisational plans and measured as part of annual objectives.

A joint report from the four trusts of the Foundation Group on progress in delivering their respective Green Plans is presented annually at a meeting of the Foundation Group Boards. This provides an opportunity for benchmarking and learning.

An update on this report, including the climate adaptation plan was presented to the Trust Board part way through the year.

The Chief Clinical Strategy Officer is the Board-level Net Zero Lead who oversees the resourcing and delivery of the Green Plan, which includes Climate Change Adaptation.

A Green Steering Group (GSG) meets monthly to review progress against the Green Plan and associated performance measures. The group also supports the sharing of best practice and

encourages innovation and new ways of working, drawing on input from members, the Green Champions network and the Clinical Sustainability Group.

Compliance with the Green Plan, including climate change adaptation, is now included in the standard operating process for business cases utilising a sustainability impact assessment tool. Reports are provided to the Trust Management board (TMB) to give assurance that the Trust is on track.

The Green Plan was published in July 2025 in line with NHS England guidance and sets out the Trust's approach to delivering its net zero and sustainability objectives. The Plan is currently being refreshed for 2026/27, with divisional leadership teams expected to reflect the strategic priority to 'lead the NHS on carbon reduction' within their annual plans. Delivery is monitored through the Green Steering Group.

The Trust is an active member of the Worcestershire Public Sector Sustainability Group, working alongside local partners to take coordinated action on sustainability across the county. Through this group, the Trust contributes data, clinical insight and estate expertise to support the development and delivery of sustainability plans, including the local climate change adaptation plan. This work focuses on understanding the likely impact of climate change across the region and identifying practical steps to reduce and manage those effects. Recent work has included action to improve local air quality and a strategic assessment of opportunities to expand heat networks across the area.

Strategy Pillar

Climate-related risks and opportunities

The Trust has identified a range of climate-related risks and opportunities across the short, medium and long term, aligned to organisational planning cycles and delivery of the Green Plan.

In the short term, risks include the impact of extreme weather on service delivery and estates infrastructure, such as overheating of buildings, flooding and disruption to clinical services. There are also operational risks linked to supply chain resilience, including availability of clinical equipment and medicines.

In the medium to long term, risks relate to the scale of change required to meet NHS net zero targets, including the need for investment in estates, infrastructure and service redesign. There is also a risk of increased financial and operational pressure if action is delayed.

Alongside these risks, there are opportunities to improve efficiency and sustainability across the organisation. These include reducing emissions through more efficient use of energy and resources, delivering more sustainable models of care, and improving population health outcomes through reduced environmental impact.

Impact on the organisation

These risks and opportunities have an impact across how the Trust operates, plans and uses its resources.

From an operational perspective, extreme weather and climate-related events can affect the resilience of our estate and the continuity of services. These risks are considered as part of our business continuity and emergency preparedness arrangements.

From a strategic point of view, delivery of the Green Plan and progress towards NHS net zero targets are built into our organisational objectives and planning. This includes embedding sustainability into service transformation, procurement, estates planning and clinical pathways.

There are also financial considerations. Investment is needed to support decarbonisation and adaptation, but there are opportunities to reduce costs over time through more efficient use of resources and reduced waste.

Overall, the Trust is managing these risks and opportunities through its existing governance, risk management and programme structures, ensuring climate considerations are part of wider decision making rather than a separate activity.

Risk Management Pillar

Processes for identifying and assessing climate-related risks

The Trust's established risk management framework is used to assess climate-related risks. Assessment of climate-related risks is described in the Trust's climate adaptation policy and plan (approved in 2024). A Climate Adaption Working Group reviews these risks as part of business resilience under the Emergency Prevention, Preparedness and Response (EPPR) committee.

Risks include funding to achieve our objectives and the management of climate-related issues such as overheating of buildings and disruption caused by flooding or problems with supply of clinical equipment and medication.

The Trust is continuing to develop and refine a standard set of performance metrics and measures to support delivery of the Green Plan, with progress monitored through established reporting arrangements.

Processes for managing climate-related risks

Climate-related risks are included within the Trust risk register, which is overseen by the Executive Risk Management Committee as well as the Climate Adaptation Working Group to ensure appropriate mitigations, controls and plans are in place.

These risks are used to inform planning and prioritisation of actions within the Green Plan and wider organisational decision making.

Metrics and target pillar

Carbon Footprint

The NHS has set two main targets for achieving net zero emissions:

- Net zero by 2040 for emissions directly controlled by the NHS.
- Net zero by 2045 for emissions influenced by the NHS, with an ambition for an interim 80% reduction by 2036-2039.

These targets are part of the NHS's commitment to addressing climate change and improving health outcomes.

Taking 2020/21 as the Trust baseline, total emissions needed to be reduced by 25% by 2024/25. The total carbon emissions for 2024-25 amounted to 14,397 tonnes, representing a 4.6% reduction compared to the 2021-22 baseline year. This reduction demonstrates that progress is being made but

is behind expectations to comply with NHSE targets for achieving Net Zero emissions. Year on year progress is detailed within the table below.

	2021/22 tCO ₂ e	2022/23 tCO ₂ e	2023/24 tCO ₂ e	2024/25 tCO ₂ e
Total Emissions	15,098	14,826	15,211	14,397
Scope 1	5,284	6,937	7,747	8,195
Scope 2	7,917	5,883	6,718	5,350
Scope 3	1,897	2,007	746	852

WAHT total GHGe emissions have shown a gradual decrease over the four-year period, dropping from 15,098 tCO₂e in 2021/22 to 14,397 tCO₂e in 2024/25. However, the trend across scopes varies:

- Scope 1 (Direct emissions): Increased significantly from 5,284 tCO₂e in 2021/22 to 8,195 tCO₂e in 2024/25. This rise suggests higher on-site fuel use or other direct sources.
- Scope 2 (Purchased electricity and steam): Decreased sharply from 7,917 tCO₂e in 2021/22 to 5,350 tCO₂e in 2024/25, partly due to grid decarbonisation or improved energy efficiency. In 2024/25 the incinerators were non-operational for the heating season and nil consumption return aligns.
- Scope 3 (Indirect emissions): Fluctuated, peaking at 2,140 tCO₂e in 2022/23 before reducing to 852 tCO₂e in 2024/25.

2024/25 Energy consumption 65,779,630 kWh, and Energy spend £7,729,925.

The table below depicts the trajectory so far of the emissions the Trust has direct control of. The Trust’s GHG emissions footprint has been calculated according to the GHG Protocol for Corporate Reporting and aligned to ISO 14064:1.

The Trust monitors progress against its sustainability objectives using a range of metrics aligned to the Green Plan and national reporting requirements. Progress against targets is monitored through regular reporting and reviewed through the Trust’s governance structures.

Trust GHG emissions trajectory by emission source.

Grouped Emission Source and metric	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Total Emissions (tCO ₂ e)	Total Emissions (tCO ₂ e)	Total Emissions (tCO ₂ e)	Total Emissions (tCO ₂ e)	Total Emissions (tCO ₂ e)	Total Emissions (tCO ₂ e)
Building Energy (Scope 1 and 2 Emissions)	22,840	16,085	16,158	14,562	14,973	15,189
Water Consumption & Treatment (Scope 3 Emissions)	222	260	69	84	74	56
Waste Arisings (Scope 3 Emissions)	1,445	1,120	1,259	1,126	694	580
Business Travel inc commuting (Scope 1 and Scope 3 Emissions)	NA	NA	NA	NA	NA	NA

Anaesthetic Gases & Inhalers (Scope 1 Emissions)	1,974	1,563	1,680	1,501	1,372	900
Patient & Visitor Travel (Scope 3 Emissions)	Not available					
Carbon Footprint Plus	26,481	19,028	19,166	17,273	17,113	16,725

Source: NHS Greener Dashboard

The carbon report is incomplete, missing data for key Scope 3 elements such as procurement and staff/patient commuting, which are potentially major sources of emissions.

The Trust is currently focusing on the following Carbon reduction schemes:

- We are finalising the replacement of our old steam boilers with newly refurbished boilers, expecting this to provided significant savings at the Alexandra site.
- We are currently replacing all lighting at the Worcestershire Royal site with LED. Similar projects exist at the Alexandra site, and piecemeal replacement at KTC.
- A green initiative to optimise theatre ventilation systems for optimum start has been approved by the capital priority decisions group (CPDG), this will commence imminently with a view to driving our £100k per annum in energy savings across the Trust.

Waste

The current recycling rate across Trust-owned sites is 25%.

NHS England has set a 20:20:60 target for clinical waste to be segregated with the aim of 20% going for high-temperature incineration, 20% alternative treatment and 60% offensive waste by 2026. In 2024/25 we improved our split on clinical waste.

Our waste strategy is site specific. The Alexandra site no longer acquires steam provided from incineration from clinical waste, as the incinerator is currently offline with little likelihood of returning to a functioning state.

	KTC	AGH	WRH	Other	Total
Waste Costs (£)	63,872	187,452	862,938	130,706	1,244,968
Water Volume (m3)	23,068	60,967	100,861	3,423	188,319

Waste stream	Waste recycled	ICT waste recycled / reused / recovery (externally)	Waste composted / food waste	Waste incinerated with energy recovery	Waste incinerated without energy recovery	Waste to landfill
Basis tonnage	316	0	46	0	1682	3
Allocated expenditure (£)	191,254.20	0	27,840.80	0	1,024,057.30	1,815.70

Medicines and Anaesthetic Gases

The Trust was one of the first nationally to eliminate desflurane, one of the most harmful anaesthetic gases. It has now completed a programme of decommissioning nitrous oxide manifolds at all three clinical sites, substantially reducing its clinical carbon footprint. It is estimated that up to 99% of nitrous oxide supplied via manifolds is lost to the atmosphere, representing both inefficiency and a significant carbon impact; medical nitrous oxide is estimated to contribute up to 1% of global greenhouse gas emissions. The Trust's experience informed an international consensus statement published in 2024, which recommends removal of nitrous oxide manifolds across the UK and Ireland by the end of the 2026/27 financial year.

The Trust was also one of the first in the country to remove the mandatory use of a sterile gown for single-shot spinal anaesthesia, following approval from Infection Prevention and Control (IPC) colleagues. This work has been used as the basis for international consensus guidance on the use of sterile gowns in single-shot spinal anaesthesia, endorsed by major anaesthetic bodies in the UK, Ireland, Australia and New Zealand, and published in April 2026.

The Trust's Clinical Green Lead, Dr Paul Southall, coordinated and led both international initiatives.

The next stages of clinical work will focus on implementing reusable medical items, in line with recommendations from the Department of Health and Social Care (DHSC) Design for Life programme when it reports in mid/late 2026. Work is also underway to develop a plan to switch theatre ventilation systems off out of hours, reducing energy use, cost and associated carbon dioxide emissions. In addition, through its clinical lead, the Trust is participating in the Greener Surgical Pathways programme led by Get It Right First Time (GIRFT), which aims to improve the carbon efficiency of selected surgical pathways; relevant elements will be implemented as they are released.

Signed:



Chief Executive

Date: 6 August 2026

Accountability Report

Corporate Governance Report

Directors' Report and Corporate Governance Disclosures

The Trust Board comprises a non-executive Chair, five other non-executive directors and five executive directors. During the year there was one temporary executive vacancy as described below.

Non-voting members of the Board include associate non-executive directors and other executive directors.

Significant interests of all Board members can be found in the Board's Register of Interests, which is published annually on the Trust's [website](#)

Non-Executive Directors during 2024/25		
Name	Skills and Expertise	Audit Committee Member
Russell Hardy MBE, Chair	Finance, executive leadership, board leadership – private, public and charitable sector.	✗
Simon Murphy, Deputy Chair	Leadership, management, strategy, politics.	✓
Dame Julie Moore	Nursing, NHS executive leadership	✗
Colin Horwath	Accountancy, audit, NHS board leadership.	✓
Tony Bramley	Executive leadership, housing, NHS Board leadership	✓
Karen Martin	Human resources, organisational development, NHS executive leadership, board leadership.	✓

All the non-executive directors are considered to be independent.

Two non-executive directors have served on the Trust Board for more than six years from the date of their first appointment:

- Dame Julie Moore was appointed as Non-Executive Director on 1 October 2018 and her current term is due to end on 30 September 2027.
- Colin Horwath was appointed as Non-Executive Director on 1 February 2019 and his current term is due to end on 10 October 2026.

NHS England is satisfied that both non-executive directors remain independent.

Executive Directors during 2025/26		
Name	Role	Skills, Expertise and Experience
Stephen Collman	Acting Chief Executive	Mental health nursing, NHS operational management and executive leadership
Neil Cook	Chief Finance Officer	Financial accountant, financial and executive leadership, NHS acute, commissioning and regulatory
Sarah Shingler	Chief Nursing Officer	Nurse consultant, emergency and critical care, NHS clinical and executive leadership.
Dr Juliette Walton	Chief Medical Officer	Consultant in Emergency Medicine
Hayley Flavell	Chief Nursing Officer	Senior nurse, executive nurse leadership, strategic advisor
Katie Osmond	Interim Chief Finance Officer	NHS financial accountant, senior finance executive.

On 1 April 2025 Glen Burley was seconded to a national role with NHSE, retaining his position as Foundation Group Chief Executive but stepping back temporarily from his responsibility as Accountable Officer for the Trust until 31 March 2026. Stephen Collman, Managing Director was appointed Acting Chief Executive for the for the duration of the interim secondment as a joint role for both the Trust and for Wye Valley NHS Trust, its Foundation Group partner.

On 1 April 2026 Glen Burley returned to his role as Chief Executive Officer at the Trust and Stephen Collman returned to his role as Managing Director.

Neil Cook left the Board on 6 January 2026 but remained employed by the Trust until 31 March 2026. Katie Osmond joined the Board as Interim Chief Finance Officer on 12 January 2026. Jo Kirwan, Deputy Chief Finance Officer provided temporary cover for the role between 6 and 12 January 2026.

Sarah Shingler, Chief Nursing Officer left the Board on 3 September 2025. Hayley Flavell joined the Board as Interim Chief Nursing Officer on 4 September 2025 and was appointed to the post substantively on 8 October 2025.

Non-Voting Board Members during 2025/26		
Name	Role	Skills, Expertise and Experience
Michelle Lynch	Associate Non-Executive Director	Accounting and finance, strategic leadership.
Sue Sinclair	Associate Non-Executive Director	Consultant in Anaesthesia and Critical Care Medicine, NHS management, governance and leadership.
Alex Moran	Associate Non-Executive Director	Senior executive leadership in healthcare and charity.
Catherine Driscoll	Associate Non-Executive Director	Strategic transformation in public sector, health, social care and community services.
Ali Koeltgen	Chief People Officer	Human Resources and organisational development, senior NHS leadership.
Chris Douglas	Chief Operating Officer	Senior NHS leadership – operations, transformation, performance and regulatory.
Jo Newton	Chief Strategy Officer	Senior executive NHS leadership – provider and commissioning.
Julian Berlet	Chief Clinical Strategy Officer	Consultant Anaesthetist, senior operational NHS leadership.
Rebecca Brown	Chief Digital Information Officer	Senior NHS and local government leadership.

Alex Moran resigned from his Board role during the year and his term ended on 31 January 2026.

Jo Newton left the Board on 27 June 2025. Her responsibilities were passed to Julian Berlet.

Chris Douglas was Interim Chief Operating Officer from 2024/25 until he was appointed substantively to the post on 1 February 2026.

Rebecca Brown was Interim Chief Digital Information Officer from 2024/25 until she was appointed substantively to the post on 1 February 2026.

Board and Committee Meeting Attendance

Name Title	Trust Board	Audit & Assurance	Quality & Governance	Remuneration	People & Culture
Russell Hardy MBE, Chairman	12/14	n/a	n/a	5/6	n/a
Simon Murphy, Non-Executive Director and Deputy Chair	14/14	5/7	8/10	4/6	1/6
Dame Julie Moore, Non- Executive Director	10/14	n/a	9/10	4/6	n/a
Colin Horwath, Non-Executive Director	9/14	7/7	n/a	1/6	4/6
Tony Bramley, Non-Executive Director	12/14	7/7	n/a	3/6	n/a
Karen Martin, Non-Executive Director	10/14	4/7	n/a	4/6	5/6
Glen Burley, Chief Executive Officer	4/14	n/a	n/a	n/a	n/a
Stephen Collman, Managing Director	14/14	4/7	n/a	5/6	4/6
Neil Cook, Chief Finance Officer	9/11	4/5	n/a	n/a	n/a
Sarah Shingler, Chief Nursing Officer	5/6	n/a	2/5	n/a	0/3
Hayley Flavell, Interim Chief Nursing Officer	6/8	n/a	4/5	n/a	1/3
Dr Juliette Walton, Chief Medical Officer	11/14	n/a	9/10	n/a	5/6
Michelle Lynch, Associate Non- Executive Director	7/14	n/a	9/10	3/6	n/a
Sue Sinclair, Associate Non- Executive Director	10/14	n/a	6/10	4/6	4/6
Alex Moran, Associate Non- Executive Director	7/11	n/a	n/a	1/5	n/a
Catherine Driscoll, Associate Non-Executive Director	12/14	n/a	n/a	3/6	n/a
Ali Koeltgen, Chief People Officer	11/14	n/a	n/a	5/6	5/6
Chris Douglas, Chief Operating Officer	14/14	n/a	1/10	n/a	n/a
Jo Newton, Chief Strategy Officer	2/2	n/a	n/a	n/a	n/a
Julian Berlet, Chief Clinical Strategy Officer	10/14	n/a	n/a	n/a	n/a
Rebecca Brown, Chief Digital Information Officer	13/14	n/a	8/10	n/a	n/a

The Trust Board regularly meets alongside the three Boards of the other members of the Foundation Group. Three of the 14 meetings referenced above were Foundation Group Boards meetings.

Audit and Assurance Committee membership comprises non-executive directors only. The Chief Finance Officer routinely attends all meetings of the Audit Committee. The Acting Chief Executive attended four of seven meetings. Other executive directors attended meetings by invitation to contribute to discussions relevant to their roles or to present the management response to an Internal Audit for which they were the lead manager.

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.

Code of Governance disclosures

Personal data related incidents reported to the Information Commissioner

Five information governance incidents were reported to the Information Commissioner during the year. More information about these incidents is provided in the Annual Governance Statement later in this document.

Partners

The Trust’s relationships with its key Integrated Care System and Foundation Group partners are described in the Performance Report. Governance arrangements relating to these partnerships include:

- Membership of Integrated Care Board, committees and working groups.
- Foundation Group four Boards meetings.
- Foundation Group Strategy Committee.

Stakeholders

Our most important stakeholders are our patients and their families and our staff. Information about how we have engaged and consulted with staff during the year is included in the Staff Report. Engagement with patients and our communities includes:

- A patient story at each of our Trust Board workshops.
- An active Patient and Public Forum (PPF).
- A biannual report on the work of the PPF presented to the Trust Board in public by the PPF Chair.
- Regular observation of Board meetings by the PPF Chair.
- Live streaming and recording publication of Trust Board meetings.
- External Learning Disabilities Stakeholders Group.
- Big Quality Conversation survey about people’s experiences of care at our hospitals.
- d/Deaf Community Workshop.
- Cancer Patient Forum
- Growing our volunteer service. The service now includes discharge response, wayfinding, patient experience (supporting completion of Friends and Family Test surveys), Ward and Emergency Department Volunteers, Clinic Volunteers, Chaplaincy Volunteers, Transformation Team, Administration support, Breast-Feeding Friends, Dementia Buddies, end of life care support and Therapy Dogs.

Opportunities and risks to future sustainability

This information is included in the Performance Report and the Annual Governance Statement.

Activities to promote the wellbeing of the workforce

Information about how the Trust invests in and promotes the wellbeing of its workforce is included in the Staff Report.

Work of the Remuneration Committee

This information is included in the Remuneration Report.

Emergency Preparedness, Resilience and Response

Worcestershire Acute Hospitals NHS Trust is required to plan for and respond to a wide range of incidents and emergencies that may impact patient care or service continuity, in line with statutory duties under the Civil Contingencies Act 2004 and associated health legislation. This work is collectively referred to as Emergency Preparedness, Resilience and Response (EPRR).

The Trust is subject to an annual EPRR assurance process led by NHS England. In the most recent assessment, the Trust achieved full compliance in 59 of the 62 EPRR core standards increasing from the previous year, resulting in an overall rating of Substantially compliant. The remaining areas are all partially compliant and relate to the Delivery of Mass countermeasures, Assurance of external providers, Cyber assurance framework. The Trust has no non-compliant standards

An action plan is in place to address these areas and is being monitored through the Emergency Planning Committee, Trust Management Board, and Trust Board.

DRAFT

Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS England 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 have 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.

Signed:



Chief Executive

Date:

6 August 2026

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.

Signed:



Chief Executive

Date:

6 August 2026

Signed:



Chief Finance Officer

Date:

6 August 2026

Annual Governance Statement

1. Scope of responsibility

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

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 2026 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

As Accountable Officer, I have overall responsibility for risk management, including the maintenance of a Board Assurance Framework that supports the identification of emerging and principal risks to achievement of the Trust's strategic objectives.

The Trust Board is responsible for approving the Risk Management Strategy and for considering the Trust's most significant operational risks alongside the Board Assurance Framework.

The Audit and Assurance Committee's role is to review the effectiveness of the system of risk management.

Oversight of risk management is the responsibility of the Board's committees. This includes the Executive Risk Management Committee, which meets regularly to review all high and extreme rated risks with the senior divisional leadership teams who have responsibility for risk management within their own areas. Through this forum, leaders are also guided about risk assessment, mitigation and recording.

Other committees are responsible for overseeing management of risks specific to their terms of reference, including Quality Governance (safety, experience and effectiveness), People and Culture, Health and Safety, Information Governance and Digital Risk.

Risk management guidance is available to staff on the Trust intranet, including the risk management framework and associated policy and guidance on the use of the Trust risk register system.

Support and advice are provided to staff by the Risk Team, with executive leadership from the Chief Digital Information Officer.

The Freedom to Speak Up Guardian can also provide advice to staff by directing them to the most appropriate reporting route, including incident and risk reporting, as well as the raising concerns process.

Staff are encouraged to share learning from incidents, good practice, transformation and Quality Improvement (QI) through a range of methods, including:

- Improvement System Showcasing Walls.
- Patient Safety Lessons of the Week.
- Learning from Inquests briefings.
- Annual Foundation Group Improvement Week.
- Transformation Tuesday session.
- Wide sharing of learning from Patient Safety Incident Framework (PSIRF) thematic reviews, including with national patient safety specialists.
- Divisional meetings.
- Department and team huddles.

4. The risk and control framework

The Trust's Risk Management Framework sets out the Trust's aim to promote:

- A risk awareness culture in which all risks are identified, assessed, understood and proactively managed.
- A way of working that ensures risk management is embedded in the Trust's culture and becomes an integral part of the Trust's objectives, plans, practices and management systems.

The Board recognises that to deliver its strategic objectives there is a need for robust systems and processes to support continuous improvement, enabling staff to integrate risk management into their daily activities wherever possible and supporting better decision making through a good understanding of risks and their likely impact.

This may be achieved through an open and just culture where risks, accidents, mistakes and near misses are identified promptly and acted upon in a positive and constructive way. Staff are, therefore, encouraged and supported to share best practice in a way that creates a culture of learning and a drive to reduce future risk.

The Risk Management Framework sets out:

- the responsibilities for risk management of leaders, staff and committees.
- the risk assessment process using a likelihood and impact risk matrix.
- Risk reporting, escalation and monitoring.
- Risk tolerance, or appetite.

The Trust Board recognises that risk is inherent in the provision of healthcare and its services and therefore a defined approach is necessary to identify risk context, ensuring that the Trust understands and is aware of the risks it is prepared to accept in the pursuit of the delivery of its aims and objectives.

The Trust’s Risk Appetite Statement makes clear the Board’s expectations in relation to the category of risks and the level of such risk that is acceptable. The statement is based on the premise that the lower the risk appetite, the higher the levels of controls that must be put in place to manage the risk.

Risk appetite for each category of risk is assessed using the following matrix:

Avoid	Avoidance of risk and uncertainty is a key organisational objective
Minimal	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust

Each risk is recorded on the Risk Register with a target risk score, which is aligned to the risk appetite for the relevant risk category.

The Trust has in place a digital risk management system (Datix) which is used by staff to assess, record, monitor and report risks. New risks are reviewed at a divisional and executive level to ensure they are appropriately assessed and scored, with mitigations and controls properly described. Once agreed, risks are regularly monitored to ensure they are appropriately updated at a frequency in line with the Risk Management Policy. Risks are closed with executive approval based on assurance that the risk has been effectively controlled and the target risk score has been achieved.

5. Quality Governance Arrangements

The Quality Governance Committee (QGC) oversees the Trust’s quality governance arrangements on behalf of the Board. It sets an annual reporting schedule aligned to the quality framework (safety, effectiveness and experience) and regulatory compliance comprising key reports on matters of compliance, risk and assurance.

Quality Governance Committee Reporting 2025/26	
Sub-Committee Reports	
Improving Patient Safety	Infection Prevention and Control
Fundamentals of Care	Safeguarding
Clinical Audit and Effectiveness	Medical Devices
Other Regular Reports	
Safe staffing	Perinatal safety
Medicines safety and optimisation	Learning from Deaths
Integrated Performance Report	Learning Disabilities
Patient safety alerts	Deep-dive reviews – divisions, departments, risks and QI projects
Urgent and Emergency Care	High-scored risks
End of life care	Health and Safety

Additional Areas of Focus During the Year	
Nursing education	Antimicrobial resistance and stewardship

Through this broad oversight of the Trust's clinical services through a quality lens, the Quality Governance Committee is able to identify and obtain assurance regarding any risks to compliance with Care Quality Commission (CQC) registration requirements.

The Trust's overall CQC ratings remain as follows:

Location	Rating
Alexandra Hospital (ALX)	Requires Improvement
Kidderminster Hospital and Treatment Centre (KHTC)	Good
Worcestershire Royal Hospital (WRH)	Requires Improvement

The most recent CQC inspections of Trust services were as follows.

Service	Location	Publication date	Rating
Services for Children and Young People	KTC	February 2025	Good
Services for Children and Young People	ALX	April 2025	Good
Medical Care (including older people's care)	WRH	February 2025	Requires Improvement
Urgent and Emergency Services	WRH	November 2024	Requires Improvement
Critical Care	WRH	May 2024	Good

The Quality Governance Committee oversaw the implementation of action plans to improve the areas highlighted by the CQC reports.

The Quality Governance Committee also oversees the selection and prioritisation of Quality Improvement (QI) schemes based on monitoring of quality risks and compliance issues and receives regular updates on progress in addressing these quality priorities. The Health and Safety Committee oversees the management of risks to the health and safety of the Trust's estate and the people that use it and compliance with relevant regulatory requirements, including those monitored by the CQC.

6. Well-Led Framework

The CQC has not undertaken a well-led inspection of the Trust since November 2022 and the Trust's rating for this domain remains Requires Improvement.

The Trust Board undertook an internal well led board evaluation in January 2024 to identify areas of leadership and governance that would benefit from development. Becoming a full member of the Foundation Group supported a range of improvements, including the adoption of a well-established governance framework, joint leadership posts and the ability to benchmark and share learning.

During 2025/26, following a self-assessment exercise, the Trust's Provider Capability was rated amber/red by NHS England (NHSE) relating to the six domains of the Insightful Provider Board guidance. This rating indicates some concerns of varying seriousness across one or more areas to be addressed with support from NHSE.

Area of focus aligned with the well-led framework during the year included:

- Launch of new Trust values following wide consultation.

- Launch of new Trust mission, vision and strategy following wide consultation.
- A review of executive risk management and compliance oversight.
- Establishing a new Board Assurance Framework process and format.
- Refreshed Foundation Group governance arrangements to maintain the opportunity for each Trust to fully benefit from the Group model following changes in Board leadership.
- Review of the effectiveness of the Audit and Assurance Committee, with a particular focus on its impact on the Trust's governance and internal controls.
- A refreshed Green Plan published for 2025-2028, outlining projects, schemes and activities to lead the Trust towards its target of net zero.

7. Risks to Data Security

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees. This applies to both personal confidential data and special category data (sensitive). The framework is supported by the Data Security and Protection Toolkit and the annual submission process provides assurances to the Trust, partner organisations and data subjects (patients and staff) that personal information is dealt with legally, securely, efficiently, and effectively.

The Information Governance Steering Group (IGSG) manages information risks and is chaired by the Senior Information Risk Owner (SIRO), the Chief Digital Information Officer.

Other senior members of IGSG are the Data Protection Officer and the Caldicott Guardian.

The IGSG reports to the Trust Management Board to provide assurance on data protection and cyber security. Three sub-committees report to IGSG, the IT Security Forum, the Data Quality Steering Group and the Health Records Group.

IGSG met regularly throughout 2025/26 and assessed risks to the security and integrity of information and the management of confidential information. IGSG also monitored the completion of the Data Security and Protection Toolkit (DSPT) submission, oversaw the management of information incidents and risks and ensured an effective framework with up-to-date policies, processes and management arrangements were in place.

Ahead of the DPST submission for 2024/25, the Trust's Internal Auditor undertook an independent review of the Trust's self-assessment. The conclusions were:

- Overall risk associated with the security and information governance control environment:
Low
- Veracity of self-assessment/confidence that the submission reflects the risks and controls:
High

The Trust DSPT submission for 2024/25 was made at the end of June 2025 and demonstrated that the Trust has appropriate technical and organisational measures in place to keep personal, confidential data and special category data secure.

As the Trust did not have the full evidence in place for eight of the forty-seven requirements, additional actions have formed the basis of the Trust's improvement plan. With the submission of an improvement plan, the Trust achieved the status of 'approaching standards'.

The Trust carried out an annual assessment of its position against the Data Security and Protection Standards and submitted a 'Baseline Assessment' on 31 December 2025. An internal audit will ensure that any evidence gaps can be addressed prior to the final submission by 30 June 2026.

The Data Protection and Information Governance Team monitors the management of data security incidents and reviews these regularly with the Data Protection Officer. Any incidents that meet the external reporting criteria are assessed.

The IGSG reviews all incidents each quarter to identify any themes and ensure action is taken to address any issues.

The Trust also has robust processes for incident reporting and the investigation of serious incidents. The process is followed up by lessons learned and provision of guidance or training where required.

The management of cyber security is a key strategic risk area for the Trust and is described in the Board Assurance Framework. The risk of a successful cyber-attack on the Trust's electronic systems is rated as 'extreme' reflecting the potential consequences for patient services and the likelihood of a successful attack due to the evolving nature of the external threat.

8. Major Risks

The Trust Board, its committees and the Trust's Divisions regularly review the Trust's major risks, including strategic, corporate and operational to ensure they are well managed, controlled and mitigated, with appropriate plans to reduce or eliminate the risk. The Executive Risk Management Committee meets regularly to review all corporate, Trust-wide and divisional risk registers including routine reviews of every risk scored 15-25 (extreme) and a regular divisional deep dive into all risks scored 12+ (high).

The major organisational risks are set out below. The impact of these risks and their management is described within the Performance Report earlier in this document.

Risk	Strategic (S) or Operational (O)	In-year (IY) or Future (F)	Management & mitigation	How outcomes will be assessed
Failure to improve Urgent and Emergency Care (UEC) flow	S, O	IY, F	Oversight by new UEC Recovery Board UEC navigators Stress-tested winter plans NHSE support Call Before Convey ambulance process Ambulance pitstop UEC 'sprint' Ambulance handover improvement project	Achievement of emergency access standard Achievement of ED 12-hour standard Achievement of ambulance handovers target
Failure to deliver the Trust's agreed financial plan	S, O	IY, F	Financial Recovery Board oversight Agency Reduction Programme National financial controls adopted. Enhanced financial controls Enhanced controls of temporary staff usage Strengthened forecasting Recovery framework	Achieved financial plan Achieved CPIP Achieved staff agency reduction plans
Poor staff health and wellbeing	S	IY, F	Health and Wellbeing Steering Group oversight Occupational Health service Clinical psychologist support Health @ Work service Menopause Support Group Targeted intervention and support Annual vaccination programme Updated reasonable adjustment support	Sickness absence rate below target Sustained reduction in sickness absence related to work stress Flu vaccination target achieved Improved staff survey scores for 'We are Safer and Healthy' questions.
Failure to deliver workforce transformation and achieve a sustainable workforce	S, O	IY, F	Agency Reduction Programme Vacancy and agency controls Quality Impact Assessments for workforce transformation programmes Job planning consistency panel	Reduction in agency expenditure Reduction in reliance on Bank Staff Reduced vacancy rate Staff turnover below target Consultant job planning completion target met

Risk of a successful cyber-attack on the Trust's systems	S, O	IY, F	Perimeter level cyber security mechanisms Testing exercises Business continuity plans Mandatory staff training Risk-based approach to cyber and infrastructure funding Supplier and third-party controls and oversight	Achievement of malware protection targets Achievement of mandatory data security training targets
Fire safety risk at Alexandra Hospital	S, O	IY, F	Enhanced fire safety management, controls and infrastructure Enhanced fire detection Completed capital works	Sustained achievement of fire safety training targets Reduction in fire alarm activations Positive assurance from Internal Auditor Closed Fire Authority Enforcement Notice

9. Principal Risks to Compliance with the NHS Provider Licence

There are processes in place to identify and mitigate risks to compliance with the NHS provider licence.

In February 2025 NHS England (NHSE) issued new enforcement undertakings regarding Urgent and Emergency Care (UEC) performance, which continued to deliver below trajectory. It was recognised that part of the improvement plan included working with system partners to enhance or share the risks relating to front door demand.

Existing and planned controls of potential risks to compliance with section 4 (governance) of the NHS Provider Licence include the following:

Effective Governance Structures
The Trust has well-established governance structures in place, which mirror those of the other trusts in the Foundation Group. The effectiveness of the overall structure and of the individual components are regularly reviewed with oversight of the Audit Committee. These reviews take into account the most recent regulatory requirements and corporate governance requirements, including the Code of Governance for NHS Providers.
Responsibilities of Directors and Committees
The Remuneration Committee oversees the performance of the executive directors in delivering their responsibilities. Each committee of the Trust Board has approved terms of reference, setting out their responsibilities, which are regularly reviewed and updated.
Reporting lines and accountabilities
In 2025/26 we strengthened reporting lines between some of the Board and executive committees by enhancing reporting from committees to Board, using an escalation and assurance report.
Timely and accurate information
Meetings of the Board and its committees are set at a frequency to ensure a timely flow of information that has been assessed for accuracy and effectively analysed. Where necessary, additional meetings of the Board or its committees are called.
Rigour of oversight
• The Foundation Group has agreed a standard dataset for regular reporting on performance to the respective Trust Boards, which includes national, regional and local priorities and metrics covering quality, operational performance, workforce and finance in an Integrated Performance Report (IPR). • Each quarter a joint four-trust report is presented to the four Foundation Group Boards including performance information aligned with the individual IPRs to enable benchmarking analysis and learning. • Non-executive directors observe executive led finance and performance meetings with the divisions to enhance their knowledge and understanding of divisional level issues and the executive oversight. • During the reporting year the Board continued to use the Financial Recovery Board to oversee management of the risks relating to delivery of the annual financial targets.

10. Code of Governance

The Trust's governance arrangements comply with the provisions of the current Code of Governance for NHS Provider Trusts, which is modelled on the 2018 version of the UK Corporate Governance Code.

11. Governance and Strategy

The Trust's strategy is reviewed and refreshed each year to ensure a continual focus on the key strategic priorities for the Trust. The Board Assurance Framework is aligned to the strategic objectives and reviewed regularly by the Trust Board. A focus on delivery of the strategic objectives

is embedded in the work of the Trust Board and its committees throughout the year, with programme boards established where necessary to oversee delivery of key strategies.

The Board Assurance Framework is used to escalate to Board level strategic risks that emerge during the year through analysis of operational risks. The Board Assurance Framework is then used to inform the review of the strategic objectives at the year end and the development of new strategic objectives for the following year.

The Trust is also a partner in the development and delivery of strategies at a regional level, including production of the Joint Forward Plan for NHS Herefordshire and Worcestershire.

Governance arrangements relating to this work include membership of the Integrated Care Board (ICB) and ICB Finance Committee and Trust Board member attendance at meetings of ICB committees, including Audit and Quality, Resources and Delivery.

12. Embedded Risk Management

Risk management is embedded in the activity of the organisation in a range of ways, including:

- Regular reviews of the risk register within departments and divisions, with advice and guidance from the Risk Team.
- Appropriate escalation of risk through the governance structure to the Board.
- Regular review of the Trust's strategic objectives, using the Board Assurance Framework (BAF) and Risk Register to support decision making for future strategies.
- Use of the Risk Register and BAF to inform the development of an agreed annual Internal Audit Plan targeted at potential internal control issues.
- Setting annual quality priorities based on assessment of the highest risks to quality care through analysis of quality data.
- Oversight within the governance framework of the delivery of strategic objectives and quality improvement priorities based on assessment of risk.
- Openly encouraging incident reporting across the Trust relating to patient and staff safety and data security and ensuring guidance is available to staff on the use of the incident reporting system.
- Established Quality Improvement processes to encourage the development of long-term solutions to quality issues and risks.
- Quality impact assessments undertaken on cost improvement projects and business cases.
- Equality Impact Assessments required for all business cases and policies.

13. Workforce Standards

In 2018 NHS England published a 'Developing Workforce Safeguards' document to help trusts manage common workforce problems, with recommendations to support informed, safe and sustainable workforce decision making.

The Trust has adopted the recommendations into its processes as follows:

- Incorporating evidence-based tools, professional judgement and outcomes in safe staffing processes.
- Regular review of the nursing establishment and skill mix
- Regular safe staffing reports (nursing and midwifery) presented to Quality and Governance Committee and Trust Board and published on the Trust website. This includes the planned

and actual number of nursing and midwifery staff working on each ward, together with the percentage of shifts meeting safe staffing guidelines.

- Triangulation of workforce metrics with quality indicators and productivity measures.
- An annually updated workforce plan.
- Senior nursing staff review of staffing levels at every shift.
- Triangulation of data: review of staffing levels with other indicators of care quality to identify any correlation between staffing levels and the incidence of patient safety events.
- Reporting and investigation of incidents related to staffing levels.
- Reporting and escalation of workforce related risks.

The Audit and Assurance Committee receives assurance each year on areas of staffing governance or process. In the last two years, assurance was received as follows. In each case the Committee was assured by the management response and requested continued oversight by the People and Culture Committee.

Year	Topic	Source	Rating
2024/25	Bank and Agency Staffing (Nursing)	Internal Audit	Moderate Assurance
2024/25	Consultant Job Planning	Internal Audit	Limited Assurance
2025/26	Absence Management	Internal Audit	Significant assurance

Through these processes, tools and sources of assurance, the Trust Board is assured that staffing governance processes are safe and sustainable.

14. Care Quality Commission

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

15. Register of Interests

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

16. NHS 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.

17. Equality, Diversity and Human Rights

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

18. Freedom to Speak Up

The Trust has well-established arrangements to support staff to raise concerns, including:

- Dedicated Freedom to Speak Up Guardian (FTSUG).
- Non-Executive Director FTSU Champion
- Raising concerns portal.
- Network of FTSU Champions across the Trust's three sites.

- Regular Freedom to Speak Up reports to Trust Board.
- Speak Up training for all staff.
- Sharing of learning from FTSU concerns across the Trust.

19. Fit and Proper Person Regulations

The Trust has designed its arrangements to comply with the Fit and Proper Person Regulations through alignment with the NHS England Fit and Proper Person Test Framework for Board Members. This includes a policy, process and annual report to the Trust Board.

In line with the guidance, the Internal Auditor conducted the first three-yearly review of compliance with the framework in 2025/26, with a rating of significant assurance.

20. Climate Change

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

21. Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Trust has a range of processes in place to monitor and improve the economic, efficient and effective use of resources, including:

- An annual cost and productivity improvement programme (CPIP). CPIP schemes are developed by each division and reviewed by the Executive Team to ensure the completion of an appropriate quality impact assessment before approval.
- The Finance and Performance Executive (F&PE) oversees divisional performance each month across a range of financial operational performance, quality and workforce metrics, including delivery of the CPIP, the use of Model Hospital benchmarking data and key productivity measures. Executive Directors are F&PE members and meetings are observed by Non-Executive Directors to enhance their understanding of performance, risks and challenges at divisional level.
- The Financial Recovery Board (FRB) was established in 2024, with membership comprising all Trust Board members, to undertake a monthly review of delivery of the CPIP and actions to achieve or recover performance on delivery of the financial plan.
- An integrated performance report is presented at each meeting of the Trust Board providing data and analysis on key national, regional and local metrics, including productivity.
- A joint performance report is presented to the four Boards of the Foundation Group at each of its quarterly meetings providing parallel data and analysis on key performance metrics, including productivity measures, enabling comparison, benchmarking and learning.
- An annual review of the Trust's key financial controls is included within the Internal Audit Plan.
- The Audit Committee receives regular reports to provide assurance on financial governance matters including single tender waivers, losses and special payments.
- The Trust Management Board reviews each business case to ensure proposals will achieve value for money before approval and undertakes evaluations of business case implementation to ensure delivery of planned benefits and value for money.
- Business cases that require Board approval under the Standing Financial Instructions are reviewed informally in detail by non-executive directors prior to submission to the Board to ensure that any queries, concerns or gaps are addressed before formal approval.

- An annual review is undertaken by the External Auditor of the Trust's processes to ensure delivery of Value for Money.

The Trust did not deliver its financial plan for 2025/26. In response, NHS England asked the Trust to undertake a lessons-learned exercise and to set out changes that would ensure delivery in 2026/27. This work was undertaken with Board oversight in May 2026. A key part of the plan for 2026/27 will be to establish a Financial Improvement Taskforce as part of the Board financial governance structure to:

- Deliver sustainable financial improvement.
- Embed a culture of continuous improvement, efficiency and value.
- Improve cost-effectiveness and productivity.
- Strengthen financial leadership and accountability.
- Support service and pathway improvement.
- Rebuild the credibility of the Trust through delivery.

This outcome was reflected in the annual Value for Money opinion of the External Auditor, which identified a significant weakness regarding the Trust's financial sustainability as set out below.

22. Information governance

Five serious information governance incidents were reported during the year that met the threshold for reporting to the Information Commissioner's Office (ICO). One of these was a national cyber security incident and remains open. All other incidents have been closed with no further action required by the ICO.

Nature of incident	Internal actions taken	ICO status/response
National cyber-attack on external pathology system	Monitoring external response	Open
Incorrect permissions level applied to internal documents	ICT processes strengthened to prevent recurrence	Closed with no further action required
National data synchronising issue with BadgerNet maternity data system	Monitoring external response	Closed with no further action required
Coding error resulting in clinical letters not linked to correct GP practice	ICT processes strengthened to prevent recurrence	Closed with no further action required
Two patient records incorrectly linked resulting in errors to both sets of records.	Errors corrected. Staff communication, training and learning shared.	Closed with no further action required

23. Data quality and governance

The Trust has dedicated data quality leads and informatics staff to regularly investigate, validate and quality assure performance and waiting time data. Their work is supported by operational business intelligence reporting tools that all staff can access and use for detailed analysis. Nationally available tools such as LUNA complement investigations.

The Trust complies with the national requirement to validate directly with patients waiting over 12 weeks whether they still require their appointments and treatments.

Executive oversight of divisional performance provides an opportunity to triangulate and assess data and identify any areas requiring more detailed analysis or validation.

The Trust works with its foundation group partners to develop a consistent suite of performance metrics for inclusion in its Integrated Performance Report, which is reported each month to the Trust Board. This report includes a Data Quality Mark for key indicators to provide assurance as to the data quality of individual data.

In 2024/25 the Internal Auditor provided a moderate assurance opinion on data quality in relation to diagnostics data (DM01). The Committee received assurance that the improvement recommendations were implemented.

24. 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 Executive Risk Management Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board maintains oversight of the system of internal control through a framework of governance and assurance. This includes delegating assurance functions to Board committees and receiving direct assurance from the Executive Directors. Key elements of this framework are set out below.

a. Board Governance and Assurance Framework

Audit and Assurance Committee
Responsible for providing assurance to the Board on the Trust’s financial and internal controls and risk management systems, the integrity of the financial statements and the effectiveness of the internal audit function. This includes: - Agreeing an annual Internal Audit Plan that includes both core internal control matters and areas identified as high risk or high priority for improvement. - Agreeing an annual counter fraud plan that is both proactive in reviewing and establishing fraud controls, and reactive in responding to possible instances of fraud. - Reviewing the Trust’s governance framework and processes, including risk management and the Board Assurance Framework. - Reviewing the processes to ensure compliance with and effectiveness of policies including managing conflicts of interest, the Fit and Proper Person Test and Raising Concerns (Freedom to Speak Up). A review of the work and effectiveness of the Committee during the year has identified full compliance with the terms of reference and a good link between assurance mechanisms and risks to internal control.
Quality Governance Committee
Provides assurance to the Board on the adequacy of controls to ensure the provision of high quality and safe care. This includes: Oversight of the delivery of quality improvement plans aligned with the priorities set out in the annual Quality Account.

• Receiving regular reports from sub committees and groups focused on the core elements of quality – safety, effectiveness (including clinical audit) and patient experience. • Monitoring compliance in areas such as safeguarding, infection control and safe working environments. • Monitoring the quality of care provision within each Division. • Reviewing independent assurance on quality from regulatory and other review bodies. • Monitoring key quality metrics • Reviewing the effectiveness of governance and assurance processes such as mortality review and Patient Safety Incident Response. A review of the work and effectiveness of the Committee during the year has identified full compliance with the terms of reference and a broad and detailed oversight of risks to the delivery of high-quality services.
People and Culture Committee
Provides assurance to the Trust Board on matters relating to people and culture and the provision of a workforce capable of delivering safe, high quality, patient centred care. Oversees the development, implementation and effectiveness of the Trust's People and Culture Strategy and associated plans, ensuring appropriate alignment with the relevant national, regional and local strategies and plans. Provides assurance to the Board on the operation of effective and robust people and culture practices and governance frameworks.
Remuneration Committee
Oversees the performance of the executive members of the Board and assesses the mix of skills required on the Board.
Executive Risk Management Committee
Provides assurance to the Board regarding: • Appropriate oversight and management of moderate to serious risks by divisions and corporate departments. • Compliance with statutory health and safety responsibilities.
PFI Exit Committee
Provides assurance to the Board on the implementation of a compliant process to manage the expiry of the Private Finance Initiative (PFI) arrangements and associated contracts. This includes identifying and managing future risks, obtaining and following independent advice and effecting a transfer of a well-maintained estate and well managed estates and facilities service at the date of contract expiry.
Financial Recovery Board
Established during 2024/25 in response to below plan performance on delivering the financial plan, the forum was maintained during 2025/26 to support the delivery of a challenging financial plan. Receives assurance on: • Implementation of divisional and Trust-wide cost and productivity improvement (CPIP) schemes. • Identification of additional CPIP schemes or other measures to mitigate gaps or shortfalls. • Identification of CPIP schemes for the following year.
Meeting of the four Boards of the Foundation Group
Each quarter the Trust Board met in parallel with the other three Boards of the Foundation Group trusts. Regular reports include a focus in key performance measures across finance, operations, workforce and quality and enable comparisons and learning to be drawn. This provides additional assurance to the Board on the effectiveness of its own internal controls particularly in relation to the quality of data and the oversight and management of performance.

From March 2026, the Foundation Group adopted a less formal approach, with its meetings replaced by a workshop style forum focused on exploring variations in performance between the four trusts, sharing best practice solutions and aligning strategy to the 10-year plan.

b. Executive Governance and Performance Framework

Trust Management Board
Receives progress reports from subcommittees and programme boards. Reviews cases for investment in line with the Standing Financial Instructions and Scheme of Delegation Provides assurance to the Trust Board regarding the decision-making process and the assessments of value for money and quality impact of each case requiring Board approval.
Finance and Performance Executive
Oversight of delivery by each clinical division of key financial and operational performance targets. Observed by non-executive Trust Board members to gain direct assurance regarding performance management and accountability arrangements overseen by the executive directors.

c. Board Assurance Framework

The areas of priority focus for the Trust Board were reflected in the Board Assurance Framework, which is aligned to the Trust Strategy. The governance and performance frameworks ensured that these priority areas were well controlled and appropriately escalated.

d. Audit and Assurance

The Audit and Assurance Committee is the Board's main source of assurance about the strength of its internal controls and the management of any internal control issues and gaps. During the year the Audit and Assurance Committee considered the following matters:

- Contract governance
- Local security management
- Internal Audit Reviews
- Committee effectiveness
- Worcester UEC capital project value for money
- Fit and Proper Person Test Policy
- Effectiveness of processes for raising concerns
- Financial governance
- Counter fraud
- External Audit Reports
- Digital Programme benefits realisation
- Updated Standing Orders and Standing Financial Instructions
- Conflicts of interest policy

The Committee also undertook a detailed review of the draft financial statements for 2025/26 and considered the going concern assessment and significant critical judgements.

Key sources of assurance for the Audit and Assurance Committee and for the Board Assurance Framework are as follows:

Counter Fraud

The Trust has appointed an independent Local Counter Fraud Specialist (LCFS), which sets an annual counter fraud work plan aligned to the NHS Counter Fraud Authority Functional Standards, provides regular progress reports to the Committee on its proactive and reactive work, assesses fraud risks and engages with staff to encourage the raising of concerns about potential or actual fraud.

A key area of focus during the year was the Trust's compliance with requirements to meet new legislation creating the offence of Failure to Prevent Fraud, whereby an organisation is criminally

liable if an employee, agent, subsidiary, or other “associated person” commits a specified fraud offence intending to benefit the organisation (or its client)”.

The LCFS has supported the Trust to assess its compliance with the NHS Counter Fraud Authority checklist to ensure it has ‘reasonable fraud prevention procedures’ in place in relation to this new offence.

A key source of information on the reasonableness of these procedures is the annual Counter Fraud Functional Standard Return which describes the Trust’s compliance with the 12 components of the standard. The Trust’s return for 2025/26 assessed compliance overall as green, with two amber areas, both of which require more proactive work, which is included in the 2026/27 Counter Fraud Plan.

Internal Audit

The independent Internal Auditor provides the Audit and Assurance Committee with its key source of assurance on its internal controls. The Internal Audit Annual Plan sets out the reviews to be undertaken during the financial year. The plan comprises core reviews, which are key to the findings of the Head of Internal Audit’s Opinion and include financial controls, governance and risk management, and risk-based reviews of areas where the Trust Board requires independent assurance regarding the strength of internal controls. The reviews within the plan are selected and prioritised based on an examination of the Board Assurance Framework and the Risk Register and consultation with Audit and Assurance Committee members and the executive directors.

An assurance rating is applied to each review as follows.

Substantial assurance	Limited assurance
Significant assurance	Weak assurance
Moderate assurance	NHS opinion level (DPST) or Advisory Only

During the year the Committee received reports as follows:

Review	Rating
Safeguarding	Significant assurance
Procurement	Significant assurance
Fit and Proper Persons Test	Significant assurance
Financial Ledger	Significant assurance
Contracted out Payroll	Significant assurance
Consent	Limited assurance
Joint Handover and Transfer of Care	Limited assurance
DPST	NHS opinion level
Fire Safety Enforcement Notice Action Plan	Substantial assurance
Board Assurance Framework	Moderate assurance
Absence Management	Significant assurance

For each review the Internal Auditor made recommendations for improvement. In each case the Audit and Assurance Committee was assured by the management responses to the recommendations and the implementation plans. Where appropriate, oversight of those plans was referred to the most relevant committee; for example, the audit of consent processes was referred to the Quality Governance Committee.

The Audit and Assurance Committee also received regular updates on progress in implementing the Internal Auditor's Recommendations. Progress continued to be positive during the year, with no overdue recommendations in March 2026.

At the end of each year, the Head of Internal Audit provides an annual opinion based on delivery of the plan and the Trust's response. The annual Head of Internal Audit Opinion 2025/26 was:

Significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.

External Audit

The Trust's external auditor is Grant Thornton UK LLP. No non-audit services were provided by Grant Thornton during the year.

During 2024/25 the Trust participated in a joint Foundation Group procurement exercise for the appointment of an external auditor for each trust. Following a thorough assessment, which included effectiveness and independence, Grant Thornton was selected by the Auditor Panel for reappointment on a three-year contract from 2025/26 with an optional 12-month extension.

Each year, alongside an opinion on the financial statements, the External Auditor undertakes an assessment of the Trust's arrangements for securing value for money, which includes opinions on governance and on 'improving economy, efficiency and effectiveness'. The report for 2024/25 was presented to the Audit and Assurance Committee in June 2025 and outlined the following opinion:

Financial Sustainability

One significant weakness in arrangements identified and a key recommendation made in respect of the Trust's efficiency savings plan.

Governance

No significant weakness in arrangements identified but two improvement recommendations have been made.

Improving economy, efficiency and effectiveness

One significant weakness in arrangements identified and a key recommendation made in relation to agency spend.

The Audit and Assurance Committee received updates during the year on progress in implementing the recommendations.

The 2025/26 report on value for money concluded as follows:

Financial Sustainability

Significant weakness in arrangements identified and a key recommendation made relating to the Trust's financial position and delivery of recurrent savings.

Governance

Our work did not identify any areas where we considered that key or improvement recommendations were required. We have closed two prior year improvement recommendations.

Improving economy, efficiency and effectiveness

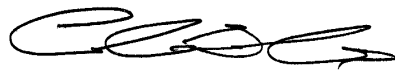
We have updated the prior year key recommendation in respect of bank and agency spend and have identified a significant weakness in arrangements in respect of Urgent and Emergency Care (UEC) performance. We have closed the prior year improvement recommendation.

As described above, the Board and the Financial Recovery Board will oversee the financial and urgency and emergency care improvement plans throughout 2026/27. The Audit and Assurance Committee will monitor implementation of the External Auditor's recommendations.

25. Conclusion

This Annual Governance Statement has identified financial governance underpinning financial delivery as a significant internal control issue. The Board is overseeing the development of an improvement plan for 2026/27, which will be approved and monitored by NHS England.

Signed:



Chief Executive

Date:

6 August 2026

DRAFT

Remuneration and Staff Report

Remuneration Report

The purpose of this report is to provide transparency and accountability relating to the remuneration of the Trust's senior managers.

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

Pension related benefits have been calculated in line with the 2025/26 Group Accounting Manual.

Remuneration Policy

The remuneration of executive directors is determined by the Remuneration Committee with reference to national guidance, pay awards made to other staff groups through national awards, benchmarking data and intelligence from independent specialists in pay and labour market research. Executive director contract terms and conditions and remuneration are aligned with NHS England guidance and established pay ranges for acute NHS trusts.

No performance related pay, long-term performance related pay or bonuses were paid to the directors in 2025/26 or 2024/25.

The Trust's executive directors included the following joint roles. In each case the other relevant Trust or Trusts contributed to the remuneration:

- Acting Chief Executive Officer with Wye Valley NHS Trust.
- Interim Chief Finance Officer with Wye Valley NHS Trust.
- Foundation Group Chief Executive with the four trusts of the Foundation Group.

The Trust has complied with the Very Senior Managers Pay Framework. No national approval for a pay case was required during the year.

Performance Appraisal

Performance appraisals of each executive director are undertaken annually to review performance against objectives set at the start of the year and to agree objectives for the coming year, aligned to the Trust's strategic objectives. Progress is regularly reviewed.

Remuneration Committee

The Remuneration Committee is chaired by the Trust Chair and its membership comprises all the non-executive directors, with associate membership of the associate non-executive directors. The Acting Chief Executive Officer and Chief People Officer routinely attended meetings to support the Committee's deliberations and are absent when a conflict of interest arises.

The Remuneration Committee met four times during the year and considered the following matters:

- Very Senior Manager pay award in line with NHS England recommendations.
- Appointment of a Chief Nursing Officer (interim and substantive).
- Appointment of a substantive Chief Operating Officer.
- Appointment of a substantive Chief Digital and Information Officer.
- Appointment of a Deputy Managing Director
- Appointment of an Interim Chief Finance Officer
- Outcome of the annual Fit and Proper Person Test

Appointment Process

The executive appointment process includes the following:

- Open advertising.
- Stakeholder interviews.
- Final panel interview comprising executive and non-executive Board members.
- Decision by the Remuneration Committee.

Diversity within our Board, as within our workforce, is a priority for the Trust and part of Board appointment processes and succession planning.

Succession Planning

The approach to succession planning and talent management is developed and overseen at Foundation Group level to share best practice, align processes and identify opportunities for joint development. This recognises the need to increase diversity within the Trust’s Board and senior leadership teams and comprises the following:

Talent Management					
Attracting	Identifying	Developing	Engaging	Retaining	Deploying
Critical Enablers					
Inclusivity	Skilled support	Protected development	Pipeline visibility	Alignment to demand	
Identifying readiness and Gaps through Performance Appraisal					
Ready Now		Ready Soon		Long-Term Ready	

Chair and Non-Executive Director Remuneration

The Secretary of State for Health sets and reviews the level of remuneration payable to the chair and non-executive directors of NHS trusts. The Chair and Non-Executive Directors are not entitled to a pension provision as part of their remuneration.

Remuneration tables (subject to audit)

Executive Director Remuneration 2025/26

Name	Job title (and period of office if relevant)	Salary & fees (in bands of £5k)		All taxable benefits (nearest £100)	All pension-related benefits (bands of £2.5k)		Total (bands of £5k)	
		£000s		£s	£000s		£000s	
Glen Burley	Group Chief Executive (excludes pay from SWFT, WVT and GEH)	50	55	3,200	10.0	12.5	65	70
Joanna Newton	Chief Strategy & Sustainability Officer (to 27 June 2025)	35	40	0	0.0	2.5	35	40
Neil Cook	Chief Finance Officer	175	180	0	65.0	67.5	245	250
Katie Osmond	Interim Chief Finance Officer (from 12 January 2026) (excludes pay from WVT)	20	25	0	2.5	5.0	25	30
Sarah Shingler	Chief Nursing Officer (to 7th September 2025)	70	75	200	17.5	20	90	95
Hayley Flavell	Chief Nursing Officer (Interim Chief Nursing Officer from 4 September to 7 October 2025)	95	100	0	0.0	2.5	95	100
Stephen Collman	Acting Chief Executive (until 31 March 2026)	165	170	0	82.5	85	250	255
Julian Berlet	Chief Clinical Strategy Officer	220	225	0	35.0	37.5	255	260
Juliette Walton	Chief Medical Officer	215	220	0	57.5	60	275	280
Ali Koeltgen	Chief People Officer	135	140	0	42.5	45	180	185
Rebecca Brown	Chief Digital Information Officer (Interim Chief Digital Information Officer until 31 January 2026)	135	140	100	40.0	42.5	175	180
Chris Douglas	Chief Operating Officer (Interim Chief Operating Officer until 31 January 2026)	145	150	0	130.0	132.5	275	280

Note 1. Glen Burley is seconded from South Warwickshire University NHS Foundation Trust on a shared appointment with SWFT, Wye Valley and George Eliot NHS Trust for a proportion of his time and the remuneration identified above reflects this. G Burley's full salary was within the range £295k to £300k.

Note 2. Neil Cook had the same title and role throughout the year, but he ceased to be a Board member on 6 January 2026. The remuneration above includes £42,546.67 for the period 6 January 2026 to 31 March 2026.

Note 3. Sarah Shingler ceased being a member of the Board on 3 September 2025 but was remunerated until 7 September 2025.

Note 4. Katie Osmond was Interim Chief Finance Officer from 12 January 2026. Katie is seconded from Wye Valley Trust on a shared appointment for a proportion of her time and the remuneration identified above reflects this. K Osmond's full salary was within the range £40k to £45k for the period 12 January 2026 to 31 March 2026.

Note 5. Julian Berlet's remuneration for Chief Clinical Strategy Officer was agreed during the current financial year. Julian was appointed substantive Chief Clinical Strategy Officer in March 2025 and as a result, payments related to 24/25 were processed this financial year (The full salary for 2024/2025 was within the range £215k to £220k). The total remuneration package also includes medical elements. Remuneration split is set out below:

Basic Pay as Chief Clinical Strategy Officer	£177,854
Medical Elements	£44,150
Total Remuneration reported above	<u>£222,004</u>

Payments related to 2024/2025 £532

Note 6. Juliette Walton's remuneration for Chief Medical Officer was agreed during the current financial year. Jules was appointed substantive Chief Medical Officer in March 2025 and as a result, payments related to 24/25 were processed this financial year. The total remuneration package also includes medical elements. Remuneration split is set out below:

Basic Pay as Chief Medical Officer	£190,664
Medical Elements	£28,000
Total Remuneration reported above	<u>£218,664</u>

Payments related to 2024/2025 £1,568

Note 7. Stephen Collman was acting Chief Executive under a shared appointment with Wye Valley Trust for 2025/26. Remuneration relating to the additional responsibilities undertaken at WVT have been recharged to this organisation and is therefore excluded from this table. The costs are an additional £65k to £70k. The full annual salary was within the range £235k to £240K. The remuneration recharged is based on a percentage of 30%. Pension benefits have not been apportioned and therefore include the full pension entitlement.

Note 8. All taxable benefits relate to cars and the benefits in kind are based on the HMRC guidance.

Executive Director Remuneration 2024/25

		Salary & fees (in bands of £5k)		All taxable benefits (nearest £100)	All pension-related benefits (bands of £2.5k)		Total (bands of £5k)	
Name	Job title (and period of office if relevant)	£000s		£s	£000s		£000s	
Richard Haynes	Director of Communications & Engagement	120	125	0	22.5	25	140	145
Glen Burley	Chief Executive (excludes SWFT, WVT and GEH)	145	150	0			145	150
Helen Lewis (known as Vikki)	Chief Digital Officer (to 20.10.24)	80	85	0	2.5	5	85	90
Joanna Newton	Chief Strategy Officer to 30.09.24, Chief Strategy & Sustainability Officer from 01.10.24	135	140	100	37.5	40	175	180
Neil Cook	Chief Finance Officer	170	175	100	22.5	25	195	200
Helen Lancaster	Chief Operating Officer (to 03.02.25)	165	170	200	105.0	107.5	270	275
Sarah Shingler	Chief Nursing Officer	165	170	400			165	170
Stephen Collman	Managing Director	210	215	0	195.0	197.5	405	410
Julian Berlet	Interim Chief Medical Officer to 20.02.25, Chief Clinical Strategy Officer from 21.02.25.	220	225	0	147.5	150	370	375
Juliette Walton	Interim Chief Medical Officer to 20.02.25, Chief Clinical Strategy Officer from 21.02.25.	210	215	0	122.5	125	335	340
Ali Koeltgen	Chief People Officer	130	135	200	135.0	137.5	270	275
Rebecca Brown	Acting Chief Digital Officer from 21.10.24	55	60	100	27.5	30	85	90
Chris Douglas	Acting Chief Operating Officer from 06.11.24, Interim Chief Operating Officer from 04.02.25	55	60	0	90.0	92.5	145	150

Non-Executive Director Remuneration 2025/26 (subject to audit)

Name	Job title (and period of office if relevant)	Salary & fees (bands of £5k)		All taxable benefits (to nearest £100)	Total (bands of £5k)	
		£000s		£s	£000s	
Russell Hardy	Chair (excludes SWFT, WVT and GEH) (to 31.03.26)	35	40	0	35	40
Julie Moore	Non-Executive Director	10	15	0	10	15
Colin Horwath	Non-Executive Director	10	15	0	10	15
Tony Bramley	Non-Executive Director	10	15	0	10	15
Karen Martin	Non-Executive Director	10	15	100	10	15
Simon Murphy	Non-Executive Director/Deputy Chair	20	25	0	20	25
Susan Sinclair	Associate Non-Executive Director	10	15	0	10	15
Michelle Lynch	Associate Non-Executive Director	10	15	0	10	15
Catherine Driscoll	Associate Non-Executive Director	10	15	0	10	15
Alex Moran	Associate Non-Executive Director (to 31.01.26)	10	15	0	10	15

Note 1. Russell Hardy is seconded from South Warwickshire University NHS Foundation Trust on a shared appointment with SWFT, Wye Valley and George Eliot NHS Trust for a proportion of his time and the remuneration identified above reflects this. Russell Hardy's full salary was within the range £90k to £95k.

Note 2. All taxable benefits relate to cars and the benefits in kind are based on the HMRC guidance.

Non-Executive Director Remuneration 2024/25

		Salary & fees (bands of £5k)		All taxable benefits (to nearest £100)	Total (bands of £5k)	
Name	Job title (and period of office if relevant)	£000s		£s	£000s	
Julie Moore	Non-Executive Director	10	15	0	10	15
Colin Horwath	Non-Executive Director	10	15	0	10	15
Richard Oosterom	Associate Non-Executive Director (until 30.06.24)	0	5	0	0	5
Simon Murphy	Non-Executive Director/Deputy Chair	20	25	0	20	25
Susan Sinclair	Associate Non-Executive Director	15	20	0	15	20
Tony Bramley	Non-Executive Director	10	15	100	10	15
Karen Martin	Non-Executive Director	10	15	100	10	15
Michelle Lynch	Associate Non-Executive Director	10	15	0	10	15
Russell Hardy MBE	Chair (excludes SWFT, WVT and GEH)	40	45	0	40	45
Catherine Driscoll	Associate Non-Executive Director (from 01.08.24)	5	10	0	5	10
Alex Moran	Associate Non-Executive Director (from 01.08.24)	5	10	0	5	10

Pensions table 2025/26 (subject to audit)

	Real increase in pension at pension age (bands of £2,500)	Real increase in Lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2026 £000	Cash Equivalent Transfer Value at 01 April 2025 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Sarah Shingler	0-2.5	0-0	0-5	0-0	20	0	11	0
Joanna Newton	0-0	0-0	0-0	0-0	0	334	0	0
Neil Cook	2.5-5	2.5-5	70-75	170-175	1,715	1,610	83	0
Stephen Collman	5-7.5	2.5-5	90-95	230-235	2,098	1,977	95	0
Julian Berlet	2.5-5	0-2.5	60-65	155-160	1,481	1,413	46	0
Juliette Walton	2.5-5	2.5-5	50-55	125-130	1,121	1,042	57	0
Ali Koeltgen	2.5-5	0-2.5	30-35	70-75	662	608	36	0
Rebecca Brown	2.5-5	0-0	30-35	0-0	463	422	27	0
Chris Douglas	5-7.5	10-12.5	30-35	75-80	626	502	106	0
Hayley Flavell	0-0	0-0	55-60	140-145	1,277	1,533	0	0
Katie Osmond	2.5-5	0-2.5	45-50	110-115	951	43	874	0

Note 1: CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant on 31 March 2026.

Note 2: Joanna Newton has already drawn down pension benefits; therefore, no CETV is applicable.

Note 3. Stephen Collman is under a shared appointment with Wye Valley Trust. Pension benefits have not been apportioned and therefore include the full pension benefits.

Note 4. Katie Osmond is seconded from Wye Valley Trust on a shared appointment. Pension benefits have not been apportioned and therefore includes the full pension benefits.

Note 5. The following directors are not included in the Directors’ Pensions Benefits table: Glen Burley chose not to be covered by the pension arrangements during the reporting year. He retains an NHS pension and as he is not adding any more contributions his CETV balance will remain intact until drawn down.

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Pension Benefits

Pension-related benefits represent the value accrued during the financial year through participation in the NHS Pension Scheme. This includes benefits arising from service in previous roles within the Trust prior to an individual's appointment as 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 on 31 March 2026 and deducting the equivalent value from the amount due on 31 March 2025. 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 2025/26 the Director was either not a director at the beginning of the year or is not a member of the NHS Pension Scheme.

Calculation of Pension Benefits

The value of pension benefits accrued during the year is calculated as the real increase in pension benefits, grossed up using a factor of 20, less any contributions made by the individual. This calculation excludes increases due to inflation and any changes resulting from a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

No additional benefits will become receivable by the individuals if they retire early.

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, arrangement to secure pension benefits in another pension scheme or 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 pension scheme and any contingent spouse's pension payable from the Scheme, not just their service in a senior capacity to which the disclosure applies.

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.

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 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 table above details the current pension benefits of the Trust’s senior managers. Where the executive director in post on 31 March 2025 is not a member of the NHS Pension Scheme, there are no pension benefits to be disclosed.

As non-executive directors do not receive pensionable remuneration, there are no entries in respect of non-executives.

Exit Packages (subject to audit)

Exit packages might include redundancies or other departures. No exit packages were agreed during the year.

Compensations for loss of office and payments to past directors (subject to audit)

No compensation payments were made for loss of office nor payments made to past directors in 2025/26.

Fair Pay Disclosures (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation to the median, 25th and 75th percentile remuneration values. These are disclosed in the table below for 2025/26 and the prior year. The table also discloses the remuneration for the highest paid director and remuneration of the median, 75th and 25th percentile employees.

	Pay Ratio		
	25 th percentile	Median	75 th percentile
2025/26	8.1:1	5.7:1	4.5:1
2024/25	8.7:1	6.1:1	4.8:1

The purpose of the ratios is to demonstrate the range of remuneration within the Trust by expressing the remuneration of the highest paid director as a multiple of the remuneration of the median, 25th and 75th percentiles.

The prior-year pay ratios have been updated following the correction of an error in the reported highest-paid director’s remuneration in the 2024/25 Annual Report.

The pay ratios have decreased compared to the previous year, reflecting increases in employee pay across the wider workforce that have outpaced movements in senior remuneration.

The banded remuneration of the highest paid director in the financial year 2025-26 was £222,536 (2024-25, £223,200). The relationship to the remuneration of the Trust’s workforce is disclosed in the below table.

	Total Remuneration			
	2025/26	% Change	2024/25	% Change
Highest Pay Director	222,536	0%	223,200	5%
Minimum	15,643	52%	10,324	0%
Median	39,043	7%	36,483	6%
75 th percentile	49,387	7%	46,148	0%
25 th percentile	27,476	7%	25,674	5%
Average Remuneration	51,244	7%	47,756	7%

The total remuneration has been disclosed within the fair pay calculations; this is the same as the salary component, meaning these have not been split out.

Salaries paid by the Trust on a full-time equivalent basis varied between £15,643 and £273,756 per annum.

In 2025/26 3 employees received remuneration in excess of the highest paid director. In 2024/25, 12 employees received remuneration in excess of the highest paid director.

The annualised salary of £273,756 is for a consultant who worked shifts through NHSP compared to the highest paid director of £222,536.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind and severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The remuneration calculations also cover staff engaged on a bank and agency basis as well as substantive posts.

Non-executive directors are excluded from the scope of the fair pay disclosures in 2025/26. They were included in the disclosures in prior years.

Staff Report

People Dashboard

Key people metrics on 31 March 2026 compared to last year were as follows.

Metric	31 March 2025		31 March 2026	
	Staff	Senior Managers*	Staff	Senior Managers*
Numbers (headcount)	8,058	20	8,257	18
Gender %	20% male; 80% female	50% male; 50% female	21% male; 79% female	39% male; 61% female
Sickness absence	5.53% (cumulative)	n/a	5.44% (cumulative)	n/a
Turnover	9.15%	n/a	7.43%	n/a
Staff Survey engagement	6.82	n/a	6.84	n/a

*Senior Managers are defined as board members, both voting and non-voting

Staff numbers and costs analysis (subject to audit)

The average number of Full Time Equivalent (FTE) staff during the year was 7,133.98. This is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year.

The workforce profile on 31 March 2026 compared with previous years was as follows:

Full Time Equivalent (FTE) Staff Numbers							
Staff Group	Sub Staff Group	March -21	March -22	March -23	March -24	March -25	March -26
Medical and Dental	n/a	676	689	738	792	854	913
Ambulance Staff	Registered Ambulance Staff	2	1	2	2	2	7
Administration and Estates	n/a	1048	1065	990	1081	1146	1121
Healthcare Assistants and Other Support Staff	n/a	1088	1016	1186	1323	1368	1413
Nursing, Midwifery and Health Visiting Staff	NMC Registered Nurses, Midwives and Health Visitors	1857	1921	1990	2144	2348	2445
	Nursing Associates and support to NMC Registered Nurses, Midwives and Health Visitors	71	138	147	166	139	126
Nursing, Midwifery and Health Visiting Learners	Un-registered Nursing Learners	51			1	3	3

Healthcare Scientists	Qualified Healthcare Science and Public Health Scientific Staff	170	165	180	176	187	208
	Support to Qualified Healthcare Science and Public Health Scientific Staff	106	108	111	121	126	113
Scientific, Therapeutic and Technical Staff	Qualified Allied Health Professionals	437	436	428	439	491	505
	Qualified Other Scientific, Therapeutic & Technical	151	161	160	162	171	177
	Support to Qualified Allied Health Professionals	106	108	112	126	140	130
	Support to Qualified Other Scientific, Therapeutic & Technical	66	75	40	43	58	59
Grand Total		5827	5881	6084	6577	7032	7219

Assignment status of our on-payroll staff as of 31 March 2026 (subject to audit):

Assignment Category	31 March 2025		31 March 2026	
	FTE	Headcount	FTE	Headcount
Fixed Term/Temporary/Locum	598.93	635	629.83	673
Permanent	6,433.32	7,423	6,588.85	7,584
Grand Total	7,032.25	8,058	7,218.68	8,257

The Trust contracts with NHS Professionals as sole provider of Bank and Agency staff. As of 31 March 2026, the following substantive and temporary staff actually worked during the month (Source: Worked from Finance ADI):

Type Breakdown	31 March 2025	31 March 2026
Agency	275.14	162.53
Bank	535.51	667.90
Substantive (worked)	6,920.52	7,061.82
Grand Total	7,731.17	7,892.25

Staff Costs during 2025/26 compared with the previous year were as follows. (subject to audit)

Staff Cost 2025/26	Permanent £'000	Other £'000	Total £'000	2024/25 Total
Salaries and Wages	341,695	0	341,695	315,461
Social Security Costs	46,184	3,593	49,777	36,995
Apprenticeship Levy	1,783	77	1,860	1,693
NHS Pension Costs	68,945	2,093	71,038	64,836
Other Pension Costs	67	0	67	79
Temporary Staff	0	68,082	68,082	78,510
Less: recoveries in respect of outward secondments (where treated net)	0	0	0	0
Total Staff Costs	458,674	73,845	532,519	497,574

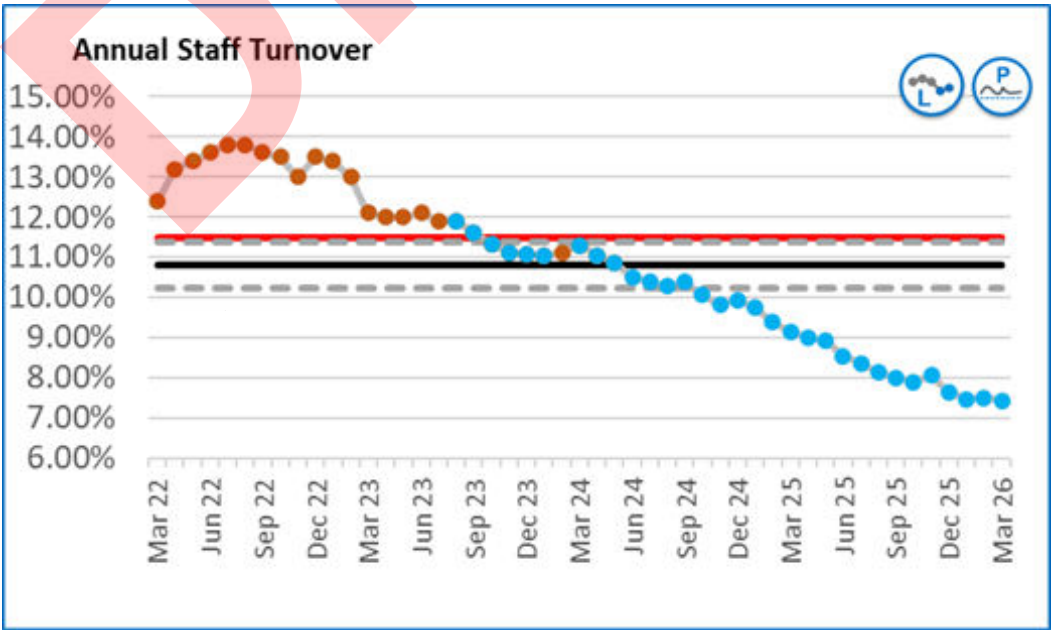
This shows a 7% increase in staffing costs over the year, reflecting:

- An increase in the FTE workforce overall.
- An increase in the FTE workforce in in every staff group except administration and clerical.
- An increase in the temporary FTE workforce overall but a reduction in agency workforce.
- Increases in national pay awards.

Staff Turnover

The Trust’s staff survey data is captured as part of NHS workforce statistics; this is an official NHS England statistics publication complying with the UK Statistics Authority’s Code of Practice.

Our annual staff turnover has been steadily improving and, at 7.43% for the year, meets the target of 11.5% and, compared to 9.15% the previous year shows an improving trajectory. This also benchmarks well with other trusts at quartile 1 (best) on the Model Hospital rates for December 2025.



Equality, Diversity and Inclusion

As an NHS provider we are committed to ensuring that our services are accessible to, and meet the diverse needs of, all our patients and visitors. We work in partnership with colleagues in other NHS organisations, voluntary and community groups and our key stakeholders to enable us to plan and deliver our services in a way which best meets the needs of everyone in the communities we serve.

We are an equal opportunities employer committed to fair and equitable treatment of all our staff and all job applicants. We are opposed to any form of negative discriminatory or unfair treatment in all aspects of employment.

We are committed to the elimination of discrimination and ensure our workforce is given the necessary training to support this.

We have a framework of policies and processes in place to support us to achieve this.

Policies	Training	People and Teams
Equality, Diversity and Inclusion Flexible Working Family Leave Freedom to Speak Up Sickness Absence, health & Wellbeing Reasonable Adjustments Dignity at Work Supporting Colleagues who are Transgender, Non-Binary or Gender Non-Conforming	Recruitment and selection Recruitment champion Mandatory EDI Freedom to Speak Up: Speak Up, Listen Up Unconscious Bias	Freedom to Speak Up Guardian Freedom to Speak Up Champions Staff Networks Reciprocal mentoring
Objectives and Commitments	Reporting and Action Plans	Collaboration
Board member annual EDI objectives Inclusive Leadership Pledge	Gender Pay Gap WRES WDES EDS 22 High Impact Improvement Actions	Foundation Group: benchmarking, shared learning, collaboration Integrated Care System: Culture and Inclusion Strategy 2024-29

The NHS High Impact Equality Diversity and Inclusion (EDI) Improvement plan sets out targeted actions to address the direct and indirect prejudice and discrimination that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

The EDI Improvement Plan supports the long-term Workforce Plan by improving the culture of workplaces and the experiences of the workforce.

To support the achievement of strategic EDI outcomes for patients and employees, NHS trusts are expected to do the following:

- Address discrimination, enabling staff to use the full range of their skills and experience to deliver the best possible patient care.
- Increase accountability of all leaders to embed inclusive leadership and promote equal opportunities and fairness of outcomes in line with the NHS Constitution and the Equality Act 2010.

- Improve EDI within the NHS workforce, enhancing the NHS's reputation as a model employer and an anchor institution, and thereby continuing to attract diverse talents to our workforce.
- Make opportunities for progression equitable, facilitating social mobility in the communities we serve.

The Trust's progress on these areas was reported to the Trust Board when it met with the other three members of the Foundation Group, which enabled information sharing, learning and benchmarking.

Board leadership	Fair and inclusive recruitment	Pay gaps
• Annual EDI objective for every Board member • The Trust is acting as anchor organisation	• Recruitment champion training • Essential criteria interview guarantee scheme	• Gender pay gap action plan • Developing an action plan to address race and disability pay gaps
Health inequalities in the workforce	Programme for international staff	Address bullying, discrimination, harassment, physical violence
• People Strategy • Staff Survey actions • Leadership & management development programmes • Health and Wellbeing conversations	• Pastoral Care • Staff networks • international staff charter • Students Integration Programme	• FTSU Guardian and champions • Speak Up, Listen Up training • Sexual safety policy & charter in place • Safe Learning Charter

Staff with Disabilities and Long-Term Conditions

Workforce by Disability	Total Headcount Mar 24	Total Headcount Mar 25	Total Headcount Mar 26	Total % Mar 26
No	7,057	7,478	7,571	91.69
Not Declared	141	137	122	1.48
Prefer Not to Answer	35	32	35	0.42
Unspecified	14	15	34	0.41
Yes	299	396	495	5.99
Grand Total	7,546	8,058	8,257	100

Support for colleagues with disabilities and long-term conditions includes the following:

- The Trust's Recruitment and Selection Policy requires a guaranteed interview for applicants with disability who meet the essential person specification criteria for the role, in line with the DWP Disability Confident Employer scheme.
- For senior posts (band 8a and above) selection processes must include a dedicated Recruitment Champion who has received Inclusive Recruitment Training to ensure inclusive practice within all stages of selection.
- The Inclusive Recruiting Managers toolkit includes unconscious bias training.
- The Sickness Absence, Health and Wellbeing Policy describes the approach that may need to be taken where an employee becomes disabled during their employment, including making reasonable adjustments to support return to work.
- A Health and Wellbeing Passport launched in September 2023 in partnership with the Staff Disability Network supports colleagues to undertake their role effectively within a

supportive environment. It can be used by any member of staff who feels that they need support at work in relation to their wellbeing.

- Health and wellbeing offer, which includes:
 - Occupational health service
 - Staff psychological wellbeing service
 - Counselling Service
 - Mental Health First Aiders
 - Stress Management toolkit for employees and managers
 - Free health checks for all staff
 - Monthly wellbeing webinars
 - Stress awareness drop-in sessions
- Diverse Ability Working Network (DAWN) (see below).

Health and safety at work

Risks to the health and safety of our staff at work are overseen by the Health and Safety Committee, which meets monthly and reports to the Executive Risk Management Committee. Sub-committees and groups reporting to the Committee cover areas such as security and water, electrical, ventilation and fire safety. Key matters considered during the year included:

- Health and safety incidents
- Fire safety
- Security
- Violence and aggression incidents

Staff Wellbeing

A Wellbeing Hub on the staff intranet draws together all the information about the Trust's wellbeing offer to staff.



Key elements of this offer are:

- Occupational health service
- Staff psychological wellbeing service
- Counselling Service
- Mental Health First Aiders
- Stress Management toolkit
- Free health checks
- Monthly wellbeing webinars
- Stress awareness drop-in sessions
- Wellbeing and relaxation rooms
- Health and wellbeing passport
- Financial wellbeing hub
- Neurodiversity Hub

Human Capital Management

To attract and retain our workforce we need to support staff to stay safe, well and fulfilled at work. As well as supporting their safety and wellbeing, ensuring our staff can progress and develop in their careers is an essential element of this.

The Trust's Education Academy includes a range of opportunities available for staff from all professional groups. These include:

- Apprenticeships
- Coaching and mentoring
- Reciprocal mentoring
- Fellowships
- Professional Nurse/Midwife Advocates
- Career frameworks for different staff groups
- Leadership programmes
- Leadership management and development
- Team engagement development

Employee consultation and participation

The Trust maintains regular communication with its staff in a number of ways, including:

- Weekly emailed newsletters
- Staff intranet containing up to date information and daily news.
- Monthly 'Exec Live' Teams Session for all staff.
- Monthly Leaders Briefings
- Quarterly Foundation Group Leaders Briefings
- Monthly Trust Board meetings – live streamed and recordings published.

During 2025/26 the Trust consulted with staff on the development and implementation of strategies and plans including:

- Trust Strategy
- Ambulance handover improvements.
- Divisional structure
- Outpatient services strategy
- UEC/unplanned flow improvements

One of the main ways in which the Trust engages with its staff is through the staff networks; details of each of these are as follows:

Staff Networks	
Diverse Ability Working Network (DAWN)	
Aims and purpose:	
• Support a fairer and more diverse Trust for everyone. • Tackle issues for under-represented and disadvantaged groups and individuals. • Share experiences and facilitate learning and development. • Help shape and deliver organisational strategy and policy. • Provide training and guidance to aid an understanding of disability. • Listen to the voices of disabled colleagues.	

- Improve workforce data.

EmBRACE Network

Active network of colleagues and allies working together to help create a culture where all staff and patients - regardless of their race or ethnicity - feel supported, cared for and are treated with dignity, kindness and respect. Key areas of focus:

- Support and Advocacy.
- Training and Education.
- Inclusive Recruitment and Retention.
- Launch of Anti-Racism Charter
- Support to International Staff and Students

Faith and Spirituality Network

Objectives:

- Assist in formulating new and reviewing existing policies and procedures
- Support the Trust to attract, recruit and retain staff of all faiths and none.
- Provide learning and development opportunities within the Trust's training and education offer.
- Encourage Trust volunteers with a faith or belief, to be part of the Network.
- Build resilient and positive partnerships with faith groups and leaders across the County.

LGBTQ+ Network

Purpose:

- To influence and support the Trust Board to tackle the key barriers to healthcare for LGBTQ+ patients, whilst also promoting a more diverse and inclusive workplace.
- Safe space for colleagues to share experiences and ideas to improve staff and patient experience.
- Supporting staff and answering questions.
- Reviewing and creating policies to shape the way the Trust supports LGBTQ+ patients and staff.
- Working with fellow Staff Networks to foster an intersectional approach for our communities.

Women's Network

Aims:

- Create a supportive and inclusive environment for all women and those who identify as women.
- Share experiences and champion positive change.
- Promote equality and raise awareness of the challenges women may face in their daily lives.
- Break down barriers to healthcare
- Create a workplace where all women feel valued and empowered.
- Collaboration with all staff networks to foster an equitable culture for all women.

Armed Forces Network

Network of veterans, reservists, military spouses and staff with an interest in the armed forces. Aims:

- To support the aims of the Armed Forces Covenant.
- Maintain 'Gold standard' Armed Forces Covenant accreditation.
- Support patients, families and staff with links to the armed forces.
- Help to maintain our 'Veteran Accreditation' standard.

Trade Union Relationships

In the NHS, 'Staff Side' is a term for the interface with various trade unions and recognised professional bodies. These bodies have locally accredited representatives and working together they are termed 'Staff Side'. The role of Staff Side is to ensure a collective approach to issues such as terms and conditions of employment and receiving advice and guidance from the various unions and organisations. They consider concerns raised by staff members and consult and negotiate with Trust

managers through the Joint Negotiating Consulting Committee (JNCC) where staff side and management come together to discuss matters arising.

Staff side plays a vital role in looking after employee interests and has an excellent working relationship with the Trust.

Expenditure on consultancy

The Trust spent £234,000 on consultancy during 2025/26 compared to £284,000 the previous year. This equates to 0.028% per cent of the Trust's turnover in 2025/26.

Off Payroll Engagements

Off payroll engagements relate to individuals employed by the Trust but not remunerated via the organisation's payroll function. Typically, this would relate to self-employed individuals or those contracted via agencies. The Department of Health requires NHS bodies to report any off-payroll engagements as of 31 March 2026, for more than £245 per day*

Table 1: length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2026, for more than £245 per day :	Number of Engagements
Number of existing engagements as at 31 March 2026	7
No. that have existed for less than one year at time of reporting	0
No. that have existed for between one and two years at time of reporting	3
No. that have existed for between two and three years at time of reporting	1
No. that have existed for between three and four years at time of reporting	1
No. that have existed for four or more years at the time of reporting	2

For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day:

Table 2: off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day:	Number of Engagements
Number of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	6
of which:	
Number not subject to off-payroll legislation	
Number subject to off-payroll legislation and determined as in-scope of IR35(1)	
Number subject to off-payroll legislation and determined as out of scope of IR35(1)	6
Number of engagements reassessed for compliance or assurance purposes during the year	2
of which:	
Number of engagements that saw a change to IR35 status following review	2

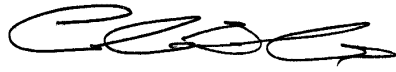
The six engagements reported above all relate to engagements outside of IR35 and therefore the Trust have not been required to introduce contractual clauses.

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026:

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

Off-payroll engagements of board members, and/or senior officers with significant financial responsibility between 1 April 2025 and 31 March 2026	Number of Engagements
Number of off-payroll engagements of board members, and/or senior officials with significant responsibility, during the financial year (1)	0
Number of individuals that have been deemed 'board members and/or senior official's with significant financial responsibility' during the financial year, including both off-payroll and on-payroll engagements.	22

Signed:



Chief Executive Officer

Date:

6 August 2026

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Worcestershire Acute Hospitals NHS Trust

Annual accounts for the year ended 31 March 2026

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Statement of Comprehensive Income		Restated	
		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	789,932	769,005
Other operating income	4	41,820	38,323
Operating expenses	7,9	(823,012)	(789,926)
Operating surplus/(deficit) from continuing operations		8,740	17,402
Finance income	11	1,976	2,030
Finance expenses	12	(14,960)	(14,819)
PDC dividends payable		(4,279)	(4,847)
Net finance costs		(17,263)	(17,636)
Other gains / (losses)	13	(230)	(714)
Surplus / (deficit) for the year from continuing operations		(8,753)	(948)
Surplus / (deficit) for the year		(8,753)	(948)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(7,361)	(2,831)
Revaluations	17	36	54
Total other comprehensive income for the period		(7,325)	(2,777)
Total comprehensive income / (expense) for the period		(16,078)	(3,725)

Statement of Financial Position				
		31 March 2026 £000	Restated 31 March 2025 £000	Restated 01-Apr-24 £000
	Note			
Non-current assets				
Intangible assets	14	11,731	11,415	8,518
Property, plant and equipment	15	326,559	329,371	329,878
Right of use assets	18	10,242	12,210	12,007
Receivables	20	3,432	3,231	3,076
Total non-current assets		351,964	356,227	353,479
Current assets				
Inventories	19	14,917	13,266	12,637
Receivables	20	25,640	19,719	23,158
Cash and cash equivalents	21	7,484	35,616	11,745
Total current assets		48,041	68,601	47,540
Current liabilities				
Trade and other payables	22	(78,004)	(86,089)	(74,878)
Borrowings	24	(16,278)	(14,846)	(13,276)
Provisions	25	(1,212)	(4,509)	(7,553)
Other liabilities	23	(3,964)	(5,799)	(6,221)
Total current liabilities		(99,458)	(111,243)	(101,928)
Total assets less current liabilities		300,547	313,585	299,091
Non-current liabilities				
Borrowings	24	(121,261)	(133,122)	(142,880)
Provisions	25	(2,059)	(2,133)	(3,416)
Other liabilities	23	(3,010)	(3,188)	(4,043)
Total non-current liabilities		(126,330)	(138,443)	(150,339)
Total assets employed		174,217	175,142	148,752
Financed by				
Public dividend capital		707,177	692,023	661,909
Revaluation reserve		54,975	62,300	66,485
Other reserves		(861)	(861)	(861)
Income and expenditure reserve		(587,074)	(578,320)	(578,781)
Total taxpayers' equity		174,217	175,142	148,752

The notes on pages 1 to 59 form part of these accounts.

Name Glen Burley
Position Chief Executive
Date 6th August 2026



Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	692,023	62,300	(861)	(578,320)	175,142
Surplus/(deficit) for the year	-	-	-	(8,753)	(8,753)
Impairments	-	(7,361)	-	-	(7,361)
Revaluations	-	36	-	-	36
Public dividend capital received	15,154	-	-	-	15,154
Taxpayers' equity at 31 March 2026	707,177	54,975	(861)	(587,074)	174,217

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025 - Restated

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	661,909	66,485	(861)	(567,088)	160,445
Prior period adjustment	-	-	-	(11,692)	(11,692)
Implementation of IFRS 17 at 1 April 2024 transition date	-	-	-	-	-
Taxpayers' equity at 1 April 2024 - restated	661,909	66,485	(861)	(578,780)	148,753
Surplus/(deficit) for the year	-	-	-	(948)	(948)
Other transfers between reserves	-	(1,406)	-	1,406	-
Impairments	-	(2,831)	-	-	(2,831)
Revaluations	-	54	-	-	54
Transfer to retained earnings on disposal of assets	-	(2)	-	2	-
Public dividend capital received	30,114	-	-	-	30,114
Taxpayers' equity at 31 March 2025	692,023	62,300	(861)	(578,320)	175,142

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.

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Statement of Cash Flows		2025/26	Restated 2024/25
	Note	£000	£000
Cash flows from operating activities			
Operating (deficit)/surplus		8,740	17,402
Non-cash income and expense:			
Depreciation and amortisation of PPE and other intangible assets	7	21,735	20,218
Net impairments	8	3,898	2,048
Income recognised in respect of capital donations	4	(830)	(375)
Amortisation of PFI deferred credit		(628)	(966)
(Increase) in receivables and other assets		(6,068)	(2,014)
(Increase) in inventories		(1,651)	(629)
(Decrease)/increase in payables and other liabilities		(7,532)	13,874
(Decrease) in provisions		(3,427)	(4,371)
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		1	(1)
Net cash flows from operating activities		14,238	45,186
Cash flows from investing activities			
Interest received		1,976	2,030
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(4,030)	(4,504)
Purchase of PPE and investment property		(24,663)	(22,468)
Proceeds from sale of PPE and investment property		42	56
Initial direct costs or up front payments in respect of new right of use assets		-	(282)
Receipt of cash donations to purchase assets		145	204
Net cash flows (used in) investing activities		(26,530)	(24,964)
Cash flows from financing activities			
Public dividend capital received		15,154	30,114
Repayment of Loans from DHSC		(668)	(668)
Capital element of lease rental payments		(1,465)	(1,291)
Capital element of PFI, LIFT and other service concession payments		(13,208)	(11,673)
Interest on loans		(236)	(255)
Other interest		(24)	-
Interest paid on lease liability repayments		(257)	(271)
Interest paid on PFI, LIFT and other service concession obligations		(10,090)	(10,789)
PDC dividend (paid)		(5,046)	(1,518)
Net cash flows (used in)/from financing activities		(15,840)	3,649
Increase / (decrease) in cash and cash equivalents		(28,132)	23,871
Cash and cash equivalents at 1 April - brought forward		35,616	11,745
Cash and cash equivalents at 31 March	21	7,484	35,616

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 2025/26 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 2026 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.

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.

Contract payments in year have been based on expected contract value divided by calendar month. The adjustment at year end for final settlement is to be settled post year end.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to Trust's for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices reimbursement depends on the NHS commissioner. Reimbursement is either on actual usage or an agreed budget set at the start of the year.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. BPT are paid as part of the fixed payment that covers emergency, maternity, radiotherapy etc. Elective activity is funded as part of NHSE's variable payment or otherwise known as Elective Recovery Scheme (ERF). This activity is funded for activity delivered priced at the published payment by results (PbR) prices and locally agreed prices otherwise.

The CQUIN schemes have not been applied in year per NHSE Guidance.

NHSE Specialised Commissioning makes a mixture of payments direct to the Trust and also to ICBs to then pay over to the Trust. These payments cover both Variable activity, accounted for under IFRS15 and Fixed payments

Income for activity outside of API contracts or LVAs are accounted for under IFRS15

Education and Training Income

Education and Training income (note 4) relates to the NHS Education Contract of £22.5m (£19.2m in 2024/25). The Trust contracts with the NHS England 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 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 apprenticeship service 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.

The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024. The NHS Pension Scheme remains at 23.7% from April 2025.

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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

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

Measurement

Valuation

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

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use 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. 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, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' 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.

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

PFI 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. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's *FReM*, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

In 2013 the PFI provider was found to be in default of the service agreement, due to building defects. A settlement was reached between the Trust and the PFI provider in June 2016. The Deed of Variation included two broad elements; a lump sum compensation payment (£6.5m) and alterations to future service charges (£7.3m). The lump sum payment was credited to other operating revenue. In 2016/17 the Trust recognised the revenue coming from future service charges 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 future service charges element of the Unitary Payment is 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	5	80
Dwellings	47	52
Plant & machinery	3	20
Information technology	3	12
Furniture & fittings	7	7

Note 1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets 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, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

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

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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
Development expenditure	5	5
Software licences	3	10

Note 1.9 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 £14.9m is material to the Trust's accounts. The Trust is satisfied that its inventory balance is presented fairly in all material respects: the Trust has well-established stocktake procedures which are regularly reviewed and continue to use the digital app. for data collection. Trust staff were able to complete the stock counts for 2025/26.

Note 1.10 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 1.11 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

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

Expected credit losses are determined by providing 50% for non-NHS debtors over 90 days old and for Injury Cost Recovery income using national guidance. In accordance with the Department of Health guidelines 24.62% of injury costs recovery revenue is provided in a bad debt provision.

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 1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised. After the commencement date, a lessee is only required to reassess the lease term upon the occurrence of a significant event or a significant change in circumstances that is within control of the lessee and affects whether the lessee is reasonably certain to exercise, or not exercise, an option which previously informed the assessment made regarding the lease term.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

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

Income from operating leases is recognised on a straight-line basis or another systematic 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 1.13 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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

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.

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 1.14 Contingencies

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

Contingent liabilities are not recognised, but are disclosed in Note 26.

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 1.15 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 1.16 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 1.17 Corporation tax

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

Note 1.18 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 1.19 Losses and special payments

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

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

Note 1.20 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 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - the standard applies to annual reporting periods on or after 1 January 2027. It replaces IAS1 and the main impacts relate to classification of income and expenses and balance sheet items, along with disclosure of management defined performance measures (MPMs).

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £271m as at 31 March 2026.

Note 1.23 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 (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 desk top revaluation in 2025/26 after completing a full revaluation in 2023/24. The valuation was reviewed between December 2025 and April 2026; with a valuation date of 31 March 2026.

The valuation is based on a number of key assumptions, including:

- Build cost indices (BCIS) applied within the Depreciated Replacement Cost (DRC) methodology
- Modern Equivalent Asset (MEA) assumptions, including asset size, configuration and specification used to reflect a modern replacement asset
- Functional and external obsolescence adjustments, reflecting the condition, utilisation and suitability of assets for current service delivery
- Remaining useful economic lives applied to asset components
- Regulatory and compliance requirements, including the impact of building safety legislation on asset configuration and cost

These assumptions require significant professional judgement and are sensitive to changes in market conditions, regulatory requirements and service delivery models.

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards ('Red Book'), the valuer has stated that the UK continues to experience heightened uncertainty due to a number of factors, including:

Volatility in construction costs and supply chains

Ongoing changes in building safety regulation, including the Building Safety Act

Broader macroeconomic and geopolitical conditions, which may impact property and construction markets

Due to the specialised nature of NHS assets, there is limited market evidence to directly support valuations.

Market participants continue to be affected by details of construction, health and safety, and particularly fire prevention, 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 the valuer has recommended that it is kept under regular review.

There are numerous geopolitical and economic tensions across the world causing uncertainty at present, although these pressures are concentrated in specific regions rather than being globally uniform. There is the potential for unpredictable escalation which could produce a significant impact on global trade, economies and property values. Experience has shown that consumer and investor behaviour can quickly change during fluctuating market conditions. Conclusions set out in the valuation report are valid as at valuation date only, and should be monitored closely to track how markets respond to the current environment.

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 specialised assets have been valued on a Depreciated Replacement Cost basis and any movement in build costs associated with the Building Safety Act (BSA), would therefore impact on value. The valuation is based on build cost indices published by the BCIS, current as at 31 March 2026. The build costs and consequently the valuation therefore take into account any movement in build cost and value associated the BSA as at the valuation date.

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.

Operating segments are identified on the basis of internal reports that are regularly reviewed by the Trust's Board, in order to allocate resources and assess performance. The Trust is managed as a single operating segment, with the Trust Board receiving and reviewing financial and operational information on an organisation-wide basis. Accordingly, the Trust identifies one operating segment for the purposes of IFRS 8 Operating Segments, as interpreted by the Department of Health and Social Care Group Accounting Manual.

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 has only one operating segment, that is the provision of Healthcare Services.

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.

The Trust's adjusted financial performance is detailed as below:

Adjusted financial performance (control total basis):	2025/26	2024/25
Surplus / (deficit) for the period	(8,753)	(621)
Remove net impairments not scoring to the Departmental expenditure limit	3,898	1,405
Remove (gains) / losses on transfers by absorption	-	-
Remove I&E impact of capital grants and donations	(619)	(217)
Prior period adjustments	562	-
Remove non-cash element of on-SoFP pension costs	-	-
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	44,879	44,090
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis	(51,009)	(50,222)
Remove net impact of DHSC centrally procured inventories	-	81
Remove loss recognised on peppercorn lease disposals	-	-
Remove loss recognised on capital grants in kind	-	-
Adjusted financial performance surplus / (deficit)	(11,042)	(5,484)

Once audited accounts have been submitted and the consolidated accounts have been closed, adjusted financial performance and capital resource limits do not change for that year, and prior year 2024/25 remains at previous stated surplus/deficit for that period rather than the restated value as per updated SOCI. For adjusted financial performance any prior period adjustments (PPAs) are adjusted in the year the PPA is recognised which flows into the Breakeven duty calculation on the same basis. Please refer to Note 38 Prior Period Adjustments.

In 2025/26 the Trust accounted for a prior period adjustment relating to the CHEC building lease by reinstating comparatives back to IFRS 16 transitional date of 1st April 2022.

Income Sources

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

The ICB income for 2025/26 was £688.002 million (£673.898m 2024/26) and NHS England from which £94.489 million (£89.534 million in 2024/25 from NHSE) 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)	2025/26	2024/25
	£000	£000
Income from commissioners under API contracts - variable element*	160,756	155,598
Income from commissioners under API contracts - fixed element*	523,062	508,028
High cost drugs income from commissioners	59,867	56,779
Other NHS clinical income	17,632	17,696
All services		
Private patient income	589	565
National pay award central funding***		1,143
Additional pension contribution central funding**	28,026	25,573
Other clinical income	-	3,623
Total income from activities	789,932	769,005

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

In 2025/26, the Trust applied an accrual for partially completed inpatient spells at the year end, recognising income for activity delivered but not yet invoiced. This reflects the reintroduction of activity based payment mechanisms and is consistent with the Trust's application of IFRS 15 principles for recognising revenue as performance obligations are satisfied

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)	2025/26	2024/25
	£000	£000
Income from patient care activities received from:		
NHS England	113,058	89,534
Integrated care boards	669,433	673,898
Other NHS providers	2,010	2,562
Non-NHS: private patients	589	565
Non-NHS: overseas patients (chargeable to patient)	283	237
Injury cost recovery scheme	1,666	1,440
Non NHS: other	2,893	769
Total income from activities	789,932	769,005
Of which:		
Related to continuing operations	789,932	769,005
Related to discontinued operations	-	-

Injury cost recovery income is subject to a provision for impairment of receivables of 24.62% to reflect expected rates of recovery.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)		
	2025/26	2024/25
	£000	£000
Income recognised this year	283	237
Cash payments received in-year	132	301
Amounts written off in-year	14	70

Note 4 Other operating income	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,437	-	1,437	1,303	-	1,303
Education and training	22,520	-	22,520	19,220	-	19,220
Non-patient care services to other bodies	6,382	-	6,382	6,657	-	6,657
Receipt of capital grants and donations and peppercorn leases	-	830	830	-	375	375
Charitable and other contributions to expenditure	-	250	250	-	210	210
Revenue from operating leases	-	41	41	-	42	42
Amortisation of PFI deferred income / credits	-	628	628	-	966	966
Other income	9,732	-	9,732	9,550	-	9,550
Total other operating income	40,071	1,749	41,820	36,730	1,593	38,323

Of which:

Related to continuing operations	41,820	38,323
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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 England £22.5m (Note 1.3).

Included in Other income is £2.35m for car parking, which is referenced in Note 5.

Contract income is recognised in accordance with IFRS15.

Note 5 Fees and charges

The following disclosure is of income from charges to service users where the full cost of providing 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.

	2025/26	2024/25
	£000	£000
Income	2,350	2,209
Full cost	(1,661)	(1,520)
Surplus / (deficit)	689	689

The income and full costs relate to the Trust car parking, which are included in Other Income (Note 4). Free staff parking continued for 2025/26 for all staff. Patients and visitors charges have been in place for 2024/25.

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Note 6 Operating leases - Worcestershire Acute Hospitals NHS Trust as lessor

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

Note 6.1 Operating lease income

	2025/26 £000	2024/25 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	41	42
Total in-year operating lease income	41	42

Note 6.2 Future lease receipts

	31 March 2026 £000	31 March 2025 £000
Future minimum lease receipts due in:		
- not later than one year	41	41
- later than one year and not later than two years	23	41
- later than two years and not later than three years	7	26
- later than three years and not later than four years	-	8
Total	71	116

The future lease relates to new lease agreement for premises at Alexandra Hospital and Kidderminster sites.

Note 7 Operating expenses		
	2025/26	Restated
	£000	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,710	5,826
Purchase of healthcare from non-NHS and non-DHSC bodies	9,134	9,858
Purchase of social care	-	-
Staff and executive directors costs *	531,961	496,958
Remuneration of non-executive directors	174	170
Supplies and services - clinical (excluding drugs costs)	68,247	69,157
Supplies and services - general	26,603	28,607
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	74,962	72,109
Inventories written down	240	200
Consultancy costs	234	284
Establishment	5,583	4,937
Premises	18,686	21,462
Transport (including patient travel)	1,688	1,932
Depreciation on property, plant and equipment	19,207	18,406
Amortisation on intangible assets	2,528	1,812
Net impairments **	3,898	2,048
Movement in credit loss allowance: contract receivables / contract assets	(21)	623
Change in provisions discount rate(s)	(78)	7
Fees payable to the external auditor		
audit services- statutory audit ***	363	158
Internal audit costs	132	167
Clinical negligence	22,934	23,367
Legal fees	873	1,039
Insurance (as a policy holder)	264	287
Education and training	1,735	1,383
Expenditure on short term leases	25	63
Expenditure on low value leases	-	3
Variable lease payments not included in the liability	184	254
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	28,635	28,694
Other ****	(889)	115
Total	823,012	789,926
Of which:		
Related to continuing operations	823,012	789,926
Related to discontinued operations	-	-

Net Impairments are linked to the desktop valuation of the Trust estate as at 31st March 2026.

*Staff and Executive costs excludes staff capitalised of £558k.

** Net Impairments - Net Impairments are linked to the desktop valuation of the Trust estate as at 31st March 2026 (Note 18.3)

*** Audit Service is shown gross of VAT. £360k for the Statutory Annual Audit, £3k for Statutory Regulatory Pathology Audit

**** Other - Release of Provisions - (Note 25.1).

Note 7.1 Other auditor remuneration

There has been no other remuneration paid to the external auditor in either 2025/26 or 2024/25.

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1,125k (2024/25: £1,000k).

Note 8 Impairment of assets	2025/26	Restated
	2024/25	
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	3,898	2,048
Total net impairments charged to operating surplus / deficit	3,898	2,048
Impairments charged to the revaluation reserve	7,361	2,831
Total net impairments	11,259	4,879

The Trust engaged a professional property adviser to undertake a desktop revaluation in 2025/26 after having a full revaluation previously in 2023/24. Any buildings assets which reduced in value were impaired to either the revaluation reserve or to I&E in 2025/26. In 2025/26, the Trust instructed the valuation exercise to include right of use asset buildings. The Trust also restated comparatives under the revaluation model for one right of use asset building back to 2022/23 as part of an agreed prior period adjustment.

Note 9 Employee benefits		
	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	341,705	315,461
Social security costs	49,777	36,995
Apprenticeship levy	1,860	1,693
Employer's contributions to NHS pensions	71,028	64,836
Pension cost - other	67	79
Temporary staff (including agency)	68,082	78,510
Total gross staff costs	532,519	497,574
Recoveries in respect of seconded staff	-	-
Total staff costs	532,519	497,574
Of which		
Costs capitalised as part of assets	558	616

Note 9.1 Retirements due to ill-health

During 2025/26 there were 4 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £220k (£388k in 2024/25).

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

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 11 Finance income

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

	2025/26 £000	2024/25 £000
Interest on bank accounts	1,976	2,030
Total finance income	1,976	2,030

Note 12.1 Finance expenditure

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

	2025/26 £000	Restated 2024/25 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	236	255
Interest on lease obligations	238	271
Interest on late payment of commercial debt	24	-
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	10,090	10,789
Remeasurement of the liability resulting from change in index or rate	4,316	3,460
Total interest expense	14,904	14,775
Unwinding of discount on provisions	56	44
Total finance costs	14,960	14,819

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2025/26 £000	2024/25 £000
Total liability accruing in year under this legislation as a result of late payments	24	-
Amounts included within interest payable arising from claims made under this legislation	24	-

Note 13 Other gains / (losses)

	2025/26 £000	2024/25 £000
Gains on disposal of assets	39	46
Losses on disposal of assets	(269)	(760)
Total gains / (losses) on disposal of assets	(230)	(714)
Total other gains / (losses)	(230)	(714)

This includes losses on disposals of PPE of £29k and £240k of PFI IFRIC 12 equipment.

Note 14 Intangible assets - 2025/26

	Software licences £000	Internally generated information technology £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Cost at 1 April 2025 - brought forward *	8,438	4,404	-	8,024	20,866
Additions	1,238	-	-	1,606	2,844
Reclassifications	8,410	-	47	(8,457)	-
Disposals / derecognition	-	(199)	-	-	(199)
Cost at 31 March 2026	18,086	4,205	47	1,173	23,511
Amortisation at 1 April 2025 - brought forward	6,329	3,122	-	-	9,451
Provided during the year	1,961	566	1	-	2,528
Disposals / derecognition	-	(199)	-	-	(199)
Amortisation at 31 March 2026	8,290	3,489	1	-	11,780
Net book value at 31 March 2026	9,796	716	46	1,173	11,731
Net book value at 1 April 2025	2,109	1,282	-	8,024	11,415

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively

Note 14.1 Intangible assets - 2024/25

	Software licences £000	Internally generated information technology £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	8,434	4,475	-	3,764	16,673
Additions	(20)	(26)	-	4,775	4,729
Reclassifications	338	177	-	(515)	-
Disposals / derecognition	(314)	(222)	-	-	(536)
Valuation / gross cost at 31 March 2025	8,438	4,404	-	8,024	20,866
Amortisation at 1 April 2024 - as previously stated	5,419	2,736	-	-	8,155
Amortisation at 1 April 2024 - restated	5,419	2,736	-	-	8,155
Provided during the year	1,208	604	-	-	1,812
Disposals / derecognition	(298)	(218)	-	-	(516)
Amortisation at 31 March 2025	6,329	3,122	-	-	9,451
Net book value at 31 March 2025	2,109	1,282	-	8,024	11,415
Net book value at 1 April 2024	3,015	1,739	-	3,764	8,518

Note 15.1 Property, plant and equipment - 2025/26

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2025 - brought forward	41,777	232,649	835	15,178	48,186	32,325	2,116	373,066
Additions	-	1,543	10	16,636	5,875	1,240	-	25,304
Impairments	-	(11,148)	(34)	-	-	-	-	(11,182)
Reversals of impairments	-	1,112	6	-	-	-	-	1,118
Revaluations	-	(7,221)	(36)	-	-	-	-	(7,257)
Reclassifications	-	7,910	24	(12,894)	2,204	3,764	(1,008)	-
Disposals / derecognition	-	(1)	-	-	(3,123)	(1,209)	-	(4,333)
Valuation/gross cost at 31 March 2026	41,777	224,844	805	18,920	53,142	36,120	1,108	376,716
Accumulated depreciation at 1 April 2025 - brought forward	-	1,386	-	-	21,310	20,656	343	43,695
Provided during the year	-	7,625	36	-	4,656	5,518	(16)	17,819
Impairments	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-
Revaluations	-	(7,257)	(36)	-	-	-	-	(7,293)
Reclassifications	-	(123)	-	-	-	-	123	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(1)	-	-	(2,854)	(1,209)	-	(4,064)
Accumulated depreciation at 31 March 2026	-	1,630	-	-	23,112	24,965	450	50,157
Net book value at 31 March 2026	41,777	223,214	805	18,920	30,030	11,155	658	326,559
Net book value at 1 April 2025	41,777	231,263	835	15,178	26,876	11,669	1,773	329,371

Note 15.2 Property, plant and equipment - 2024/25

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	41,777	234,462	861	10,238	49,303	32,026	2,849	371,516
Additions	-	3,920	-	12,097	5,473	(78)	-	21,412
Impairments	-	(8,158)	-	-	-	-	-	(8,158)
Reversals of impairments	-	3,913	9	-	-	-	-	3,922
Revaluations	-	(7,044)	(35)	-	-	-	-	(7,079)
Reclassifications	-	5,747	-	(6,986)	823	1,120	(704)	-
Disposals / derecognition	-	(191)	-	(171)	(7,413)	(743)	(29)	(8,547)
Valuation/gross cost at 31 March 2025	41,777	232,649	835	15,178	48,186	32,325	2,116	373,066
Accumulated depreciation at 1 April 2024 - as previously stated	-	1,231	-	-	23,866	16,469	72	41,638
Accumulated depreciation at 1 April 2024 - restated	-	1,231	-	-	23,866	16,469	72	41,638
Provided during the year	-	7,253	35	-	4,573	4,817	306	16,984
Revaluations	-	(7,098)	(35)	-	-	-	-	(7,133)
Reclassifications	-	-	-	-	6	-	(6)	-
Disposals / derecognition	-	-	-	-	(7,135)	(630)	(29)	(7,794)
Accumulated depreciation at 31 March 2025	-	1,386	-	-	21,310	20,656	343	43,695
Net book value at 31 March 2025	41,777	231,263	835	15,178	26,876	11,669	1,773	329,371
Net book value at 1 April 2024	41,777	233,231	861	10,238	25,437	15,557	2,777	329,878

Note 15.3 Property, plant and equipment financing - 31 March 2026

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	41,777	153,698	805	18,899	18,496	11,133	658	245,466
On-SoFP PFI contracts and other service concession arrangements	-	68,842	-	-	10,101	-	-	78,943
Owned - donated/granted	-	674	-	21	1,433	22	-	2,150
Total net book value at 31 March 2026	41,777	223,214	805	18,920	30,030	11,155	658	326,559

The Trust has no operating leases in 2025/26.

Note 15.4 Property, plant and equipment financing - 31 March 2025

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	41,777	160,103	835	15,178	15,968	11,650	1,773	247,284
On-SoFP PFI contracts and other service concession arrangements	-	70,909	-	-	9,769	-	-	80,678
Owned - donated/granted	-	251	-	-	1,139	19	-	1,409
Total net book value at 31 March 2025	41,777	231,263	835	15,178	26,876	11,669	1,773	329,371

The Trust had no operating leases in 2024/25.

Note 16 Donations of property, plant and equipment

The Trust has received the PPE donations below:

£229k donation of physical assets (medical equipment) compared to £171k 24/25.

£145k donation of cash towards medical equipment purchases compared to £186k 24/25.

£451k donation of physical building improvement.

Note 17 Revaluations of property, plant and equipment

The valuations have been prepared in accordance with the RICS Valuation – Global Standards, which incorporate the International Valuation Standards (“IVS”) and the RICS UK National Supplement (the “RICS Red Book”), edition current at the valuation date, 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 Market Value - Existing Use for non-specialised operational property.

In line with HM Treasury guidance, the revaluation as at 31st March 2026 was based on the 'Modern Equivalent Asset' approach to valuation. The valuation of the specialised assets takes into account that the modern equivalent re-provision of the existing service would be from the same number of locations as exist currently. The functional obsolescence attributed to the buildings and the size and location of the 'alternative' sites required for the modern equivalent asset takes this into account.

The Valuer has undertaken a desktop update review of the Trusts asset base including site inspection of any assets subject to significant alterations in-year. Each site is defined as the "property asset" with the 3 significant components defined as land, buildings and external works.

The Trust used Cushman and Wakefield as the appointed independent valuers who are RICS Registered.

As a result of the revaluation, the Trust has a £36k revaluation surplus which is held on the balance sheet.

For right of use asset valuations, please refer to Note 18.3.

Note 18 Leases - 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. Lease payments due later than five years relates to the Charles Hasting Education Centre, car parking and Kings Court as the agreement is more than a 5 years commitment.

Note 18.1 Right of use assets - 2025/26

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000
Valuation / gross cost at 1 April 2025 - brought forward	12,308	3,206	183	15,697
Transfers by absorption	-	-	-	-
Additions	-	1	-	1
Remeasurements of the lease liability	589	-	25	614
Impairments	(1,195)	-	-	(1,195)
Revaluations	(2,053)	-	-	(2,053)
Valuation/gross cost at 31 March 2026	9,649	3,207	208	13,064
Accumulated depreciation at 1 April 2025 - brought forward	2,025	1,304	158	3,487
Provided during the year	731	607	50	1,388
Revaluations	(2,053)	-	-	(2,053)
Accumulated depreciation at 31 March 2026	703	1,911	208	2,822
Net book value at 31 March 2026	8,946	1,296	-	10,242
Net book value at 1 April 2025	10,283	1,902	25	12,210

Note 18.2 Right of use assets - 2024/25 Restated

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	44,010	2,249	131	46,390
Prior period adjustments	(31,980)	-	-	(31,980)
Valuation / gross cost at 1 April 2024 - restated	12,030	2,249	131	14,410
Transfers by absorption	-	-	-	-
Additions	-	1,120	-	1,120
Remeasurements of the lease liability	981	113	52	1,146
Movements in provisions for restoration / removal costs	-	-	-	-
Impairments	(643)	-	-	(643)
Reversal of impairments	-	-	-	-
Revaluations	(60)	-	-	(60)
Reclassifications	-	-	-	-
Disposals / derecognition	-	(276)	-	(276)
Valuation/gross cost at 31 March 2025	12,308	3,206	183	15,697
Accumulated depreciation at 1 April 2024 - brought forward	2,096	947	107	3,150
Prior period adjustments	(749)	-	-	(749)
Accumulated depreciation at 1 April 2024 - restated	1,347	947	107	2,401
Transfers by absorption	-	-	-	-
Provided during the year	738	633	51	1,422
Impairments	-	-	-	-
Reversal of impairments	-	-	-	-
Revaluations	(60)	-	-	(60)
Reclassifications	-	-	-	-
Disposals / derecognition	-	(276)	-	(276)
Accumulated depreciation at 31 March 2025	2,025	1,304	158	3,487
Net book value at 31 March 2025	10,283	1,902	25	12,210
Net book value at 1 April 2024	10,683	1,302	24	12,009

Note 18.3 Revaluations of right of use assets

In 2025/26, the Trust instructed its valuers Cushman and Wakefield to perform a desktop valuation of the two right of use building assets that are held. The Valuation was undertaken in accordance with the appropriate sections of the current edition of the RICS Valuation – Global Standards which incorporate the International Valuation Standards ("IVS") and the RICS UK national supplement (the "RICS Red Book").

Due regard for the basis of valuation was given to IFRS 16: Principles for UK Real Estate Professionals - Accounting for leases on the balance sheet, as prepared by the RICS, dated March 2022. The valuation was undertaken under the right of use value basis, which is the value of a lessee's right to use and underlying asset for the lease term.

The decapitalisation/recapitalisation method was adopted for one of the building assets as determined to be specialised in nature. The Decapitalisation / Recapitalisation method is used for Specialised Assets where there is an absence of comparable evidence in the market. The methodology is to establish a rental value (a proxy DRC rent) which is capitalised over the non-cancellable lease term.

A gross replacement cost is adopted which is depreciated on a straight line basis (reflecting the building as new / design life and weighted remaining economic life) to arrive at a Proxy DRC Rent. This is then capitalised over the non-cancellable lease term to arrive at the ROU value. The other building asset was considered non specialised in nature, and capitalised in the opinion of market rent over the term. Market rent is referred as the estimated amount for which an interest in real property should be leased on the valuation date between willing parties in an arm's length transaction.

All other right of use assets have been valued at cost with regular rental reviews for certain leases to ensure that payments are in-line with the market value.

The Trust has applied the revaluation model to the specialised right of use building asset from IFRS 16 transition date of April 2022 and restate the comparatives accordingly in 2025/26. The Trust obtained suitable proxy rent from its valuers for March 2023, 2024 and 2025 to calculate revised closing asset valuations.

Note 18.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 24.1.

	2025/26 £000	Restated 2024/25 £000
Carrying value at 1 April	24,746	43,595
Prior period adjustments		(19,542)
Carrying value at 1 April - restated	24,746	24,053
Transfers by absorption	-	-
Lease additions	1	838
Lease liability remeasurements	614	1,146
Interest charge arising in year	238	271
Lease payments (cash outflows)	(1,722)	(1,562)
Carrying value at 31 March	23,877	24,746

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 18.5 Maturity analysis of future lease payments

	Total 31 March 2026 £000	Of which leased from DHSC group bodies: 31 March 2026 £000	Total 31 March 2025 £000	Restated Of which leased from DHSC group bodies: 31 March 2025 £000
Undiscounted future lease payments payable in:				
- not later than one year;	1,446	-	1,681	-
- later than one year and not later than five years;	4,788	-	5,100	-
- later than five years.	24,832	-	25,165	-
Total gross future lease payments	31,066	-	31,946	-
Finance charges allocated to future periods	(7,189)	-	(7,200)	-
Net lease liabilities at 31 March 2026	23,877	-	24,746	-

Note 19 Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	4,970	4,981
Work In progress	98	50
Consumables	9,708	8,141
Energy	141	94
Total inventories	14,917	13,266
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £76,462k (2024/25: £75,544k). Write-down of inventories recognised as expenses for the year were £240k (2024/25: £200k).

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Note 20.1 Receivables		
	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	14,605	12,693
Allowance for impaired contract receivables / assets	(1,172)	(1,659)
Deposits and advances	1	5
Prepayments (non-PFI)	4,373	2,191
PFI lifecycle prepayments	-	711
PDC dividend receivable	765	-
VAT receivable	5,582	5,441
Other receivables	1,486	337
Total current receivables	25,640	19,719
Non-current		
Contract receivables	3,042	2,821
Other receivables	390	410
Total non-current receivables	3,432	3,231
Of which receivable from NHS and DHSC group bodies:		
Current	12,655	11,706
Non-current	390	410

Note 20.2 Allowances for credit losses		
	2025/26	2024/25
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	1,659	1,493
Allowances as at 1 April - restated	1,659	1,493
New allowances arising	492	426
Reversals of allowances	(513)	197
Utilisation of allowances (write offs)	(466)	(457)
Allowances as at 31 Mar 2026	1,172	1,659

Injury cost recovery income: subject to a provision for credit losses of 24.62% (24.45% 2024/25) as per DHSC guidance for 2025/26 receivables.

Non-NHS receivables that are over 3 months old, are subject to a provision for credit losses of 50%.

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.

The allowance of £1.172m above at 31 March 2026 (£1.659m 2024/25) includes £732k relating to Injury Cost Recovery Scheme debtors (£673k for 2024/25). These are provided for, using national assumptions about the likelihood of debt recovery for all debts since 1 April 2019 and in full for older debts. The Trust's policy for calculating the allowance against other debtors is that debts over 90 days are reviewed and an allowance made for any debts for which there is a risk of non-recovery.

Note 20.3 Exposure to credit risk

The majority of the Trust's revenue comes from contracts with other public sector bodies, therefore the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2026 are in receivables from customers, as disclosed in the trade and other receivables note.

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.

	2025/26 £000	2024/25 £000
At 1 April	35,616	11,745
Net change in year	(28,132)	23,871
At 31 March	7,484	35,616
Broken down into:		
Cash at commercial banks and in hand	104	359
Cash with the Government Banking Service	7,380	35,257
Total cash and cash equivalents as in SoFP	7,484	35,616
Total cash and cash equivalents as in SoCF	7,484	35,616

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Note 22 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	41,142	34,222
Capital payables	6,249	8,185
Accruals	13,243	28,970
Receipts in advance and payments on account	284	(86)
Social security costs	5,325	4,223
Other taxes payable	5,687	5,021
PDC dividend payable	-	2
Pension contributions payable	6,071	5,551
Other payables	3	1
Total current trade and other payables	78,004	86,089
Of which payables from NHS and DHSC group bodies:		
Current	4,297	7,277

Note 23 Other liabilities		
	31 March 2026 £000	31 March 2025 £000

Current

Deferred income: contract liabilities	2,534	5,171
Deferred PFI credits / income	1,430	628
Total other current liabilities	3,964	5,799

Non-current

Deferred PFI credits / income	3,010	3,188
Total other non-current liabilities	3,010	3,188

Note 24.1 Borrowings		
	31 March 2026 £000	Restated 31 March 2025 £000

Current

Loans from DHSC	679	680
Lease liabilities	1,203	1,437
Obligations under PFI, LIFT or other service concession contracts	14,396	12,729
Total current borrowings	16,278	14,846

Non-current

Loans from DHSC	7,354	8,021
Lease liabilities	22,674	23,309
Obligations under PFI, LIFT or other service concession contracts	91,233	101,792
Total non-current borrowings	121,261	133,122

Note 24.2 Reconciliation of liabilities arising from financing activities				
	Loans from DHSC £000	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2025	8,701	24,746	114,521	147,968
Cash movements:				
Financing cash flows - payments and receipts of principal	(668)	(1,465)	(13,208)	(15,341)
Financing cash flows - payments of interest	(236)	(257)	(10,090)	(10,583)
Non-cash movements:				
Additions	-	1	-	1
Lease liability remeasurements	-	614	-	614
Remeasurement of PFI / other service concession liability resulting from change in index or rate			4,316	4,316
Application of effective interest rate	236	238	10,090	10,564
Carrying value at 31 March 2026	8,033	23,877	105,629	137,539

	Loans from DHSC £000	Lease Liabilities £000	PFI and LIFT schemes £000	Restated Total £000
Carrying value at 1 April 2024	9,369	43,595	122,734	175,698
Prior period adjustment	-	(19,542)	-	(19,542)
Carrying value at 1 April 2024 - restated	9,369	24,053	122,734	156,156
Cash movements:				
Financing cash flows - payments and receipts of principal	(668)	(1,291)	(11,673)	(13,632)
Financing cash flows - payments of interest	(255)	(271)	(10,789)	(11,315)
Non-cash movements:				
Additions	-	838	-	838
Lease liability remeasurements	-	1,146	-	1,146
Remeasurement of PFI / other service concession liability resulting from change in index or rate			3,460	3,460
Application of effective interest rate	255	271	10,789	11,315
Carrying value at 31 March 2025	8,701	24,746	114,521	147,968

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Legal claims £000	Other £000	Total £000
At 1 April 2025	1,911	109	4,622	6,642
Change in the discount rate	(78)	-	(31)	(109)
Arising during the year	185	68	-	253
Utilised during the year	(205)	(48)	(1,642)	(1,895)
Reversed unused	(1)	(44)	(1,656)	(1,701)
Unwinding of discount	56	-	25	81
At 31 March 2026	1,868	85	1,318	3,271
Expected timing of cash flows:				
- not later than one year;	199	85	928	1,212
- later than one year and not later than five years;	796	-	36	832
- later than five years.	873	-	354	1,227
Total	1,868	85	1,318	3,271

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 utilised during the year relate to AfC claims for current and former employees. This was provided for in 2024/25 and paid in 2025/26 (£1.634m).

Other provisions reversed as unused during the year totalled £1.656m. This amount was released following a comprehensive review of the provision balances. Each provision was assessed against the criteria in IAS 37, including the age of the balance and the length of time it had been held, and was reversed where it was considered no longer required.

Note 25.2 Clinical negligence liabilities

At 31 March 2026 £212,147k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Worcestershire Acute Hospitals NHS Trust (31 March 2025: £230,703k).

Note 26 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	(18)	(43)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	(18)	(43)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(18)	(43)
Net value of contingent assets	931	-

Following the First-tier Tribunal decision in *Isle of Wight NHS Trust v HMRC*, supplies of locum doctors, including those provided by employment businesses, are treated as VAT-exempt, and any VAT refunds claimed may impact input tax recovery and partial exemption calculations. The Trust has provided for a contingent asset based on the probable inflow at a later date following the tribunal decision for the Direct Engagement of temporary staff by employment businesses.

Note 27 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	5,543	6,032
Intangible assets	2,200	670
Total	7,743	6,702

Note 28 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 2026 £000	31 March 2025 £000
not later than 1 year	5,710	6,397
after 1 year and not later than 5 years	7,137	12,331
paid thereafter	3	522
Total	12,850	19,250

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. Included in the figures above is £9m for Computacenter for the provision of IT services.

Note 29 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. retains step in rights should the contractor fail to meet minimum standards as set out within the contract.

Note 29.1 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 2026 £000	31 March 2025 £000
Gross PFI, LIFT or other service concession liabilities	137,052	154,561
Of which liabilities are due		
- not later than one year;	23,298	22,462
- later than one year and not later than five years;	94,305	90,593
- later than five years.	19,448	41,506
Finance charges allocated to future periods	(31,422)	(40,040)
Net PFI, LIFT or other service concession arrangement obligation	105,629	114,521
- not later than one year;	14,396	12,729
- later than one year and not later than five years;	72,904	64,209
- later than five years.	18,330	37,583

Note 29.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2026 £000	31 March 2025 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	283,621	324,483
Of which payments are due:		
- not later than one year;	47,235	45,815
- later than one year and not later than five years;	194,967	189,164
- later than five years.	41,418	89,504

Note 29.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2025/26 £000	2024/25 £000
Unitary payment payable to service concession operator	52,282	51,496
Consisting of:		
- Interest charge	10,090	10,789
- Repayment of balance sheet obligation	13,208	11,673
- Service element and other charges to operating expenditure	28,635	28,694
- Capital lifecycle maintenance	349	340
Total amount paid to service concession operator	52,282	51,496

Note 30 Financial instruments

Note 30.1 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 2025 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 Integrated Care Board (ICB), 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 30.2 Carrying values of financial assets			
Carrying values of financial assets as at 31 March 2026	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Trade and other receivables excluding non financial assets	17,953	-	17,953
Cash and cash equivalents	7,484	-	7,484
Total at 31 March 2026	25,437	-	25,437

Carrying values of financial assets as at 31 March 2025	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Trade and other receivables excluding non financial assets	14,186	-	14,186
Cash and cash equivalents	35,616	-	35,616
Total at 31 March 2025	49,802	-	49,802

Note 30.3 Carrying values of financial liabilities		
Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	8,033	8,033
Obligations under leases	23,877	23,877
Obligations under PFI, LIFT and other service concession contracts	105,629	105,629
Other borrowings	-	-
Trade and other payables excluding non financial liabilities	59,945	59,945
Other financial liabilities	-	-
Provisions under contract	-	-
Total at 31 March 2026	197,484	197,484

Carrying values of financial liabilities as at 31 March 2025 - restated	Held at amortised cost £000	Total book value £000
Loans from the Department of Health and Social Care	8,701	8,701
Obligations under leases	24,746	24,746
Obligations under PFI, LIFT and other service concession contracts	114,521	114,521
Other borrowings	-	-
Trade and other payables excluding non financial liabilities	69,531	69,531
Other financial liabilities	-	-
Provisions under contract	-	-
Total at 31 March 2025	217,499	217,499

Note 30.4 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.

	Restated	
	31 March 2026 £000	31 March 2025 £000
In one year or less	85,574	96,428
In more than one year but not more than five years	102,448	99,122
In more than five years	49,447	72,649
Total	237,470	268,199

Note 31 Losses and special payments				
	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000

Losses

Cash losses *	6	0	4	0
Bad debts and claims abandoned	58	32	58	106
Stores losses and damage to property	1	240	1	200
Total losses	65	272	63	306

Special payments

Ex-gratia payments	53	35	50	24
Total special payments	53	35	50	24
Total losses and special payments	118	307	113	330

Compensation payments received

* the 4 cases in 2024/25 was total of £462
* the 6 cases in 2025/26 was a total of £345

Section 30 notice to Secretary of State has been made by the external auditor in relation to a potential unapproved special payment in 2024.

Note 32 Related parties

The Department of Health and Social Care is regarded as a related party. During the year 2025/26, 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. Those entities where transactions during the year were greater than £100k and/or outstanding balances at 31 March 2026 were greater than £50k are listed below:

NHS Trusts/Foundation Trusts

Birmingham Women's and Children's NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust
South Warwickshire University NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
George Eliot Hospital NHS Trust
Herefordshire and Worcestershire Health and Care NHS Trust
The Royal Wolverhampton NHS Trust
University Hospitals Coventry and Warwickshire NHS Trust
The Dudley Group of Hospitals NHS Foundation Trust
Wye Valley NHS Trust
Sandwell & West Birmingham Hospitals NHS Trust
Mersey and West Lancashire Teaching Hospitals NHS Trust
Northumbria Healthcare NHS Foundation Trust
Oxford Health NHS Foundation Trust
Royal Devon University Healthcare NHS Foundation Trust
University Hospitals of Derby & Burton NHS Foundation Trust

NHS Commissioning bodies

NHS Birmingham and Solihull ICB
NHS Black Country ICB
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
NHS Business Services Authority
NHS Coventry and Warwickshire ICB
NHS Gloucestershire ICB
NHS Herefordshire and Worcestershire ICB
NHS Shropshire, Telford and Wrekin ICB
NHS England
NHS Bristol, North Somerset and South Gloucestershire ICB
NHS Cheshire And Merseyside ICB
NHS Devon ICB
NHS Somerset ICB
NHS Staffordshire and Stoke ICB

Other NHS organisations

NHS Resolution
NHS Blood and Transplant

In addition, the Trust has had a number of material transactions (within the limits defined above) with other government departments and other central and local government bodies. These include the following:

Welsh Government bodies

Welsh Health Bodies - Aneurin Bevan Health Board
Welsh Health Bodies - Powys Teaching Health Board

Other Government bodies

Worcestershire County Council
Worcester City Council
UK Health Security Agency
Care Quality Commission

Income Tax, NI, VAT and Superannuation transactions

HM Revenue & Customs
NHS Pension Scheme

Other organisations

NHS Supply chain (Supply Chain Coordination Limited)
Charles Hastings Education Centre

Worcestershire Acute Hospitals Charity. The executive directors and non-executive directors of the Trust Board share the responsibility for ensuring that the NHS body fulfils its duties as Trustee in managing the charitable funds. Non-executive members of the Trust Board were appointed by NHS England. Executive members are appointed by the Trust Board. Members are not individual trustees under Charity Law but act as agents on behalf of the trustee. The receivables position for the Trust includes £316k for expenditure incurred via the Trust's procure to pay system, on behalf of the charitable funds, to be repaid to the Trust.

The Trust has also received revenue and capital payments from Worcestershire Acute Hospitals Charity amounting to £763,588 (£725,254 in 2024/2025). All of these payments relate to expenditure made by the Trust on behalf of the Worcestershire Acute Hospitals Charity. As at 31 March 2026, Worcestershire Acute Hospitals Charity owed the Trust £315,773. The Trust Board is Corporate Trustee of the Trust's Charitable Funds. The summary financial statements of the funds held on Trust are included in the annual report and accounts.

Note 32.1 Related parties	Receivables	Receivables
	2025/26	2024/25
	£000	£000
Charitable Funds (where not consolidated)	316	69
Total balances with Related parties	316	69

Note 33 Better Payment Practice code				
	2025/26	2025/26	2024/25	2024/25
Non-NHS Payables	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	105,864	348,144	104,278	354,177
Total non-NHS trade invoices paid within target	92,482	311,083	73,595	276,407
Percentage of non-NHS trade invoices paid within target	87.4%	89.4%	70.6%	78.0%
NHS Payables				
Total NHS trade invoices paid in the year	2,072	23,255	2,218	16,783
Total NHS trade invoices paid within target	1,509	13,388	1,107	7,694
Percentage of NHS trade invoices paid within target	72.8%	57.6%	49.9%	45.8%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note 34 Capital Resource Limit		
	2025/26	2024/25
	£000	£000
Gross capital expenditure	28,763	27,361
Less: Disposals	(269)	(773)
Less: Donated and granted capital additions	(825)	(375)
Plus: Loss on disposal from capital grants in kind and peppercorn lease disposals	-	-
Charge against Capital Resource Limit	27,669	26,213
Capital Resource Limit	28,488	26,213
Under / (over) spend against CRL	819	-

Note 35 Adjusted financial performance		
	2025/26	2024/25
	£000	£000
Surplus / (deficit) for the period per SOCI	(8,753)	(621)
Remove net impairments not scoring to the departmental expenditure limit	3,898	1,405
Remove (gains) / losses on transfers by absorption	-	-
Remove I&E impact of capital grants and donations	(619)	(217)
Prior period adjustments	562	-
Remove non-cash element of on-SoFP pension costs	-	-
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	44,879	44,090
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis	(51,009)	(50,222)
Remove net impact of DHSC centrally procured inventories	-	81
Remove loss recognised on peppercorn lease disposals	-	-
Remove loss recognised on capital grants in kind	-	-
Other performance adjustments	-	-
Adjusted financial performance surplus / (deficit)	(11,042)	(5,484)

Once audited accounts have been submitted and the consolidated accounts have been closed, adjusted financial performance and capital resource limits do not change for that year, and prior year 2024/25 remains at previous stated surplus/deficit for that period rather than the restated value as per updated SOCI. For adjusted financial performance any prior period adjustments (PPAs) are adjusted in the year the PPA is recognised which flows into the Breakeven duty calculation on the same basis. Please refer to Note 38 Prior Period Adjustments.

Note 36 Breakeven duty financial performance		
	2025/26	2024/25
	£000	£000
Adjusted financial performance surplus / (deficit)	(11,042)	(5,484)
Remove impairments scoring to Departmental Expenditure Limit	-	-
Add back non-cash element of On-SoFP pension scheme charges	-	-
IFRIC 12 breakeven adjustment	6,130	6,132
Breakeven duty financial performance surplus / (deficit)	(4,912)	648

Note 37 Breakeven duty rolling assessment

	1997/98 to 2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000
Breakeven duty in-year financial performance		3,135	287	88	17	(14,191)	(25,918)	(59,831)	(28,748)
Breakeven duty cumulative position	(21,854)	(18,719)	(18,432)	(18,344)	(18,327)	(32,518)	(58,436)	(118,267)	(147,015)
Operating income		312,889	321,829	336,594	348,763	346,029	364,656	368,981	403,348
Cumulative breakeven position as a percentage of operating income		(6.0%)	(5.7%)	(5.4%)	(5.3%)	(9.4%)	(16.0%)	(32.1%)	(36.4%)

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000
Breakeven duty in-year financial performance	(52,562)	(68,790)	(80,844)	6,652	(1,082)	(19,775)	(36,576)	648	(4,912)
Breakeven duty cumulative position	(199,577)	(268,367)	(349,211)	(342,559)	(343,641)	(363,416)	(399,992)	(399,344)	(404,256)
Operating income	400,918	411,966	443,722	559,003	596,391	644,967	699,801	807,328	831,752
Cumulative breakeven position as a percentage of operating income	(49.8%)	(65.1%)	(78.7%)	(61.3%)	(57.6%)	(56.3%)	(57.2%)	(49.5%)	(48.6%)

Note 38 Prior period adjustments

During 2025/26, the Trust completed a review of the accounting treatment applied to the Charles Hastings Education Centre (CHEC) lease. As a result of a further assessment regarding the determination of lease payments and the measurement basis applied under IFRS 16 Leases, Management concluded that the historical accounting treatment required revision.

The Trust has therefore corrected the accounting treatment retrospectively in accordance with IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors. The revision affects the measurement of the lease liability, right-of-use asset and associated depreciation, interest and impairment charges recognised since 1 April 2022. The comparatives have been restated accordingly.

Impact on the Statement of Financial Position

2024/25	Adjustment £000	As Previously Reported £000	Restated £000
Right-of-use assets	(30,437)	42,646	12,209
Total non-current assets	(30,437)	386,663	356,226
Current Liabilities - Borrowings	158	(15,004)	(14,846)
Non Current Liabilities - Borrowings	18,262	(151,381)	(133,119)
Income and Expenditure Reserve	(12,020)	(566,301)	(578,321)

2023/24	Adjustment £000	As Previously Reported £000	Restated £000
Right-of-use assets	(31,233)	43,240	12,007
Total non-current assets	(31,233)	384,712	353,479
Current Liabilities - Borrowings	154	(13,430)	(13,276)
Non Current Liabilities - Borrowings	19,386	(162,266)	(142,880)
Income and Expenditure Reserve	(11,693)	(567,088)	(578,781)

2022/23	Adjustment £000	As Previously Reported £000	Restated £000
Right-of-use assets	(19,241)	33,057	13,816
Total non-current assets	(19,241)	419,707	400,466
Current Liabilities - Borrowings	79	(6,320)	(6,241)
Non Current Liabilities - Borrowings	8,943	(88,361)	(79,418)
Income and Expenditure Reserve	(10,222)	(433,273)	(443,495)

Impact on the Statement of Comprehensive Income

2024/25	Adjustment £000	As Previously Reported £000	Restated £000
Operating Expenses	(502)	(789,424)	(789,926)
Finance Expenses	175	(14,994)	(14,819)
Surplus / (deficit) for the year from continuing operations	(327)	(621)	(948)
Surplus / (deficit) for the year	(327)	(621)	(948)
Total comprehensive income / (expense) for the period	(327)	(3,398)	(3,725)
Adjusted financial performance surplus / (deficit)	563	(5,484)	(4,921)

2023/24	Adjustment £000	As Previously Reported £000	Restated £000
Operating Expenses	(1,657)	(736,897)	(738,554)
Finance Expenses	185	(34,523)	(34,338)
Surplus / (deficit) for the year from continuing operations	(1,472)	(76,649)	(78,121)
Surplus / (deficit) for the year	(1,472)	(76,649)	(78,121)
Total comprehensive income / (expense) for the period	(1,472)	(112,719)	(114,191)
Adjusted financial performance surplus / (deficit)	247	(34,761)	(34,514)

2022/23	Adjustment £000	As Previously Reported £000	Restated £000
Operating Expenses	(10,306)	(651,590)	(661,896)
Finance Expenses	84	(15,301)	(15,217)
Surplus / (deficit) for the year from continuing operations	(10,222)	(29,532)	(39,754)
Surplus / (deficit) for the year	(10,222)	(29,532)	(39,754)
Total comprehensive income / (expense) for the period	(10,222)	(25,811)	(36,033)
Adjusted financial performance surplus / (deficit)	35	(19,775)	(19,740)

Impact on the Statement of Changes in Equity

2024/25	Adjustment £000	As Previously Reported £000	Restated £000
Taxpayers' equity at 1 April 2024 - brought forward	(11,693)	160,445	148,752
Surplus/(deficit) for the year	(327)	(621)	(948)
Taxpayers' equity at 31 March 2025	(12,020)	187,161	175,141

2023/24	Adjustment £000	As Previously Reported £000	Restated £000
Taxpayers' equity at 1 April 2023 - brought forward	(10,222)	294,660	284,438
Surplus/(deficit) for the year	(1,472)	(76,649)	(78,121)
Taxpayers' equity at 31 March 2024	(11,693)	160,445	148,752

2022/23	Adjustment £000	As Previously Reported £000	Restated £000
Taxpayers' equity at 1 April 2022 - brought forward	-	282,157	282,157
Surplus/(deficit) for the year	(10,222)	(29,532)	(39,754)
Taxpayers' equity at 31 March 2023	(10,222)	294,660	284,438

Impact on the Statement of Cash Flows

2024/25	Adjustment £000	As Previously Reported £000	Restated £000
Operating (deficit)/surplus	(502)	17,904	17,402
Depreciation and amortisation of PPE and other intangible as:	(392)	20,610	20,218
Net impairments	643	1,405	2,048
Net cash flows from operating activities	(248)	45,438	45,190
Capital element of lease rental payments	77	(1,368)	(1,291)
Interest paid on lease liability repayments	171	(446)	(275)
Net cash flows (used in)/from financing activities	248	3,397	3,645

2023/24	Adjustment £000	As Previously Reported £000	Restated £000
Operating (deficit)/surplus	(1,657)	(37,096)	(38,753)
Depreciation and amortisation of PPE and other intangible as:	(384)	20,112	19,728
Net impairments	1,683	28,600	30,283
Net cash flows from operating activities	(358)	1,799	1,441
Capital element of lease rental payments	173	(1,524)	(1,351)
Interest paid on lease liability repayments	185	(429)	(244)
Net cash flows (used in)/from financing activities	358	3,671	4,029

2022/23	Adjustment £000	As Previously Reported £000	Restated £000
Operating (deficit)/surplus	(10,306)	(6,623)	(16,929)
Depreciation and amortisation of PPE and other intangible as:	(115)	16,944	16,829
Net impairments	10,257	9,658	19,915
Net cash flows from operating activities	(162)	20,900	20,738
Capital element of lease rental payments	78	(1,506)	(1,428)
Interest paid on lease liability repayments	84	(315)	(231)
Net cash flows (used in)/from financing activities	162	7,673	7,835

Third Statement of Financial Position

The retrospective restatement has had a material effect on the Statement of Financial Position at 1 April 2024. In accordance with IAS 1.40A, the Trust has therefore presented a third Statement of Financial Position as at that date.

Statement of Financial Position - 01/04/2024

	Adjustment £000	As Previously Reported £000	Restated £000
Non-current assets			
Intangible assets		8,518	8,518
Property, plant and equipment		329,878	329,878
Right of use assets	(31,233)	43,240	12,007
Investment property			
Investments in associates and joint ventures			
Other investments / financial assets			
Receivables		3,076	3,076
Other assets			
Total non-current assets	(31,233)	384,712	353,479
Current assets			
Inventories		12,637	12,637
Receivables		23,158	23,158
Other investments / financial assets			
Other assets			
Non-current assets for sale and assets in disposal groups			
Cash and cash equivalents		11,745	11,745
Total current assets		47,540	47,540
Current liabilities			
Trade and other payables		(74,878)	(74,878)
Borrowings	154	(13,430)	(13,276)
Other financial liabilities			
Provisions		(7,553)	(7,553)
Other liabilities		(6,221)	(6,221)
Liabilities in disposal groups			
Total current liabilities	154	(102,082)	(101,928)
Total assets less current liabilities	(31,079)	330,170	299,091
Non-current liabilities			
Trade and other payables			
Borrowings	19,386	(162,266)	(142,880)
Other financial liabilities			
Provisions		(3,416)	(3,416)
Other liabilities		(4,043)	(4,043)
Total non-current liabilities	19,386	(169,725)	(150,339)
Total assets employed	(11,693)	160,445	148,752
Financed by			
Public dividend capital		661,909	661,909
Revaluation reserve		66,485	66,485
Financial assets reserve			
Other reserves		(861)	(861)
Merger reserve			
Income and expenditure reserve	(11,693)	(567,088)	(578,781)
Total taxpayers' equity	(11,693)	160,445	148,752

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
ANNUAL REPORT 2025/26

DRAFT

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Welcome from the Chair

It is my pleasure to present the Annual Report for Worcestershire Acute Hospitals NHS Trust for 2025/26.

Like many NHS organisations, this has been a year characterised by sustained and, at times, exceptional operational pressure. Demand for urgent and emergency care remained consistently high, with ongoing challenges in patient flow, bed occupancy and timely discharge. Regrettably these pressures have had a direct impact on waiting times, patient experience in some areas, and the delivery of key national standards, particularly within emergency care and some cancer pathways. Industrial action has also had an impact, creating disruption and additional complexity for our teams.

Alongside this, the Trust has continued to operate within a challenging financial environment. Despite strengthened financial controls and governance, we did not achieve our planned financial position, reflecting the ongoing cost of maintaining safe capacity, addressing demand, and delivering improvement programmes at pace.

However, it is equally important to recognise the significant achievements made during the year. Within a highly pressured system, our teams have delivered measurable improvements. We have seen progress in elective recovery, with reductions in waiting times and improvements against the 18-week standard, alongside better theatre utilisation and strengthened waiting list management.

In urgent care, although performance has remained challenging, there have been important areas of improvement. Initiatives to improve ambulance handovers, patient triage and flow have delivered tangible benefits at key points in the year and provide a strong foundation for our recovery programme moving forward. We remain committed to improving access and experience in the year ahead.

A particularly important development this year has been the strengthening of our understanding of health inequalities. Our most detailed analysis to date has highlighted clear disparities in access, experience and outcomes for some communities, providing a strong evidence base to inform future action with system partners.

We have also continued to make progress in digital transformation, strengthening our approach to sustainability and reducing our carbon footprint, and advancing collaboration through our membership of the Foundation Group and as a key partner in our Integrated Care System. These partnerships are essential in addressing the complex challenges facing our services and ensuring a sustainable future for healthcare for the Worcestershire population.

Our workforce remains at the heart of everything we do. Despite the sustained pressures, our NHS Staff Survey results demonstrated that staff engagement has continued to improve, and I want to acknowledge the professionalism, compassion and resilience shown by colleagues who continue to demonstrate our shared values: being open and honest, ensuring people feel cared for, and showing respect for everyone. We remain committed to staff wellbeing, development and engagement, recognising that our people are the foundation of our success and have continued to invest in initiatives that support physical and mental health, while also providing opportunities for learning and progression.

Looking ahead, we remain clear about the priorities for the coming year. These include improving urgent and emergency care flow, delivering financial recovery, reducing waiting times further, and continuing to enhance the quality and equity of care for our patients.

I would like to extend my sincere thanks to all our staff, volunteers and partners for their continued dedication and commitment, and our patients and communities for their support and trust. Finally, I would like to thank my fellow Board members for their leadership and support, with particular thanks to my predecessor Russell Hardy for his leadership as Chair of the Trust since 2023, as well as the key role he played in establishing and growing the Foundation Group.

Together, guided by our values and our shared purpose of helping people to live healthier, happier lives, we will continue to learn, improve and move forward with confidence.

Frances Martin

Chair, Worcestershire Acute Hospitals NHS Trust

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Performance Report

Performance Overview

The purpose of this section is to describe the Trust's purpose and its performance and the key risks to achievement of its objectives during the year.

Chief Executive Officer's Statement on Performance

I am pleased to introduce our annual performance report, which sets out our performance, achievements and challenges over the last year and reflects the continued commitment of our staff, volunteers and partners to deliver safe, compassionate care for our communities. It has been a year marked by sustained - and at times extreme - demand for Urgent and Emergency Care (UEC), consistently high bed occupancy and length of stay pressures, and the operational and financial consequences of maintaining safe capacity. In that context, I want to acknowledge the professionalism and resilience shown across our services, often in difficult conditions.

Within these pressures, we have made tangible progress. We strengthened elements of front-door delivery, with periods of improved ambulance handovers and triage; we reduced waiting times for planned care in several specialties; we continued to invest in our people and leadership; and we advanced key programmes in quality improvement, research and digital transformation. At the same time, performance has often been fragile, particularly where operational congestion has impacted patient flow, experience and some quality metrics, and we have had ongoing challenges in delivering sustainable financial recovery and productivity, including the delivery of our Cost and Productivity Improvement Plans (CPIP).

Quality and Safety

Quality performance was mixed and closely linked to operational pressures. Positively, mortality remained within expected ranges and the number of patient falls remained below national average. However, numbers of hospital-acquired infections increased, highlighting the fragility of quality metrics during periods of high bed occupancy and use of additional bed capacity. Improvement programmes progressed in antimicrobial stewardship, sepsis care and implementation of Martha's Rule. Complaint management was an area of sustained focus, with reductions in the number of open complaints following targeted work. Patient experience, as reflected by Friends and Family Test results, was strong in some areas but below target in ED and outpatients during high-pressure periods.

Operational Performance

UEC demand remained the dominant performance driver throughout the year, with long waits, high bed occupancy and constraints on patient flow, particularly at Worcestershire Royal Hospital. During the summer and early autumn, there were improvements in ambulance handovers, triage times and long ED waits, supported by changes to streaming processes and collaboration with system partners and NHS England support, which contributed to a shift in escalation status (from Tier 1 to Tier 2) during the year. This performance was more challenged over the winter but the work of our teams during our urgent care sprint towards the end of the financial year started to bear fruit and will form the basis of our Urgent Care Recovery Plans in 2026/27.

Elective performance improved overall, including reductions in waiting times and progress on waiting list management. Cancer performance was consistently challenged, however, by high referral volumes and capacity constraints in some specialties.

Health Inequalities

Our most detailed analysis to date reveals clear inequalities in Worcestershire based on deprivation, with, for example, people from the most deprived areas significantly more likely than those from the least deprived areas both to attend our Emergency Departments and to be admitted as emergencies. This analysis provides the Trust with its strongest baseline to date and will inform targeted action, service improvement and partnership working in 2026/27.

Finance and Productivity

Financial performance reflected the operational volatility of the year. Early performance against the balanced plan was adverse, attributed to additional unfunded capacity and under-delivery of CPIP. Ongoing high UEC demand and continued use of additional bed capacity contributed to a highly challenged position throughout the year. This was reflected in our NHS Oversight Framework status, which improved to segment 3 in quarter 2 but remained at segment 4 for the rest of the year.

Strengthened financial governance arrangements and enhanced grip-and-control measures were put in place; however, our end of year position was an adjusted deficit of (£11)m which was in line with the revised forecast outturn but not within the annual plan agreed with NHSE.

Sustainability

During the year, the Trust continued to strengthen the governance, strategy and risk management arrangements supporting delivery of its Green Plan and wider net zero objectives, with climate change remaining subject to Board oversight and established assurance processes. Total greenhouse gas emissions for the year were 4.6% lower than the 2021/22 baseline, although progress remains below the trajectory required to meet NHS net zero ambitions. We are proud to be one of the first trusts in the country to eliminate the harmful anaesthetic gas desflurane and to be participating in international initiatives in areas such as sterile gown usage.

Workforce

Workforce indicators were broadly stable, though there was increased sickness absence during peak operational pressure. Reducing reliance on temporary staffing remained a consistent priority and challenge and despite strengthened oversight and significant reductions in agency usage, levels remained high in some divisions, driven by the need to staff additional capacity and maintain safe UEC services.

I want to place on record my sincere thanks to our staff for the extraordinary commitment, flexibility and compassion they have shown in continuing to care for patients and supporting one another through these sustained pressures.

Trust's Purpose and Activities

Worcestershire Acute Hospitals NHS Trust was established on 1 January 2000 and provides hospital-based services to a population of over 603,600 people in Worcestershire as well as caring for patients from surrounding counties and further afield.

Services are provided from three main sites:

- Alexandra Hospital in Redditch
- Kidderminster Hospital and Treatment Centre
- Worcestershire Royal Hospital in Worcester

The Trust also provides community-based services in Bromsgrove, Evesham and Malvern.

The Trust has four clinical divisions: Medicine, Surgery, Women's and Children and Specialised Clinical Services.

Foundation Group

The Trust is part of a Foundation Group with South Warwickshire NHS Foundation Trust, George Eliot Hospital NHS Trust and Wye Valley NHS Trust, with a single Chief Executive Officer and, until the end of 2025/26, a single Chair. From 2026/27 the single chair role was split between two new Chairs, each leading two of the Group trusts. All four organisations face similar challenges and have a common strategic vision for how these can be solved. The Foundation Group model retains the identity of each individual trust whilst strengthening the opportunities available to secure a sustainable future for local health services and providing a platform to share best practice and improve whole system patient pathways.

Shared Foundation Group long term strategic objectives and Big Moves



The Big Moves are underpinned by six Strategic Pillars:

- **Quality:** We will improve the experience, outcomes and safety of people accessing our services. We will embed a culture that is open to change and through Quality Priorities we will focus on improvement that will support people to live healthier, happier lives.
- **Workforce:** Our staff are our organisation. The retention, happiness and wellbeing of our workforce is essential. We want the Trust to continue to be an employer of choice, attracting the very best.
- **Productivity:** Making the best use of our limited resources and maximising the benefits of Foundation Group working will help us to be an efficient and effective organisation. We will respond to national programmes and develop a financial and operational strategy that makes us sustainable for future healthcare delivery.
- **Digital:** Digital solutions can enhance services and patient experience. We have an opportunity to use technology and data to transform care and experience for our staff.

- **Sustainability:** We recognise our environmental obligations and we are committed to minimising our impact on the local environment and helping to improve it.
- **Research:** We will create a culture which harnesses and supports research opportunities and improved access to clinical research.

Integrated Care System

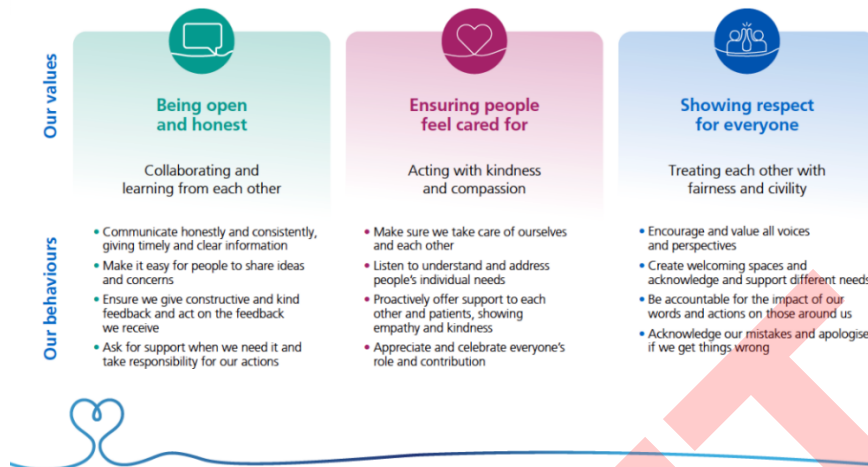
The Trust is part of the Herefordshire and Worcestershire Integrated Care System (ICS). The ICS is responsible for improving health outcomes for the local population, reducing health inequalities and supporting broader social and economic development. The Integrated Care Board (ICB) does this through ensuring effective joined up working with local partners across health, social care, voluntary and community sectors and the allocation of NHS resources to ensure services are in place to deliver the jointly agreed ambitions. During 2025/26, the ICB created a strategic cluster with NHS Coventry and Warwickshire ICB and appointed a shared Chair, Chief Executive and joint non-executive board members.

Trust Vision, Values and Strategy

After engaging with colleagues across and beyond the Trust in 2024/25, a new Trust Strategy for 2025-30 was launched, including purpose, vision, strategic objectives and values that align with the strategies of the NHS, the ICS and the Foundation Group.



Our shared values and behaviours



Performance Appraisal

The performance analysis below describes how in 2025/26 the Trust managed risks to achieving its strategic objectives and performed on key targets and measures.

Taken as a whole, the analysis shows that the Trust met expectations in some important areas, including delivery of the final capital plan, elective recovery against the 18-week standard, theatre utilisation, ambulance handovers under 45 minutes, patient experience, mortality and continued improvement in staff engagement.

However, expectations were not met consistently across financial performance, urgent and emergency care access, some cancer standards, diagnostic waits, sickness absence and aspects of infection prevention and control.

In the main, this reflected sustained demand, discharge and flow pressures, capacity constraints in key specialties, workforce challenges, and the impact of operating within a constrained financial environment.

The report also demonstrates that these issues and risks have been actively managed through strengthened executive and Board oversight, monthly performance and recovery review processes, targeted improvement programmes, specialty-level recovery actions, and continued use of risk management and governance arrangements to monitor delivery, escalation and mitigation.

While these controls have supported improvement in a number of areas, material risks to financial sustainability, operational resilience, access standards, patient flow and infection control remain and require close oversight in 2026/27.

The principal risks to achievement of the Trust's strategic priorities in 2025/26 are set out in the Board Assurance Framework as follows.

Strategic Priority	Principle Risks to Achievement	Changes during the year
People	Health and wellbeing of staff	The risk remained high, reflecting some improvement but missed targets and continued pressures.

	Failure to deliver workforce transformation and achieve a sustainable workforce	The risk remained high reflecting ongoing work to reduce reliance on temporary staff while continuing to meet high demand.
	Failure to sustain a positive change in organisational culture	The risk reduced to moderate ahead of 2025/26 while the new values became embedded.
Patients	Failure to improve urgent and emergency care	The risk remained high throughout the year reflecting continued challenges though performance improved towards the year end.
Collaboration	Failure to improve urgent and emergency care	
Excellence	Failure to develop, modernise and improve information technology through timely delivery of the digital strategy	Good progress was made during the year on delivery of the strategy and the risk reduced to a moderate level.
	Successful cyber-attack on the Trust's systems	The risk remained high throughout the year, reflecting the constantly developing external threat.
Effectiveness	Failure to deliver the Trust's agreed financial plan	The risk remained high throughout the year as the Trust sought to deliver an ambitious plan,
	Fire safety risk at the Alexandra Hospital	The risk reduced during the year as mitigations were implemented and regulatory expectations were met.

These risks will be refreshed for 2026/27 in line with new annual objectives aligned to the overarching Trust Strategy.

Going Concern

International Accounting Standard 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity.

The Trust has a forecast outturn for 2025/26 of £14m deficit, with a stretched ambition to reduce this to £11.6m (as at month 10, January 2026) after receipt of deficit support funding from Herefordshire and Worcestershire ICB of £47.3m. The Trust's final position for 2025/26 was a £11m deficit.

In the 2026/27 plan the Trust forecasts and adjusted financial performance of breakeven positions which includes deficit support funding of £42.194m and CIP target of £57.1119m. This has been agreed in conjunction with the Herefordshire and Worcestershire ICB.

The Directors have carefully considered the principle of going concern. The Trust has agreed contracts with its local commissioners for 2026/27. Services continue to be commissioned in the same manner as in prior years and there are no discontinued operations. The Trust's strategic partnership with the Foundation Group also continues to provide executive leadership and support to the Trust.

The Board has thus concluded that the Trust remains a going concern and the going concern basis has been adopted for the preparation of the accounts. Further details on going concern can be found within the disclosure within the financial statements.

Performance Analysis

This section provides a summary of how we measure performance and manage risk and a detailed integrated performance analysis.

Measuring and Monitoring Performance

The Trust reports each month on a large dataset covering operations, quality, workforce and finance, which is consistent across the Foundation Group, enabling useful comparison and benchmarking. The dataset includes national targets set by NHS England, measures aligned to our annual Trust objectives and other data agreed by the Foundation Group trusts as key measures for Board oversight.

Performance is overseen by the Trust Board and a number of committees, including Quality Governance Committee, Financial Recovery Board and divisional Finance and Performance Executive Committees. Key Performance Indicators (KPI) are included in an Integrated Performance Report (IPR), which is reviewed at each meeting of the Trust Board in public, with all meeting papers published on our website to aid transparency. The IPR comprises data and information about four main areas.

Key Performance Reporting	
Quality	Mortality
	Infections
	Patient Surveys
	Patient feedback
	Clinical incidents
Operations	Urgent care access
	Elective care access
	Cancer services
	Clinic and theatres utilisation (productivity)
Workforce	Sickness absence
	Turnover
	Vacancies and staffing levels
	Staff survey results
Finance	Delivery of financial plan
	Development and implementation of cost and productivity

Every quarter, this information is collated in a single report for the four Trusts of the Foundation Group, which provides useful benchmarking and opportunities for shared learning. Where there is benefit to joint working between the four trusts, this information is discussed by the four Boards together. Areas of Foundation Group focus in 2025/26 included:

- Outpatient services
- Urgent and emergency care impact on mortality and morbidity
- Safe staffing
- Operational planning for winter
- Equality and diversity
- Patient initiated follow-up
- Cancer services
- Home First initiatives

As well as using KPIs to measure performance against specific targets, KPIs also help identify areas of risk, provide assurance about how well risks are being managed or mitigated and inform our annual Trust objectives. This is reflected in our risk register and Board Assurance Framework.

Risk Profile

The Trust faced a range of challenges during the year which were assessed as risks to achievement of the Trust's strategic objectives and delivery of its key priorities. The basis of many of these risks is inherent within the wider NHS while others are particular to the Trust as an individual organisation. Many of these challenges are expected to continue into the coming years, impacting the delivery of the Trust's operational performance improvement priorities. The Trust takes these into account when reviewing its strategy. These include:

- Increased demand in both numbers and acuity at the Trust's 'front door', linked to and helping to drive long waiting lists.
- Challenges in community health and social care impacting the ability to discharge patients from the Trust's acute services when they are ready.
- Private Finance Initiative (PFI) funded hospital estate, which creates a current and future financial pressure. Ensuring an effective transfer of PFI responsibilities and a fully functioning, well managed estate will be a strategic priority for the Trust over the coming years.
- Estate infrastructure issues requiring a high level of financial and people resource to address.
- Workforce pressures in some teams creating 'fragile' services.
- Challenging financial, efficiency and productivity targets, which require careful balancing to ensure core service delivery alongside productivity and quality improvement.

The Trust Board considers its strategic and operational risks regularly through oversight of the Board Assurance Framework, risk register and reports from its committees.

More information on these risks is included within the Annual Governance Statement later in this document.

The impact of these risks and their mitigations is included where relevant in the performance appraisal below.

Financial Performance

Statutory basis

The Trust has fulfilled its responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with the Manual for Accounts and the International Financial Reporting Standards which give a true and fair view in accordance therewith.

Financial Break-even

In 2025/26, the Trust delivered a deficit of (£9)m. Once adjustments for the reversal of impairments and donations are accounted for this equates to an adjusted deficit of (£11)m.

The table below indicates the overall value of the deficit once factors relating to the change in value of tangible assets and other technical adjustments are accounted for.

The Trust break-even duty is calculated based on the retained Surplus/(Deficit) for the year adjusted for asset impairments and revaluations and the impact of donated assets and capital grants received.

In 2025/26 the Trust reported an adjusted deficit of (£11)m which was in line with the revised forecast outturn but not within the annual plan agreed with NHSE.

As part of the 2025/26 audit, the Trust's external auditors, Grant Thornton, concluded that the Charles Hastings Education Centre had not been accounted for appropriately in 2025/26, with an adjustment required back to IFRS 16 lease transition date of 1st April 2022. To align with the audit position and ensure compliance with IAS 8 (Accounting Policies, Changes in Accounting Estimates and Errors), management has agreed to treat this as a prior period adjustment and restate the comparatives accordingly, which is shown in the below table:

Financial Position – Income and Expenditure	Actual 2025/26 £000's	Actual 2024/25 £000's
Operational (Adjusted) financial performance surplus/(deficit)	(11,042)	(5,484)
<i>Adjust Remove I&E impact of capital grants and donations</i>	(619)	(217)
<i>Adjust Remove net impairments not scoring to the Departmental expenditure limit</i>	3,898	1,405
<i>Remove PFI revenue costs on IFRS 16 basis</i>	44,879	44,090
<i>Add back PFI revenue costs on an IAS 17 basis (comparative only)</i>	0	0
<i>Add Prior Period Adjustment</i>	562	0
<i>Add back PFI revenue costs on a UK GAAP basis</i>	(51,009)	(50,222)
<i>Adjust Remove net impact of inventories received from DHSC group bodies for COVID response</i>	0	81
Surplus / (deficit) for the period	(8,753)	(621)

Prior to the Health and Care Act 2022 coming into force, we also had a statutory financial duty to achieve a break-even position on revenue and expenditure taking one year with another. However, our financial performance is now based on agreed financial targets with NHSE. We continue to report on the break-even positions, and the table below shows the cumulative performance against the break-even duty for the last five years.

	2021/22	2022/23	2023/24	2024/25	2025/26
	£'000	£'000	£'000	£'000	£'000
Breakeven duty in-year financial performance	(1,082)	(19,775)	(36,576)	648	(4,912)
Breakeven duty cumulative position	(343,64)	(363,416)	(399,99)	(399,344)	(404,256)
Operating income	596,391	644,967	699,802	807,328	831,752
Cumulative breakeven position as a percentage of operating income	(57.6%)	(56.3%)	(57.2%)	(49.5%)	(48.6%)

NHS trusts also have non-statutory (administrative) duties to meet. These are

- Pay a public dividend capital (PDC) dividend to the DHSC each year.
- Remain within the capital resource limit (CRL)
- Comply with the better payment practice code (BPPC) 178 for the payment of invoices.

Details below for the CRL and BPPC are below:

Capital Resource Limit					
	2021/22	2022/23	2023/24	2024/25	2025/26
	£'000	£'000	£'000	£'000	£'000
Gross capital expenditure	52,565	50,899	48,705	27,361	28,763
Less: Disposals	(884)	(363)	(436)	(773)	(269)
Less: Donated and granted capital additions	(218)	(289)	(371)	(375)	(825)
Charge against Capital Resource Limit	51,463	50,247	47,898	26,213	27,669
Capital Resource Limit	54,112	51,630	47,898	26,213	28,488
Under / (over) spend against CRL	2,649	1,383	-	-	819

Better payment practice code

The trade creditor payment policy of the NHS is to comply with both the Confederation of British Industry (CBI) prompt payment code and the government accounting rules. The Government accounting rules stipulate that, unless otherwise stated, all invoices should be paid within 30 days of receipt of goods or services.

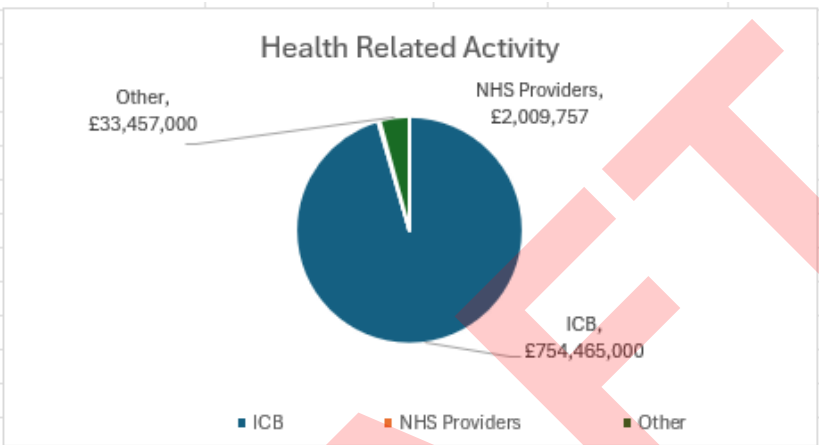
The Trust is measured against a 95% compliance rate target in terms of both value and number of invoices.

Non-NHS Payables	2025/26 Invoice Count	2025/26 £'000	2024/25 Invoice Count	2024/25 £'000	2023/24 Invoice Count	2023/24 £'000
Total non-NHS trade invoices paid in the year	105,864	348,144	104,278	354,177	100,049	357,448
Total non-NHS trade invoices paid within target	92,482	311,083	73,595	276,407	90,391	319,099
Percentage of non-NHS trade invoices paid within target	87.4%	89.4%	70.6%	78.0%	90.3%	89.3%
NHS Payables						
Total NHS trade invoices paid in the year	2,072	23,255	2,218	16,783	2,109	21,234
Total NHS trade invoices paid within target	1,509	13,388	1,107	7,694	1,497	16,186
Percentage of NHS trade invoices paid within target	72.8%	57.6%	49.9%	45.8%	71.0%	76.2%

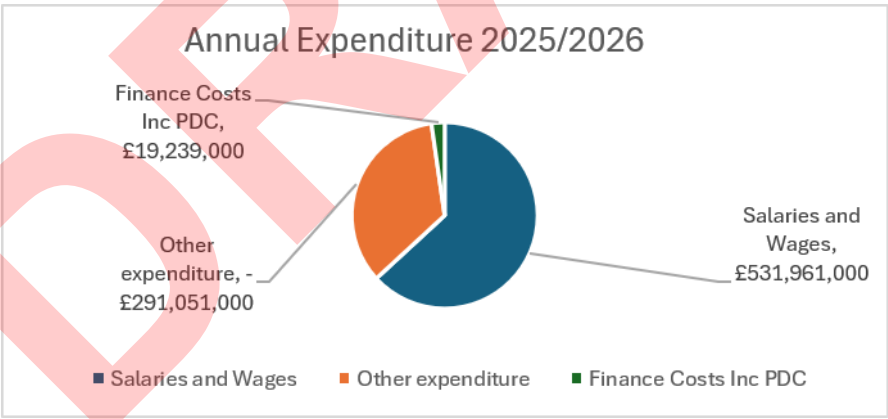
It can be seen in the table above that in invoice volume terms the Trust increased in its performance against the Better Payment Practice Code during 2025/2026. This was aided by changes to processes.

Resources – Income and Expenditure

The Trust generated income of £833.7m which includes £2m finance income during 2025/26. The chart below identifies income received from different sources for health-related activity. The largest share of income is derived from Integrated Care Board (ICB) with the primary source being NHS Herefordshire and Worcestershire ICB.



Annual expenditure incurred in the year totalled £842.3m, which includes £19.2m on finance costs and PDC dividend. Salaries and wages paid to permanent and temporary staff, including those employed through agencies, totalled £532m. Total expenditure on goods and services amounted to £291.1m.



Resources – Capital Expenditure

The Trust spent £28.8m on capital investments during 2025/26 in line with the final plan for the year. The most significant elements within the capital programme were:

2025/26 Capital Expenditure	2025/26 £'000
Clinical Equipment	9.2
Strategic Schemes	1.7
Other Estates Schemes	10.1
Digital	7.2
Lease additions and modifications	0.6
Total Capital Expenditure	28.8

£47.3m of deficit support funding was received due to the planned deficit of the Trust in 2025/26.

The Trust received £15.155m of Public Dividend Capital (PDC) and System Support PDC to support targeted capital schemes, which included £3.0m for the Alexandra Hospital Fire safety scheme and £2.3m for a LINAC (linear accelerator) machine at Worcester Royal Hospital.

The Trust ended the year with a positive cash balance of £7.48m ensuring compliance with its external financing limit.

The current CQC Use of Resources (UOR) assessment rating of the Trust is Inadequate and as such the Trust set up a Financial Recovery Board to meet monthly to oversee the delivery of its overarching financial recovery. Divisions are held to account through monthly executive-led Finance and Performance Executive meetings that are observed by non-executive members of the Board. Finance reports are provided to Board as part of the Trust's Integrated Performance Reports that triangulate quality, finance and performance

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 Executive (FPE) on key performance indicators covering finance and activity.
- Detailed monthly review by the Finance Recovery Board (FRB) on performance against the financial recovery plan.
- Monthly oversight of the delivery of Cost and Productivity Improvement Plans (CPIP) by both the FPE and FRB.
- Monthly Trust Management Board meetings where key operational decisions are made and financial performance reviewed.
- Regular Budget Holder meetings.
- Monthly ICS Finance Committee meetings to review the financial performance and forecasts of system partners and oversee system financial strategy.
- Quarterly ICS level review meetings with NHSE Regional Office.
- Monthly Capital Planning & Delivery Group meetings.

- Monthly Strategic Programme Board meetings.
- Regular CPIP work stream meetings.
- Rapid improvement events and reporting to reflect targeted benefit realisation and improvements.

Pension Liabilities

Within the annual accounts, ongoing employer pension contribution costs are included within employee costs (see Note 9 to the annual accounts for more detail).

Past and present employees are covered by the provisions of the NHS pension scheme. Details of the benefits payable under these provisions can be found on the [NHS Pensions website](#).

Statement of Disclosure for Auditors

Each director knows of no information which would be relevant to the auditors for the purpose 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.

Operational Performance Analysis

NHS Oversight Framework

The NHS Oversight Framework was a new, one-year framework for 2025/26, which is supported by a set of national priorities and other metrics. Organisations’ performance was assessed each quarter during 2025/26 to provide a segment score that determined the level of support or intervention needed by NHS England (NHSE) as follows:

Segment	Description
1	Consistently high performing across all domains, delivering against plans.
2	Good performance across most domains. Specific issues exist.
3	Off track in a range of domains or in financial deficit.
4	Significantly off-track in a range of domains.

All organisations in financial deficit or in receipt of deficit support are limited to a segment score of no greater than 3.

Each quarter, NHSE published data for each organisation, including performance against relevant metrics as well as segment, overall score and rank. The Trust’s overarching performance each quarter was as follows (lower numbers are better):

Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Score	Segment	Rank	Score	Segment	Rank	Score	Segment	Rank	Score	Segment	Rank
2.68	4	110	2.57	3	92	2.79	4	106	2.65	4	109

The Trust continued in financial deficit with deficit support during the year and was challenged on access targets. Although there was an improvement in quarter 2, the position deteriorated at quarter 3 and was reflected in our scores and ranking compared to other acute trusts for the remainder of the year.

The Trust’s performance within each domain was described as follows in the National Oversight Framework quarter 4 results.

Access to services	4 – Low performing
Finance and productivity	4 - Low performing
Effectiveness and experience	3 – Below average
Patient safety	1 – High performing
People and workforce	2 – Above average

National Priorities

The national priorities set for 2025/26 were supported by planning guidance which described how trusts and ICBs should work to achieve the defined measures of success.

Not all the priorities were previously measured by the Trust. Comparative data for previous years is provided where possible.

1. Improve Accident and Emergency waiting times

This priority aligned with the Trust's strategic objectives and was a key area of focus during the year.

The national planning guidance sought to drive improvement through reducing avoidable ambulance dispatches and conveyances, reducing handover delays and improving and standardising urgent care at the front door of the hospital.

a) Percentage of emergency department attendances admitted, transferred or discharged within 4 hours (March results)

Standard	2023/24	2024/25	2025/26
78%	68%	66%	67.26%

b) Percentage of emergency department attendances spending over 12 hours in the department (March results)

2023/24	2024/25	2025/26
Not available	Not available	7.5%

c) Ambulance handovers under 45 minutes (March results)

Standard	2023/24	2024/25	2025/26
80%	Not available*	Not available	83.4%

**The standards previously measured were 30 and 60 minutes.*

The Trust missed the 4-hour target due to a range of pressures including record high levels of demand and congestion throughout the urgent care pathway.

Towards the end of 2025/26, as part of the national urgent care sprint, the Trust implemented an improvement plan focused eliminating corridor care in the Emergency Department (ED) and any ambulance waits over 45 minutes and reducing the overall length of stay in the ED.

Following a successful pilot, the Trust also opened a new Acute Medical Assessment Unit and a new Acute Surgical Assessment Unit.

Due to this work the Trust did see improvements in all emergency access standards in the last few weeks of the year and into 2026/27.

The Urgent and Emergency Care (UEC) Recovery Programme has subsequently been relaunched, focused on discharges from inpatient wards. Improving elective care in this way will help improve emergency access and patient outcomes and experience, as people will be seen and treated earlier, reducing the need for some people to seek acute emergency care.

Implementation of this programme will be overseen by a new Urgent Care Recovery Board.

2. Reduce the time people wait for elective care

The national planning guidance required all providers to deliver this through increased activity levels, effective demand management, driving pathway reform and giving patients choice and control over their care.

Elective care means non-urgent, planned medical procedures that are scheduled in advance. One of the Trust’s key priorities is ensuring patients can access the elective treatment they need in as timely a manner as possible. Prior year performance has been below standard and the Trust’s recovery plans during the year focused on the specialities with the poorest performance.

Performance overall was challenged during the year by a number of factors, such as resident doctor industrial action and adverse weather conditions, both of which required patient appointments to be rearranged.

Key changes made during the year to improve our performance included increasing capacity in our most challenged services, upgrading treatment rooms so we can protect our theatre resources for theatre-only procedures and undertaking an ‘elective sprint’ in quarter 4.

a. Percentage of patients waiting no longer than 18 weeks for elective treatment

Standard	2023/24	2024/25	2025/26
65% by March 2026, with a minimum 5% improvement on 2024/25	54.3%	59.3%	69.9%

b. Percentage of people waiting over 52 weeks for acute care

Standard	2023/24	2024/25	2025/26
<1%	Not available	Not available	1.4%

This standard was not measured in the same way in previous years so a direct comparison is not available. However, from April 2025, performance has improved from 3.57% to 1.4% in March 2026. Although the target was missed and there is more work to do, this is a significant improvement.

3. Reduce the time people wait for elective cancer care

The national focus was on systems working with Cancer Alliances to improve cancer waiting times by maximising care for low-risk patients in non-cancer settings and improving productivity in cancer pathways.

a. Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral

Standard	2023/24	2024/25	2025/26
80%	57.6%	71.1%	74.7%

b. Percentage of patients treated for cancer within 62 days of referral

Standard	2023/24	2024/25	2025/26
75%	71.1%	78.9%	59.8%

While some cancer specialities performed well during the year, there were particular issues in breast and urology in relation to the 28-day standard, and in skin and urology for the 62-day standard.

Recovery plans and support focused on these specialities include:

- Plans to expand operational capacity.
- Robotic process automation solution in Teledermatology
- Support from Wye Valley NHS Trust.
- New low-risk breast pathway.
- Risk stratification at triage to prioritise patients for treatment.

4. Effectiveness and Experience of Care

a) Mortality

The Trust closely monitors rates of mortality and learning from deaths and regularly reports to the Quality Governance Committee and the Board. A key national measure is the Summary Hospital-level Mortality (SHMI), the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die (based on average England figures), given the characteristics of the patients treated.

SHMI is reported each month on a rolling 12-month basis. Data takes time to be analysed nationally and at the time of reporting the most recent data available is for November 2025. Data is sensitive to changes such as coding and inpatient numbers at speciality level.

SHMI is monitored at both Trust and speciality level, which enables more detailed analysis.

The Trust also monitors the ‘crude mortality rate’ – the number of deaths and the percentage of deaths of all inpatient admissions and Emergency Department attendances, which helps identify any potential concerns more quickly.

This, together with detailed reviews of individual deaths, helps provide assurance regarding mortality levels at the Trust.

December 24-November 25	December 23-November 24	November 22-October 23
1.10 (within expected range)	1.05 (within expected range)	1.04 (within expected range)

a) Care Quality Commission Inpatient Survey

The CQC’s annual adult inpatient survey provides useful benchmarking information and a helpful opportunity to triangulate more data about the experience of patients that use our services. The results of the survey are presented to the Quality Governance Committee so they can be considered alongside other information such as complaints, access data and patient feedback.

A key measure taken from the survey is the patient satisfaction rate. The most recent survey for which data is available was undertaken in 2024, the results of which were published in September 2025. The improvement achieved in 2023 was sustained in 2024.

Metric	2022	2023	2024
Overall experience	7.1/10	8.0/10	8.0/10
Compared with other trusts	About the same	About the same	About the same

More information about how we are working to improve patient experience can be found in our annual Quality Account, published on our website: [Annual Reports and Quality Accounts - Worcestershire Acute Hospitals NHS Trust](#).

5. Patient Safety

a. Infection Prevention and Control

The rate of certain infections is monitored closely internally, by the Trust Board and by NHSE.

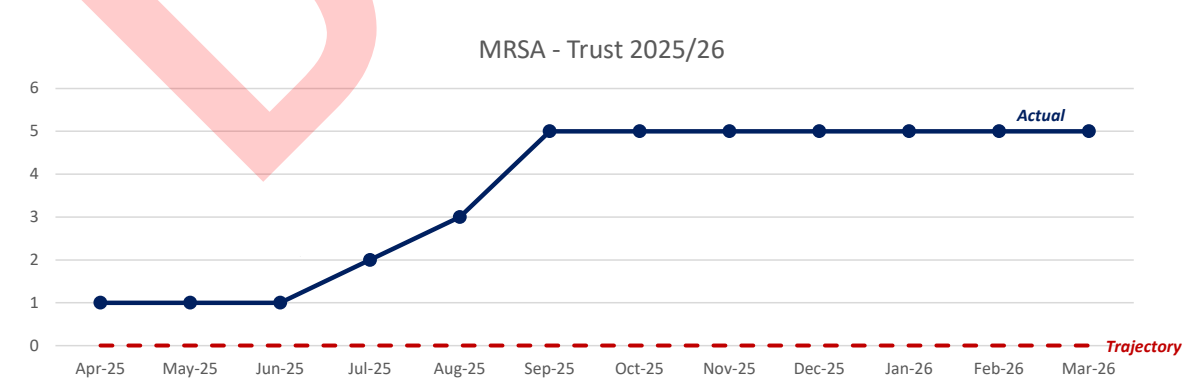
Unfortunately, the number of MRSA cases was above threshold. Each case was reviewed and learning will be reflected in a revised policy.

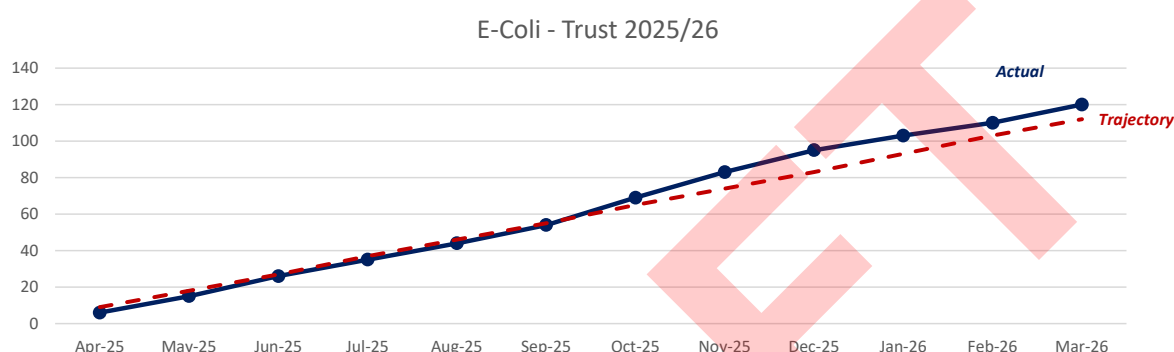
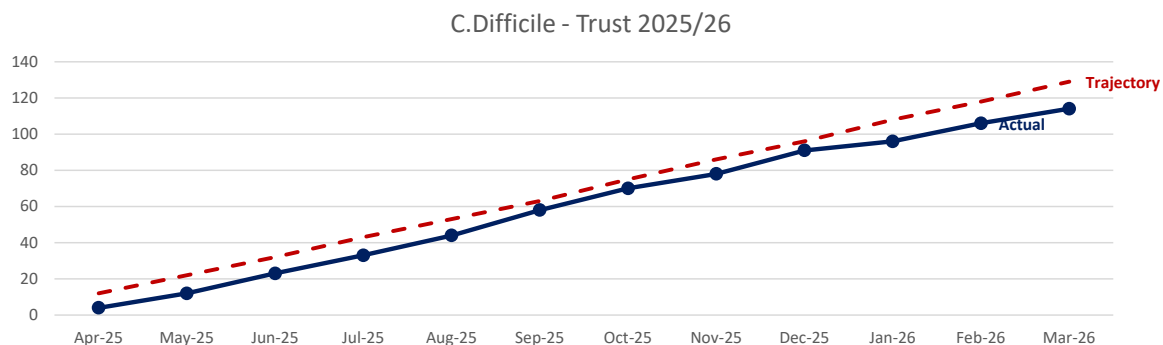
An increase in C-Difficile cases was a common pattern nationally and monitored by the UK Health Security Agency (UKHSA) but the rate improved compared to last year and was below the national threshold.

The number of E-Coli infections was above the national threshold. All cases are reviewed to identify learning and implementation of any changes is carefully monitored. National data indicates that urinary catheter care and timely surgical management of cholecystitis are important and these are therefore a focus for the Trust.

Detailed information about actions we are taking to drive down healthcare acquired infections can be found in the Trust’s annual Quality Account.

Metric	Threshold	2025/26	2024/25	2023/24
MRSA bacteraemia cases	0	5	1	0
Reportable C-Difficile infections	>129	114	137	94
E-Coli bacteraemia infections	>108	120	112	55





b. Staff Survey Raising Concerns Sub-Score

The annual, national NHS Staff Survey provides valuable information not only about staff experience but also the effectiveness of our safety arrangements. This includes questions about raising concerns. The Trust's scores have gradually improved over the last three years and are about average compared to peer organisations.

This is an area of focus for the People and Culture Committee, which receives regular reports from the Freedom to Speak Up Guardian about reactive and proactive work to support people to raise concerns.

Standard	2025	2024	2023
Out of 10	6.47	6.38	6.14

6. People and Workforce

a. Sickness Absence Rate

The Trust Board monitors the staff sickness absence rate closely throughout the year. The Trust target was not met, with varied performance across clinical and corporate divisions. Mitigations and controls included support through occupational health and other wellbeing support, targeted interventions in areas with high sickness absence and support for managers to ensure compliance with policy.

Standard	2025/26	2024/25	2023/24
4%	5.4%	5.1%	5.75%

b. Staff Survey Engagement Theme Score

This important measure provides an indicator of how motivated, involved and committed staff feel, which links directly with the quality of care.

The Trust's engagement score continued the gradual improvement trajectory of the last three years, remaining above the national average.

Standard	2025	2024	2023
Out of 10	6.84	6.90	6.60

Overall, the Trust's staff survey results for 2025 were positive, with overall scores showing improvement across all seven People Promise themes for second year running. There were significant improvements in five areas and all scores in the People Promise themes were above the national average.

People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	7.31	3473	7.36	3861	Not significant
We are recognised and rewarded	5.90	3477	6.03	3863	Significantly higher
We each have a voice that counts	6.67	3444	6.73	3839	Not significant
We are safe and healthy	6.12	3455	6.26	3835	Significantly higher
We are always learning	5.61	3275	5.69	3635	Not significant
We work flexibly	6.43	3453	6.64	3845	Significantly higher
We are a team	6.71	3472	6.81	3861	Significantly higher
Themes					
Staff Engagement	6.82	3478	6.84	3867	Not significant
Morale	5.95	3478	6.13	3872	Significantly higher

Other Performance Measures

The Trust Board monitors many measures of performance against targets and standards relevant to safety, patient experience, patient outcomes, productivity and patient flow. Some of the important measures, including national targets and those linked to Trust, ICB and Foundation Group strategies are as follows.

Measure	Standard	2025/26	2024/25	2023/24
Percentage of people waiting over 6 weeks for a diagnostic procedure or test	5%	24.5%	14.4%	25.8%
Theatre utilisation	85%	85.3%	84%	82.0%
Outpatient appointments not attended (did not attend - DNA - rate)	<4%	4.4%	4.6%	5.0%

Quality Priorities

Each year the Trust publishes a Quality Account which sets out progress on achieving our quality priorities and describes the new priorities we intend to measure the following year. More detail can be found in our Quality Account 2025/26 on our website. Oversight of progress is incorporated in the workplan of the Quality Governance Committee.

Quality Account Priorities Care that is safe	
• Reduce avoidable healthcare acquired infections • Ensure patients experience safe and timely discharge from hospital, with a focus on Hospital Acquired Functional Decline (HAFD) • Ensure a high standard of nutrition and hydration assessment for all patients	
Progress Partially met national infection thresholds and improved performance on C.difficile. We met targets for MUST (malnutrition universal screening tool) and fluid balance training. There was a reduction in complaints and incidents relating to nutrition and hydration.	Further work needed We did not meet all our discharge targets. We have embedded principles that support patient flow and reduce HAFD (hospital acquired functional decline) and expect to see improvements in 2026/27. We missed targets for weighing patients on admission and completing MUST assessments. We have expanded our nutritional and dietetics teams and this will support improvement in 2026/27.
Quality Account Priorities Care that is clinically effective	
• Continually learn from deaths and ensure patients in hospital at the end of their lives receive high quality, individualised care • Reduce the time patients are waiting for treatment	
Progress Mortality rates were 'as expected'. We increased use of the AMBER care bundle for adult patients with an unplanned admission. Achieved target for ambulance handover times. Improved performance on waits under 18 weeks. Reduced the number of people waiting over 52 weeks.	Further work needed We missed the target for expected adult deaths having an individualised Last Days of Life care plan. Staff will receive training in 2026/27 on caring for patients likely to be in the last year of life. We are working to improve our performance on elective and cancer waiting times.
Quality Account Priorities Care that is a positive experience	
• Ensure all patient, including those requiring reasonable adjustments, receive safe, personalised care and achieve equality of outcomes • Ensure patients, their relatives and carers feel listened to • Continuously learn from patient feedback	
Progress Met the target for Oliver McGowan training. Delivered plans to engage and partner with stakeholders to support better patient experience Met targets for improving response to PALS (patient advice and liaison service) contacts and complaints. Achieved a 95% recommended rate in the Friends and Family Test (FFT)	Further work needed We will continue to work with divisions to support achievement of targets for FFT and inpatient survey response rates.

Quality Governance

Information about quality governance is included in the Annual Governance Statement within the Accountability Report later in this document.

Equality, Diversity and Inclusion

Equality of Service Provision

The Public Sector Equality Duty (PSED) under the Equality Act 2010 applies to Worcestershire Acute Hospitals Trust and other public bodies that carry out public functions. It supports good decision-making by ensuring public bodies consider how different people will be affected by their activities. This helps them deliver services that are efficient and effective, accessible to all, and meet the needs of different people. This applies to the Trust as a service provider and employer.

The PSED requires the Trust to have due regard (think about and act) to the: “Need to eliminate discrimination, advance equality of opportunity and foster good relations for people with a protected characteristic when developing its policies, services or when carrying out day-to-day functions and activities”.

In order to meet this duty, all our business cases and policies are required to include an equality impact assessment.

As an NHS provider we are committed to ensuring that our services are accessible to, and meet the diverse needs of, all our patients and visitors. We are committed to working in partnership with colleagues in other NHS organisations, voluntary and community groups and all our key stakeholders to enable us to plan and deliver our services in a way which best meets the needs of everyone in the communities we serve.

Each year we publish information about our compliance with the PSED in an Equality Report. The most recent report can be found on the Trust [website](#). The report includes a review of formal complaints through an equality, diversity and inclusion lens.

In addition to established arrangements, new initiatives to promote equality of service delivery during 2025/26 included:

- Expanded the Chaplaincy service, creating a new multi-faith chaplaincy hub.
- As part of our Allied Health Professionals annual awards, created a new EDI Award to celebrate individuals who have demonstrated a strong commitment to advancing equality, diversity, and inclusion through their everyday work.
- The Patient and Public Forum has shared lived experiences with a focus on health inequalities.
- Continued to access opportunities to raise awareness of initiatives to support people who are D/deaf.
- Specialist Applied Psychology and Cardiac colleagues have worked collaboratively to support patients who have experienced trauma and who find it difficult to access and trust services, to work in partnership and find new ways to be fully engaged in their care.
- Working with AccessAble we now have 155 Detailed Access Guides to our departments, wards and facilities, which are reviewed and updated annually.
- Promoted “On Demand” Interpreting machines and additional digital options.
- Dementia care and enrichment programme.
- Launched the Anti-Racism Charter with an implantation workplan.
- A charity funded programme for International Staff and Students Integration.
- Initiatives to improve the accessibility of the complaints process, including making the service more inclusive for patients using assistive technology, those with visual impairments, and non-native English speakers

- Established new volunteer services:
 - Peony End of Life Volunteer Service: provides support, comfort, and companionship to patients who are on an end-of-life pathway, and those closest to them.
 - Discharge Response Volunteers: an invaluable link between ward staff and Pharmacy teams, helping to speed up the discharge process for patients who are ready to go home.
 - Breastfeeding Friends: support for new mothers and families during their stay in hospital.

Tackling Health Inequalities

1. Understanding our population and service use

Health inequalities are the avoidable, unfair and systematic differences in health outcomes across the population and between different groups within society. Healthcare inequalities relate specifically to differences in access to services, experiences of care and outcomes from healthcare.

Worcestershire has a population of approximately 603,600 people (2021 Census). During 2025/26, the Trust provided services across urgent and emergency care, elective inpatient and day case care, and outpatient services.

Table 1: Population of Worcestershire and Trust activity

Worcestershire census	Non-elective/emergency admissions			Elective inpatient day case activity			Outpatient Activity		
	2019/20	2024/25	2025/26	2019/20	2024/25	2025/26	2019/20	2024/25	2025/26
603,600	62,940	57,220	54,000	93,355	95,040	96,000	581,570	702,450	731,000

This year, the Trust has undertaken detailed analytical work, linking patient-level activity data across all major care settings to the Index of Multiple Deprivation 2025 and to ethnicity data. This section presents the findings of that analysis across five areas: urgent and emergency care, emergency admissions, elective care, outpatient care and cancer diagnosis.

This analysis is now informing the Trust’s strategic planning and its engagement with system partners.

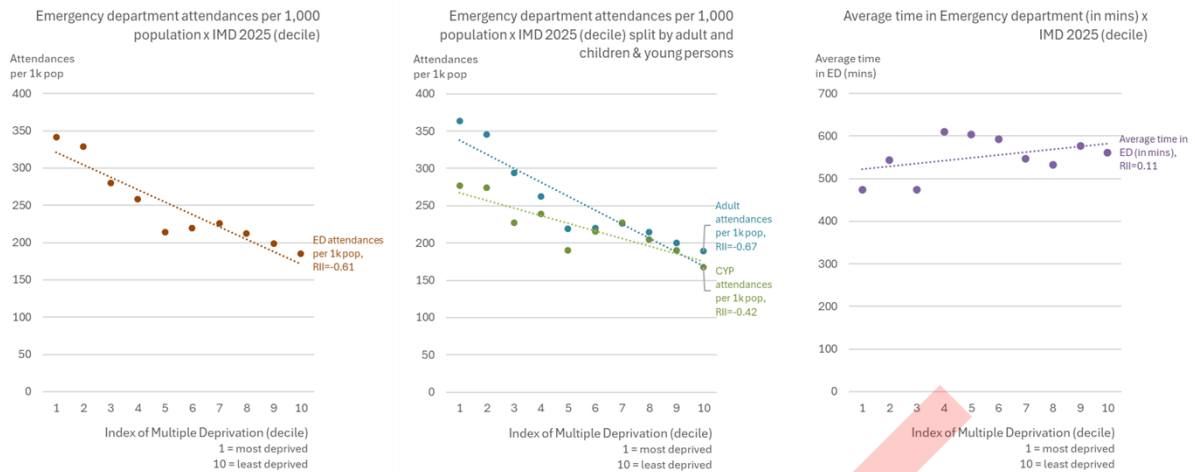
2. About the Index of Multiple Deprivation

The IMD 2025 is a composite measure of deprivation across small geographic areas in England. Decile 1 represents the 10% most deprived areas in England; Decile 10 the least deprived.

Approximately 12% of Worcestershire’s population lives in deciles 1 or 2 compared to 23% in deciles 9 or 10. This means the county is, on balance, less deprived than England as whole, but that a significant minority of our population faces significant disadvantage.

3. Urgent and Emergency Care

Charts 1-3: (1) Emergency Department attendance rate per 1,000 population by IMD2025 decile, (2) adults and children separately, and (3) average time in ED



Observations from Charts 1, 2 and 3:

- Patients from the most deprived areas of Worcestershire are 1.5 times more likely to attend our Emergency Departments than those from the least deprived areas. This is statistically significant (meaning it is very unlikely to be due to chance) and consistent across both sites.
- The gradient is most pronounced for adults, with a similar though less steep pattern observed for children and young people.
- There is no deprivation-related inequality in time spent in the Emergency Department. Patients from all IMD groups are treated within broadly comparable timeframes.

3.1 Emergency Department attendance by ethnicity vs 2021 Census information

Table 2: Proportion of ED attendances by ethnic grouping

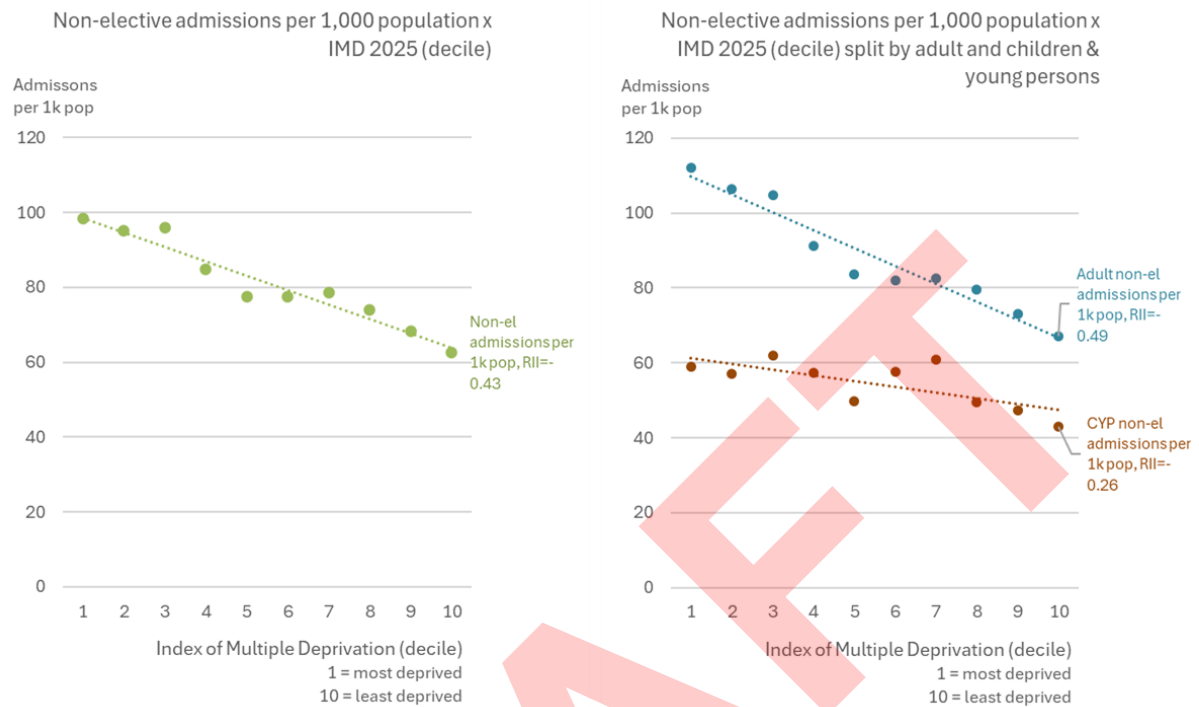
Ethnic group	Emergency department attendances	2021 Census	Difference	Average time in Emergency department (all patients, in minutes)	Average time in Emergency department for admitted patients (in minutes)	Average time in Emergency department for non-admitted patients (in minutes)
Asian	3.7%	3.1%	0.6%	392	756	343
Black	1.0%	0.7%	0.3%	408	712	366
Mixed	1.0%	1.9%	-0.9%	273	472	243
White	88.0%	93.8%	-5.8%	568	978	437
Other	1.0%	0.6%	0.4%	359	778	275
Not known	5.3%			524	968	402
of which not given or patient not medically fit to answer	0.1%					
			Avg (all ethnic groups)	552	967	426

Observations from Table 2:

- Recording of patient ethnicity in the Emergency Department is incomplete and robust conclusions about ethnic inequalities in ED access cannot therefore be drawn.
- On available data, there is no clear evidence of differential waiting times by ethnicity.

3.2 Emergency Admissions

Charts 4-5: (4) non-elective admission rate per 1,000 population by IMD decile and (5) adults and children separately



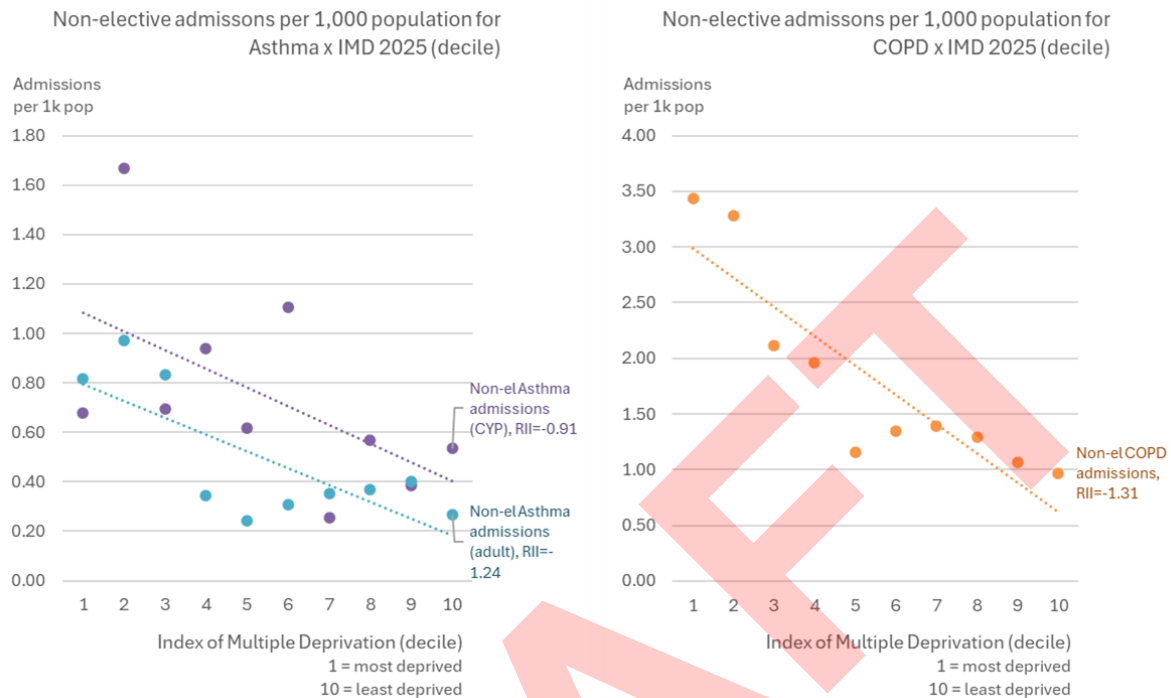
Observations from charts 4 and 5:

- Strong deprivation gradient seen in ED attendances is replicated in non-elective admissions. Patients from more deprived areas are significantly more likely to be admitted as emergencies, and this effect is again more pronounced in adults.
- Patients from the most deprived communities who require emergency admission are, on average, a decade younger than those from the least deprived areas – a clear illustration of the impact of deprivation on health.
- There is no statistically significant difference in average length of stay for adults by deprivation, though children and young people from more deprived areas show a slight tendency toward longer inpatient stays.

3.3 Focus on non-elective admissions for specific conditions:

1. Respiratory disease

Charts 6-7: Non-elective admissions for asthma and COPD by IMD decile

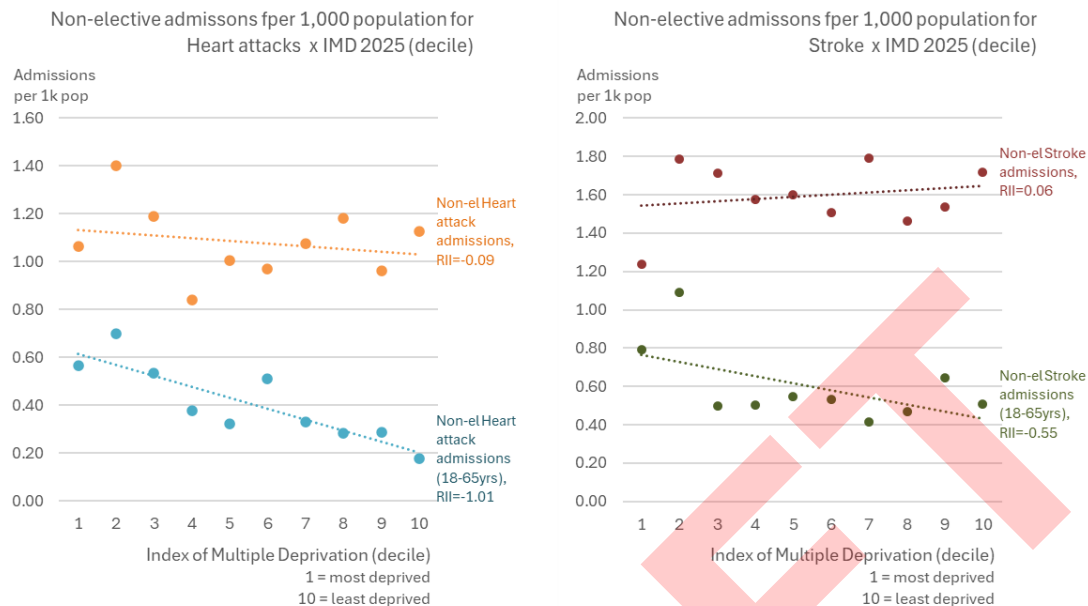


Observations from charts 6 and 7:

- Non-elective admissions for COPD show a strong and statistically significant deprivation gradient. Patients from the most deprived areas are over three times more likely to be admitted with COPD than those from the least deprived areas and tend to be younger at admission.
- For asthma, a similar gradient is observed for both adults and children, though the effect in CYP does not reach statistical significance given smaller sample sizes.

Cardiovascular disease

Charts 8-9: Working-age admission rates for Heart Attack and Stroke by IMD decile

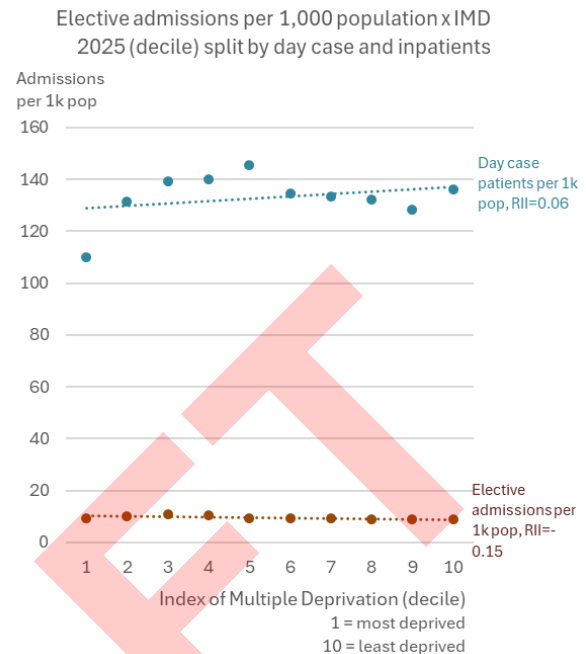
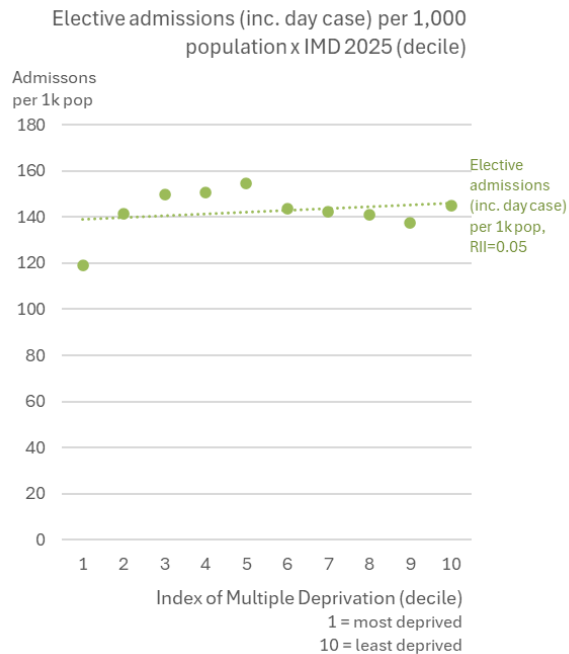


Observations from Charts 8-9:

- When the full age range is considered, admission rates for heart attack and stroke do not show a clear deprivation gradient – a function of the older average age of patients from less deprived areas.
- However, for working-age patients, the picture is markedly different. Working-age patients from the most deprived areas are almost three times more likely to be admitted with a heart attack than people from the least deprived areas of Worcestershire. A similar pattern is seen for stroke.
- This represents a significant premature mortality and morbidity risk concentrated in the most disadvantaged communities in Worcestershire.

4. Elective Care (Inpatient and Day Case)

Charts 10-11: Elective admission rate by IMD decile – all specialties

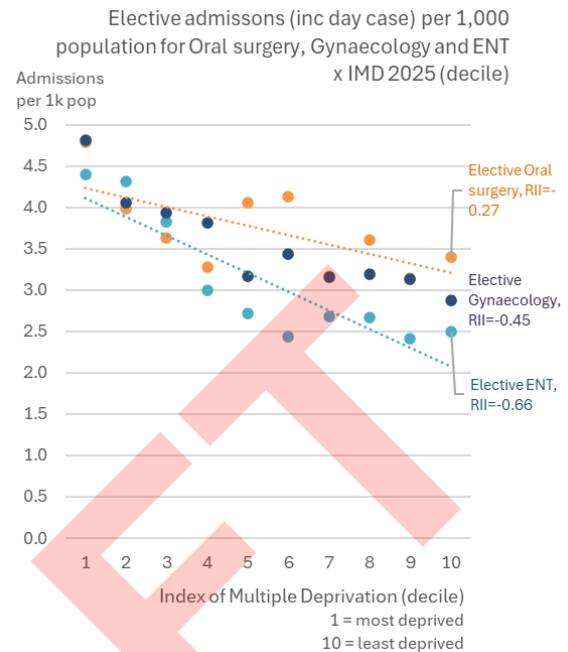
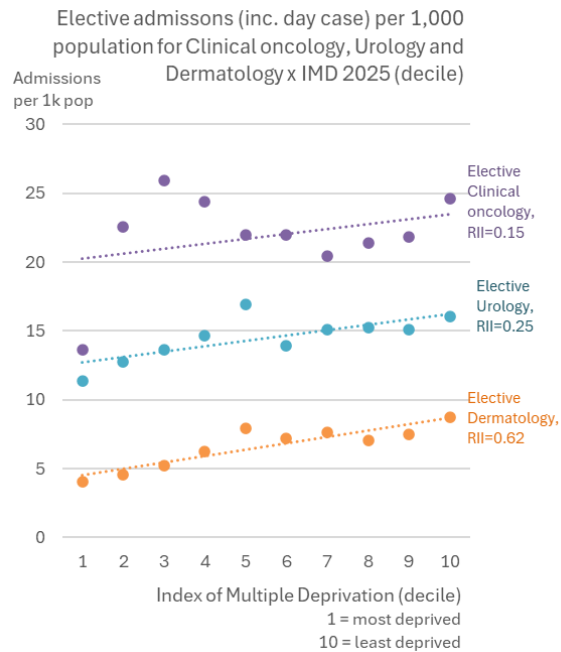


Observations from Charts 10 and 11:

- Overall, elective inpatient and day case activity does not show the deprivation gradient seen in emergency care. On aggregate, patients from all deprivation groups access elective care at broadly comparable rates. This is a reassuring indicator that clinical prioritisation, rather than deprivation, is the primary driver of elective access.
- However, this picture is not consistent across all specialities.

4.1 Elective care specialties

Charts 12-13: Specialties with significant deprivation bias



Observations from Charts 12 and 13:

- Dermatology shows a pronounced and consistent bias towards patients from less deprived areas accessing elective care which is likely to reflect barriers to early help-seeking.
- Clinical Oncology and Urology show a less severe bias in the same direction as above.
- Conversely, Oral Surgery and Gynaecology and ENT show activity weighted towards patients from more deprived areas – a pattern consistent with higher rates of relevant acute need in those communities.
- Ethnicity data quality remains a challenge in elective care with approximately 1 in 10 elective inpatient records not including a valid ethnicity code. Available data suggests some underrepresentation of Asian and Mixed-race patients in elective admissions.

5. Outpatient Care

Chart 14-16: Outpatient activity rate by IMD decile, Obstetrics, Thoracic and Diabetic medicine, and Urology and Dermatology

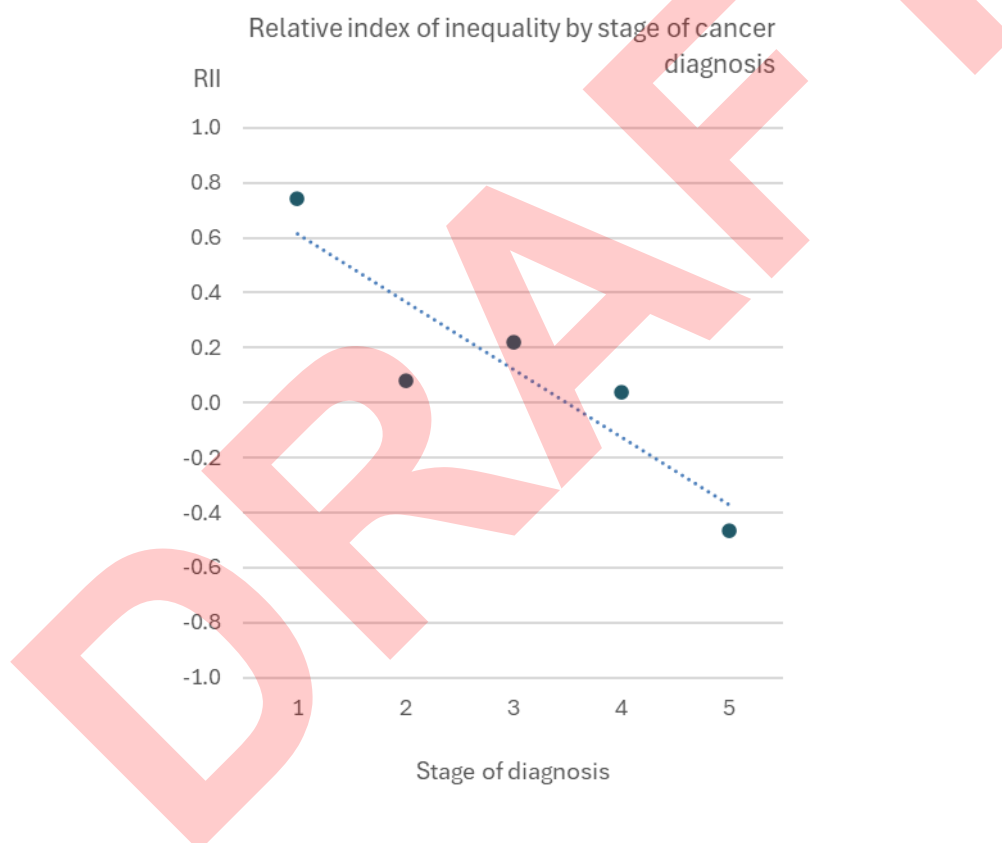


Observations from Charts 14, 15 and 16 show:

- Overall outpatient activity shows a statistically significant deprivation gradient, although less pronounced than in emergency care.
- Obstetrics, Diabetic Medicine and Thoracic Medicine all show higher rates of outpatient activity in more deprived patient groups, reflecting higher population prevalence of the conditions these specialties treat.
- Urology and Dermatology show the reverse, a bias towards patients from less deprived areas, consistent with the elective care findings above.
- Ethnicity recording in outpatients is better than in inpatient settings, but approximately 1 in 12 outpatient records still lacks a valid ethnicity code.

6. Cancer Diagnosis

Chart 17: Stage of cancer diagnosis by IMD decile (data from April 2025 to February 2026)



Observations from Chart 17 show:

- Data shows a consistent trend with patients from less deprived areas being more likely to receive an early (stage 1 or 2) cancer diagnosis while patients from more deprived areas are more likely to be diagnosed at a later stage.
- This later stage diagnosis gradient is more clearly observable for Breast, Colorectal and Urological Cancers.
- Later stage diagnosis is associated with poorer outcomes and higher treatment costs. This finding highlights the importance of upstream action on cancer awareness, screening uptake and GP access in deprived communities.

- Ethnicity data is recorded in only 13% of records in cancer datasets making analysis unreliable.

7. Summary

The analysis represented in this section is the most comprehensive the Trust has undertaken and confirms patterns consistent with the national evidence base on health inequalities.

Acute hospitals occupy a particular position in the health inequalities landscape, seeing the downstream consequences of social disadvantage. We will work with our local health and care system partners to ensure that when patients from deprived communities do need our services, they receive equitable access, experience and outcomes, and that our data meaningfully informs the system's wider prevention and intervention response.

In line with NHS England's *Statement on Information on Health Inequalities*, the Trust has published quantitative and qualitative information within this Annual Report to demonstrate how it is identifying and responding to healthcare inequalities. This year's analysis represents the most comprehensive baseline the Trust has established to date and provides the foundation for a more targeted and evidenced response in 2026/27.

Countering Fraud, Bribery and Corruption

The Counter Fraud Functional Standard (CFFS) was introduced by the Cabinet Office to standardise how fraud is dealt with across government. Since April 2021 the NHS Counter Fraud Authority (NHSCFA) has been required to report to the Cabinet Office in relation to the NHS response to the Functional Standard.

All NHS funded services are required to comply with the Functional Standard. Within the Trust, progress against the requirements of the Functional Standard is overseen by the Trust's Chief Finance Officer and the Audit and Assurance Committee.

The Trust is required to self-assess against the requirements of the Functional Standard annually by completing and submitting the Trust's Counter Fraud Functional Standard Return (CFFSR).

The Trust has a nominated Local Counter Fraud Specialist (LCFS) in place provided by NHS consortium 360 Assurance. The LCFS is responsible for carrying out a range of activities in compliance with the above standards.

The Trust has a Counter Fraud Bribery and Corruption Policy to make sure staff are aware of their responsibilities should they suspect an offence has been committed. When economic crime is suspected, it is fully investigated in line with legislation and can result in criminal, disciplinary and civil sanctions.

Fraud, bribery, and corruption can result in resources being diverted away from their intended purpose. The Trust does not tolerate fraud and works with the LCFS to identify instances of fraud, impose the appropriate level of sanctions where fraud has been committed and reduce the possibility of fraud taking place.

If staff are concerned about fraud within the Trust, they can report direct to the LCFS or can contact the confidential NHS Fraud and Corruption Reporting Line.

The LCFS agrees with the Audit and Assurance Committee an annual plan to deliver this work, which is both proactive and reactive.

Proactive Work

- Review of the Trust's governance arrangements to ensure that anti-crime measures are embedded at all levels.
- Raising awareness of economic crime risks against the NHS, including fraud awareness sessions for staff and the completion of a counter fraud risk assessment.
- Proactive detection exercises based on identification and assessment of fraud risk.
- Reporting to the Trust the outcomes, system weaknesses and losses identified through proactive exercises and recording these on the NHSCFA's fraud case management system.

Reactive Work

- Detecting and investigating economic crime, applying sanctions and seeking redress.

Failure to Prevent Fraud Offence

In September 2025, new legislation was introduced stating that "an organisation is criminally liable if an employee, agent, subsidiary, or other "associated person" commits a specified fraud offence intending to benefit the organisation (or its client)".

The Trust is confident that it complies with the legalisation and is reviewing the requirements of the NHSCFA checklist to ensure that all requirements are in place or steps are taken to address any possible gaps. A link to the CEO's statement on the new legislation can be found on the Trust's [website](#).

Partnership Working

The Trust's key partnerships during the year were with its partners in the Foundation Group and the Integrated Care System.

The Trust engaged as a key partner in the production of the ICB Joint Forward Plan.

The core areas of the plan align with the Trust's strategic priorities which are reflected in our operational and financial plans.

The Trust delivered its capital programme in accordance with the ICS capital resource plans and agreed allocations.

Environmental Matters

As a healthcare provider, the Trust has a duty to protect the health of our natural environment for the benefit and for delivery of sustainable healthcare services in our area. As the largest healthcare services institution in our county, we play an important role beyond the boundaries of our estate for both the population we serve and the wellbeing of the staff we employ.

Our Green Plan sets out our strategies to achieve this and to meet the targets set by NHS England, including reducing emissions we have influence over to net zero by 2040 and for emissions we can influence to net zero by 2045. More information can be found within the Green Plan on our [website](#).

Task force on climate-related financial disclosures (TCFD)

The Department of Health and Social Care Group Accounting Manual (GAM) has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025-26 financial year.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

Where relevant, supporting information is included within this report and the Trust's Green Plan.

The following sections set out how the Trust is managing climate-related risks and opportunities through its governance arrangements, strategic planning, risk management processes and performance monitoring.

Governance Pillar

Board oversight of climate-related issues

One of the Foundation Group Big Moves is to 'lead the NHS on carbon reduction', which includes climate resilience and adaptation. Delivery of this ambition is incorporated in the Trust's organisational plans and measured as part of annual objectives.

A joint report from the four trusts of the Foundation Group on progress in delivering their respective Green Plans is presented annually at a meeting of the Foundation Group Boards. This provides an opportunity for benchmarking and learning.

An update on this report, including the climate adaptation plan was presented to the Trust Board part way through the year.

The Chief Clinical Strategy Officer is the Board-level Net Zero Lead who oversees the resourcing and delivery of the Green Plan, which includes Climate Change Adaptation.

A Green Steering Group (GSG) meets monthly to review progress against the Green Plan and associated performance measures. The group also supports the sharing of best practice and

encourages innovation and new ways of working, drawing on input from members, the Green Champions network and the Clinical Sustainability Group.

Compliance with the Green Plan, including climate change adaptation, is now included in the standard operating process for business cases utilising a sustainability impact assessment tool. Reports are provided to the Trust Management board (TMB) to give assurance that the Trust is on track.

The Green Plan was published in July 2025 in line with NHS England guidance and sets out the Trust's approach to delivering its net zero and sustainability objectives. The Plan is currently being refreshed for 2026/27, with divisional leadership teams expected to reflect the strategic priority to 'lead the NHS on carbon reduction' within their annual plans. Delivery is monitored through the Green Steering Group.

The Trust is an active member of the Worcestershire Public Sector Sustainability Group, working alongside local partners to take coordinated action on sustainability across the county. Through this group, the Trust contributes data, clinical insight and estate expertise to support the development and delivery of sustainability plans, including the local climate change adaptation plan. This work focuses on understanding the likely impact of climate change across the region and identifying practical steps to reduce and manage those effects. Recent work has included action to improve local air quality and a strategic assessment of opportunities to expand heat networks across the area.

Strategy Pillar

Climate-related risks and opportunities

The Trust has identified a range of climate-related risks and opportunities across the short, medium and long term, aligned to organisational planning cycles and delivery of the Green Plan.

In the short term, risks include the impact of extreme weather on service delivery and estates infrastructure, such as overheating of buildings, flooding and disruption to clinical services. There are also operational risks linked to supply chain resilience, including availability of clinical equipment and medicines.

In the medium to long term, risks relate to the scale of change required to meet NHS net zero targets, including the need for investment in estates, infrastructure and service redesign. There is also a risk of increased financial and operational pressure if action is delayed.

Alongside these risks, there are opportunities to improve efficiency and sustainability across the organisation. These include reducing emissions through more efficient use of energy and resources, delivering more sustainable models of care, and improving population health outcomes through reduced environmental impact.

Impact on the organisation

These risks and opportunities have an impact across how the Trust operates, plans and uses its resources.

From an operational perspective, extreme weather and climate-related events can affect the resilience of our estate and the continuity of services. These risks are considered as part of our business continuity and emergency preparedness arrangements.

From a strategic point of view, delivery of the Green Plan and progress towards NHS net zero targets are built into our organisational objectives and planning. This includes embedding sustainability into service transformation, procurement, estates planning and clinical pathways.

There are also financial considerations. Investment is needed to support decarbonisation and adaptation, but there are opportunities to reduce costs over time through more efficient use of resources and reduced waste.

Overall, the Trust is managing these risks and opportunities through its existing governance, risk management and programme structures, ensuring climate considerations are part of wider decision making rather than a separate activity.

Risk Management Pillar

Processes for identifying and assessing climate-related risks

The Trust's established risk management framework is used to assess climate-related risks. Assessment of climate-related risks is described in the Trust's climate adaptation policy and plan (approved in 2024). A Climate Adaption Working Group reviews these risks as part of business resilience under the Emergency Prevention, Preparedness and Response (EPPR) committee.

Risks include funding to achieve our objectives and the management of climate-related issues such as overheating of buildings and disruption caused by flooding or problems with supply of clinical equipment and medication.

The Trust is continuing to develop and refine a standard set of performance metrics and measures to support delivery of the Green Plan, with progress monitored through established reporting arrangements.

Processes for managing climate-related risks

Climate-related risks are included within the Trust risk register, which is overseen by the Executive Risk Management Committee as well as the Climate Adaptation Working Group to ensure appropriate mitigations, controls and plans are in place.

These risks are used to inform planning and prioritisation of actions within the Green Plan and wider organisational decision making.

Metrics and target pillar

Carbon Footprint

The NHS has set two main targets for achieving net zero emissions:

- Net zero by 2040 for emissions directly controlled by the NHS.
- Net zero by 2045 for emissions influenced by the NHS, with an ambition for an interim 80% reduction by 2036-2039.

These targets are part of the NHS's commitment to addressing climate change and improving health outcomes.

Taking 2020/21 as the Trust baseline, total emissions needed to be reduced by 25% by 2024/25. The total carbon emissions for 2024-25 amounted to 14,397 tonnes, representing a 4.6% reduction compared to the 2021-22 baseline year. This reduction demonstrates that progress is being made but

is behind expectations to comply with NHSE targets for achieving Net Zero emissions. Year on year progress is detailed within the table below.

	2021/22 tCO ₂ e	2022/23 tCO ₂ e	2023/24 tCO ₂ e	2024/25 tCO ₂ e
Total Emissions	15,098	14,826	15,211	14,397
Scope 1	5,284	6,937	7,747	8,195
Scope 2	7,917	5,883	6,718	5,350
Scope 3	1,897	2,007	746	852

WAHT total GHGe emissions have shown a gradual decrease over the four-year period, dropping from 15,098 tCO₂e in 2021/22 to 14,397 tCO₂e in 2024/25. However, the trend across scopes varies:

- Scope 1 (Direct emissions): Increased significantly from 5,284 tCO₂e in 2021/22 to 8,195 tCO₂e in 2024/25. This rise suggests higher on-site fuel use or other direct sources.
- Scope 2 (Purchased electricity and steam): Decreased sharply from 7,917 tCO₂e in 2021/22 to 5,350 tCO₂e in 2024/25, partly due to grid decarbonisation or improved energy efficiency. In 2024/25 the incinerators were non-operational for the heating season and nil consumption return aligns.
- Scope 3 (Indirect emissions): Fluctuated, peaking at 2,140 tCO₂e in 2022/23 before reducing to 852 tCO₂e in 2024/25.

2024/25 Energy consumption 65,779,630 kWh, and Energy spend £7,729,925.

The table below depicts the trajectory so far of the emissions the Trust has direct control of. The Trust’s GHG emissions footprint has been calculated according to the GHG Protocol for Corporate Reporting and aligned to ISO 14064:1.

The Trust monitors progress against its sustainability objectives using a range of metrics aligned to the Green Plan and national reporting requirements. Progress against targets is monitored through regular reporting and reviewed through the Trust’s governance structures.

Trust GHG emissions trajectory by emission source.

Grouped Emission Source and metric	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
	Total Emissions (tCO ₂ e)	Total Emissions (tCO ₂ e)	Total Emissions (tCO ₂ e)	Total Emissions (tCO ₂ e)	Total Emissions (tCO ₂ e)	Total Emissions (tCO ₂ e)
Building Energy (Scope 1 and 2 Emissions)	22,840	16,085	16,158	14,562	14,973	15,189
Water Consumption & Treatment (Scope 3 Emissions)	222	260	69	84	74	56
Waste Arisings (Scope 3 Emissions)	1,445	1,120	1,259	1,126	694	580
Business Travel inc commuting (Scope 1 and Scope 3 Emissions)	NA	NA	NA	NA	NA	NA

Anaesthetic Gases & Inhalers (Scope 1 Emissions)	1,974	1,563	1,680	1,501	1,372	900
Patient & Visitor Travel (Scope 3 Emissions)	Not available					
Carbon Footprint Plus	26,481	19,028	19,166	17,273	17,113	16,725

Source: NHS Greener Dashboard

The carbon report is incomplete, missing data for key Scope 3 elements such as procurement and staff/patient commuting, which are potentially major sources of emissions.

The Trust is currently focusing on the following Carbon reduction schemes:

- We are finalising the replacement of our old steam boilers with newly refurbished boilers, expecting this to provided significant savings at the Alexandra site.
- We are currently replacing all lighting at the Worcestershire Royal site with LED. Similar projects exist at the Alexandra site, and piecemeal replacement at KTC.
- A green initiative to optimise theatre ventilation systems for optimum start has been approved by the capital priority decisions group (CPDG), this will commence imminently with a view to driving our £100k per annum in energy savings across the Trust.

Waste

The current recycling rate across Trust-owned sites is 25%.

NHS England has set a 20:20:60 target for clinical waste to be segregated with the aim of 20% going for high-temperature incineration, 20% alternative treatment and 60% offensive waste by 2026. In 2024/25 we improved our split on clinical waste.

Our waste strategy is site specific. The Alexandra site no longer acquires steam provided from incineration from clinical waste, as the incinerator is currently offline with little likelihood of returning to a functioning state.

	KTC	AGH	WRH	Other	Total
Waste Costs (£)	63,872	187,452	862,938	130,706	1,244,968
Water Volume (m3)	23,068	60,967	100,861	3,423	188,319

Waste stream	Waste recycled	ICT waste recycled / reused / recovery (externally)	Waste composted / food waste	Waste incinerated with energy recovery	Waste incinerated without energy recovery	Waste to landfill
Basis tonnage	316	0	46	0	1682	3
Allocated expenditure (£)	191,254.20	0	27,840.80	0	1,024,057.30	1,815.70

Medicines and Anaesthetic Gases

The Trust was one of the first nationally to eliminate desflurane, one of the most harmful anaesthetic gases. It has now completed a programme of decommissioning nitrous oxide manifolds at all three clinical sites, substantially reducing its clinical carbon footprint. It is estimated that up to 99% of nitrous oxide supplied via manifolds is lost to the atmosphere, representing both inefficiency and a significant carbon impact; medical nitrous oxide is estimated to contribute up to 1% of global greenhouse gas emissions. The Trust's experience informed an international consensus statement published in 2024, which recommends removal of nitrous oxide manifolds across the UK and Ireland by the end of the 2026/27 financial year.

The Trust was also one of the first in the country to remove the mandatory use of a sterile gown for single-shot spinal anaesthesia, following approval from Infection Prevention and Control (IPC) colleagues. This work has been used as the basis for international consensus guidance on the use of sterile gowns in single-shot spinal anaesthesia, endorsed by major anaesthetic bodies in the UK, Ireland, Australia and New Zealand, and published in April 2026.

The Trust's Clinical Green Lead, Dr Paul Southall, coordinated and led both international initiatives.

The next stages of clinical work will focus on implementing reusable medical items, in line with recommendations from the Department of Health and Social Care (DHSC) Design for Life programme when it reports in mid/late 2026. Work is also underway to develop a plan to switch theatre ventilation systems off out of hours, reducing energy use, cost and associated carbon dioxide emissions. In addition, through its clinical lead, the Trust is participating in the Greener Surgical Pathways programme led by Get It Right First Time (GIRFT), which aims to improve the carbon efficiency of selected surgical pathways; relevant elements will be implemented as they are released.

Signed:



Chief Executive

Date: 6 August 2026