Walsall Healthcare NHS
NHS Trust

Walsall Healthcare NHS Trust Annual Report and Accounts **2017/18**

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Becoming your partners for first class integrated care

Safe, high quality care | Care at home | Partners | Value colleagues

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Welcome to Walsall Healthcare NHS Trust's Annual Report and Accounts

Our Annual Report provides an ideal opportunity for all of us to take stock of another busy, challenging and rewarding year in the life of Walsall Healthcare NHS Trust.

It has been a year that saw the NHS once again dominating news headlines with reports of the significant impact that winter pressures were having on hospitals and the wider healthcare economy across the country. NHS England took the unprecedented step of allowing hospitals to cancel tens of thousands of planned operations in order to free up beds, given the extra demand for treatment.

In Walsall our staff were under extreme pressure to deliver the safe, high quality care that our patients expect and deserve. We thank those who work in the Manor Hospital and our community services for everything they did during this difficult period.

More recently, the hospital had to deal with an outbreak of norovirus which resulted in large numbers of ward areas being closed. We took the decision to close the hospital to visitors for a period leading up to and during the Easter Bank Holiday and we thank our patients, their families and carers for bearing with us while we took the necessary actions to stop the infection spreading even further.

The hard work of our teams across the Trust to improve services for patients was recognised in the latest inspection report released by the Care Quality Commission (CQC), which showed progress in each service area. The CQC rated the Trust as "Requires Improvement" overall, with a rating of "Good" for the caring domain and a rating of "Outstanding" for our community services. Maternity services remained inadequate though the CQC recognised improvement in the service since 2015.

Further details on the report's findings can be found on page 7 of this Annual Report but it should be noted that the progress the Trust has made since its 2015 inspection, which saw it placed into Special Measures, has been excellent. We need to keep up this momentum and set ourselves four priorities:

1 Improving patient care – by focusing on maternity services and the CQC's recommendations to ensure we can exit Special Measures in 2018.

2 Improving our emergency care pathway – to reduce the risk when we are at our busiest and provide care that keeps people well at home for longer.

3 Delivering our financial recovery plan –improving our finances by around £600,000 a month to deliver our 2017/18 deficit and improve further next year.

4 Accelerating culture change – by using Listening into Action as part of a suite of quality improvement methods which we will deploy through our new Quality Academy. Our revised engagement approach will also include clinical leaders taking an equal seat at our Trust Management Board for critical decision-making.

For the coming year we have set ourselves four priorities:

- **Quality improvement** – Continue our improvement journey on patient safety culture and clinical quality through a comprehensive improvement programme which focuses on outcomes
- **Culture development and clinical leadership** – Continue to develop the culture of the organisation to ensure mature decision making and clinical leadership, underpinned by open and transparent deployment of our new Trust values and behaviours
- **Financial improvement** – Deliver the next stage of our journey of financial improvement, driven by improvements to services' progress and productivity through our improvement programme
- **Clinical strategy through collaboration** – Develop and deliver our clinical services strategy through the implementation of integrated local care (Walsall Together) and increased hospital collaboration to ensure service resilience and sustainability

Delivery against these priorities will help us to realise our vision for 2020 of "Becoming your partners for first class integrated care".

Two examples of this new approach to clinical strategy are evidenced within pathology and stroke services in Walsall.

A single Black Country Pathology Service, with a hub at New Cross Hospital in Wolverhampton and essential services laboratories at each of the acute hospitals in the Black Country, is being created. Suspected stroke patients in Walsall will now be taken to the specialist unit at New Cross Hospital, rather than treated in the borough. More details of these important changes to ensure sustainability can be found on page 10 of this Annual Report.

This year the Trust bid farewell to Chief Executive Richard Kirby and welcomed new Chief Executive Richard Beeken.

There is a strategic need to work collaboratively across the whole population if we want to effectively address the future health and care needs of our residents and the work that has been undertaken through Walsall Together set the wheels in motion for doing things differently. The year ahead will see us step this activity up a gear with the continued support and feedback from our colleagues, patients and stakeholders.

SECTION 1: PERFORMANCE REPORT

OVERVIEW

This overview is a short summary that provides readers with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Chief Executive's Statement on Performance

Walsall Healthcare NHS Trust is now two years into its five year ambition to deliver its vision of "Becoming your partners for first class integrated care".

This vision is underpinned by five objectives.

1. ***Provide Safe, High Quality Care.*** We will provide care that we would want for our family and friends.
2. ***Care for Patients at Home.*** We will keep people well at home, provide alternatives to acute care and return people home safely and quickly after admission.
3. ***Work Closely with Partners.*** We cannot do this alone and will work with our partners in Walsall and the Black Country.
4. ***Value Colleagues.*** We will be a clinically-led, engaged and empowered organisation.
5. ***Use Resources Well.*** We will ensure future sustainability by living within our means.

We have continued to achieve all cancer standards and diagnostic waits against an increasing demand.

After a particularly difficult winter involving flu and norovirus our four-hour waits were challenging. We remain heavily focused on improving our overall ED (Emergency Department) performance and patient experience within urgent care. Working with Walsall Council's Social Care we have developed the Intermediate Care Model – more details of which can be found on page 11.

We are already working with clinicians to prepare for next winter.

We acknowledge that the ED environment is not fit for purpose and have submitted our business case to ensure we can get the residents of Walsall and staff who work there a better and far more appropriate environment to meet demand.

The Trust is also working to co-ordinate with mental health services and social care to ensure that patients who have long term conditions are supported at home, where they want to be, so that they can avoid admission to hospital wherever possible. This agenda is central to the Walsall Together developments we are driving forward in 2018/19.

We are also looking at how we can work with patients' families and carers to improve our management of patients whilst they are in hospital: encouraging them to get up and dressed, mobilise and increase their chances of independent recovery. As a result, the patient's stay will be reduced and beds will be freed up. All of this is being managed through an urgent care improvement plan being led by our Chief Operating Officer.

Our demand and capacity planning manager is working with clinical services to develop their planning capabilities. This is an ongoing process as we build on and develop the demand and capacity capability of the organisation, which will include capacity requirements to improve quality, meet national standards and to reduce dependence on locum and agency staff.

We've also had a real drive to maximise the potential of our Discharge Lounge to ensure early discharges from all wards and free up our Emergency Department. We are getting a daily average of around 25 patients through its doors and will continue to ensure all teams are making the most of this important facility.

Richard Beeken, Chief Executive

Purpose and Activities of Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust is an integrated Trust. The Manor Hospital provides a full range of district general hospital services and community health services for adults and children which are run from more than 60 settings across the borough, including health centres and GP surgeries, while community services also provide support in people's own homes.

Walsall borough is made up of a diverse multi-cultural population of more than 270,000 and suffers from a number of health inequalities.

The 2017 Health Profile published by Public Health England shows that Walsall is one of the 20% most deprived districts/unitary authorities in England and about 30% (17,000) of children live in low income families.

Life expectancy for both men and women is lower than the England average. In Year 6, 25.5% (833) of children are classified as obese, worse than the average for England. Levels of teenage pregnancy, GCSE attainment and breastfeeding initiation are worse than the England average.

In adults, the rate of alcohol-related harm hospital stays and the rate of smoking-related deaths is worse than the average for England. Estimated levels of adult excess weight and physical activity are worse than the England average.

In more affluent areas of the borough there is a longer life expectancy and a growth in dependency from frail elderly patients.

We have integrated health and social care with the development of seven Integrated Locality Teams. The teams are co-located Community, Social Care staff and Mental Health staff who provide a 'wrap-around' service to GP Practices. This approach is expected to deliver reduced attendances in ED, reduced re-admission of patients and reduced length of stay which will have an overall positive impact on occupied bed days.

There has been earmarked an overall investment of £50m in healthcare services across the hospital's estate which includes two new, state-of-the-art MRI scanners, the creation of a new Integrated Critical Care Unit and a new Obstetric Theatre and expansion of the Neonatal Unit. The Emergency Department is also being redeveloped.

The Trust has also invested £800,000 in mobile technology for staff working within its community teams, a development which has been universally applauded by those teams.

Walsall Healthcare is an active partner in the Black Country Sustainability and Transformation Partnership which brings together more than 10 healthcare providers, Local Authorities and four CCGs. The STP's vision is to transform health and care in the Black Country and West Birmingham through the development of place-based care, acute hospital collaboration and tackling the wider determinants of health.

Milestones over the last 12 months

CQC Inspection

The Care Quality Commission's inspection in June 2017 was an important milestone for Walsall Healthcare NHS Trust. Inspectors published their report in December 2017 and it showed that we had made progress in each service area.

The CQC rated the Trust as "Requires Improvement" overall, with a rating of "Good" for the caring domain and a rating of "Outstanding" for its community services. There are only a handful of community services in the country with this rating.

The inspectors told us that the Trust they inspected in 2017 was "a very different Trust" to the one they visited back in 2015 confirming that the improvements we have made are starting to show significant results. The CQC also described our staff as "kind caring and compassionate."

Seventy per cent of the ratings in the report were "good" or "outstanding". The report also emphasised several areas of "outstanding practice" in Urgent and Emergency Services, End of Life Care and Outpatients and Diagnostic Imaging and repeatedly referenced the "kind, compassionate and respectful" care shown to patients.

June 2017 CQC Inspection - Final Rating

SERVICE	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL-LED	OVERALL
Urgent and Emergency Care Services	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Medical Care	Requires Improvement	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Critical care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Maternity & Gynaecology	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Children & Young People	Good	Good	Good	Good	Good	Good
End of Life Care	Good	Requires Improvement	Good	Good	Good	Good
Outpatients & Diagnostic Imaging	Good	Inspected Not Rated	Good	Requires Improvement	Good	Good
Hospital - Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community - Adults	Good	Good	Good	Good	Outstanding	Good
Community - Children, Young People & Families	Requires Improvement	Good	Good	Good	Good	Good
Community - End of Life Care	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Community - Overall	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Trust - Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

A number of examples of significant improvement since the 2015 inspection included:

- Increased staff numbers and dedicated separate paediatric and waiting areas in ED
- The culture in the Outpatients Department has changed considerably for the better with local staff taking responsibility and ownership for their own areas and specialities
- Evidence seen of good multidisciplinary team working where staff worked together to safely discharge patients or plan their future care
- Trust's Frail Elderly Service has helped prevent many unnecessary hospital admissions
- Most staff reported their managers were "visible, supportive and approachable"

Maternity services remain inadequate though the CQC has recognised improvement in the service since 2015.

We know that we still have challenges to address in maternity services where the pace of change was not initially as swift as in other areas of the Trust. The establishment of the new leadership team took longer than anticipated, but there is now consistent delivery against the key indicators of quality care that we want to continue to embed.

The CQC report stated that management is "visible and approachable" in maternity, and we are moving in the right direction and creating a culture where staff are encouraged and supported to raise concerns and make suggestions.

Since the inspection the Trust has recruited new midwives and has also appointed four specialist midwives including a specialist bereavement midwife. The Trust has also worked hard to reduce its midwife to birth ratio from 1:35 in 2015 to around 1:23 currently.

Maternity admissions were limited to 4,200 and this is reviewed regularly with our local partners. The Midwifery-Led Unit was temporarily closed in July 2017 with the activity and staffing relocated to the Delivery Suite within the Manor Hospital.

We must continue to build on the foundations we've laid and to work with partners across the health and social care system to collectively deliver services that meet the needs of the communities we serve. We will be working with our clinical teams to take the action needed to ensure that all of our teams are able to achieve "good" or "outstanding" ratings in the future.

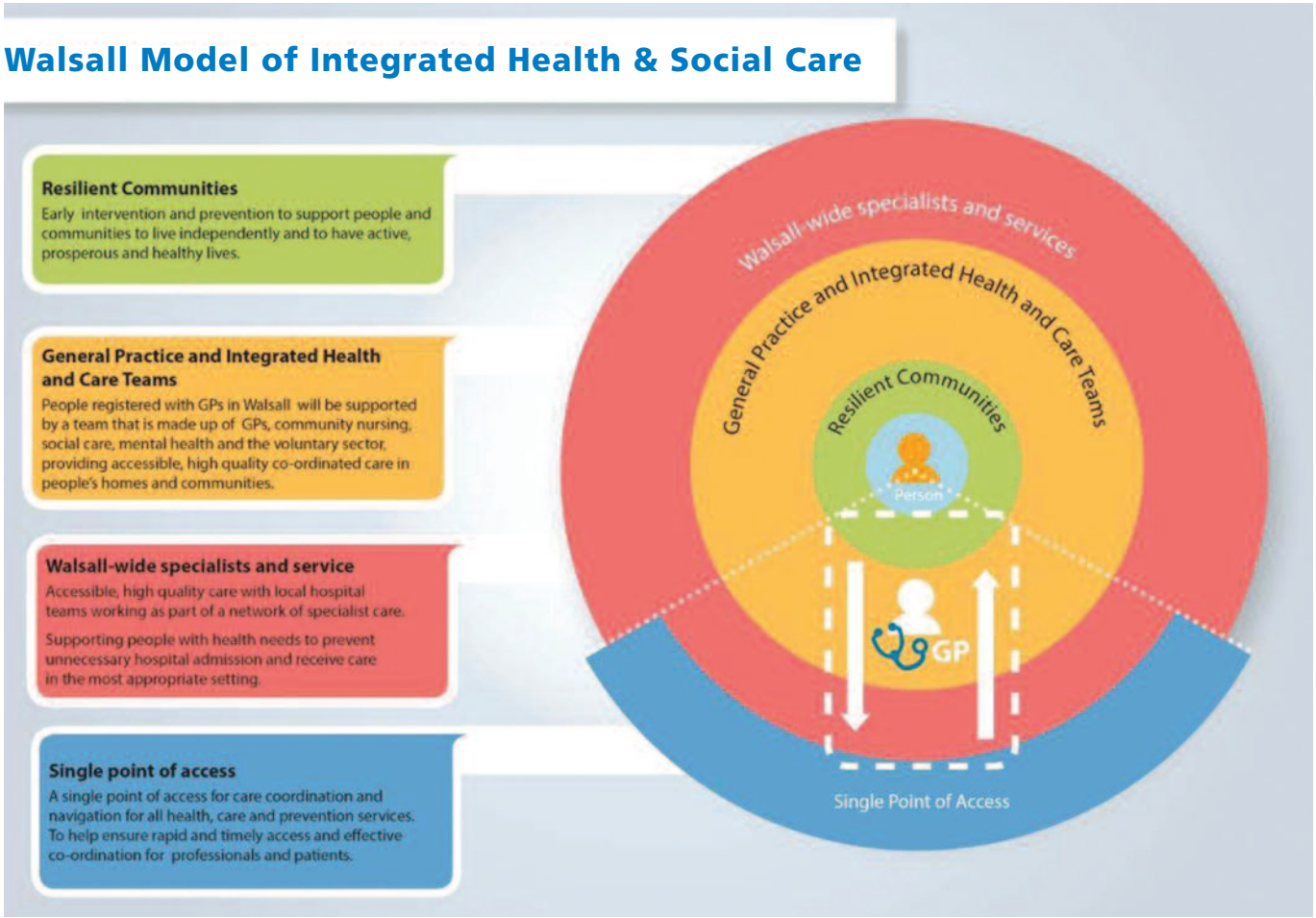
The CQC is due to re-inspect our services in the summer of 2018.

The Trust developed a Patient Care Improvement Plan (PCIP) to tackle the issues identified by the CQC. Executive leadership for quality governance is provided by the Director of Nursing and the Medical Director.

Actions in the PCIP range from safe staffing levels to timely Mental Capacity Act assessments, improved assessment of patients at risk of Venous Thromboembolism (VTE), improvement of fracture clinic environment and reinforcement of professional boundaries between staff and patients.

The majority of these actions are not dependant on finance or additional resources but by us working together to do things differently, complying with best practice and coming up with solutions that we know will make the most impact.

Creating a more integrated health and social care system



The Executive Team has been working closely with partners across the health and care economy to further develop plans for creating a more integrated health and social care system in Walsall. There is a strategic need to work collaboratively across the whole population if we want to effectively address the future health and care needs of residents.

In Walsall, this is set against the challenges of health inequality, a rising elderly population, deprivation driven disease and cultural differences at the same time as our desire to improve pathways of care for our patients.

We know we can't continue to work in the same way as we have been because it simply isn't sustainable. Meanwhile our patients, their families and carers repeatedly tell us that their biggest frustrations are often not being able to access the appropriate support and services they need as and when they need them, in particular avoiding potentially unnecessary acute hospital admission.

The Walsall Together Case for Change has been produced by the Walsall Together Board as an outline of change - together with a proposal of next steps for the next 12 months to establish a Host Provider Contract with Commissioners by April 2019. The Board has endorsed its statement of intent and work will continue in terms of governance and practical delivery.

Sustainability Reviews

As part of its annual planning process, the Trust has been carrying out a full sustainability review of all of the acute hospital services it provides to gain a strategic understanding of the strengths and weaknesses of its service models.

Following a high level review of each service, co-ordinated through its clinical leadership teams, the Trust is prioritising the required interventions to ensure future sustainability. The process is designed to provide greater insight into the requirements of both its patients and the population of Walsall to help the Trust achieve and sustain high quality services for the future.

The review considers each of the seven domains shown below:

Intermediate Care Model

Walsall's health and social care economy relies too heavily on a bed-based model of post-acute care when national and local evidence shows that a significant proportion of this care could be provided in a home setting with the appropriate clinical or support services.

The Trust consistently fails to meet the 95% waiting target set for patients in ED and patient flow is impacted by a significant proportion of patients who are medically fit for discharge being unable to leave hospital. They may be waiting for something from external partners which adversely affects flow through the hospital and availability of beds for those in ED or the Acute Medical Unit who need admission.

Prolonged hospital stays mean poorer outcomes for patients who can suffer muscles wastage, loss of mobility and a decline in the skills that they need to maintain their independence.

Intermediate Care Services in Walsall have tended to work in isolation, making pathways complex to navigate, delays in handover, and potential duplication of effort.

The Intermediate Care Model, introduced in 2017, is a community-based health and social care single service with responsibility for complex patients who require support to enable them to leave an in-patient hospital bed.

It provides a rapid response to care delivery in the right place at the right time to maximise a patient's independence. This response is appropriate and proportionate to the patient's assessed needs with the focus being concentrated on the patient being able to return home.

The service operates seven days per week.

£50m investment in our estate

Work is well underway to house two new state-of-the-art MRI scanners at Walsall Manor Hospital as part of the Trust's overall £50 million investment in healthcare services. This investment will also see the creation of our new Integrated Critical Care Unit, a new Obstetric Theatre and expansion of the Neonatal Unit and the redevelopment of the Emergency Department.

In partnership with the InHealth Group which provides the service, the Trust has entered into a 15 year contract which will see the replacement of the current old scanner and installation of a second. This will enable the Trust to make better use of its financial resources.

By doubling our provision we can reduce the length of time patients wait for a scan and increase the number of patients we see which will have a huge impact on their health and wellbeing. Not only will they receive speedier diagnoses but also more timely assessments on how effective previous treatment has been.

A temporary MRI unit was put into place in January 2017 while this vital, six month project progresses.

Work is progressing well on the 18 bedded Integrated Critical Care Unit which is on schedule for Winter 2018 completion.

Creation of Black Country Pathology Service

All four Trust Boards in the Black Country supported the creation of a single Black Country Pathology Service with a hub at Royal Wolverhampton and essential services laboratories at each of the acute hospitals. This will result in one of the largest pathology services in the country and is only the second such collaboration to go live. Detailed work is continuing on all elements of this development including staffing arrangements, how the services work together, the buildings and IT requirements with the date of change being in 2019.

The new service aims to make sure that we maintain and continue to develop high quality pathology services in the Black Country.

Stroke Services centralised

Suspected stroke patients in Walsall are now be treated at New Cross Hospital's specialist unit

Following extensive consultation with patients, their families and clinicians, a decision was made by NHS Walsall Clinical Commissioning Group's (CCG) Governing Body to transfer the Hyper Acute Stroke Unit (HASU) from Walsall Manor Hospital to Royal Wolverhampton NHS Trust (New Cross Hospital) for acute stroke care.

Rehabilitation and community services will continue to be provided in Walsall.

Currently Walsall Manor Hospital cares for 360-400 patients per year, which is rated good overall but the number of stroke cases is insufficient to meet the nationally recognised standards for acute stroke care. To be a viable HASU it is recommended there is a minimum of 600 confirmed stroke patients per year.

All changes in stroke services are subject to NHS England's assurance process. The move is also a result of a six week public consultation that took place last year to hear the views of Walsall residents.

Successful diabetes funding bids

Walsall has the third highest rate of diabetes in the country with 8.8% of its population affected compared to the national average of 6%. And this is expected to rise to 10.9% by 2030 making the need for effective care and support a priority.

Walsall Healthcare secured funding through NHS England's Diabetes Transformation Fund. The Trust worked with colleagues in podiatry, Public Health Walsall, Walsall Clinical Commissioning Group, Diabetes UK and a Consultant from Dudley Group NHS Foundation Trust to develop the successful bid.

Two funding bids made to improve the treatment and care of Walsall patients with diabetes were successful resulting in a £1.2m boost over the next two years.

The Trust will now be able to double its diabetes nurse specialists from two to four and speed up the process for patients who need to be seen by the Multi-Disciplinary Foot Team. This enhanced service will aim to improve patients' experience as well as reduce their length of stay in hospital.

A new Foot Protection Team was launched in November 2017 for Walsall people living with diabetes or at risk from developing the condition in a bid to reduce hospital admissions and amputations. The team, which has been developed following feedback from patients, comprises of specialists who work together across both the community and Walsall Manor Hospital to better meet the needs of people with diabetes across the borough.

Mobile technology for our community teams

Hundreds of our community nurses are now using mobile technology thanks to an £800,000 investment.

All seven of the Trust's locality teams are live with 160 clinicians using tablets to access and input clinical information. The administrative support staff, Clinical Leads and Service Management for each team are using the desktop version of the new Totalmobile system.

The rest of the teams within Phase 1 Community Services will be live by the end of May 2018.

The new Totalmobile system is a switch from a paper-based patient assessments and means that community staff can give patients the results of their blood tests for example, reducing any delay in starting treatment. They can also access details of new patients more quickly and the devices offer greater security for lone workers.

The new system incorporates the capture of referral and contact information, aids the scheduling of appointments and allows visit information to be inputted on to the system .The mobile application works in both online and offline mode, allowing staff to carry on working out in the field, even if there is no Wi-Fi or 4G signal. Staff have all the clinical information that they require at the point of care and a Sepsis alert has also been introduced aiding communication between the community and acute services.

Engaging and empowering our staff

Listening into Action

Staff told CQC inspectors that they had seen many positive improvements since the implementation of the Trust's Listening into Action (LiA) approach which puts staff in the driving seat and empowers them to make sustainable changes. And the third LiA Pulse Check Survey which took place during July 2017 shows a clear improvement in Pulse Check scores since May 2016, with an average 13.9% point increase across the 15 questions, within 14 months.

This includes: 16% up on managers and leaders seeking our views, 15% up on how valued staff feel, 17% up on staff recommending the Trust to family and friends, 15% up on effective communication, and 15% up on being able to prioritise patient care over other work.

In the July 2017 Pulse Check, 7 out of 15 questions scored under 50% positive responses highlighting the opportunities for improvement. The seven areas were:

Q4 Day-to-day frustrations (33%)
Q5 Communicating priorities and goals (44%)
Q8 Recommend Trust to family and friends (49%)
Q10 Communications between senior management and staff (38%)
Q13 Structures and processes support staff (40%)
Q14 Systems and facilities support staff (39%)
Q15 Organisation supports me to grow (43%).

Listening into Action will no longer work in isolation but will come together with the Trust's newly established Quality Improvement Academy; the importance of a multidisciplinary approach to quality improvement is key with staff-led, on the ground ownership of change ideas.

A Staff Engagement Lead has also been working with the Trust and during summer 2017 carried out 19 focus groups with staff across all levels of the organisation, with some work specifically within Maternity. The conversations and feedback provided helped get a real sense of how it feels to work within the organisation.

The Executive Team has agreed that the following five areas will be focused on as a priority

- Recognition
- Values
- Change and improvements at work
- Bullying, harassment and behaviour
- Appraisal

The Staff Engagement Lead has also been working to refresh the Trust's values so that they represent the true values of staff and what it means to work for Walsall Healthcare NHS Trust. These values, and a subsequent behaviours framework, will be launched at our Trust Leadership Conference in June 2018.

Staff Survey

The 2017 national staff survey results for Walsall Healthcare showed that colleagues are not as satisfied with their experience at work and feeling engaged in the organisation's objectives, as many other Trusts.

Whilst the results have not deteriorated from 2016 they have only marginally improved despite the work we have been doing to:

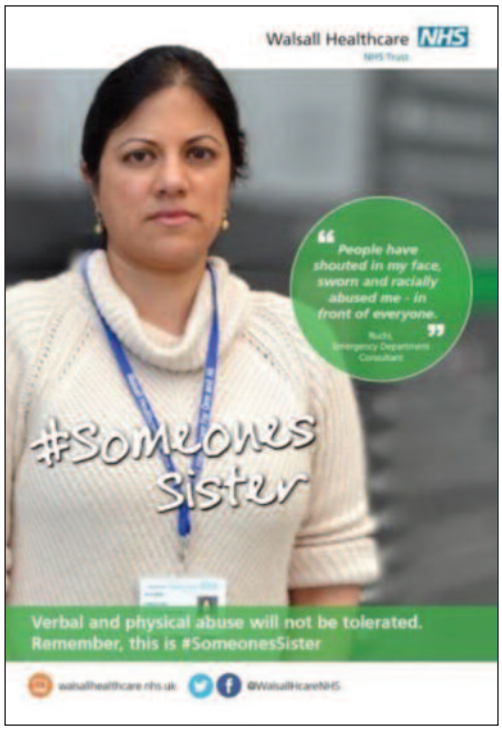
- Resource clinical staffing better wherever we can, particularly on our inpatient wards
- Enable local service improvement and engagement through a high energy programme (Listening into Action)
- Improve the fundamentals of quality and patient safety at the Trust through our Patient Care Improvement Plan

There are clear signs that staff feel they are listened to compared with last year and have more of a say than previously. But there are also clear signs of the pressure staff are feeling, with more people feeling work-related stress and also feeling less well paid than previously.

These results must motivate the Trust to continue trying to improve the culture of the organisation while accepting that change will take time.

Staff also stated they were less likely to report physical violence if they experienced it. In spring 2017 we launched a new anti-violence and aggression campaign featuring the hashtag #someonesdaughter or #someonesson in a bid to get people to stop and think how they'd feel if their loved one was subjected to such abuse while trying to do their job.

The Trust will continue to support its staff to report these incidents and ensure the perpetrators are dealt with appropriately.

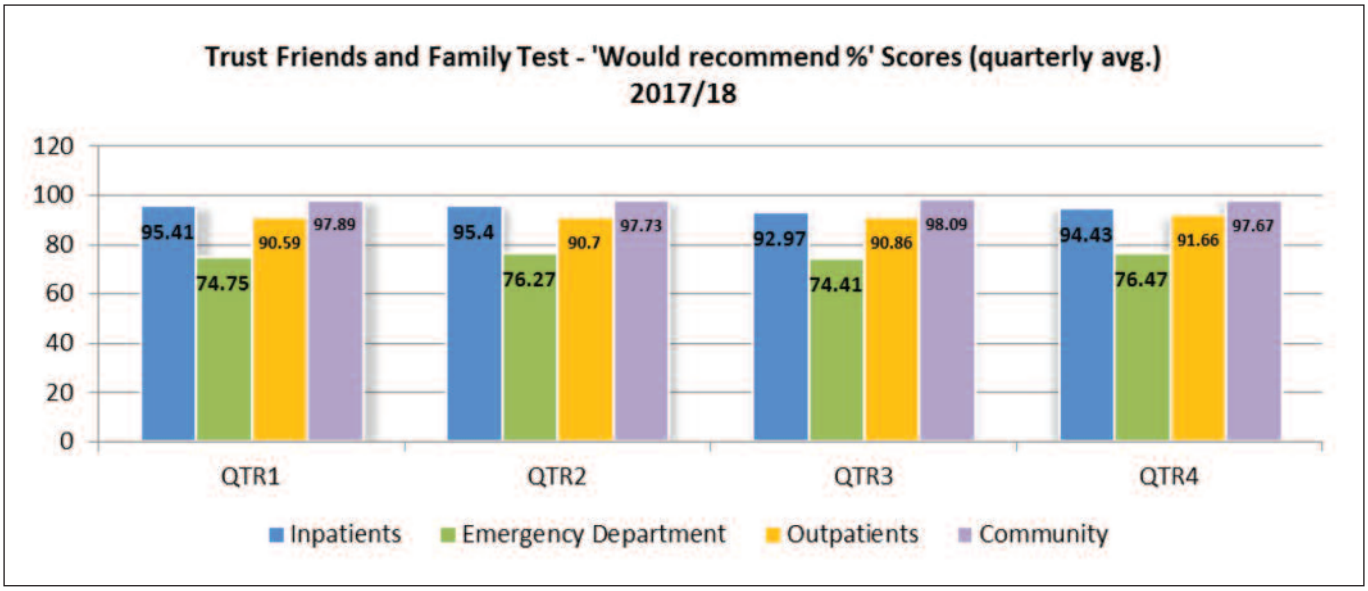


Improving our patients' experience

Over the last year we have continued to implement our patient experience strategy that puts the patient voice at the heart of our services and ensures that the Trust has a co-ordinated approach of 'listening to' and 'learning from' patient feedback.

We saw patients reporting a better experience in our hospital through the Friends and Family Test (FFT), national and local surveys. More than 52,000 patients responded to our feedback surveys and 91% said they would recommend our services.

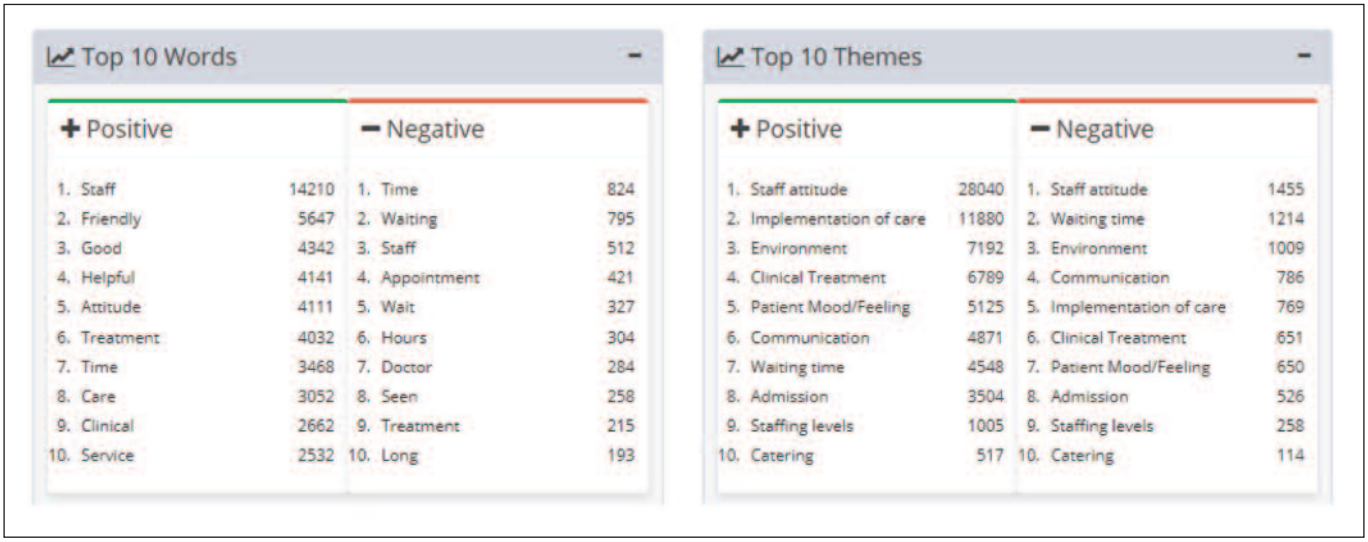
The chart below shows FFT results for positive recommendation scores (%) for the FFT for inpatients, A&E, outpatients and community services in 2017-2018



Key improvements included the introduction of the Quiet Protocol to help patients sleep well at night, establishing a patients' reading panel, piloting the Always Event® improvement programme and the 'Observe and Act' tool for a better feel of the total experience journey. We continued with our 'You & I' programme for staff engagement inpatient experience, and the Trust's 'Listening into Action' along with the 'Maternity Whose Shoes' approach has further embedded co-production and collaboration with patients, carers and staff members.

Key areas highlighted for improvements in our national surveys included communication, patient involvement in decisions about care and treatment, arrangements around discharge and waiting times.

The Friends and Family Test showed the following themes from patient feedback:



The Trust is also extremely grateful to its 308 volunteers who support staff and patients across the hospital, Palliative Care Centre, Chaplaincy and Self Care Management.

Celebrating our staff

Staff in the hospital and community have been putting Walsall on the national map by scooping a host of prestigious awards over the last year.

These include:

Our Clinical Cancer Research Team being judged "Team of the Year" in the National Institute of Health Research Clinical Research Network Division 1 - Cancer AGM.

The team works tirelessly to encourage patient involvement in trials and to support colleagues in their own studies.

Professional lead for the School Nursing Service Sallyann Sutton gaining the Elizabeth Garrett Anderson (EGA) NHS Leadership Award through a programme that works to develop robust, senior healthcare leadership; training the next generation of leaders in healthcare.

An app designed to help young patients and carers have a great experience while in hospital winning the *Patient Experience Network (PEN)* 'Innovative Use of Technology/Social Media' award.

The Walsall Children's Healthcare app was prompted by Dr Hesham Abdalla's experience of shadowing a patient on the hospital's Paediatric Assessment Unit.

Managers and staff from nursing homes throughout Walsall have also been recognised for the improvements they have made in quality, safety and culture over the last year.

Awards were presented for Most Improved Care Home, Most Innovative Improvement (Environment and Clinical Care), Most Improved Safety Culture and Care Home Manager of the Year as part of The SPACE – Safer Provision and Caring Excellence – initiative which is being pioneered by the Walsall Quality Improvement Project. This is a partnership between Walsall Healthcare NHS Trust and NHS Walsall Clinical Commissioning Group.

A busy charity year

With a boxing match, fashion show, fun run, Trust's Got Talent, Make A Will Fortnight and bag pack among just some of the events over the last 12 months our Well Wishers charity has had another busy year.

The charity raises money for items above and beyond what the NHS can provide to enhance patients' experience. Success stories include the creation of a quiet/parents room on the children's ward at the Manor Hospital and the creation of a medical tattooing service for women who have had reconstructive surgery following breast cancer.

One of the charity's biggest achievements has been the £15,000 appeal launched last September to improve the sensory room used by children with complex conditions and disabilities at the Shelfield Child Development Centre. The equipment used for group work and one to one sessions is outdated and broken but thanks to a host events including a 100 mile bike ride, cake bakes and raffles and generous donations from the public, the fundraising target looks set to be reached very soon.

See our website www.walsallhealthcare.nhs.uk/charity/home, call the fundraising team on 01922 656643 or email fundraising@walsallhealthcare.nhs.uk

Key issues and risks

During 2016/17, the Trust identified the following key risks to the delivery of its strategic objectives. The major risks identified and monitored through the Board Assurance Framework during the year related to:

1 That the quality & safety of care we provide across the Trust does not improve in line with our commitment in line with our Quality Commitment
2 That we continue to provide inadequate care for patients attending our Emergency Department
3 That we continue to provide "inadequate" care for patients of our maternity & neonatal services
4 Integration of community services fails to deliver the required reduction in acute admissions
5 That our emergency care pathway does not improve resulting in continued delays for patients and poor flow through the hospital
6 Insufficient capacity leads to inability to deliver the elective national constitutional standards resulting in potential harm to patients
7 That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff
8 That we are not successful in our work to establish a clinically led, engaged and empowered culture
9 That the Trust overspends compared to its agreed plan and is unable to deliver future financial sustainability
10 That we cannot deliver our planned programme of hospital estate improvement including ITUY, Neonatal Unit, 2nd Maternity Theatre and a plan for the Emergency Department

11 That our governance remains "inadequate" as assessed under the CQC well-led standard
12 That the overall strategy does not deliver required changes resulting in services that are not affordable to the local health economy
13 New entrants into the market will succeed in attracting services resulting in income loss to the Trust
14 If the Trust does not agree a suitable alliance approach with local health economy partners it will be unable to deliver a sustainable integrated care model

This process is described in more detail in the Annual Governance Statement section of this Annual Report.

Statement of Going Concern

These accounts have been prepared on a going concern basis. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

The Trust has recorded revenue deficits in the three financial years prior to 2017/18. The Board are committed to addressing the current deficit position and the Trust's five year model shows a planned breakeven in 2020/21. This financial recovery is dependent upon the achievement of cost improvement programmes over the period during which the Trust will also be reliant on financial support from the Department of Health to continue the provision of services.

The Trust recognises there is significant risk associated with the achievement of cost improvements targets included the forthcoming financial years. The Trust has delivered a cost improvement target of £10.9m for 2017/18 and is continuing to develop initiatives to deliver future savings beyond this financial year.

The Board of Directors have therefore given careful consideration to the Going Concern principle when preparing these accounts, and the planned revenue deficit for 2018/19.

In respect of the £18.6m planned revenue deficit for 2018/19 the Trust has access to the Uncommitted Interim Revenue Support Facility and cash supporting loans are agreed monthly with the Department of Health dependent on cash requirements

The Board has concluded that although the financial circumstances represents a material uncertainty that casts significant doubt upon the Trust's ability to continue as a going concern, the Directors have a reasonable expectation that the Trust will have access to sufficient resources, including revenue and capital loan funding, to continue to provide services to patients for the foreseeable future. For this reason the Board has adopted the going concern basis when preparing these accounts.

Performance Summary

The table below shows the Trust's Key Clinical Performance Indicators:

Measure	Target 15-16	Actual 15-16	Target 16-17	Actual 16-17	Target 17-18	Actual 17-18
18weeksRTT (Referral to Treatment) Incomplete		Decision taken in Nov 2014 not to submit RTT pathway performance to NHS England for a period of time	92%	85.22%	92%	84.74%
Total Time in A & E 4 Hour wait	95%	87.90%	95%	84.10%	95%	82.67%
C. Diff Cases	18	7	18	21	18	11
MRSA Cases	0	1	0	0	0	0
% of patients whose operations were cancelled for non-clinical reasons	0.75%	0.47%	n/a	0.65%	0.75%	0.45%
Cancer 2 week wait	93%	90.80%	93%	96.1%	93%	95.4%
Cancer 2 week wait Breast Symptoms	93%	90.80%	93%	96.1%	93%	96.5%
Cancer 31 day diagnosis to treatment	96%	99%	96%	99.3%	96%	99.4%
Cancer 31 day wait surgery	94%	97.30%	94%	99.1%	94%	98.9%
Cancer 31 day wait drug	98%	99.50%	98%	100.0%	98%	100.0%
Cancer 62 day wait all cancer	85%	79.80%	85%	87.0%	85%	88.0%
Cancer 62 day wait screening	90%	100%	90%	96.2%	90%	98.0%
Cancer 62 day wait consultant upgrade	92.10%	91%	91%	92.2%	85% (From Jan 18)	86.2%

All 2017/18 figures are based on a full YTD position with the exception of 18 weeks RTT (March 18 position).

The Trust continued to endeavour to meet the requirements placed on it by its regulators and the Government. The figures show how it is performing against these key requirements.

Performance Analysis

The Trust experienced significant emergency pressures combined with a difficult winter which resulted in utilisation of additional capacity to service increased emergency activity and additional sessional work needed to support referral to treatment (RTT).

The Trust reviews and monitors performance against key performance indicators (KPIs) via a number of forums as part of its governance processes. Dependent on the nature of the KPIs, performance is monitored, daily, weekly and monthly using a number of reporting tools and online dashboards. The KPIs are made up of national, local and internally agreed standards.

Performance is reviewed weekly by the operational leads, including executive oversight. Escalation processes are put into place regarding any concerns including actions required to remediate performance and to assess any impact on the delivery of action plans.
Performance is also benchmarked against peer providers to show how the Trust compares to similar sized organisations and also against organisations within the local health economy. Monthly reported performance is signed off by both operational and executive leads. It is then reported to the appropriate sub-committees of the Trust Board and to the Trust Board for scrutiny.

In addition to the internal processes, performance against key national indicators is reviewed and scrutinised externally by commissioners via a number of external meetings associated with system resilience. The Trust then works collaboratively with commissioners in agreeing remedial action plans for any recovery required and associated trajectories.

The Trust benchmarks its performance with other Acute Trusts. It provides a monthly report that is available on its Performance Hub and is presented to the Performance, Finance and Investment Committee.

Shown below are some examples of monthly/quarterly positions.

Measures which have Improved (in terms of National Rank)

Cancer 2 Week Waits – 25th (Q4 17/18) compared to 41st (Q3 17/18)
Total Time Spent in ED Overall – 79th (Apr 18) compared to 92nd (Mar 18)

Measures which have Declined (in terms of National Rank)

SHMI* – 110th (Oct16-Sept17) compared to 101st (Jul16-Jun17)
Cancer 62 Day RTT – 38th (Q4 17/18) compared to 28th (Q3 17/18)

*Standardised Hospital Mortality Indicator – this looks at the relative risk of death of all patients managed by the Trust and includes the period up to 30 after discharge.

Measures which are similar to the previous ranking (in terms of National Rank)

18 weeks RTT Incomplete – 90th (Mar 18) compared to 101st (Feb 18)
Cancer 62 Day Screening – 1st (Q4 17/18) compared to 1st (Q3 17/18)

The Trust achieved a deficit of £24.2m for the financial year, (following national adjustment) against a planned £20.5m deficit. This deterioration in performance was due to increased pressure on services requiring additional bed capacity and the associated premium costs of temporary staffing to maintain services. The Trust also received reduced income from obstetric and maternity services due births being significantly lower than planned. The national adjustment was applied for non-achievement of 2016/17 financial target.

The Trust established a target for delivery of £11.0m of cost efficiencies for the year and has delivered £10.9m of this total. Included within this target was an objective to reduce total spending on agency staffing, to £8.2m, with spending outturn at £7.5m, with reductions in medical agency expenditure and other staffing. The Trust introduced initiatives to improve outpatient productivity and theatre efficiency through earlier start times and through reduction in non-attendances. The full benefit of these improvements will result in the ability to see more patients in 2018/19.

The major redevelopment of the hospital's urgent and critical care facilities commenced in year and will complete in 2018/19. The Trust has now agreed the redevelopment of maternity services and work was due to start on site in May 2018. In addition, an Outline Business Case to extend and redevelop emergency services was submitted to NHS Improvement for approval in October 2017.

Following agreed investment from Walsall Clinical Commissioning Group, the Trust has commissioned and implemented a mobile system for recording of activity for community based services. This will result in reducing clinician time on administration and allow better inter clinician communication for improved patient outcomes.

Walsall Healthcare NHS Trust is committed to reducing the level of fraud, bribery and corruption within both the Trust and the wider NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. The Trust does not tolerate fraud, bribery and corruption and aims to eliminate all such activity as far as possible. This is outlined for staff in the Anti-Fraud, Bribery & Corruption Policy.

The Trust is a significant employer in Walsall and aims to go beyond the requirements of its contracts and contribute to the wider wellbeing of the communities it serves.

In 2017-18 the Trust supported a wide variety of community events. These included support for sexual health within harder to reach communities, older people's mental health, awareness of FGM (Female Genital Mutilation) and a wide range of wellbeing initiatives. Engagement with community representatives from local temples and mosques also continued.

The Trust has an important role to play in protecting human rights through its administration of the Mental Health Act (1983) (MHA) and oversight of the Mental Capacity Act (2005). The Trust issues and maintains a comprehensive set of policies which describe how it protects patients' human rights including Safeguarding and the Depravation of Liberties Act.

Walsall Healthcare is a publicly-funded organisation and does not engage in service provision in order to make a profit. Whilst some services operate on a commercial basis they only generate a modest income and these services are not considered commercial as they do not generate income in excess of £36 million per annum. A statement on the steps the Trust has taken to ensure that slavery and human trafficking is not taking place in the Trust's supply chain or any part of the Trust's business is therefore not required.

The Trust has a continuing commitment to carbon reduction and providing sustainable environments and its Energy Efficiency Committee meets regularly to discuss ideas that improve both operational efficiency and user experience.

To utilise space more efficiently within the hospital, Estates and Facilities have been using 'OccupEye' devices which rely on wireless sensors to capture the presence of people within various areas (without identifying who they are) and note how frequently these areas are occupied. This gives the Trust an opportunity to check that it is utilising space efficiently.

These devices will support the Trust to ensure that it achieves its goal of operating with a maximum of 35% of non-clinical floor space and 2.5% of unoccupied/under-used space by April 2020; ensuring that resources are used in a cost-effective manner.

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Chief Executive

SECTION 2: ACCOUNTABILITY REPORT

CORPORATE GOVERNANCE REPORT

The Directors' Report

Directors of the Trust

The Chair and Chief Executive

Ms Danielle Oum is the Chair of the Trust and took office on 8 April 2016.

Mr Richard Beeken is the Chief Executive of the Trust (Accountable Officer) and was appointed on 26 February 2018, taking over from Mr Richard Kirby who had been Chief Executive since May 2011.

The table below sets out the names of the Chair, Chief Executive and all individuals who were directors of the Trust from April 2017 until the publication date of this Annual Report. The individuals in the table form the composition of the Trust Board and have authority or responsibility for directing or controlling the major activities of the Trust during the year.

TRUST BOARD COMPOSITION

Name	Designation	In Year Start / Leave Dates
Danielle Oum	Chair	-
Professor Russell Beale	Non-Executive Director	-
John Dunn	Non-Executive Director	-
Victoria Harris	Non-Executive Director	-
Sukhbinder Heer	Non-Executive Director	-
Dr Jonathan Shapiro	Non-Executive Director Senior Independent Director	 To 31 October 2017
John Silverwood	Non-Executive Director	To 31 January 2018
Deborah Carrington	Associate Non-Executive Director (non-voting)	To 2 February 2018
Philip Gayle	Non-Executive Director	From 1 November 2017
Paula Furnival	Associate Non-Executive Director (non-voting)	-
Richard Kirby	Chief Executive	To 28 February 2018
Russell Caldicott	Director of Finance & Performance	-
Daren Fradgley	Director of Strategy & Transformation (non-voting)	-
Mr Amir Khan	Medical Director	-
Rachel Overfield	Director of Nursing	To 29 October 2017
Mark Sinclair	Director of Organisational Development & Human Resources (non-voting)	To May 2017
Linda Storey	Trust Secretary	To March 2018
Philip Thomas-Hands	Chief Operating Officer	-
Louise Ludgrove	Interim Director of Organisational Development & Human Resources (non-voting)	From 30 May
Barbara Beal	Interim Director of Nursing	From 6 November
Richard Beeken	Chief Executive	From 26 February 2017

Trust Board Member Profiles

Danielle Oum
Chair of the Trust Board (Voting Position)
Appointed April 2016

Danielle has more than 10 years' experience of leading public service business improvement and programme management, and has also worked extensively in the private sector, building and leading international teams. Danielle's professional expertise is in stakeholder engagement and transformational change. Her other professional interests are socio-economic inclusion, cross sector partnerships and regeneration. Danielle was previously the Chair of Dudley and Walsall Mental Health Partnership NHS Trust.

Professor Russell Beale
Non-Executive Director (Voting Position)
Chair of Charitable Funds Committee (until October 2017)
Champion for Information and Computer Technology
Appointed June 2016

Professor Russell Beale holds the Chair in Human-Computer Interaction in the School of Computer Science at the University of Birmingham, and is also the founder and Director of the Human-Computer Interaction Research Centre, a cross-University Research Institute. Russell has a broad range of interests across the field of HCI, being particularly interested in the use of artificial intelligence to model and optimise interaction, and in technologically-mediated behaviour change.

His research and development activities are funded through a mix of Government grants, innovation awards, commercial partnerships, EU funding, and venture capital.

Russell has commercial and entrepreneurial experience as well as an academic background. He has founded six high-technology companies, and run four of these; one works on intelligent healthcare apps. He has won awards with websites he has been involved in, and some of the products have an extensive user base. When not researching HCI he can be mostly be found outside with his children, dogs and wife, either sailing, mountain biking, or otherwise trying to be active.

John Dunn
Non-Executive Director (Voting Position)
Chair of Performance, Finance and Investment Committee
Champion for the Emergency Department
Appointed February 2015

John's professional life was spent almost exclusively in the Telecoms sector and he has extensive experience in the field of operations, and customer service. His career includes 20 years' experience at divisional board level in a variety of executive and non-executive roles and his last position with BT was as Managing Director Openreach. As MD, he was responsible for the delivery and repair of customer service and for the provision and maintenance of the local access network for the south of the UK.

Victoria Harris
Non-Executive Director (Voting Position)
Chair of Charitable Funds Committee (from November 2017)
Champion for Maternity and Neonatal Services
Appointed April 2015

Vicky has strong local links, having worked in Walsall for over 12 years and lived most of her life in the Black Country. An honours graduate in psychology, much of her career has been in the public sector in mental healthcare, although it began in the voluntary sector. Vicky has developed numerous projects and partnerships to support local people into employment. For almost a decade she was a non-executive director of the Black Country Partnership NHS Foundation Trust, during which time she saw its transition to achieving FT status, and to acquiring new services across the Black Country under the Transforming Community Services agenda.

Sukhbinder Heer
Non-Executive Director (Voting Position)
Chair of Audit Committee
Champion for Improvement
Appointed September 2016

Sukhbinder has more than 30 years' senior management experience in corporate finance and private equity as well as leading one of the UK's top professional services companies. Over the past few years Sukhbinder has also undertaken a number of non-executive positions in private, public and charity sectors and is currently also Non-Executive Director and Chair of Audit at Birmingham Community Healthcare Foundation Trust (BCHCFT).

Dr Jonathan Shapiro
Non-Executive Director (Voting Position)
Senior Independent Director
Chair of Quality and Safety Committee
Champion for Safeguarding
Appointed October 2013
Left the organisation 31st October 2017

Jonathan's interests have always centred on the 'whole system' of healthcare, and his career reflects this. Originally a GP, he then became a medical manager, before working as a senior academic for many years.

His most recent research explored organisational change in the NHS, and he now applies the lessons of his work in a variety of ways, carrying out consultancy in this area, as well as in broader policy analysis and change; he chairs the charity Education for Health, and regularly produces journal articles as well as more detailed reports. Other roles have included being Chair of a large Mental Health Trust and Clinical Director for Humana Europe until its move back to the USA.

John Silverwood
Non-Executive Director (Voting Position)
Chair of People and Organisational Development Committee
Appointed February 2015
Left the organisation 31st January 2018

A Chartered Fellow of The Institute of Personnel and Development, John spent most of his career working in the manufacturing sector in textiles and later in soaps and detergents. He was Group HR Director for PZ Cussons plc, working extensively in Africa, Asia and Europe before retiring in 2008. John then became HR Director for the University Hospital of South Manchester NHS Foundation Trust before retiring for a second time in 2012. He hails from Nottingham but has lived in Macclesfield and the Staffordshire Moorlands and now lives in Stafford. In addition to his new position with the Trust, he is a Non-Executive Director of The High Peak Theatre Trust which is responsible for the running of Buxton Opera House.

Deborah Carrington
Associate Non-Executive Director (Non-Voting Position)
Champion for Improvement, Staff Experience (including Duty of Candour, Freedom to Speak Up, Whistleblowing and Junior Doctors).
Appointed July 2016
Left the organisation 2nd February 2018

Over the past 20 years Deborah has held a number of senior executive roles in both the public and private sector and has a wealth of experience leading organisations through periods of transition and challenge along with an in-depth knowledge of governance and developing strategic partnerships.

Philip Gayle
Associate Non-Executive Director (Non-Voting Position)
Champion for Patient Care, Equality, Diversity and Inclusion
Appointed August 2016

Phil is currently Chief Executive Officer for Connect West Midlands, an organisation that supports those affected by substance misuse. Phil has considerable experience of the health sector and has also worked as a Non-executive Director for Sandwell and West Birmingham NHS Trust. Phil is passionate about contributing to improving services for patients in particular their experience of care at the Trust and has a strong interest in equality, diversity and ethics.

Paula Furnival
Associate Non-Executive Director (non-voting position)

Paula is the Executive Director of Adult Social Care for Walsall Council, and her experience has been gained in working within the NHS and councils who have social care responsibility.

Prior to that Paula was a solicitor working in criminal, youth court and child care law, where she gained a real insight into the social and emotional issues facing many families which led to her gaining her first role in social care in Knowsley on Merseyside, 20 years ago.

She has been a District Director in Staffordshire where she was a commissioner and provider of services across a population of about 150,000, running assessment and care management support for older people, mental health and learning and physical disability services and, care homes, and day services.

In 2010, Paula was part of a small team which helped to form a new provider of community health and social care, the Staffordshire and Stoke on Trent Partnership NHS Trust; the largest single integrated provider of health and care. More recently Paula has worked for NHS England supporting commissioning delivery and transformation developing CCG five year plans, negotiating on Better Care Fund plans and leading programmes of integrated commissioning, prevention and early intervention support.

She describes herself as an advocate of enabling people to live as independently as possible and works to integrate services to best meet the needs of local communities.

Richard Kirby
Chief Executive (Voting Position)
Appointed May 2011
Left the organisation in February 2018

Richard is a graduate of the NHS Management Training Scheme. After undertaking roles in commissioning at both health authority and primary care group level, he was Head of Performance at Birmingham and Black Country Strategic Health Authority, where he ensured that the SHA maintained its position as one of the best performing in the country. Richard gained board level NHS Trust experience by joining Sandwell and West Birmingham Hospitals NHS Trust initially as Director of Strategy and then as Chief Operating Officer. In these roles he led the development of new models of care working with local partners, delivered service reconfigurations in paediatrics, surgery and pathology, maintained the Trust's track record of delivery on access targets and secured significant improvements in performance across the organisation. Richard was also chosen to take part in the national NHS Top Leaders Programme.

Russell Caldicott
Director of Finance and Performance (Voting Position)
Appointed July 2015

Russell lives locally and has in excess of 20 years' experience of working within the acute sector of the NHS, formerly undertaking roles such as Senior Divisional Accountant, Associate Director of Finance and Deputy Director of Finance. A Qualified Accountant and advocate of continuing professional development, Russell occupies the role of Executive on the Board of the West Midlands Healthcare Financial Management Association, providing support and opportunities for development to the finance teams of Central England.

Daren Fradgley
Director of Strategy and Transformation (Non-Voting Position)
Appointed January 2016

Daren joined the Trust after holding numerous operational and director posts at West Midlands Ambulance Service NHS Foundation Trust (WMAS). A paramedic by background Daren joined WMAS in 1994 on frontline operations initially in the Black Country and then Birmingham before moving to the Emergency Control Rooms in 2005. He then went on to manage the Trust Performance Improvement team including informatics and Business Intelligence team. In 2013 he became the A&E Operations Director before moving to NHS 111.

Daren is responsible for the Trust's transformation and cost improvement programme together with strategic and business development.

Amir Khan
Medical Director and Director of Infection Prevention and Control (Voting Position)
Appointed October 2011

Amir is a General Surgeon with a specialist interest in Vascular and Bariatric Surgery and joined Walsall in 1992 after completing his training. Amir led on the establishment of Walsall as a regional Bariatric Centre and is the lead accountable Director for the Medical workforce. Amir is also the Director of Infection Prevention and Control and the organisations Caldicott Guardian. Patient Safety and quality of care are key priorities for Amir in ensuring that our clinical outcomes for patients are of a high standard.

Rachel Overfield
Director of Nursing (Voting Position)
Appointed June 2016
Left the organisation in October 2017

Rachel joined the Trust in January 2016 as Interim Director of Nursing before becoming Director of Nursing in June 2016. Rachel trained in Worcester and worked in Worcestershire before leaving to become a Macmillan Nurse in Dudley and Wolverhampton, specialising in breast oncology. A spell at the Royal Marsden Hospital in London followed before Rachel returned to Worcestershire to take up a Matron role in head and neck trauma, orthopaedics and outpatients. She went on to the Deputy Director of Nursing role before rapidly becoming transitional director for the new Worcestershire Royal Hospital.

Around five years later she moved to Sandwell and West Birmingham Hospitals Trust as Director of Nursing. From there Rachel moved to Leicestershire as Chief Nurse. Before coming to Walsall, Rachel has also worked at the Trust Development Authority as Head of Quality.

Mark Sinclair
Director of Organisational Development and Human Resources. (Non-voting position).
Left organisation May 2017

Mark's early career included Oil and Gas, the Military and Specialist Chemicals followed by NHS jobs in Norfolk and Norwich and NHS Grampian and Orkney. He spent time working in Higher Education, in research at Glasgow Caledonian University and JHI before becoming Jersey's Director of Public Sector reform and HR. He has a diverse portfolio of Organisational Development, HR, Health and Safety, Estates & Facilities, Communications, Engagement, Procurement and Occupational Health

Linda Storey
Trust Secretary
Appointed June 2015
Left the organisation in March 2017

Linda was previously Trust Secretary at Ipswich Hospital NHS Trust from 2007 – 2014 and joined the NHS in 2003.She is a qualified chartered secretary and an associate member of both the Institute of Chartered Secretaries and Administrators and the Chartered Institute of Personnel and Development.

Responsible for the corporate governance of the Trust, she advises the board of directors about their responsibilities. As well as having worked in the acute hospital sector, Linda has worked within clinical commissioning in London and in the private sector.
Her professional interests include corporate social responsibility and risk.

Philip Thomas-Hands
Chief Operating Officer (Voting Position)
Appointed October 2016

Philip has worked in healthcare since 1985, working across acute hospitals, Mental Health, Primary Care, Medicine, Surgery and Specialised Services across both Gloucestershire and the Midlands.

Philip has also worked for GP fund holders and in the private sector, spending five years as management consultant to the manufacturing and healthcare industries. For the past four years he has been a Non-executive Director for a housing association. His role is to deliver systems, and constantly improve them, to ensure that clinicians can look after as many patients as possible within the resources available. Professional interests include change management, succession planning, task management and a strong focus on patient experience.

Louise Ludgrove
Interim Director of HR
Appointed May 2017 (non-voting position)

Louise joined the Trust in May 2017 as Interim Director of OD & HR. She has worked in the NHS since the early 1990s in provider, integrated and Foundation Trusts. Louise became a Director in 2003 and having worked in permanent roles, became an interim Director in 2011.

Barbara Beal
Interim Director of Nursing (Voting Position)
Appointed November 2017

Approaching 45 years in the NHS, Barbara's career has seen her start out as a cadet nurse before progressing to Head of Midwifery and Executive Director of Nursing & Midwifery, Chief Operating Officer and Deputy Chief Executive as well as a Non-Executive Director.

Her range of skills means she has been able to offer her knowledge as an experienced nurse and midwife, a clinical advisor, and executive/coach mentor in both the NHS and independent healthcare sector;

Barbara is committed to help support the Trust on the next stage of its improvement journey: "To focus on the safety, quality of care and experience of our patients, families, carers and our staff"
When not at work, Barbara enjoys spending time with her family and travelling.

Richard Beeken
Chief Executive (Voting Position)
Appointed February 2018

A graduate of the NHS Management Training Scheme and the NHS Top Leaders Programme, Richard has extensive NHS Leadership experience, including a number of executive roles. As CEO at Wye Valley NHS Trust, Richard led the organisation out of special measures.

He was previously Delivery and Improvement Director for NHS Improvement West Midlands, Interim Chief Executive at Worcestershire Acute Hospitals NHS Trust, and most recently was the Chief Operating Officer for University Hospitals of North Midlands NHS Trust.

Audit Committee

The Trust has an Audit Committee comprised of four Non-Executive Director members, one of which is Chair. The members of the Audit Committee are:

Sukhbinder Heer: Non-Executive Director and Committee Chair

John Dunn: Non-Executive Director

Jonathan Shapiro: Non-Executive Director (left October 2017)

Russell Beale: Non-Executive Director

John Silverwood: Non-Executive Director (left January 2018)

Further information relating to the Audit Committee, including key responsibilities and highlights from the year, can be found in the governance statement section of this annual report.

Company Directorships and Other Significant Interests held by members of the Board

The Board of Directors has a legal obligation to act in the best interests of the organisation in accordance with its governing document and to avoid situations where there may be a potential conflict of interest. As such, there is a requirement for Board Members to register company directorships and other significant interests that they hold that may be perceived as conflicting with their overriding duty as a Board Member.

Name	Designation	In Year Start / Leave Dates	
Danielle Oum	Chair	-	Board Member: West Midlands Housing Group Board Member: Wrekin Housing Chair Healthwatch Birmingham Committee Member: Healthwatch England
Prof. Russell Beale	Non-Executive Director	-	Director, shareholder: CloudTomo- security company – pre commercial. Founder & minority shareholder: BeCrypt – computer security company. Director, owner: Azureindigo – health & behaviour change company, working in the health (physical & mental) domains; producer of educational courses for various organisations including in the health domain. Academic, University of Birmingham: research into health & technology – non-commercial. Spouse: Dr Tina Newton, is a consultant in Paediatric A&E at Birmingham Children's Hospital & co-director of Azureindigo. Journal Editor, Interacting with Computers. Governor, Hodnet Primary School. Honorary Race Coach, Worcester Schools Sailing Association. Non-Executive Director for Birmingham and Solihull Mental Health Trust with effect from January 2017.
John Dunn	Non-Executive Director	-	No Interests to declare.
Victoria Harris	Non-Executive Director	-	Manager at Dudley & Walsall Mental Health Partnership NHS Trust Governor, All Saints CE Primary School Trysull Husband, (Dean Harris) Deputy Director of IT at Sandwell & West Birmingham Hospital from March 2017

Sukhbinder Heer	Non-Executive Director	-	Non-Executive Director of Hadley Industries PLC (Manufacturing) Partner of Qualitas LLP (Property Consultancy). Non-Executive Director Birmingham Community NHS Foundation Trust (NHS Entity). Chair of Mayfair Capital (Financial Advisory).
Dr Jonathan Shapiro	Non-Executive Director Senior Independent Director	To 31 Oct 2017	Researcher-in-Residence Chair, Education for Health Independent Chair Transformation Herefordshire
John Silverwood	Non-Executive Director	To 31 Jan 2018	Non-Executive Director of High Peak Theatre Trust
Deborah Carrington	Associate Non-Executive Director (non-voting)	To 2 Feb 2018	No interests to declare.
Philip Gayle	Non-Executive Director	From 1 Nov 2017	Chief Executive Newservol (charitable organisation – services to mental health provision).
Paula Furnival	Associate Non-Executive Director (non-voting)	-	Executive Director of Adult Social Care, Walsall Council.
Richard Kirby	Chief Executive	To 28 Feb 2018	Steward (Trustee) Selly Oak Methodist Church
Russell Caldicott	Director of Finance & Performance	-	Chair and Executive Member of the Branch of the West Midlands Healthcare Financial Management Association
Daren Fradgley	Director of Strategy & Transformation (non-voting)	-	Director of Oaklands Management Company Clinical Adviser NHS 111/Out of Hours
Mr Amir Khan	Medical Director	-	Trustee of UK Rehabilitation Trust International Trustee of Dow Graduates Association of Northern Europe Director of Khan's Surgical Director and Trustee of the Association of Physicians of Pakistani Origin of Northern Europe
Rachel Overfield	Director of Nursing	To 29 Oct 2017	No interests to declare.
Mark Sinclair	Director of Organisational Development & Human Resources (non-voting)	To 11 May 2017	No interests to declare
Philip Thomas-Hands	Chief Operating Officer	-	Non-Executive Director, Aspire Housing Association, Stoke-on-Trent. Spouse, Nicola Woodward is a senior manager in Specialised Surgery at University Hospital North Midlands.
Louise Ludgrove	Interim Director of Organisational Development & Human Resources (non-voting)	From 30 May	Director of Ludgrove Consultancy Services Ltd.
Barbara Beal	Interim Director of Nursing	From 6 Nov	Non-Executive Director at University Hospital Coventry and Warwickshire. Managing Director – Griffis-Beal Healthcare Company Ltd. Associate Fine Green Limited
Richard Beeken	Chief Executive	From 26 Feb 2017	Spouse, Fiona Beeken is a Midwifery Lecturer at Wolverhampton University.

The register is updated as interests are declared and at least annually and is reviewed by the Audit Committee and the Trust Board.

Personal data related incidents reported to the Information Commissioner's Officer

The Trust had a total of 5 reportable serious information governance incidents during 2017/18 related to clinical information being sent to the wrong address, information being sent to the wrong email address, a letter regarding a forthcoming operation sent to a wrong patient, a formal complaint response letter containing sensitive information about inpatient treatment sent to another address and a discharge summary was attached to another patient's letter. These were all reported to the Information Commissioner's Office and appropriate action taken.

Summary of serious information governance incidents requiring investigation involving personal data as reported to the Information Commissioner's Office in 2017/18

Incident Date	Nature of Incident	Nature of Data Involved	Number of Data Subjects	Notification Steps
14 Mar 2018	Disclosed letter in error	Name, address, NHS number, clinical information	1	ICO informed, CCGs informed, data subjects informed by letter.
17 Aug 2017	Referral forms Emailed in error	Name, address, NHS number, GP details and the reason for referral	9	ICO informed, CCGs informed,
26 May 2017	Disclosed letter in error	Name, address, NHS number, clinical information	1	ICO informed, CCGs informed, data subjects informed by letter.
4 May 2017	Disclosed letter in error	Name, address, NHS number, clinical information	1	ICO informed, CCGs informed, data subjects informed by letter.
6 Apr 2017	Discharge summary – disclosed in error	Name, address, NHS number, clinical information	1	ICO informed, CCGs informed.

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Chief Executive

Statement of Disclosure to Auditors

Each individual who is, or was, a member of the Trust Board in the year covered by this report confirmed that, as far as they are aware, there is no relevant audit information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and have taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

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

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer. As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

The Annual Report and Accounts as a whole are fair, balanced and understandable and as Accountable Officer I take personal responsibility for the judgments required for determining that they are fair, balanced and understandable.

Signed: ..... Chief Executive

Date: 11 July 2018

Annual Governance Statement 2017/18

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 Accountable Officers' Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Walsall Healthcare 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 Walsall Healthcare NHS Trust for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

The objectives for 2017/18 and the associated principal risks were approved by the Trust Board at its January 2017 meeting. They are shown below at **Table 1**.

Table 1

Approved Objective	Principal Risk(s)
Embed the quality, performance and patient experience improvements that we began in 2016/17	• That the quality & safety of care we provide across the Trust does not improve in line with our commitment in line with our Quality Commitment. • That we continue to provide inadequate care for patients attending our Emergency Department • That we continue to provide "inadequate" care for patients of our maternity & neonatal services.
Embed an engaged, empowered and clinically-led organisational culture	• That we are not successful in our work to establish a clinically-led, engaged and empowered culture
Track our financial position so that the deficit reduces	• That the Trust overspends compared to its agreed plan & is unable to deliver future financial sustainability. • That the Service Improvement and Cost Improvement Programme does not deliver the financial impact planned resulting in non-delivery of financial plan. • New entrants into the market will succeed in attracting services resulting in income loss to the Trust.
With local partners change models of care to keep hospital activity at nor more than 2016/17 outturn	• Integration of community services fails to deliver the required reduction in acute admissions.
Embed continual service improvement as we do things linked to our Improvement Plan	• That the Service Improvement and Cost Improvement Programmes do not deliver the financial impact planned resulting in non-delivery of financial plan
Ensure our hospital estate is future proof and fit for purpose	• That we cannot deliver our planned programme of hospital estate improvements including ITU, Neonatal Unit, 2nd Maternity Theatre, and plans for a new Emergency Department.
Deliver a sustainability review of all our services to set plans for the next five years.	• That our emergency care pathway does not improve resulting in continue delays for patients and poor • New entrants into the market will succeed in attracting services resulting in income loss to the Trust.

The means by which strategic and operational risks are managed, monitored and reported in the Trust are set out below.

Capacity to handle risk

As Accountable Officer I am accountable for the quality of the services provided by the Trust. I have overall responsibility for risk management within the Trust and this responsibility is incorporated within the Risk Management Strategy. Elements of risk management are delegated to members of my Executive Management Team and designated specialist staff:

Overall Risk Management	Director of Nursing
Clinical Governance	Director of Nursing
Clinical Risk & Medical Leadership	Medical Director
Corporate Governance	Trust Secretary
Board Assurance & Escalation	Trust Secretary
Financial Risk	Director of Finance & Performance
Compliance with NHSI Regulatory Framework	Director of Finance & Performance and Trust Secretary
Compliance with CQC Regulatory Framework	Director of Nursing
Information Risk	Director of Strategy & Improvement (Senior Responsible Officer)

In addition, the Chief Operating Officer is responsible for risks associated with the operational delivery of performance standards and for are ensuring that the Divisions implement the Risk Management Strategy. The Director of Organisational Development and Human Resources is responsible for risks associated with staff engagement and communications and through the Divisional Director for Estates and Facilities risks relating to the management of buildings, catering, transport, decontamination, security, fire and waste management and health and safety risks. Finally the Director of Strategy and Improvement is responsible for managing the Trust's principal risks relating to strategic planning, service transformation and the cost improvement programme.

Staff members have a responsibility for handling the management of clinical and non-clinical risks according to their roles and duties within the Trust.

Sharing the learning through risk related issues, incidents, complaints and claims is an essential component to maintaining the risk management culture within the Trust. Learning is shared through Patient Safety Teams and Specialist Governance Leads who cascade information through many mechanisms which include:

- lessons learned bulletins
- Safety huddles
- Divisional Quality Boards, Quality Executive and Quality & Safety Committee
- team meetings
- Messages on the staff TV
- attendance at Nurse and Junior Doctor forums and inductions
- Listening into Action (LiA)

Training and education are key elements of the development of a positive risk management culture. Risk management forms a fundamental aspect of many training activities throughout the Trust, where staff are provided with the necessary awareness, knowledge and skills to work safely and to minimise risks at all levels. Risk management awareness training is delivered to all members of staff through our induction programme and to existing staff through mandatory training programmes.

The risk and control framework

The Risk Management Strategy provides a framework for managing risks across the Trust and is consistent with best practice and Department of Health guidance. The strategy provides a clear, structured and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation. The strategy sets out the role of the Trust Board and its committees together with the individual responsibilities of the Chief Executive, Executive Directors and all staff, in managing risk.

Risk management by the Trust Board is underpinned by four (4) interlocking systems of internal control:

- The Board Assurance Framework
- Trust Risk Register (informed by Divisions, Care Groups and Teams)
- Audit Committee
- Annual Governance Statement

The *Board Assurance Framework* (BAF) sets out the key risks to the Trust's strategic objectives together with the controls in place to mitigate the risks and the assurance that can be evidenced relating to their control. During 2017/18 the Trust Board has refreshed its Board Assurance Framework. The Trust Board has received and reviewed the Board Assurance Framework three times throughout the year.

The major risks identified and monitored through the Board Assurance Framework during the year related to:

BAF No. 1: That the quality & safety of care we provide across the Trust does not improve in line with our commitment in line with our Quality Commitment.

BAF No. 2: That we continue to provide inadequate care for patients attending our Emergency Department

BAF No. 3: That we continue to provide "inadequate" care for patients of our maternity & neonatal services

BAF No. 4: 'Integration of community services fails to deliver the required reduction in acute admissions'.

BAF No. 5: 'That our emergency care pathway does not improve resulting in continued delays for patients and poor flow through the hospital'.

BAF No. 6: 'Insufficient capacity leads to inability to deliver the elective national constitutional standards resulting in potential harm to patients'.

BAF No. 7: 'That we cannot deliver safe sustainable staffing levels reducing our reliance on expensive agency staff'.

BAF No. 8: 'That we are not successful in our work to establish a clinically led, engaged and empowered culture'.

BAF No. 9: 'That the Trust overspends compared to its agreed plan and is unable to deliver future financial sustainability'.

BAF No. 10: 'That we cannot deliver our planned programme of hospital estate improvement including ITUY, Neonatal Unit, 2nd Maternity Theatre and a plan for the Emergency Department'.

BAF No.11: 'That our governance remains "inadequate" as assessed under the CQC well-led standard".

BAF No.12: 'That the overall strategy does not deliver required changes resulting in services that are not affordable to the local health economy'.

BAF No. 13: 'That the Service Improvement and Cost Improvement Programme does not deliver the financial impact planned resulting in non-delivery of financial plan'.

BAF No.14: 'New entrants into the market will succeed in attracting services resulting in income loss to the Trust'.

BAF No. 15: 'If the Trust does not agree a suitable alliance approach with local health economy partners it will be unable to deliver a sustainable integrated care model'.

Following the work undertaken during the year to improve the Board Assurance Framework, Internal Audit has undertaken its annual review and concluded an opinion of 'requires improvement' for 2017/18 which is a decline on the previous year's opinion which was "substantial". The deterioration in the overall opinion is due to a number of recommendations raised last year not being actioned and further weaknesses being identified. The issues highlighted and action being taken is as follows:

The wording of the 2 year objectives are not consistent with published data on the Intranet	The Trust Board has agreed four (4) objectives for 2018/19 and a Board Development session will be held to develop the BAF for 2018/19 to reflect the risks associated with these objectives. The BAF on the intranet will be updated to reflect this
Some putative controls associated with the risks are not actual controls	During the Board Development Session members will discuss what a control is and what assurances are so that this can be reflected in the BAF
Dates are not consistently added to the evidence section in the assurances section of the AF	The BAF format will be reviewed to ensure that all information required is captured appropriately
When amendments are made to the AF these are not clearly highlighted when presented to the Board for challenge	The Board will receive the BAF on a quarterly basis and a report will highlight the changes made to the BAF since the last update to ensure members are able to challenge the recommendations

The Risk Strategy describes a framework that devolves responsibility and accountability throughout the organisation via a tiered *Risk Register* system (Corporate, Divisional, Care Group, Ward and Department) which enables risks to be identified, analysed, prioritised and managed at all levels of the organisation. The method of assessing the severity and likelihood of risk is by the use of the National Patient Safety Association model matrix. This is based on scoring the impact of the Trust of not addressing the risk against the likelihood of its occurrence.

The Audit Committee is responsible for scrutinising the overall systems of internal control (clinical and non-clinical) and for ensuring the provision of effective independent assurance via internal audit, external audit and local anti-fraud services. The Audit Committee reports to the Board via a Highlight Report after every meeting and annually on its work via the Annual Report of the Audit Committee in support of the *Annual Governance Statement*, specifically commenting on the fitness for purpose of the BAF, the completeness and extent to which risk management is embedded in the Trust and the integration of governance arrangements. The Audit Committee also assesses its own effectiveness, what it has accomplished and whether it has fulfilled its responsibilities along with that of the Board sub committees.

The Trust Board and its sub committees have taken an active role in the improvement of risk management processes. This has included the alignment of Board Assurance Framework and Corporate Risks to the Board sub committees and agreed schedules of review of the risks at each.

The Trust Board is comprised of a Chair, six non-executive director members (currently one vacancy) and five executive director members: the Chief Executive, Medical Director, Director of Nursing, Director of Finance and Performance and Chief Operating Officer. Two other executive director members without voting rights attend each Trust Board meeting: the Director of Organisational Development and Human Resources and the Director of Strategy and Improvement. The Chair of the Trust Board has a second and casting vote on any decision making matters. The Trust Secretary also attends all Board Meetings.

The Trust Board saw the departure of three non-executive director members during 2017/18 Dr Jonathan Shapiro and John Silverwood voting members and Deborah Carrington an associate member of the Board. Mr Philip Gayle, who was an associate non-executive director, was made a full voting member in November 2017.

The executive team has undergone a period of change during the year with the departure of four members of the team including Richard Kirby, Chief Executive, Rachel Overfield, Director of Nursing, Mark Sinclair, Director of OD and HR and Linda Story Interim Trust Secretary. Richard Beeken was appointed as Chief Executive in November 2017, Philip Thomas-Hands was appointed as Chief Operating Officer, Louise Ludgrove was appointed as Interim Director of OD and HR and Barbara Beal was appointed as Interim Director of Nursing.

The Trust Board is supported by a framework of sub-committees. The Trust governance structure at **Appendix 1** illustrates the robustness and effectiveness of the risk management and performance processes via our governance structure. **Appendix 2** illustrates the reporting processes in place for providing assurance through the governance structure.

The Board has overall responsibility for the effectiveness of the governance framework and plans to undertake a review of its own effectiveness in June 2018. The Board also requires that each of its sub-committees has agreed terms of reference which describe their responsibilities, accountabilities and methods of monitoring effectiveness. There are six formally designated sub-committees of the Board all of which are Chaired by a non-executive director:

- Audit Committee, chaired by Sukhbinder Heer, Non-executive Director.
- Quality and Safety Committee, chaired by Professor Russell Beale, Non-executive Director.
- Finance, Performance and Investment Committee, chaired by John Dunn, Non-executive Director from January 2016.
- People and Organisational Development Committee –chaired by Philip Gayle, Non-executive Director.
- Nominations and Remuneration Committee chaired by Danielle Oum, Chair of Trust
- Charitable Funds Committee, chaired by Victoria Harris, Non-executive Director.

The Trust Board is responsible for setting the risk appetite of the organisation as described in the Risk Management Strategy. This is defined as the amount of risk exposure or the potential adverse impact from an events occurrence that the organisation is willing to accept/retain before further action is deemed necessary to reduce it. In January 2018 the Board had an initial discussion regarding its risk appetite which will be reviewed over the next three months in order to clearly define its risk appetite.

The Trust's approach to quality improvement is clear that quality is the responsibility of all staff from 'ward to board'. The Board is committed to ensuring patients receive the highest level of safe, high quality, compassionate care, through a shift to a culture of continuous quality improvement based upon the sustainable implementation of a Trust wide Integrated Improvement Programme. Reporting processes and mechanisms through Trust Board, it's Committees, Executive Team and through to Divisions and their governance processes reflect this approach. Accountability for quality is clear through the leadership and management arrangements within the Trust. The revised governance and assurance structure implemented in 2015 continues and is aligned with the clinically led management model in the Divisions providing ward to board reporting and assurance. Divisions continue to enable better and more rapid decision-making, as close as possible to the point of care delivery, which, in turn, enables more effective clinical engagement and leadership in service development and delivery as well as providing service users with greater access to decision-making. The Quality Governance Advisors embedded in the three Divisions have delivered expertise in embedding governance structures and processes at a clinical and managerial level and whilst they will continue to do so it is also planned to strengthen this at divisional and care group level so as to ensure we move to high performing clinical leaders from ward to board.

Executive leadership, accountability and responsibility for quality governance is held by the Director of Nursing and the Medical Director. Quality governance oversight and integration with corporate governance is overseen by the Trust Secretary.

The Trust's approach to clinical quality improvement is supported by a new Quality Improvement Faculty which has been established to support colleagues on the improvement journey. This encompasses the existing Listening into Action (LiA) Programme and the Service Improvement Team. This provides additional innovative, research, and evidence based support to the services and clinicians. The first phase focuses on Human Factors in Maternity and Gynaecology.

The Trust's strategic priorities and combined support service offer aligns clinical services and support functions to deliver the best care possible to those who use Trust services. Trust Board receives regular reports, directly and through the Quality & Safety Committee, on all aspects of clinical quality and safety including management of incidents and complaints, equality and diversity, service user experience, control of infection and research and development. The

Quality & Safety Committee provides assurance to Trust Board that issues and risks identified in a number of portfolio areas, such as managing aggression and violence, safeguarding adults and children, infection prevention and control, and information governance, are being addressed. Where Quality & Safety Committee identifies an area of concern which has been raised at a particular time, we scrutinise that on behalf of the Trust Board by receiving regular reports for a period.

The Trust's Quality Strategy, our ''Quality Commitment" was approved at Trust Board in November 2016 and continued through 2017/18. The priorities are monitored individually via the Trust quality governance framework which is delivered through the governance structure (figure 1) and described in more detail below. This framework sets out what our strategic commitment to safe, high quality care means in practice. It incorporates national and local drivers, commissioning priorities and is consistent with STP quality priorities. It is based on three main sections:

Provide effective care – Improve Patient Outcomes
Improve safety – Reduce Harm
Care and compassion – Improve Patient Experience

The actions to implement the Quality Commitment and those included in the Patient Care Improvement Plan developed after the 2015 CQC inspection helped to improve our ratings and the Trust is now rated overall as 'Requires Improvement'. Following the 2017 inspection the PCIP has been updated and approved by the Quality & Safety Committee at its meeting in January 2018.

The Trust's quality governance framework provides the Trust Board with assurance that essential standards of quality and safety are being delivered within the Trust. It provides assurance that the processes for the governance of quality are embedded through the Trust. Performance and Quality reports to Trust Board provide assurance against a range of Key Performance Indicators relating to service quality and, where reports indicate underperformance, action plans are provided to and monitored by Trust Board.

The Board and sub committees receive assurance on compliance with quality and safety through a number of mechanisms including the Performance and Quality Report which is considered at each of the sub committees and Board. It regularly seeks out and reviews staff and patient feedback through the staff survey, pulse survey's, staff forums, leadership meetings, listening into action work streams, complaints and PALS feedback via telephone, email, face to face, Friends & Family Feedback electronic and paper and collected at point of service, National Surveys, Local Surveys, Forums, User Groups and the Membership forum. There is also regular Trust Board to staff engagement undertaken through Board walks. The Trust also uses third party assurances gained through the internal audit function, health watch, volunteers and regulatory inspections to assure itself of compliance.

The *Quality and Safety Committee* is the central driving force for quality governance, regularly reporting to the Trust Board that the essential standards of quality and safety are being delivered. This includes monitoring compliance with the Care Quality Commissions Fundamental Standards and other statutory compliance through the Performance and Quality Report prior to submission to the Trust Board. The Quality Committee's other duties include:

- Promote quality, safety and excellence in patient care;
- Identify, prioritise and manage risk arising from clinical care;
- Ensure the effective and efficient use of resources through evidence-based
- Clinical practice;
- Promote and support the duty of candour to provide a culture of shared learning and openness; and
- Protect the health and safety of Trust employees.

The Performance, Finance and Investment Committee has delegated authority to monitor and scrutinise:

- Putting the interests of patients at the heart of what the organisation does.
- Financial/Annual planning and monitoring.
- Cost transformation programmes.
- Activity and productivity including operational efficiency and effectiveness.
- Delivery of the Five Year Forward View, NHS Constitution Standards and local contractual obligations.
- Workforce cost.
- Information Management & Technology: seeking assurances about the underlying data to ensure that it is robust, reliable and accurate.
- Public Finance Initiative performance.
- Challenging relevant mangers when controls are not working or data is unreliable.
- Review, approve and evaluate business case investments and requests for capital expenditure within the powers delegated by the Trust Board.

The People and Organisational Development Committee has delegated authority to:

- Review performance data and quality indicators covering key aspects of the Trust-wide workforce matters, identifying areas for action at a corporate and local level, ensuring follow up takes place:
    - Appraisal
    - Mandatory Training
    - Sickness
    - DBS
    - Staff Survey
    - Flu Vaccination
    - Recruitment & Staffing levels
    - CQUINs
    - Staff friends & family test
    - Bank & Agency
    - Volunteers

The Trust has continued to work to embed the enhanced quality governance measures through the accountability framework maintaining a focus on strong governance and leadership across quality, finance and clinical care ensuring that there is clinically led management decision-making, as close as possible to the point of care delivery.

The Trust is commitment to promoting equality and human rights and valuing diversity in all areas of Walsall Healthcare NHS Trust. It does this by ensuring that Equality Impact Assessments are integrated into core business ensuring due regard to the aims of the Equality Act at the point when decisions are made.

The Trust Board development programme sets out the process by which it will assess itself against the NHS Improvement's well led framework as part of the Trust's journey of improvement. In May 2017 the Board conducted a self-assessment review of Well Led and will be further explored in a Board session due to be held in June 2018.

We continue to work with our two key partnerships to support future improvement – Walsall Together and the Black Country Provider Partnership.

The Trust had a total of 5 reportable serious information governance incidents during 2017/18 related to clinical information being sent to the wrong address, information being sent to the wrong email address, a letter regarding a forthcoming operation sent to two wrong patients, a formal complaint response letter containing sensitive information about inpatient treatment sent to another address and a discharge summary was attached to another patient's letter. These were all reported to the Information Commissioner Office and appropriate action taken.

High reporting of incidents is a mark of high reliability organisations and therefore incident reporting is encouraged by the Trust. It is essential that staff receive feedback, there is a focus on learning, frontline staff is engaged, and incident reporting is easy, reporting systems focus on improving safety, not blaming individuals and appropriate actions taken.

In 2017/18, NHS Trusts have been required to make an annual statement of confirmation in relation to compliance with elements of the NHS Provider Licence as follows:

- G6 – Meeting the requirements of the licence and the NHS Constitution, and, having implemented effective arrangements for the management of risk
- FT4 – Relates to corporate governance arrangements covering systems and processes of corporate governance in place and effective; effective Board and Committee arrangements; compliance with healthcare standards; effective financial decision making; sufficient capability and capacity at Trust Board and all levels in the organisation; accountability and reporting lines.

The Trust Board confirmed that it met the above requirements in May 2017 and is expected to confirm this position again, in May 2018.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. In June 2017, the CQC inspected the Trust and improvements were highlighted by the CQC following their last inspection in 2015 for all acute services at Manor Hospital with the exception of maternity and gynaecology services which remained inadequate overall and critical care which remained requires improvement overall. In the community, community health services for adults and children and young people remained at a good rating overall whilst community end of life care improved from good at our last inspection to outstanding overall.

The CQC rated the Trust as requires improvement overall and the Trust remains in special measures which was placed on the Trust in February 2016 following the CQC announced comprehensive inspection and unannounced visits in September 2015. In addition, the Trust was issued with a Section 29a Warning Notice which wholly related to the quality and safety of maternity services.

The Trust has continued to ensure that the PCIP delivers against the recommendations from the December 2017 CQC report and that these actions to the overall improvement direction of the Trust. The Quality & Safety Committee has received regular updates on delivery of the programme.

The key focus of the PCIP going forward is to make it business as usual as the Trust moves from a 'Requires Improvement' status to one of 'Good'.

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's rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that the organisation complies with all relevant equality, diversity and human rights legislation.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The National Data Guardian (NDG) "Review of Data Security, Consent and Opt-Outs" and CQC "Safe Data, Safe Care" publications were published in June and July 2016 and contain a number of recommendations and standards relating to IT security and leadership / governance related elements of information security. The Trust has ensured that these will be included within the new Data Security & Protection Toolkit which the Trust will complete in April 2018. The Trust manages and controls data security through the risk management framework and records it on Safeguard. There is 1 corporate risk (665 rated 12- amber) that pertains to risk to data security. Action is underway to mitigate where possible. There are 2 departmental risks for IT Services (1221 rated 12-Amber & 1138 rated 16 - red). Action is underway to mitigate where possible.

The Trust has assessed itself against the Department of Health and Social Care, NHS England and NHS Improvement set of 10 data and cyber security standards – the 2017/18 Data Security Protection Requirements (2017/18 DSPR) and have deemed to have:

- Fully implemented 5 of the standards
- Partially implement 4 of the standards
- Has not implemented 1 of the standards

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

As Accountable Officer I have responsibility to the Trust Board for the economy, efficiency and effectiveness of the use of resources. This is achieved operationally through good governance and systems of internal control designed to ensure that resources are applied efficiently and effectively.

The effective and efficient use of resources is managed by the following key policies:

Standing Orders

The *Standing Orders* are contained within the Trust's legal and regulatory framework and set out the regulatory processes and proceedings for the Trust Board and its committees and working groups including the Audit Committee, whose role is set out below, thus ensuring the efficient use of resources.

Standing Financial Instructions (SFIs)

The SFIs detail the financial responsibilities, policies and principles adopted by the Trust in relation to financial governance. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

They do this by laying out very clearly who have responsibility for all the key aspects of policy and decision making in relation to the key financial matters. This ensures that there are clear divisions of duties, very transparent policies in relation to competitive procurement processes, effective and equitable recruitment and payroll systems and processes. The budget planning and allocation process is clear and robust and ensures costs are maintained within budget or highlighted for action.

The SFIs are to be used in conjunction with the Trust's *Standing Orders* and the Scheme of Reservation and Delegation and the individual detailed procedures set by directorates.

Scheme of reservation and Delegation

This sets out those matters that are reserved to the Trust Board and the areas of delegated responsibility to committees and individuals. The document sets out who is responsible and the nature and purpose of that responsibility. It assists in the achievement of the efficient and effective resources by ensuring that decisions are taken at an appropriate level within the organisation by those with the experience and oversight relevant to the decision being made. It ensures that the focus and rigor of the decision making processes are aligned with the strategic priorities of the Trust and it ensures that the Trust puts in place best practice in relation to its decision making.

Anti-Fraud, Bribery and Corruption Policy

The Bribery Act which came into force in April 2011 makes it a criminal offence for commercial organisations to fail to prevent bribes being paid on their behalf. Failure to take appropriate measures to avoid (or at least minimise) the risk of bribery taking place could lead to the imposition of fines, or imprisonment of the individuals involved and those who failed to act to prevent it. This will help ensure that the taking or receiving of bribes is less likely and improve the integrity and transparency of the Trust's transactions and decisions.

The Trust Board places reliance on the *Audit Committee* to ensure appropriate and sound governance arrangements are in place to deliver the efficient and effective use of resources and the Trust's internal control systems are robust and can be evidenced.

The Audit Committee agrees an annual work programme for the Trust's Internal Auditors and the Counter Fraud Team, and reviews progress on implementation of recommendations following audit and other assurance reports and reviews.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by NHS Counter Fraud Team (formerly NHS Protect), reports from which are reviewed by the Audit Committee. In addition, further assurance on the use of resources is obtained from external agencies, including the external auditors and the Regulators.

The Trust Board also places reliance on the *Performance, Finance and Investment Committee* to provide appropriate scrutiny and review in respect of Trust performance relating to a number of areas including efficient and effective use of resources. The Trust identified a risk to CIP delivery in 2017/18 and entered into the Financial Improvement Programme supported by NHS Improvement. This robust programme was delivered through three phases for sustainability and assurance (1-Diagnosis, 2- Plan for Recovery and 3-Implementation). An outcome of the programme included enhanced governance processes to support the financial improvement efforts, CIP maturity was progressing with a requirement to get existing schemes de-risked and new schemes quality impact assessed, a communication and engagement strategy was developed. The Trust has also entered into a fourth phase of the programme to assure delivery in year and embed the governance recommendations from the work undertaken by the partner organisation.

Information governance

There were five serious incidents requiring investigation during the period from
April 2017 to March 2018 these related to a letter containing clinical information was sent to the wrong address, community referral forms were emailed in error, a letter regarding a forthcoming operation was sent two wrong patients, a formal complaint response letter containing sensitive information about inpatient treatment was sent to another address and a discharge summary was attached to another patient's letter. The incidents were reported to the Information Commissioner's Office (ICO).

Information Governance Toolkit

The Trust has consistently sustained Level 2 compliance with the Information Governance Toolkit. The Information Governance Steering Group has met on a regular basis throughout the year. The committee has reported its activities to the Quality and Safety Committee. An internal audit review of the systems of internal control for complying with the Information Governance Toolkit in 2017/18 concluded that there was "substantial" assurance.

Cyber and Data Security

Cyber and data security continues to be an important focus for the Trust. This because evident in light of the events on 12 May 2017 when the NHS was subject to a well-publicised worldwide cyber-attack. As a result of the co-ordinated emergency response to the threat by the Information Communications Technology (ICT) Department, the Trust defended itself against this particular attack and there was no operational impact to the Trust.

The Trust Information Governance Steering Group receives regular reports on plans and actions to maintain and improve cyber-security defences across the Trust. Some of the proactive work undertaken has included a cyber-security awareness campaign.

Each year the Trust undertakes a cyber penetration as part of its internal audit plan. This involves being subjected to a simulated cyber-attack probing both our external and internal networks. The results provide areas for improving including specific recommendations which are implemented to strengthen our cyber security. The overall opinion provided by the 2017/18 test is a split opinion with 1 optimal, 1 substantial and 1 requires improvement and 1 insufficient. The Trust has taken a number of actions to strengthen its ability to respond to cyber security intelligence through its subscription to alerts from NHS Digital Care Computer Emergency Response Team (CARECert). This provides advance alerting, cyber guidance and expertise. The Trust was also accepted as an early adopter for the Care Cert Assure/React programme which has provided additional analysis of our cyber security protection.

The Trust has assessed itself against NHS England's guidance on cyber risk management following the published "10 steps to cyber security" and adopted these principles. In response to NHS England's requirement for all system suppliers to be working towards Cabinet Officer Government certification for the Cyber Essentials Standard, the Trust is to include these standards into the procurements of all new ICT systems and is requesting existing suppliers to provide statements of compliance.

Annual Quality Report

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

The Trust's Quality Account for 2017/18 provides a summary of the Trust's quality achievements and challenges, demonstrating how it meets its statutory and regulatory requirements as well as how it meets the expectations of its service users, carers, stakeholders, its members and the public. The Report was externally audited. This provided the required limited assurance opinion on the content and consistency of the report, that the content was in line with the Annual Reporting Manual (2016/17) issued by NHS Improvement and consistent with documents reviewed. In terms of the performance indicator testing of two mandatory indicators (Friends and Family and CDIF),

The Draft Quality Account is shared with partner agencies and stakeholders and commissioners for comment. Leadership comes from the Trust Board with clearly devolved responsibility and accountability for individual quality improvement priorities.

The Director of Nursing is responsible for the preparation of the Quality Account and for ensuring that the document presents a balanced view of quality within the Trust. The Quality Account is prepared with contributions from all responsible and accountable leads.

The Quality and Safety Committee is responsible for reviewing the report prior to submission with the Annual Report and Accounts to the Audit Committee and then the Trust Board. The Trust's External Auditor, Ernst and Young LLP carry out a limited review of the arrangements around the data quality and information included in the Quality Account and assess whether a balanced view of quality is presented based on other information.

Progress against the Quality Account priorities for the reporting period, 2017/18, has been reported through the Trust's governance framework via the Annual Business Cycles of the Quality and Safety Committee and the Trust Board receiving routine reports on:

- Medicines safety
- Sepsis and the deteriorating patient
- Equality and diversity

Priorities for 2018/19 are currently being developed for the Quality Account. Robust outcome metrics will be set for each priority and action to identify progress and success in achieving this improvement. The metrics we will use will be meaningful to both staff and patients. Measurement will be used to demonstrate the impact of change and then continued as on-going performance measures following the implementation of successful change, updates will be reported via Quality and Safety Committee to Trust Board.

Elective waiting time data

The Trust has been working during 2017/18 to improve the quality and accuracy relating to planned and elective waiting time data. Validation has been underway to ensure that only patients requiring further treatment or monitoring appointments remain open on the Trust's patient management system. This work has been extremely successful and will continue through 2018/19. In order to ensure this work is concluded as quickly as possible the Trust has procured Robotic software to assist with the routine data quality activities and release validators time to ensure business as usual processes are effective.

The Trust has not achieved the National standard for RTT (92% incomplete pathways waiting no longer than 18 weeks) during the 2017/18 due to capacity pressures, but data quality indicators for the Trust monitoring system for RTT indicates that data quality has been sustained since the return to reporting in October 2016. Reports are regularly reviewed in order to ensure that data quality issues are identified and validated within 48 hours. The Trust adopted the Intensive Support Teams on line training for elective care during 2017/18, with completion of modules by administrative staff whose role is to support elective pathways in the Trust. The plan is to roll this out to more staff groups in 2018/19.

The Trust Access Policy outlines standards of practice with regard to capture of outcomes following inpatient discharge and outpatient attendance. KPIs are in place supporting the standards and there are weekly meetings held where compliance is monitored. There is a monthly meeting where NHSE/NHSI are represented, along with Walsall CCG. The RTT performance and data indicators are reported.

In March 2018 an internal audit of RTT pathways was carried out and the report is currently being formulated.

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 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 Trust Board, the Audit Committee, Quality & Safety Committee, Finance, Performance and Investment Committee, People and Organisational Development Committee, Risk Management Committee and Trust Quality Executive and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that had been applied in maintaining and reviewing the effectiveness of the system of internal control, I have set out below some examples of the work undertaken and the roles of the Trust Board and Committees in this process:

The Trust Board has met in public on eleven occasions and each meeting has been both well attended and quorate. The Committees of the Board operate to formal terms of reference that the Board has approved, and carry out a range of Board work at a level of detail and scrutiny that is not possible within the confines of a Trust Board meeting. Each of the Committees provides assurance to the Board in relation to the activities defined within its terms of reference; this is reported to the next meeting of the Board in the form of a highlight report to ensure that necessary issues are highlighted in a timely way. The Board also receives the formal minutes of the meetings of each of the Committees once approved by the Committee as a true record.

The work that has been undertaken by the committees includes:

- scrutiny and approval of the annual financial statements and annual report, including the Trust's Quality Account;
- receiving all reports prepared by the Trust's Internal and External Auditors and tracking of the agreed management actions arising;
- monitoring the Clinical Audit Programme, serious incidents and never events and ensuring that risk is effectively and efficiently managed and that lessons are learned and shared;
- monitoring of compliance with external regulatory standards including the Care Quality Commission and the Information Governance toolkit;
- monitoring of the Cost Improvement Programme and the delivery of service development;
- ensuring the adequacy of the Trust's Strategic Financial Planning;
- monitoring the implementation of the key strategies that the Board has approved; and, relevant policy approval/ratification.

The internal audit plan which is risk based, is approved by the Audit Committee at the beginning of each year. Progress reports are then presented to the Audit Committee at each meeting with the facility to highlight any major issues. The Chair of the Audit Committee can, in turn, quickly escalate any areas of concern to the Trust Board via a Highlight Report and produces an annual report on the work of the Committee and a self-evaluation of its effectiveness. The plan also has the flexibility to change during the year.

The Head of Internal Audit's overall opinion on the effectiveness of the organisation's system of internal control is that "Limited Assurance" can be given as weaknesses in the design, and/or inconsistent application of controls, put the achievement of the organisations objectives at risk in a number of areas reviewed. This is based on a range of work undertaken as part of the annual internal audit plan, including assessment of the Board Assurance Framework and an assessment of the range of individual opinions arising from risk based audit assignments throughout the year.

Internal audit has reported four areas of audit activity as requiring improvement during 2017/18 these include:

- Performance and Operations (Substantial in 2016/17)
- Clinical and Quality (Requires Improvement in 2016/17)
- Governance and Risk (Substantial in 2016/17)
- IT and Information Governance (Substantial in 2016/17).

In order to address the issues highlighted within each of the areas the following action is being taken:

Performance and Operations	Business Continuity	A further review of the draft policy will be undertaken to ensure that it is in line with the NHSE recommendations. The Trust will continue to review the Risk register and risk assessments in relation to Business Impact Assessments. The Trust will ensure all staff aware of the wards/ clinical business impact assessments. A review of the BIA template will be undertaken. All Business Continuity Plans will be reviewed annually. Training will continue to be offered to members of staff relevant to their role. Table top exercises have been undertaken. A review of the BCP group will be undertaken.
Clinical and Quality	Safer Bundles	The Trust is replacing the SAFER policies with a SOP as part of the overall Discharge Policy. Medical staff will ensure that they have estimated the dates of discharge then the nurses will transfer this data to the 'EDD' cell on the Nursing Assessment Document. The Trust are currently partnering with Adult Social Care to implement a 'Discharge to Assess' programme. 'Teletracking' or similar electronic bed board system will be considered for implementation by the Trust. Evidence that Board Rounds are being undertaken is being audited daily by the Care Group Managers. Further work to be undertaken on engaging the medical workforce in Safer and with patients and their carers. Progress against planned roll out of SAFER and outputs will be regularly reported to the Trust Management Board.
Clinical and Quality	Anaesthetic Rotas	A number of actions have been agreed to address the weakness identified in this area including: Trust-wide roll out of 'Allocate' for Medical Rotas. All rotas to be available via the Trust intranet and identify all activity including annual leave, protected teaching time and records working patters in order to ensure transparency, will transition to Allocate. Variation from pre-agreed working patters will be recorded, monitored and tracked to ensure compliance with contracted hours. Job plans to be agreed and entered into Allocate supported by the Job Planning Manager with the CD. Training will be provided for all CGM on allocate.
Governance and Risk	Board Assurance Framework	Actions are described above in the Risk and Control Framework section.
Governance and Risk	Conflicts of Interest	The Trust is reviewing the current policy and will ensure it use the model policy (gateway ref. 06649) as the basis for policy
IT and Information Governance	Ransomware	The Trust continues to improve its Cyber Security, in particular addressing the threat of Ransomware. This includes installation of a web filtering software to block malicious websites, email hygiene systems to block malicious emails and updating our patching regime to ensure all of our critical infrastructure has the latest patches installed. In addition the trust has signed up to the national CareCERT program, receiving weekly updates on Cyber Security from NHS digital which our IT Services department review take the appropriate action.

Taking account of national and local context, the strategic direction for the Trust has been reviewed by the Trust Board. Areas key to the delivery of the Trust's business strategy, managed and monitored by the Trust Board and the Committees of the Board includes:

- Review and maintenance of the Annual Plan and Assurance Framework
- Development of partnership working arrangements with Walsall Together and the Black Country Provider Partnership
- Delivery against the Internal Audit programme; and,
- Income, expenditure and activity

The Trust Board recognises the importance of ensuring that it is fit for purpose to lead the Trust and a programme of Board Development activity has taken place during the year through a programme of Board Seminars.

The Audit Committee has responsibility for overseeing systems of internal control and effective governance and receives assurances from the Quality & Safety Committee, Performance, Finance & Investment Committee and People and OD Committee through formal reporting arrangements following each meeting and cross membership by the Chairs of the respective committees. Additionally, assurance is received by regular internal audit reports on delivery of the internal audit programme and monitoring of actions to further strengthen governance arrangements.

The Trust Board is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended in 2011 and 2012) to prepare a Quality Account for each financial year. The Quality Governance and Risk Committee assume a scrutiny role in the development of this account prior to submission to the Trust Board for approval.

The Performance, Finance and Investment Committee has provided a forum for the Trust Board to seek additional assurance in relation to all aspects of financial and general performance, including performance against nationally set and locally agreed targets, monitoring of the Cost Improvement programme, and monitoring of the Service Transformation Programme.

Significant internal controls issues

In 2016/17 the Trust received from its external auditors, Ernst and Young LLP, a qualified Value for Money Conclusion based on the overall CQC rating of "requires improvement", financial resilience and staff survey results for 2016. The Trust continues to view these areas as significant risk areas for 2017/18.

Care Quality Commission

The CQC visited the Trust in 2015 and rated the Trust as 'inadequate'. The Trust was placed in special measures by the Secretary of State for Health in February 2016 following the CQC announced comprehensive inspection and unannounced visits in September 2015.

Following this the CQC served the Trust with a Section 29a Warning Notice of the Health and Social Care Act 2008. The warning notice set out the points of concern and timescales to address this and was wholly related to maternity services.

An announced visit was undertaken by the CQC in June 2017, and at this inspection, improvements were recognised by the CQC for all acute services at Manor Hospital with the exception of maternity and gynaecology services which remained inadequate overall and critical care which remained requires improvement overall. In the community, community health services for adults and children and young people remained at a good rating overall whilst community end of life care improved from good at our last inspection to outstanding overall.

The CQC rated the Trust as requires improvement overall and the Trust remains in special measures.

During 2017/18 the Trust continued to ensure that the Patient Care Improvement Programme (PCIP) delivered against the recommendations from the December 2017 CQC report. NHSI oversight meetings were held to monitor the actions relating to maternity services and progress has been made to address the actions.

The key focus of the PCIP going forward is to make it business as usual as the Trust moves from a 'Requires Improvement' status to one of 'Good'. In preparation for this the Trust is developing a comprehensive CQC preparation plan which will be shared with Executive Directors in May and the Trust Board in June. Monitoring of this plan will be undertaken in a weekly meeting, chaired by the Chief Executive, with Directors, Divisions and Heads of Service in attendance. The Trust is also organising a series of workshops across the Trust to support staff in the preparation for a CQC inspection and undertaking regular audits of compliance including peer review. The Trust is keen to ensure that areas of good practice are highlighted and celebrated and as part of this preparedness will undertake a self-assessment against the key lines of enquiry to give a holistic understanding of the issues and areas of celebration.

Financial position

The Trust has achieved a £24.2m deficit, following national adjustment, against the original planned deficit £20.5m.

The contracted income position is down against plan (£6,029k). The underperformance was largely a consequence of reduced Obstetric activity, outpatients and elective utilisation. Other income over-performed largely as a consequence of additional funding allocations for winter (£1.85m total) and other one off income additions such as Diabetes (£800k).

Expenditure is overspent as a result of increased staffing costs, the main cause being temporary workforce to cover nursing and medical vacancies and additional capacity. The expenditure position improved in latter months, an element of this improvement following the allocation of winter monies also review and transfer of expenditure meeting the capital definition.

The Trust's targeted efficiency savings for 2017/18 are £11m. The actual savings delivery was £10.9m, an under achievement of just £0.1m. However, of this total £4.6m is delivered non-recurrently (includes asset sales of £1.3m), placing increased pressure on future requirement to recover this shortfall

The financial position has been closely scrutinised by the Trust Board and its committees throughout the year. It has been agreed that going forward this will be strengthen with the introduction of weekly oversight meetings reviewing the CIP programme to ensure there is a clear understanding of mitigation around any slippage in the plan. The Trust's Executive Performance and Finance Group will continue to provide oversight and challenge on a monthly basis providing assurance into the Performance, Finance & Investment Committee.

Staff Survey
The overall national average response rate for Combined Acute and Community Trusts for the staff survey was 40.4%. The Trust reached a response rate of 36.0%, a slight reduction from the previous year but which equated to 1,536 responses. The People and Organisational Development Committee reviewed the findings and plans have been identified to address the issues. The Trust Board has considered the feedback and felt that the overall picture for Walsall Healthcare had improved (going from 37th to 35th against other Trusts) and felt that there had been early signs of improvements across the Trust. The key findings compared nationally to the 2016 survey are:

- No change in 28 key findings
- Improvement in 3 key findings
- Worsening in 1 key finding
- The Trust has improved by 2% or more from 2016 results for 42% of the survey (35 questions)
- The Trust has worsened by 2% or more from 2016 survey for 13% of the survey (11 questions)
- The Trust has stayed about the same (within 1%) from 2016 survey for 45% of the survey (37 questions)
- According to Listening into Action we have improved from 37/37 Acute & Community Trusts to 35/37

The Trust has a dedicated Staff Engagement Action Plan to focus attention on what staff see as areas required for improvement and to support that the Trust has also asked for feedback on a number of key areas relating to the survey results asking for suggestions of improvement, which will feed into that plan. In addition all divisions will have their own dedicated action plan, which will be discussed monthly with the Executive Directors.

Conclusion

The Trust has identified three significant control issues (CQC, financial deficit and staff engagement) which have been identified in the body of the AGS.

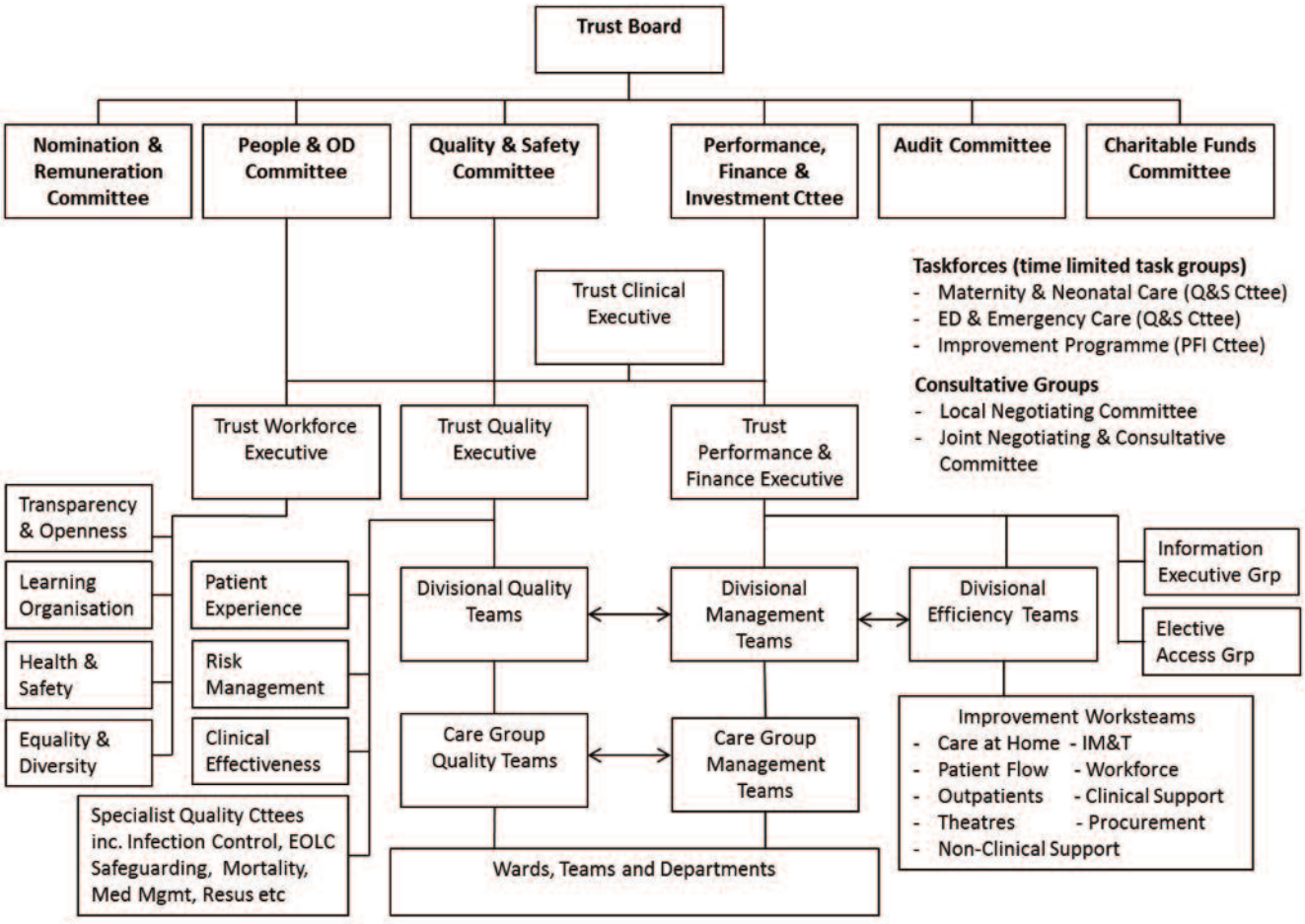
There are no other significant issues to highlight.

Richard Beeken

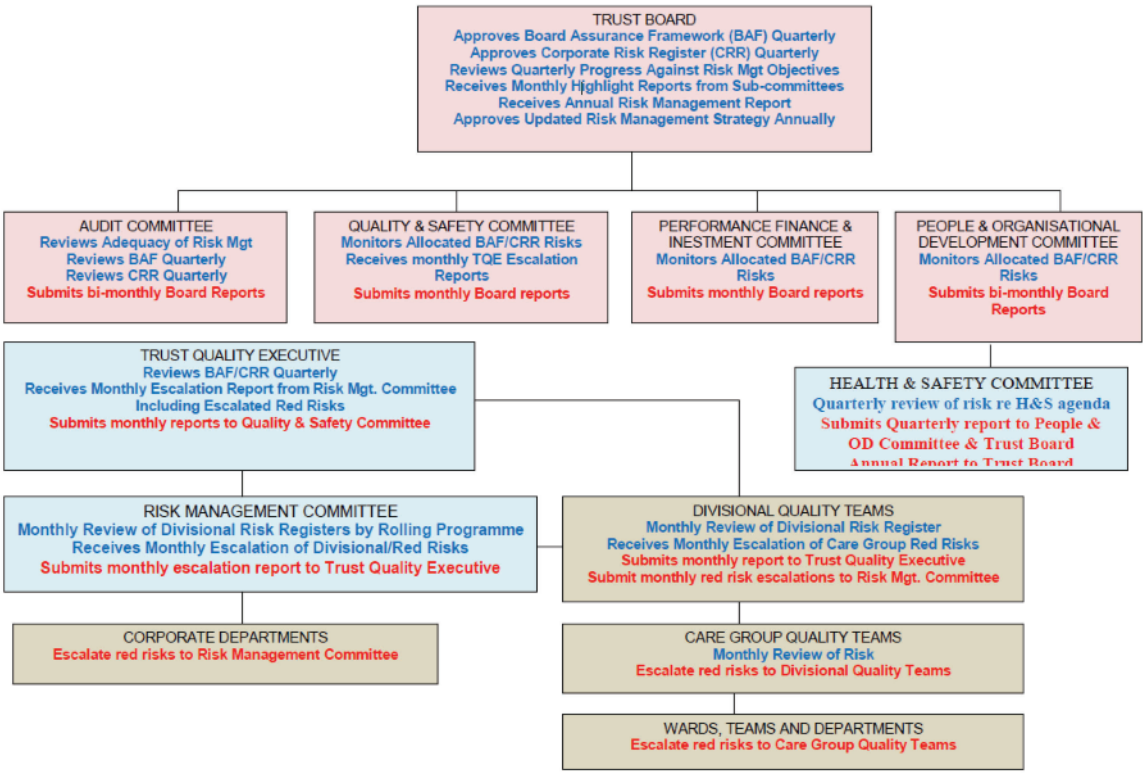
Chief Executive

Date: 11 July 2018

Appendix 1 - Trust Governance Structure - February 2017



Appendix 2 - Risk Management Governance Structure



Remuneration and Staff Report

Remuneration Policy

The Trust's approach to Remuneration Policy for Directors is ensuring the salary is within the average range for Trusts of a similar size and scope in order that directors' pay remains both competitive and value for money.

The Trust has a Nominations and Remuneration Committee that agrees the remuneration packages for executive directors.

Further information about the committee can be found in the Corporate Governance Report section of this Annual Report.

Fair Pay Disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

In 2017/18, no employees received remuneration in excess of the highest-paid Director (there were 0 in 2016/17). Remuneration ranged from £15,404 to £200,000 (2016-17 - £15,251 to £198,000).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The Nominations and Remuneration Committee agrees remuneration packages for Executive Directors. The notice period and termination payments are defined within the NHS Agenda for Change payment model as for all employees. No performance bonus payments were made to directors during the financial year.

The information contained within summary financial statements has been subject to external audit scrutiny. In addition, the directors' remuneration tables have been audited for compliance with Statutory Instrument 2008 No 410.

Pay Multiples – Audited

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Walsall Healthcare NHS Trust in the financial year 2017-18 was £200,000 (2016-17, £198,000). This was 7.8 times (2016-17, 8.2) the median remuneration of the workforce, which was £26,000 (2016-17, £24,000). In 2017-18 no employees received remuneration in excess of the highest-paid director.

Name and Title	2017-18						2016-17					
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Long-term Performance Pay & Bonuses (bands of £5000) £000	Expense Payments (taxable) to the nearest £100	All Pension Related Benefits (bands of £2500) £000	TOTAL (bands of £5000) £000	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Bonus Payments (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	All Pension Related Benefits (bands of £2500) £000	TOTAL (bands of £5000) £000
Ms D.OUM, Chairman (from 8 April 2016)	30-35					30-35	30-35					30-35
Mr R.BEEKEN, Chief Executive (from 26 February 2018)	10-15				7.5-10	20-25						
Mr R.KIRBY, Chief Executive (left 28 February 2018)	140 145				40 42.5	180 185	150 155				37.5 40	190 195
Mr R.CALDICOTT, Director of Finance (from 1 July 2015)	110-115					110-115	110-112.5					110-112.5
Mr P.THOMAS HANDS, Chief Operating Officer (from 10 December 2016)	120 125				40 42.5	160 165	55 60				50 52.5	110 112.5
Mr S.VAUGHAN, Interim Chief Operating Officer (left 30 September 2016)							150-155					150-155
Mr A.KHAN, Medical Director (from 1 October 2010)	85-90	85-90	30-35			200-205	80-85	80-85	25-30			195-200
Ms B.Beal, Director of Nursing (from 6 November 2017)	35-40					35-40						
Mrs R.Overfield, Director of Nursing (1 June 2016)	70 75					70 75	95 100					95 100
Mr M.SINCLAIR, Director of Strategy (left 11 May 2017)	40-45					40-45	105-110					105-110
Mr D FRADGLEY, Director of Transformation and Strategy (from 1 January 2016)	95 100					95 100	95 100					95 100
Dr J. SHAPIRO, Non-Executive Director (left 31 October 2017)	0 5					0-5	5-10					5-10
Mr J.DUNN, Non-Executive Director (from 1 February 2015)	5-10					5-10	5-10					5-10
Mr J.SILVERWOOD, Non-Executive Director (from 1 February 2015)	5-10					5-10	5-10					5-10
Mrs V.HARRIS, Non-Executive Director (from 1 April 2015)	5-10					5-10	5-10					5-10
Mr R.BEALE, Non-Executive Director (from 1 June 2016)	5-10					5-10	5-10					5-10
Ms D.CARRINGTON, Associate Non-Executive Director (from 1 July 2016)	5-10					5-10	0-5					0-5
Mr P.GAYLE, Associate Non Executive Director (from 1 August 2016)	5 10					5 10	0 5					0 5
Mr S.HEER, Non Executive Director (from 15 September 2016)	5 10					5 10	0 5					0 5

**Other Remuneration - This is the salary payment as a Medical Consultant.
The bonus payment for Mr A. Khan is in respect of a National Clinical Excellence Award.
Mr S. VAUGHAN, Interim Chief Operating Officer (from 10 January 2016) his salary represents agency costs.
Mrs R. OVERFIELD, Interim Nurse Director (from 1 November 2015) her salary represents a recharge from the NHS Trust Development Authority (NTDS).

Name and Title	Real increase in pension at pension age in Bands of (£2,500)	Real increase in pension lump sum at pension age in Bands of (£2,500)	Total accrued pension as pension age at 31 March 2018 in Bands of (£5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 in Bands of (£5,000)	Cash Equivalent Transfer Value at 31 March 2018 £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Real Increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Mr R.KIRBY, Chief Executive (left 28 February 2018)	2.5-5	0	45-50	115-120	693	634	48	0
Mr R.BEEKEN, Chief Executive (from 28 February 2018)	0	0	45-50	115-120	742	689	5	0
Mr P.THOMAS-HANDS, Chief Operating Officer (from 10 December 2016)	2.5-5	15.0-17.5	40-45	120-125	845	692	146	0
Mr R.CALDICOTT, Director of Finance (from 1 July 2015)	0	(2.5)-(5)	25-30	65-70	411	386	21	0
Miss R.OVERFIELD, Nurse Director (from 1 June 2016)	0	0	0	0	0	0	0	0
Ms B.BEAL, Nurse Director (from 6 November 2018)	0	0	0	0	0	0	0	0
Mr A.KHAN, Medical Director (from 1 October 2010)	0	0	0	0	0	0	0	0
Mr D FRADGLEY, Director of Transformation and Strategy (1 January 2016)	0-2.5	0	25-30	70-75	409	362	43	0
Mr M.SINCLAIR, Director of Strategy (left 11 May 2017)	0	0	5-10	0	74	34	4	0

Our organisation and people

As at 31 March 2018, Walsall Healthcare NHS Trust employed 4361 substantive staff. Of these, 4002 colleagues were permanently employed on recurrent, open-ended contracts of employment. A further 359 colleagues were employed on fixed term contracts of employment.

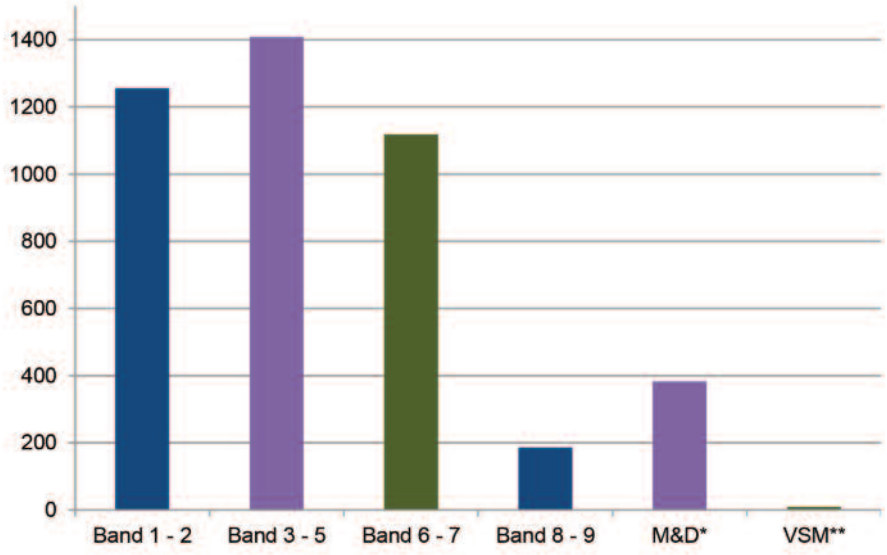
The following table provides a snapshot of the average workforce composition during 17/18:

	Headcount
Additional Clinical Services	800
Additional Professional Scientific and Technical	134
Administrative and Clerical	976
Allied Health Professionals	251
Estates and Ancillary	397
Healthcare Scientists	105
Medical and Dental	390
Nursing and Midwifery Registered	1327
Students	36

All staff by pay band:

Band 1 - 2	1256	28.80%
Band 3 - 5	1409	32.31%
Band 6 - 7	1118	25.64%
Band 8 - 9	186	4.27%
M&D*	383	8.78%
VSM**	9	0.21%

**Medical & Dental*
***Very Senior Manager/Director*



Equal Opportunities

All staff by gender		Senior Managers* by gender	
Female	**Male**	**Female**	**Male**
3198	1151	80	146
73.3%	26.4%	35.4%	64.6%

**For the purposes of this document, "Senior Managers" represent colleagues employed on a Band 8B+, VSM or Medical Consultant contract.*

During the next year, specific actions will be carried out to reduce the gender pay gap, including:

- A review of current recruitment & selection practices to ensure that opportunities are inclusive.
- Establishing what more can be done to improve flexible working.
- Investigating how we can recognise female contributions to the continuous improvement of NHS services by encouraging applications for Clinical Excellence Awards (CEA).

All staff by ethnicity			Senior Managers* by ethnicity		
White	**BAME**	**Unknown**	**White**	**BAME**	**Unknown**
3198	1151	12	98	127	1
73.3%	26.4%	0.3%	43.4%	56.2%	0.4%

Ninety nine per cent of the substantive workforce has chosen to disclose its ethnic background, with 26% of colleagues declaring themselves to be from a BAME background, representative of the local population and national NHS Workforce. (NHS BAME Workforce population – 18.2%).

BAME (Black, Asian and Minority Ethnic) colleagues account for 73% of the medical consultant workforce, whilst 11% of the Band 8B – Band 9 workforce have identified themselves as being from a BAME background.

The Trust is committed to equality of opportunity and recognises that a renewed Equality, Diversity and Inclusion action plan is required to address the disparity identified in publications such as the Workforce Race Equality Standards review.

Substantive senior staff (or senior managers) by band	**Headcount**
Band 8 - Range B	33
Band 8 - Range C	15
Band 8 - Range D	4
Band 9	1
Senior Manager Grade (Director etc.)	9
Consultant (Medical & Dental)	164
	226

	Female		**Male**	
All Substantive Colleagues	3566	82%	795	18%
Of which are:				
Directors	4	31%	9	69%
Senior staff	80	35%	146	65%

Our workforce is predominately female (82%), and this is the predominant gender in all of the staff groups except for medical staff and senior managers where the position is the reverse.

NHS Employers estimates that the NHS workforce is 77% female and 23% male. Our workforce gender percentage is therefore slightly higher compared to the overall NHS gender percentage in England. As part of the Trust's Equality, Diversity and Inclusion Strategy consideration will be given to the gender distribution and whether targeted intervention is required, particularly at the senior manager level where the gender percentage is lower than average.

While the gender gap for colleagues within Band 1-8a roles falls in line with the overall NHS gender percentage in England, the average number of female colleagues holding more senior positions is 57%. Amongst the medical and dental workforce only 4 out of every 10 positions is held by a female colleague, with men making up 73% of consultant staff. We can use this data to inform our recruitment campaigns to try and rebalance the gender difference at higher bands.

Other Protected Characteristics

The Equality, Diversity and Inclusion strategy and action plan which is currently being reviewed will ensure that all nine protected characteristics identified under Equality Act 2010 are of equal importance.

Our values and behaviours, as well as staff engagement campaigns, are being developed to support an inclusive culture across the Trust, where diversity is embraced.

We will continue our work in building partnerships with local community groups and supporting the establishment of internal network groups for our employees. We will recognise diversity as an important aspect of what makes people unique, allowing individuality and growth to create a positive inclusive environment that encourages respect that will benefit patient care and safety.

The Equality, Diversity and Inclusion Committee will continue to monitor the achievement of agreed actions taken from the plan, as well as agreeing how key milestones will be measured and identify accountable leads across the Trust. It will also challenge where progress has not been achieved within the agreed timescales.

We will continue to organise events to support new and expectant mothers within the community through schemes such as 'Whose Shoes' a national programme with the purpose of improving maternity experiences. We have also created a WREN team (**W**omen **R**equiring **E**xtra **N**urturing) – a new team of midwives committed to supporting vulnerable women throughout pregnancy and beyond into the early postnatal period.

We will also use events such as Equality, Diversity & Human Rights Week to capture feedback about what we can do differently to promote and embed equality and diversity.

The Trust will also continue to collaborate with NHS England to compare the experiences of disabled and non-disabled staff, via the Workforce Disability Equality Standard. This information will be used to develop a local action plan, which promotes and measures progress against the indicators of disability equality and build on our already established practices. These include:

- Ensuring our recruitment and selection practices are inclusive such as additional time, as well as other adjustments to support candidates during the interview process
- Participation in Disability Confident which is a national scheme designed to help us recruit and retain disabled people and people with health conditions based on their skills and talent.
- Working with our local Job Centre to support targeted recruitment of potential employees with disabilities
- Making reasonable adjustments for new and existing disabled employees, including redeployment for existing employees who become disabled during their employment.

Staff Sickness Absence

	2017/18	2016/17
Total Days Absent	42,776	39,391
Total Average Staff	3,791	3,796
Average working Days absent	11	10

The Trust continues to implement measures to support a reduction in sickness absence.

During the past 12 months the Trust has:

- Offered weekly Stress Management groups.
- Collaborated with Walsall & Dudley Mental Health Trust to provide Resilience and Stress Management training sessions for Managers.
- Provided access to a Psychologist, via our Occupational Health service.
- Provided fast-track referrals to a physiotherapist.
- Made Mindfulness training available to all staff.
- Promoted healthy lifestyle benefits via the Health & Well-Being Hub.
- Developed Key Performance Indicators (KPIs) to further support attendance management.
- Supported staff by offering phased returns to work/rehabilitation programmes and redeployment.

During the 2018/19, we will continue to build on the above actions, and we will:

- Review the Attendance Policy to ensure it supports our staff and the effective management of sickness absence.
- Reintroduce training for managers so they feel more able to support staff effectively while they are in work and if they are absent due to illness.
- Review the support given through our Occupational Health and Counselling services.
- Support the effective implementation of a risk assessment process relating to stress management.
- Continue to develop our Health & Wellbeing agenda.

Staff Policies

The Trust has a range of HR policies that support staff and which are widely available on the Intranet.

In respect of disability, the Trust's Recruitment and Selection Policy and Guidelines sets out the Trust's commitment to ensuring that all staff, including those who are disabled are treated fairly and equitably in relation to the appointment processes. The Trust maintains 'Two-Tick's' accreditation, guaranteeing an interview for disabled applicants who meet the person specification and to ensure reasonable adjustments are made.

The Trust has an Equality and Diversity Steering group, which amongst others ensures that disabled persons have equal access to development and support.

The Attendance Policy and Occupational Health Service ensure that staff who become disabled are given appropriate training, support and redeployment opportunities. The Trust monitors its employment and policies to ensure actions are taken to avoid unlawful discrimination whether director or indirect.

The Trust has signed up to the Dying Matters pledge as promoted by Unison.

The full range of Human Resources Policies is available to all Trust employees via the Trust's Intranet.

Consultancy Costs

The Trust paid £2.3m on consultancy costs during 2017/2018.

Off Payroll Arrangements

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

TABLE 1 Off-payroll engagements longer than 6 months	
For all off payroll engagements as of 31.3.18, for more than £245 per day lasting longer than 6 months	**Number**
Number of existing engagements as of 31.3.2018	**5**
Of which, the number that have existed:	
less than 1 year at the time of time of reporting	4
for between 1 and 2 years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and March 2018, for more than £245 per day and that last for longer than six months:

TABLE 2 New Off-payroll engagements	**Number**
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	4
Of which...	
No. assessed as caught by IR35	4
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	1
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Table 3: Off-payroll board member/senior official engagements	**Number**
Number of off payroll engagements of 'board members, and/or senior officers with significant financial responsibility' during the year (1)	0
Number of individuals that have been deemed 'board members and/or senior officers' with significant financial responsibility during the year. This figure includes both off payroll and on payroll engagements (2)	12

Note:

(1) There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months

(2) As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero

In any cases where individuals are included within the first row of this table the department should set out:

Details of the exceptional circumstances that led to each of these engagements.
Details of the length of time each of these exceptional engagements lasted.

Exit Packages

Exit package cost band (including any special payment element)	Number compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'000s	Number	£'000s	Number	£'000s	Number	£'000s
Less than £10,000								
£10,000 - £25,000								
£25,001 - £50,000	1	43			1	43		
£50,001 - £100,000								
>£100,000								
Totals	1	43			1	43		

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Walsall Healthcare NHS Trust has agreed early retirements, the additional costs are met by the Walsall Healthcare NHS Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

A Mutually Agreed Resignation (MAR) Scheme is a scheme whereby organisations may offer a severance payment to an employee to leave their employment voluntarily. The scheme has been developed to assist employers in addressing some of the financial challenges facing the NHS and its key purpose is to create job vacancies for colleagues facing redundancy. The scheme is time limited and has HM Treasury approval. There have been no MARS agreements in the financial year.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

SECTION 3: FINANCIAL STATEMENTS AND NOTES

2017/18 Financial Position

The Trust has reported a deficit of £23m for the financial year (excluding impairments) and the Trust did not achieve its financial duty to break-even. The deficit for the year totalled a £24.2m including impairments that related to the new build and renovation.

In order to attain the financial plan in 2017/18 the Trust initially had to achieve savings of £11 million; these savings were needed to meet the required national efficiency savings target and deliver the financial plan for the year. The Trust over-spend of £23m exceeded the initial planned deficit of £20.5m, largely a consequence of the significant emergency demands serviced by the Trust and therefore the need to use additional capacity areas and temporary workforce. The Trust has had loan support during the year from the Department of Health to settle creditor accounts within reasonable time frames thereby ensuring continuity of services.

How is our financial performance assessed?

The Department of Health measures NHS Trust financial performance against the following four targets.

Definition of Target		Target Set	Actual	Target Met
Income and Expenditure Revised Break Even (Managing Services within the income received by the Trust)	£'000	(20,500)	(22,985)	NO
External Financing Limit (Managing Services within the "cash limit" agreed with the Department of Health)	£'000	27,496	27,496	YES
Capital Resource Limit (Managing Capital Expenditure within the Capital Resource Limits agreed with the Department of Health)	£'000	9,846	8,972	YES
Capital Cost Absorption Duty (return on assets employed). The Trust was not required to submit a dividend payment.	%	3.5%	0.0%	YES

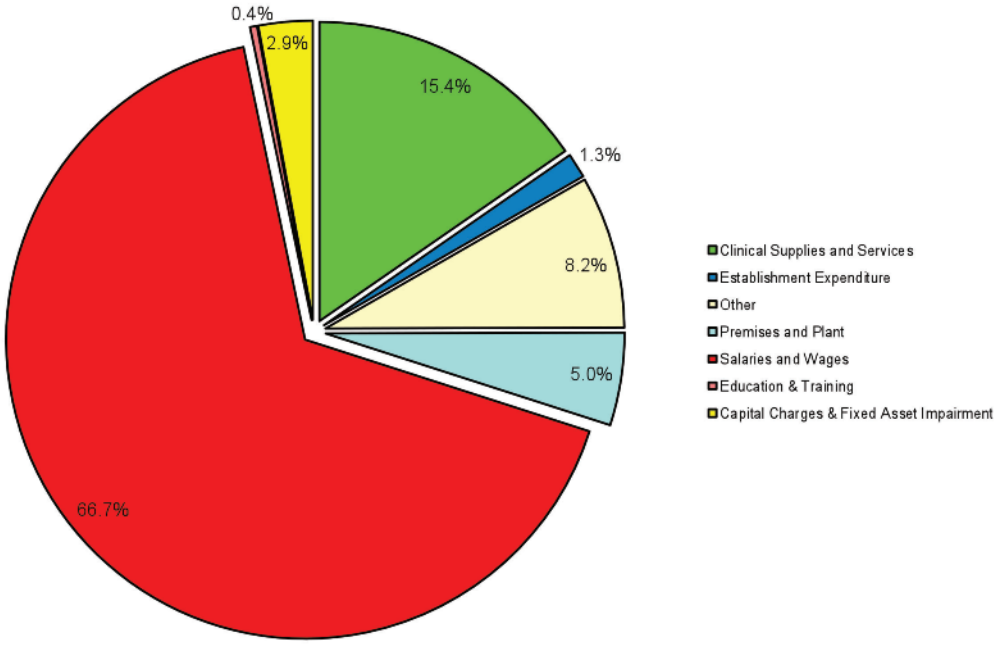
Where our money comes from

The majority of Trust income comes from the provision of patient care services (£225 million), the remainder of income comes from such things as Education, Training and Research, Income Generation (car parking, staff catering and accommodation) and the provision of non-patient related services to Walsall Commissioning Care Group.

What we spend our money on

The Trust spent £270million in the financial year 2017/18. The largest component of this expenditure was salaries and wages where we spent £174million, with the average number of staff employed being 4,157 whole time equivalents. The Trust spent a further £36.6million on clinical supplies and services such as drugs and consumables used in providing healthcare to patients.

The chart below shows a breakdown of the main categories of expenditure for 2017/18.



Capital Investment

The total capital expenditure in 2017/18 totalled £10.1million. The main areas of investment were:

	£'m
Reconfiguration, lifecycle and refurbishment works	7.7
Computer replacement and Information systems	1.0
Medical and theatre equipment	1.4
Total	10.1

Income and expenditure account for the year ended 31 March 2018

	2017/18 £'000	2016/17 £'000
Revenue from patient care activities	225,136	223,025
Other operating revenue	18,827	21,717
Operating expenses	(259,154)	(258,015)
*PFI Impairment	(1,234)	(12,833)
OPERATING SURPLUS	**(16,425)**	**(26,106)**
Profit/(Loss) on disposal of asset	1,329	6
SURPLUS BEFORE INTEREST	**(15,096)**	**(26,100)**
Interest receivable	24	21
Other Gains and (Losses)	-	-
Finance Costs	(9,147)	(8,050)
SURPLUS FOR THE FINANCIAL YEAR	**(24,219)**	**(34,129)**
Public Dividend Capital Dividend Payable	-	-
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR	**(24,219)**	**(34,129)**
*Impairments (excluding IFRIC 12 impairments)	1,234	12,833
Adjustments in respect of donated asset reserve elimination	(282)	(96)
Adjustments in respect of 16/17 CQUIN	(814)	-
Adjusted retained surplus/(deficit)	**(24,081)**	**(21,392)**

*The Trust had a full site revaluation during the year ending 31st March 2018 that resulted in an impairment of £1,234k being charged to the operating expenses. The 2016/17 impairment was specific to the revaluation of the Trust's PFI in respect of Department of Health instruction for accounting VAT on PFI assets.

Balance Sheet at 31 March 2018

	31 March 2018 £'000	31 March 2017 £'000
Non-current assets		
Property, plant and equipment	138,291	133,168
Intangible assets	1,311	1,010
Trade and other receivables	1,054	1,119
	140,656	**135,297**
CURRENT ASSETS		
Stock and work in progress	2,277	2,107
Trade and other receivables	17,214	14,603
Cash and cash equivalents	2,277	1,705
	21,768	**18,415**
CURRENT LIABILITIES		
Trade and other payables	(30,703)	(29,457)
Borrowings	(3,697)	(3,489)
DH revenue & capital support loan	(7,085)	-
Provision for liabilities and charges	(431)	(420)
NET CURRENT ASSETS/(LIABILITIES)	**(20,148)**	**(14,951)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**120,508**	**120,346**
NON-CURRENT LIABILITIES		
Trade and other payables	-	-
Borrowings	(124,162)	(127,857)
DH revenue & capital support loan	(53,655)	(31,183)
PROVISIONS FOR LIABILITIES AND CHARGES	-	-
TOTAL ASSETS EMPLOYED	**(57,309)**	**(38,694)**
FINANCED BY:		
Public dividend capital	58,318	56,318
Revaluation reserve	16,023	12,752
Retained earnings	(131,650)	(107,764)
TOTAL CAPITAL AND RESERVES	**(57,309)**	**(38,694)**

Cash flow statement for the year ended 31 March 2018

	2017/18 £'000	2016/17 £'000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	(19,812)	(18,564)
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE		
Interest received	24	22
Net cash inflow from returns on investments and servicing of finance	**(19,788)**	**(18,542)**
CAPITAL EXPENDITURE		
(Payments) to acquire tangible fixed assets	(8,916)	(3,738)
(Payments) to acquire intangible fixed assets	(811)	(376)
Receipts from sale of tangible fixed assets	2,019	-
Net cash (outflow) from capital expenditure	**(7,708)**	**(4,114)**
DIVIDENDS PAID	-	-
Net cash inflow before management of liquid resources and financing	(27,496)	(22,656)
MANAGEMENT OF LIQUID RESOURCES		
(Purchase) of current asset investments	-	-
Sale of current asset investments	-	-
Net cash inflow from management of liquid resources	-	-
Net cash inflow before financing	**(27,496)**	**(22,656)**
FINANCING		
Public dividend capital received	2,000	-
Public dividend capital repaid	-	-
Other loans received	29,557	25,457
Other loans repaid	-	(1,157)
Capital element of finance leases and PFI	(3,489)	(3,304)
Capital grants and other capital receipts	-	-
Net cash (outflow) from financing	**28,068**	**20,996**
Increase (reduction) in cash	**572**	**(1,660)**
Opening cash holding	1,705	3,365
Closing cash holding	2,277	1,705

Better Payment Practice Code

The Trust is a member of the 'Better Payment Practice Code' in dealing with our suppliers. The code sets out the following principles:

- agree payment terms at the outset of a deal and stick to them
- pay bills in accordance with any contract agreed with the supplier or as agreed by law i.e. the code requires the Trust to pay all valid invoices by the due date or within 30 days of receipt
- tell suppliers without delay when an invoice is contested and settle disputes quickly

During 2017/18 the percentage of bills paid within target was:

- number of bills : 13%
- value of bills : 22%

	2017/18 Number	2016/17 Number
Better payment practice code - measure of compliance		
Total Non-NHS trade invoices paid in the year	57,119	64.641
Total Non-NHS trade invoices paid withinn the target	11,024	9,885
Percentage of Non-NHS trade invoices paid within the target	**19.3%**	**15.3%**
Total NHS trade invoices paid in the year	1,394	1,428
Total NHS trade invoices paid withinn the target	179	254
Percentage of NHS trade invoices paid within the target	**12.8%**	**17.8%**

	2017/18 Value £'000	2016/17 Value £'000
Better payment practice code - measure of compliance		
Total Non-NHS trade invoices paid in the year	93,330	113,318
Total Non-NHS trade invoices paid withinn the target	40,749	59,065
Percentage of Non-NHS trade invoices paid within the target	**43.7%**	**52.1%**
Total NHS trade invoices paid in the year	14,815	10,787
Total NHS trade invoices paid withinn the target	3,228	1,574
Percentage of NHS trade invoices paid within the target	**21.8%**	**14.6%**

Russell Caldicott
Director of Finance & Performance

These financial statements are summaries of the information contained in the Annual Accounts of Walsall Healthcare NHS Trust. The Trust's auditors have issued an unqualified report on the Annual Accounts.

The full financial statements are available as a separate document from the Trust's website **www.walsallhealthcare.nhs.uk.com** or on request from:

Mr. Trevor Baker, Head of Financial Accounting, Finance Department, Walsall Healthcare NHS Trust, The Manor Hospital, Moat Road, Walsall WS2 9PS.

The Trust's policy for managing risk is set out in the Annual Governance Statement.

The Trust's external auditors are Ernst & Young LLP. The fee for the statutory audit for 2017/18 was £64,000 (including VAT) with an additional £16,800 for audit related services (i.e. the review of the Trust's Quality Account).

Independent Auditors' Report Opinion on the financial Statements

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF WALSALL HEALTHCARE NHS TRUST

Opinion

We have audited the financial statements of Walsall Healthcare NHS Trust for the year ended 31 March 2018 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust's Statement of Financial Position, the Trust's Statement of Changes in Taxpayers' Equity, the Trust's Statement of Cash Flows and the related notes 1 to 52. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2017-18 HM Treasury's Financial Reporting Manual (the 2017-18 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2017/18 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:

- give a true and fair view of the financial position of Walsall Healthcare NHS Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.
We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of our report

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

Material uncertainty related to going concern

We draw attention to note 1 in the financial statements, which indicates that the Trust has found it difficult- to meet its financial targets and have reported a significant deficit in year and is budgeting for a further deficit in the next financial year. As stated in note 1, these events or conditions indicate that a material uncertainty exists that may cast significant doubt on the Trust's ability to continue as a going concern.

Our opinion is not modified in respect of this matter.

Other information

The other information comprises the information included in the annual report set out on pages 67, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

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

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

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if[1]:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or

We have nothing to report in these respects

[1] Where the auditor has issues to report under any of the issues listed, they should be deleted from this section and a suitable exception report, briefly explaining the action taken, inserted in the following section.

Section 30 Referral

We refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency

The Trust anticipated an in-year deficit for the 2017-18 financial year and we referred this matter to the Secretary of State on 22 May 2017 under section 30 of the Local Audit and Accountability Act 2014.The Trust have delivered a deficit in 2017/18 of £24.2million.

Proper arrangements to secure economy, efficiency and effectiveness

We report to you, if we are not satisfied that the Trust has put in place proper arrangements to secure economy efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

Special Measures

The Care Quality Commission (CQC) inspected the Trust in May and June 2017; and issued the Trust with an overall rating of requires improvement. The report highlighted concerns in respect of urgent and emergency services; surgery; critical care; maternity and gynaecology.

Sustainable Resource Deployment

The Trust's outturn position for 2017/18 was a £24.2million deficit, which is a significant deterioration compared to the 2017/18 planned deficit of £20.5million.
The deterioration in the Trust's financial outturn was due to failure to maintain effective controls over temporary staffing.

Workforce Development

The results of the 2017 National NHS staff survey show continuing poor performance for staff engagement with 24 out of 32 measures below average. The Trust's response plan to the CQC inspection included actions to improve workforce and staffing, however these actions have not yet demonstrated a sustained improvement in staff engagement or confidence in the quality of services provided by the Trust.

Internal Controls

The Trust has been issued with a Limited Assurance opinion by the internal auditors, due to weaknesses in the design, and/or inconsistent application of controls, that have put the achievement of the organisations objectives at risk in a number of areas reviewed. This has been reflected in the Annual Governance Statement for 2017-18.

Qualified conclusion (Adverse)

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in August 2017, we are not satisfied that, in all significant respects, Walsall Healthcare NHS Trust have put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 39, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility for the audit of the financial statements

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

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in August 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of Walsall Healthcare NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Stephen Clark Ernst and Young LLP

Stephen Clark (Audit Partner)
For and on behalf of Ernst and Young LLP (Local Auditor)
Birmingham
25th May 2018

The maintenance and integrity of the Walsall Healthcare NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.
Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

NOTES

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Walsall Healthcare NHS
NHS Trust

Annual Report 2017/18

If you require this publication in an alternative format and or language please contact the Patient Relations Service on 01922 656463 to discuss your needs.

Walsall Healthcare NHS
NHS Trust

Walsall Healthcare NHS Trust Annual Accounts 2017/18

www.walsallhealthcare.nhs.uk

@WalsallHcareNHS

Becoming your partners for first class integrated care

Safe, high quality care
Care at home
Partners
Value colleagues
Resources

Statement of the chief executive's responsibilities as the accountable officer of the trust

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

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

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

Signed.....Chief Executive

Date.....24/5/18.....

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, recognised gains and losses 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.

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.

By order of the Board

24/5/18 .....Date.....Chief Executive

24/5/18 .....Date..... Director of Finance & Performance

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF WALSALL HEALTHCARE NHS TRUST

Opinion

We have audited the financial statements of Walsall Healthcare NHS Trust for the year ended 31 March 2018 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust's Statement of Financial Position, the Trust's Statement of Changes in Taxpayers' Equity, the Trust's Statement of Cash Flows and the related notes 1 to 52. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2017-18 HM Treasury's Financial Reporting Manual (the 2017-18 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2017/18 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:

- give a true and fair view of the financial position of Walsall Healthcare NHS Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.
We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of our report

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

Material uncertainty related to going concern

We draw attention to note 1 in the financial statements, which indicates that the Trust has found it difficult- to meet its financial targets and have reported a significant deficit in year and is budgeting for a further deficit in the next financial year. As stated in note 1, these events or conditions indicate that a material uncertainty exists that may cast significant doubt on the Trust's ability to continue as a going concern.

Our opinion is not modified in respect of this matter.

Other information

The other information comprises the information included in the annual report set out on pages 67, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

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

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

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if[1]:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or

We have nothing to report in these respects

[1] Where the auditor has issues to report under any of the issues listed, they should be deleted from this section and a suitable exception report, briefly explaining the action taken, inserted in the following section.

Section 30 Referral

We refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency

The Trust anticipated an in-year deficit for the 2017-18 financial year and we referred this matter to the Secretary of State on 22 May 2017 under section 30 of the Local Audit and Accountability Act 2014.The Trust have delivered a deficit in 2017/18 of £24.2million.

Proper arrangements to secure economy, efficiency and effectiveness

We report to you, if we are not satisfied that the Trust has put in place proper arrangements to secure economy efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

Special Measures

The Care Quality Commission (CQC) inspected the Trust in May and June 2017; and issued the Trust with an overall rating of requires improvement. The report highlighted concerns in respect of urgent and emergency services; surgery; critical care; maternity and gynaecology.

Sustainable Resource Deployment

The Trust's outturn position for 2017/18 was a £24.2million deficit, which is a significant deterioration compared to the 2017/18 planned deficit of £20.5million.
The deterioration in the Trust's financial outturn was due to failure to maintain effective controls over temporary staffing.

Workforce Development

The results of the 2017 National NHS staff survey show continuing poor performance for staff engagement with 24 out of 32 measures below average. The Trust's response plan to the CQC inspection included actions to improve workforce and staffing, however these actions have not yet demonstrated a sustained improvement in staff engagement or confidence in the quality of services provided by the Trust.

Internal Controls

The Trust has been issued with a Limited Assurance opinion by the internal auditors, due to weaknesses in the design, and/or inconsistent application of controls, that have put the achievement of the organisations objectives at risk in a number of areas reviewed. This has been reflected in the Annual Governance Statement for 2017-18.

Qualified conclusion (Adverse)

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in August 2017, we are not satisfied that, in all significant respects, Walsall Healthcare NHS Trust have put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 39, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility for the audit of the financial statements

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

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in August 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of Walsall Healthcare NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Stephen Clark Ernst and Young LLP

Stephen Clark (Audit Partner)
For and on behalf of Ernst and Young LLP (Local Auditor)
Birmingham
25th May 2018

The maintenance and integrity of the Walsall Healthcare NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.
Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	225,136	223,025
Other operating income	4	18,827	21,717
Operating expenses	6, 8	(260,388)	(270,848)
Operating deficit from continuing operations		**(16,425)**	**(26,106)**
Finance income	11	24	21
Finance expenses	12	(9,147)	(8,050)
PDC dividends payable		-	-
Net finance costs		**(9,123)**	**(8,029)**
Other gains	13	1,329	6
Share of profit / (losses) of associates / joint arrangements	20	-	-
Gains / (losses) arising from transfers by absorption		-	-
Corporation tax expense		-	-
Surplus / (deficit) for the year from continuing operations		**(24,219)**	**(34,129)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	**-**	**-**
Surplus / (deficit) for the year		**(24,219)**	**(34,129)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	-	-
Revaluations	18	3,604	-
Share of comprehensive income from associates and joint ventures	20	-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability / asset	37	-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains / (losses) on available-for-sale financial investments	13	-	-
Recycling gains / (losses) on available-for-sale financial investments	13	-	-
Foreign exchange gains / (losses) recognised directly in OCI	13	-	-
Total comprehensive expense for the period		**(20,615)**	**(34,129)**

The Trust completed a revaluation of its estate in year see note 18 for further information.

The Trust sold land and buildings, the profit on the sales (£1.329m) is shown above in other gains (note 13).

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	15	1,311	1,010
Property, plant and equipment	16	138,291	133,168
Investment property	19	-	-
Investments in associates and joint ventures	20	-	-
Other investments / financial assets	21	-	-
Trade and other receivables	24	1,054	1,119
Other assets	25	-	-
Total non-current assets		**140,656**	**135,297**
Current assets			
Inventories	23	2,277	2,107
Trade and other receivables	24	17,214	14,603
Other investments / financial assets	21	-	-
Other assets	25	-	-
Non-current assets held for sale / assets in disposal groups	26	-	-
Cash and cash equivalents	27	2,277	1,705
Total current assets		**21,768**	**18,415**
Current liabilities			
Trade and other payables	28	(29,292)	(27,701)
Borrowings	31	(10,782)	(3,489)
Other financial liabilities	29	-	-
Provisions	33	(431)	(420)
Other liabilities	30	(1,411)	(1,756)
Liabilities in disposal groups	26	-	-
Total current liabilities		**(41,916)**	**(33,366)**
Total assets less current liabilities		**120,508**	**120,346**
Non-current liabilities			
Trade and other payables	28	-	-
Borrowings	31	(177,817)	(159,040)
Other financial liabilities	29	-	-
Provisions	33	-	-
Other liabilities	30	-	-
Total non-current liabilities		**(177,817)**	**(159,040)**
Total assets employed		**(57,309)**	**(38,694)**
Financed by			
Public dividend capital		58,318	56,318
Revaluation reserve		16,023	12,752
Available for sale investments reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		(131,650)	(107,764)
Total taxpayers' equity		**(57,309)**	**(38,694)**

The following notes form part of these accounts.

Name Richard Beeken
Position Chief Executive
Date **24th May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**56,318**	**12,752**	**(107,764)**	**(38,694)**
Deficit for the year	-	-	(24,219)	**(24,219)**
Transfers by absorption: transfers between reserves	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	**-**
Other transfers between reserves	-	(145)	145	**-**
Impairments	-	-	-	**-**
Revaluations	-	3,604	-	**3,604**
Transfer to retained earnings on disposal of assets	-	(188)	188	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	**-**
Other recognised gains and losses	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	**-**
Public dividend capital received	2,000	-	-	**2,000**
Public dividend capital repaid	-	-	-	**-**
Public dividend capital written off	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	**-**
Other reserve movements	-	-	-	**-**
Taxpayers' equity at 31 March 2018	**58,318**	**16,023**	**(131,650)**	**(57,309)**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**56,318**	**12,859**	**(73,742)**	**(4,565)**
Prior period adjustment	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**56,318**	**12,859**	**(73,742)**	**(4,565)**
Deficit for the year	-	-	(34,129)	**(34,129)**
Transfers by absorption: transfers between reserves	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	**-**
Other transfers between reserves	-	(107)	107	**-**
Impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Transfer to retained earnings on disposal of assets	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	**-**
Other recognised gains and losses	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	**-**
Public dividend capital received	-	-	-	**-**
Public dividend capital repaid	-	-	-	**-**
Public dividend capital written off	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	**-**
Other reserve movements	-	-	-	**-**
Taxpayers' equity at 31 March 2017	**56,318**	**12,752**	**(107,764)**	**(38,694)**

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.

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

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating deficit		(16,425)	(26,106)
Non-cash income and expense:			
Depreciation and amortisation	6.1	6,393	6,810
Net impairments	7	1,234	12,833
Income recognised in respect of capital donations	4	(475)	(259)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(2,546)	(2,515)
(Increase) / decrease in inventories		(170)	250
Increase / (decrease) in payables and other liabilties		1,277	(1,523)
Increase / (decrease) in provisions		11	(3)
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		-	-
Net cash generated used in operating activities		**(10,701)**	**(10,513)**
Cash flows from investing activities			
Interest received		24	22
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(811)	(376)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(8,916)	(3,738)
Sales of property, plant, equipment and investment property		2,019	-
Receipt of cash donations to purchase capital assets		-	-
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions/disposals of subsidiaries		-	-
Net cash generated used in investing activities		**(7,684)**	**(4,092)**
Cash flows from financing activities			
Public dividend capital received		2,000	-
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		29,557	24,300
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		-	-
Capital element of PFI, LIFT and other service concession payments		(3,489)	(3,304)
Interest paid on finance lease liabilities		-	-
Interest paid on PFI, LIFT and other service concession obligations		(7,800)	(7,587)
Other interest paid		(1,311)	(464)
PDC dividend (paid) / refunded		-	-
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from financing activities		**18,957**	**12,945**
Increase / (decrease) in cash and cash equivalents		**572**	**(1,660)**
Cash and cash equivalents at 1 April - brought forward		**1,705**	**3,365**
Prior period adjustments			**-**
Cash and cash equivalents at 1 April - restated		**1,705**	**3,365**
Cash and cash equivalents transferred under absorption accounting	44	**-**	**-**
Unrealised gains / (losses) on foreign exchange		**-**	**-**
Cash and cash equivalents at 31 March	27.1	**2,277**	**1,705**

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 2017/18 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 accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

The Trust has recorded revenue deficits in the three financial years prior to 2017/18. The Board are committed to addressing the current deficit position and the Trust's five year model shows a planned breakeven in 2020/21. This financial recovery is dependent upon the achievement of cost improvement programmes over the period during which the Trust will also be reliant on financial support from the Department of Health to continue the provision of services.

The Trust recognises there is significant risk associated with the achievement of cost improvements targets included the forthcoming financial years. The Trust has delivered the cost improvement target of £11m for 2017/18 and is continuing to develop initiatives to deliver future savings beyond this financial year.

The Board of Directors have therefore given careful consideration to the Going Concern principle when preparing these accounts, and the planned revenue deficit for 2018/19.

The Trust has access to the Uncommitted Interim Revenue Support Facility and cash supporting loans are agreed monthly with Department of Health dependant on the cash requirement.

The Board has concluded that although the financial circumstances represents a material uncertainty, the Directors have a reasonable expectation that the Trust will have access to sufficient resources, including revenue and capital loan funding, to continue to provide services to patients for the foreseeable future. For this reason the Board has adopted the going concern basis when preparing these accounts.

Note 1.2 Critical judgements in applying accounting policies

In the application of the NHS trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.2.1 Sources of estimation uncertainty

The Trust is forecasting a deficit position for 2017/18 and will require revenue loan support from the Department of Health to maintain current services. The Trust is working with NHS Improvement Authority on a plan for financial recovery.

3 Note 1.3 Interests in other entities

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Walsall Healthcare NHS 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 e.g. by an insurer. Walsall Healthcare NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

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

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

The Trust offers an additional defined contribution workplace pension scheme e.g. the National Employment Savings Scheme (NEST), that a minority of staff participate in.

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

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

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

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments
In accordance with the *GAM* , impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

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

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet Walsall Healthcare NHS Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.
The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Note 1.7.6 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Land	-	-
Buildings, excluding dwellings	1	41
Dwellings	20	20
Plant & machinery	1	145
Transport equipment	1	3
Information technology	1	5
Furniture & fittings	1	10

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

Note 1.8 Intangible assets

Note 1.8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

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

Software
Software which is integral to the operation of hardware, 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.

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

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

Note 1.8.3 Useful economic lives of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	-	-
Development expenditure	-	-
Websites	-	-
Software licences	1	10
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-
Goodwill	-	-

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

[Note 1.10 Investment properties

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

Note 1.13 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

De-recognition

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

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

Classification and measurement

Financial assets are categorised as fair value through income and expenditure, loans and receivables.

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

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.14 Leases

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

Note 1.14.1 The trust as lessee

Finance leases

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

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

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14.2 The trust as lessor

Finance leases

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

Operating leases

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

Note 1.15 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution 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 33.1 but is not recognised in the trust’s accounts.

Non-clinical risk pooling

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

Note 1.16 Contingencies

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

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.18 Value added tax

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

Note 1.19 Corporation tax
The Trust has determined that it is has no corporation tax liability.

Note 1.20 Foreign exchange
Walsall Healthcare NHS Trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions.

Note 1.21 Third party assets

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

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers.

Note 1.24 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted
This is not applicable to the accounts for 2017/8.

Note 2 Operating Segments

The Trust has one operating segment, which is the provision of healthcare.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Elective income	24,355	25,498
Non elective income	69,403	66,499
First outpatient income	18,158	17,385
Follow up outpatient income	8,778	9,325
A & E income	10,624	8,660
High cost drugs income from commissioners (excluding pass-through costs)	13,386	10,884
Other NHS clinical income	40,653	43,119
Community services		
Community services income from CCGs and NHS England	30,116	30,137
Income from other sources (e.g. local authorities)	8,585	10,765
All services		
Private patient income	5	19
Other clinical income	1,073	734
Total income from activities	**225,136**	**223,025**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	22,558	20,589
Clinical commissioning groups	192,915	190,174
Department of Health and Social Care	-	667
Other NHS providers	-	72
NHS other	-	5
Local authorities	8,585	10,765
Non-NHS: private patients	5	19
Non-NHS: overseas patients (chargeable to patient)	57	17
NHS injury scheme	763	544
Non NHS: other	253	173
Total income from activities	**225,136**	**223,025**
Of which:		
Related to continuing operations	225,136	223,025
Related to discontinued operations	-	-

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

	2017/18	2016/17
	£000	£000
Income recognised this year	57	17
Cash payments received in-year	17	3
Amounts added to provision for impairment of receivables	44	105
Amounts written off in-year	-	-

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	232	-
Education and training	9,140	9,850
Receipt of capital grants and donations	475	259
Charitable and other contributions to expenditure	-	-
Non-patient care services to other bodies	4,545	3,027
Support from the Department of Health and Social Care for mergers	-	-
Sustainability and transformation fund income	-	2,100
Rental revenue from operating leases	272	213
Rental revenue from finance leases	-	-
Income in respect of staff costs where accounted on gross basis	388	449
Other income	3,775	5,819
Total other operating income	**18,827**	**21,717**
Of which:		
Related to continuing operations	18,827	21,717
Related to discontinued operations	-	-

Other income includes carparking income, IT recharges and other trading income.

Note 5 Fees and charges

	2017/18	2016/17
	£000	£000
Income	-	-
Full cost	-	-
Surplus / (deficit)	**-**	**-**

Note 6.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,202	2,025
Purchase of healthcare from non-NHS and non-DHSC bodies	1,434	1,341
Purchase of social care	-	-
Staff and executive directors costs	173,686	172,118
Remuneration of non-executive directors	84	82
Supplies and services - clinical (excluding drugs costs)	17,754	19,252
Supplies and services - general	3,451	3,779
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	18,824	18,077
Inventories written down	56	56
Consultancy costs	2,267	1,439
Establishment	3,466	3,609
Premises	7,663	8,552
Transport (including patient travel)	702	551
Depreciation on property, plant and equipment	5,883	6,395
Amortisation on intangible assets	510	415
Net impairments	1,234	12,833
Increase/(decrease) in provision for impairment of receivables	319	138
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services- statutory audit	48	81
other auditor remuneration (external auditor only)	43	43
Internal audit costs	144	144
Clinical negligence	12,989	11,808
Legal fees	134	97
Insurance	179	174
Research and development	-	-
Education and training	980	1,019
Rentals under operating leases	687	784
Early retirements	-	-
Redundancy	-	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	4,224	4,122
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	-	-
Car parking & security	462	410
Hospitality	-	-
Losses, ex gratia & special payments	55	47
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other	908	1,457
Total	**260,388**	**270,848**
Of which:		
Related to continuing operations	260,388	270,848
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	43	43
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**43**	**43**

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

Note 7 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	-	-
Other	1,234	12,833
Total net impairments charged to operating surplus / deficit	**1,234**	**12,833**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**1,234**	**12,833**

The Trust undertook a whole site revaluation as part of the triennial valuation process in 2017/18 which resulted in the devaluation of 6 buildings that could not be offset against an accumulated revaluation reserve balance. The 2016/17 impairment of £12.8m was a result of the revaluation of the PFI building excluding VAT which did not have an accumulated reserve balance due to previous impairments.

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	137,035	132,890
Social security costs	12,794	12,692
Apprenticeship levy	636	-
Employer's contributions to NHS pensions	15,718	15,604
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	-
Temporary staff (including agency)	7,503	10,932
Total gross staff costs	**173,686**	**172,118**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**173,686**	**172,118**
Of which		
Costs capitalised as part of assets	-	-

Note 8.1 Retirements due to ill-health

During 2017/18 there were 4 early retirements from the trust agreed on the grounds of ill-health (9 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £298k (£673k in 2016/17).

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

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The Trust offers an additional defined contribution workplace pension scheme e.g. the National Employment Savings Scheme (NEST), that a minority of staff participate in.

Note 10 Operating leases

Note 10.1 Walsall Healthcare NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Walsall Healthcare NHS Trust is the lessor. The Trust receives rental income for use of the Urgent Care Centre and from Homeless Supported Accomodation.

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	272	213
Contingent rent	-	-
Other	-	-
Total	**272**	**213**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	209	213
- later than one year and not later than five years;	733	733
- later than five years.	3,482	3,665
Total	**4,424**	**4,611**

Note 10.2 Walsall Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Walsall Healthcare NHS Trust is the lessee.

The Trust has leases relating to cars primarily for employees working within the local community. Employees have the option to renew their lease arrangment after 3 years. Employees do not have the option to purchase the vehicle at the end of the agreement.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	687	784
Contingent rents	-	-
Less sublease payments received	-	-
Total	**687**	**784**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	710	722
- later than one year and not later than five years;	286	342
- later than five years.	241	301
Total	**1,237**	**1,365**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	24	21
Interest on impaired financial assets	-	-
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total	**24**	**21**

Note 12.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,347	463
Other loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	7,800	7,587
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	**9,147**	**8,050**
Unwinding of discount on provisions	-	-
Other finance costs	-	-
Total finance costs	**9,147**	**8,050**

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

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	1,329	6
Losses on disposal of assets	-	-
Total gains / (losses) on disposal of assets	1,329	6
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of available-for-sale financial investments	-	-
Total other gains / (losses)	**1,329**	**6**

The Trust disposed of land and buildings during the year and recognised a profit on the sale which will be used to support the delivery of healthcare.

Note 14 Discontinued operations

	2017/18	2016/17
	£000	£000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Gain on disposal of discontinued operations	-	-
(Loss) on disposal of discontinued operations	-	-
Corporation tax expense attributable to discontinued operations	-	-
Total	**-**	**-**

Note 15.1 Intangible assets - 2017/18

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**6,811**	**-**	**-**	**-**	**6,811**
Transfers by absorption	-	-	-	-	**-**
Additions	811	-	-	-	**811**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Gross cost at 31 March 2018	**7,622**	**-**	**-**	**-**	**7,622**
Amortisation at 1 April 2017 - brought forward	**5,801**	**-**	**-**	**-**	**5,801**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**
Provided during the year	510	-	-	-	**510**
Impairments	**-**	**-**	**-**	**-**	**-**
Reversals of impairments	**-**	**-**	**-**	**-**	**-**
Revaluations	**-**	**-**	**-**	**-**	**-**
Reclassifications	**-**	**-**	**-**	**-**	**-**
Transfers to / from assets held for sale	**-**	**-**	**-**	**-**	**-**
Disposals / derecognition	**-**	**-**	**-**	**-**	**-**
Amortisation at 31 March 2018	**6,311**	**-**	**-**	**-**	**6,311**
Net book value at 31 March 2018	**1,311**	**-**	**-**	**-**	**1,311**
Net book value at 1 April 2017	**1,010**	**-**	**-**	**-**	**1,010**

Note 15.2 Intangible assets - 2016/17

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**6,435**	**-**	**-**	**-**	**6,435**
Prior period adjustments	**-**	**-**	**-**	**-**	**-**
Valuation / gross cost at 1 April 2016 - restated	**6,435**	**-**	**-**	**-**	**6,435**
Transfers by absorption	-	-	-	-	**-**
Additions	376	-	-	-	**376**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Valuation / gross cost at 31 March 2017	**6,811**	**-**	**-**	**-**	**6,811**
Amortisation at 1 April 2016 - as previously stated	**5,386**	**-**	**-**	**-**	**5,386**
Prior period adjustments	**-**	**-**	**-**	**-**	**-**
Amortisation at 1 April 2016 - restated	**5,386**	**-**	**-**	**-**	**5,386**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**
Provided during the year	**415**	**-**	**-**	**-**	**415**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Amortisation at 31 March 2017	**5,801**	**-**	**-**	**-**	**5,801**
Net book value at 31 March 2017	**1,010**	**-**	**-**	**-**	**1,010**
Net book value at 1 April 2016	**1,049**	**-**	**-**	**-**	**1,049**

Note 16.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**8,788**	**126,920**	**2,438**	**1,463**	**37,350**	**253**	**9,535**	**682**	**187,429**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	3	1,773	70	5,428	1,770	-	203	79	**9,326**
Impairments	-	(1,195)	(39)	-	-	-	-	-	**(1,234)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	(6)	3,337	273	-	-	-	-	-	**3,604**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	(600)	-	(90)	-	-	-	-	-	**(690)**
Valuation/gross cost at 31 March 2018	**8,185**	**130,835**	**2,652**	**6,891**	**39,120**	**253**	**9,738**	**761**	**198,435**
Accumulated depreciation at 1 April 2017 - brought forward	**69**	**15,321**	**1,259**	**-**	**28,602**	**253**	**8,265**	**492**	**54,261**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**3,475**	**70**	**-**	**1,785**	**-**	**510**	**43**	**5,883**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2018	**69**	**18,796**	**1,329**	**-**	**30,387**	**253**	**8,775**	**535**	**60,144**
Net book value at 31 March 2018	**8,116**	**112,039**	**1,323**	**6,891**	**8,733**	**-**	**963**	**226**	**138,291**
Net book value at 1 April 2017	**8,719**	**111,599**	**1,179**	**1,463**	**8,748**	**-**	**1,270**	**190**	**133,168**

Note 16.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**8,782**	**137,246**	**2,320**	**1,536**	**36,134**	**253**	**9,152**	**682**	**196,105**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016 - restated	**8,782**	**137,246**	**2,320**	**1,536**	**36,134**	**253**	**9,152**	**682**	**196,105**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	6	1,970	118	851	1,216	-	383	-	**4,544**
Impairments	-	(13,220)	-	-	-	-	-	-	**(13,220)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	924	-	(924)	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2017	**8,788**	**126,920**	**2,438**	**1,463**	**37,350**	**253**	**9,535**	**682**	**187,429**
Accumulated depreciation at 1 April 2016 - as previously stated	**69**	**12,025**	**1,065**	**-**	**26,767**	**251**	**7,632**	**444**	**48,253**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 - restated	**69**	**12,025**	**1,065**	**-**	**26,767**	**251**	**7,632**	**444**	**48,253**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**3,683**	**194**	**-**	**1,835**	**2**	**633**	**48**	**6,395**
Impairments	-	(387)	-	-	-	-	-	-	**(387)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2017	**69**	**15,321**	**1,259**	**-**	**28,602**	**253**	**8,265**	**492**	**54,261**
Net book value at 31 March 2017	**8,719**	**111,599**	**1,179**	**1,463**	**8,748**	**-**	**1,270**	**190**	**133,168**
Net book value at 1 April 2016	**8,713**	**125,221**	**1,255**	**1,536**	**9,367**	**2**	**1,520**	**238**	**147,852**

Note 16.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	8,116	49,323	1,323	6,891	7,593	-	959	187	**74,392**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	62,013	-	-	-	-	-	-	**62,013**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	703	-	-	1,140	-	4	39	**1,886**
NBV total at 31 March 2018	**8,116**	**112,039**	**1,323**	**6,891**	**8,733**	**-**	**963**	**226**	**138,291**

Note 16.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	8,719	47,905	1,179	1,463	7,873	-	1,264	185	**68,588**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	63,082	-	-	-	-	-	-	**63,082**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	612	-	-	875	-	6	5	**1,498**
NBV total at 31 March 2017	**8,719**	**111,599**	**1,179**	**1,463**	**8,748**	**-**	**1,270**	**190**	**133,168**

Note 17 Donations of property, plant and equipment

The received cash donations totalling £300k from the League of Friends(£100k) and the Trust's Well Wishers (£200k) as a contribution to support the purchase of a gamma camera.

Note 18 Revaluations of property, plant and equipment

The Trust appointed registered valuers from GVA Grimley Ltd, as Independent valuers, using the Modern Equivalent Asset (MEA) methodology for estimating the depreciated replacment cost valuation. The effect of the revaluation increased the overall value of assets by £2.3 million (net of impairments totalling £1.2 million). The Trust has also reviewed and revised the asset lives of the portfolio of equipment.

During the year Walsall Hospitals NHS Trust General Charitable Fund purchased various assets for the Trust from accumulated donations received from various donors.

Note 19.1 Investment Property

	2017/18	2016/17
	£000	£000
Carrying value at 1 April - brought forward	**-**	**-**
Prior period adjustments		-
Carrying value at 1 April - restated	**-**	**-**
Transfers by absorption	-	-
Acquisitions in year	-	-
Movement in fair value	-	-
Reclassifications to/from PPE	-	-
Transfers to/from assets held for sale	-	-
Disposals	-	-
Carrying value at 31 March	**-**	**-**

Note 19.2 Investment property income and expenses

	2017/18	2016/17
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	-	-
Direct operating expense arising from investment property which did not generate rental income in the period	-	-
Total investment property expenses	**-**	**-**
Investment property income	-	-

Note 20 Investments in associates and joint ventures

	2017/18	2016/17
	£000	£000
Carrying value at 1 April - brought forward	**-**	**-**
Prior period adjustments	-	-
Carrying value at 1 April - restated	**-**	**-**
Transfers by absorption	-	-
Acquisitions in year	-	-
Share of profit / (loss)	-	-
Impairments	-	-
Reversal of impairment	-	-
Transfers to / from assets held for sale and assets in disposal groups	-	-
Disbursements / dividends received	-	-
Disposals	-	-
Share of Other Comprehensive Income recognised by joint ventures / associates	-	-
Other equity movements (translation gains / losses)	-	-
Carrying value at 31 March	**-**	**-**

Note 21 Other investments / financial assets (non-current)

	2017/18	2016/17
	£000	£000
Carrying value at 1 April - brought forward	**-**	**-**
Prior period adjustments	-	-
Carrying value at 1 April - restated	**-**	**-**
Transfers by absorption	-	-
Acquisitions in year	-	-
Movement in fair value	-	-
Net impairment	-	-
Transfers to / from assets held for sale and assets in disposal groups	-	-
Amortisation at the effective interest rate (assets held at amortised cost only where applicable)	-	-
Current portion of loans receivable transferred to current financial assets	-	-
Disposals	-	-
Carrying value at 31 March	**-**	**-**

Note 21.1 Other investments / financial assets (current)

	31 March 2018	31 March 2017
	£000	£000
Loans receivable within 12 months transferred from non-current financial assets	-	-
NLF deposits (where not considered to be cash equivalents)	-	-
Other current financial assets	-	-
Total current investments / financial assets	**-**	**-**

Note 22 Disclosure of interests in other entities

The Trust has no interest in other entities.

Note 23 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	975	1,075
Work In progress	-	-
Consumables	1,133	881
Energy	141	109
Other	28	42
Total inventories	**2,277**	**2,107**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £39,429k (2016/17: £41,770k). Write-down of inventories recognised as expenses for the year were £56k (2016/17: £56k).

Note 24.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	14,048	13,271
Capital receivables (including accrued capital related income)	-	-
Accrued income	-	230
Provision for impaired receivables	(1,344)	(1,064)
Deposits and advances	-	-
Prepayments (non-PFI)	598	848
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	-	-
VAT receivable	108	318
Corporation and other taxes receivable	-	-
Other receivables	3,804	1,000
Total current trade and other receivables	**17,214**	**14,603**
Non-current		
Trade receivables	-	-
Capital receivables (including accrued capital related income)	-	-
Accrued income	-	-
Provision for impaired receivables	(183)	(144)
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	1,237	1,263
Total non-current trade and other receivables	**1,054**	**1,119**
Of which receivables from NHS and DHSC group bodies:		
Current	12,710	11,764
Non-current	-	-

Note 24.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**1,208**	**1,070**
Prior period adjustments	-	-
At 1 April - restated	**1,208**	**1,070**
Transfers by absorption	-	-
Increase in provision	319	138
Amounts utilised	-	-
Unused amounts reversed	-	-
At 31 March	**1,527**	**1,208**

Note 24.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	1,527	-	1,208	-
Total	**1,527**	**-**	**1,208**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	3,655	-	2,894	-
30-60 Days	-	-	-	-
60-90 days	174	-	245	-
90- 180 days	1,176	-	1,469	-
Over 180 days	4,500	-	4,053	-
Total	**9,505**	**-**	**8,661**	**-**

The majority of the debts included within the table relate to outstanding accounts with other NHS bodies. The Trust maintains these debts are retrievable.

Note 25 Other assets

	31 March 2018	31 March 2017
Current	**£000**	**£000**
EU emissions trading scheme allowance	-	-
Other assets	-	-
Short term PFI finance lease asset	**-**	**-**
Total other current assets	**-**	**-**
Non-current		
Net defined benefit pension scheme asset	-	-
Other assets	-	-
Total other non-current assets	**-**	**-**

Note 26 Non-current assets held for sale and assets in disposal groups

	2017/18	2016/17
	£000	**£000**
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**
Prior period adjustment		**-**
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**-**	**-**
Transfers by absorption	-	**-**
Assets classified as available for sale in the year	-	**-**
Assets sold in year	-	**-**
Impairment of assets held for sale	-	**-**
Reversal of impairment of assets held for sale	-	**-**
Assets no longer classified as held for sale, for reasons other than disposal by sale	-	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

Note 26.1 Liabilities in disposal groups

	31 March 2018 £000	31 March 2017 £000
Categorised as:		
Provisions	-	-
Trade and other payables	-	-
Other	-	-
Total	**-**	**-**

Note 27.1 Cash and cash equivalents movements

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

	2017/18 £000	2016/17 £000
At 1 April	**1,705**	**3,365**
Prior period adjustments	-	-
At 1 April (restated)	**1,705**	**3,365**
Transfers by absorption	-	-
Net change in year	572	(1,660)
At 31 March	**2,277**	**1,705**
Broken down into:		
Cash at commercial banks and in hand	35	47
Cash with the Government Banking Service	2,242	1,658
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**2,277**	**1,705**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**2,277**	**1,705**

Note 27.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018 £000	31 March 2017 £000
Bank balances	-	1
Monies on deposit	-	-
Total third party assets	**-**	**1**

Note 28.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	17,875	16,980
Capital payables	645	710
Accruals	4,664	4,083
Receipts in advance (including payments on account)	-	-
Social security costs	1,876	1,844
VAT payables	-	-
Other taxes payable	1,454	1,357
PDC dividend payable	-	-
Accrued interest on loans	284	23
Other payables	2,494	2,704
Total current trade and other payables	**29,292**	**27,701**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	7,817	6,549
Non-current	-	-

Note 28.2 Early retirements in NHS payables above

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

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-
- outstanding pension contributions	2,129		2,147	

Note 29 Other financial liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**
Non-current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total	**-**	**-**

Note 30 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	1,411	1,756
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Total other current liabilities	**1,411**	**1,756**
Non-current		
Deferred income	-	-
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**-**	**-**

Note 31 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health and Social Care	7,085	-
Other loans	-	-
Obligations under finance leases	-	-
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	3,697	3,489
Total current borrowings	**10,782**	**3,489**
Non-current		
Loans from the Department of Health and Social Care	53,655	31,183
Other loans	-	-
Obligations under finance leases	-	-
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	124,162	127,857
Total non-current borrowings	**177,817**	**159,040**

Note 32 Finance leases

Note 32.1 Walsall Healthcare NHS Trust as a lessor

Future lease receipts due under finance lease agreements where Walsall Healthcare NHS Trust is the lessor:

	31 March 2018 £000	31 March 2017 £000
Gross lease receivables	**-**	**-**
of which those receivable:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Unearned interest income	-	-
Allowance for uncollectable lease payments	-	-
Net lease receivables	**-**	**-**
of which those receivable:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
The unguaranteed residual value accruing to the lessor	-	-
Contingent rents recognised as income in the period	-	-

Note 32.2 Walsall Healthcare NHS Trust as a lessee

Obligations under finance leases where Walsall Healthcare NHS Trust is the lessee.

	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	**-**	**-**
of which liabilities are due:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Finance charges allocated to future periods	-	-
Net lease liabilities	**-**	**-**
of which payable:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

Note 33.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Continuing care	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017	**-**	**112**	**-**	**-**	**-**	**-**	**308**	**420**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	-	-	-	**-**
Arising during the year	-	69	-	-	-	-	-	**69**
Utilised during the year	-	-	-	-	-	-	-	**-**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	**-**
Reversed unused	-	(58)	-	-	-	-	-	**(58)**
Unwinding of discount	-	-	-	-	-	-	-	**-**
At 31 March 2018	**-**	**123**	**-**	**-**	**-**	**-**	**308**	**431**
Expected timing of cash flows:								
- not later than one year;	-	123	-	-	-	-	308	**431**
- later than one year and not later than five years;	-	-	-	-	-	-	-	**-**
- later than five years.	-	-	-	-	-	-	-	**-**
Total	**-**	**123**	**-**	**-**	**-**	**-**	**308**	**431**

Note 33.2 Clinical negligence liabilities

At 31 March 2018, £225,020k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Walsall Healthcare NHS Trust (31 March 2017: £164,031k).

Note 34 Contingent assets and liabilities

	31 March 2018	31 March 2017
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	-	-
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**-**	**-**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**-**	**-**
Net value of contingent assets	-	-

Note 35 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	310	306
Intangible assets	-	-
Total	**310**	**306**

Note 36 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 2018	31 March 2017
	£000	£000
not later than 1 year	-	-
after 1 year and not later than 5 years	-	-
paid thereafter	-	-
Total	**-**	**-**

Note 37 Defined benefit pension schemes

This Trust does not have a defined benefit pension scheme.

Note 37.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2017/18	2016/17
	£000	£000
Present value of the defined benefit obligation at 1 April	**-**	**-**
Prior period adjustment	-	-
Present value of the defined benefit obligation at 1 April - restated	**-**	**-**
Transfers by absorption	-	-
Current service cost	-	-
Interest cost	-	-
Contribution by plan participants	-	-
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses	-	-
Benefits paid	-	-
Past service costs	-	-
Business combinations	-	-
Curtailments and settlements	-	-
Present value of the defined benefit obligation at 31 March	**-**	**-**
Plan assets at fair value at 1 April	**-**	**-**
Prior period adjustment	-	-
Fair value of plan assets at 1 April -restated	**-**	**-**
Transfers by normal absorption	-	-
Interest income	-	-
Remeasurement of the net defined benefit (liability) / asset		
- Return on plan assets	-	-
- Actuarial gain / (losses)	-	-
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling	-	-
Contributions by the employer	-	-
Contributions by the plan participants	-	-
Benefits paid	-	-
Business combinations	-	-
Settlements	-	-
Plan assets at fair value at 31 March	**-**	**-**
Plan surplus/(deficit) at 31 March	**-**	**-**

Note 37.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	31 March 2018	31 March 2017
	£000	£000
Present value of the defined benefit obligation	**-**	**-**
Plan assets at fair value at	**-**	**-**
Fair value of any reimbursement right	**-**	**-**
The effect of the asset ceiling	**-**	**-**
Net (liability) / asset recognised in the SoFP	**-**	**-**

Note 37.3 Amounts recognised in the SoCI

	2017/18	2016/17
	£000	£000
Current service cost	-	-
Interest expense / income	-	-
Past service cost	-	-
Losses on curtailment and settlement	-	-
Total net (charge) / gain recognised in SOCI	**-**	**-**

Note 38 On-SoFP PFI, LIFT or other service concession arrangements

Note 38.1 Imputed finance lease obligations

Walsall Healthcare NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**202,267**	**211,487**
Of which liabilities are due		
- not later than one year;	9,273	9,220
- later than one year and not later than five years;	36,839	37,172
- later than five years.	156,155	165,095
Finance charges allocated to future periods	(74,408)	(80,141)
Net PFI, LIFT or other service concession arrangement obligation	**127,859**	**131,346**
- not later than one year;	3,697	3,489
- later than one year and not later than five years;	16,275	15,904
- later than five years.	107,887	111,953

Note 38.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	525,791	540,455
Of which liabilities are due:		
- not later than one year;	16,351	15,839
- later than one year and not later than five years;	69,936	67,998
- later than five years.	439,504	456,618

Note 38.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017/18:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	16,351	15,869
Consisting of:		
- Interest charge	7,800	7,587
- Repayment of finance lease liability	3,489	3,304
- Service element and other charges to operating expenditure	4,224	4,122
- Capital lifecycle maintenance	838	856
- Revenue lifecycle maintenance	-	-
- Contingent rent	-	-
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-
Total amount paid to service concession operator	**16,351**	**15,869**

Note 39 Off-SoFP PFI, LIFT and other service concession arrangements

Walsall Healthcare NHS Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

	31 March 2018 £000	31 March 2017 £000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	-	-
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:		
- not later than one year;	-	-
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	**-**	**-**

Note 40 Financial instruments

Note 40.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that Walsall Healthcare NHS Trust has with CCGs and the way CCGs are financed, Walsall Healthcare NHS 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. Walsall Healthcare NHS 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 Walsall Healthcare NHS Trust in undertaking its activities.

Walsall Healthcare NHS Trust's treasury management operations are carried out by the finance department, within parameters defined formally within Walsall Healthcare NHS Trust's standing financial instructions and policies agreed by the board of directors. Walsall Healthcare NHS Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

Walsall Healthcare NHS Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

Walsall Healthcare NHS Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. TheTrust therefore has low exposure to interest rate fluctuations.

Walsall Healthcare NHS Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

Walsall Healthcare NHS Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Walsall Healthcare NHS Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

Walsall Healthcare NHS Trust's operating costs are incurred under contracts with CCGs, 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.

Note 40.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	17,328	-	-	-	**17,328**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	2,277	-	-	-	**2,277**
Total at 31 March 2018	**19,605**	**-**	**-**	**-**	**19,605**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	14,555	-	-	-	**14,555**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	1,705	-	-	-	**1,705**
Total at 31 March 2017	**16,260**	**-**	**-**	**-**	**16,260**

Note 40.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	60,740	-	**60,740**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	127,859	-	**127,859**
Trade and other payables excluding non financial liabilities	23,883	-	**23,883**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2018	**212,482**	**-**	**212,482**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	31,183	-	**31,183**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	131,346	-	**131,346**
Trade and other payables excluding non financial liabilities	22,372	-	**22,372**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2017	**184,901**	**-**	**184,901**

Note 40.4 Fair values of financial assets and liabilities

The book value (carrying value) is used as a reasonable approximation of fair value.

Note 40.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	34,665	56,859
In more than one year but not more than two years	8,192	7,186
In more than two years but not more than five years	58,000	12,207
In more than five years	111,625	108,649
Total	**212,482**	**184,901**

Note 41 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	2	1
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	2	55	3	56
Total losses	**2**	**55**	**5**	**57**
Special payments				
Compensation under court order or legally binding arbitration award	7	107	14	66
Extra-contractual payments	-	-	-	-
Ex-gratia payments	37	20	41	16
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**44**	**127**	**55**	**82**
Total losses and special payments	**46**	**182**	**60**	**139**
Compensation payments received		72		-

Note 42 Gifts

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Total gifts	**-**	**-**	**-**	**-**

Note 43 Related parties

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
Mr Richard Beeken, Chief Executive	203,462		342,786	
Mr Russell Caldicott, Finance Director	12,238	-	2,329	-
Mr Russell Beale, Non-executive Director	36,574		26,561	
Ms Paula Furnival,Executive Director of Adult Social Care, Walsall Council.				
Mrs Victoria Harris, Manager at Dudley & Walsall Mental Health Partnership NHS Trust and Spouse is Deputy Director of IT at Sandwell & West Birmingham Hospital from March 2017.				
Mr Sukhbinder Heer, Non-executive Director Birmingham Community NHS Foundation Trust				

Mr Caldicott is Chair of the Branch of the West Midlands Healthcare Financial Management Association. During the year finance staff within Walsall Healthcare NHS Trust attended national and regional courses and conferences.

Ms Paula Furnival, Mrs Victoria Harris and Sukhbinder Heer are included above due to their association or spousal association with healthcare providers/ commisioners with which the Trust has annual transactions.

The Department of Health is regarded as a related party. During the year the Trust had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with organisations detailed below.

Walsall Clinical Commissioning Group
Dudley And Walsall Mental Health Partnership NHS Trust
Sandwell and West Birmingham Clinical Commissioning Group
South East Staffs and Seisdon Peninsular Clinical Commissioning Group
Dudley Clinical Commissioning Group
Cannock Chase Clinical Commissioning Group
Birmingham Cross City Clinical Commissioning Group
Stafford and Surrounds Clinical Commissioning Group
Wolverhampton Clinical Commissioning Group
Royal Wolverhampton Hospitals NHS Trust
Sandwell and West Birmingham Hospitals NHS Trust
Birmingham Womens NHS Foundation Trust
Heart of England NHS Foundation Trust
Unversity Hospitals Birmingham NHS Foundation Trust
West Midlands Ambulance Service NHS Foundation Trust
The Dudley Group of Hospitals
NHS England
Health Education England
NHS Business Services Authority
NHS Pension Scheme
National Insurance Fund
NHS Litigation Authority
NHS Property Services
Walsall Metropolitan Borough Council

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the Trust board.

Note 44 Transfers by absorption

There have been no transfers by absorption in the financial year.

Note 45 Prior period adjustments

There were no prior period adjustments.

Note 46 Events after the reporting date

There are no material events post close of the financial reporting period.

Note 48 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	56,822	96,276	64,641	113,318
Total non-NHS trade invoices paid within target	11,029	42,697	9,885	59,065
target	19.41%	44.35%	15.29%	52.12%
NHS Payables				
Total NHS trade invoices paid in the year	1,391	12,869	1,428	10,787
Total NHS trade invoices paid within target	174	1,280	254	1,574
Percentage of NHS trade invoices paid within target	12.51%	9.95%	17.79%	14.59%

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

Note 49 External financing

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

	2017/18 £000	2016/17 £000
Cash flow financing	**27,496**	22,656
Finance leases taken out in year		
Other capital receipts		
External financing requirement	**27,496**	22,656
External financing limit (EFL)	27,496	24,731
Under / (over) spend against EFL	-	2,075

Note 50 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	10,137	4,919
Less: Disposals	(690)	-
Less: Donated and granted capital additions	(475)	(259)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	8,972	4,660
Capital Resource Limit	9,846	4,777
Under / (over) spend against CRL	874	117

Note 51 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(24,081)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
Remove CQUIN risk reserve adjustment	814
IFRIC 12 breakeven adjustment	1,917
Breakeven duty financial performance surplus / (deficit)	(21,350)

Note 52 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	671	1,998	3,247	4,164	3,853	565	(12,861)	(9,790)	(21,392)	(21,350)
Breakeven duty cumulative position	5,933	7,931	11,178	15,342	19,195	19,760	6,899	(2,891)	(24,283)	(45,633)
Operating income	161,162	168,545	179,749	226,983	228,409	237,049	239,491	243,525	244,742	243,963
Cumulative breakeven position as a percentage of operating income	3.68%	4.71%	6.22%	6.76%	8.40%	8.34%	2.88%	-1.19%	-9.92%	-18.70%

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS [organisation]'s financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

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