Walsall Healthcare NHS
NHS Trust

ANNUAL REPORT AND ACCOUNTS 2019/20

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Caring for Walsall together

Safe, high quality care | Care at home | Partners | Value colleagues | Resources | Respect Compassion Professionalism Teamwork

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

We started the financial year with a degree of optimism as we awaited publication of our latest Care Quality Commission (CQC) inspection; our third inspection in as many years. And we were not disappointed.

Continuing improvement, a positive culture and innovative ideas led to the trust coming out of special measures. The CQC rated care as "Outstanding" across the trust and highlighted a number of areas of outstanding practice in both the hospital and community.

While the trust has been rated as "Requires Improvement" overall, there has been significant progress made since it was rated Inadequate in 2016 and Requires Improvement in 2017.

The 2019 assessment followed the CQC's new inspection regime, which examines whether the trust is well-led and looks at its use of resources.

Professor Stephen Powis, National NHS Medical Director, said: "We have accepted the CQC's recommendation to remove Walsall Healthcare NHS Trust from quality special measures. This decision reflects the improvements that have been made and sustained by the trust since its previous inspection, particularly in maternity and urgent and emergency services.

"This has been a long journey for Walsall Healthcare and staff can be rightly proud of their achievements to date and their strong desire to improve. There is of course more work still to do to ensure that patient services are the very best they can be and we will continue to work closely with the trust to ensure that further improvements are made and sustained."

To be able to exit quality special measures was an incredibly proud moment for all of us at Walsall Healthcare. There's no clearer proof that the effort, commitment and pride that our staff have demonstrated obviously made a huge impact. Inspectors also noted the promotion of a positive culture across the trust with staff feeling supported and valued and a "significant improvement" in their sense of pride in representing the organisation.

The CQC detailed the areas which need to improve including ensuring staffing levels are safe and reduce the risk of patient harm, greater engagement with patients and better monitoring of infection risk.

Under the well-led domain, while stating that leaders were well engaged with external partnerships to secure experiences and quality across health and care, inspectors noted that staff below director level could do more to ensure accountability and the flow of information.

The trust has also got a long way to go in making the most effective use of its estate and its workforce and is picking this up through its improvement programme, which is the trust's strategic response to how we will achieve our ambition of being an outstanding rated organisation by 2022.

Moving into 2020, the NHS has been involved in responding to the biggest public health crisis in over 100 years - the COVID-19 (Coronavirus) pandemic.

There have been and, at the time of writing, will continue to be logistical challenges through critical care demand increases, PPE availability, staffing resilience and communication in a time of unprecedented stress. We also are now moving to a period in which we must link post COVID surge recovery with the ambitions of our improvement programme.

Our staff have been flexible and shown great resilience amidst this crisis and have demonstrated our values of Compassion, Respect, Professionalism and Teamwork admirably. But we have to be realistic and say that COVID-19's aftermath will have a significant impact on our organisation both in the coming months and well beyond and none of us can truly predict how that will look.

Walsall is one of the most deprived and diverse boroughs in the country and its residents are relying on us to step up to this challenge and lead by example by using the precious resources we have available to us in the most careful and least wasteful way. Going forward, our strategy and delivery will be much more focused on reducing health inequalities and working with residents to better manage their health and wellbeing. This will help us to protect those resources for those who most need it.

SECTION 1: PERFORMANCE REPORT

Overview

This overview is a short summary to inform an understanding of 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

Winter pressures were reportedly the most severe on record for the NHS and Walsall certainly hasn't been immune to this. In December we had our highest month of Type 1 (unplanned) Emergency Department attendances ever, and January saw our third highest month on record.

Yet Walsall Healthcare managed to deliver safer and more timely emergency care than many other trusts this winter.

Our national ranking for the 4-hour emergency access standard rose from 108th (out of 132 trusts) in April 2019 to 53rd in February 2020, (out of 118 trusts, the number has reduced due to a number of trusts scoping the new national ED measures and not submitting the 4-hour data). Our Midlands regional ranking rose from 15th (out of 21 Midland trusts) to 9th (out of 29 trusts) in February 2020. March 2020 saw deterioration in ED 4 hour performance due to the Covid-19 pandemic.

This couldn't have happened without a huge team effort that saw:

- ED managing assessment waiting times so well despite record demand
- Our emergency assessment units in Medicine, Surgery, Gynaecology and Paediatrics supporting patient flow from ED so effectively, despite such high demand.
- Ambulatory Emergency Care, Frail Elderly Service and Surgical Ambulatory Care Unit for timely acute assessments, and brilliant admission avoidance.
- Inpatient wards, Therapies, Community and Intermediate Care Service teams for contributing to reduced length of stay, and reduced numbers of medically fit for discharge patients staying in hospital compared to last year.
- Critical care managing some extremely unwell patients, particularly during peak influenza season.
- Pharmacy support to ensure safe, timely patient discharges.
- Radiology significantly reducing turnaround times for scans - helping clinicians make the right decisions for our patients.
- Discharge Lounge superbly managing record numbers of patients, and freeing up acute ward beds earlier in the day.
- Operating Theatres managing a substantial emergency surgical and trauma caseload at times.
- Infection Prevention and Control colleagues and our Housekeeping team supporting our wards during outbreaks.
- Our Portering team keeping the hospital moving in a timely manner.
- The Clinical Site Practitioner Team staying calm and professional in the face of extreme pressure, and co-ordinating the site so well.

Members of staff also picked up additional shifts to support our Winter Plan, and all our management, administration and corporate teams helped to deliver it.

On RTT (Referral To Treatment) the total incomplete waiting list has seen a reduction; at its peak in October 2019 there were 16,225 patients waiting on a 18 weeks pathway, this reduced to 14,852 patients in March 2020. Our focus continues to bring long waits down.

On cancer services, work continues across a number of tumour sites to improve the 62 day RTT performance with a focus on reducing the front end of the pathway.

Walsall patients will have access to more surgical clinics across the Cancer Alliance footprint, which will support efforts to reduce delays.

Performance against the national constitutional standard for treatment within 62 days varied through the year, however it improved in March 2020 to 85.9% and achieved the national target of 85%.

We use a system called CareFlow Vitals and from March an upgrade to this system was made available throughout the hospital, including the Emergency Department.

The number of patients being seen by our Rapid Response Team has increased during the year due to recruitment within the team and also within the locality teams allowing Rapid Response to hand over patients earlier to create more capacity.

The service has also been piloting a model whereby in addition to GPs, ambulance crews are able to refer in for patients that otherwise would have been taken to ED. The numbers of patients being seen has increased, but the percentage of referrals kept in their place of residence has remained stable, indicating that the quality of referrals has remained consistent and that greater demand exists than the service currently has capacity for.

We have a Private Nursing Homes scheme that provides a healthcare service for patients in nursing homes that identifies and treats deteriorating patients in their place of residence. The scheme covers seven residential homes and provides a pharmacist to support medication reviews.

A Quality in Care Team is now established with action plans for all care homes in the borough.
The trust is now four years into its five year strategy to deliver its vision of "Caring for Walsall together".

This vision is underpinned by five strategic 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.

Our Walsall Together integrated care partnership, with us as host provider, is now underway, and the trust is undergoing a massive digital transformation with the introduction of the EPR (Electronic Patient Record) system.

These are just two of the elements that we hope will help us achieve our ambition of becoming an Outstanding trust by 2022.

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.

The trust has 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.

The area the trust serves

Walsall borough is made up of a diverse multi-cultural population of 283,400 (ONS, mid-2018) and suffers from a number of health inequalities.

According to the Local Authority Health Profile 2019, the health of people in Walsall is varied compared with the England average. Walsall is one of the 20% most deprived districts/unitary authorities in England and about 25.8% (15,070) children live in low income families. Life expectancy for both men and women is lower than the England average.

Life expectancy is 10.4 years lower for men and 8.8 years lower for women in the most deprived areas of Walsall than in the least deprived areas.

In Year 6, 26.2% (958) of children are classified as obese, worse than the average for England. The rate for alcohol-specific hospital admissions among those under 18 is 15*, better than the average for England. This represents 10 admissions per year. Levels of teenage pregnancy, GCSE attainment (average attainment 8 score) and breastfeeding are worse than the England average.

The rate for alcohol-related harm hospital admissions is 688*. This represents 1,814 admissions per year. The rate for self-harm hospital admissions is 182*. This represents 520 admissions per year. Estimated levels of excess weight in adults (aged 18+) are worse than the England average. The rates of new sexually transmitted infections and those killed and seriously injured on roads are better than the England average. The rates of hip fractures in older people (aged 65+) and new cases of tuberculosis are worse than the England average. The rate of statutory homelessness is better than the England average. The rates of under 75 mortality rate from cardiovascular diseases, under 75 mortality rate from cancer and employment (aged 16-64) are worse than the England average.

*Per 100,000 population.

Walsall is a culturally diverse town where people of Indian, Pakistani and Bangladeshi background form the largest minority ethnic groups. Walsall now has a small Eastern European population.

Looking back over the last 12 months

Care Quality Commission inspection report

The trust was inspected by the CQC in February and March 2019 and the team visited all of our medical inpatient areas and critical care services. Inspectors also attended both our public and private Board sessions. Inspectors published their report in July 2019.

Walsall Healthcare NHS Trust came out of quality special measures following this inspection which rated care as "Outstanding" across the trust and highlighted a number of areas of outstanding practice in both the hospital and community.

While the trust has been rated as "Requires Improvement" overall, there has been significant progress made since it was rated Inadequate in 2016 and Requires Improvement in 2017.

The report highlighted several areas of "outstanding practice" which included:

- The new Advanced Clinical Practitioner role to improve patient target times for triage and treatment
- The award-winning initiative to improve patient care for frequent Emergency Department attendees
- The introduction of "What Matters To Me" boards for elderly patients and those living with dementia
- The introduction of communication clinics for relatives
- The CASH (Contraception And Sexual Health) team providing an exemplary programme of sex and relationship education to young people

Inspectors also noted the promotion of a positive culture across the trust with staff feeling supported and valued and a "significant improvement" in their sense of pride in representing the organisation.

The CQC detailed the areas which need to improve including ensuring staffing levels are safe and reduce the risk of patient harm, greater engagement with patients and better monitoring of infection risk.

Under the well-led domain, while stating that leaders were well engaged with external partnerships to secure experiences and quality across health and care, inspectors noted that staff below director level could do more to ensure accountability and the flow of information.

Key estate improvements

New neonatal unit opens

The trust's new £5.6m Neonatal Unit at Walsall Manor Hospital opened in November 2019.

The unit houses a purpose-built Intensive Therapy Unit and High Dependency Unit and a new obstetric theatre has also been created.

Caroline Whyte, Walsall Healthcare's Divisional Director of Nursing – Children, Young People and Neonates, said: "We've increased our provision to 20 cots – taking our HDU cots from two to four and our special care cots from 11 to 14 – and the extra space we have is fantastic.

"The construction was a challenge in as much as parts of this expansion have had to be live and running alongside the existing unit. Staff have been so accommodating – ensuring safe, high quality care has not been compromised while juggling the demands necessary for a major expansion project – and I'd like to thank them for their patience and co-operation."

Neonatal Unit Senior Nurse/Ward Manager Lisa Poston added: "As well as the much-needed investment in neonatal care that this represents there are also some lovely features in the new unit."

"We've got a special bell that can be rung when babies are ready to go home and in some windowless areas we've got some stunningly colourful light panels."

Partnership approach to building for the future

A potential layout for the new £36m Emergency Department and Acute Medical Unit at Walsall Manor Hospital has been drawn up following workshops with service users.

Interserve Construction has been appointed to build the new development and it will replace the current building whose physical environment struggles to meet increasing patient flow demands.

A full business case has been developed for NHS England/Improvement approval and enabling works are due to start in autumn 2020 with the building ready to use in 2022.

The Capital Build itself will incorporate a new Emergency Department with "front door" access to a new Urgent Treatment Centre and Paediatric Assessment Unit within it. The first floor will then provide a new Acute Medical Unit along with a Medical Ambulatory Unit.

Walsall Healthcare NHS Trust's clinical teams have been working with Interserve to define the new ways of working that will represent Best Practice and high standards of care to patients so that the building can meet these needs.

In January, all the services that are involved – including the Frailty Service, Palliative and End of Life Care, Pharmacy and Infection Prevention and Control - signed off their clinical models which will now be used to start to define the initial layout and drawings.

Colleagues from the Emergency Department, Patient Experience Team, Interserve project Team and BDP Architects joined patients, carers, service users, volunteers and stakeholders to take part in a workshop in January to pool their expertise to deliver more effective and sustainable outcomes and an improved experience for all involved. The session was opened by Miss Ruchi Joshi, Clinical Director and those taking part took part in discussions, used interactive Virtual Reality and visual exercises to help shape the ideal patient experience.

Miss Joshi said: "We looked at all aspects of the patient's journey from arrival and waiting to treatment and care, taking on board communication and information, the actual environment and all the factors that influence how we make our patients and their families feel.

"We want to thank everyone who took part and helped us enjoy an enthusiastic and lively session with plenty of food for thought in terms of feedback. People told us they'd prefer to see calming colour palettes moving away from a clinical look, audio and visual privacy with consideration to visually impaired visitors and those with hearing impairments and soft furnishing for sound absorption to name just a few suggestions.

"This co-production and co-design model will be continued over the lifespan of the project with patients, carers, 'staff as service users' and different groups from the community getting involved at specific phases of the planning and building work."

"This is a tremendously exciting time for our trust as we work in partnership to deliver a brand new department that is fit for purpose for many generations to come."

Birthing restrictions relaxed

From April 2019 women registered with all GP practices were able to give birth at Walsall Manor Hospital after restrictions were released.

A birthing cap was introduced in 2016 to reduce the number of births at the hospital and ensure the safety and stability of Maternity Services.

Following an improved CQC rating and the ongoing efforts of staff and senior leaders, Walsall Healthcare was able to release these restrictions.

It meant that from April 2019 the trust was able to increase its birth rate to its capping level of 4,200 each year and started accepting bookings from all GP practices for any pregnant women who wish to give birth at Walsall Manor Hospital. Low risk women who were already booked to deliver at another trust who would like to birth at the Manor Hospital could also request a transfer. This had previously been restricted.

MLU re-opened for births

Walsall's Midwifery-Led Unit (MLU) re-opened for births on 6 January 2020. The MLU also continues to offer supportive antenatal, postnatal and perinatal mental health clinics.

Births were suspended again in March 2020 due to the pressures of COVID-19.

Electronic Patient Record (EPR) investment

The trust is implementing a new Electronic Patient Record (EPR) system this year as part of its exciting digital transformation journey. EPR is one of the trust's key priorities as it works towards a more effective and efficient NHS.

The programme has been through a rigorous testing phase in order to identify any issues and is due to go live in autumn 2020.

There has been fantastic engagement from colleagues across the trust and EPR has been embraced as a great opportunity to develop and improve.

MEDWAY will replace the Patient Administration System (PAS), Lorenzo.

The Emergency Department will use a MEDWAY system specifically designed for ED, which will include **VITALS.**

BLUESPIER will replace ORMIS, currently used in Theatres.

CAREFLOW CONNECT will enable clear communication between clinicians creating improved patient care and experience - Piloted by Pharmacy.

This is not just a new IT system; it is transformational change with a long term commitment to service improvements.

NHS Staff Survey

Our 2019 NHS Staff Survey results showed an overall decline across ten of the 11 themes compared to the results of the 2018 survey.

In response to the outcomes of the 2018 survey, throughout 2019 the trust applied a particular focus to the health and wellbeing of colleagues and increasing the quality of appraisals. Whilst it was early days in terms of the impact of work in these areas it is encouraging to receive the following feedback from this year's survey:

- More staff have told us that their appraisal has helped them to improve how they do their job to 22.5%, the highest score since 2015.
- More staff have told us that they believe that we take positive action on health and wellbeing. 26.5% which is an increase from 25.8% in 2018 and is close to the peer benchmark average of 27.8%

Our Employee Engagement Index score fell slightly from 6.7 in 2018 to 6.6 with staff telling us that they feel unable to make suggestions and make improvements in the work of their team/department. These results contrast with our Quality Improvement approach and suggest more work is required to focus on a QI programme to enable the trust to achieve sustainable quality and efficiency improvements.

Walsall Together Integrated Care Partnership

Walsall Together Integrated Care Partnership (ICP) is a partnership between Walsall Healthcare Trust as the host provider, Walsall Clinical Commissioning Group, Black Country Partnership NHS Foundation Trust, Walsall Council, Walsall Housing Group and One Walsall.

It was fully established in April 2019 and the aim is to work together to improve the population's health outcomes, increase the quality of care provided to our residents and provide long-term financial sustainability in the system.

Governance Arrangements

A Walsall Together Partnership Board, with senior representation from each organisation, meets on a monthly basis to provide strategic oversight and operational co-ordination for the services in scope. All organisations have signed an alliance agreement which sets out how they will work together to deliver sustainable, effective and efficient services.

The Executive Director of Integration leads a Senior Management Team and Programme Office, which are responsible for overseeing the operational delivery and co-ordination of services. A robust plan is in place that describes the remit, programme governance and outcomes of the individuals and teams tasked with delivering the new clinical model.

A Clinical and Professional Leadership Group (formally known as the Clinical Operating Model Group) is chaired by the Director of Public Health. This provides strategic clinical direction and assurance on the model of care as well as overseeing and ensuring effective engagement to enable the integration of services to work. This group also co-ordinates the selection of clinical pathway redesign based on population health needs.

A Section75 agreement has been developed between Walsall Healthcare Trust as the host provider of the ICP and Walsall Council. The agreement sets out how Walsall Healthcare acts as the host for delivery of Adult Social Care Services.

Our plans for delivering an Integrated Care Partnership

Since the partnership was established, it has been working on and looking at ways in which we can plan and deliver services in a more joined up way in order to meet the changing needs of the population.

A strategic business case, supported by all partners, was approved outlining the future intentions of the partnership and further enshrined by an Alliance Agreement, which demonstrates how the partnership plans to deliver integrated care for the people of Walsall.

This includes a new model of care that will see all the people involved in a person's care operating together such as GPs, mental health, social care, pharmacy, voluntary sector and the hospital.

All levels of care will be accessed via a single point creating a seamless navigation and co-ordination service for all health and social care services. This will be accessible in person, via telephone, a mobile app or online.

Investment

In order to develop and deliver a fully integrated care partnership we are investing in our communities, workforce, digital equipment, technology and estates:

Resilient Communities

Focusing on prevention rather than treatment, we are looking at ways we can support our communities by equipping them with the tools and resources they need to improve the health and wellbeing of their population.

We are working with Walsall Council and One Walsall to align our Resilient Communities Programmes, giving people better access to services such as social prescribers, Making Connections Walsall, housing, education and training information, Expert Patient Programme, Care Navigation and Co-ordination, carer support and opportunities to be involved in volunteering projects.

Healthwatch Walsall has also been commissioned to support Walsall Together in engaging and communicating with service users, carers and the people of Walsall about the evolving integrated ways of working.

This organisation will take the lead in identifying and seeking the views of patients and the public on services delivered across the Walsall Together ICP, inform people of the benefits of integrated working and enable communities to be fully represented in the decision making process of future delivery of services and service change.

It attends the Walsall Together Partnership Board and provides patient and user stories that outline both the need and the benefits of integration.

Workforce

Building on and bringing together existing workforce into new teams to enable them to work closely together to deliver each tier of care within the model.

This will include teams to support people to manage their own health and social care within the community, a single point of access team, expanding on existing community based service teams and creating a network of specialist teams to deliver outpatient and diagnostic services as well as a range of intermediate, unplanned and crisis services.

Secondary care consultants, advance practitioners, social prescribers, pharmacists and therapists are just a few examples of the services that are being invested in to ensure that the right support is in the right place at the right time for the population.

As well at the physical co-location of teams we are also investing in organisational and workforce development to ensure that all our staff fully engaged with the aims of the partnership and integrated working and are given the opportunity to train and develop their skills in order to deliver these.

Digital Technology

We are developing resources, digital tools and the infrastructure that will enable the integrated partnership to be effective and efficient in its delivery.

This includes the Single Point of Access which will support the different tiers in allowing people to access the self-care health and social care information they need, online applications such as telehealth, appointment booking and fitness trackers and access for health and social care professionals to data from individual records (with consent) to enable informed decision making and better outcomes for individuals.

Estates

Looking at how and where we can deliver the new model of care.

This includes Health and Wellbeing Centres based across the four existing localities (North, South, East and West), a number of number of easily accessible buildings across the borough for integrated primary, social and community services as well as specialist services and Walsall Manor Hospital for high quality acute services including A&E.

Whilst some of these will be achievable in the short term, some will form part of the longer term deliverables over a five year period.

Benefits of Integrated Working

For local people and their families it will mean they are better supported within a community setting to maintain their health and independence, the way their care is provided will be easier to understand and use, professionals will have access to individuals information so they don't have to keep sharing their health and social care history and they will have more choice in who provides their care.

For our health and social care professionals they will be part of new ways of working that better meets the need of local people, will have flexibility in their roles and more development opportunities, the ability to access patient information quicker and improved communication between primary and secondary care.

For the health and care economy as a whole it will improve existing working relationships, allow for shared knowledge, resources and expertise between organisations, reduction of duplication, improved digital and technological support, ability to share resources to provider safer, more co-ordinated care that is sustainable in the future.

Achievements so far

We have made excellent progress since the partnership was formed in laying the foundations and setting out our vision and how we aim to achieve it. We recognise we have a long way to go but some of the achievements to date include:

- Co-location of all adult social care and community based service staff into new teams within the existing North, East, South and West localities in Walsall. This will enable staff to work as one team, allowing for better decision making, sharing of skills and expertise and the reduction of duplication of work.
- Recruitment of a Multi-Disciplinary Team Co-Ordinator and GP Leads across all four localities, which will allow for a co-ordinated approach of the MDT across all localities. This will lead to improved and more effective sharing of information to ensure a clear overview of the needs of Walsall population as a whole.
- Adoption of a strengths-based approach workforce development programme which is due to be rolled out imminently. Strengths-based approaches focus on individuals' strengths, including personal strengths and social and community networks. It is an holistic and multidisciplinary approach and works with the individual to promote their wellbeing. This will equip staff with the skills they need to embed the model of care into their work, improve team engagement.
- Commissioned Healthwatch Walsall to develop a Walsall Together Service User Group ensuring effective engagement with the population of Walsall enabling them to provide feedback on service redesign proposals and pathways of care. This will allow services to be designed jointly with services users ensuring they are accessible, delivered effectively and in a timely manner. It will lead to improved health and wellbeing outcomes both in terms of managing existing conditions and preventing new cases.
- Transfer of Stroke Rehabilitation patients from a hospital setting into the community to enable improved quality of care through a more integrated approach by all specialists involved in their care and improved access to intermediate care and other community services. It will also reduce the risk to these vulnerable patients of hospital associated infections, increased falls due to unfamiliar surroundings and reduce waiting times for therapy care which will lead to improved recovery times for patients.
- Piloting a Single Point of Access for GPS and Paramedics focusing on admission avoidance during winter 2019/20. This allows for a more co-ordinated and streamlined approached to patient care with their needs met in a more effective and efficient way and where possible through specialist MDT teams in the community rather than a hospital setting.

- Roll out of virtual clinics to a wide range of services such as bereavement, dermatology, paediatrics and care home service users. This allows online consultations to take place between clinicians and patients, without the need for a face to face visit, reducing the number of visits for follow up care within the hospital and community and the barriers faced by patients in accessing appointments.
- Implementing a Bedside Mobility Assessment Tool (BMAT) within the hospital to support the discharge of patients, who are medically stable, into the community by improving mobilisation and reducing deconditioning. Through the use of BMAT patients are kept mobilised and the risks of bed sores and falls are decreased which leads to reduced lengths of stay in hospital.
- Review of Respiratory, Cardiology, Diabetes, End of Life, Mental Health and 0-19 Year pathways to identify improvement opportunities, focus on prevention and management of Long Term Conditions and ways in which more care can be delivered in the community. This will allow service users to access care closer to home therefore reducing the need to travel and the cost and time associated with that. In addition they will have access to integrated services which can manage multiple conditions/issues without having to refer to other teams which will mean less waiting times and uncertainty.
- Development of a single electronic referral form to allows referrals to go directly from a GP clinical system into locality teams. This will enable the referral to be reviewed by a Multi-Disciplinary Team approach and patient care be delivered in a more effective and timely manner without the need for them to repeat their heal hand social care history to multiple providers.
- Review and expansion of Advance Care Planning to deliver ReSPECT forms, and planning for subsequent transition to an electronic system (EPaCCS), across all organisations. This will enable a person (or suitable alternative) to express preferences for clinical care in a future emergency in which they are unable to consent. It will reduce inappropriate referrals or treatment where this is not desired and/or appropriate. This will enable more personalised care with patients able to have more control over their care and their wishes taken into account at all stages of their care allowing them to die in a place of their choosing, where appropriate.

Next Steps

The Walsall Together Programme Office along with all partners is currently reviewing the proposals set out in the original business case and looking at the key deliverables and the investment required to achieve the aims set out in 2020/2021.

BMAT – helping our patients, helping our staff

BMAT (Bedside Mobility Assessment Tool) is a nursing tool that enables nursing staff to assess and identify a patient's mobility status in order to safely get them out of bed. It recommends equipment for safe patient transfers and mobility.

Staff across Walsall Manor Hospital have been receiving training in BMAT and the tool is seeing some really good results with positive feedback from staff. It provides a standardised way for staff to assess patient mobility in order to determine safe and effective practices for patient handling.

Our BMAT team is made up of Michelle Shore, Senior Paediatric Occupational Therapist, Zoe Waldron, Assistant Practitioner for Stroke Services and Sara Marple, a Clinical Support Worker from our complex discharge Ward 14.

Michelle said: "We all know how important it is to get our patients out of bed on a daily basis. Ten days in hospital can lead to 10 years of muscle aging for some patients so anything we can do to prevent deconditioning and prolonged hospital stays has to be a good thing."

Zoe said: "BMAT helps maintain the safety of both patients and staff by avoiding the use of bad practice. This should reduce work-related illness and therefore time off work which puts pressure on the remainder of the team."

While BMAT is a four step tool many patients may not need all four steps. It is a quick tool that can be incorporated into everyday tasks such as washing, changing and getting out of bed for mealtimes.

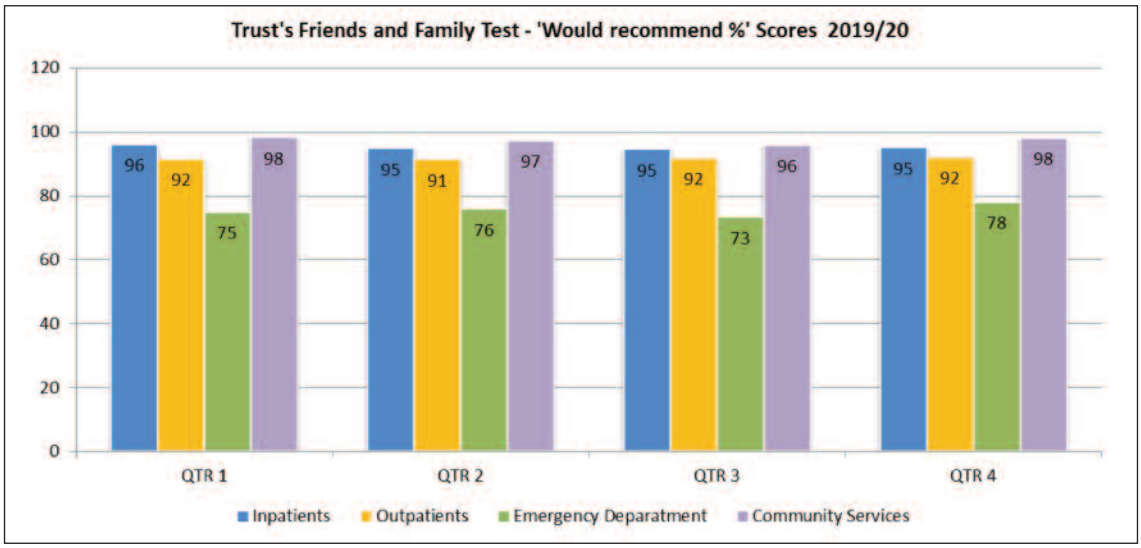
Where the patient has been seen by therapies with a mobility plan above the bed, the BMAT should still be completed on a daily basis with the aim of achieving that level of mobility. Where this is not possible, liaison is required with the appropriate Physiotherapist or Occupational Therapist.

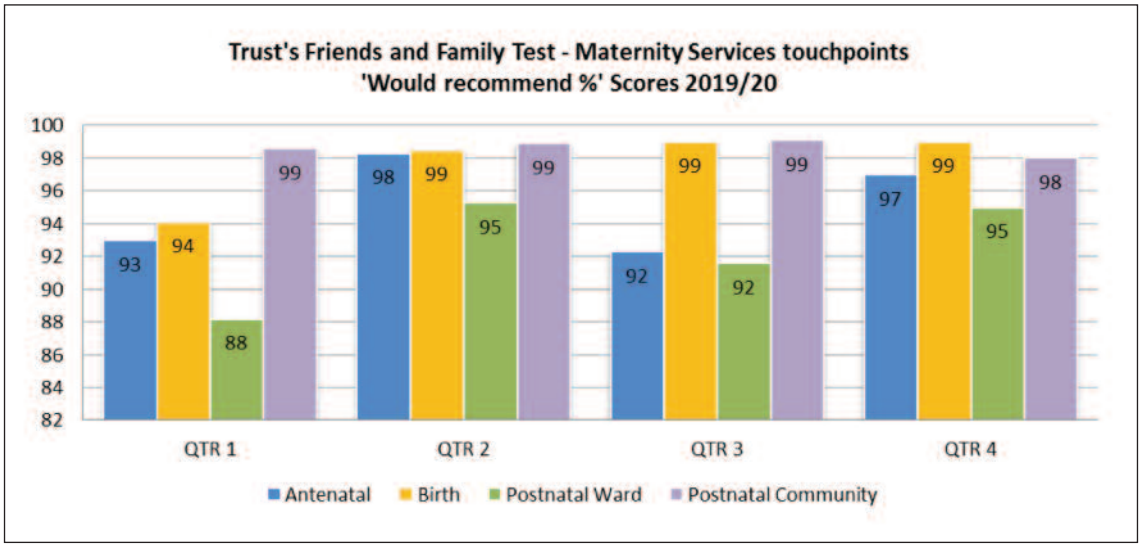
Patient experience progress

Over the last year, we have progressed further with our work for putting patients and carers' voices at the heart of our services to ensure that the trust has a co-ordinated approach of 'listening to' and 'learning from' feedback. We have particularly increased patient involvement in production and design of services and clinical units.

Around 92% of patients who used our hospital and community services said they would recommend us to their friends and family if they needed similar care or treatment. This recommendation score is based on over 52,000 Friends and Family Test (FFT) surveys completed by our patients and service users. Our national survey results continued to show improvements and also highlight areas where more work is needed such as communication, patient involvement in decisions about care and treatment, arrangements around discharge and waiting times.

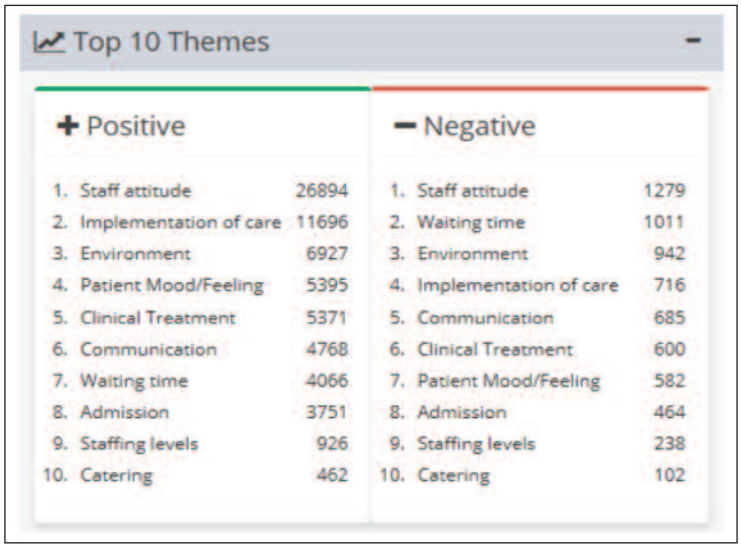
The chart below shows average FFT results for positive recommendation scores (%) for inpatients, emergency department, maternity services, outpatients and community services during 2019-2020.





Feedback comments themes

Patients positively commented the most about staff attitude, implementation of care and our healthcare environment. The themes below have been generated from over 39,000 FFT comments given by patients. The themes are ranked, and in relation to comments reported positively or negatively:



Key achievements and improvements include:

- "Making Magic with Bubbles and Butterflies - Doing What Matters!" Ward 2 Patient Experience project shortlisted for a national award.
- Patient involvement to influence the feel, look and design of the new Emergency and Urgent Care Centre.
- Partnership working with Healthwatch Walsall for ward quality and safety reviews Partnership working with Manor Farm volunteers to enhance the discharge lounge experience.
- 'Hear2Care' Patient, Carer and Staff experience stories programme improved and expanded.
- 'What matters to me' patient boards on wards.
- Quiet Protocol introduced to the paediatric wards to help patients and parents sleep well at night.
- Maternity 15 Steps – Gaining service user perspective on the maternity journey.
- Feedback Friday and Star comments initiatives promoted positive feedback for services/wards on our website and social media.
- Co-produced user-friendly visual patient journey maps for Emergency Department and Maternity Triage.
- 'You & I' Patient Experience awareness programme completed in Maternity Services and rollout began for Community Services.
- Rolled out Neonatal Unit Face2Face project to deliver a live audio/visual stream to new mothers who could not see or visit their babies in NNU.
- 'Images speak a thousand words' project on ward 3 - using pictures to help patients feel at home and less anxious about their hospital stay.
- Supported Maternity Services - its aim to gain Baby Friendly Initiative accreditation by working closely with our League of Friends Shops.
- Lay Reading Panel participation increased for reviewing non-clinical patient leaflets/information.
- Trust Quality Improvement Programme: Supported working groups and involvement of lay members/volunteers.
- Partnership work with local schools such as Queen Mary School for community project and curriculum's enrichment programme on PAU/Ward 21.
- Kids Saturday Club - Operation theatre tour for anxious children and those with additional needs/Learning disabilities to reduce anxiety when they actually go for their procedure.
- Monthly FFT staff award – A recognition Award for wards with most positive staff member mentions in the Friends & Family Test.

The trust is also extremely grateful to over 300 volunteers who support staff and patients across the hospital, Palliative Care Centre, Chaplaincy and Self Care Management. We continue to increase the number of our volunteers and develop new roles based on the requirements of our different clinical and non-clinical services.

QI update

The trust's Quality Improvement Academy launched its formal Quality, Service Improvement and Redesign (QSIR) training across the organisation.

QSIR is supported by NHSE/I and has two separate accredited programmes; a one day Fundamentals which gives participants enough understanding to get started with a QI project, and a five day Practitioner level course that covers eight modules.

The initial plan was to have three cohorts of delegates but colleagues within the trust were engaged to a greater extent and five cohorts were completed. In total 87 colleagues completed the five day practitioner programme and 150 colleagues completed the one day Fundamentals.

The Senior Nurses Development Programme required delegates to undertake a QI Project within their clinical area. The first QI Awards event took place in July 2019 showcasing the Quality Improvement Projects which medical colleagues had been working on. The event saw submissions from all divisions and was a platform to build on for a multi-professional event to be held each year moving forward.

The QI Academy also sponsored two QI Conferences through the year, with national speakers across a wide range of topics including Compassionate Leadership, Leading Improvement and Plot the Dots delivered by the NHSI Analytics team, as well as local QI Projects being presented at both events.

The QI Academy also took over the sponsorship and co-ordination of the Human Factors training that was being delivered within the trust and across the STP. This programme of training supports staff to make it easier to do the right things within high-pressured clinical roles as well as within other services, using scenario and simulation training techniques. Three sessions introducing the concepts within Health Care Systems Engineering were also delivered to a range of colleagues through the summer.

Towards the end of the year, the trust demonstrated its commitment to continuous Quality Improvement with the appointment of Divisional Clinical Leads for QI and Research. Their role along with the trust's Clinical Lead for QI, is to promote QI and research within their division and to engage the clinical body in applying QI tools and methodology in all that they do.

Charity year success stories

From climbing Mount Snowdon, to a trek in the Sahara with sponsored bike rides, head shaves, a boxing match and a fashion show – fundraisers for our Well Wishers charity have had another busy year!

A host of charity events have taken place over the last 12 months to help swell our charity coffers and Well Wishers also teamed up with Marks & Spencer for a fundraising partnership to support the parents and carers of premature babies.

A successful partnership with Enoch Evans LLP Solicitors continued with a Make A Will Fortnight and the charity's Patron Martin Gethin, former British Lightweight Champion and IBF Super Lightweight Champion, has carried out his own events as well as supporting the charity throughout the year.

Donations have also continued to flood into the Purple Hub on the outpatients corridor. Books and bric a brac are sold Monday to Friday and this has helped generate additional funds for the charity.

Other highlights include the charity funding adapted Tai Chi training courses for Assistant Practitioners within the Community Neurological Rehabilitation Team based at Short Heath Clinic. This has meant Walsall patients with Parkinson's Disease and Multiple Sclerosis have been able to try these specialist sessions to help them manage their long term conditions.

Well Wishers has also joined the Best of Walsall, which champions the borough's businesses and shops and is helping to promote the charity.

Key issues and risks

During 2019/20, 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:

- Prolonged or substantial failure to deliver fundamental standards of care, results in harm to patients.
- Failure to engage patients and the public in service development results in poor patient experience and services which do not meet the needs of patients
- Failure to develop effective partnerships within the Walsall Together partnership may result in the trust being unable to deliver integrated secondary care pathways and social care collaboration
- Failure to deliver the objectives defined in the long-term plan, results in poor partnership working across the system, therefore impacting on the trusts long-term sustainability.
- Lack of an inclusive and open culture impacts on staff morale, staff engagement and patient care
- Failure to deliver the trusts financial plan:
  - Impacts on the quality of care the trust is able to deliver
  - Results in the trust being placed into financial special measures

Statement of Going Concern

These accounts have been prepared on a going concern basis.

The trust recorded a surplus in 2019/20. The Board is committed to continue to generate surpluses in future years and current long term planning models show the trust at breakeven or surplus for the financial years 20/21 to 23/24. To achieve this forecast the Trust will be relying on support from the Financial Recovery Fund (FRF) from NHSI/E. For the Trust to receive the funds financial targets need to be achieved by both the Trust and the wider Black Country and West Birmingham Sustainability and Transformation Partnership (STP). Planning has been centred around ensuring these targets are met. In March 2020 of this year, NHSE/I informed all trusts in England that funding would be provided to ensure that each trust could achieve breakeven in April 2020 to July 2020. Where allocated funding was insufficient trusts have the opportunity to bid for further funds to cover expenditure incurred for meeting the challenges associated with the Covid 19 pandemic. The Trust awaits further updates about the exact funding arrangements for 20/21.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £130,534 is classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

The Board has concluded that the Directors have a reasonable expectation that the Trust has access to sufficient resources, including revenue allocations, additional funding to support Covid 19 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.

SECTION 2: ACCOUNTABILITY REPORT

2a CORPORATE GOVERNANCE REPORT

Directors' Report

The Trust Board meets in public and the meetings are open to anyone who wants to attend. Details, including agenda and papers are available on the trust website.

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.

The table below sets out the names of the Chair, Chief Executive and all individuals who were directors of the trust from April 2019 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.

Non-executive directors are not employees of the trust and are appointed to provide independent support and challenge to the Trust Board. All Board directors are required to comply with the trust Standards of Business Conduct, including declaration of any actual or potential conflict of interest.

Trust Board Composition

Name	Designation	In Year Start / Leave Dates
NON EXECUTIVE DIRECTORS		
Danielle Oum	Chair	April 2016
John Dunn	Non-executive Director	February 2015
Sukhbinder Heer	Non-executive Director	September 2016
Philip Gayle	Non-executive Director	August 2016
Anne Baines	Non-Executive Director with effect from 14 December 2018 (Associate NED pre December 2018)	July 2018
Pam Bradbury	Non-Executive Director	December 2018
Ben Diamond	Non-Executive Director	October 2019
ASSOCIATE NON EXECUTIVE DIRECTORS		
Dr Elizabeth England	Associate Non-Executive Director (non-voting)	December 2018 to July 2019
Alan Yates	Associate Non-Executive Director (non-voting)	April 2018 to August 2019
Sally Rowe	Associate Non-Executive Director (non-voting)	April 2019
Paul Assinder	Associate Non-Executive Director (non-voting)	October 2019
Rajpal Virdee	Associate Non-Executive Director (non-voting)	October 2019
EXECUTIVE DIRECTORS		
Richard Beeken	Chief Executive Officer	February 2018
Daren Fradgley	Director of Integration/ Deputy CEO	December 2015
Russell Caldicott	Director of Finance and Performance	July 2015
Jenna Davies	Director of Governance	June 2018
Catherine Griffiths	Director of People & Culture	September 2018
Margaret Barnaby	Interim Chief Operating Officer	December 2018 to July 2019
Dr Karen Dunderdale	Director of Nursing / Deputy CEO	August 2018 to March 2020
Dr Matthew Lewis	Medical Director	-
Ned Hobbs	Chief Operating Officer	July 2019
Ann Marie Riley	Interim Director of Nursing	March 2020
NON EXECUTIVE AND EXECUTIVE DIRECTORS WHO HAVE LEFT THE TRUST		
Dr Elizabeth England	resigned from her role as an Associate Non-Executive Director in July 2019.	
Mr Alan Yates	resigned from his role as an Associate Non-Executive Director in August 2019.	
Mrs Karen Dunderdale	has been seconded to another NHS Trust since March 2020.	

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. Danielle has also recently joined The Royal Wolverhampton NHS Trust Board as a non-executive member to improve collaboration and partnership working.

John Dunn
Non-Executive Director (Voting Position)
Chair of Performance, Finance and Investment Committee
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.

Sukhbinder Heer
Non-Executive Director (Voting Position)
Chair of Audit Committee
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).

Philip Gayle
Non-Executive Director (voting position)
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.

Anne Baines
Non-Executive Director (voting position)
Chair of Walsall Together Committee
Appointed 14th December 2018

Anne has had near 40 years' experience within the NHS in the West Midlands. Before taking (semi) retirement in 2017 she had spent the last 15 years in and around Board level roles in both providing and commissioning roles covering strategy, business development and transformation, communications and HR. She was the Director of Strategy at Walsall Healthcare Trust from 2010-2014 and is happy to have returned as a Non-Executive member as she has fond memories of the Trust and colleagues working there. Anne is a member of the Quality and Safety Committee and has been appointed the NED lead for the Freedom to Speak Up policy.

Sally Rowe
Associate Non-Executive Director
Appointed October 2019

Sally Rowe has been a qualified social worker for 30 years, working across children's and adults services in different types of local authorities and in frontline and management roles. She has also spent time as Her Majesty's Inspector of local authorities and a senior manager within Ofsted. She is now Director of Children's Services in Walsall, a Non-Executive Director of a Health Trust and a Trustee of a national charity Grandparents Plus.

Paul Assinder
Associate Non- Executive Director
Chair of Charitable Funds
Appointed October 2019

Paul is one of the most experienced and respected finance professionals working in healthcare in the UK. He was elected as National President of the Healthcare Financial Management Association (HFMA), the leading professional body for finance staff working in UK healthcare, in December 2009 and has more than 25 years' experience at board level in both the public and commercial sectors.

Doubly qualified as an accountant, with a University background in both economics and management, he trained and worked with Ernst & Young Co in the UK after graduation, before specialising in the healthcare and technology sectors.

Paul is a graduate of the Senior Managers Course at Insead (French Business School) and was one of the first FDs to be selected to join the elite NHS Top Leaders Programme in 2010. Paul has a broad portfolio of financial and business experience most recently as European CFO of the US transformational genomics provider Nant Health Inc. In the local NHS, Paul has advised policy makers on transformational change through the NHS STP Programme and has also served as Director of Finance and Deputy Chief Executive of Dudley Group NHS Foundation Trust. Before that he held similar positions at Sandwell & West Birmingham Hospitals NHS Trust, Birmingham City Hospital NHS Trust and a number of other board-level appointments in the NHS and private sector.

He is committed to the development of the next generation of healthcare leaders and holds the position of Senior lecturer at the University of Wolverhampton Business School and with others, founded the MBA qualification in Business & Finance for the HFMA Academy in 2017.

Rajpal Virdee
Associate Non-Executive Director
Appointed October 2019

Rajpal has 30+ years of being involved in both the public and voluntary sector. Initially, a social worker rapidly moving through to senior management in Dudley Social Services and latterly at Birmingham Social Services.

He has extensive experience with health care bodies, in the capacity of a Non-Executive Director, which included East Birmingham Primary Care Trust, Walsall Primary Care Trust and Walsall Clinical Commissioning Group.

Amongst his many achievements as a Non – Executive Director include, the development of Castle Vale Health Care Centre, Pelsall Medical Health Centre and Walsall Hospice where he was the Chair of the project.

Another passion of Raj is the provision of affordable housing and he has been involved with numerous hosing associations, including Black Country Housing Group where as Vice Chair he leads the development of numerous affordable housing schemes, to the benefit of local families.

Raj was appointed in 2002 by the Judiciary to sit as a Lay Member at the Birmingham Employment Tribunal, which deals with employment disputes between employers and employees over employment rights.

Ben Diamond
Non- Executive Director
Appointed October 2019

Ben has recently retired from the Fire Service after over 30 years working in emergency response and senior management positions throughout the West Midlands.

During his time in the Fire Service, he developed many innovative partnerships, all focussing on prevention of incidents and ill health. Ben's focus is on prevention being better than cure and he is keen to influence partnerships to develop this principle at Walsall Healthcare NHS Trust.

Pamela Bradbury
Non-Executive Director
Appointed December 2018

Pam's career has spanned far and wide, gaining experience as a nurse, manager and leader in the NHS and as a professional advisor within the Dept.of Health. Pam is also a key figure within Healthwatch England – central region.

Richard Beeken
Chief Executive (Voting Position)
Appointed March 2018

A graduate of the NHS Management Training Scheme and the NHS Top Leaders Programme, Richard has extensive NHS Leadership experience, having been an executive director since January 2005. 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.

Daren Fradgley
Director of Integration/ Deputy Chief Executive Officer
SIRO
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 the Lead for the Walsall Together PLACED based model, and is also the executive lead for Digital Technology.

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.

Jenna Davies
Director of Governance
Appointed 04th June 2018

Jenna joined the NHS in 2008 and has predominately worked in senior leadership roles in the Corporate and Clinical Governance fields. Jenna studied Law at the University of Birmingham and qualified in June 2008. Jenna has led and contributed to a number of large scale improvement programmes including a highly complex OD project and preparation for FT application status. Jenna was appointed as Director of Governance in June 2018 and is responsible for the efficient administration of the Trust, particularly with regard to ensuring compliance with statutory and regulatory requirements and for ensuring that decisions of the board of directors are implemented. Jenna is the lead for Governance across the organisation including Health and Safety, Quality Governance and Information Governance

Catherine Griffiths
Director of People & Culture
Appointed - 10th September 2018 (non-voting position)

Catherine has a background in local government and more than 20 years' experience of HR and large scale service transformation and redesign. Her expertise lies in employee engagement and empowering those around her to make positive changes for the benefit of the organisation and its service users.

She joined the NHS for the first time in 2015 where she took on the role of Deputy Director of HR as part of Royal Wolverhampton NHS Trust.

Catherine then made the move to Walsall Healthcare in September 2018 and now sits on the Trust Board as Director of People and Culture – overlooking HR and Organisational Development.

Her focus is to ensure a positive and inclusive culture amongst the workforce to ensure staff have the support they need to develop their own talents in order to improve patient experience. Her role also means ensuring staff are living by the trust values (Respect, Compassion, Professionalism and Teamwork) and are supported to be happy and healthy while at work.

Catherine has lived in and around the West Midlands for more than 25 years and is qualified at Masters level in Strategic HR management and holds an LLM in Employment Law.

Dr Matthew Lewis
Medical Director / Caldicott Guardian
Appointed 22nd October 2018 (voting position)

Matthew was previously Consultant Gastroenterologist at Sandwell & West Birmingham Hospitals NHS Trust, where he has also been a Divisional Director. As Medical Director at Walsall Healthcare NHS Trust, his key areas of focus are to further develop our service integration with primary care and other hospitals, to improve medical engagement in quality governance and patient safety and to better link service plans to medical workforce plans. Matthew is also the organisation's Caldicott Guardian. Patient Safety and quality of care are key priorities for Matthew in ensuring that our clinical outcomes for patients are of a high standard.

Ned Hobbs
Chief Operating Officer
Appointed July 2019

Ned graduated from the University of Nottingham with a first class degree in Pure Mathematics before joining the NHS Graduate Management Training scheme in 2008 in the West Midlands region. He completed his Masters in Health & Public Leadership from Birmingham's HSMC in 2011 and has carried out a variety of operational management roles – predominantly in the acute hospital sector and within mental health.

Ned's previous role was as Director of Operations for the Division of Surgery, Women & Children at Dudley Group NHSFT where he delivered the fifth best elective 18-week Referral to Treatment waiting times in the country.

He has a passion for clinical leadership, having written his dissertation on this subject, and has lectured to medical students and doctors in training on leadership in the NHS. He also has a keen interest in Quality Improvement and the use of comparative clinical outcome measurements to improve patient care.

Ann Marie Riley
Interim Director of Nursing
Appointed March 2020

Ann-Marie joined the Trust from Nottingham University Hospitals (NUH) where she was deputy Chief Nurse. Ann-Marie hails from Lancashire originally and has worked in senior nursing positions in both Birmingham and the Black Country before starting her four year stint as the Deputy to one of the most respected and experienced chief nurses in the country, Mandie Sunderland.
Ann-Marie has vast experience and has implemented some award-winning innovative ideas such as #NUHmemorymenu as well as being one of the key people behind the national #endPJparalysis campaign.

Arrangements for the performance review of Board members

All Board members have an annual appraisal. The Chair has her appraisal with the appropriate Director of NHSE/I. The Chair conducts appraisals with all Non-Executive Directors. The annual objectives of the Chief Executive reflect the priorities of the Trust set by the Trust Board and are agreed with the Chair. The Chair reviews the Chief Executive's performance against these objectives. Each executive director agrees objectives with the Chief Executive. The Chief Executive conducts performance reviews for each Director. The annual appraisals for all Executive Directors, including the Chief Executive, are reported to the Remuneration Committee.

Attendance at Trust Board meetings

Trust Board	Total %	Attended	Sessions
Executive Directors			
Richard Beeken	100%	10	10
Russell Caldicott	100%	10	10
Catherine Griffiths (non voting)	100%	10	10
Matthew Lewis	100%	10	10
Mags Barnaby	100%	3	4
Karen Dunderdale	90%	9	10
Ned Hobbs	100%	7	7
Daren Fradgley (non voting)	100%	10	10
Jenna Davies (non voting)	100%	10	10
Non-Executive Directors			
Danielle Oum	100%	10	10
John Dunn	90%	9	10
Philip Gayle	90%	9	10
Sukhbinder Heer	90%	9	10
Pam Bradbury	90%	9	10
Anne Baines	80%	8	10
Ben Diamond	100%	5	5
Sally Rowe (non voting)	67%	6	9
Elizabeth England (non voting)	50%	2	4
Alan Yates (non voting)	25%	1	4
Paul Assinder (non voting)	80%	4	5
Rajpal Virdee (non voting)	60%	3	5

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.

The Trust's register of interest is shown below and is also available on our public website and can be found by using the following link:

www.walsallhealthcare.nhs.uk

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

Register of Interests

Name	Position held in Trust	Description of Interest	Date
Ms Danielle Oum	Chair	Chair: Health watch Birmingham Committee Member: Health watch England Chair: Midlands Landlord WHG Non-Executive Director: Royal Wolverhampton NHS Trust Co-Chair of the NHS Confederation BME Leaders Network Co - Chair, Centre for Health and Social Care Leadership, University of Birmingham	03/06/2020
Mr John Dunn	Non-executive Director	No Interests to declare	17/01/2019
Mr Sukhbinder Heer	Non-executive Director	Powerfab Excavators Limited Evoke Education Technologies (UK) Limited Non-executive Director Birmingham Community NHS Foundation Trust (NHS Entity) Non-executive Director Black Country Partnership NHS Foundation Trust Mind Matrix (Europe) Limited Consilium Consulting (Cardiff) Limited Chester Rutland Limited Persona Holdings Limited	05/12/2018
Mr Philip Gayle	Non-executive Director	Chief Executive Newservol (charitable organisation – services to mental health provision) Non-Executive Director – Birmingham and Solihull Mental Health Trust Director of PG Consultancy	
Mrs Anne Baines	Non-executive Director	Director/Consultant at Middlefield Two Ltd Associate Consultant at Provex Solutions Ltd	17/01/2019
Ms Pamela Bradbury	Non-executive Director	Consultant with Health Education England People Champion – NHS Leadership Academy Partner Dr George Soloman is a Non-Executive Director at Dudley Integrated Healthcare Trust	05/05/2020

Name	Position held in Trust	Description of Interest	Date
Mr Ben Diamond	Non-executive Director	Director of the Aerial Business Ltd Partner - Registered Nurse and General Manager at Gracewell of Sutton Coldfield Care Home	
Mr Paul Assinder	Non-executive Director	Chief Executive Officer - Dudley Integrated Health & Care Trust Director of Rodborough Consultancy Ltd. Governor of Solihull College & University Centre Honorary Lecturer, University of Wolverhampton Associate of Provex Solutions Ltd	01/04/2020
Mr Rajpal Virdee	Non-executive Director	No Interests to declare	
Mr Richard Beeken	Chief Executive	Spouse Fiona Beeken is a Midwifery Lecturer at Wolverhampton University Director – Watery Bank Barns Ltd	08/01/2019
Mr Russell Caldicott	Director of Finance and Performance	Member of the Executive for the West Midlands Healthcare Financial Management Association (HFMA)	28/05/2020
Mr Daren Fradgley	Director of Integration	Director of Oaklands Management Company Clinical Adviser NHS 111/Out of Hours Non-Executive Director at WHG	
Dr Matthew Lewis	Medical Director	Spouse Dr Anne Lewis, is a partner in general practice at the Oaks Medical, Great Barr Director of Dr MJV Lewis Private Practice Ltd	
Ms Jenna Davies	Director of Governance	No Interests to declare	
Ms Catherine Griffiths	Director of People and Culture	Catherine Griffiths Consultancy Ltd Chattered Institute of Personnel (CIPD)	17/01/2019
Mr Ned Hobbs	Chief Operating Officer	Father – Governor Oxford Health FT Sister in Law – Head of Specialist Services St Giles Hospice	01/08/2019
Ms Allison Heseltine	Associate Nurse Director Infection, Prevention Control	Employed by Staffordshire and Stoke on Trent CCGs until 31/01/19 Director of husband's Company NetTechnology UK Ltd	04/03/2019
Mrs Sally Rowe	Associate Non-executive Director	Executive Director - Childrens Services Walsall MBC Trustee Grandparents Plus - Registered charity	29/04/2019

Personal data incidents 2019/20

During this period, the Trust had 1 reportable incident relating to an information governance data breach. The breach occurred as a result of inappropriate access by two Trust employees to a patient's confidential health record. Whilst both employees had legitimate access to the information system to enable them to fully undertake their duties, they were not authorised to access the record of the data subject. The incident was promptly reported to the Information Commissioner's Office and appropriate remedial and investigative actions taken. The Information Commissioner was satisfied with the trusts approach and issued a Decision Notice on 04/09/2019.

Incident Date	Nature of Incident	Nature of Data Involved	Number of Data Subjects	Notification Steps
29/07/2019	A patient raised an informal concern via our Patient Advice & Liaison Team that their personal health data may have been accessed by relatives who work for the organisation. This incident occurred as a direct result of these staff accessing the personal data of the patient to which they had no legitimate right to do so. The employees were both aware of the policies that were in place to protect personal data, and that access in these circumstances was strictly prohibited.	Personal health data of the patient held on the Trusts Clinical Portal (Fusion) included demographics, test results and a discharge summary.	One	The Information Governance Team was notified 26/07/2019. Duty of Candour applied. Reported on STEIS 29/07/2019 Reported on the IG Toolkit 29/07/2019 Acknowledgement received from ICO 30/07/2019

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 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 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.

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

By order of the Board.

Date: 24/06/20  **Chief Executive**

Date: 24/06/20  **Finance Director**

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.

Date: 24/06/20  **Chief Executive**

Governance Statement 2019/20

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 2020 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Trust Board has the ultimate responsibility for risk management and must be satisfied that appropriate policies and strategies are in place and that systems are functioning effectively. The Board has established an Audit Committee, which assists the Board in this process by performing an annual review of the effectiveness of the risk management activities supported by the Chief Internal Auditor's annual work, report and opinion on the effectiveness of the system of internal control.

The Trust Board is supported by a range of committees that scrutinise and review assurances on internal control; such committees include the People and Organisational Development Committee, Performance, Finance, and Investment Committee, and the Quality, Patient Experience, and Safety Committee.

The Trust Board regularly scans the horizon for emergent opportunities or threats, and considers the nature and timing of the response required in order to ensure risk is kept under prudent control at all times.

Operationally, risk management is led by the Executive Team, who have responsibility for the overall management and mitigation of risks within their areas of responsibility. The Director of Governance leads the overall Risk Management Group, which has an operational overview of risk across the Trust to support the Board and its committees. All staff have both the opportunity and expectation of reporting all perceived risks within their area of operation, which are then subject to a process of review, validation and (if appropriate) scoring and management. Management of risk is undertaken at a level appropriate to the potential impact of the risk, including departments, care groups, divisions and on a cross-Trust basis. Additionally, the Board maintains a Board Assurance Framework, reflecting the risks identified to the achievement of the Trust's strategic objectives and how they are managed.

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. During the 2019/20 year the Trust has revised its Risk Management Strategy which was approved by the Trust Board in October 2020. 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.

There are comprehensive policies and systems in place for the identification and management of risks at all levels, within a single framework to ensure that the evaluation of risk is consistent and reliable. The Trust has also approved a new risk management policy to ensure that risks are managed at the level appropriate to the identified impact and likelihood of the risk eventuating, including departmental, divisional and cross-divisional structures. Overall responsibility for oversight of operational risks is undertaken by the Risk Management Group, led by the Director of Governance to ensure that there is appropriate leadership and accountability for the management of risk. The Board and Board Committees

are regularly updated on high-rated risks on the operational and corporate risk registers, enabling them to challenge and assess the level of assurance available.

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.

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate risks which may threaten the achievement of the Trust's objectives. The Board achieves this primarily through the work of its sub committees, through use of Internal Audit and other independent inspection and by systematic collection and scrutiny of performance data to evidence the achievement of the objectives.

The BAF is designed to provide the Board with a simple but comprehensive method for the effective and focused management of Principal Risks to Trust objectives. The Board defines the Principal Risks and ensures that each is assigned to a Lead Director as well as to a Lead Committee:

- The Lead Director is responsible for assessing any principal risks assigned to them by the Board and for providing assurance as to the effectiveness of primary risk controls to the Lead Committee.
- The role of the Lead Committee is to review the Lead Director's assessment of their Principal Risks, consider the range of assurances received as to the effectiveness of primary risk controls, and to recommend to the Lead Director any changes to the BAF to ensure that it continues to reflect the extent of risk exposure at that time.
- The Audit Committee is responsible for reviewing the whole BAF in order to provide assurance to the Board that Principal Risks are appropriately rated and are being effectively managed; and for advising the Board as to the inclusion within the BAF of additional risks that are of strategic significance.

During 2019/20 the Board has spent time revising its approach to risk management and has approved a revised the Risk Management Strategy and Policy. The Board recognises that, working in a healthcare environment, many of its day-to-day activities will carry relatively high risks that are not susceptible to effective reduction. This arises from the specialist nature of many medical procedures, and also the need to provide care and treatment for individuals who are undergoing acute health challenges.

Within that context, the Board has adopted an approach to risk appetite. The assessment of each risk includes an assessment of the risk appetite in relation to that risk, which seeks to identify the Trust's willingness to accept risk in that area; and a target score is set, which seeks to express the irreducible minimum risk associated with the activity (the point where the decision becomes to accept the risk or cease the activity). Each assessment of risk appetite and target risk score is reviewed regularly at the appropriate level of governance, with the Board reviewing the assessments for risks on the Board Assurance Framework on a regular basis. The Board is in the process of its annual reviews of the Trust's overall approach to risk appetite. The Trust Board has also started reviewing and revising the way that the Board Assurance framework is presented to the Board and Committees, to enable better understanding of the information presented.

The Trust Board has received and reviewed the high-level Board Assurance Framework risks, twice throughout the year. The Trust Board has received and reviewed, at a high-level, some of the Board Assurance Framework risks, in the year. The Committees, except for Audit Committee, have reviewed extracts from BAF during the year, and challenged the strategic risks, together with controls and assurances.

Internal audit has reviewed the Board Assurance Framework together including the processes and controls. The conclusion of the Audit concluded that the processes provide partial assurance with improvement required. The Audit specifically identified some moderate weaknesses in the activities and controls. The Board Assurance Audit raised one high and one medium risk rated recommendation. The high rated recommendation relates to the reporting of the Board Assurance Framework to the Board on a regular basis as this was identified as a gap during 2019/20. The Audit also highlighted that the Board has received high level snapshots of the BAF but had not received a full BAF during 2019/20.

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

1. Failure to deliver fundamental standards of care, which may result in harm to patients.

2. Failure to develop and cultivate effective partnerships within the local integrated care partnership, impacts on the Trust's ability to deliver care in patients' homes, or in local community setting which results in;

- Poor patient experience
- Poor patient outcomes
- Continued reliance on acute and emergency based care provision.

3. Failure to integrate functional and organisational form change within the Black Country will result in lack of resilience in workforce and clinical services, potentially damaging the trust's ability to deliver sustainable high-quality care.

4. Lack of an Inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care.

5. Long term sustainability negatively impacted through failure to deliver an efficient and productive healthcare offering to the staff, visitors and users of the services.

The Trust undertook a comprehensive review of the Board Assurance Framework in response to feedback from the Board. We updated the risk descriptors added a further BAF risk;

6. If we do not engage and involve patients and carers in service quality assessment and quality improvement then we will fail to deliver the Patient Experience Improvement programme, which forms part of the Safe, High Quality workstream, and we will not maximise opportunities to improve processes of care delivery, improve patient outcomes and improve patient experience.

The Trust has agreed an additional Board Assurance Framework risk in relation to COVID-19 pandemic on the provision of services.

7. The impact of COVID-19 on our clinical and managerial operations is such that it prevents the organisation from delivering its strategic objectives and annual priorities.

The key risk factors are:

- Our people and the impact on their overall health and wellbeing.
- Patient Safety and the Quality of Care.
- Clinical Equipment, Personal Protective Equipment, Environmental and Procurement.
- Financial.
- Recovery and Post-Pandemic impacts.

The response to this risk is being undertaken through the Emergency Preparedness, Resilience and Response (EPRR) route, with national leadership and co-ordination provided by NHS England/Improvement and the Department of Health and Social Care. Internally, the Trust has adopted a Command structure, with clear levels of responsibility. The Board has approved temporary changes to the Scheme of Delegation and related documents, to reflect the temporary command structure and to ensure that necessary expenditure for COVID-19 work can be approved, whilst retaining appropriate levels of control.

Ensuring that quality is at the heart of everything that the Trust does for patients is a key activity for the Board. This is undertaken in a number of ways:

At each scheduled meeting, the Board receives a detailed Integrated Performance Report which includes performance data for all significant areas of activity. Areas that have failed to achieve the agreed or nationally set targets are subject to exception reporting which outlines the details of the failures, any identified underlying causes, and the steps being taken by management to bring performance back to target. The Board has the opportunity to challenge the steps proposed and to require further or different actions to be taken in order to address these challenges.

The Board has appointed a Quality, Patient Experience and Safety Committee, which is responsible to the Board for detailed oversight of management actions to ensure the quality of services; and for recommending to the Board strategic actions to improve service quality. The committee meets on a monthly basis, and exercises detailed oversight of the quality of services provided by the trust; including reviewing deaths and serious untoward incidents, quality performance data, and feedback from patients. The committee reports both findings and recommendations to the Board at each Board meeting following a committee meeting, for consideration and approval. At each scheduled meeting, the Board receives a 'patient story' to understand the journey and experience of care at the trust.

The Board has also appointed a People and Organisational Development Committee to ensure that there is a key focus on ensuring the workforce is sufficient in numbers and skills to provide safe and quality care. The committee regularly reviews performance and future strategy on workforce and Organisational Development matters. The Board regularly reviews information of nursing staffing on a ward basis, together with details of new and continuing investigations where staff suspensions have been judged necessary.

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, 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.

Performance information is subject to regular review to ensure that it is reliable and continues to meet the requirements of the Trust. Performance information produced through data systems is regularly triangulated against the Quality elements of care, using qualitative information from sources such as complaints and compliments, national and local surveys of patients experience (including the 'Friends and Family' test), and triangulation visits from Board Members, External visits and reviews. Mismatches are challenged in a variety of forums, and it is a responsibility of the Director of Finance and Performance to ensure that mismatches are explored to ensure that the data reporting systems remain reliable. Performance reporting systems are also subject to regular review by both the Internal and External Audit services.

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 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.

During the course of the year, the Board has undertaken a programme of development focused on addressing key areas of Board responsibility, as well as delivering sessions focused on the delivery of the strategic objectives. The Board as a unitary board has also taken part in Board Effectiveness to support improved communication, and relationships with an external facilitator.

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 Director of Governance.

The Trust's approach to clinical quality improvement is supported by the 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, Patient Experience & 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, Patient Experience & 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, Patient Experience & 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 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 Trust recognises that it is vital to ensure that risk management is embedded throughout the organisation. There are a range of systems and procedures in place that support this embedding, including:

- The trust continues to encourage all staff, at all levels, to identify and report incidents including 'near misses'. There is a comprehensive system in place to enable colleagues to report incidents, supported by dedicated resource that reviews all reports and identifies the appropriate level for response. Learning from incidents is a key part of the process, and each colleague who reports an incident is entitled to a response that identifies both the response of the trust and how learning will be taken to prevent recurrence of that type of incident. During the course of the year, the trust has identified the need to improve our current system and process and this will delivered though the safe, and high quality care workstream of our improvement programme in 2020/21.

- Similarly, there are systems in place to enable risk at all levels to be identified, from the ward to the Board of Directors. Risks are regularly reviewed at the appropriate level: with the management-level Risk Management Group on a monthly basis. Each Board Committee has responsibility for review and assessing available levels of assurance for risks within its area of responsibility, and the Board regularly reviews both the Board Assurance Framework and the high-rated risks on the Corporate Risk Register.

- Each death of a patient under the care of the Trust is subject to review, with the aim of identifying and sharing learning; this may be either good practice, or areas for development. There are established systems to ensure that this learning is shared and embedded across the care that the Trust provides. Throughout the year the Trust has reviewed and improved its mortality review processes, and has gained assurance through independent NHSi review that our process align to the national framework.

In 2019/20, 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 NHS Long-Term Plan informs workforce strategy; recognising that all strategic and operational objectives depend on the collective skills, power and strength of our workforce. This principle underpins a workforce planning methodology, which places long-term sustainability, achieved through system-wide improvement approach, at the heart of all Trust objectives.

In line with recommendations, outlined within 'Developing Workforce Safeguards', the Trust will address workforce challenges, maximise opportunities and deploy safe staffing by;

- Setting medical and nursing establishments
- Proactively managing Temporary Staffing Usage
- Taking a Proactive Approach to Brexit-Related Risks
- Implement New Roles & Workforce Opportunities

Regular reviews of both the Medical and Nursing establishment provide evidence-based intelligence to inform proactive decision making, both at board and service level. A clinically-led Safeguarding Team ensures that suitably qualified and competent colleagues are providing safe, effective care to patients. Workforce Transformation forums, adhering to both current legislation and best practice, provide professional accountability in regard to new processes or working practice.

Management of risk to the security of the data held by the trust, both on patients and staff colleagues, is a key activity. Data risks are included within the overall risk management process, and regularly reviewed. A comprehensive suite of policies and procedures are in place to ensure that data is handled appropriately and with care, and these are supported by a comprehensive programme of training for staff. The Trust participates in the annual assessment of our compliance through the national Data Security and Protection Toolkit (which has replaced the Information Governance Toolkit), and our compliance has been reviewed by the Internal Audit service, which reported Significant Assurance in April 2020.

Where a data security incident is identified, it will be treated as a serious incident and investigated accordingly. All incidents meeting the requirements of the Information Commissioner are reported to their office as a matter of course, and that office may also choose to investigate independently. During the year, two incidents have required reporting to the Information Commissioner; however, both of these have resulted in no further action taken by their office.

The Trust is committed 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 purpose of an Equality Impact Assessment (EIA) is to improve the work of the Trust by making sure it does not discriminate and that, where possible, it promotes equality. The Equality Impact Assessment (EIA) focuses on systematically assessing and recording the likely equality impact of an activity or policy. There is a focus on assessing the impact on people with protected characteristics. This involves anticipating the consequences of activities on these groups and making sure that, as far as possible, any negative consequences are eliminated or minimised and opportunities for promoting equality are maximised. The Trust has made limited progress in year in aligning the equality impact assessment processes into our business processes, for example of annual planning cycle, however through the valuing colleagues workstream of the improvement programme we will be progressing improving our equality impact assessment processes.

In response to the concerns raised through both the WRES and Staff survey feedback the Trust has established an accelerated improvement in equality, diversity and inclusion practice plan, which will be overseen by the Trust refreshed Equality Diversity and Inclusion Group, together with the Trust People and Organisational Development Committee.

The trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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

The Trust recognises that there are ongoing challenges to the Trust ensuring services achieve best outcomes against the premises of achieving financial balance; no impact on the quality of care; and maintaining the quality of patient, service user and staff experience.

The most significant risk to becoming an outstanding trust by 2022 is poor colleague experience of the trust as a place to work and the fact that structural inequalities persist. Our WRES, WDES and NHS staff survey results evidence discrimination in recruitment and career progression opportunities and heightened experience of bullying, our focus group work with colleagues evidence the trust values are not a lived experience. Whilst the improvement programme seeks to address the evident inequalities and to change behaviours that are not in line with trust values, the actions are not embedded yet and have not yet made an impact on the long-standing organisational culture challenges the trust faces.

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

I and the Trust recognise that Parliament has set out a requirement for the Trust to ensure that the services that are provided have due regard to the economy, efficiency and effectiveness of the use of public resources. The Trust undertakes a number of activities to seek to ensure the it's activities deliver all three of these requirements, each of which Parliament has given an equal weighting.

Ultimate responsibility for ensuring that the Trust complies with this legal duty rests with the Board of Directors, through setting the strategic direction of the Trust, together with monitoring and oversight of performance. This work is supported by the Board's committees, which look more closely at both performance and strategic direction and provide advice and recommendation to the Board. In particular, the Finance, Performance and Investment Committee (PFIC) has a close oversight of the Trust's efficiency plans which closely support the delivery of these responsibilities. The Quality, Patient Experience and Safety Committee oversees the quality impacts which impacts on the efficiency and effectiveness of delivery of services: both preventive of illness and treating illness when it arises.

The Trust's executive leadership is also aware of the need to ensure that the provision of services meet these requirements. When considering service developments, consideration is given to how the proposals will impact on these requirements, both when proposals are being developed and considered through governance for approval. In line with regulatory requirements, efficiency is recognised through the need for quality impact approval from the Medical Director and the Director of Nursing for all significant projects. When reviewing implementation, consideration is given to how well the project or development has advanced these requirements, and where further improvements might give better achievement of them.

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 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 rigour 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 Authority (NHSCFA) (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.

Information governance

Management of risk to the security of the data held by the Trust, both on patients and staff colleagues, is a key activity. Data risks are included within the overall risk management process, and regularly reviewed. A comprehensive suite of policies and procedures are in place to ensure that data is handled appropriately and with care, and these are supported by a comprehensive programme of training for staff. The Trust participates in the annual assessment of our compliance through the national Data Security and Protection Toolkit (which has replaced the Information Governance Toolkit), and our compliance has been reviewed by the Internal Audit service, which reported Significant Assurance in April 2020.

Where a data security incident is identified, it will be treated as a serious incident and investigated accordingly. All incidents meeting the requirements of the Information Commissioner are reported to their office as a matter of course, and that office may also choose to investigate independently. During the year, two incidents have required reporting to the Information Commissioner; however, both of these have resulted in no further action taken by their office.

Cyber and Data Security

Cyber and data security continues to be an important focus for the Trust. This became 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 improvement including specific recommendations which are implemented to strengthen our cyber security.

Ensuring Data Quality

The trust recognises the importance of having effective data collection and analysis, in order to understand the operation of it's services and enable the Board to effectively judge what actions are needed to improve performance. The trust has in place a number of systems for the collection of data regarding the operation of services and these are automated where possible in order to reduce the possibility of human error. The Executive team receives a full suite of performance data monthly from across the trust, which is reviewed to identify any areas which are starting to be a concern and take immediate action to address them. This suite of performance data is used as part of the Trusts' Performance Review Process with Divisional and Corporate teams. The Board and its Committees review a more selective set of data, which enables them to focus on the key areas of strategic performance, together with exception reporting to identify the underlying cause of underperformance and the steps being taken to bring performance back to the required standard.

Quality of Care

The trust has a clear policy process in place to ensure that the care provided to patients is safe and to the highest standards. It is important, in this context, to keep in mind that the general approach is that policies should normally be followed; but it is recognised that, in some circumstances, the professional judgement of clinical colleagues will justify a departure from policy in the individual case and for the best interests of the patient. Policies are subject to a formal process of development, approval and regular review, to ensure that they continue to reflect best practice. In respect of each patient the policy is to provide a care plan that responds to the individual needs of the patient, with a view to ensuring that they are cared for in a way that minimises the period and impact of their condition. In appropriate cases plans will be prepared on a multi-disciplinary basis, including colleagues from other agencies, in order to ensure that all relevant conditions are taken into account and that care is planned across agencies.

Having access to colleagues with the necessary skills and experience is also crucial in order to ensure that patient care is provided in a safe and appropriate manner. The Board, supported by the People and Organisational Development Committee, regularly reviews the level of staffing available in the various areas of the Trust: in respect of nursing and midwifery staff, this is prepared in accordance with the guidance of the National Quality Board and NHS Improvement and against local standards for medical and other staff. The Trust has also put into place workforce plans, taking into account anticipated acuity and demand levels, with the aim of ensuring that staff with the appropriate skills and experience are available when required. The Board has also sought to minimise the usage of agency staff, taking into account the national policy and this is reviewed by the full Board at each scheduled meeting.

The Trust has developed its capability for Referral To Treatment (RTT) time monitoring and reporting, using its data warehouse and bespoke reporting tool and based on national RTT guidance, to ensure that it is able to maintain compliance with the requirements. The data used to generate these reports is subject to rigorous, and routine, validation.

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, Patient Experience & Safety Committee, Finance, Performance and Investment Committee, People and Organisational Development Committee, 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 ten 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;
- 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.

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.

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 Development.

The Audit Committee has primary responsibility for oversight of the controls systems for the Trust, including financial and governance, and for advising the Board as to the available levels of assurance. It is supported in this work by the internal and external audit providers, the Local Counter-Fraud Service (LCFS), and work undertaken by other committees (as discussed below). Key functions that it undertakes which enable it to judge the amount of available assurance include:

- The regular reports of the Internal Audit service, which provide specific advice on the level of assurance available in relation to the area reviewed. These also enable the Audit Committee to review management's response and proposed actions to the review's findings, and to form a view about the level of assurance those responses provide;
- Advice from both the internal and external audit providers on the environment in which the Trust is operating;
- The work of the LCFS which provides evidence for the Committee to judge the available assurance for systems to detect and prevent fraud and misappropriation on the public funds made available to the Trust;
- Regular review of the main documentation related to the Trust's control systems - this will usually cover the Standing Financial Instructions, the Schedule of Delegations, and the Schedule of Matters Reserved to the Board of Directors (for decision).

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, Patient Experience, and Safety Committee also has oversight on behalf of the Board of clinical audit activities, which form an important part of the trust's work. A plan for clinical audits is agreed at the start of every year, and progress is monitored through the course of the year to ensure that the work plan is being appropriately prosecuted. The majority of the programme reflects national audit programmes and similar, which the Trust is expected to participate in, and details of which are provided in the Quality Report. The Trust does seek to ensure that it obtains learning and implements change as a result of the work of clinical audit, and the Quality, Patient Experience, and Safety Committee is responsible for assessing the assurance available and reporting to the Board.

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, and monitoring of the Cost Improvement Programme.

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 "during the period, partial assurance can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control."

During 2019, the Trust requested that NHSI undertake a review of the Governance and Accountability processes within the organisation. The review specifically focused on the:

- Trust's Accountability Framework (AF);
- Divisional Governance specifically focused on the design of the system and how these seem to be working in practice;
- financial capacity and capability, delivery of financial targets and management of the Cost Improvement Programme (CIP).

The Trust received the final report and the recommendations in May 2020. The outputs of the review and the recommendations will be delivered through the Well-Led Workstream of the trust's Improvement programme.

Conclusion

The Trust has made improvements to internal control systems during the financial year 2019/20, however we acknowledge that there are still weaknesses that require improvement. A number of control Issues classified as limited assurance by our core internal audit processes were noted during the year, the Trust Board Assurance Framework and Risk Management internal audits both received limited assurance with improvement ratings. The Board Assurance Audit raised one high and one medium risk rated recommendation. The High rated recommendation relates to the reporting of the Board Assurance Framework to the Board on a regular basis as this was identified as a gap during 2019/20. Improvement plans have been agreed in response to both these audits.

In addition to the areas identified through Internal Audit, the Trust has also highlighted through the Annual Governance Statement that our overall staff survey results and our Workforce Race Equality Standards remain a concern and risk for the Trust. The Trust has agreed improvement plans to address both of these risks.

Richard Beeken, Chief Executive.

Modern Slavery Act 2015 – Transparency in Supply Chains

The Modern Slavery Act 2015 established a duty for commercial organisations to prepare an annual slavery and human trafficking statement of the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business.

The Department of Health and Home Office have established that NHS bodies are not considered to be carrying on a business where they are engaged in publicly funded activities and that it was not intended that such activities should be within the scope of the Act. Income earned by NHS providers like the trust from government sources, including clinical commissioning groups and local authorities, is considered to be publicly funded for this purpose so the trust does not meet the threshold for having to provide a statement. Nevertheless the trust undertakes its procurement from suppliers in line with NHS standards and includes standard NHS terms. In relation to its own activities the trust has employment, identity and employee welfare arrangements in place to combat any exploitation of people.

In accordance with the Modern Slavery Act 2015, the Trust ensures that Modern Slavery i.e. slavery and human trafficking, is not taking place in any part of its own business or any of its supply chains. This is achieved through ensuring that services are procured through approved providers only or tendered through robust procurement processes.

2b REMUNERATION AND STAFF REPORT

Remuneration Report

The Trust has a Remuneration Committee whose role is to advise the Board on appropriate remuneration and terms of service for the Chief Executive and other Executive Directors. Membership of the committee comprises of the Chair and all Non-Executive Directors.

Remuneration for the Trust's Executive Directors is set by reference to job scope, personal responsibility and performance. This also takes into account the comparison with remuneration levels for similar posts, both within the National Health Service and the local economy. Whilst performance is taken into account in setting and reviewing remuneration, there are currently no arrangements in place for ''performance-related pay".

It is not the Trust's policy to employ Executive Directors on ''rolling" or ''fixed term" contracts. All directors' contracts conform to NHS standard for directors, with arrangements for termination in normal circumstances by either party with written notice of six months.

Remuneration for the Trust's Executive and Non-Executive Directors during the financial year ended 31 March 2020 is set out in the attached schedules.

Richard Beeken, Chief Executive.

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 Remuneration Committee that agrees the remuneration packages for Executive Directors. Further information about this committee can be found in the Remuneration and Staff 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 2019/20, 0 employees received remuneration in excess of the highest-paid Director (there were 0 in 2018/19). Remuneration ranged from £18,005 to £165,479 (2018-19 - £17,652 to £162,075).

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 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 2019/20 was £165,479 (2018-19, £162,075). This was 6.04 times (2018-19, 5.97) the median remuneration of the workforce, which was £27,416 (2018-19, £27,146). In 2018/19, no employees received remuneration in excess of the highest-paid director.

The pay multiple has increased to 6.04 from 5.97 times the median salary largely due to the rate of the salary increase of the highest paid Director being greater than the rate of the median increase during the financial year.

Salary and Pension Entitlement of Senior Managers - Audited

A) Remuneration

Name and Title	2019-20									2018-19								
	Salary	All Pension Related Benefits	TOTAL	Salary	Other Remuneration	Long-term Performance Pay & Bonuses	Expense Payments	All Pension Related Benefits	TOTAL	Salary	All Pension Related Benefits	TOTAL	Salary	Other Remuneration	Long-term Performance Pay & Bonuses	Expense Payments	All Pension Related Benefits	TOTAL
	£	£	£	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	(taxable) to the nearest £100	(bands of £2500) £000	(bands of £5000) £000	£	£	£	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	(taxable) to the nearest £100	(bands of £2500) £000	(bands of £5000) £000
Mr D.OUM, Chairman (from 8 April 2016)	35,000		35,000	30-35					30-35	35,000		35,000	30-35					30-35
Mr R.BEEKEN, Chief Executive (from 26 February 2018)	165,479	30,265	195,744	165-170				27.5-30	195-200	162,075	11,187	173,262	160-165				10-12.5	170-175
Mr R.CALDICOTT, Director of Finance (from 1 July 2015)	129,813	27,738	157,551	125-130				27.5-30	155-160	127,164	2,979	130,143	125-130				2.5-5	130-135
Ms E.HOBBS, Chief Operating Officer (from 17 June 2019)	88,777	48,258	137,035	85-90				47.5-50	135-140									
Mrs M.BARNABY, Interim Chief Operating Officer (from 6 December 2018 to 19 June 2019)	51,401	40,909	92,401	50-55				40-42.5	90-95	75,061	12,560	87,621	75-80				12.5-15	85-90
Mr P.THOMAS-HANDS, Chief Operating Officer (from 10 December 2016 to 6 Jan 2019)	0	0	0	0				0	0	82,802	0	82,802	90-95				0	90-95
Mr M.LEWIS, Medical Director (from 22 October 2018)	181,226	86,997	268,223	60-65	85-90	30-35		85-87.5	265-270	78,559	23,386	101,946	25-30	35-40	10-15		22.5-25	100-105
Mr A.KHAN, Medical Director (left 31 December 2018)			0						0	150,745	0	150,745	60-65	60-65	20-25		0	150-155
DR K.DUNDERDALE, Director of Nursing(from 30 July 2018 - Seconded on 24 February 2020)	135,994		135,994	135-140					135-140	88,749		88,749	85-90					85-90
Ms B.BEAL, Director of Nursing (left 18 May 2018)			0						0	12,944	0	12,944	10-15					10-15
Mr D FRADGLEY, Director of Transformation and Strategy (April 2015 Interim, Permanent from 1 January 2016)	114,429	25,774	140,203	110-115				25-27.5	140-145	109,153	7,427	116,580	105-110				5-7.5	115-120
Ms C.GRIFFITHS, Director of Culture & People (from 10 September 2018)	112,075		112,075	110-115					110-115	56,992		56,992	55-60					55-60
Mrs J.DAVIES, Director of Corporate Governance & Trust Secretary (from 4 June 2018)	99,114		99,114	95-100					95-100	80,087		80,087	80-85					80-85
M J WHITE, Interim Trust Secretary (left post 31 March 2019)	0		0	0					0	171,133		171,133	170-175					170-175
Mr J.DUNN, Non-Executive Director (from 1 February 2015)			0	5-10					5-10				5-10					5-10
Mr P.GAYLE, Associate Non-Executive Director (from 1 August 2016)			0	5-10					5-10				5-10					5-10
Mr S.HEER, Non-Executive Director (from 15 September 2016)			0	5-10					5-10				5-10					5-10
MRS JUNE BAINES, Non-Executive Director (from 1 July 2018)			0	5-10					5-10				0-5					0-5
Mr A YATES, Non-Executive Director (left 31 August 2019)			0	0-5					0-5				0-5					0-5
MS PAMELA BRADBURY, Non-Executive Director (from 1 December 2018)			0	5-10					5-10				0-5					0-5
Dr E ENGLAND, Non-Executive Director (left 3 July 2019)			0	0-5					0-5				0-5					0-5
Mr P.Asvander, Non-Executive Director (from 1 October 2019)	5,000		5,000	0-5					0-5									
Mr R.Videe, Non-Executive Director (from 1 October 2019)	5,000		5,000	0-5					0-5									
Mr B.Diamond, Non-Executive Director (from 1 October 2019)	5,000		5,000	0-5					0-5									
Ms S.ROWE, Non-Executive Director (from 1 May to 4 June 2019)			0	0					0									
Mrs V.HARRIS, Non-Executive Director (left 10 December 2018)			0						0				0-5					0-5
Mr R.BEALE, Non-Executive Director (left 4 December 2018)			0						0				0-5					0-5

**Other Remuneration - Mr M Lewis & Mr A Khan
This is the salary payment as a Medical Consultant

B - Pension Benefits

Name and Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension as pension age at 31 March 2020	Lump sum at pension age related to accrued pension at 31 March 2020	Real increase in pension and related lump sum at age 60 at 31 March 2020	Total accrued pension and related lump sum at age 60 at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2019	Real Increase in Cash Equivalent Transfer Value - Employer Funded contribution	Real Increase in Cash Equivalent Transfer Value	All Pension Related Benefits	All Pension Related Benefits
	in Bands of (£2,500)	in Bands of (£2,500)	in Bands of (£5,000)	in Bands of (£5,000)	£000	£000	£000	£000	£000	£000	£000	in Bands of (£2,500)
Mr R.BEEKEN, Chief Executive (from 28 February 2018)	3	(0)	57	125	1	182	984	911	36	51	30	27.5-30
Mr R.CALDICOTT, Director of Finance (from 1 July 2015)	2	(0)	36	74	2	110	595	544	26	38	28	27.5-30
Mrs MARGARET BARNABY, Interim Chief Operating Officer (left 19 June 2019)	2	0	31	82	2	113	712	644	37	53	41	40-42.5
Mr E.HOBBS, Chief Operating Officer (from 17 June 2019)	3	0	20	0	3	20	176	139	19	27	48	47.5-50
Mr M.LEWIS, Medical Director (from 22 October 2018)	5	6	59	136	12	196	1,182	1,045	78	112	87	85-87.5
Mr D FRADGLEY, Director of Transformation and Strategy (1 January 2016)	2	(0)	37	81	2	118	593	545	25	35	26	25-27.5

Staff Report

As at 31 March 2020, Walsall Healthcare NHS Trust employed 4,230 substantive staff. Of these, 3,865 colleagues were permanently employed on recurrent, open-ended contracts of employment. A further 365 colleagues were employed on fixed term contracts of employment.

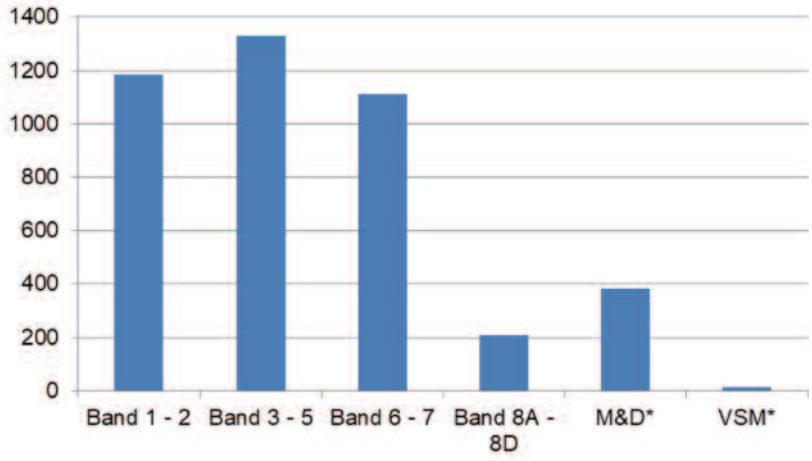
Staff Numbers Analysis

The following table provides a snapshot of the average workforce composition during 19/20:

	Headcount
Additional Clinical Services	729
Additional Professional Scientific and Technical	140
Administrative and Clerical	933
Allied Health Professionals	258
Estates and Ancillary	386
Healthcare Scientists	53
Medical and Dental	385
Nursing and Midwifery Registered	1338
Students	8

All staff by pay band:

Band 1 - 2	1185	28.01%
Band 3 - 5	1329	31.42%
Band 6 - 7	1111	26.26%
Band 8 - 9	207	4.89%
M&D*	385	9.10%
VSM**	13	0.31%



*Medical & Dental
**Very Senior Manager/Director

Equal Opportunities

All staff by gender

Female	Male
3451	779
81.58%	18.42%

***Senior Managers* by gender**

Female	Male
83	153
35.17%	64.83%

*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 and 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

White	BAME	Unknown
1169	14	1169
72.0%	27.6%	0.3%

Senior Managers* by ethnicity

White	BAME	Unknown
101	135	0
42.8%	57.2%	0.0%

99.7% of the substantive workforce has chosen to disclose its ethnic background, with 27.6% 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 73.2% of the medical consultant workforce, whilst 18.84% of the Band 8B – Band 8D 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.

Number of Senior Managers

Substantive senior staff (or senior managers) by band	Headcount
Band 8 - Range B	36
Band 8 - Range C	16
Band 8 - Range D	3
VSM**	13
Consultant (Medical & Dental)	168
Total	**236**

**Very Senior Manager/Director

	Female		Male	
All Substantive Colleagues	3451	81.6	779	18.4%
Of which are:				
Directors	3	37.5%	5	62.5%
Senior staff	83	35.2%	135	64.8%

Our workforce is predominately female (81.5%), 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 1-7 roles falls in line with the overall NHS gender percentage in England, the average number of female colleagues holding more senior positions is 52%. 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

Diversity and Inclusion is integral to how we attract, retain, develop and engage our staff and the team relationship we build with each other. If staff feel engaged, motivated, valued and part of a team with a sense of belonging patients are more likely to be satisfied with the service they receive. Inclusive workplaces are crucial for our wellbeing in improving the quality of patient care and outcomes and minimising risk.

Walsall Healthcare NHS Trust embraces the diversity of people from all groups in society. It values differences in age, disability, gender, marital status, pregnancy and maternity, race, sexual orientation, and religion or belief. It is committed to eliminating unlawful discrimination by ensuring that equality, diversity and human rights are central to its policy making, service planning, employment practices, patients and community engagement and involvement.

As a public sector organisation the trust has an obligation as an employer to have policies and procedures that are sensitive to these differences. It aims to employ a workforce which is representative of the population it serves because by doing so the trust is better able to treat its patients effectively and be a better place to work.

Although health overall is improving, unacceptable health inequalities persist between different communities in the region. As a provider of both acute and community services, the trust is in a powerful position to make a lasting difference to the health and wellbeing of the population.

The trust has made some gains in embedding inclusive practice as an integral part of the organisation, but still has much to do. As well as fulfilling its statutory responsibilities, the trust also needs to make sure that people in the West Midlands experience real improvements in health and wellbeing. The trust's ambition is for Walsall to be recognised as a leader of equality and diversity in the workplace and more importantly, in the delivery of inclusive and high-quality healthcare services for all.

Sickness Absence

The NHS Digital publication of NHS sickness absence rates can be found by following this link:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

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 is a disability confident employer and as two tick accreditation, guaranteeing an interview for disabled applicants who meet the person specification and to ensure reasonable adjustments are made.

The trust has an Equality, Diversity and Inclusion Group, which 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.

The Trust maintains an excellent relationship with staff side representatives through established employee and management consultation and negotiating forums (Joint Staff Consultation and Negotiating Committee, Local Negotiating Committee and Junior Doctors forum). These forums continue to provide invaluable feedback to Trust management on matters of concern to employees and allow for consultation of any proposed changes.

The Trust continues to maintain the Department of Health and Social Care's principle of improving the working lives of staff and supports the NHS agenda of maintaining healthy work environment for all staff. Our Occupational Health service delivers health awareness and offers health surveillance programmes for staff and maintains a comprehensive counselling service.

Regulation 8, Schedule 2 2017/328 Declaration of Facility Time

Relevant Union Officials	
Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
2	2 FTE

Percentage of time spent on facility time	
Percentage of time	Number of Employees
0%	
1-50%	
51-99%	
100%	2 FTE

Percentage of pay bill spent on facility time	
Provide the total cost of facility time	£60k
Provide the total pay bill	£155.6m
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.04%

Paid trade union activities	
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	100%

Consultancy costs

The Trust paid £1.1m on consultancy costs during 2019/2020.

Off Payroll Arrangements

TABLE 1: Off-payroll engagements longer than 6 months	
For all off payroll engagements as of 31.3.20, for more than £245 per day lasting longer than 6 months	Number
Number of existing engagements as of 31.3.2020	3
Of which, the number that have existed:	
less than 1 year at the time of time of reporting	1
for between 1 and 2 years at the time of reporting	2
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and March 2020, 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 2019 and 31 March 2020	1
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	1
No. engaged directly (via PSC contracted to department) and are on the entities payroll	0
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 2019 and 31 March 2020.

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

Number of off payroll engagements of board members, and/or senior officers with significant financial responsibility' during the year (1)	0
Total no. of individuals on payroll and off-payroll that have been deemed 'board members and/or senior officials' with significant financial responsibility during the year. This figure includes both on payroll and off payroll engagements (2)	20

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 of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000's	Number	£000's	Number	£000's	Number	£000's
Less than £10,000					0			
£10,000 - £25,000	1	15			1			
£25,001 - £50,000	2	85			2			
£50,001 - £100,000	1	81			1			
£100,001 -					0			
Total	**4**	**181**	**0**	**0**	**4**	**181**	**0**	**0**

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.

Compensation - Early Retirement/Loss of Office & Payments to Past Directors

There were no compensation payments during the financial year ending on the 31st March 2020 for early retirements or loss of office or payments made to past directors.

Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for Walsall Healthcare NHS Trust.

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2018/19 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:

   - the financial records maintained by the NHS trust
   - accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
   - the template accounting policies for NHS trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.

2. I certify that the TAC schedules are internally consistent and that there are no validation errors.

3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.

[Signature]

[Name] Russell Caldicott

[Date] 24/06/20

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Trust is required to submit to NHS Improvement.

2. I have reviewed the schedules and agree the statements made by the Director of Finance above.

[Signature]

[Name] Richard Beeken

[Date] 24/06/20

SECTION 3: FINANCIAL STATEMENTS AND NOTES

2019/20 Financial Position

The trust has reported a surplus of £50,000 for the financial year and has therefore achieved its revised financial duty to break even. The retained surplus figure that is used to evaluate financial performance for the year is adjusted for impairments relating to the new build and renovation of the maternity unit, and the change in accounting treatment for recording donated assets within exchequer accounts.

In order to maintain financial balance in 2019/20 the trust initially had to identify and achieve savings of £8.5 million (2.9% of turnover). These savings were needed to meet the required national efficiency savings target and also for reinvestment into service developments. The Trust however experienced a very challenging year in terms of meeting quality and performance targets. 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	50	50	YES
External Financing Limit (Managing Services within the 'cash limit' agreed with the Department of Health)	£'000	39,282	31,293	YES
Captial Resource Limit (Managing Capital Expenditure within the Capital Resource Limits agreed with the Department of Health)	£'000	11,611	11,611	YES
Capital Cost Absorption Duty (return on assets employed). The trust was not required to submit a dividend payment.	%	3.5%	0.0%	YES

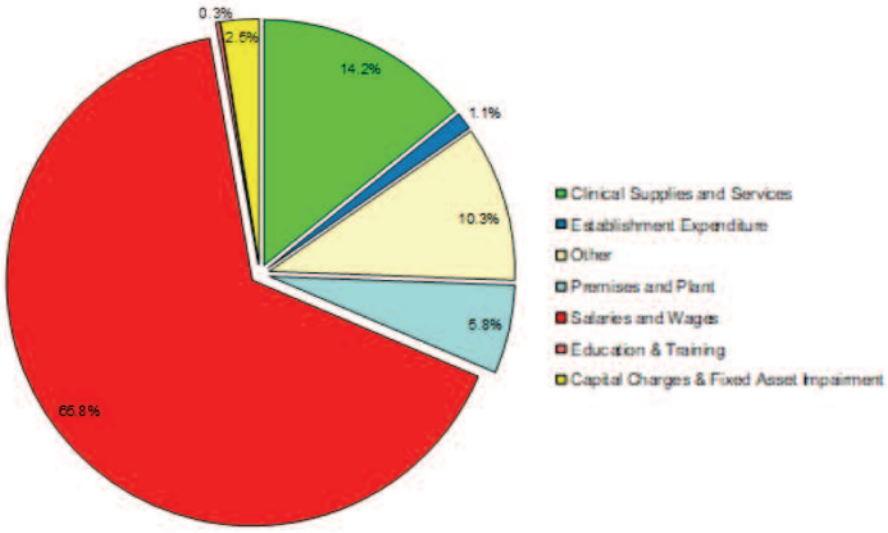
Where our money comes from

The majority of trust income comes from the provision of patient care services (£257million), 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 Clinical Commissioning Group.

What we spend our money on

The trust spent £295million in the financial year 2019/20. The largest component of this expenditure was salaries and wages where we spent £187million. The Trust spent a further £36.9million 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 2019/20.



Capital Investment

The total capital expenditure in 2019/20 totalled £11.6million. The main areas of investment were:

	£'m
Reconfiguration, lifecycle and refurbishment works	4.75
Computer replacement and Information systems	4.87
Medical and theatre equipment	1.98
Total	11.6

Income and expenditure account for the year ended 31 March 2020

	2019/20 £'000	2018/19 £'000
Revenue from patient care activities	257,026	234,735
Other operating revenue	37,133	18,299
Operating expenses	(284,183)	(276,533)
OPERATING SURPLUS	**9,976**	**(23,499)**
Profit/(Loss) on disposal of asset	-	(160)
SURPLUS BEFORE INTEREST	**9,976**	**(23,659)**
Interest receivable	86	61
Other Gains and (Losses)	-	-
Finance Costs	(10,960)	(10,260)
SURPLUS FOR THE FINANCIAL YEAR	**(898)**	**(33,858)**
Public Dividend Capital Dividend Payable	-	-
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR	**(898)**	**(33,858)**
*Impairments (excluding IFRIC 12 impairments)	983	6,186
Adjustments in respect of donated asset reserve elimination	130	131
Adjustments in respect of 16/17 CQUIN	-	-
Remove 2018/19 post audit PSF reallocation (2019/20 only)	(165)	-
Adjusted retained surplus/(deficit)	**50**	**(27,541)**

Statement of Financial Position at 31 March 2020

	31 March 2020 £'000	31 March 2019 £'000
Non-current assets		
Property, plant and equipment	142,395	139,153
Intangible assets	1,610	1,277
Trade and other receivables	861	778
	144,866	141,208
CURRENT ASSETS		
Stock and work in progress	2,620	2,362
Trade and other receivables	39,001	16,532
Cash and cash equivalents	9,056	4,186
	50,677	23,080
CURRENT LIABILITIES		
Trade and other payables	(25,955)	(29,461)
Borrowings	(134,693)	(15,590)
Other Liabilities	(1,480)	(1,445)
Provision for liabilities and charges	(437)	(117)
NET CURRENT ASSETS/(LIABILITIES)	(111,888)	(23,533)
TOTAL ASSETS LESS CURRENT LIABILITIES	32,978	117,675
NON-CURRENT LIABILITIES		
Trade and other payables	-	-
Borrowings	(116,013)	(202,939)
PROVISIONS FOR LIABILITIES AND CHARGES	-	-
TOTAL ASSETS EMPLOYED	(83,035)	(85,264)
FINANCED BY:		
Public dividend capital	68,300	64,190
Revaluation reserve	14,832	15,925
Retained earnings	(166,167)	(165,379)
TOTAL CAPITAL AND RESERVES	(83,035)	(85,264)

Cash flow statement for the year ended 31 March 2020

	2019/20 £'000	2018/19 £'000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	(20,670)	(20,635)
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE		
Interest received	83	55
Net cash inflow from returns on investments and servicing of finance	**(20,587)**	**(20,580)**
CAPITAL EXPENDITURE		
(Payments) to acquire tangible fixed assets	(10,039)	(12,603)
(Payments) to acquire intangible fixed assets	(667)	(267)
Receipts from sale of tangible fixed assets	-	-
Net cash (outflow) from capital expenditure	**(10,706)**	**(12,870)**
DIVIDENDS PAID	-	-
Net cash inflow before management of liquid resources and financing	(31,293)	(33,450)
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	**(31,293)**	**(33,450)**
FINANCING		
Public dividend capital received	4,110	5,872
Public dividend capital repaid	-	-
Other loans received	36,043	33,184
Other loans repaid	-	-
Capital element of finance leases and PFI	(3,990)	(3,697)
Capital grants and other capital receipts	-	-
Net cash (outflow) from financing	**36,163**	**35,359**
Increase (reduction) in cash	**4,870**	**1,909**
Opening cash holding	4,186	2,277
Closing cash holding	9,056	4,186

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 2019/20 the percentage of bills paid within target was:

- number of bills : 4%
- value of bills : 25%

	2019/20 Number	2018/19 Number
Better payment practice code-measure of compliance		
Total Non-NHS trade invoices paid in the year	64,799	64,650
Total Non-NHS trade invoices paid within the target	16,694	15,346
Percentage of Non-NHS trade invoices paid within the target	**25.8%**	**23.7%**
Total NHS trade invoices paid in the year	1,340	1,759
Total NHS trade invoices paid within the target	59	68
Percentage of NHS trade invoices paid within the target	**4.4%**	**3.9%**

	2019/20 Value £000's	2018/19 Value £000's
Better payment practice code-measure of compliance		
Total Non-NHS trade invoices paid in the year	109,975	110,084
Total Non-NHS trade invoices paid within the target	48,470	53,859
Percentage of Non-NHS trade invoices paid within the target	**44.1%**	**48.9%**
Total NHS trade invoices paid in the year	14,207	12,566
Total NHS trade invoices paid within the target	3,598	1,939
Percentage of NHS trade invoices paid within the target	**25.3%**	**15.4%**

Independent auditor's report to the Directors of Walsall Healthcare NHS Trust

Report on the financial statements

Opinion on the financial statements

We have audited the financial statements of Walsall Healthcare NHS Trust ('the Trust') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by HM Treasury's Financial Reporting Manual 2019/20 as contained in the Department of Health and Social Care Group Accounting Manual 2019/20, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

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 section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Material uncertainty related to going concern

We draw attention to Note 1.2 in the financial statements, which indicates that the Trust is in a cumulative deficit position and is committed to achieving at least break-even until 2023/24. To achieve this, the Trust is reliant on support from the Financial Recovery Fund (FRF). As stated in Note 1.2, 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 Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

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

We have nothing to report in this regard.

Responsibilities of the Directors and the Accountable Officer for the financial statements

As explained more fully in the Statement of Directors' Responsibilities in Respect of the Accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

Auditor's responsibilities for the audit of the financial statements

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

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

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Referral to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014

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

On 24 June 2020, we issued a referral to the Secretary of State under section 30 a) and b) of the Local Audit and Accountability Act 2014 in relation to both the breach of the Trust's statutory financial duty as at 31 March 2020 and the planned breach as at 31 March2021 under Paragraph 2(1) of Schedule 5 of the National Health Service Act 2006 that:

"Each NHS trust must ensure that its revenue is not less than sufficient, taking one year with another, to meet outgoings properly chargeable to revenue account."

Other matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS Improvement; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

The Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in April 2020, we are not satisfied that, in all significant respects, Walsall Healthcare NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for adverse conclusion

In considering the Trust's arrangements for properly informed decision making and for securing sustainable resource deployment, we identified the following matters:

- The Trust has achieved the control total for 2019/20 of a £0.3million deficit, including central funding of Provider Sustainability & Financial Recovery Funds (PSF & FRF). Whilst there is evidence of improvement over 2018/19, as at 31 March 2020, the Trust has a cumulative deficit in the Income & Expenditure Reserve of £165million and remains reliant on Financial Recovery Funds.
- The Trust exited special measures for quality in 2019 and currently holds a "Requires Improvement" rating from the CQC. However, clinical performance in a number of areas remain challenged with performance below the Trust's target and/or worse than 2018/19, including, but not limited to the following indicators as reported to Trust Board in May 2020:
    - Infections: Incidents of C-Difficile; and
    - Access: Cancer 2 week wait; Emergency re-attendances within 7 days; Delayed transfers of care.
- The Trust has failed to demonstrate basic principles of good governance for managing risk during 2019/20 by not giving the Board nor the Audit Committee regular opportunities to adopt or fully consider the Board Assurance Framework.
- In 2019/20, the Trust has continued to take action to address staff engagement through its People and Organisational Development Committee. However, these actions have not yet demonstrated a significant improvement in planning, organising and developing the workforce because the NHS Staff Survey published in February 2020 shows sustained issues for the Trust. Scores are below the national average in all 11 themes, including, but not limited to Staff Engagement, Immediate Managers, Morale, Safety Culture, and Quality of Care.

These matters are evidence of significant weaknesses in the Trust's arrangements for:

- Acting in the public interest, through demonstrating and applying the principles and values of sound governance;

- Planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions; and
- Planning, organising and developing the workforce effectively to deliver strategic priorities.

Responsibilities of the Accountable Officer

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

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

We are required by section 21(3)(c) and schedule 13(10)(a) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, 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 2020.

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.

Use of the audit 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. 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 of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Certificate

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

Mark Surridge, Key Audit Partner
For and on behalf of Mazars LLP

45 Church Street, Birmingham, UK, B3 2RT

25 June 2020

NOTES

Walsall Healthcare NHS
NHS Trust

Annual Accounts 2019/20

www.walsallhealthcare.nhs.uk

@WalsallHcareNHS

Caring for Walsall together

Safe, high quality care
Care at home
Partners
Value colleagues
Resources
Respect
Compassion
Professionalism
Teamwork

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

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

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

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Signed.....Chief Executive

Date.....23/6/20

Statement of directors' responsibilities in respect of the accounts

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

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

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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

By order of the Board

23/6/20 Date ..... Chief Executive

22/6/20 Date ..... Finance Director

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	257,026	234,735
Other operating income	4	37,133	18,299
Operating expenses	7, 9	(284,183)	(276,533)
Operating surplus/(deficit) from continuing operations		**9,976**	**(23,499)**
Finance income	12	86	61
Finance expenses	13	(10,960)	(10,260)
PDC dividends payable		-	-
Net finance costs		**(10,874)**	**(10,199)**
Other gains / (losses)	14	-	(160)
Share of profit / (losses) of associates / joint arrangements		-	-
Gains / (losses) arising from transfers by absorption		-	-
Corporation tax expense		-	-
Deficit for the year from continuing operations		**(898)**	**(33,858)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations		**-**	**-**
Deficit for the year		**(898)**	**(33,858)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	-	-
Revaluations	18	(983)	31
Share of comprehensive income from associates and joint ventures		-	-
Fair value gains / (losses) on equity instruments designated at fair value through OCI		-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability / asset		-	-
Gain / (loss) arising from on transfers by modified absorption		-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on financial assets mandated at fair value through OCI		-	-
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI		-	-
Foreign exchange gains / (losses) recognised directly in OCI		-	-
Total comprehensive income / (expense) for the period		**(1,881)**	**(33,827)**
Adjusted financial performance (control total basis):			
Deficit for the period		(898)	(33,858)
Remove net impairments not scoring to the Departmental expenditure limit		983	6,186
Remove (gains) / losses on transfers by absorption		-	-
Remove I&E impact of capital grants and donations		130	131
Prior period adjustments		-	-
Remove non-cash element of on-SoFP pension costs		-	-
Remove 2018/19 post audit PSF reallocation (2019/20 only)		(165)	
Adjusted financial performance surplus / (deficit)		**50**	**(27,541)**

A valuation exercise was undertaken on the refurbished Neonatal Unit and new Maternity Theatre which resulted in a total impairment loss on the development of £1.966m. £983k of the impairment was taken to the revaluation reserve to offset brought forward cumulative balances, and the balance of £983k was charged to the Statement of Comprehensive Income.

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	15	1,610	1,277
Property, plant and equipment	16	142,395	139,153
Investment property	19	-	-
Investments in associates and joint ventures	20	-	-
Other investments / financial assets	21	-	-
Receivables	21	861	778
Other assets	22	-	-
Total non-current assets		**144,866**	**141,208**
Current assets			
Inventories	20	2,620	2,362
Receivables	21	39,001	16,532
Other investments / financial assets	21	-	-
Other assets	22	-	-
Non-current assets for sale and assets in disposal groups	23	-	-
Cash and cash equivalents	22	9,056	4,186
Total current assets		**50,677**	**23,080**
Current liabilities			
Trade and other payables	23	(25,955)	(29,461)
Borrowings	25	(134,693)	(15,590)
Other financial liabilities	26	-	-
Provisions	26	(437)	(117)
Other liabilities	24	(1,480)	(1,445)
Liabilities in disposal groups	23	-	-
Total current liabilities		**(162,565)**	**(46,613)**
Total assets less current liabilities		**32,978**	**117,675**
Non-current liabilities			
Trade and other payables	23	-	-
Borrowings	25	(116,013)	(202,939)
Other financial liabilities	26	-	-
Provisions	26	-	-
Other liabilities	24	-	-
Total non-current liabilities		**(116,013)**	**(202,939)**
Total assets employed		**(83,035)**	**(85,264)**
Financed by			
Public dividend capital		68,300	64,190
Revaluation reserve		14,832	15,925
Financial assets reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		(166,167)	(165,379)
Total taxpayers' equity		**(83,035)**	**(85,264)**

The notes on the following pages form part of these accounts.

Name
Position Chief Executive
Date 23 June 2020

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

	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**64,190**	**15,925**	**-**	**-**	**-**	**(165,379)**	**(85,264)**
Deficit for the year	-	-	-	-	-	(898)	**(898)**
Gain/(loss) arising from transfers by mofieid absorption	-	-	-	-	-	-	**-**
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	-	(110)	-	-	-	110	**-**
Impairments	-	-	-	-	-	-	**-**
Revaluations	-	(983)	-	-	-	-	**(983)**
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	**-**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	-	-	-	**-**
Fair value gains/(losses) on equity instruments designated at fair value through OCI	-	-	-	-	-	-	**-**
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	-	-	-	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly through OCI	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	**-**
Public dividend capital received	4,110	-	-	-	-	-	**4,110**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	-	**-**
Other reserve movements	-	-	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2020	**68,300**	**14,832**	**-**	**-**	**-**	**(166,167)**	**(83,035)**

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

	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**58,318**	**16,023**	**-**	**-**	**-**	**(131,650)**	**(57,309)**
Prior period adjustment	-	-	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2018 - restated	**58,318**	**16,023**	**-**	**-**	**-**	**(131,650)**	**(57,309)**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-	-	**-**
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	-	-	**-**
Deficit for the year	-	-	-	-	-	(33,858)	**(33,858)**
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	-	(129)	-	-	-	129	**-**
Impairments	-	-	-	-	-	-	**-**
Revaluations	-	31	-	-	-	-	**31**
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	**-**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	-	-	-	**-**
Fair value gains/(losses) on equity instruments designated at fair value through OCI	-	-	-	-	-	-	**-**
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	-	-	-	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly through OCI	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	**-**
Public dividend capital received	5,872	-	-	-	-	-	**5,872**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	-	**-**
Other reserve movements	-	-	-	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2019	**64,190**	**15,925**	**-**	**-**	**-**	**(165,379)**	**(85,264)**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

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

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

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

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		9,976	(23,499)
Non-cash income and expense:			
Depreciation and amortisation	7.1	6,163	6,166
Net impairments	8	983	6,186
Income recognised in respect of capital donations	4	(93)	(92)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(22,549)	964
(Increase) / decrease in inventories		(258)	(85)
Increase / (decrease) in payables and other liabilities		(4,376)	299
Increase / (decrease) in provisions		320	(314)
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		-	-
Net cash flows used in operating activities		**(9,834)**	**(10,375)**
Cash flows from investing activities			
Interest received		83	55
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(667)	(267)
Sales of intangible assets		-	-
Purchase of PPE and investment property		(10,039)	(12,603)
Sales of PPE and investment property		-	-
Receipt of cash donations to purchase assets		-	-
Prepayment of PFI capital contributions		-	-
Investing cash flows from discontinued operations		-	-
Cash from acquisitions / disposals of subsidiaries		-	-
Net cash flows used in investing activities		**(10,623)**	**(12,815)**
Cash flows from financing activities			
Public dividend capital received		4,110	5,872
Public dividend capital repaid		-	-
Movement on loans from DHSC		36,043	33,184
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		-	-
Capital element of PFI, LIFT and other service concession payments		(3,990)	(3,697)
Interest on loans		(2,603)	(2,193)
Other interest		-	-
Interest paid on finance lease liabilities		-	-
Interest paid on PFI, LIFT and other service concession obligations		(8,233)	(8,067)
PDC dividend (paid) / refunded		-	-
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash flows from financing activities		**25,327**	**25,099**
Increase in cash and cash equivalents		**4,870**	**1,909**
Cash and cash equivalents at 1 April - brought forward		**4,186**	**2,277**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**4,186**	**2,277**
Cash and cash equivalents transferred under absorption accounting	33	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	22.1	**9,056**	**4,186**

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

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

The Trust recorded a surplus in 2019/20 which brings the Breakeven Duty Cumulative Position to £69.753million deficit. The Board are committed to continue to generate surpluses in future years and current long term planning models show the Trust at breakeven or surplus for the financial years 20/21 to 23/24. To achieve this forecast the Trust will be relying on support from the Financial Recovery Fund (FRF) from NHSI/E. These conditions indicate that a material uncertainty exists that may cast significant doubt on the Trust's ability to continue as a going concern. For the Trust to receive the funds financial targets need to be achieved by both the Trust and the wider Black Country and West Birmingham Sustainability and Transformation Partnership (STP). Planning has been centred around ensuring these targets are met. In March 2020 of this year NHSE/I informed all trusts in England that funding would be provided to ensure that each trust could achieve breakeven in April 2020 to July 2020. Where allocated funding was insufficient trusts have the opportunity to bid for further funds to cover expenditure incurred for meeting the challenges associated with the Covid 19 pandemic. The Trust awaits further updates about the exact funding arrangements for 20/21.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £130,534k are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

The Board has concluded that the Directors have a reasonable expectation that the Trust has access to sufficient resources, including revenue allocations, additional funding to support Covid 19 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 1.3 Interests in other entities

Joint operations
The Trust has no interest in other entities for 2019/20. However, from the 1st April 2020 the Trust in conjunction with Walsall MBC will be forming a joint alliance (section 75) in the form of 'Walsall Together' to provide a more comprehensive health and social care service to the population of Walsall. The terms of the arrangement are to be finalised during 2020/21.

Note 1.4 Revenue from contracts with customers

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

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.
The Trust receives payment of its contract activity income monthly and is adjusted where necessary following a forecast of performance which is agreed at the financial year-end. The income is invoiced and recognised in the accounts and may potentially have minor revisions following validation through the national contract reconciliation process.

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.
Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

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

NHS injury cost recovery scheme

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

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

Note 1.5 Other forms of income

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

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Note 1.7 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 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

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

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

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

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

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

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

In making these judgements, the Trust is aware that the Royal Institute of Chartered Surveyors (RICS) has issued a valuation practice notice which gives guidance to valuers where a valuer declares a materiality uncertainty attached to a valuation in light of the impact of COVID-19 on markets. As explained above, the Trust has not obtained a valuation report for 2019/20 but it should be noted that there may now be greater uncertainty in markets on which the valuation obtained in [date] and reflected in these financial statements is based. Given the judgements explained above in preparing these 2019/20 financial statements, the Trust has not deviated from its existing accounting policy by obtaining an additional valuation to which a materiality uncertainty might be attached.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

Depreciation

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

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

Revaluation gains and losses

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

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

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

Impairments

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

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

De-recognition

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

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

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

Donated and grant funded assets

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

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

Private Finance Initiative (PFI) transactions

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

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

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.
Lifecycle replacement is capitalised annually and therefore included within the capital additions Property, Plant and

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	62
Dwellings	1	20
Plant & machinery	1	15
Transport equipment	1	7
Information technology	1	10
Furniture & fittings	1	10

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

Note 1.10 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, 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.

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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

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

Note 1.11 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.

The Trust has been unable to perform its planned year-end inventory counts due to the outbreak of COVID-19, however it is estimated that the movement in the valuation of inventory will not have a material effect on the reported position of the accounts. The main component of inventories is drugs which has a rolling stock-take and is computerised and controlled within National guidelines and does not raise significant valuation issues.

Note 1.12 Investment properties

The Trust does not have investment properties.

Note 1.13 Cash and cash equivalents

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

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

Note 1.14 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 1.15 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

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

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

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

Derecognition

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

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

Note 1.16 Leases

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

The trust as a lessee

Finance leases

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

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

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

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

The trust as a lessor

Finance leases

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

Operating leases

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

Note 1.17 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

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

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

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

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

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 26.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.18 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, but are disclosed, unless the probability of a transfer of economic benefits is probable.

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 1.19 Public dividend capital

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

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

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

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

Note 1.20 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 1.21 Corporation tax
The Trust has determined that it has no corporation tax liability.

Note 1.22 Foreign exchange
The functional and presentational currency of the trust is sterling.

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

Note 1.23 Third party assets

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

Note 1.24 Losses and special payments

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

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

Note 1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.26 Transfers of functions to other NHS bodies

The Trust entered into a partnership agreement with Wolverhampton, Dudley and Sandwell & West Birmingham acute hospital trusts for the provision of pathology services. The agreement will eventually lead to a capital development at Wolverhampton hospital as the main service hub with minor facitlities retained at other hospitals. Staffing transfers have previously been actioned in preparation for the planned future service structure. All physical assets remain with the Trust at present.

The Trust has also transferred its Payroll Service to the Royal Wolverhampton in January 2020 which involved primarily the transfer of staff.

Note 1.27 Early adoption of standards, amendments and interpretations

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

Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

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

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

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate (1.27%). The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2020 for existing finance leases.

For leases commencing in 2020/21, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

Other standards, amendments and interpretations

This is not applicable to the accounts for 2019/20.

Note 1.29 Critical judgements in applying accounting policies

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

There are no critical judgements in the preparation of the accounts.

Note 1.30 Sources of estimation uncertainty

There are no estimation issues in the preparation of the accounts.

Note 2 Operating Segments

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

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2019/20	2018/19
	£000	£000
Acute services		
Elective income	27,832	26,986
Non elective income	77,946	71,211
First outpatient income	17,683	18,747
Follow up outpatient income	9,532	9,547
A & E income	12,911	11,237
High cost drugs income from commissioners (excluding pass-through costs)	13,084	12,669
Other NHS clinical income	48,475	39,209
Community services		
Community services income from CCGs and NHS England	32,216	30,824
Income from other sources (e.g. local authorities)	9,261	10,150
All services		
Private patient income	43	25
Agenda for Change pay award central funding*		2,843
Additional pension contribution central funding**	7,035	
Other clinical income	1,008	1,287
Total income from activities	**257,026**	**234,735**

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

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

Note 3.2 Income from patient care activities (by source)

	2019/20	2018/19
Income from patient care activities received from:	**£000**	**£000**
NHS England	28,225	18,536
Clinical commissioning groups	216,791	200,772
Department of Health and Social Care	-	2,843
Other NHS providers	1,698	1,102
NHS other	-	-
Local authorities	9,261	10,170
Non-NHS: private patients	43	25
Non-NHS: overseas patients (chargeable to patient)	68	177
Injury cost recovery scheme	940	1,086
Non NHS: other	-	24
Total income from activities	**257,026**	**234,735**
Of which:		
Related to continuing operations	257,026	234,735
Related to discontinued operations	-	-

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

	2019/20	2018/19
	£000	£000
Income recognised this year	68	177
Cash payments received in-year	64	40
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	-	-

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	366	-	**366**	197	-	**197**
Education and training	7,821	-	**7,821**	7,578	-	**7,578**
Non-patient care services to other bodies	4,807	-	**4,807**	4,381	-	**4,381**
Provider sustainability fund (PSF)	5,665	-	**5,665**	2,153	-	**2,153**
Financial recovery fund (FRF)	11,885	-	**11,885**	-	-	-
Marginal rate emergency tariff funding (MRET)	1,383	-	**1,383**	-	-	-
Income in respect of employee benefits accounted on a gross basis	502	-	**502**	392	-	**392**
Receipt of capital grants and donations	-	93	**93**	-	92	**92**
Charitable and other contributions to expenditure	-	-	**-**	-	-	**-**
Support from the Department of Health and Social Care for mergers	-	-	**-**	-	-	**-**
Rental revenue from finance leases	-	-	**-**	-	-	**-**
Rental revenue from operating leases	-	201	**201**	-	304	**304**
Amortisation of PFI deferred income / credits	-	-	**-**	-	-	**-**
Other income	4,410	-	**4,410**	3,202	-	**3,202**
Total other operating income	**36,839**	**294**	**37,133**	**17,903**	**396**	**18,299**
Of which:						
Related to continuing operations			**37,133**			**18,299**
Related to discontinued operations			**-**			**-**

Other income includes car parking income, IT recharges and other trading income.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,445	1,411
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2020 £000	31 March 2019 £000
within one year	-	-
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**-**	**-**

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

Note 6.1 Fees and charges

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

	2019/20	2018/19
	£000	£000
Income	-	-
Full cost	-	-
Surplus / (deficit)	**-**	**-**

Note 7.1 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	12,972	5,977
Purchase of healthcare from non-NHS and non-DHSC bodies	1,653	1,536
Purchase of social care	-	-
Staff and executive directors costs	186,929	179,269
Remuneration of non-executive directors	102	77
Supplies and services - clinical (excluding drugs costs)	18,433	18,865
Supplies and services - general	3,449	3,646
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	18,422	18,418
Inventories written down	59	43
Consultancy costs	1,064	1,730
Establishment	3,244	3,299
Premises	10,310	9,189
Transport (including patient travel)	1,515	1,391
Depreciation on property, plant and equipment	5,829	5,865
Amortisation on intangible assets	334	301
Net impairments	983	6,186
Movement in credit loss allowance: contract receivables / contract assets	67	50
Movement in credit loss allowance: all other receivables and investments	-	-
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services- statutory audit	106	64
other auditor remuneration (external auditor only)	17	16
Internal audit costs	94	93
Clinical negligence	9,672	10,987
Legal fees	164	125
Insurance	199	223
Research and development	458	395
Education and training	742	1,358
Rentals under operating leases	1,143	930
Early retirements	-	-
Redundancy	-	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	4,486	4,376
Charges to operating expenditure for off-SoFP PFI schemes	-	-
Car parking & security	647	504
Hospitality	-	-
Losses, ex gratia & special payments	77	68
Grossing up consortium arrangements	-	-
Other services, eg external payroll	-	-
Other	1,013	1,552
Total	**284,183**	**276,533**
Of which:		
Related to continuing operations	284,183	276,533
Related to discontinued operations	-	-

Note 7.2 Other auditor remuneration

	2019/20	2018/19
	£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	17	16
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	**17**	**16**

Note 7.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2019/20 or 2018/19.

Note 8 Impairment of assets

	2019/20	2018/19
	£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	983	6,186
Total net impairments charged to operating surplus / deficit	**983**	**6,186**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**983**	**6,186**

The Trust completed the development of the Neonatal Unit and new Maternity theatre in year. Following completion of the schemes, the Trust commissioned an independent valuation resulting in the recognition of a total impairment loss of £1.966 million against the original cost of the development. The impairment was initially offset against the carried forward revaluation reserve balance for the Maternity Unit, and the remaining balance of £983k was charged to operating expenses as an impairment.

Note 9 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	140,525	141,809
Social security costs	13,503	13,154
Apprenticeship levy	666	652
Employer's contributions to NHS pensions	22,976	15,818
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	-
Temporary staff (including agency)	10,087	8,745
Total gross staff costs	**187,757**	**180,178**
Recoveries in respect of seconded staff	-	-
Total staff costs	**187,757**	**180,178**
Of which		
Costs capitalised as part of assets	-	-

Note 9.1 Retirements due to ill-health

During 2019/20 there were 4 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £234k (£21k in 2018/19).

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

Note 10 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

The Trust offers an additional defined workplace pension scheme, National Employment Savings Scheme (NEST), to which a minority of staff contribute.

Note 11 Operating leases

Note 11.1 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 has received rental income for use of the Urgent Care Centre.

	2019/20	2018/19
	£000	£000
Operating lease revenue		
Minimum lease receipts	201	304
Contingent rent	-	-
Other	-	-
Total	**201**	**304**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	201	195
- later than one year and not later than five years;	802	779
- later than five years.	3,409	3,506
Total	**4,412**	**4,480**

Note 11.2 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 operating leases with NHS Property Services for shared occupancy of numerous properties within the Walsall locality to deliver community healthcare services. The Trust has vehicle leases primarily relating to cars for employees working within community services. The 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.

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	1,143	930
Contingent rents	-	-
Less sublease payments received	-	-
Total	**1,143**	**930**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,016	935
- later than one year and not later than five years;	250	284
- later than five years.	120	181
Total	**1,386**	**1,400**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

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

	2019/20	2018/19
	£000	£000
Interest on bank accounts	86	61
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total finance income	**86**	**61**

Note 13.1 Finance expenditure

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

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,727	2,193
Other loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	8,233	8,067
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	**10,960**	**10,260**
Unwinding of discount on provisions	-	-
Other finance costs	-	-
Total finance costs	**10,960**	**10,260**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20	2018/19
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	58	80
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 14 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	-	(160)
Total gains / (losses) on disposal of assets	**-**	**(160)**
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 financial assets mandated as fair value through OCI	-	-
Other gains / (losses)	-	-
Total other gains / (losses)	**-**	**(160)**

The loss on disposal in 2018/19 refers to a restatement of the profit on the sale of buildings.

Note 15.1 Intangible assets - 2019/20

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**7,889**	**-**	**-**	**-**	**-**	**7,889**
Transfers by absorption	-	-	-	-	-	**-**
Additions	667	-	-	-	-	**667**
Impairments	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	**-**
Valuation / gross cost at 31 March 2020	**8,556**	**-**	**-**	**-**	**-**	**8,556**
Amortisation at 1 April 2019 - brought forward	**6,612**	**-**	**-**	**-**	**-**	**6,612**
Transfers by absorption	-	-	-	-	-	**-**
Provided during the year	334	-	-	-	-	**334**
Impairments	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	**-**
Amortisation at 31 March 2020	**6,946**	**-**	**-**	**-**	**-**	**6,946**
Net book value at 31 March 2020	**1,610**	**-**	**-**	**-**	**-**	**1,610**
Net book value at 1 April 2019	**1,277**	**-**	**-**	**-**	**-**	**1,277**

Note 15.2 Intangible assets - 2018/19

	Software licences	Licences & trademarks	Patents	Internally generated information technology	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**7,622**	**-**	**-**	**-**	**-**	**7,622**
Prior period adjustments	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2018 - restated	**7,622**	**-**	**-**	**-**	**-**	**7,622**
Transfers by absorption	-	-	-	-	-	**-**
Additions	267	-	-	-	-	**267**
Impairments	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	**-**
Valuation / gross cost at 31 March 2019	**7,889**	**-**	**-**	**-**	**-**	**7,889**
Amortisation at 1 April 2018 - as previously stated	**6,311**	**-**	**-**	**-**	**-**	**6,311**
Prior period adjustments	-	-	-	-	-	**-**
Amortisation at 1 April 2018 - restated	**6,311**	**-**	**-**	**-**	**-**	**6,311**
Transfers by absorption	-	-	-	-	-	**-**
Provided during the year	301	-	-	-	-	**301**
Impairments	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	**-**
Amortisation at 31 March 2019	**6,612**	**-**	**-**	**-**	**-**	**6,612**
Net book value at 31 March 2019	**1,277**	**-**	**-**	**-**	**-**	**1,277**
Net book value at 1 April 2018	**1,311**	**-**	**-**	**-**	**-**	**1,311**

Note 16.1 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**8,325**	**136,792**	**2,926**	**12,171**	**39,997**	**253**	**9,939**	**945**	**211,348**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	9	1,800	44	6,097	2,083	-	987	17	**11,037**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(983)	-	-	-	-	-	-	**(983)**
Reclassifications	(24)	13,531	(54)	(13,449)	(72)	-	60	8	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2020	**8,310**	**151,140**	**2,916**	**4,819**	**42,008**	**253**	**10,986**	**970**	**221,402**
Accumulated depreciation at 1 April 2019 - brought forward	**69**	**28,493**	**1,471**	**-**	**32,139**	**253**	**9,206**	**564**	**72,195**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,692	158	-	1,647	-	283	49	**5,829**
Impairments	-	983	-	-	-	-	-	-	**983**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2020	**69**	**33,168**	**1,629**	**-**	**33,786**	**253**	**9,489**	**613**	**79,007**
Net book value at 31 March 2020	**8,241**	**117,972**	**1,287**	**4,819**	**8,222**	**-**	**1,497**	**357**	**142,395**
Net book value at 1 April 2019	**8,256**	**108,299**	**1,455**	**12,171**	**7,858**	**-**	**733**	**381**	**139,153**

Note 16.2 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	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 2018 - as previously stated	**8,185**	**130,835**	**2,652**	**6,891**	**39,120**	**253**	**9,738**	**761**	**198,435**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2018 - restated	**8,185**	**130,835**	**2,652**	**6,891**	**39,120**	**253**	**9,738**	**761**	**198,435**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	140	5,926	274	5,280	877	-	201	184	**12,882**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	31	-	-	-	-	-	-	**31**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2019	**8,325**	**136,792**	**2,926**	**12,171**	**39,997**	**253**	**9,939**	**945**	**211,348**
Accumulated depreciation at 1 April 2018 - as previously stated	**69**	**18,796**	**1,329**	**-**	**30,387**	**253**	**8,775**	**535**	**60,144**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2018 - restated	**69**	**18,796**	**1,329**	**-**	**30,387**	**253**	**8,775**	**535**	**60,144**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,511	142	-	1,752	-	431	29	**5,865**
Impairments	-	6,186	-	-	-	-	-	-	**6,186**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2019	**69**	**28,493**	**1,471**	**-**	**32,139**	**253**	**9,206**	**564**	**72,195**
Net book value at 31 March 2019	**8,256**	**108,299**	**1,455**	**12,171**	**7,858**	**-**	**733**	**381**	**139,153**
Net book value at 1 April 2018	**8,116**	**112,039**	**1,323**	**6,891**	**8,733**	**-**	**963**	**226**	**138,291**

Note 16.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	8,241	57,260	1,287	4,819	7,359	-	1,437	318	**80,721**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	60,150	-	-	-	-	-	-	**60,150**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	562	-	-	863	-	60	39	**1,524**
NBV total at 31 March 2020	**8,241**	**117,972**	**1,287**	**4,819**	**8,222**	**-**	**1,497**	**357**	**142,395**

Note 16.4 Property, plant and equipment financing - 2018/19

	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 2019									
Owned - purchased	8,256	46,527	1,455	12,171	6,883	-	678	339	**76,309**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	61,191	-	-	-	-	-	-	**61,191**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	581	-	-	975	-	55	42	**1,653**
NBV total at 31 March 2019	**8,256**	**108,299**	**1,455**	**12,171**	**7,858**	**-**	**733**	**381**	**139,153**

Note 17 Donations of property, plant and equipment

The Trust received cash donations totalling £93k from the donors to the Walsall Healthcare General Charitable Fund as a contribution to support the purchase of a equipment.

Note 18 Revaluations of property, plant and equipment

During the year the Trust completed the development of a Neonatal Unit and new Maternity theatre, which was subsequently valued by an independent valuer using the depreciated replacement cost on a modern equivalent asset (MEA) basis. The impact of the valuation resulting in an impairment of £1.966m against the asset.

Note 19 Disclosure of interests in other entities

The Trust has no interest in other entities.

Note 20 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	1,234	965
Work In progress	-	-
Consumables	1,132	1,155
Energy	123	123
Other	131	119
Total inventories	**2,620**	**2,362**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £39,263k (2018/19: £40,866k). Write-down of inventories recognised as expenses for the year were £59k (2018/19: £43k).

Note 21.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	39,025	17,556
Contract assets	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	(1,404)	(1,359)
Allowance for other impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	548	125
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	9	6
Finance lease receivables	-	-
PDC dividend receivable	-	-
VAT receivable	823	204
Corporation and other taxes receivable	-	-
Other receivables	-	-
Total current receivables	**39,001**	**16,532**
Non-current		
Contract receivables	-	-
Contract assets	1,101	996
Capital receivables	-	-
Allowance for impaired contract receivables / assets	-	-
Allowance for other impaired receivables	(240)	(218)
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	-	-
Total non-current receivables	**861**	**778**
Of which receivable from NHS and DHSC group bodies:		
Current	32,049	9,036
Non-current	-	-

The current contract receivables has increased significantly by £25m when compared to 2019/20 primarily due to the Trust invoicing for year-end overperformance on activity and high cost drugs, other service deliverables, and accruing for the financial support due from the Department of Health & Social Care for COVID-19 in addition to achieving financial balance.

Note 21.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**1,577**	**-**	**-**	**1,527**
Prior period adjustments			-	-
Allowances as at 1 April - restated	**1,577**	**-**	**-**	**1,527**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			1,527	(1,527)
Transfers by absorption	**-**	**-**	-	-
New allowances arising	67	-	50	-
Changes in existing allowances	-	-	-	-
Reversals of allowances	-	-	-	-
Utilisation of allowances (write offs)	-	-	-	-
Changes arising following modification of contractual cash flows	-	-	-	-
Foreign exchange and other changes	-	-	-	-
Allowances as at 31 Mar 2020	**1,644**	**-**	**1,577**	**-**

Note 21.3 Exposure to credit risk

The Trust does not consider that it is exposed to credit risk as it is underwritten by the Department of Health & Social Care.

Note 22.1 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.

	2019/20	2018/19
	£000	£000
At 1 April	**4,186**	**2,277**
Prior period adjustments		-
At 1 April (restated)	**4,186**	**2,277**
Transfers by absorption	-	-
Net change in year	4,870	1,909
At 31 March	**9,056**	**4,186**
Broken down into:		
Cash at commercial banks and in hand	54	37
Cash with the Government Banking Service	9,002	4,149
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**9,056**	**4,186**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**9,056**	**4,186**

Note 22.2 Third party assets held by the trust

Walsall Healthcare NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020	31 March 2019
	£000	£000
Bank balances	-	-
Monies on deposit	-	-
Total third party assets	**-**	**-**

Note 23.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	13,374	18,912
Capital payables	1,738	833
Accruals	3,912	3,129
Receipts in advance and payments on account	-	-
PFI lifecycle replacement received in advance	-	-
Social security costs	1,953	1,941
VAT payables	-	-
Other taxes payable	1,625	1,541
PDC dividend payable	-	-
Other payables	3,353	3,105
Total current trade and other payables	**25,955**	**29,461**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance and payments on account	-	-
PFI lifecycle replacement received in advance	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	7,263	7,881
Non-current	-	-

Note 23.2 Early retirements in NHS payables above

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

	31 March 2020 £000	31 March 2020 Number	31 March 2019 £000	31 March 2019 Number
- to buy out the liability for early retirements over 5 years	**-**		**-**	
- number of cases involved		**-**		**-**

Note 24 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	1,480	1,445
Deferred grants	-	-
Deferred PFI credits / income	-	-
Lease incentives	-	-
Other deferred income	-	-
Total other current liabilities	**1,480**	**1,445**
Non-current		
Deferred income: contract liabilities	-	-
Deferred grants	-	-
Deferred PFI credits / income	-	-
Lease incentives	-	-
Other deferred income	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**-**	**-**

Note 25.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from DHSC	130,534	11,600
Other loans	-	-
Obligations under finance leases	-	-
Obligations under PFI service concession contracts	4,159	3,990
Total current borrowings	**134,693**	**15,590**
Non-current		
Loans from DHSC	-	82,767
Other loans	-	-
Obligations under finance leases	-	-
Obligations under PFI service concession contracts	116,013	120,172
Total non-current borrowings	**116,013**	**202,939**

Note 25.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	PFI scheme	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2019	**94,367**	**-**	**-**	**124,162**	**218,529**
Cash movements:					
Financing cash flows - payments and receipts of principal	36,043	-	-	(3,990)	**32,053**
Financing cash flows - payments of interest	(2,603)	-	-	(8,233)	**(10,836)**
Non-cash movements:					
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	-	**-**
Application of effective interest rate	2,727	-	-	8,233	**10,960**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2020	**130,534**	**-**	**-**	**120,172**	**250,706**

Note 25.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Other loans	Finance leases	PFI scheme	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**60,740**	**-**	**-**	**127,859**	**188,599**
Prior period adjustment	**-**	**-**	**-**	**-**	**-**
Carrying value at 1 April 2018 - restated	**60,740**	**-**	**-**	**127,859**	**188,599**
Cash movements:					
Financing cash flows - payments and receipts of principal	33,184	-	-	(3,697)	**29,487**
Financing cash flows - payments of interest	(2,193)	-	-	(8,067)	**(10,260)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	284	-	-	-	**284**
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	-	**-**
Application of effective interest rate	2,193	-	-	8,067	**10,260**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	159	-	-	-	**159**
Carrying value at 31 March 2019	**94,367**	**-**	**-**	**124,162**	**218,529**

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2019	**-**	**-**	**108**	**-**	**-**	**-**	**9**	**117**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Change in the discount rate	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Arising during the year	**-**	**-**	**-**	**-**	**-**	**-**	**341**	**341**
Utilised during the year	-	-	(12)	-	-	-	(9)	**(21)**
Reclassified to liabilities held in disposal groups	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Reversed unused	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Unwinding of discount	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
At 31 March 2020	**-**	**-**	**96**	**-**	**-**	**-**	**341**	**437**
Expected timing of cash flows:								
- not later than one year;	-	-	96	-	-	-	**341**	**437**
- later than one year and not later than five years;	-	-	-	-	-	-	**-**	**-**
- later than five years.	-	-	-	-	-	-	**-**	**-**
Total	**-**	**-**	**96**	**-**	**-**	**-**	**341**	**437**

The Trust has provided a general provision for annual leave payments due to frontline staff carrying forward untaken leave whilst delivering patient care during the COVID-19 pandemic.

Note 26.2 Clinical negligence liabilities

At 31 March 2020, £205,110k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Walsall Healthcare NHS Trust (31 March 2019: £226,938k).

Note 27 Contractual capital commitments

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	2,776	322
Intangible assets	-	-
Total	**2,776**	**322**

Note 28 On-SoFP PFI service concession arrangements

Walsall Healthcare NHS Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI scheme.

Note 28.1 On-SoFP PFI service concession arrangement obligations

The following obligations in respect of the PFI service concession arrangements are recognised in the statement of financial position:

	31 March 2020 £000	31 March 2019 £000
Gross PFI service concession liabilities	**183,593**	**192,994**
Of which liabilities are due		
- not later than one year;	9,390	9,401
- later than one year and not later than five years;	36,091	36,432
- later than five years.	138,112	147,161
Finance charges allocated to future periods	(63,421)	(68,832)
Net PFI service concession arrangement obligation	**120,172**	**124,162**
- not later than one year;	4,159	3,990
- later than one year and not later than five years;	16,976	16,586
- later than five years.	99,037	103,586

Note 28.2 Total on-SoFP PFI service concession arrangement commitments

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

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI service concession arrangements	**478,081**	**495,535**
Of which payments are due:		
- not later than one year;	17,797	17,366
- later than one year and not later than five years;	75,748	73,914
- later than five years.	384,536	404,255

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2019/20 £000	2018/19 £000
Unitary payment payable to service concession operator	**17,363**	**16,941**
Consisting of:		
- Interest charge	8,233	8,067
- Repayment of balance sheet obligation	3,990	3,697
- Service element and other charges to operating expenditure	4,486	4,376
- Capital lifecycle maintenance	654	801
- 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	**17,363**	**16,941**

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to 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

Cash flow financing

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 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 2020 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 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	38,491	-	-	**38,491**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	9,056	-	-	**9,056**
Total at 31 March 2020	**47,547**	**-**	**-**	**47,547**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	16,980	-	-	**16,980**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	4,186	-	-	**4,186**
Total at 31 March 2019	**21,166**	**-**	**-**	**21,166**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	130,534	-	**130,534**
Obligations under finance leases	-	-	**-**
Obligations under PFI service concession contracts	120,172	-	**120,172**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	20,218	-	**20,218**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2020	**270,924**	**-**	**270,924**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	94,367	-	**94,367**
Obligations under finance leases	-	-	**-**
Obligations under PFI service concession contracts	124,162	-	**124,162**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	23,842	-	**23,842**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2019	**242,371**	**-**	**242,371**

Note 29.4 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	154,911	39,432
In more than one year but not more than two years	4,058	55,281
In more than two years but not more than five years	12,918	39,271
In more than five years	99,037	108,387
Total	**270,924**	**242,371**

Note 29.5 Fair values of financial assets and liabilities

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

Note 30 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	1	59	1	43
Total losses	**1**	**59**	**1**	**43**
Special payments				
Compensation under court order or legally binding arbitration award	11	83	10	34
Extra-contractual payments	-	-	-	-
Ex-gratia payments	23	11	29	17
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**34**	**94**	**39**	**51**
Total losses and special payments	**35**	**153**	**40**	**94**
Compensation payments received		28		20

Note 31 Gifts

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Gifts made	-	-	-	-

Note 32 Related parties

	Payments to Related Party
Ms D Oum, Chair	£69,874.97
Mr S Heer, Non-executive Director	Included in list below
Ms P Bradbury, Non-executive Director	£59,786.22
Mr P Assinder, Non-executive Director	£5,784.00
Mr Richard Beeken, Chief Executive	£59,786.22
Mr R Caldicott, Director of Finance and Performance	

The payments to related parties refer to non-nhs organisation only as significant transactions with the NHS organisations are included within the entities list below.

Ms D Oum is Co - Chair, Centre for Health and Social Care - University of Birmingham, and Non-executive Director of Royal Wolverhampton NHS Trust.
Mr S Heer is Non-executive Director Birmingham Community NHS Foundation Trust (NHS Entity), Black Country Partnership NHS Foundation Trust.
Ms P Bradbury is a consultant with Health Education England, Partner is an Independent Clinical Lead with Sandwell and West Birmingham Clinical Commissioning Group.
Mr P Assinder, is Chief Executive Officer - Dudley Integrated Health & Care Trust, and a Honorary Lecturer at University of Wolverhampton.
Mr R Beeken; spouse is a Midwifery Lecturer at Wolverhampton University.
Mr R Caldicott, is Chair and Executive Member of the West Midlands Branch of the Healthcare Financial Management Association

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 Women's & Children's Hospital NHS Foundation Trust
Unversity Hospitals Birmingham University 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
St Helens and Knowsley NHS Trust

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

Note 33 Transfers by absorption

This is not applicable to the accounts for 2019/20.

Note 34 Prior period adjustments

There were no prior period adjustments.

Note 35 Events after the reporting date

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £130,534k as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months

Note 36 Final period of operation as a trust providing NHS healthcare

Not Applicable.

Note 37 Better Payment Practice code

Non-NHS Payables	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Total non-NHS trade invoices paid in the year	64,799	109,975	64,650	110,084
Total non-NHS trade invoices paid within target	16,694	48,470	15,346	53,859
Percentage of non-NHS trade invoices paid within target	25.8%	44.1%	23.7%	48.9%
NHS Payables				
Total NHS trade invoices paid in the year	1,340	14,207	1,759	12,566
Total NHS trade invoices paid within target	59	3,598	68	1,939
Percentage of NHS trade invoices paid within target	4.4%	25.3%	3.9%	15.4%

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 38 External financing limit

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

	2019/20 £000	2018/19 £000
Cash flow financing	31,293	33,450
Finance leases taken out in year		
Other capital receipts		
External financing requirement	**31,293**	**33,450**
External financing limit (EFL)	39,282	37,103
Under / (over) spend against EFL	**7,989**	**3,653**

Note 39 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	11,704	13,149
Less: Disposals	-	-
Less: Donated and granted capital additions	(93)	(92)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**11,611**	**13,057**
Capital Resource Limit	11,611	13,057
Under / (over) spend against CRL	**-**	**-**

Note 40 Breakeven duty financial performance

	2019/20 £000
Adjusted financial performance surplus / (deficit) (control total basis)	50
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2018/19 post-accounts PSF reallocation	165
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	1,624
Breakeven duty financial performance surplus / (deficit)	**1,839**

Note 41 Breakeven duty rolling assessment

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, Walsall Healthcare NHS Trust 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.

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,998	3,247	4,164	3,853	565
Breakeven duty cumulative position	5,933	7,931	11,178	15,342	19,195	19,760
Operating income		168,545	179,749	226,983	228,409	237,049
Cumulative breakeven position as a percentage of operating income		4.7%	6.2%	6.8%	8.4%	8.3%

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(12,861)	(9,790)	(21,392)	(21,350)	(25,959)	1,839
Breakeven duty cumulative position	6,899	(2,891)	(24,283)	(45,633)	(71,592)	(69,753)
Operating income	239,491	243,525	244,742	243,963	253,034	294,159
Cumulative breakeven position as a percentage of operating income	2.9%	(1.2%)	(9.9%)	(18.7%)	(28.3%)	(23.7%)

Walsall Healthcare NHS
NHS Trust

Annual Report 2019/20

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