Wirral University Teaching Hospital
NHS Foundation Trust

2020 - 2021

Annual Report and Accounts

Wirral University Teaching Hospital NHS Foundation Trust
Annual Report and Accounts 2020/21

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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Introduction

Message from the Chairman and Chief Executive

It's been an incredibly challenging year; and we are proud to introduce our annual report with the most heartfelt thanks to our staff, patients and families, volunteers, our partners in the Wirral healthcare system and the communities of Wirral who have all gone above and beyond to support the Trust this year.

We started the year with the publication of our pre-pandemic CQC inspection report, where although being rated 'Requires Improvement', the CQC provided encouragement to our journey to change how and where we work. The hospitals' caring approach got a rating of 'good' in the report and described how staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Services in maternity, diagnostic imaging and end of life care were also rated good and the CQC acknowledged that the leadership of the Trust had improved.

The CQC returned to Arrowe Park Hospital in February 2021 to do an unannounced inspection focussed on infection prevention and control (IPC) and although we have not yet had the full report, we received a follow up letter shortly afterwards reporting 'no major concerns' and praising staff for their confidence in speaking about IPC in a year when the emphasis on controlling the spread of infection could not have been higher.

The year 2020-21 has been the year of COVID-19 and Arrowe Park Hospital particularly had early sight of the processes and procedures for IPC that would become commonplace in every hospital throughout the country.

In accommodating guests from Wuhan and the Diamond Princess cruise liner for two weeks in January and February 2020, the Trust developed and adapted its ways of working to deal with COVID-19. The waves of the pandemic and the restrictions in wider society meant that staff had to cope with an increased workload with very little downtime, the stresses of working in full PPE and for many, unfamiliar duties, as they were redeployed to deal with the pandemic. Our staff proved themselves to be resourceful, adaptable and resilient as they moved services online, supported families who could not visit their loved ones in person, cared for some very poorly patients and still kept vital services like the Emergency Department, cancer and urgent care going. We have reflected on the year since cruise ship guests arrived and paid tribute to what all our staff members have done in this most exceptional year.

As a teaching and research hospital, we are also at the forefront of research into COVID-19. Clinicians and the Research Department at WUTH are contributing to eight studies, categorised as an Urgent Public Health Research by the Department of Health and Social Care. One of these, the RECOVERY Trial, is the largest randomised controlled trial of potential COVID-19 treatments in the world, involving 130 NHS hospitals across the UK. The Trust has recruited 439 patients to this important study as at the end March 2021..

And as a teaching hospital, many of our doctors in training and student nurses joined us on the COVID-19 frontline early to provide invaluable support to our staff. Medical and nursing students

joined our volunteers, together with an influx of new volunteers because many of our existing volunteers found themselves needing to shield at home.

Being a research hub is also a thread in our strategy and this year saw us putting the finishing touches to our Wirral University Teaching Hospital (WUTH) NHS FT Strategy (2021-26), which was launched at our Council of Governors' meeting in October 2020.

Significant engagement with staff, clinicians and system partners has enabled us to develop a new strategic platform to build our services, infrastructure, workforce and plans on an exciting and shared vision for the future. We built and opened investments in a new oxygen plant at Arrowe Park, new facilities in our Emergency Department to stream COVID-19 and non COVID-19 patients as they arrive; and delivered a new cardiac catheter laboratory. We invested in operating theatre facilities at Clatterbridge increase our ability to take complex surgical cases and to make the most of Clatterbridge as a site for elective work. We also made good progress in developing our outline business case for a new Urgent and Emergency Care Upgrade Programme and commenced updated site master planning for Arrowe Park and Clatterbridge sites.

One of the silver linings of the pandemic has been the way in which Wirral, as a place, has worked together in partnership, including our colleagues at Wirral Council, in third sector and other providers – giving life and meaning to the practical realities of integrated care system working and delivering the best benefits to our patients and the community.

That support from the community was also evident in the fundraising spearheaded by our local partner, the Wirral Globe, which saw £150,000 raised locally for projects to benefit staff wellbeing, in addition to WUTH's share of the national monies raised for the NHS. Together, this will enable us to make a significant investment in staff wellbeing facilities for the future and we are deeply grateful to everyone who took part.

Finally, we were honoured to be part of the vanguard of hospital vaccination hubs in England, delivering one of the first batches of the much awaited vaccines in early December 2020. We converted offices into a vaccination hub in a matter of days and we continue to run a busy vaccine operation serving the people of Wirral.

As we look back on this last year, it's with a sense of sadness for the lives lost, the grieving families and the impact of the pandemic. But it's also with pride, thankfulness and hope as our staff, our community and our partners have shown indomitable spirit and lived our values that 'Together we will…' And we'll build back stronger and better in the years ahead.

Sir David Henshaw
Chair

Janelle Holmes
Chief Executive

Performance Report – 2020/21

This section provides an overview of the Trust. It sets out the purpose and key activities of Wirral University Teaching Hospital. We also use this opportunity to highlight some key achievements and recognition over the past year including a summary of the Trust's key performance figures and what we delivered in 2020/21.

The purpose of the Trust and its key activities

Wirral University Teaching Hospital NHS Foundation Trust (WUTH) is one of the largest employers in Wirral and is one of the largest and busiest acute trusts in the North West of England. It was formed under the provisions of the Health and Social Care (Community Care and Standards) Act 2003 (consolidated in the National Health Service Act 2006). The Trust received its Terms of Authorisation on 1st July 2007. In April 2013 this was superseded by a Trust Licence from the current regulator, NHS Improvement.

The status of Foundation Trust (FT) enables us to:

- Provide and develop healthcare according to the core NHS principles of free care based on need and not ability to pay.
- Have greater freedom to decide our own strategy and the way we run our services.
- Retain any financial surplus at the end of the year to reinvest in services and care provision.
- Borrow to invest in new and improved services for patients and service users

We have a key accountability to our local community through our public members and governors. In addition. we are accountable to our commissioners (through contracts), Parliament and NHS Improvement. Our workforce of over 6000 staff serves a population of approximately 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West footprint. Our principal activities during 2020/21 centred on contracts placed by primary care organisations and specialist commissioning bodies.

The Trust operates from two main sites:

- Arrowe Park Hospital, Upton – delivering a full range of emergency (adults and children) and acute services for adults in the main hospital building. The Wirral Women's and Children's Hospital provides maternity, neonatal, gynaecology, children's inpatient, day case and outpatient units.
- Clatterbridge Hospital, Bebington – undertaking planned surgical services, dermatology services, breast care and specialist stroke and neuro rehabilitation services.

Outpatient services are provided from a number of community locations including:

- St Catherine's Health Centre, Birkenhead – providing x-ray, community paediatric services, paediatric audiology and a range of outpatient clinics
- Victoria Central Health Centre, Wallasey – providing x-ray, some outpatient services and antenatal clinic
- GP practices, schools and children's centres.

Our full range of our services include:

- accident & emergency services for adults and children
- a diverse range of acute and non-acute specialties
- outpatient services
- day surgery services
- maternity including a midwifery led unit
- neonatal level 3 unit
- diagnostic and clinical support services
- specialist services, such as:
    - renal medicine
    - dermatology
    - orthopaedics (hip & knee revisions)
    - ophthalmology (retinal)
    - urology (cancer centre)
    - stroke (hyper-acute unit)
    - gynaecology (advanced laparoscopic endometriosis centre)
    - neonatal level 3 unit and
    - Ronald McDonald House: charity home providing accommodation for parents of sick children and premature babies.

Clinical work is complemented and supported by a comprehensive range of corporate services, which include, amongst others:

- quality and safety
- corporate nursing and midwifery
- operations and performance
- strategy and partnerships
- finance and procurement
- human resources and organisational development
- information and IT services
- facilities and estates management.

In 2020/21 the Trust undertook the following activity:

	20/21
Total Births	**2,867**
New Outpatient Attendances	**89,684**
F/Up Outpatient Attendances	**258,210**
Diagnostic Orders	**307,159**
Diagnostic examinations performed	**261,244**
A&E Attendances	**77,184**
Emergency Admissions*	**48,550**
Elective Day Case Admissions**	**25,874**
Elective Planned Admissions	**4,965**

*Including maternity emergencies but excluding births
**Excluding Nephrology

2020/21 Achievements

During the year, the Trust has received multiple national awards, along with recognition of achievements across a number of services, including:

- **Cancer patients give Wirral University Teaching Hospital above average care score National Cancer Patient Experience Survey (CPES) -** the National Cancer Patient Experience Survey 2019 (published June 2020) showed improvements across the board. Of the patients who took part, 90% rated the administration of their care as good or very good; and 89% felt they were treated with respect and dignity while in hospital.

- **Wirral University Teaching Hospital scored 8.2 out of 10 by patients – CQC Inpatient Survey -** the Trust achieved a score of 8.2 out of 10 for patient experience by patients responding to the annual Care Quality Commission (CQC) survey of inpatients. Overall, the CQC found that people were most positive about being treated with dignity and respect whilst in hospital. In this section of the survey, patients gave WUTH a score of 9 out of 10.

- **5 Stars for the Clatterbridge Vaccination Centre -** Healthwatch Wirral (Jan-March 2021) collected feedback from people's experiences while getting their COVID-19 vaccinations - with 98% of people leaving feedback rating their quality of care and cleanliness as 5 - star. The feedback spoke very highly of the staff, saying they were friendly, reassuring and informative.

Charity Appeal

Staff engagement and wellbeing was a vital part of the Charity's contribution to the Trust's work during the pandemic. There was a huge local response to support staff with gifts in kind and corporate volunteering to improve outdoor spaces. The Charity team have throughout ensured donors have been recognised and new relationships have been formed. The COVID-19 support fund, in partnership with the Wirral Globe, raised over £150k locally. The Charity was also successful in securing £182k from NHS Charities Together national appeal, with an additional grant of £143k submitted in March 2021. These combined funds will be used to improve staff well-being.

Vision, Values & Behaviours

A huge amount of engagement has been carried out with staff and the public to develop the Trust's vision, values and behaviours. Engagement workshops were held with staff across the Trust and face to face surveys were carried out with over 2,000 members of the public and staff. During 2020-21 we have continued to promote our vision and values as an integral part of the new Trust Strategy embedding our values in how we operate across the Trust.

The vision, values and behaviours were further developed through engagement activity and alignment with processes such as recruitment and appraisals. The brand was adapted to support infection prevention and control messaging and is being rolled out on new information boards for wards and the main hospital public areas. We provided all our staff with new uniforms for each of their professions.

We have echoed the vision and values approach in an employee health and wellbeing brand, which has helped signpost staff to the significant number of national and local resources to support their resilience, mental and physical wellbeing.

Development and Launch of our 2021-2026 Trust Strategy

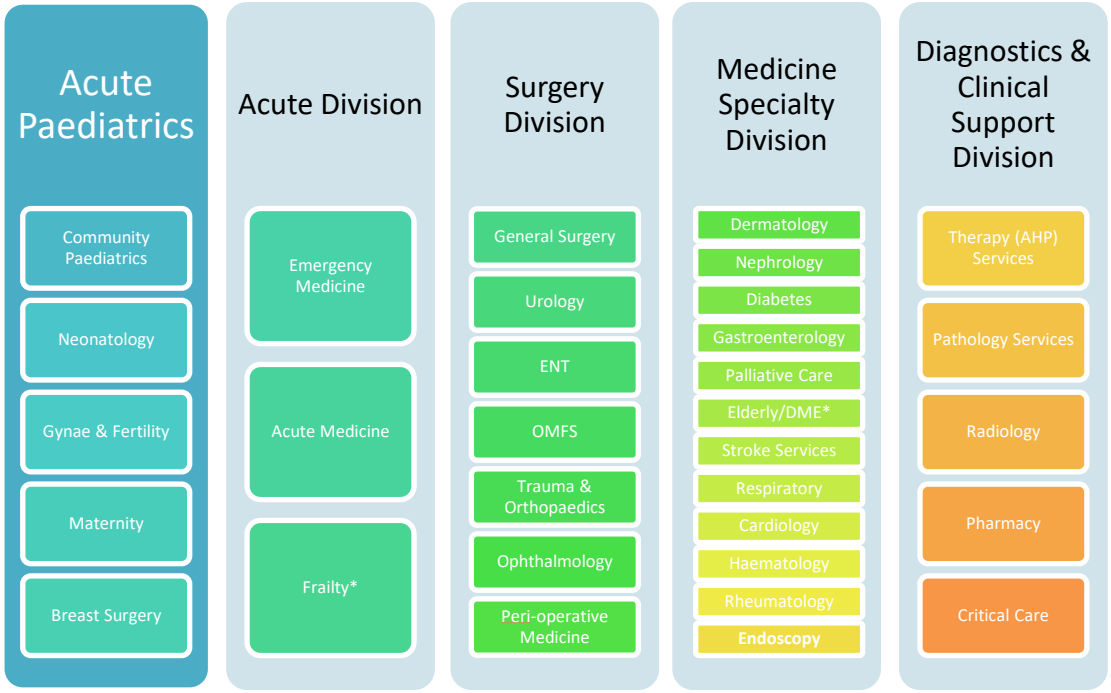
In February 2020, the Trust commenced the development of the 2021-2026 Strategy, which included a refresh of the Trust's strategic framework. A number of engagement sessions were undertaken that focussed on the development of the Trust's objectives and priorities. Over 120 staff, governors and local stakeholders attended these facilitated sessions, helping to shape the way forward for the Trust over the next five years.

From these sessions, the Trust was able to develop and refine the strategic priorities, as detailed below. Our six strategic objectives and priorities demonstrate our intention to provide outstanding care across the Wirral through our hospital sites and units, as a lead provider within the Wirral system. Our 2021-2026 Strategy was launched in October 2020.

Clinical Service Strategy

In June 2020, the Trust commenced the development of the Clinical Service Strategy; working with 32 individual clinical services to understand how they will support the Trust to deliver its strategic objectives over the next five years. The result of this is the creation of the organisation's five-year clinical strategy, an aggregation of the strategies for each clinical specialty.

The 32 specialties (detailed below) have each undertaken a workshop, where they have completed a SWOT analysis to determine their current position and identify areas for development or improvement. Facilitated discussions led to the identification and formation of specialty level priorities, aligned to the Trusts strategic objectives. The Clinical Service Strategy will be launched in quarter one of 2021/22.



Healthy Wirral

The Healthy Wirral Programme was reconstituted in 2020/21 to support development of the Healthy Wirral Plan, which incorporates the requirements of the NHS Long Term Plan. The plan outlines a population health approach to determine what the Wirral neighbourhood communities need. Alongside this, there is a focus on prevention, reducing health inequalities and supporting people with long term conditions to live well. The aim is to develop a plan that will allow Wirral to do this within their financial envelope by delivering efficiency and better value. The Healthy Wirral Programme has five key workstreams: planned care; unplanned care; out of hospital; medical optimisation; and back office. The Trust is working with system partners to support in achieving the vision of a healthier Wirral and have started service redesigns of two specialties: Dermatology and Ophthalmology. The Trust will continue to collaborate with system partners during 2021/22 with further development of all key workstreams.

As mentioned in the Chair's and Chief Executive's introduction, partnership working has been critical during the past year in dealing with the unprecedented challenges we have faced. This is why working with our partners is one of the six strategic priorities in our Trust Strategy. More details on working with our partners can be found on the partnership section on our website.

Partnerships | Wirral University Hospital NHS Foundation Trust (wuth.nhs.uk)

Hospital Upgrade Programme (Urgent Care)

In late 2019, the Trust was successful in obtaining £18m capital funding, from the Department of Health and Social Care and NHS England, for the redevelopment of the urgent and emergency care precinct at Arrowe Park Hospital. Following this announcement, the Trust commenced the drafting of an outline business case (OBC) for the redevelopment, in line with HM Treasury and NHS England Guidance. As a first step, the Trust undertook wide clinical and stakeholder consultation to support the development of a new clinical and workforce model for urgent and emergency care services at Arrowe Park Hospital, aligning with national and international good practice and new ways of working. This clinical model underpinned the further development of the OBC, including the strategic, economic, financial and commercial cases.

The OBC was approved by the Trust Board, along with Wirral partner organisations, in late January 2021 and submitted to NHS England in February 2021. Whilst the OBC is reviewed and approved by NHS England and the Department of Health and Social Care, the Trust is continuing to work on early design and architectural plans for the redevelopment, along with undertaking a procurement process for the appointment of construction managers, through the NHS Procure 22 procurement programme. The Trust expects to finalise design and commence construction of the new urgent and emergency care precinct in early 2023.

Financial Overview 2020/21

2020/21 has been a year like no other. As the country struggled to come to terms with COVID-19, the NHS was thrust to the centre of the response. This affected all aspects of the Trust, including our financial management and reporting; the conventional structures of finance had to be amended at pace to ensure funding was directed to where it was most needed.

On 17th March 2020, the operational planning process for 2020/21 was suspended and NHS England/Improvement announced amended financial arrangements for the period between 1 April and 31 July 2020 (subsequently extended to 30 September 2020), to enable the NHS to respond to COVID-19.

A key part of these changes included a nationally determined monthly 'block contract' payment and 'top-up' payment designed to cover costs. This gave all NHS providers, including WUTH, a guaranteed minimum level of income based on months 7 to 9 of 2019/20. In addition, where actual costs exceeded income, the Trust was able to claim for additional and reasonable costs including additional staffing and other costs associated with COVID-19.

After six months these arrangements were replaced and the Trust was allocated budgets based on historical expenditure with the expectation that we did not incur any deficit.

Despite the scale of the challenges in managing this position we delivered a year-end surplus of £440k and ended 2020/21 with a cash balance of £21.3m.

The following commentary provides more detail on the Trust's key financial results, which are formally reported in the Trust's annual accounts. Given the unprecedented disruption caused by COVID-19 we will not make comparisons with the plan agreed prior to the onset of the pandemic.

Income

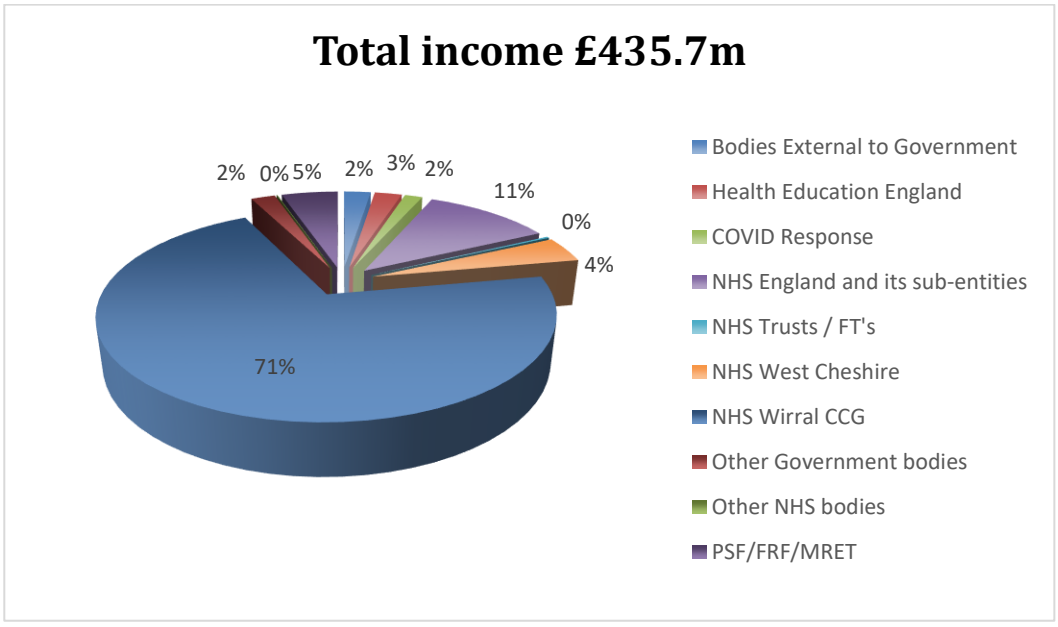
The Trust has generated operating income and gains of £435.7m in the year.

NHS income in respect of patient care, at £380.4m, was the largest aspect of income in 2020/21. This was funded largely through 'block' contracts with our key commissioners, with Payment by Results mechanisms suspended as part of NHS England's response to COVID-19. Wirral Clinical Commissioning Group remains the largest commissioner of services from the Trust, generating £307.7m (71%) of the Trust's overall income, which was broadly consistent with prior years.

Remaining income includes £78.4m in respect of Income Guarantee Support to offset loss of income due to reduced clinical activity, £22m in National Top-up funding to ensure that the Trust achieved break-even for the first half of the year and £18.7m allocated by Cheshire & Merseyside Health & Care Partnership to fund our COVID-19 response in the second half of the year.

Other income in year includes £10.6m in respect of education and training, £6.9m in respect of charges to other public sector bodies, £3.3m in respect of staff recharges and £5m in respect of funding for our annual leave accrual.

The chart below depicts the Trust's total income and gains for 2020/21, split by customer or commissioner type:



The Trust has met the requirements of section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), in that the income from the provision of goods and services for the purposes of the health service in England (principal) has exceeded income from the provision of goods and services for any other purposes (non-principal). Non-principal income is used to provide additional funding for the Trust. It is directly reinvested in the delivery of high-quality NHS services.

Expenditure

Total expenditure incurred by the Trust during 2020/21 was £435.2m (£402.5m 2019/20), which is an increase of £32.7m or 8.1% from the previous year.

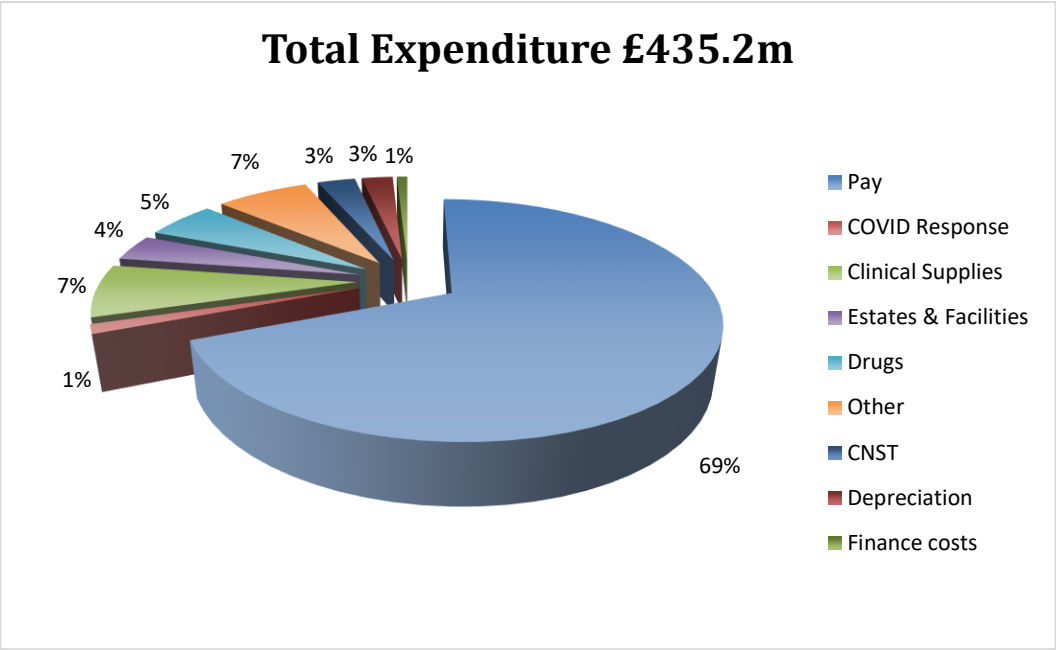
Pay is the largest expenditure category at £300m which is 69% of the Trust's total expenditure. Within this pay figure, the amount spent on substantive staff was £272.4m, with £19.8m on bank staff and a further £7.7m on agency staff. Including bank and agency staff, the Trust spent £73.2m on medical staff and £76.1m on qualified nursing. The level of qualified nurse vacancies across the Trust has been a major challenge again this year, and work continues to recruit nurses to substantive positions both at home and abroad.

Non-pay and financing costs (£135.3m) represent 31.1% of the Trust's expenditure. Some notable expenditure items in 2020/21 are as follows.

- £37.2m on clinical supplies
- £23.4m on drugs
- £15.1m on premises
- £12.9m for the Trust's clinical negligence insurance (CNST) premium
- £3.5m on finance costs, including public dividend capital to DHSC.

Depreciation and amortisation of £10.6m is included in the overall expenditure figure. This is a non-cash item, which is charged annually to reflect the usage and consumption of capital assets which were purchased in 2020/21 and previous years. Net impairments of £0.7m were also recorded, this expenditure was not contained within the Trust's plan.

The chart below depicts the main categories within total reported expenditure for 2020/21. "Other" includes premises, training, leasing and IT-related costs.



Capital investment

Capital expenditure for the year totalled £17m which included £7.1m of public dividend capital funded assets. This funding has included monies to assist the Trust in its response to COVID 19, enabling critical infrastructure works to be completed as well as supporting the Trust's critical care resilience. All of this expenditure underpins safety management, patient experience, service delivery and the achievement of efficiencies in the medium and long-term.

The Trust's capital schemes for 2020/21 were as follows:

- **£8m** Medical equipment
- **£6m** Improvements to the Trust's built estate.
- **£2m** Information technology improvement schemes
- **£1m** Schemes to support the Trust's response to COVID-19.

Cash

The cash balance held at 31 March 2021 was £21.3m. This was significantly higher than planned as the Trust benefited from the early payment of block income all year.

Within the Directors' report, the Trust's performance in 2020/21 on the *Better Payment Practice Code (BPPC)* targets is disclosed. The Trust did not achieve its payment targets this year, but the percentage of invoices paid within the BPPC targets increased slightly as well as the percentage value of invoices paid within target increasing slightly.

Cost Improvement Plans (CIPs)

The CIP requirement is a national Department of Health & Social Care strategy requiring all NHS organisations to seek to improve productivity whilst maintaining high quality standards.

The Trust's formal CIP was suspended during 2020/21 to ensure focus on the pandemic. However, productivity improvements that have been made to support the COVID-19 response are being developed further and the Trust is working with the Healthy Wirral system partners on areas which can further support system capacity as part of the integrated care agenda.

Future outlook

The major focus of 2021/22 will be the continued management of the COVID-19 response and recovery of the Trust's elective programme. Patients are now experiencing unacceptable delays in respect of many treatments and our priority is to return to maximum capacity and work with our partners in Cheshire and Merseyside to reduce waiting lists across the entire system. Whilst national funding is in place to support this through the Elective Recovery Fund there is still uncertainty as to the level of funding that will be received.

NHS England instructed Trusts not to undertake an extensive planning process for 2021/22 and calculated organisational plans for the first half of the year as a default position to adopt based on actual income and expenditure in quarter 3 of 2020/21. The Trust was asked to consider the impact recurrent impact of COVID-19 and the likely cost of elective recovery against the calculated organisational plan.

This plan was submitted to Cheshire and Merseyside Health & Care Partnership (HCP) and negotiations took place at system level to redistribute monies to ensure a break-even position for all organisations. This exercise is now complete and the Trust has agreed with Cheshire and Merseyside HCP and NHS England a break-even plan for the first half of 2021/22. A plan for the 2nd half of the year will be agreed in due course.

Looking further forwards, the Trust continues to be fully engaged with Health & Care Partnership processes, working closely with other health and social care providers in Cheshire and Merseyside, with the aim of delivering financially sustainable services for the local health economy and the region beyond 2021/22 and into the medium and long-term.

Going Concern Disclosure

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.

After making enquiries, the directors have a reasonable expectation that the services provided by the Wirral University Hospital NHS foundation trust will continue to be provided by the public sector for the foreseeable future.

Performance Analysis

There are key performance measures the Trust is legally obliged to report upon both locally to its commissioners and nationally to external bodies. These derive from the NHS England national standard contract, Commissioning for Quality and Innovation and locally agreed measures with our Clinical Commissioning Group.

To help the Trust understand its performance, the Trust measures its effectiveness in delivering priorities by monitoring and reporting performance data in in three main areas:-

- National quality standards.
- Local outcome measures.
- Financial performance.

Performance is managed through the Trust's operational management arrangements with assurance provided through the Board's committees. Where required exception reporting is applied to areas where the Trust is not meeting specific KPIs or outcomes.

National targets and regulatory requirements	Target	Q1	Q2	Q3	Q4
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	Minimum 93%	90.23%	92.48%	94.20%	97.64%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	Minimum 96%	98.56%	92.44%	97.55%	94.73%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer (surgery)	Minimum 94%	95.12%	74.31%	77.11%	82.19%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer (drugs)	Minimum 98%	100%	100%	100%	100%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	Minimum 85%	85.28%	80.68%	84.60%	82.56%
Maximum waiting time of 62 days from screening referral to treatment for all cancers	Minimum 90%	96.30%	81.82%	96.43%	71.43%
Referral to treatment time – incomplete pathways < 18 weeks	Minimum 92%	54.07%	50.91%	68.21%	68.52%
Referral to treatment time – incomplete pathways: total waiting	Maximum 22,980 by March '21	21,383	24,212	21,792	23,444
Maximum waiting time of four hours in A&E from arrival to admission,	Minimum 95%	89.71%	84.09%	73.19%	73.06%

Impact of the COVID-19 Pandemic

The COVID-19 pandemic significantly impacted the provision of NHS services, for both primary and secondary care sectors. The Trust experienced a significant reduction in GP referrals and patients self-presenting at the emergency department in the first few months of the pandemic and again to a lesser degree in early 2021.

During this time the priority for in hospital services was the treatment of COVID-19 patients and the need to adapt services to function under greatly enhanced infection and prevention guidelines. The external scrutiny on performance against NHS standards was significantly reduced during the COVID-19 pandemic. The Trust has maintained its own arrangements for monitoring quality and performance. The impact of the changes on service areas is summarised below.

Access for Emergency Patients

An immediate impact of the COVID-19 pandemic and the early national campaign to 'Protect the NHS' was a significant reduction in the number of patients attending the Trust's emergency department and the Wirral Community Trust managed walk-in-centre, both located on the Arrowe Park Hospital site. In the first quarter of 2020-21, attendances at the site were down to 58% of the levels of 2019-20. There had also been a concerted effort across the Wirral health economy to release beds at Arrowe Park Hospital in anticipation of the first COVID-19 wave. With reduced demand and greater available bed capacity, performance against the emergency access 4-hour standard improved on the previous levels, up to 89.7% for the first quarter although still below the national standard of 95%.

The demand on the Arrowe Park emergency department slowly returned from quarter two onward. The more severe wave of COVID-19 in January 2021 did not result in the same level of demand reduction, with emergency department attendances at approximately 85% of pre-COVID levels. Attendances at the Arrowe Park walk-in centre have remained at the reduced levels throughout the year. With the return of increasing demand, and increased bed occupancy, performance against the 4-hour standard deteriorated correspondingly, with the final quarter being 73%.

Access to Elective Care

The Trust immediately ceased all non – urgent elective activities in March 2020 in accordance with national guidance. As a direct result, routine waiting times increased and so performance against the referral to treatment 18-week standards deteriorated.

The total number of patients awaiting treatment initially reduced as a result of the fewer referrals. However, as the number of referrals increased and the Trust continued to prioritise urgent care, we saw a significant increase in the percentage of our patients who were awaiting treatment at 18 weeks, which is reflected in the number of patients waiting over 52 weeks which increased from just 15 at 31st March 2020 to 1,168 at 31st March 2021.

As the pressure from the 1st wave subsided the Trust restarted non urgent activities from late summer and through autumn achieving close to pre-pandemic levels and tackling the backlog in nationally determined clinical priority order. For any patient whose treatment was delayed beyond 52 weeks a clinical review was undertaken to assess the level of harm.

The impact of the COVID-19 wave in January – February 2021 necessitated a further suspension of non-urgent activities. By March 2021 the suspension was lifted with an objective to return to pre-COVID levels by August 2021.

Access to Cancer Care

The provision of cancer services has been maintained as a priority throughout the pandemic although treatments have been delayed for a number of patients where is has been clinically appropriate to do so.

During the pandemic referrals for patients with suspected cancer reduced but not to the extent of general referrals and returned to pre-COVID levels sooner.

Harm reviews are undertaken for each patient who breaches the 31- and 62- day standards. Following the 3rd wave treatments for those patients clinically deferred have recommenced with the expectation that the waiting list and compliance with all standards will be met by June 2021.

Quality of Service

In accordance with revised reporting arrangements as a result of COVID-19, the Trust is not required to include a Quality Report as part of the Annual Report. However, a Quality Account will be prepared, as required by the Health Act 2009, and published on 30 June 2021. The following sections provide an overview of a number of key quality issues for 2020/21.

Care Quality Commission Assessment

Following the publication of the CQC inspection report on 31 March 2020, the Trust has made significant progress in both the response to the requirements and recommendations made to achieve improvements.

The Trust remained at 'requires improvement' overall but improved in the well-led and safe domains. The Trust has a comprehensive action plan which incorporate the findings (31 must do's and 76 should do's).

Organisational pressures during the pandemic resulted in confirm and challenge meetings to review progress being suspended during the latter part of 2020. These meetings will be re-established from April 2021 and will be used to ensure the continued relevance of actions and to assess the impact of the improvement work undertaken over the past twelve months. Progress is reported through Quality Committee to the Board of Directors every quarter.

Infection Prevention & Control

Embedding high standards of infection prevention and control remains a Trust priority, and even more so during the COVID 19 pandemic. Whilst the COVID pandemic has challenged the Trust's ability to consistently follow outbreak guidelines and incidents of nosocomial transmission were reported, the actions and mitigations introduced to reduce the risk, resulted in an improving position by the year end. There have been two reported MRSA bacteraemia during the year. The patient safety investigations determined one was unavoidable due to individual patient complexities and one avoidable resulting in Trust wide shared learning. All other alert organisms have remained within

the Trust's annual objectives for the first time in several years. Going forward the hard work will continue to reduce all avoidable infections.

The CQC carried out an unannounced focused inspection of infection prevention and control procedures in February 2021. Whilst the report was not published until April 2021 it highlighted a significant improvement made by the Trust with no "must do" actions and three "should dos". Positive findings included:

- Leaders understood and managed the priorities and were visible and approachable.
- Staff felt respected, supported, and valued.
- The Trust had a clear vision and action plan for continuously improving practices.
- The Trust had effective governance structures and processes.
- The Trust collected and analysed reliable data.

We are really pleased with the outcome of the inspection, reflecting the hard work of all our staff. We will continue to strive to retain and improve on these standards incorporating the "should dos" which include improving compliance with standard operating procedures and dynamic risk assessment in relation to the use of single rooms for patients with identified infections and ensuring adherence to national guidance for eye protection when caring for COVID-19 positive patients.

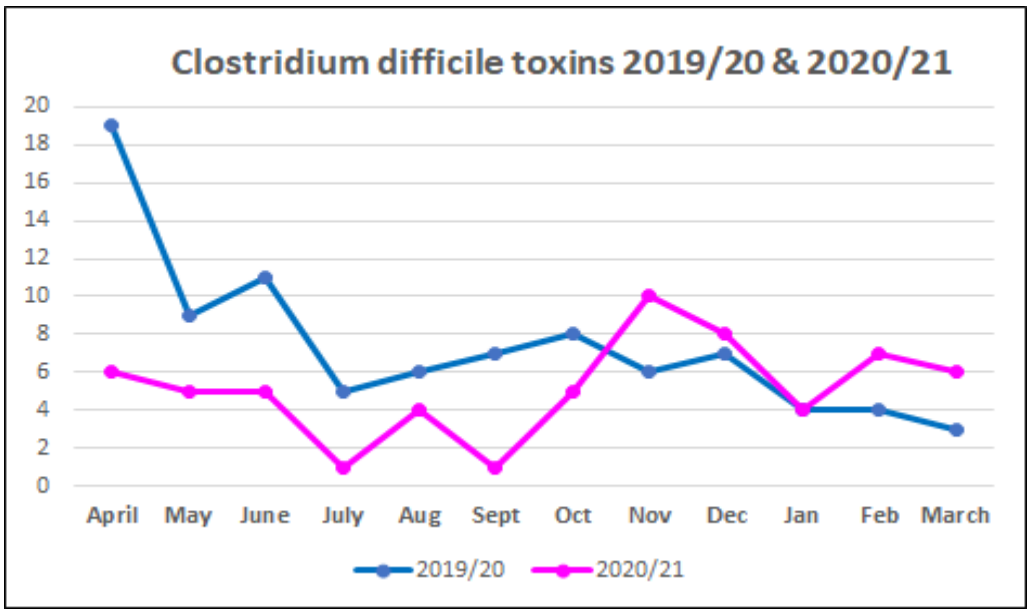
***Clostridium difficile* (C.diff)**

The 2020/21 target for WUTH for C.diff was no more than 88 cases. During 2019/20 an improvement plan was introduced with clinical teams, estates and infection prevention & control teams all involved in implementation of relevant actions. This improvement plan has supported a significant reduction in the number of hospital onset healthcare associated C.diff cases.

The definition for a hospital onset healthcare associated C.diff is as follows compared with the definition for community acquired:

- **hospital onset healthcare associated:** cases detected in the hospital two or more days after admission (day of admission being day 0)

- **community onset indeterminate association:** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous twelve weeks but not the most recent four weeks.



Clostridium difficile													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	19	9	11	5	6	7	8	6	7	4	4	3	89
Trajectory 2020/21	7	7	7	7	7	8	8	7	8	7	8	7	88
2020/21	6	5	5	1	4	1	5	10	8	4	7	6	62

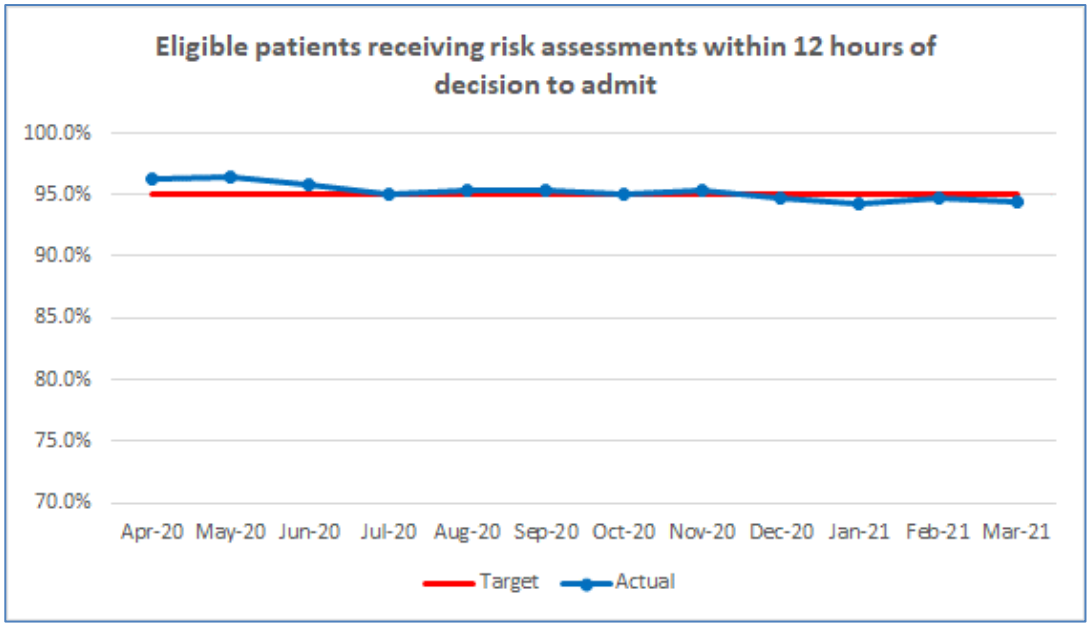
All hospital acquired infections have a full root cause analysis undertaken to identify learning outcomes and areas for improvement.

Eligible Patients Receiving Venous Thromboembolism (VTE) Risk Assessments During Hospital Admission

The Department of Health requires quarterly reports regarding eligible adult patients receiving VTE risk assessments during their hospital stay. The compliance target for this measure is +95%. The Trust achieved this target with an outturn position for 2020/21 performance of 95.3% compliance.

The VTE assessment tool developed is now fully implemented within the Trust and this, combined with the implementation of a Trust-wide teaching package, has led to sustained assessment compliance with less variation than the year prior.

The overall performance for 2020/21 is 95.2% compliance, and having achieved the target for another year, was very positive. Ongoing monitoring of performance through the Trust's VTE Group will ensure continued consistency of performance.

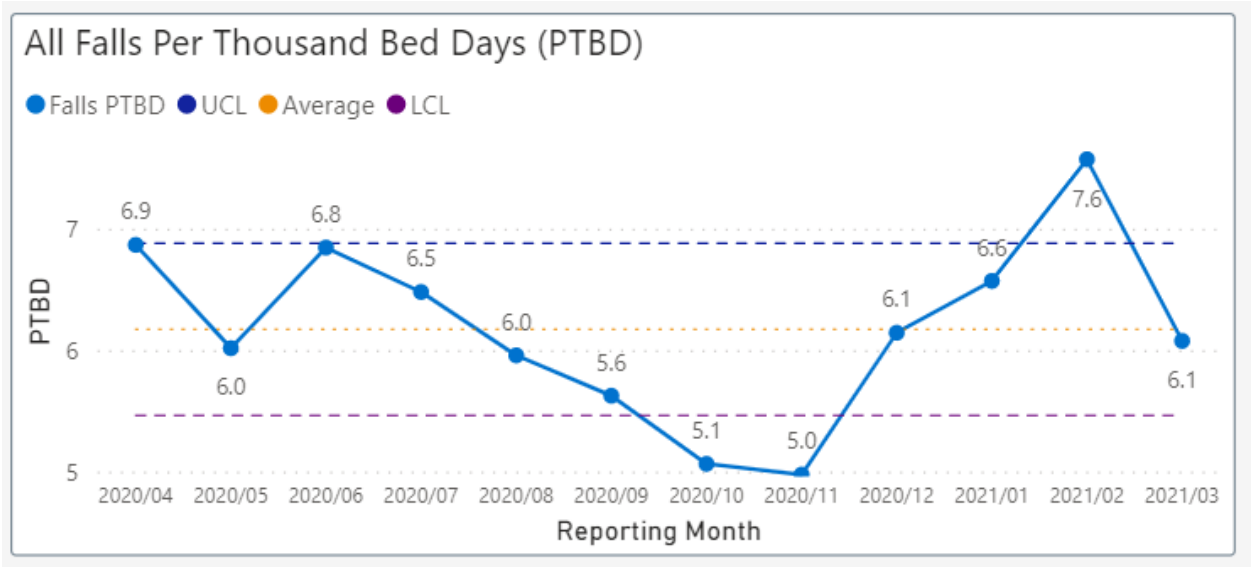


CQC National Patient Experience Surveys 2020

Due to the Covid-19 pandemic there have been no CQC patient experience surveys undertaken and reported during 2020/ 21.

Falls

All categories of falls consistently reduced between July and November 2020, however rose again between December 2020 - February 2021 above the locally agreed target. A comprehensive falls analysis was undertaken to understand the increase in falls during this period and concluded that the increase was as an impact of the third COVID-19 wave. Falls have reduced in March 2021 and are anticipated to continue to reduce further during the following months.



Falls with moderate harm and above have remained below the Trust target of 0.24 per 1000 bed days with the exception of April and June 2020.

Indicator	Threshold	Set by	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	≤0.24 per 1000 Bed Days	WUTH	0.25	0.14	0.29	0.13	0.18	0.21	0.00	0.11	0.21	0.15	0.11	0.16

During 2020 /21 the Trust has significantly invested in the provision of assisted technology. Sensor mats are now available across the Trust and staff have been provided with a full training programme to support their correct use.

Malnutrition Universal Screening Tool (MUST) Compliance

A target of 95% for malnutrition screening within 7 days was introduced in April 2020 which has been consistently achieved with the exception of April 2020 where compliance dipped to 93.6% and January 2021 where it dipped to 94.1%. These reductions are aligned to the peaks of the operational challenges in relation to COVID – 19.

Indicator	Threshold	Set by	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	≥95%	93.6%	96.5%	96.4%	99.1%	99.0%	96.8%	97.4%	97.5%	96.2%	94.1%	95.3%	98.0%

An additional target for undertaking 95% MUST assessments within 24 hours was introduced in April 2020. This has been consistently achieved since May 2020 as displayed below.

Indicator	Threshold	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Nutrition and Hydration - MUST completed within 24 hours of admission	≥90% to June 2020, ≥95% from July 2020	96%	94%	95%	93%	98%	97%	98%	98%	96%	96%	98%	97%	95%	97%	97%

Hospital Acquired Pressure Ulcers and Deep Tissue Injuries

During 2020/21 the Trust launched our own localised version of the SSKIN campaign. SSKIN is a pressure ulcer prevention guide focusing on 'skin, surface, keep moving, incontinence and nutrition and hydration'. To ensure that this campaign is embedded within the organisation the Trust has committed to focus each month on one of the SSKIN elements incorporating additional learning from reviews undertaken by the Combined Harm Panel.

To support ownership and improvement monitoring a dedicated business intelligence portal section has been designed for tissue viability with data that can be analysed by a specific area or category.

The Trust has had one hospital category 4 during 2020/21; this incident was reviewed by the combined harm panel who determined that there had been no lapses in care.

Hospital acquired category 3's and above are monitored via the Trust Quality Dashboard with a zero tolerance. During 2020/21 the trust had a total of 8.

During 2020/21 WUTH has seen the start of a steady reduction in Hospital Acquired Category 2's as displayed in the graph below

Management of Serious Incidents / Duty of Candour

During 2020/21 the Trust continued to strengthen its incident management aligned with our cultural improvement programme with high levels of reporting and timely management review and investigation. This has enabled faster facilitation of duty of candour to ensure we are open and honest with our patients and families if there has been an error or omission resulting in harm.

Serious incidents are managed ahead of the national 60-day deadline and learning identified, alongside learning from mortality reviews and other sources of information. This helps us to continue to improve the safe and quality of care we provide across all our services.

During 2020/21 we reported one surgical never event. The incident was subject to a full investigation utilising root cause analysis methodology and the Trust took immediate improvement actions to reduce the risk of reoccurrence of similar incidents. Duty of candour was performed.

Reviews of Harm

The Trust has previously operated a weekly review of harms to ensure a continuous improvement and focus on reducing hospital acquired harms . Reflecting the significant demand placed on front line staff treating patients, the combined harms panel was suspended for several months. In order to ensure that learning outcomes, themes and trends were still identified, the corporate nursing team continued to review the data and offered localised support to areas identified. The combined harms panel recommenced in February 2021 with a dedicated review of falls in response to a Trust wide increase. The monitoring of compliance against the national early warning scores (NEWS 2) has been added as a criterion for attendance which will support the collaborative quality improvement project “Deteriorating Patient “.

Complaints

The Trust registered 183 new formal complaints during 2020/21, which was a 4% reduction from the previous financial year. There was also a 15% reduction in informal concerns (PALS) for the same period.

As in other areas, the COVID-19 pandemic had an impact upon activity and performance. During the first lockdown, between April and June 2020, there was a marked reduction in the number of complaints received and registered, although the complaints process at WUTH was not paused (although this was permitted by NHS England).

Despite the slight reduction in formal complaints, there was a considerable rise in the Trust’s average response time, from 33 to 45 working days. Only 40% of complainants received a formal response within the Trust’s agreed policy timeframe, which was changed to 40 working days in October 2020 to bring the Trust in line with other local Trusts and NHSE.

Analysis of the end-to-end process has shown that the majority of the delays have been with the clinical divisions in providing timely and comprehensive reports. These delays were partly attributable to the pressures of the pandemic. We kept complainants informed and updated of any delays in the handling of their complaint.

The number of complaints referred on to the PHSO and the number of complaints then upheld or partially upheld is small, with only a single case then being partially upheld.

Comparative performance summary	2019/20	2020/21	Percentage change
Formal complaints registered	190	183	Down 4%
Informal concerns registered	2119	1794	Down 15%
Formal complaints acknowledged in three working days	100%	97%	Down 3%
Formal complaint responses sent within agreed timescale	51% (167 responses)	40% (158 responses)	Down 11%
Avg. response time to formal complaints	33 working days	45 working days	Up 36%
PHSO cases opened	14	4	Down 5% as a proportion of Trust responses
PHSO completed investigations upheld or partially upheld	3 (30% of completed investigations)	1 (100% of completed investigations)	Down 1% as a proportion of Trust responses

Ward Accreditation

Delivering high quality individualised, safe care to patients is a key priority for the Trust. To support this, the Trust has developed the WISE ward assessment and accreditation programme.

W – Wirral **I** – Individual **S** – Safe Care **E** - Every time.

This process is based on successful ward assessment and accreditation models used across NHS hospitals and ensures local policies are accurately referenced and that compliance with "harm prevention inspections" is monitored.

Wards are assessed and scored using a ward accreditation scoring matrix. To date all general inpatient areas have been assessed at least twice with six wards being awarded level three status, one step away from achieving full WISE ward status, and no wards within level 1. Following each

ward assessment and accreditation divisional teams create an action plan which is integrated with learning outcomes from self-inspections to form a comprehensive improvement plan for the ward.

Full WISE ward accreditation activity has been suspended throughout 2020 as a result of COVID-19. An adapted version of the full WISE Accreditation tool that can be used at times of extreme escalation has been developed which provides assurance in relation to harm prevention, medication management and compliance with infection prevention and control measures.

Perfect Ward™

Throughout 2020 – 2021 The Trust has sustained a Perfect Ward™ inspection programme. During times of extreme escalation the schedule for inspections has been reduced, to prioritise direct patient care whilst maintaining relevant patient safety and COVID-19 related inspections. The programme continues to provide the Trust with real time, high visibility assurance inspections created by clinical teams. Over 36,000 individual inspections have been undertaken across 54 clinical areas. Inspection results are visible on the Trust business intelligence portal.

Environment

The Trust is committed to creating a workplace culture that has a positive impact on our services, health and wellbeing of our patients and our workforce. At the core of this is balancing different needs against an awareness of the environmental, social and economic factors. We are committed to working with our local partners to reduce the impact we have on the environment. We are a partner in the Cool Wirral Partnership which co-ordinates local action on climate change. In conjunction with our partners across Cheshire and Merseyside we are working to create and embed social values criteria into our contracts

Procurement continues to make up the largest proportion of our carbon footprint, so we are building circular economy principles including waste prevention, re-use and recycling considerations into our procurement practices. Waste is one of the key aspects of sustainability and is therefore an area of priority. The Trust is an active member of the Cheshire Mersey sustainable procurement group and in collaboration with the other NHS providers in the region we are embarking on a programme to reduce our consumption of single use plastics and to reduce packaging.

The Trust has moved an additional £2.6m of its consumables spend to NHS Supply Chain meaning that a single daily delivery removes a significant number of vehicles from the roads and supports the Trust's net zero carbon journey

We are working to increase the proportion of our spend with local suppliers particularly for works and maintenance contracts. The planned redevelopment of our redevelopment urgent and emergency care precinct described previously will provide an opportunity to make a meaningful contribution to the sustainability of the local economy. A key consideration in the selection of our partner was how those benefits can be realised in the construction and delivery of the new facility

with the creation of local jobs and apprenticeships and the wider benefits to the surrounding community.

Organisational Development and Workforce Strategy

Owing to the impact of the pandemic, we refocused our organisational development work programmes and activities to provide COVID-19 specific support. This included new ways of delivering programmes such as virtual induction, provision of local and national e-learning and other digital solutions. A strong focus was placed on supporting the workforce through the provision of a range of support including:

- Range of psychological support services including psychological support practitioner on site
- Wellbeing hubs at Arrowe Park and Clatterbridge hospital sites.
- Wellbeing communications in a variety of formats.
- Staff support floor walkers and staff support line.
- Hype Bike scheme, virtual Zumba and choir
- Employee assistance programme – 605 calls in the 12-month period 1 December 2019-30 November 2020 with 571 counselling calls, with anxiety the most common reason.
- Implementation of "Team Time", mindfulness sessions and COVID debriefing sessions with lessons learned.
- Creation of staff rest areas and shower facilities supported by staff wellbeing charitable donations.

In August 2020, "***We are the NHS: People Plan 2020/21 – action for us all",*** was published. This sets out an ambitious vision to create a workplace that values our people and enables us to nurture existing staff and recruit new people for the future.

Our workforce priorities from this are based around: health and wellbeing, equality and diversity, culture and leadership and workforce supply (recruitment and retention). There is recognition that the Trust will need to transform the way we work together. A focus on wellbeing, careers, team working and enhanced use of technology will enable our people to work to their full potential.

Equality and Diversity

WUTH recognises the importance of the equality, diversity and inclusion agenda in achieving its overall strategic aims and in addressing both health and employment inequalities.

The Trust is fully committed to the requirements of the Equality Act 2010 and Public Sector Equality Duty and achievement of its diversity and inclusion strategy and objectives (2018-2022). Progress with the strategy is overseen through a dedicated steering group, through the workforce governance structure and through to the Board of Directors.

The Trust's current ratings under the national Equality Delivery System (EDS2) are detailed below, with a further review currently underway:

Goal 1: Better Health Outcomes

	Indicator	Self-assessment Rating
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing
1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Developing
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Developing
1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	Developing
1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	Achieving

Goal 2: Improved Patient Access and Experience

	Indicator	Self-assessment Rating
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Achieving
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Developing
2.3	People report positive experiences of NHS	Achieving
2.4	Peoples complaints about services are handled respectfully and efficiently	Developing

Goal 3: A Representative and Supported Workforce

	Indicator	Self-assessment Rating
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Developing
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving
3.3	Training and development opportunities are taken up and positively evaluated by all staff	Developing
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Achieving
3.6	Staff report positive experiences of their membership of the workforce	Developing

Goal 4: Inclusive Leadership

	Indicator	Self-assessment Rating
4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing
4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Developing
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free form discrimination.	Achieving

The Trust continues to enjoy well established working relationships and engagement activities with a range of local stakeholder groups and organisations who represent patients with protected characteristics. A number of these groups attend our Patient and Family Experience Group and provide feedback on health and social care related issues, which can be incorporated into service delivery that will support improvements in patient and family/carer experience

Some key achievements for 2020/21 are:

- Continued improvement in national staff survey data, with the theme of equality, diversity and inclusion increasing from 9.2 to 9.31 and remaining significantly higher than the national average in this area.
- Diversity and Inclusion Steering Group identified as "National Unsung Heroes" Award Winners
- New interpretation and translation service provider commissioned this year, following feedback and consultation with staff and patients
- Hidden Disabilities Sunflower initiative launched to recognise and ensure appropriate support for staff, patients and service users with hidden / invisible disabilities
- 2000+ staff signed up for the NHS rainbow pin badge initiative, to ensure greater awareness and understanding of the challenges faced by our patients, service users and staff and offering a symbol of support for those in need.
- Multi-faith chaplaincy and spiritual care team in place to offer support to patients, service users and staff, which has been particularly important due to COVID

- Continuation of staff support networks for staff with disabilities and long-term health conditions (WUTH Sunflowers) and our lesbian, gay, bisexual and transgender (LGBT) and non-binary colleagues (The Rainbow Alliance).
- Re-launch of our Black, Asian and Ethnic Minorities staff network
- Supported the first ever Race Equality Week and highlighted its commitment to being anti-racist and providing information and support routes for staff.
- Enhanced Trust-wide communications to promote a range of national and international awareness days, spiritual and religious festivals and to share experiences of staff and patients.
- New policy and reasonable adjustment guidance documentation developed to support staff with disabilities and long-term health conditions
- 95.15% compliance level with mandated equality, diversity and inclusion training (as at 31 March 2021).

The Trust is proud to have received the LGBT+ Navajo accreditation with Merseyside In-Touch, in recognising the Trust's commitment to promoting and supporting LGBT+ people.

We are also proud to be a Disability Confident Committed organisation.

The Trust is an active participant in local and regional collaborative forums, to ensure best practice is achieved across all areas of equality, diversity and inclusion. Links are in place with regional and national advisory committees such as the North West BAME Strategic Advisory Committee. The Trust is part of the Cheshire and Merseyside Health and Care Partnership, striving to support collaborative diversity and inclusion pledges.

The Accessible Information Standard is currently being rolled out in a phased approach with reviews being undertaken within pilot areas. Enhanced recording functionality with Millennium, now allows the capture of patient communication and/ or information needs, with a patient alert provided. Browsealoud software is also integrated within our website for enhanced accessibility options.

We continue to ensure that due consideration is given to those who share protected characteristics through ensuring equality analysis and impact assessments are undertaken as part of the policy and strategic planning processes.

We will continue to strengthen our equality, diversity and inclusion provision, cultural awareness and development programme with active engagement with our community stakeholders throughout 2021/22.

The organisation continues to ensure its compliance with key reporting requirements, including Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) and Gender Pay Gap Reporting, with annual reports accessible on the public section of the Trust's Diversity and Inclusion webpage

Feedback from all reporting requirements is included within an overarching Diversity and Inclusion annual report and actions identified to improve. This report can also be found here The Trust has a Diversity and Inclusion Steering Group that monitors progress with the action plan required to

ensure achievement of the Trust objectives, and has regular update reports reviewed through the workforce governance structure and to the Board of Directors.

Leadership and Culture

The Trust has delivered a 3-year Leadership and Management Development Framework to develop leadership capability to ensure we have the capacity and skills needed to lead the organisation effectively. The Framework supports talent management and succession planning and is integrated into our Contribution Framework (appraisal) process, with a focus on behaviours as well as performance and readiness for progression.

During the pandemic we paused some of our training to enable us to focus on COVID-19 specific development. However, we have continued to provide some leadership masterclasses and completed our fourth cohort on the multi-disciplinary Top Leaders Programme and two cohorts on the Effective Manager Development Programme. Both programmes have been certificated by the Institute of Leadership and Management. We have identified future aspiring directors who completed our first Shadow Board Programme supported by the NHS Leadership Academy.

A new Board Development Programme was developed with an initial focus on team development, vision and leadership. Work has been undertaken on culture and talent mapping, along with development of a behavioural strategy. We have extended development to deputy roles and divisional triumvirates which will commence in quarter 1 2021/22.

Our cultural improvement work continues supported by the organisational development team (OD). Cultural reviews have been undertaken in a number of areas with improvement actions taken forward by service areas with support from divisional leaders. Results from the 2020 national staff survey, questions on awareness and demonstrating values have all significantly improved but remain below sector scores. The progress is significant and potentially reflects our increased focus and visibility of the vision and values roll out.

We have values and behaviours team workshops available and these also support the outcomes of some cultural reviews.

Education

Following a full review of education provision in the previous year and taking into consideration the OD implications of the NHS Long Term Plan and Interim People Plan, the OD team has strengthened talent management processes, supported educational implications of nurse vacancy schemes such as International Recruitment and Clinical Support Worker (CSW) recruitment and are preparing for nurse apprenticeships and CSW apprenticeships. We have provided a range of clinical education programmes through our clinical skills team as well a strong undergraduate education programme which has received positive feedback in the recent Quality Visit. We have provided education for the increased numbers of students brought in to support the Trust response to the pandemic through our undergraduate team and practice educators.

In 2020/21, the OD teams focussed on a number of priorities reflecting the impact of the pandemic on organisational priorities:

- Clinical skills upskilling and simulation
- Induction of pre F1 doctors, nursing students and recruitment of volunteers
- Mandatory training and identified role specific training
- Trust-wide educational priorities for nurses, midwives and allied health professionals
- Identified leadership and management development
- Maintenance of public sector duty for apprenticeships.
- Meeting the educational requirements of the Learning and Development Agreement
- E-learning and digital education solutions
- Working with universities on curriculum changes and implementing undergraduate changes as required and planned for increased placement capacity
- COVID-19 training delivered with over 4000 various training episodes completed

Mandatory Training and Appraisals

Mandatory training compliance at 31 March 2021 was below the target of 90% at 86.2% and appraisal compliance was 77% which is below the target of 88%). Operational pressures related to the COVID Pandemic have contributed to this. However, a significant focus has been placed on training related to COVID in 2020/21 with well over 4000 training episodes completed. Compliance with mandatory training and appraisals is monitored through our divisions and education and workforce governance structure.

Library and Knowledge Service

The Library & Knowledge Service (LKS) continues to serve staff and students on placement at Wirral University Teaching Hospital NHS Foundation Trust, Clatterbridge Cancer Centre NHS Foundation Trust and Wirral Community Health and Care NHS Foundation Trust, with all their library and knowledge requirements. This enables NHS workforce members to freely access LKS resources, services and support so that they can use the right knowledge and evidence to achieve excellent healthcare and health improvement across Wirral.

During 2020/21 the LKS adapted its services to be accessible remotely to all of its stakeholders. This work has resulted in a blended approach to service delivery which will continue to be utilised and further developed.

The LKS is currently 99% compliant with the Health Education England Library Quality Assurance Framework.

Janelle Holmes
Chief Executive **Date: June 2021**

Accountability Report - Directors' Report

Board of Directors - Role and Composition

The Board of Directors has collective responsibility for all aspects of the Trust's performance. The specific responsibilities of the Board include:

- setting the organisation's strategic aims, taking into consideration the views of the Council of Governors, and ensuring the necessary financial and human resources are in place to deliver the Trust's plans
- ensuring compliance with the Trust's Provider Licence, constitution, mandatory guidance and contractual and statutory duties
- providing effective and proactive leadership of the Trust within a robust governance framework of clearly defined internal controls and risk management processes
- ensuring the quality and safety of services, research and education, and application of clinical governance standards including those set by NHS England/Improvement, the Care Quality Commission, NHS Resolution and other relevant bodies
- setting and maintaining the Trust's vision, values and behaviour, ensuring that its obligations to stakeholders, including patients, members and the local community are met
- actively promoting the success of the organisation through the direction and supervision of its affairs.

The Board of Directors is held to account by the Council of Governors to discharge the Trust's accountability to the local population.

The Board of Directors has established a governance structure which sets out how performance management is organised and assurance obtained on delivery. This is defined by the Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation. Together they define the governance arrangements and include decisions reserved for the Board and its committees and those delegated through the Chief Executive to management.

In 2020/21 the Board comprised *a non-executive chair, six independent non-executive directors and five executive directors*. In addition, there are two non-voting executive directors who regularly attend the Board to bring additional capacity and capability . Non-executive directors are generally appointed to a three-year term of office, with appointments phased where possible to provide stability and reduce unnecessary disruption.

The unitary nature of the Board of Directors means that non-executive and executive directors are collectively and corporately responsible. for organisational performance. There is a clear division of responsibilities between the Chair and the Chief Executive. The Chair is responsible for the leadership and effectiveness of the Board of Directors and the Council of Governors, ensuring that members of both bodies receive information that is timely, accurate and appropriate for their respective duties. It is also the role of the Chair to facilitate the effective contribution of all Directors, and for ensuring that constructive relationships exist between the Board of Directors and the Council of Governors. The Chief Executive is responsible for the performance of the Executive Directors, the day-to-day running of the Trust and the implementation of approved strategy and policies.

Non-Executive Directors

Sir David Henshaw, Chair

Sir David was appointed Chair effective from February 2019 prior to this he was the interim Chair from March 2018. During his time as interim Chair Sir David was also the Chair of Alder Hey Children's NHS Foundation Trust. At the request of the regulator, Sir David has also undertaken the role of interim Chair at a number of NHS Foundation Trusts.

Alongside his valuable experience within the health arena, Sir David has worked extensively in local government. He spent ten years at Knowsley Borough Council before being appointed as Chief Executive of Liverpool City Council, a role which he occupied for seven years. Sir David has undertaken non-executive director roles for a number of other public and private organisations including the Chair of Manchester Academy for Health Sciences and for Albany Investment PLC.

He was appointed Chair of National Museums Liverpool early in 2017 and Chair of Natural Resources, Wales from November 2018. He is a Trustee at North Wales Heritage Trust.

John Sullivan, Deputy Chair and Chair of Workforce Assurance Committee

John was appointed as a non-executive director in July 2015.

He has extensive international manufacturing, business change and HR experience at senior levels in ICI, Texaco Canada Inc, Ineos Chlor Ltd, Sanofi Aventis Ltd and Novartis Vaccines & Diagnostics Ltd. From 2013 to 2019 he provided management consultancy and executive coaching support to senior manufacturing and general management leaders in various industries.

John has been a Chartered Chemical Engineer for over 30 years and holds an MBA from York University, Toronto, Canada.

Steve Igoe*, *Senior Independent Director, Chair of Audit Committee and Chair of Safety Management Assurance Committee

Steve was appointed as non-executive director / senior independent director in October 2018 and brings a wealth of experience to the Trust. He was previously a Non–Executive Director and Senior Independent Director at Alder Hey Children's NHS Foundation Trust.

Steve is also the Deputy Vice-Chancellor of Edge Hill University where he has responsibility for the operational areas of capital projects, financial services, human resources, IT services, learning services, strategic policy & planning, and facilities management. He is also a director of a number of Edge Hill's commercial enterprises.

He graduated with a first degree in Law from the University of Liverpool. He subsequently qualified as a Chartered Accountant in 1988 and went on to become a senior manager at PricewaterhouseCoopers, with specific expertise in project management and advising listed PLCs on corporate governance and risk management.

Sue Lorimer, Chair of Finance Business Performance and Assurance Committee

Sue was appointed as a non-executive director in July 2017. She has spent most of her career in NHS finance, mainly in the provider sector and is an associate member of the Chartered Institute of Management Accountants. She took up her first finance director post in 1990 and has held Board level posts in a variety of NHS providers including ambulance, community and specialised services. She joined the NHS Trust Development Authority, (later NHS Improvement) when it was formed in 2013, taking the lead on provider finance across the north of England.

Sue is a keen supporter of training and development and was a trustee of the Healthcare Financial Management Association for 9 years, taking the role of president in 2015.

Chris Clarkson

Chris was appointed as a non-executive director in July 2018 and brings with him great knowledge and experience of technology developments and project management from his career in the aerospace Industry.

Having held a number of senior executive level positions with BAE Systems, Chris has worked both nationally and internationally. His primary talents and interest are within the areas of technology development, project management and leadership where he has made many notable achievements.

Chris has a strong wish to support the community and the NHS through sharing his wealth of experience supporting the organisation and its dedicated workforce.

Jayne Coulson

Jayne was appointed as a non-executive director in July 2018 and brings with her great knowledge and business executive insight having worked in several blue-chip organisations including BT, HSBC and Marks and Spencer. Jayne is also the Director of Service at Experian.

She has held a number of executive level positions across differing operational areas: HR, customer service and people development. Jayne's primary talents and interest sit within the areas of transformation and leadership, where she has made many notable achievements across several business areas.

Steve Ryan. Chair of Quality and Safety Committee

Steve was appointed as a non-executive director in January 2021. Steve was a consultant paediatrician and specialised mainly in general paediatrics but included specialty work in his clinical career. He spent some time in academic practice - his main research interests being in nutrition of premature babies and headaches in children.

Steve has over 12 years of experience as an Executive Medical Director at Alder Hey Children's NHS Foundation Trust and at Barts Health NHS Trust. He undertook a range of regional strategic roles in the North West and London including being the clinical chair of the NHS Next Stage ("Darzi") review in the north west in 2008. Whilst in London he provided leadership in the transformation of young people's mental health services and in the reconfiguration of cancer and cardiac services.

John Coakley, Chair of Quality and Safety Committee

John was appointed as a non-executive director in July 2017 with his term of office ending December 2020. John retired in 2014 as Medical Director and Deputy Chief Executive of Homerton University Hospital NHS Foundation Trust, which he had held for 16 and 10 years respectively. Prior to that John was a consultant physician in intensive care medicine.

John set up the first ICU follow up and bereavement clinic in London and was awarded the OBE for contribution to the NHS in the Queen's Birthday Honours list in 2014. He was also awarded a national Sliver Clinical Excellence Award by ACCEA in 2007 and renewed in 2011. John was an active researcher before his Consultant appointment and for several years after.

Executive Directors

Janelle Holmes Chief Executive

Janelle was appointed as Chief Executive in June 2018, having already spent two years at the Trust as Chief Operating Officer.

Janelle has worked in the NHS since qualifying as a Registered General Nurse in 1991. She is passionate about service improvement, staff development and whole system working to improve patient outcomes and experience.

Nikki Stevenson, Medical Director

Dr Nikki Stevenson joined the Trust in 2007 as a Consultant Physician in Respiratory & General (Internal) Medicine. In 2015 she became Clinical Service lead for Respiratory Medicine, and in 2018 was appointed Associate Medical Director for Medical and Acute Specialties.

She was appointed as Medical Director in October 2018 and was also appointed Deputy CEO in April 2020. She continues to undertake clinical work; both in respiratory outpatient clinics and by participating in the medical on-call rota.

Nikki is a trained mentor and coach with a keen interest in education, research and quality improvement.

Anthony Middleton, Chief Operating Officer

Anthony was appointed as Chief Operating Officer in June 2018 having previously held the post of Director of Operations. Prior to joining the Trust, Anthony had spent 30 years working in the Warrington and Manchester health systems.

Having started work in finance through contracting and performance before moving into operational management, including directing the day-to-day operations of some of Manchester's biggest hospitals.

Hazel Richards, Chief Nurse

Hazel joined the Trust as Chief Nurse in January 2020. She joined us from her previous role as Director of Nursing for Integration at Liverpool University Hospitals Foundation Trust. Prior to this she was the Director of Nursing for Cheshire & Merseyside, NHS England for three years. Over the last decade, Hazel has held several Executive Director of Nursing posts in acute, mental health and community Trusts.

She has a strong track record of improving services for patients and staff, through her passion for patient and family centred care. In 2011, she was awarded the Florence Nightingale Leadership Scholarship which afforded her the opportunity to advance this work and study at Harvard Business School, USA.

Claire Wilson, Chief Finance Officer

Claire joined the Trust in January 2020 from Liverpool Heart and Chest NHS Foundation Trust where she was Chief Finance Officer. Prior to that appointment, Claire had been the Chief Finance Officer at NHS Bury Clinical Commissioning Group. During her career, Claire has worked in finance roles in a number of NHS organisations in the North West. She has also worked as Chief of Staff to the Chief Finance Officer of NHS England. Claire is a trustee of the Healthcare Financial Management Association.

Having held a number of senior roles at local, regional and national level, Claire brings a wealth of financial experience and expertise to the work of the Board.

Matthew Swanborough, Director of Strategy & Partnership (non-voting)

Matthew Swanborough joined the Trust in November 2019. Prior to this, he was Director of Resilience at Manchester University NHS Foundation Trust. Matthew has also held a number of operational roles at Manchester University Hospitals NHS Foundation Trust including Director of Operations at Manchester Infirmary and Trust Turnaround Director, directing the financial recovery programme.

Prior to this, Matthew worked as a Director of Healthcare Consulting at PricewaterhouseCoopers in Sydney, Australia, leading on service improvement, financial recovery and mergers with a range of public and private healthcare organisations.

Jacqui Grice, Director of Workforce (non – voting)

Jacqui was appointed as the Director of Workforce in October 2020 having joined the Trust on an interim basis from July 2020.

Jacqui started her health sector career in 1996 when she was Head of GP fundholding in Wirral. Following that she moved to Yorkshire to join a Health Authority and in 1998 become a Director of HR/OD and Corporate Affairs. She has been a workforce lead and director across the NHS including the Department of Health and a PCT. She moved into the acute sector in 2008 as a Director of Workforce & Communications and has worked in a number of hospitals as an Executive Director including a tertiary hospital in the Middle East.

Jacqui has also worked in other sectors such as the British Equestrian Federation, DVLA, The Highways Agency and BT.

Helen Marks, Director of Workforce (non – voting)

Helen worked as the Director of Workforce until June 2020. Helen has worked in HR for over 30 years and at executive level for 18 years.

Having started in work in a local authority in Leicestershire, Helen moved into the NHS in 1999. Her health service experience included commissioning, primary care, mental health and acute.

As a qualified HR professional, Helen was awarded HR Director of the Year in 2013 at the Healthcare People Management Association (HPMA) Award

Board Meetings and Attendance

The Board of Directors met on 12 occasions in 2020/21. Each meeting was quorate. Board member attendance at the meetings was as follows:

Director	Meeting Attendance Actual/ Possible
Sir David Henshaw (Chair)	12/12
John Sullivan (Deputy Chair)	12/12
Steve Igoe (Senior Independent Director)	12/12
Sue Lorimer (Non-Executive Director)	10/12
Chris Clarkson (Non-Executive Director)	11/12
Jayne Coulson (Non-Executive Director)	8/12
Steve Ryan (Non-Executive Director from January 2021)	2/2
Janelle Holmes (Chief Executive)	12/12
Nicola Stevenson (Medical Director)	11/12
Anthony Middleton (Chief Operating Officer)	11/12
Matthew Swanborough (Director of Strategy & Partnerships)	11/12
Hazel Richards (Chief Nurse)	12/12
Claire Wilson (Chief Finance Officer)	12/12
Jacqui Grice (Director of Workforce from September 2020)	5/5
John Coakley (Non-Executive Director until December 2020)	9/10
Helen Marks (Director of Workforce until June 2020)	3/3

Directors' Interests

Under the Trust Constitution, members of the Board are required to declare any interest which may conflict with their appointment. The Board of Directors reviews their respective register of declared interests on an annual basis to identify any potential conflicts of interest. No such conflicts of interest have been identified. Directors are required to make known any interest in relation to matters being discussed at a Board meeting, and any changes to their declared interests.

In 2020/21 the Chair had no significant commitments outside of the Trust that conflicted or impacted upon his ability to meet his responsibility as Chair.

The Registers of Interest for the Board of Directors available to the public on the Trust's website via https://www.wuth.nhs.uk/about-us/declarations-of-interest/

Balance, completeness and appropriateness

In accordance with the requirements of the NHS Foundation Trust Code of Governance, the Board considers each of the Non-Executive Directors, including the Chair, to be independent in character and judgement and has identified no relationships or circumstances that are likely to affect, or appear to affect, their judgement. The Board endorsed this consideration at its meeting in April 2021. The criteria considered by the Board in determining the independence of the Non-Executive Directors were:

- Whether the individual had been an employee of the Trust within the last five years
- Whether the individual has, or has had within the last three years, a material business relationship with the Trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust
- Whether the individual has received, or receives, remuneration from the Trust in addition to a director's fee, participates in a performance-related pay scheme or is a member of the Trust's pension scheme
- Whether the individual has close family ties with any of the Trust's advisers, directors or senior employees
- Whether the individual holds cross-directorships or has significant links with other Directors through involvement in other companies or bodies
- Whether the individual has served on the Board of the Trust for more than six years from the date of their first appointment
- Whether the individual is an appointed representative of the Trust's university, medical or dental school.

Performance evaluation of the Board, its Committees and individual Directors is undertaken in a number of ways including annual review of its business cycle and periodic review of committee terms of reference. At the conclusion of each meeting, the Board assesses the effectiveness of the meeting.

The Board believes that its composition is appropriate with a good balance of skills, experience and length of service, but also recognises the value of effective and timely succession planning. All directors participate in an annual appraisal process which includes evaluation of their performance against objectives agreed at the beginning of each year.

The Chair appraises all non-executive directors, and the senior independent director appraises the Chair, taking into account the views of other Board members and members of the Council of Governors as part of this process and in accordance with the national guidance published by NHSEI in 2019. The outcomes from appraisals of the Chair and non-executive directors are reported to the Nomination & Remuneration Committee of the Council of Governors.

The Chief Executive appraises executive directors, and the Chair appraises the Chief Executive. A report on outcomes of these appraisals is presented to the Remuneration & Appointments Committee of the Board of Directors.

Board of Directors' Committees

The Board of Directors undertakes regular reviews to ensure that the Trust maintains a robust committee structure which enables it to fulfil its purpose. The Board delegates specific functions to

its committees as outlined within their terms of reference and the Scheme of Reservation and Delegation.

Due to the COVID-19 pandemic, some of the committee meetings were stood down in line with NHSI guidance. The Trust introduced interim governance arrangements which were reviewed by the Board of Directors throughout the year. During 2020/21 the following committees took place:

- Audit (five meetings)
- Finance Business Performance and Assurance (seven meetings)
- Quality (six meetings)
- Workforce Assurance (six meetings)
- Safety Management Assurance (nine meetings)
- Charitable Funds (two meetings)
- Capital (two meetings)
- Remuneration & Appointment (five meetings).

All committees have access to legal services and resources required to discharge their respective responsibilities.

Reports are presented to the next Board of Directors following the committee meeting to provide a summary of the key areas of discussion and any resultant actions to be monitored by the committee. In addition, the reports highlight items for escalation that require consideration and/or approval of the Board of Directors.

Audit Committee

The Audit Committee membership consists of non – executives only. Its purpose is to scrutinise the Trust's risk and assurance structure and processes to ensure they are effective and support all aspects of the Trust's business. The terms of reference of the Committee were reviewed and updated in January 2019 in line with the NHS Audit Committee Handbook. The Committee has undertaken a review of its effectiveness with the recommendations used to inform a number of improvement actions.

The Audit Committee met five times during 2020/21. All meetings were quorate and a Chair's report was submitted to the Board of Directors following each meeting to outline the key areas of discussion and actions to be undertaken to address any issues identified.

Attendance at the Committee meetings was as follows:

Committee Member	**Attendance**
Steve Igoe, Chair	5/5
John Sullivan	5/5
Jayne Coulson	4/5

Audit Committee members have met in private with both internal and external auditors and are committed to continuing with this practice.

The principal areas of review and significant issues considered by the Audit Committee during 2020/21 reflecting key objectives of the committee as set out in its terms of reference are summarised below.

- **Internal Control and Risk Management** Review of the effectiveness of the revised Board Assurance Framework management processes.
- Review of risks and controls around financial management, including losses, special payments and financial assurance.
- Audit Reports and follow up actions. The Committee has continued to reinforce the importance of management follow up and further work is needed to ensure that this is robust.

Significant internal control issue/s identified as part of the Audit Committee's work relating to workforce controls and estate and statutory compliance are described in the Annual Governance Statement at pXX.

Financial assurance - significant issues considered by the Audit Committee during 2020/21

The Committee discussed a number of significant accounting issues for the year ended 31 March 2021. These included the following matters:

- Revenue recognition.
- Management override of controls.
- Valuation of land and buildings.
- Going Concern.
- Impact of COVID-19.
- Payroll and workforce controls.
- Holiday pay accrual.

The majority of the audit risks are inherent to most reporting organisations and the Committee was content that these matters would not have an adverse impact in relation to audit work on the 2020/21 financial statements.

Going concern was discussed at the meetings in January and April 2021 and updated guidance from NHSEI was considered. Guidance from NHSEI confirmed that while all NHS bodies are required to document their basis for adopting the going concern basis, the assessment should solely be based on the anticipated future provision of services in the public sector meaning that it would be highly unlikely that NHS organisations would have any material uncertainties over going concern to disclose, although this would still be subject to sufficient and appropriate audit procedures by external audit.

In addition, the Committee critically assessed the appropriateness of the accounting policies adopted and were satisfied that the policies were reasonable and appropriate.

The Trust's land and buildings (including dwellings) are valued at £134m as at 31 March 2021, representing a significant balance on the Statement of Financial Position. As discussed in Note 1 to the accounts, valuation is an area of critical judgement and estimation uncertainty. The Audit

Committee has discussed and approved the Trust's annual cycle of revaluation (with full revaluation every 5 years the last one taking place as at 31 March 2019.

Internal Audits

Throughout the year the Committee has worked effectively with internal audit to ensure the design and operation of the Trust's internal control processes are sufficiently robust. A summary of the internal audits and the assurances provided are included within the Annual Governance Statement.

A number of internal audits were undertaken during the year including a review of financial systems, integrity and reporting. This review generated a *substantial* assurance opinion, defined as "a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently", providing the committee with assurance as to the figures for the year that have been included within the financial statements.

Compliance

The Audit Committee has reviewed compliance against the Provider Licence and each licence provision to identify any new or emerging licencing risks.

Internal Audit Services

Internal audit was provided by Mersey Internal Audit Agency (MIAA) during 2020/21. The main purpose of the internal audit is:

- To provide an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives; and
- The provision of an independent and objective consultancy service specifically to assist the Trust's management to improve the organisation's risk management, control and governance arrangements.

The service is based on a risk-assessed audit plan, which is approved by the Audit Committee. The plan is delivered by appropriately qualified and trained auditors led by a nominated Audit Manager.

The 2020/21 Internal Audit Plan was delivered in accordance with the schedule agreed with the Audit Committee at the start of the financial year, including approved plan variations reflecting the significant impact of the pandemic. The total cost for the service during 2020/21 was £110k.

Anti-Fraud and Corruption

Anti-fraud services are provided by MIAA. The Anti-Fraud Specialist regularly attends the Committee to update on proactive anti-fraud work, ongoing cases and progress against the work plan agreed by the Audit Committee.

The Anti-Fraud Services Annual Report for 2020/1 was considered by the Audit Committee in April 2021. The Audit Committee noted the assurance provided by the outcomes of the self-assessment

against the Standards for Providers issued by the NHS Counter Fraud Authority with just one of the 23 standards amber-rated, 20 green and two neutral. The standard rated as amber related to the embeddedness of the Trust's arrangements in relation to code of conduct for declaring interests and this remains an area of continued focus.

External Audit

External Audit services were provided by Grant Thornton UK LLP for 2019/20. Azets Audit Services were appointed by the Council of Governors for three years from 2020/21 with the option to extend for a further two-year period. The total fees for the 2020/21 annual audit were £128k excluding irrecoverable VAT.

The external audit providers did not undertake any non-audit work during the 2020/21 reporting period

Quality Governance

The Board is committed to quality governance and ensures that the combination of structures at Board level and below supports the delivery of quality throughout the Trust. Trust has a quality governance and assurance structure which has been formally approved by the Board of Directors. The Quality Committee monitors performance in quality and patient experience. It also monitors compliance with CQC standards.

All methods of feedback including incidents, complaints, claims and formal reviews are analysed to ensure that lessons are learnt.

Further assurance of our quality systems and processes has been gained from internal assessments and external reviews. The Trust will produce a Quality Account, led by the Chief Nurse, which includes quality objectives set to improve patient safety, experience and outcomes. This will be published on 30 June 2021.

NHS Improvement's Well-led Framework

The NHSI Well-Led Framework provides a structure for trusts to assess their arrangements for effective leadership and governance.

An inspection was undertaken by the CQC in October/November 2019 which resulted in a rating of 'requires improvement' for the Well-led element which was an improvement from the previous inspection in 2018. Areas for improvement included updating the Trust strategy, cultural development and strengthening engagement with the public, which is detailed in the Performance Report (pp XX, the Code of Governance (pp Xx) and the Annual Governance Statement (pp Xx). Following the publication of the CQC inspection report on 31 March 2020, the Trust has made significant progress in both the response to requirements and recommendations made with quarterly updates provided to the Board. Key improvements already made include arrangements to increase visibility and accessibility of senior leaders, launch of our new Trust Strategy, cultural change programmes and work to strengthen engagement with our community.

As reported in last year's Annual Report we had intended to complete a comprehensive self-assessment against all elements of the well led framework by September 2020 with the outcomes to be consolidated with the CQC inspection findings to form a comprehensive development plan. However, this was deferred owing to the pandemic and we intend to undertake the self- assessment by September 2021. We will then commission an external review to test and validate self-assessment outcomes.

Council of Governors

Role and Composition

The Council of Governors has responsibility for representing the interests of our members and partner organisations. A principal role of the Council of Governors is to hold non-executive directors, individually and collectively to account for the performance of the Board of Directors.

The Council of Governors comprises:

- 13 public governor seats
- 5 staff governor seats
- 4 seats assigned to nominated partner organisations.

Our governors are appointed for a three-year term and may serve up to a maximum of nine years if they are re-elected / re-appointed and they continue to :-

- reside in the area of their constituency (public governors).
- be in employment at the Trust (staff governors).
- be nominated by the organisation they represent (appointed governors).

Governor Elections

Civica Election Services manages the elections on behalf of the Trust. One round of elections took place in 2020/21 in accordance with the model election rules. Elections took place in four public constituencies (one unopposed) and one staff constituency (unopposed). We are delighted to welcome both new governors and those who have been re-elected. We currently have vacancies in three public constituencies and one staff constituency which we will run elections for in 202.

Governor attendance at Council of Governor Meetings 2020/21

The following tables list the governors who have served as a governor during 2020/21, their term of office and attendance at Council of Governors meetings. Four meetings of the Council of Governors were held in 2020/21.

Public Governor (Elected)	First Elected	Current Term Expires	Meeting Attendance 2020/21
Bidston & Claughton			
Rohit Warikoo	February 2015	September 2021	0 of 4
Birkenhead, Tranmere & Rock Ferry			
Frieda Rimmer	November 2016	September 2022	3 of 4
Bromborough & Eastham			

Public Governor (Elected)	First Elected	Current Term Expires	Meeting Attendance 2020/21
Steve Evans	September 2014	September 2023	3 of 4
Greasby, Frankby, Irby, Upton & Woodchurch			
Eileen Hume	September 2015	September 2021	4 of 4
Leasowe, Moreton, & Saughall Massie			
Allen Peters	September 2018	September 2021	4 of 4
Neston, Little Neston, Parkgate, Riverside, Burton, Ness, Willaston & Thornton			
Ian Linford	September2017	September 2020	3 of 3
Alison Owens	December 2020	September 2023	1 of 1
New Brighton & Wallasey			
Sheila Hillhouse	September 2017	September 2023	3 of 4
North West & North Wales			
Angela Tindall (Lead Governor)	February 2015	September 2021	4 of 4
Oxton & Prenton			
Paul Dixon	September 2018	September 2021	3 of 4
West Wirral			
John Fry	September 2017	September 2020	3 of 3
Heswall, Pensby & Thingwall			
Robert Thompson	December 2020	September 2023	1 of 1
Staff Governor (Elected)	**First Elected**	**Current Term Expires**	**Meeting Attendance 2020/21**
Medical Practitioners & Dentists			
Richard Latten	February 2018	September 2021	4 of 4
Nurses & Midwifes			
Pauline West	September 2018	September 2021	2 of 4
Ann Taylor	September 2018	September 2021	1 of 4
Other Trust Staff			
Norman Robinson	September 2013	September 2020	0 of 3
Philippa Boston	December 2020	September 2023	1 of 1

Stakeholder Governor (appointed)	First Appointed	Current Term Expires	Organisation	Meeting Attendance 2020/21
Mandy Duncan	Dec 2011	September 2020	Wirral Third Sector Assembly	1 of 4

Public Governor (Elected)	First Elected		Current Term Expires	Meeting Attendance 2020/21
Mike Collins	May 2019	September 2022	Wirral Metropolitan Borough Council	2 of 4
Irene Williams	May 2019	September 2022	Wirral Metropolitan Borough Council	0 of 4

***Note:** a meeting planned for April 2020 was stood down due to COVID-19, in line with national guidance.

Board Member Attendance at Council of Governor Meetings 2020/21

Name	Role	Meeting attendance actual / possible
Sir David Henshaw	Chair	4/4
John Coakley	Non-Executive Director	0/3
Steve Igoe	Non-Executive Director/ Senior Independent Director	2/4
Sue Lorimer	Non-Executive Director	3/4
Jayne Coulson	Non-Executive Director	1/4
John Sullivan	Non-Executive Director/ Deputy Chair	3/4
Chris Clarkson	Non-Executive Director	3/4
Steve Ryan (from Jan ’21)	Non-Executive Director	0/0
Janelle Holmes	Chief Executive	4/4
Anthony Middleton	Chief Operating Officer	3/4
Helen Marks (until Jun ’20)	Director of Workforce	0/1
Nicola Stevenson	Medical Director	3/4
Matthew Swanborough	Director of Strategy & Partnership	3/4
Hazel Richards	Chief Nurse	3/4
Claire Wilson	Chief Finance Officer	3/4
Jacqui Grice (from July ’20)	Director of Workforce	3/3

Strengthening the links between the Governors and the Board

The Chair has ensured that the Board of Directors and Council of Governors work effectively together through the provision of timely and appropriate information and attendance of Board members at Council of Governors’ meetings. Opportunities for governors to meet with Board members have been impacted by the pandemic but as restrictions are lifted these will be re-introduced.

Non-executive directors are also invited to public events where they can meet members, such as the Annual Members’ Meeting. Each of the Board’s assurance committees has a public governor in attendance and all governors are invited to observe the Board of Directors’ meetings.

Members of the Board attend the meetings of the Council of Governors in order to present information and respond to questions raised by governors. The non-executive directors who chair

Board committees present an overview of the work of their committee to Governors on a rotational basis enabling the Council of Governors to discharge their responsibility to hold the non-executives to account for the performance of the Board.

Governors were engaged in developing the Trust's Strategy 2021-2026 with the draft Strategy presented to the Council of Governors and their views sought.

Strengthening excellent relationships with governors and members

The Trust considers the views of the Council of Governors to be invaluable in representing the local population and helping ensure that the views of our patients are reflected in our decision-making.

During 2020/21 opportunity to hold the workshops with governors has been limited due to the pandemic. The programme of workshops will be refreshed during 2021/22 as restrictions are lifted.

As part of the induction programme for new governors we provided an online e-learner module. This was extended to include existing governors as we thought it would provide a timely re-fresh and a useful reference point. The induction session incorporated an overview of the statutory role of governors and how the Trust works with governors to fulfil their statutory role.

The Trust will work with the governors during 2021/22 to re-introduce arrangements including the Membership & Engagement Committee to support the Council of Governors in the discharge of their statutory functions.

Members of the Trust

Our members play a vital role in influencing the way we serve our local communities and we are committed to ensuring that our membership is representative of the population we serve. We currently have 8498 public members and 6474 staff members.

Members support the Trust in a variety of ways, including:

- voting in governor elections
- acting as a yardstick of public opinion about our plans
- volunteering.

We are committed to ensuring that our membership is representative of the population we serve. The Trust welcomes members from the age of 11 and they are eligible to stand in an election to become a governor from the age of 16.

The public constituency divided into 13 geographical areas which are included in the table above.

Our staff membership is open to anyone employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or has been continuously employed for at least 12 months. Staff members are automatically recruited and may 'opt out' on request, though to date, no members of staff have opted out of membership.

The classes within the staff constituency are as follows:

- Registered medical practitioners and registered dentists
- Registered nurses and registered midwives
- Other healthcare professional staff
- Other Trust staff.

Our Annual Members' Meeting took place on 28 October 2020 by digital link. The event was well attended and the presentations are available on the Trust website.

Membership Events | Wirral University Hospital NHS Foundation Trust (wuth.nhs.uk)

Membership Strategy

We believe that our membership makes a real contribution to improving the health of our communities. Our emphasis is to ensure good representation across our communities and encouraging an active and engaged membership. We intend to target recruitment activity towards under-represented groups within the communities we serve.

The Trust intends to develop an effective membership scheme as an integral part of its vision to be a leading provider of outstanding care. The Council of Governors has a critical role to play in developing a representative membership scheme with effective mechanisms for supporting engagement with governors and members. This work will be progressed in 2021/22.

Membership Profile

Membership size and movements		
Public constituency	**2019/20**	**2020/21**
At year start (1st April)	8,696	8,633
New members	80	12
Members leaving	143	147
At year end (31st March)	8,633	8,498
Staff constituency	**2019/20**	**2020/21**
At year start (1st April)	6187	6258
New members	735	949
Members leaving	664	749
At year end (31st March)	6258	6474

Any member who wishes to communicate with governors and / or directors should contact the Trust Secretary at:

Executives' Offices,
Wirral University Teaching Hospital NHS Foundation Trust,
Arrowe Park Hospital,
Arrowe Park Road,
Upton, Wirral,
CH49 5PE
☎ 0800 0121 356 or email WUTH.governors@nhs.net

There are no material inconsistencies between the Annual Governance Statement, the Corporate Governance Statement, the Annual Report and reports arising from CQC planned and responsive reviews of the Trust and any consequent action plans developed by the Trust.

HM Treasury cost allocation and charging guidance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Policy on the payment of suppliers

It is the Trust's policy to follow the Better Payment Practice Code (BPPC), which gives NHS organisations a target of paying 95% of invoices within 30 calendar days of the receipt of either goods or a valid invoice (whichever is later), unless other payment terms have been agreed.

	2020/21		2019/20	
	Number	£000	Number	£000
Non-NHS				
Trade invoices paid in the period	74,366	228,230	83,427	218,893
Trade invoices paid within target	67,025	213,351	68,573	181,013
Percentage of trade invoices paid within target	90.1%	93.5%	82.2%	82.7%
NHS				
Trade invoices paid in the period	3,267	43,234	3,378	41,949
Trade invoices paid within target	2,261	38,303	2,006	33,646
Percentage of trade invoices paid within target	69.2%	88.6%	59.4%	80.2%

During the COVID 19 pandemic in organisations were encouraged to pay suppliers promptly in order to assist with cash flows and to facilitate the continuous supply chain. This was made possible by receiving the majority of our income in block payments on a monthly basis. Whilst this was a contributing factor to the improved BPPC figures during the year, it was also a joint effort between the finance department and clinical divisions to ensure the "No PO, no Pay" policy was adhered to. BPPC will continue to be a focus of attention in 2021/22.

There were no payments of interest in 2020/21 (one in 2019/20) under the Late Payment of Commercial Debts (Interest) Act 1998, as disclosed in Note 11.2 to the accounts. The payment value in 2019/20 was £1,455.

Political donations

The Trust did not receive any political donations during the reporting period or in the previous financial year.

Fees and charges (income generation)

During the year, the Trust received income in relation to fees charged for car parking and catering, against which costs were incurred, and the full cost exceeded £1 million.

Totals relating to these arrangements are disclosed in the table (below).

	2020/21 £000	2019/20 £000
Income	937	3,148
Full Cost	(1,899)	(3,140)
Surplus/(Deficit)	(962)	8

The figures above represent income and cost from car parking and catering operations within the trust. In line with all Trusts car parking charges were suspended as a result of the pandemic for most of the financial year. In addition, the reduction in visitor numbers onto our hospital sites resulted in a loss of income in our refreshment outlets.

Income for the purposes of the health service in England

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England (principal) must be greater than its income from the provision of goods and services for any other purposes (non-principal). The Trust has met this statutory requirement. Non-principal income is used to provide additional funding for the Trust. It is directly reinvested in the delivery of high-quality NHS services.

Statement of disclosure to auditors

Each of the Trust Directors (excluding those who have resigned during the financial year):

- is not aware of any relevant audit information of which the Trust's auditors are unaware
- has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

Janelle Holmes
Chief Executive **Date: June 2021**

Remuneration Report

This report to stakeholders:

- Sets out the Trust's remuneration policy
- Explains the policy under which the chair, executive directors and non-executive directors were remunerated for the period 1 April 2020 to 31 March 2021.
- Sets out tables of information showing details of the salary and pension interest of all directors for the financial period 1 April 2020 to 31 March 2021.

Senior Managers' Remuneration Policy

The Remuneration & Appointments Committee is a statutory committee of the Board of Directors. Membership of the committee comprises the Chair and all non-executive directors.

Salaries for all directors are considered carefully on appointment and approved by the Remuneration & Appointments Committee. Steps are taken to ensure that remuneration is commensurate with an individual's experience and with reference to benchmarking data. The aim is to remunerate senior managers at a level sufficient to attract and retain whilst avoiding excessive payments.

Members of the Remuneration & Appointments Committee have no financial interest in the matters to be decided. The Chief Executive, Director of Workforce and the Associate Director of Corporate Affairs normally attend meetings except where their own salaries or performance were discussed. The Committee met on five occasions during the year to consider:

- the establishment of a Deputy Chief Executive role. An additional responsibility payment of £10000 was agreed.
- the recruitment arrangements for the Director of Workforce and Chief Nurse.
- changes to the Executive Team portfolios, to strengthen operational performance and the delivery of key work programmes during the COVID-19 pandemic.
- Chief Executive and Executive Directors' objectives for the forthcoming year.
- the cost-of-living uplift for Executive Directors and those staff not covered under agenda for change, which was approved in line with NHS Improvement guidance for Very Senior Managers.
- Approved increased remuneration for the Director of Strategy and Partnerships, reflecting additional responsibilities.

The Trust had two senior managers whose salary was above the threshold of £150,000. In determining the salary levels, the Trust has taken into account the market rates for equivalent roles, its ability to secure the skills it required and the risks posed in not recruiting into these positions.

Attendance at Remuneration and Appointments Committee Meetings in 2020/21

	Meeting Attendance Actual / Possible
Sir David Henshaw, Chair	5/5
John Coakley (until Dec 2020)	3/4
Sue Lorimer	5/5
John Sullivan	5/5
Chris Clarkson	5/5
Jayne Coulson	4/5
Steve Igoe	4/5
Steve Ryan (from Jan 2021)	1/1

Council of Governors' Nomination & Remuneration Committee

Under the Trust's Constitution it is the responsibility of the Council of Governors to appoint and remove the Chair and the non – executive directors of the Trust and to determine their remuneration. The Council of Governors' Nomination and Remuneration Committee are responsible for making recommendations to the Council of Governors for appointment. Removal of the Chair or a non-executive director requires the approval of three quarters of the members of the Council of Governors voting in person at the meeting.

The Committee met twice during the year. The first meeting was to establish the recruitment process for a clinical non-executive director. The second meeting was to review the Chair and non-executive director appraisals, consider and recommend the re-appointment of three non-executive directors and consider the option to recruit an associate non-executive director supporting the Trust's succession planning and further strengthening the skills at the Board. The recruitment would also provide an opportunity to encourage candidates from within the Black, Asian and Minority Ethnic (BAME) community.

The recruitment process for the clinical non-executive director took place in December 2020. The process included a stakeholder panel discussion followed by an interview consisting of members of the Nomination & Remuneration Committee, who were supported by an experienced Chair from a neighbouring Trust who acted as an expert adviser.

Nomination & Remuneration Committee Membership & Attendance 2020/21

Name	Role	Meetings attended

Sir David Henshaw	Chair	2/2
Steve Igoe	Senior Independent Director	2/2
Steve Evans	Public Governor	2/2
Richard Latten	Staff Governor	2/2
Angela Tindall	Lead Governor (Public)	2/2
Frieda Rimmer	Public Governor	1/2

Directors' and governors' expenses

Expenses paid to directors and governors include all business expenses arising from the normal course of business of the Trust and are paid in accordance with Trust policy. The total amount of expenses reimbursed to eight directors during the year was £2563 (eight directors reimbursed £8059 in 2019/20). In 2020/21 17 directors and non-executive directors held office (17 in 2019/20).

The total amount of expenses reimbursed to two governors during the year was £115 (three governors were reimbursed £679 in 2019/20). In 2020/21, 18 governors were in office (19 in 2019/20).

Remuneration disclosures which are subject to audit

The following disclosures up to and including *Hutton review of fair pay* are subject to audit.

Salaries and benefits of senior managers (continued)

	2019/20				2018/19			
	Salary & fees (in bands of £5,000) £000	**Taxable benefits** (to the nearest £100) £	**Pension-related benefits** (in bands of £2,500) £000	**Total** (in bands of £5,000) £000	**Salary & fees** (in bands of £5,000) £000	**Taxable benefits** (to the nearest £100) £	**Pension-related benefits** (in bands of £2,500) £000	**Total** (in bands of £5,000) £000
Dr Mark Lipton Acting Medical Director (from June 2018 to October 2018)	n/a	n/a	n/a	n/a	70 - 75	0	n/a	70 - 75
Dr Susan Gilby Medical Director (to May 2018)	n/a	n/a	n/a	n/a	30 - 35	700	35 - 37.5	65 - 70
Carole Self Director of Corporate Affairs (to May 2018)	n/a	n/a	n/a	n/a	60 - 65	700	0	60 - 65
Terry Whalley Director of Strategy (to May 2018)	n/a	n/a	n/a	n/a	15 - 20	0	52.5 - 55	70 - 75
Natalia Armes Director of Transformation and Partnerships (from September 2018 to February 2019)	n/a	n/a	n/a	n/a	40 - 45	0	n/a	40 - 45
Sir David Henshaw Chairman (from March 2018)	45 - 50	0	n/a	45 - 50	60 - 65	0	n/a	60 - 65
John Coakley OBE Non-Executive Director	10 - 15	0	n/a	10 - 15	10 - 15	0	n/a	10 - 15
Christopher Clarkson Non-Executive Director (from July 2018)	10 - 15	0	n/a	10 - 15	10 - 15	0	n/a	10 - 15
Jayne Coulson Non-Executive Director (from July 2018)	10 - 15	0	n/a	10 - 15	10 - 15	0	n/a	10 - 15
Steve Igoe Non-Executive Director (from October 2018)	15 - 20	0	n/a	15 - 20	5 - 10	0	n/a	5 - 10
Susan Lorimer Non-Executive Director	10 - 15	0	n/a	10 - 15	10 - 15	0	n/a	10 - 15
John Sullivan Non-Executive Director	15 - 20	0	n/a	15 - 20	15 - 20	0	n/a	15 - 20
Graham Hollick Non-Executive Director (to November 2018)	n/a	n/a	n/a	n/a	5 - 10	0	n/a	5 - 10

[1] This officer was no longer deemed to be a 'senior manager' beyond the stated dates. They remained employed by the Trust thereafter, and they were employed by the Trust as at 31 March 2020.

[2] This officer was no longer deemed to be a 'senior manager' beyond the stated dates. They remained employed by the Trust thereafter, but they were not employed by the Trust as at 31 March 2020.

[3] This officer opted out of the pension scheme in February 2018. They made no contributions to the scheme in 2018/19 or 2019/20.

	2020/21				2019/20			
	Salary & fees (in bands of £5,000) £000	**Taxable benefits** (to the nearest £100) £	**Pension-related benefits** (in bands of £2,500) £000	**Total** (in bands of £5,000) £000	**Salary & fees** (in bands of £5,000) £000	**Taxable benefits** (to the nearest £100) £	**Pension-related benefits** (in bands of £2,500) £000	**Total** (in bands of £5,000) £000
Janelle Holmes Chief Executive	175 - 180	5,500	47.5 - 50	230 - 235	175 -180	4,600	37.5 - 40	215 - 220
Dr Nicola Stevenson [5] Medical Director (from October 2018)	200 - 205	0	105 - 107.5	305 - 310	190 - 195	0	270 - 272.5	460 - 465
Hazel Richards Chief Nurse (from January 2020)	125 - 130	4,000	117.5 - 120	245 - 250	30 - 35	1,000	12.5 - 15	45 - 50
Gaynor Westray [2] Director of Nursing and Midwifery (to July 2019)	n/a	n/a	n/a	n/a	30 - 35	1,200	0	30 - 35
Claire Wilson Chief Finance Officer (from January 2020)	135 - 140	4,000	0	140 - 145	30 - 35	1,000	0	35 - 40
Karen Edge [1] Acting Director of Finance (to December 2019)	n/a	n/a	n/a	n/a	80 - 85	0	40 - 42.5	120 - 125
Anthony Middleton Chief Operating Officer	130 - 135	4,000	40 - 42.5	175 - 180	130 - 135	4,000	42.5 - 45	180 - 185
Helen Marks [3] Executive Director of Workforce (to June 2020)	35 - 40	5,000	n/a	40 - 45	125 - 130	11,100	n/a	135 - 140
Jacqui Grice Executive Director of Workforce (from Sept 2020)	60 - 65	0	0	60 - 65	n/a	n/a	n/a	n/a
Paul Moore [4] Director of Governance & Quality Improvement (to July 2019) Acting Chief Nurse and Director of Governance & Quality Improvement (from July 2019 to December 2020) Director of Governance & Quality Improvement (to July 2020)	30 - 35	0	0 - 2.5	30 - 35	115 - 120	0	22.5 - 25	140 - 145
Matthew Swanborough Director of Strategy and Partnership (from November 2019)	120 - 125	4,000	30 - 32.5	155 - 160	45 - 50	1,600	7.5 - 10	55 - 60
Sir David Henshaw Chairman (from March 2018)	45 - 50	0	n/a	45 - 50	45 - 50	0	n/a	45 - 50
John Coakley OBE Non-Executive Director (to Dec 2020)	10 - 15	0	n/a	10 - 15	10 - 15	0	n/a	10 - 15
Christopher Clarkson Non-Executive Director (from July 2018)	10 - 15	0	n/a	10 - 15	10 - 15	0	n/a	10 - 15
Jayne Coulson Non-Executive Director (from July 2018)	10 - 15	0	n/a	10 - 15	10 - 15	0	n/a	10 - 15
Steve Igoe Non-Executive Director (from October 2018)	15 - 20	0	n/a	15 - 20	15 - 20	0	n/a	15 - 20
Susan Lorimer Non-Executive Director	10 - 15	0	n/a	10 - 15	10 - 15	0	n/a	10 - 15
John Sullivan Non-Executive Director	15 - 20	0	n/a	15 - 20	15 - 20	0	n/a	15 - 20
Steve Ryan Non-Executive Director (from Jan 2021)	0 - 5	n/a	n/a	0 - 5	n/a	n/a	n/a	n/a

[1] Prior year figures only, this officer is no longer employed by the Trust

[2] Prior year figures only, this officer is no longer employed by the Trust

[3] This officer opted out of the pension scheme in February 2018 and this officer is no longer employed by the Trust.

[4] This officer is no longer employed by the Trust.

[5] The element of the Medical Director's remuneration above includes both remuneration for their management role as Medical Director, and remuneration for their clinical role as a Consultant Respiratory Physician. The element included which relates to their clinical role is in the range £105k - £110k

Unless otherwise indicated, all of the listed senior managers were in post for the twelve-month period to 31 March 2021. The tables include remuneration only for the period during which each individual was deemed to be a senior manager and includes remuneration for duties that are not specifically part of the senior management role.

The element of the Medical Director's remuneration above includes both remuneration for their management role as Medical Director, and remuneration for their clinical role as a consultant respiratory physician. The element included which relates to their clinical role is in the range £105k - £110k.

Taxable benefits relate to a vehicle scheme which forms part of some executives' remuneration. No annual performance-related bonuses or long-term performance-related bonuses were paid during the period.

Pension-related benefits represent the value of pension benefits accrued during the year and are calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table below provides further information on the pension benefits accruing to the individual.

Pension benefits of senior managers

	2020/21							2019/20						
	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash equivalent transfer value (CETV) at 1 April 2020 (to the nearest £1,000) £000	Real increase in CETV (to the nearest £1,000) £000	CETV at 31 March 2021 (to the nearest £1,000) £000	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2020 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £000	Cash equivalent transfer value (CETV) at 1 April 2019 (to the nearest £1,000) £000	Real increase in CETV (to the nearest £1,000) £000	CETV at 31 March 2020 (to the nearest £1,000) £000
Janelle Holmes Chief Executive	2.5 - 5	0 - 2.5	55 - 60	155 - 160	1,052	49	1,144	2.5 - 5	0	50 - 55	150 -155	946	58	1,052
Dr Nicola Stevenson Medical Director	5 - 7.5	7.5 - 10	60 - 65	140 - 145	1,013	91	1,158	12.5 - 15	30 - 32.5	55 - 60	130 - 135	755	226	1,034
Hazel Richards Chief Nurse (From January 2020)	5 - 7.5	10 - 12.5	50 - 55	120 - 125	816	104	953	0 - 2.5	0 - 2.5	45 - 50	105 - 110	735	11	816
Gaynor Westray Director of Nursing and Midwifery (to July 2019)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0 - 2.5	0 - 2.5	45 - 50	140 - 145	955	2	1,001
Claire Wilson [4] Chief Finance Officer (from January 2020)	n/a	n/a	n/a	n/a	521	n/a	n/a	0	0 - 2.5	30 - 35	75 - 80	510	0	521
Karen Edge [1] Acting Director of Finance (to January 2020)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0 - 2.5	2.5 - 5	20 - 25	35 - 40	333	35	402
Anthony Middleton Chief Operating Officer	2.5 - 5	0 - 2.5	55 - 60	130 - 135	972	41	1,049	2.5 - 5	0 - 2.5	55 - 60	130 - 135	890	42	972
Helen Marks [2] Executive Director of Workforce (to June 20)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jacqui Grice Executive Director of Workforce (from September 20)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Paul Moore [3] Director of Governance & Quality Improvement (to July 2019) Acting Chief Nurse and Director of Governance & Quality Improvement (from July 2019 to December 2020) Director of Governance & Quality Improvement (from January 2020)	0 - 2.5	0	40 - 45	100 - 105	734	4	777	0 - 2.5	0	40 - 45	100 - 105	553	153	734
Matthew Swanborough Director of Strategy and Partnerships (from November 2019)	0 - 2.5	0	10 - 15	0	85	7	112	0 - 2.5	0	5 - 10	0 - 5	64	1	85

1 Prior year figures only, this officer is no longer employed by the Trust

2 This officer opted out of the pensions scheme in February 2018 and this officer is no longer employed by the Trust.

3 This officer was not employed by the Trust as at 31 March 2021.

4 This officer no longer contributes to the scheme, NHS Business Services were unable to provide us with CETV for this year

Non-executive Directors do not receive pensionable remuneration. Other directors disclosed in the *Salaries and benefits* table, who do not appear in the *Pensions benefits* table, are not in receipt of workplace pension benefits. All pension benefits relate to the NHS Pension Scheme.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to pension benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement. During the year, the Government announced that public sector pension schemes will be required to provide indexation on the Guaranteed Minimum Pension element of the pension. NHS Pensions has updated the methodology used to calculate CETV values as at 31 March 2020. The impact of the change in methodology is included within the reported real increase in CETV for the year.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Hutton review of fair pay

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 this context, the median is defined as the total remuneration of the staff member who lies in the middle of the linear distribution of staff, excluding the highest paid director. The highest paid director is, at 31 March, a 'senior manager' as defined previously in this *Remuneration report.*

The banded remuneration of the Trust's highest paid director (Medical Director) in the financial year 2020/21 was £200k to £205k (2019/20 £190k to £195k). This was 6.7 times (2019/20 6.9 times) the median remuneration of the workforce, which was £28,034 (2019/20 £27,198).

In 2020/21 23 employees received remuneration in excess of the highest paid director (2019/20 14 employees). Their remuneration in 2020/21 ranged from £203k to £433k (2019/20 £237k to £395k). In both years, these employees were all medical staff and the pay figures do not reflect actual paid salary, but rather, the calculated annualised, full-time equivalent salary as described below.

Total remuneration includes salary, non-consolidated performance-related pay if applicable and benefits-in-kind. It does not include severance payments, employer pension contributions or the

cash equivalent transfer value of pensions. As in previous years, temporary agency staff have been excluded from the calculations. The calculation methodology is kept the same so that the 2020/21 results are comparable with those in previous years.

In this *Fair pay* section, remuneration figures are based on the annualised, full time equivalent remuneration at 31 March, and they therefore may vary from *actual annual pay* per individual. In particular, the actual 2020/21 salary and taxable benefits of the senior manager who held the office of Medical Director as at 31 March 2020 is disclosed within the *Salaries and benefits* table of the *Remuneration report* as being higher than the banded remuneration within this disclosure, as their pay included an element of pay arrears relating to the prior year.

The year-on-year increase in the ratio is driven by the effect of an increase the highest paid director's pay band. Summary results are included in the table below.

	2020/21	**2019/20**
Band of highest paid director's remuneration (£000)	200 - 205	185 - 190
Median total (£)	28,034	27,198
Ratio	6.7	6.9

Janelle Holmes
Chief Executive **Date: June 2021**

STAFF REPORT

The Trust's Employees

The number of whole-time equivalents (WTE) employed by the Trust as at March 2021 was 5404.36 WTE and the total number of employees (headcount) were 6474. The following table provides a more detailed breakdown of our employees by WTE and headcount for 2020/21 (as at March 2021). This is broken down by the number of male and female employees and by staffing groups**.**

	Female		Male		Total WTE	Total Headcount
Staff Group	WTE	Headcount	WTE	Headcount		
Add Prof Scientific and Technic	176.43	194	57.65	62	234.08	256
Additional Clinical Services	942.24	1139	155.34	165	1097.58	1304
Administrative and Clerical	808.17	940	231.06	247	1039.23	1187
Allied Health Professionals	254.36	327	63.69	66	318.05	393
Estates and Ancillary	367.42	658	257.57	309	624.99	967
Healthcare Scientists	84.22	100	44.40	46	128.62	146
Medical and Dental	193.16	211	251.43	266	444.59	477
Nursing and Midwifery Registered	1354.65	1564	136.77	148	1491.41	1712
Students	25.80	32			25.80	32
Grand Total	**4206.46**	**5165**	**1197.90**	**1309**	**5404.36**	**6474**

Analysis by gender

	Female	Male	Total
Board of Directors	7	7	14
Other Senior Managers	233	80	313
Consultants	102	166	268
Other staff	4823	1056	5879

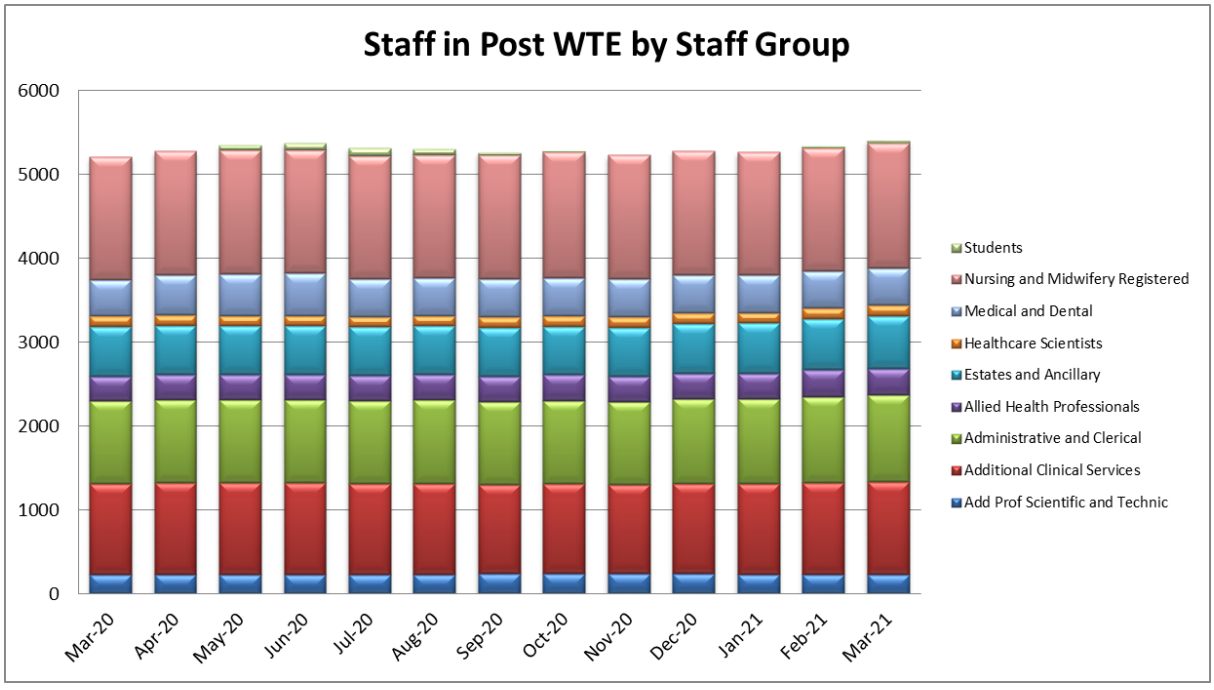
2020/21 Table

Employee category	Permanently employed	Other	2020/21 Total	Permanently employed	Other	2019/20 Total
Medical and dental	665	59	724	588	67	655
Administration & estates	926	197	1,123	1,040	35	1,075
Healthcare assistants and other support staff	1,851	113	1,964	1,657	160	1,817
Nursing, midwifery and health visiting staff	1,489	139	1,628	1,439	102	1,541
Scientific, therapeutic and technical staff	557	21	578	385	18	403
Healthcare science staff	130	3	133	251	8	259
Other	-	7	7	-	7	7
Total average staff numbers	5,618	539	6,157	5,360	397	5,757
of which						
Number of employees engaged on capital projects	7	-	7	27	-	27

The average number of employees is calculated as the whole-time equivalent number of employees under contract of service in each week of the financial year, divided by the number of weeks in the financial year. Staff on external secondment are not included in the table above.

The *Other* category (column) in the above table represents agency and contract staff and bank staff.

The *Other* category (row) in the above tables includes non-executive directors and engagements without a permanent employment contract, including agency / temporary staffing and inward secondments from other organisations.



The Trust has a total vacancy rate of 7.55%. For our nursing staff it is 9.69% and for our medical and dental workforce 6.36%. However, for consultant medical staff we have a vacancy rate of 4.85%. The Trust is committed to reducing vacancy rates with a focus on recruitment and retention initiatives.

Analysis of Staff Costs

	Permanently employed	Other	2020/21 Total	Permanently employed	Other	2018/19 Total
Salaries and wages	204,413	13,338	217,751	201,342	12,810	214,152
Social security costs	19,566	-	19,566	18,395	311	18,706
Apprenticeship levy	943	-	943	925	12	937
Employer's contributions to the NHS Pension Scheme	34,152	-	34,152	32,545	194	32,739
Employer's contributions to the National Employment Savings Scheme (NEST)	-	-	-	65	-	65
Bank and agency staff	-	27,559	27,559	-	7,774	7,774
Total pay costs	259,074	40,897	299,971	253,272	21,101	274,373

Other salaries and wages costs include payments to St Helens and Knowsley NHS Trust as the lead employer for our junior doctors and external bank staff.

Staff policies and actions applied during the financial year

The Trust's workforce policies and procedures are reviewed and updated on a regular basis. Of particular note is the refresh to the Managing Attendance Policy and supporting procedures in December 2020. In addition, a significant project to support an improvement in overall attendance has commenced, whilst acknowledging the impact of the pandemic, which has included a star chamber approach to review long term sickness absence cases. Workshops are taking place with key staff groups to improve morale and engagement to encourage culture change.

In addition, a review of Occupational Health services has been completed to ensure the service is resilient and offers a full suite of wellbeing and health surveillance and intervention services for staff and managers. This builds on the success of the fast-intervention service for musculo-skeletal conditions. Wellbeing support has been extended including management coaching, wellbeing hubs and quiet spaces for staff; debrief sessions to support staff psychological safety, together with psychological support on site and referral to specialised PTSD support for those staff members who require it.

The Respect at Work Group was temporarily suspended due to COVID-19 but is now being refreshed including a review of group membership and terms of reference in line with national learning and methodology relating to psychological safety and culture change.

The Trust is also due to undertake significant reviews of the Disciplinary and Grievance Policies. It is anticipated that the policies will be revised to reflect learning from work on the 'Just Culture' as well as the national review following the Amin Abdullah case.

The Trust continues to enjoy productive working relationships with all the recognised trades unions which we see as essential to the delivery of our ambition. Executive Directors and senior workforce colleagues meet the trade unions on a regular basis with a commitment to openness, transparency and co-operation.

Freedom to Speak Up (FTSU)

The Trust continues to work towards a culture where speaking up is regarded as usual to effect cultural change in line with recommendations and guidance from the National Guardian's Office (NGO).

The Director of Workforce is the Trust's executive lead for FTSU matters, along with Jayne Coulson, who is the non-executive lead.

The Trust continues to see increases in the number of staff speaking up with 157 raising concerns in 2020/21 as opposed to 106 people in 2019/20. This increase is seen as a positive and includes a wider range of occupational groups and across all divisions.

The Trust continues to see a reduction in the number of anonymous reports it has received, with only three received this year.

The Trust successfully recruited two additional FTSU guardians in 2020/21 and as a result, widened the demographic of support and access for staff.

The network of FTSU champions continues to grow, with 18 now in place. The FTSU champions promote the importance of speaking up locally, signposting people to key contacts and support, including FTSU guardians. The Trust will continue to grow and develop this network. The Trust also recognises the need to link with the diversity and inclusion agenda and to further encourage staff who share protected characteristics to speak up. Three BAME FTSU champions have been appointed and we have received reports from our BAME staff.

The Trust has recently identified further FTSU champions from its disability and LGBT+ (lesbian, gay, bisexual and transgender) staff networks, with further Trust-wide promotions to follow.

The Trust continues to record and monitor data on the number of people who have spoken up to FTSU guardians and the themes of their concerns. Regular reports are considered through the workforce governance structure and up to the Board of Directors.

The Trust has been proactive with the development and delivery of three levels of training to support the freedom to speak up. The Trust has successfully rolled out NGO e-learning level 1 for all staff ("Speak Up"). Almost 80% of staff have completed Speak Up training. We are now rolling out the new level 2 e-learning module "Listen up", for managers and supervisors. The Trust remains one of the few Trusts to have developed and delivered a level 3 programme locally for Board members and governors.

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The Trust continues to link with regional and national FTSU Guardians and NGO representatives to ensure consistency, best practice and support for FTSU guardians is in place.

Further reviews of the FTSU process, service and governance arrangements are underway to continue to strengthen arrangements.

Staff Turnover

Information on staff turnover is published by NHS Digital and available through the link below.

NHS workforce statistics - NHS Digital

2020 National Staff Survey

The NHS Staff Survey was undertaken between September and November 2020 with 2492 complete yielding a response rate of 41%. This reflects an improvement on last year's rate of 38% although we remain below the national response rate of 45%.

The results are benchmarked against comparisons to 61 acute or acute & community organisations in the NHS. comparable organisations as well as year on year changes for the Trust across ten themes. Two themes have scored significantly better than compared with other Trusts - Equality, Diversity and Inclusion and Safe Environment (Bullying and Harassment). Seven show no significant difference to the sector average whilst team working scores significantly below the sector average.

Two themes have scored significantly better for the Trust in the 2020 survey when compared to the previous year's survey. These are Safe Environment - Bullying and Harassment and Safe Environment – Violence). There are no significantly worse themes.

The themed score on health and wellbeing is consistent with the national average but lower than we would like. A specific question which related to the organisation taking positive action on health and wellbeing to support staff during the pandemic?' scored highly which may reflect the significant focus on staff wellbeing during the pandemic which will continue to be a priority.

Overall, the staff survey results indicate there has been little change since the last survey with the exception of improvements in the scores referenced above. Whilst we recognise there are improvements to be made, sustaining the level the Trust has during the pandemic and not declining on themes should be seen positively.

Theme/Question	2018 WUTH	2018 Benchmark	2019 WUTH	2019 Benchmark	2020 WUTH	2020 Benchmark
Equality, Diversity and Inclusion	9.2	9.1	9.2	9.0	9.3	9.1
Health and Wellbeing	5.6	5.9	5.7	5.9	6.0	6.1
Immediate Managers	6.4	6.7	6.7	6.8	6.6	6.8
Morale	5.9	6.0	6.1	6.1	6.1	6.2
Quality of Care	7.3	7.4	7.4	7.5	7.5	7.5
Safe environment – Bullying & harassment	7.7	7.9	7.8	7.9	8.1	8.1
Safe environment- violence	9.4	9.4	9.4	9.4	9.5	9.5
Safety Culture	6.3	6.7	6.5	6.7	6.6	6.8
Team-working	6.2	6.5	6.3	6.6	6.3	6.5
Staff Engagement Score	6.7	7.0	6.8	7.0	6.9	7.0
Recommendation to family and friends for work (From National Staff Survey)	55.2	62.3	60.4	62.5	62.1	66.9
Recommendation to family and friends for Care (From National Staff Survey)	65.7	71.2	67.9	70.5	72.1	74.3
Feeling secure raising concerns about unsafe clinical practice	64.8	69.3	67.8	70.4	67	71.8

The organisation has shared results through feedback sessions about what the Trust is doing to improve. A summary of key actions taken in response to the 2019 National Staff Survey and next

steps in response to the 2020 survey are shown below. A number of the actions taken are detailed elsewhere in the Annual Report.

- We continued to deliver on aims set out in the Diversity and Inclusion Strategy to strengthen our staff network groups including the re-launch of the BAME staff network. Some of our achievements are summarised on pXX.
- We delivered a refreshed Health and Wellbeing Plan with a strong focus on physical health, psychological support, environmental health and risk assessments for our staff. The focus placed on the health and wellbeing during COVID-19 will continue. We will ensure all staff have individual wellbeing conversations and introduce a wellbeing guardian.
- We will continue to invest in the development of leaders and managers to ensure we create stronger leadership and management skills as well as a talent pipeline throughout the Trust.
- Our staff were regularly recognised and appreciated during the pandemic by colleagues and by our local community and beyond for their unstinting service, we intend to introduce new recognition schemes in 2021 that underpin our core values so that our staff feel valued for what they do. We will focus on career structures, supporting education and development and showcasing best practice.
- The Trust continues to strengthen its systems for monitoring and improving safety; with new processes developed in response to the COVID 19 pandemic to ensure staff, patients and others were kept safe.
- The Trust will continue to strive to achieve an open and transparent culture which is described elsewhere within the Annual Report.
- The Trust actively encourages all staff to report any incidents and the work of the FTSU guardians and champions is described above The Trust operates a zero-tolerance approach to any form of bullying and harassment and Respect at Work training is in place for all staff.
- The Trust operates a zero-tolerance approach in relation to violence and aggression towards its staff. The incident reporting system records and monitors actions taken in relation to these incidents.
- We have introduced new approaches to strengthen communication and engagement with our employees to ensure that staff have opportunities to put forward suggestions and to have their views heard.

Trade Union Facility Time disclosure

Facility time is time off from an individual's job, granted by the employer, to enable a representative to carry out their trade union role. In some cases, this can mean that the Union Representative is fully seconded into a Union/Staff side role, from their regular job, enabling them to work full time on trade union tasks.

Facility time covers duties carried out for the trade union or as a health and safety representative or union learning representative. In most cases this means, for example, accompanying an employee to disciplinary or grievance hearings, attending partnership working group meetings, assisting with Job Matching and consistency checking procedures under Agenda for Change processes. It also covers training received and duties carried out under the Health and Safety at Work Act 1974.

In accordance with The Trade Union (Facility Time Publication Requirements) Regulations 2017 which took effect on 1 April 2017 the table below has been collated and represents the main staff facility time afforded at WUTH in the year. There may be very small additional ad hoc time that has also been granted which is not quantifiable.

Number of Employees who were relevant Union Officials during 2020/2021	**14**
Whole Time Equivalent number of employees	**5.0**
Percentage of full-time (i.e., 37.5 hrs per week spent on Union Duties: 100% 51-99% 20-50% Less than 20% 0%	 **2** **1** **7** **4**
Total cost of facility time at WUTH	**£130,515**
Percentage of total pay bill spent on Union facility time	0.04%

Sickness Absence

The Trust currently has a 93.48% attendance rate (6.52% sickness rate), over a rolling 12 month period. This has reduced from 94.05% (increased from 5.95%) in 2019/20.

National sickness absence data is published through NHS Digital and is available through the link provided below:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Expenditure on consultancy

Total expenditure on consultancy during 2020/21 was £0.7m (£0.4m 2019/20).

Off-payroll arrangements

The Trust is required to report on its highly paid and/or senior off-payroll engagements. The tables below meet the disclosure requirements.

Table 1: For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months.

Number of existing engagements as at 31 March 2021	21
Of which	
Number that have existed for less than one year at time of reporting	16
Number that have existed for between one year and two years at time of reporting	4
Number that have existed for between two years and three years at time of reporting	0
Number that have existed for between three years and four years at time of reporting	1
Number that have existed for between four or more years at time of reporting	0

The Trust has robust contractual agreements with agencies and intermediaries, through which it engages off-payment workers. These contracts confer an explicit obligation on the agencies to undertake an assessment and calculate and deduct tax.

Table 2: All new off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that lasted longer than six months.

Number of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	6
Of which	
Number assessed as within the scope of IR35	5
Number assessed as not within the scope of IR35	1
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payment engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the year	1
Number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year, including both off-payroll and on-payroll engagements	1

Exit packages

Foundation trusts are required to disclose summary information of staff exit packages which have been agreed in the year. This section is subject to audit.

Exit package cost band (including any special payment element)	2020/21 Number of complulsory redundancies Number	2020/21 Number of other departures agreed Number	2020/21 Total number of exit packages by cost band Number	2019/20 Number of complulsory redundancies Number	2019/20 Number of other departures agreed Number	2019/20 Total number of exit packages by cost band Number
< £10,000	-	23	**23**	-	29	**29**
£10,001 - £25,000	-	1	**1**	1	2	**3**
£25,001 - £50,000	-	-	**-**	-	3	**3**
£50,001 - £100,000	-	-	**-**	1	1	**2**
£100,001 - £150,000	-	-	**-**	1	-	**1**
Total number of exit packages	**-**	**24**	**24**	**3**	**35**	**38**
Total resource cost (£000)	**-**	**71**	**71**	**245**	**312**	**557**

There were no compulsory redundancies this year with three in 2019/20. In 2020/21, 12 of the departures were as a result of dismissal (11 cases 2019/20), and a further 6 were voluntary resignation (7 cases 2019/20). A further 6 cases comprised pay in lieu of notice relating to ill-health retirement (13 cases 2019/20). Ongoing costs related to ill-health retirements are met by NHS Pensions and are not included in this disclosure.

The following table details the number and value of non-compulsory exit packages agreed in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

	2020/21 Agreements Number	2020/21 Total value of agreements £000	2019/20 Agreements Number	2019/20 Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	2	68
Contractual payments in lieu of notice	-	-	1	60
Contractual payments in lieu of notice	24	71	33	148
Exit payments following employment tribunals or court orders	-	-	1	36
Non-contractual payments requiring HMT approval	-	-	-	-
Total average staff numbers	**24**	**71**	**37**	**312**

A single exit package can be made up of several components, each of which will be counted separately in the above table, whereas the first table details individual departures.

Non-contractual exit packages require HM Treasury pre-approval. No such payments were made in 2020/21.

Exit package cost band (including any special payment element)	2020/21 Number of complulsory redundancies Number	2020/21 Number of other departures agreed Number	2020/21 Total number of exit packages by cost band Number	2019/20 Number of complulsory redundancies Number	2019/20 Number of other departures agreed Number	2019/20 Total number of exit packages by cost band Number
< £10,000	-	23	**23**	-	29	**29**
£10,001 - £25,000	-	1	**1**	1	2	**3**
£25,001 - £50,000	-	-	**-**	-	3	**3**
£50,001 - £100,000	-	-	**-**	1	1	**2**
£100,001 - £150,000	-	-	**-**	1	-	**1**
Total number of exit packages	**-**	**24**	**24**	**3**	**35**	**38**
Total resource cost (£000)	**-**	**71**	**71**	**245**	**312**	**557**

Non-contractual exit packages require HM Treasury pre-approval. No such payments were made in 2020/21.

Gender Pay Gap

The Trust is required to publish data about its gender pay gap information on an annual basis. Data is based on a snapshot date of 31st March each year (for the public sector) and is based on six calculations as required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017:

The 2020 gender pay gap report continues to highlight an improvement in the overall mean gender pay gap between male and female colleagues, reducing from 21.6% in favour of males to 21.1%. The mean gender pay gap has increased marginally from 6.1% in favour of males to 6.2%. Whilst there is therefore still a gender pay gap, the results do continue to fall below the NHS national average of 23% and are continuing to reduce year on year.

The Trust continues to have higher levels of female colleagues (79.2% female and 20.8% male employees) across all pay quartiles. Whilst the lowest ratio of females however can be seen in the highest pay quartile, numbers have increased since reporting commenced in 2017.

2020 data identified a significant reduction in both median and mean bonus pay gaps from 37.5% to 19% (mean) and 19% to 13.5% (median).

Bonus pay gaps relate mainly to clinical excellence awards (CEA) and discretionary points and can be correlated to the number of male consultants who have additional service with the Trust and are therefore at higher levels of award. In line with national guidance and local agreements, due to the impact of COVID on the service, CEA's were distributed evenly to all eligible colleagues on the last round and not linked to an application process.

National changes to employer-based awards were also introduced, whereby awards will be subject to a review and awarded for a limited time period. It is therefore hoped that this may result in future improvements of the pay gap going forwards.

The Trust's gender pay gap report is available on the Diversity and Inclusion public section of the website.

NHS Foundation Trust Code of Governance Disclosures

NHS foundation trusts are required to provide a specific set of disclosures in their annual report to meet the requirements of the Code of Governance. Schedule A to the Code of Governance specifies everything that is required within these disclosures. Schedule A is divided into six categories:

1) statutory requirements of the Code of Governance but do not require disclosures

2) provisions which require a supporting explanation, even where the NHS foundation trust is compliant with the provision*

3) provisions which require supporting information to be made publicly available, even where the NHS foundation trust is compliant with the provision

4) provisions which require supporting information to be made to governors, even where the NHS foundation trust is compliant with the provision

5) provisions which require supporting information to be made to members, even where the NHS foundation trust is compliant with the provision and

6) other provisions where there are no special requirements as per 1-5 above and there is a "comply or explain" requirement. The disclosure should therefore contain an explanation in each case where the trust has departed from the Code of Governance, explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code of Governance (see pages 13-16 of that document).

* Where the information is already contained within the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

The information in the paragraph and table below only covers items falling into category 2 and category 6 above.

The requirements of parts 2 and 6 of schedule A to the Code of Governance are listed below. This table also includes requirements that are not part of the Code of Governance but are required by the FT ARM.

Wirral University Teaching Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The table below sets out the sections of the Code of Governance where the Trust is required to provide specific disclosures.

Part of schedule A (see above)	*Code of Governance* reference	Summary of requirement	Trust Response
2: Disclose	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	The Trust has a schedule of matters reserved for the Board which is contained within the Scheme of Reservation and Delegation. The Trust also has an approved Constitution which details the roles and responsibilities of the CoG and Codes of Conduct for Board members and the Council of Governors. The Trust's Constitution contains a general statement regarding handling of disputes between the CoG and the Board.
2: Disclose	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration[1] committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	This information is provided in the following sections: • Directors' report – page • Audit Committee report – page • Board of Directors pen portraits – page • Remuneration report – page
2: Disclose	A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual	Full details of Governors and their terms of appointment are included in the Accountability report within the Council of Governors section on page 49.

1 This requirement is also contained in paragraph 2.41 as part of the remuneration report requirements. The disclosure relating to the remuneration committee should only be made once.

		report should also identify the nominated lead governor.	
Additional requirement of FT ARM	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Details are included in the Council of Governors section from page 49.
2: Disclose	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Details are included in the Directors' Report.
2: Disclose	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Details are included in the Directors' Report.
Additional requirement of FT ARM	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Details are included in the Directors' Report.
2: Disclose	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Details are included in the Directors' Report and within Remuneration Report.
Additional requirement of FT ARM	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the	N/a

		appointment of a chair or non-executive director.	
2: Disclose	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise and included in the next annual report.	The Chair's commitments are detailed in the Directors' Report at pXX.
2: Disclose	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	It is the role of the governors to canvass opinion of Trust members on the Trust's forward plan. Details are contained in the Governors' section on pp Xx.
Additional requirement of FT ARM	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to	N/A

		propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	
2: Disclose	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Details of evaluation included in Directors' Report pXX.
2: Disclose	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	N/A
2: Disclose	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 2.95.	Included in Annual Report in following sections: Director's report Auditors report Annual Governance Statement
2: Disclose	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	The Trust's Annual Report contains a statement that the review of the effectiveness of its system of internal control has been undertaken. Contained in Annual Governance Statement

2: Disclose	C.2.2	A trust should disclose in the annual report: if it has an internal audit function, how the function is structured and what role it performs; or if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	The Trust's Annual Report discloses that the Trust has an internal audit function, its structure and its role. Contained in Audit Committee section o
2: Disclose	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	N/a
2: Disclose	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed. • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and	The Annual Report contains a separate section on the role of the Audit Committee

		• if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	
2: Disclose	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	N/A.
2: Disclose	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Details are included in the Annual Report in the Governors' section
2: Disclose	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Details of the Trust membership profile is contained in the Annual Report in the Membership section The Trust will develop a membership strategy in 2021/22 as an integral part of its vision to be a leading provider of outstanding care and review its effectiveness.
2: Disclose	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	The website and the Trust's annual report contains contact procedure for anyone who wishes to contact the Trust's Governors. Included within Annual Report within the Council of Governors section

Additional requirement of FT ARM	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership. • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Included within Annual Report within the Council of Governors section
Additional requirement of FT ARM (based on FReM requirement)	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.22 as directors' report requirement.	This information is provided within the Annual Report with a link to the Trust website.
6: Comply or explain	A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery	Performance, quality and finance management systems in place to measure and monitor the Trust's effectiveness, efficiency and economy and quality of its healthcare delivery and safeguard patient safety

			The Board reviews the Trust's performance at each of its meetings via the monthly Quality and Performance and Finance Reports. The Trust's resources are managed within the governance framework which includes the scheme of delegation and standing financial instructions. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources. The Trust has a well-established system for identifying and managing risk. Details are included in the Annual Governance Statement.
6: Comply or explain	A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance	The Board receives and reviews the Trust's Integrated Performance Report on a monthly basis. This contains relevant metrics, measures, milestones and accountabilities to understand and assess progress and delivery of performance.
6: Comply or explain	A.1.6	The board should report on its approach to clinical governance.	The Board is committed to quality governance and ensures that the combination of structures and processes at Board level and below supports quality performance throughout the Trust. Included in the Annual Report.
6: Comply or explain	A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHS Improvement (Monitor) for advising the board and the council	The CEO follows all relevant procedures.

		and for recording and submitting objections to decisions.	
6: Comply or explain	A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life	The Trust has an approved Constitution and has a Managing Conflicts of Interest Policy which references the Nolan Principles. Trust has established vision and values and expected underpinning behaviours following consultation with staff and range of stakeholders (on website).
6: Comply or explain	A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.	The Board of Directors has a Code of Conduct which is based on the Nolan Principles.
6: Comply or explain	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	The necessary insurance cover is provided by the Trust's subscription to NHS Resolution. Additional directors' and officers' insurance has been commissioned from a commercial insurance provider.
6: Comply or explain	A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	Included in the Directors' Report.
6: Comply or explain	A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.	The Trust has a Senior Independent Director.
6: Comply or explain	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.	The Chair holds informal meetings with the NEDs without executive directors present.

6: Comply or explain	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	Concerns are recorded in Board minutes.
6: Comply or explain	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.	The council met four times in 2020/21.
6: Comply or explain	A.5.2	The council of governors should not be so large as to be unwieldy.	The CoG has 22 members, which is comparable to other similar trusts.
6: Comply or explain	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.	This information is contained in the Trust's Constitution. Governors receive an Induction Pack providing information about their role.
6: Comply or explain	A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.	Details of board member attendance included in Council of Governors section.
6: Comply or explain	A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.	The policy is that the CoG would take their concerns to the senior independent director.
6: Comply or explain	A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective.	Board members regularly attend Council of Governors' meetings. The Associate Director of Corporate Affairs Governance acts as a conduit for the bi-directional flow of clear and unambiguous information.

6: Comply or explain	A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.	N/A
6: Comply or explain	A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties.	Governors receive reports to the CoG meeting summarising the work of the Board and its committees with Board members attending to present information and answer questions.
6: Comply or explain	B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	Details of Board members included in the Annual Report.
6: Comply or explain	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	No individuals are both a director and a governor of the NHS foundation trust.
6: Comply or explain	B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.	The Governors' Nominations Committee and the NEDs Remuneration Committee give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required within the board of directors to meet them.
6: Comply or explain	B.2.2	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence.	All Board members undertake an annual "fit and proper" person self-certification in order to confirm their compliance with the regulations.
6: Comply or explain	B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.	The Nominations Committees give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise

			required within the board of directors to meet them.
6: Comply or explain	B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).	The Trust's Chair is Chair of the Nomination & Remuneration Committees.
6: Comply or explain	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and nonexecutive directors.	The Nominations Committee and CoG have an agreed process for the nomination of a new Chair and other NEDs. Recommendations made by the Nominations Committee are considered for approval by the CoG.
6: Comply or explain	B.5.2	The board, and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	The board of directors are at liberty and encouraged to challenge assurances received from the executive management and may request and are provided with any additional relevant information or the assistance of external assurance.
6: Comply or explain	B.5.3	The board should ensure that directors, especially nonexecutive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.	All directors are aware that professional advice can be procured to support the delivery of their role. This is referenced in the Terms of Reference for the Board's committees.
6: Comply or explain	B.5.4	Committees should be provided with sufficient resources to undertake their duties.	Committees are structured and have annual work plans that are resourced. The Board of Directors and Council of Governors supported by the Associate Director of

			Corporate Affairs, Deputy Trust Secretary and PA team.
6: Comply or explain	B.6.3	The senior independent director should lead the performance evaluation of the chairperson.	The SID leads the performance evaluation of the Chair in accordance with Framework for conducting annual appraisals of NHS provider chairs issued by NHSI in November 2019.
6: Comply or explain	B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	The Chair uses the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members. The Board has agreed a collective development programme which will be progressed during 2021/22.
6: Comply or explain	B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	The Council periodically assesses its collective performance. This has not been undertaken in 2020/21 but will be undertaken in 2021/22. Work to strengthen communication and engagement with members to be progressed in 2021/22.
6: Comply or explain	B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	The Constitution sets out the arrangements for the removal of a Governor from the Council. (Annex 5)

6: Comply or explain	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	Executive directors who left in year, did so in accordance with their terms of contract of employment.
6: Comply or explain	C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. See also ARM paragraph 2.12.	Included in Annual Report
6: Comply or explain	C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	Included in the Annual Report and the annual operational plan required by NHS England.
6: Comply or explain	C.1.4	a) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery	Compliant. There has been nothing to report.

		performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition. • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.	
6: Comply or explain	C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.	The Trust has an appropriately constituted Audit Committee.
6: Comply or explain	C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.	Council of governors approved the appointment of external auditors from 2020/21 for a period of three years.
6: Comply or explain	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.	Azets Audit Services appointed for a period of 3 years with an option to extend for a further two years.
6: Comply or explain	C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should	N/A

		write to NHS Improvement informing it of the reasons behind the decision.	
6: Comply or explain	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	The Trust has robust policies and procedure in place which informs staff of how to raise a concern, how their concern would be dealt with and how they would be protected and supported. This includes the Freedom to Speak Up Policy and counter fraud arrangements. Regular updates are provided by the Freedom to Speak Up guardian to the Board of Directors.
6: Comply or explain	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	The Trust does not have a performance related payment policy for its executive directors.
6: Comply or explain	D.1.2	Levels of remuneration for the chairperson and other nonexecutive directors should reflect the time commitment and responsibilities of their roles.	Levels of remuneration for the chairperson and other non-executive directors reflect the time commitment and responsibilities of their roles and is in accordance with NHSEI framework to align remuneration for chairs and non-executive directors.
6: Comply or explain	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	The Remuneration Committee decides, and keeps under review, the terms and conditions of office of the Trust's Executive and Corporate Directors including pensions and compensation payments.
6: Comply or explain	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive	The Remuneration Committee has delegated responsibility for deciding and keep under review

		directors, including pension rights and any compensation payments.	the terms and conditions of office of the Trust's Executive Directors.
6: Comply or explain	D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	Plan in place for phased implementation of the NHSEI framework to align remuneration for chairs and non-executive directors.
6: Comply or explain	E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.	Non-compliant. The Trust will draft a policy as part of its work to further strengthen partnership and community working.
6: Comply or explain	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.	The Chair of the Board is also the Chair of the CoG and ensures that the views of Governors and members are communicated to the Board.
6: Comply or explain	E.2.1	The board should be clear as to the specific third-party bodies in relation to which the NHS foundation trust has a duty to cooperate.	The Board is clear as to the specific third-party bodies in relation to which the Trust has a duty to co-operate and is also clear of the form and scope of the co-operation required with each of these third-party bodies. The Board is committed to working effectively with partners and stakeholders and this is reflected in the Trust's strategic aims.
6: Comply or explain	E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third-party bodies and that collaborative and productive relationships are maintained with	The Board has ensured that effective mechanisms are in place to co-operate with relevant third-party bodies and that collaborative and productive relationships are maintained with

		relevant stakeholders at appropriate levels of seniority in each.	relevant stakeholders at appropriate levels of seniority in each.

NHS Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five key themes:

- Quality of Care
- Finance and Use of Resources
- Operational Performance
- Strategic Change
- Leadership and Improvement Capability (Well Led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

Wirral University Teaching Hospital NHS Foundation Trust has been placed in segment 3 of the NHS Oversight Framework following breach of the Trust's provider licence in 2015 with the imposition of an additional licence condition under Section 111 relating to senior management and board leadership and capability was also imposed in August 2015. Revised enforcement undertakings were issued by NHS Improvement in March 2018 and again in July 2020. The undertakings continue to relate to financial sustainability, sustainable performance against the A&E four-hour target and senior and board leadership. The Board of Directors formally endorsed the revised undertakings at the Board in August 2020 and monitor progress against the undertakings

Finance and Use of Resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These sources are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the NHS Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

2020/21

Use of Resources (UoR) Rating

Summary table

The table (right) shows the Trust's 2020/21 UoR Rating

NHSI assesses financial risk through the UoR rating. It is measured from 1 to 4 using a number of financial metrics, with 1 being the highest rating.

The Trust's overall UoR rating was 2 for 2020/21 which was an improvement from 4 in 2019/20 and was better than planned.

	UoR financial metric	Actual	Plan
		Rating	*Rating*
Financial sustainability	Liquidity	4	2
	Capital service capacity	2	2
Financial efficiency	I&E margin	2	2
Financial controls	Distance from financial plan	2	1
	Agency spend	2	1
	Overall UoR financial rating	**2**	**3**

Area	Metric	2020/21 scores				2019/20 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	2	3	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4	4	4
Financial efficiency	I&E margin	2	2	2	2	4	4	4	4
Financial controls	Distance from financial plan	1	1	1	1	4	4	1	1
	Agency spend	1	2	2	2	2	2	2	2
Overall Scoring		**2**	**2**	**3**	**3**	**4**	**4**	**3**	**3**

Statement of the Chief Executive's responsibilities as the accounting officer of Wirral University Teaching Hospital NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of an NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Wirral University Teaching Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Wirral University Teaching Hospital NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- make judgements and estimates on a reasonable basis.
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed and disclose and explain any material departures in the financial statements.
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance.
- 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 foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of Wirral University Teaching Hospital NHS Foundation Trust, and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The accounting officer is 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.

As far as I am aware, there is no relevant audit information of which the foundation 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 the *NHS Foundation Trust Accounting Officer Memorandum*.

Janelle Holmes
Chief Executive **Date: June 2021**

Annual Governance Statement 2020/21

1. Scope of responsibility

1.1 As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation 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 Foundation 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 Foundation Trust Accounting Officer Memorandum*.

2. The purpose of the system of internal control

2.1 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 Wirral University Teaching Hospital NHS Foundation 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 Wirral University Teaching Hospital NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1 The Board of Directors is responsible for the governance of the Trust. The Board of Directors is supported in the discharge of its role by a number of assurance committees that scrutinise and review assurances on internal control.

3.2 Responsibility and leadership are delegated through directors in accordance with the Trust's Scheme of Reservation and Delegation. This covers all aspects of governance relating to our service delivery including quality governance, clinical care, CQC and other regulatory and statutory requirements, finance and health and safety.

3.3 The Trust has revised its Risk Management Policy in 2020/21. The Policy describes the process for managing risk and the roles and responsibilities of staff.

3.4 The Trust has an executive-led Risk Management Committee, chaired by the Chief Executive, with membership including all Executive Directors and senior managers. The Risk Management Committee oversees the Trust's risk management arrangements to ensure:

- the correct strategy is adopted for managing risk
- controls are present and effective and
- action plans are robust for those risks that remain intolerant.

The Risk Management Committee reports through to the Trust Management Board, triangulating and prioritising risk across the Trust. The Committee provides assurance to the Audit Committee on the effective management of risk.

Risk management training

3.5 Training is provided to relevant staff on risk assessment, incident reporting and incident investigation appropriate to their role. New employees attend an induction programme and receive training appropriate to their role.

4. The risk and control framework

Risk management strategy

4.1 The Board of Directors recognises its responsibility to promote organisational success and to keep risk under appropriate control at all times. To achieve this, it is essential that we are systematic in our reporting, reviewing and learning from risk ensuring a culture of improvement Central to this is the Trust's governance framework which describes the Trust's risk management arrangements to deliver continuous improvement in safety and quality.

4.2 The risk management framework provides a structure for the identification of risk and the co-ordination of the Trust's response. Risks are identified from many sources including risk assessments, incident reporting, audit data, complaints, legal claims, feedback from patients and external reports.

4.3 The Risk Management Policy applies to all Trust employees. The Policy is underpinned by several risk related policies and procedures which provide further information and guidance to staff on the management of risk

4.4 All new significant risks are escalated to me as Chief Executive and subject to validation by the relevant Executive Director. The movement of risk is currently governed by the residual risk score (i.e., the net risk remaining after recognising the benefits of any mitigating controls). Going forward the escalation and de-escalation of risk will be governed more directly by the Board's risk appetite and tolerance.

4.5 The Board has identified and kept under review a range of risk scenarios which could, if not mitigated, impact adversely upon delivery of the Trust's strategic objectives. The Board Assurance Framework provides assurance in relation to the delivery of the Trust's strategic objectives and mitigation of the principal risks.

4.6 The Board Assurance Framework reflects: (i) the risk scenarios identified by the Board; (ii) the specific risk vectors which could, if not mitigated, lead to a risk scenario arising; (iii) risk tolerance; and (iv) the three lines of defence methodology for assuring the operation of control.

4.7 The risk management process follows the British Standard Code of Practice for Risk Management, set out in six key steps as follows:

(i) Determine priorities.
(ii) Risk identification.
(iii) Risk assessment.
(iv) Risk response (risk treatment).
(v) Risk reporting.
(vi) Risk review.

4.8 Operational risks are overseen within the divisional management structures and escalated in accordance with the Risk Management Policy Those responsible for managing risk regularly review the output from the risk register to ensure it remains valid, reflects changes and supports decision making. Risk profiles for the Divisions have been subject to detailed scrutiny as part of a rolling programme by the Risk Management Committee. The purpose of the review is to track how the risk profile is changing over time; evaluate the progress of actions to treat material risk; ensure controls are aligned to the risk; resources are reprioritised where necessary; and risk is escalated appropriately.

4.9 Detailed risk registers are in place. These set out the risk, risk treatment and further mitigating actions planned. An assurance report is provided by the Risk Management Committee to the Audit Committee.

Quality governance framework

4.10 The key elements of the governance framework include:

- a clear separation between management and assurance responsibilities within the Board's committee structure.
- a clear management structure to drive and deliver the Board's objectives and performance priorities.
- a devolved quality governance structure with clear lines of reporting, escalation, and oversight.
- a wide range of policies, procedures, and guidelines to govern operational practices and training requirements.
- an accountability framework expressed within the Corporate Governance Framework including Standing Financial Instructions and Scheme of Reservation and Delegation, that are kept under review by the Audit Committee.
- a Board Assurance Framework (BAF) incorporating the three lines of defence method of assurance, with a clear link established to key performance/risk indicators.
- a clearly articulated set of performance measures which are reviewed and used by the Board to drive accountability for performance and delivery.
- engagement with the wider stakeholder community through which the Trust is held to account for performance.

4.11 Incident reporting and investigation is a vital component of risk and safety management. An electronic incident reporting system is operational throughout the Trust organisation and accessible to all colleagues. Incident reporting is promoted through induction and mandatory training programmes, regular communications, patient safety walk rounds or other visits and inspections that take place. In addition, arrangements are also in place to raise any concerns at work confidentially and anonymously if necessary, through the 'Freedom to Speak up' guardians.

Care Quality Commission

4.12 The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). Compliance with the provisions of the Health & Social Care Act 2008 (Registration Regulations 2010) is co-ordinated by the Director of Quality & Governance who oversees compliance by:

- reporting and keeping under review matters highlighted within the CQC Insight Tool and inspections.
- liaising with the CQC and local services to address specific concerns.
- engaging with the CQC on the inspection process, co-ordinating the Trust's response to inspections and recommendations/actions.
- analysing trends from incident reporting, complaints, and patient and staff surveys to detect potential non-compliance or concerns in services.
- reviewing assurances on the effective operation of controls.

4.13 The Trust is registered with the CQC. Following a comprehensive inspection of services in 2019/20 the Trust demonstrated that progress has been made to achieve better compliance. The Trust remains at 'Requires Improvement' overall but improved in the well-led and safe domains. A robust action plan is in place and significant progress has been made in delivering the actions required. There is an ongoing process for monitoring and assuring sustained improvement with quarterly reporting provided to the Board of Directors.

Data security

4.14 The Trust has identified and evaluated the risks associated with data security and has taken steps to enhance control and resilience. The Trust has well - established information governance policies and procedures to protect confidential information

Major Risks

4.15 Major risks to the delivery of the Trust's strategic objectives include:

- **Demand that overwhelms capacity to deliver care effectively -** sustained, exceptional level of demand for services that overwhelms capacity resulting in a prolonged, widespread reduction in the quality of patient care and repeated failure to achieve constitutional standards.
- **Critical shortage of workforce capacity & capability -** critical shortage of workforce capacity with the required skills to manage demand resulting in a prolonged, widespread reduction in the quality of services and repeated failure to achieve constitutional standards.
- **Failure to achieve and/or maintain financial sustainability -** Inability to deliver the annual required financial plan trajectory resulting in a failure to achieve and maintain financial sustainability.
- **Catastrophic failure in Standards of Care - c**atastrophic failure in standards of safety and quality of patient care across the Trust resulting in multiple incidents of severe, avoidable harm and poor clinical outcome.
- **Major disruptive incident (leading to rapid operational instability)** – a major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community.
- **Fundamental loss of stakeholder confidence - p**rolonged adverse publicity or regulatory attention resulting in a fundamental loss of confidence in the Trust amongst regulators, partner organisations, patients, staff and the public.

4.16 Controls and assurances which describe how the Trust manages and mitigates the risks to achievement of its strategic objectives are reported in the BAF which is monitored by the Board and the Board committees.

4.17 As part of the implementation of the new Trust Strategy, the BAF will be refreshed and aligned to the newly defined strategic objectives. The Executive Team has reviewed all outstanding risks as reported to the Board in November 2020 identifying those risks that remain extant and may impact on the new strategic objectives. Risks that had been effectively mitigated or were no longer applicable to the new objectives/priorities have been closed with an update provided to the Board in March 2021.

4.18 During 2021/22 the Board will determine its risk appetite statement in accordance with best practice.

4.19 The level 4 incident declared by NHSEI in response to the COVID-19 pandemic led to the Trust operating within its major incident framework and revised governance arrangements. Additional changes included a revised clinical and operational model including a Clinical Advisory Group, a COVID-19 risk register, interim financial governance arrangements and extensive workforce support measures

4.20 The most significant clinical risks are caused by failure to treat patients in a timely manner as a result of demand exceeding available resources resulting in delays to treatment together with ability to recruit and retain skilled and experienced staff. The number of patients waiting for treatment has significantly increased as a direct result of the pandemic and forms a key part of the Trust's recovery plans moving forward. The Trust has a detailed recovery and reset plan which is reported to the Board each month. Specific areas of priority include reducing waiting lists and health and wellbeing support for staff.

4.21 Embedding high standards of infection prevention and control has remained paramount during the COVID 19 pandemic. Whilst the pandemic has challenged the Trust's ability to consistently follow outbreak guidelines and incidences of nosocomial transmission have been reported, the actions and mitigations introduced to reduce the risk, resulted in a decline and year end reporting as a minimal risk.

4.22 Significant work has been undertaken in relation to oversight and assurance of infection prevention and control. A recent infection, prevention and control focused inspection by the CQC in February 2021 has highlighted areas of outstanding practice and no significant major concerns. The final report is awaiting publication was published in April 2021.

4.23 The Board has concluded that there is a significant risk of a critical shortage of workforce capacity and capability. The control framework includes significant employee engagement, rota management, leave and absence management, regular establishment review and contingencies to enable continuity of service provision in the event of an unanticipated shortage of staff. Alongside recruitment and retention interventions and action plans these combine to reflect the short to medium term workforce plans.

4.24 The Board has determined that there is a significant risk of relating to workforce productivity from reduced attendance and staff morale. The control framework includes access to specialist post – traumatic psychological support for staff and access to a wide range of wellbeing resources.

Corporate governance

4.25 The Board maintains continuous oversight of the Trust's risk management arrangements and system of internal control through reporting to the Board, the Audit Committee, the Board's Committees and the Trust Management Board.

4.26 An assessment of compliance with the NHS provider condition 4 has been completed confirming that no material risks have been identified. The outcome of the evaluation of the committees will be reflected in improvement plans for each committee. Work is ongoing to strengthen the Board Assurance Framework and risk reporting to improve effectiveness

Trust response. The conditions are detailed within the Corporate Governance Statement the validity of which is assured by the Audit Committee.

4.27 A review of assessment of compliance against the NHS Foundation Trust Code of Governance was undertaken with outcomes reported to the Audit Committee. An action plan was developed with continued oversight provided by the Audit Committee.

4.28 Enforcement undertakings under S106 Health & Social Care Act 2012 were originally applied to the Trust in August 2015. An additional licence condition under S111 Health & Social Care Act 2012 in relation to senior management and board leadership and capability was also imposed in August 2015. Both the undertakings and the additional licence condition related to the need to:

- secure delivery of services on a financially sustainable basis (FT4 (5)(a), (d) and (f) and CoS3(1)); and
- ensure compliance with the A&E four-hour target on a sustainable basis condition FT4 (5)(c).

4.29 Revised enforcement undertakings were issued by NHS Improvement in March 2018 and again in July 2020. The undertakings continue to relate to financial sustainability and sustainable performance against the A&E four-hour target. The Board of Directors formally endorsed the revised undertakings at the Board in August 2020 and monitor progress against the undertakings on a two monthly cycle commencing in September 2020.

4.30 The Board has approved a comprehensive Board Development programme in accordance with the agreed enforcement undertaking agreed with NHSEI. The programme will be delivered by NHS Providers. Due to the pandemic, it has been agreed to defer the programme until 2021/2 once pressures on the Trust have eased.

4.31 The Trust reports progress with the undertaking to NHSEI. The reporting takes place through the Wirral System Improvement Board, chaired by a Regional Medical Director from NHSEI. This provides the opportunity for external stakeholder engagement with partners who are integral to effective plans to achieve both financial sustainability and sustainable delivery of the A&E four-hour target.

Workforce

4.32 The Board receives a monthly report detailing a number of metrics and narrative associated with the safety of nurse staffing levels. During 2020/21 the Board of Directors received a report of assurance of the nurse staffing establishments based on an assessment of acuity and dependency.

4.33 Register of Interests

The Trust has in place a Managing Conflict of Interests Policy, the content of which is consistent with national guidance on Conflict of Interests published by NHS England. The Trust has introduced an electronic process for recording declarations of interest, including gifts and hospitality, for senior decision-making staff. The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance

4.34 Pensions

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, diversity and human rights

4.35 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Diversity and inclusion training is mandatory for all staff. Additional steps have been taken to ensure focus on specific areas of the public sector equality duty; with particular attention on fostering good relations and advancing equality of opportunity between people who share a protected characteristic and those who do not.

4.36 The Trust Diversity and Inclusion Strategy and key objectives were published for 2018-2022, with an underpinning action plan to ensure achievement. The Trust is working in partnership with the Cheshire and Merseyside Health & Care Partnership, including embedding the inclusion pledges within the organisation. This includes promotion, monitoring and review to determine success. An annual report on progress is provided to the Board of Directors.

4.37 The Trust has integrated inclusivity as a core component of the Workforce Plan in line with the NHS People Plan. This includes working with staff and community stakeholders to review performance and identify further areas of improvement.

4.38 Carbon Reduction

The Foundation 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 ensure that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

5.1 The Trust's resources are managed within a financial governance framework that incorporates systems of financial control, budgetary control and the financial responsibilities for individuals outlined within the Trust's Standing Financial Instructions. Financial governance arrangements are supported by internal and external audit to ensure economic, effective and efficient use of resources.

5.2 The Trust has a range of processes to ensure that resources are used economically, efficiently, and effectively. This includes regular reporting to Board on quality, operational performance, finance and safety with further review and scrutiny at committees of the Board and management levels throughout the Trust.

5.3 Systems are in place to ensure the Trust complies with its duty to operate efficiently, effectively and economically including securing compliance with healthcare standards as specified by the Secretary of State for Health, the Care Quality Commission, NHS England, NHS Improvement, and statutory regulators of healthcare professions.

5.4 The Trust Board has agreed an annual audit programme with the Trust's internal auditors through delegated authority to the Trust Audit Committee. The Audit Committee receives internal audit reports in line with an agreed work plan that aims to test the economy, efficiency and effectiveness of Trust systems and processes, including financial management and control. The audit plan is reviewed and agreed by the Audit Committee in April each year. Any report which offers limited assurance results in the development of a management action plan with an agreed timescale for improvement, and progress is monitored by the Audit Committee. Serious issues are escalated to the Board of Directors

5.5 A temporary finance regime to support the response to COVID-19 was introduced in 2021/22. It was important that the Trust was able to respond quickly and flexibly to the changing requirements of our Services whilst also ensuring that we maintain strong financial control during this time. COVID-19 related expenditure was approved through the Trusts incident command structures and reviewed by the Executive Team on a regular basis, as set out in the Trust's interim financial governance arrangements. Finance reports for 2020/21 included a separate analysis on COVID-19 related expenditure to ensure that the Board of Directors was fully sighted.

6. Information Governance

6.1 During **2020/21** there were three reportable to the Information Commissioner's Office (ICO) and NHS Digital (via the DSP toolkit).

26/02/2021	Incorrect disclosure to a patient's next of kin regarding their mental health which caused distress to the patient. **Status:** Under review.
01/09/2020	A patient was discharged with another patient's Do Not Resuscitate (DNR) form in error. The form contained the patient's demographics and the reason for the DNR decision. **Status:** No further action
17/08/2020	Emails captured as part of a Subject Access Request were released to the requestor without some third-party data being redacted. **Status:** No further action.

6.2 The Trust receives regular communication from NHS Digital which supports notification of potential information security incident and has taken steps to reduce the risks posed by cyber – attacks. The Trust has previously participated in a pilot for the development of a unified cyber risk framework; and has installed access controls, fire walls, continuously updating anti-virus software and other software to minimise risk of cyber-attack.

6.3 The Trust has a Data Protection Officer overseeing Data Protection Impact assessments and giving lawful advice and guidance on issues associated with the eight rights of access. We have continued to embed the legal requirement for data protection impact assessments into the Trust's information sharing and information risk processes and strengthening data security awareness through continued education and awareness.

7. Data Quality & Governance

7.1 Internal controls are in place to ensure the accuracy of data and the collection and reporting of the measures of performance.

7.2 Mandatory training is provided to raise awareness of information governance and control with employees.

7.3 Regular internal reports are provided to the Data Quality Group on errors and corrections to patient records logged by the Data Quality Team. Frequency of errors and trends over time are tracked, with direct feedback to departmental managers in relation to repeated errors or concerns

7.4 The quality and accuracy of elective waiting time data is subject to validation at patient level. Patients are tracked along pathways and any breaches of waiting time standards confirmed through further validation prior to Executive sign-off of Trust performance. A rolling monthly audit on referral to treatment and cancer 62-day patients that are treated

within the national waiting time standards is undertaken by the Data Quality Team, to ensure scrutiny is equally applied to non-breaching patients and their waiting times.

8. Review of effectiveness

8.1 As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditor in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee, Quality Committee and Risk Management Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

8.2 The governance structure aligns the Trust's quality, risk and performance management arrangements. Committees, sub committees, groups and individuals have defined responsibilities to ensure delivery of the Trust's objectives through compliance with performance and quality indicators and monitoring of associated risks. The Board of Directors receives assurance from its committees and the Trust Management Board.

8.3 The Board of Directors has set out the governance arrangements including the committee structure within the Scheme of Reservation and Delegation. The Board is supported by seven committees:

- Audit
- Finance Business and Performance Assurance
- Quality
- Workforce Assurance
- Safety Management
- Remuneration & Appointment
- Capital (November 2020).

8.4 In addition, the Trust's Trust Management Board which is chaired by the Chief Executive reports to the Board of Directors Chairs of the board's committees report to the Board of Directors at the first available meeting after each Committee meeting. Urgent matters are escalated by the committee chair to the Board of Directors as deemed appropriate.

8.5 At its meeting held in May 2020, the Board of Directors considered and approved interim governance arrangements which had been developed in response to the declaration of the Level 4 national incident. National guidance was provided in March 2020 to explain additional steps required to repurposing NHS services, staffing and capacity and to free-up

management capacity and resources. Whilst NHSEI were responsible for commanding resources and planning in response to the pandemic, the Board of Directors retained all other responsibilities to ensure oversight and scrutiny. The Board reviewed the revised governance arrangements in May, July and November 2020 and approved arrangements to ensure appropriate oversight and control whilst reflecting the unprecedented demand on the Trust.

8.6 The pandemic has presented unprecedented challenges for the Trust, the NHS and its partners. The Board of Directors has continued to discharge it responsibilities and progress continues to be made to strengthen the Board, improve CQC compliance and build more productive stakeholder relationships. The Board of Directors understands the challenges relating to financial sustainability and managing demand more effectively. These challenges are now more acute with the impact of the pandemic with prolonged waits for treatment and inequalities in health and social care. These priorities are embedded in our organisational objectives for the year ahead.

8.7 The Trust's system of control is designed to identify principal risks to the achievement of policies, aims and objectives. This has been further strengthened this year by the continuing work on the Board Assurance Framework and risk management systems. As with all Internal control systems they are designed to manage rather than eliminate the risk of failure and can therefore only provide reasonable and not absolute assurance of effectiveness against material mis-statement or loss.

8.8 The Audit Committee is aware of workforce issues which directly stem from a failure of the control environment. The Audit Committee is providing oversight of the improvement plan to rectify the situation and to prevent those situations from arising in the future. The Committee is also aware of issues relating to estates and compliance with statutory responsibilities which directly stems from a failure of the control environment. The Audit Committee is not aware of any other material issues regarding fundamental failures which directly stem from a failure of the control environment or internal controls which comprise that environment.

8.9 The Board of Directors met 12 times between 1 April 2020 and 31 March 2021. Details about board members and changes to Board membership during the year can be found in the Directors' Report and the Remuneration Report.

8.10 The responsibilities of Directors are reviewed through individual performance review process.

8.11 The responsibilities of the Board of Directors' assurance committees and the executive led management meetings are defined in the terms of reference which are subject to review on a regular basis.

8.12 The Trust undertakes an annual assessment of all directors to ensure that they continue to meet the requirement of the fit and proper person's regulation. This is in addition to checks undertaken during the appointment process.

8.13 In 2020/21 the Head of Internal Audit opinion was that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.

8.14 As a result of the pandemic, the internal audit plan was revised, to focus on the Trust's Assurance Framework, core and mandated reviews and a number of individua risk-based assurance reviews. There was limited coverage of the quality areas. The impact on the organisation's strategic priorities previously highlighted in the risk assessment and planning process and these will be re-visited as part of planning for 2021/22.

8.15 The assurance framework was externally validated by the Trust's Internal Auditors in March 2021 and the Head of Internal Audit Opinion provides assurance that the assurance framework is structured to meet the NHS requirements, is visibly used by the organisation and clearly reflects the risks discussed by the Board.

8.16 During 2020/21 six internal audits were undertaken. Two received 'substantial assurance', one received 'moderate assurance' and three received 'limited assurance'.

Substantial Assurance	Key Financial Systems Governance and Divisional Performance Review (2019/20)
Moderate Assurance	Cyber Security Organisational Controls
Limited Assurance	Sickness and Absence Reporting Medical Staffing Review IT Infrastructure

8.17 On each occasion when an internal audit is drafted, recommendations or actions are proposed by the internal auditors to management. These are formalised and captured. Progress with implementation of the audit recommendations is reported to the Audit Committee ensuring Executive input, scrutiny of findings and oversight of the management response.

8.18 Reported incidents, complaints, claims and patient feedback are routinely analysed to identify risks, learning and improvement to support robust internal control. Lessons learnt are disseminated to staff using a variety of methods including safety huddles, and safety

bulletins. The Trust continues to evolve the mechanisms used for triangulation of feedback, safety data and intelligence to support continuous improvement.

8.19 There were 35 events reported during 2020/21 year that crossed the seriousness threshold and were declared a serious incident in accordance with NHS England's Serious Incident Framework. This represents a 5% reduction compared to 2019/20. The Trust continues to be open and transparent in relation to all known incidents including those that result in significant harm. The Trust has a well-established Serious Incident Panel with strong clinical engagement. Each serious incident has been thoroughly investigated and reported to local commissioners. Detailed action plans were developed and implemented or are being implemented.

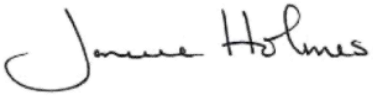
8.20 One incident qualified for reporting as a Never Events during 2020/21. This related to wrong site surgery.

8.21 There were 27 events that met the criteria for reporting to the Health & Safety Executive under the provisions of the Reporting of Injuries, Diseases or Dangerous Occurrences (RIDDOR) Regulations. This reflects an increase of 6.5% from 2019/20. The Health & Safety management systems within the Trust continue to be strengthened. The Health & Safety plan for 2021/22 will focus on policy development, internal Health & Safety Audits and Inspections and Training.

9. Conclusion

9.1 My review confirms that Wirral University Teaching Hospital NHS Foundation Trust has generally sound systems of internal control that support the achievement of its objectives and the Head of Internal Audit Opinion has provided Moderate Assurance that there is an adequate system of internal control. However, there are some areas where further improvement is required, as referenced at section XX of this statement, which put the achievement of some of the Trust's objectives at risk. Action plans have been prepared to address these issues and the Board is confident that there is a robust system in place to oversee the implementation of these actions.

9.2 No significant internal control issues have been identified during the year ending 31 March 2021 and up to the date of approval of the annual report and accounts.



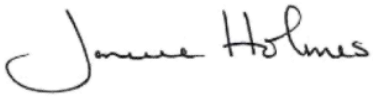
Janelle Holmes

Chief Executive **Date: June 2021**

Report on the audit of the Financial Statements

Foreword to the accounts

These accounts, for the year ended 31 March 2021, have been prepared by Wirral University Teaching Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.



Signed …….

Name **Janelle Holmes**
Job title **Chief Executive Officer**
Date **14 June 2021**

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	2	380,410	343,754
Other operating income	3	55,311	41,769
Operating expenses	6	(431,607)	(398,720)
Operating surplus/ (deficit) from continuing operations		**4,114**	**(13,197)**
Finance income	10	2	130
Finance expenses	11	(221)	(2,224)
PDC dividends payable		(3,361)	(1,560)
Net finance costs		**(3,580)**	**(3,654)**
Other gains / (losses)	11	(94)	(64)
Surplus / (deficit) for the year		**440**	**(16,915)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(4,747)	2,422
Revaluations		61	436
Other recognised gains and losses		29	-
Total comprehensive income / (expense) for the period		**(4,217)**	**(14,057)**

The notes on pages 7 to 38 form part of these accounts.

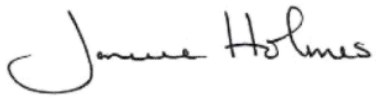
All income and expenditure is derived from continuing operations.

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	12	12,864	14,029
Property, plant and equipment	13	163,560	161,492
Receivables	18	869	974
Total non-current assets		**177,293**	**176,495**
Current assets			
Inventories	17	4,788	3,992
Receivables	18	17,263	24,376
Cash and cash equivalents	19	21,293	5,931
Total current assets		**43,344**	**34,299**
Current liabilities			
Trade and other payables	20	(44,537)	(41,873)
Borrowings	22	(1,090)	(85,234)
Provisions	24	(5,914)	(2,926)
Other liabilities	21	(4,622)	(3,000)
Total current liabilities		**(56,163)**	**(133,033)**
Total assets less current liabilities		**164,474**	**77,761**
Non-current liabilities			
Borrowings	22	(5,193)	(6,274)
Provisions	24	(8,659)	(7,555)
Other liabilities	21	(2,479)	(2,588)
Total non-current liabilities		**(16,331)**	**(16,417)**
Total assets employed		**148,143**	**61,344**
Financed by			
Public dividend capital		171,122	80,106
Revaluation reserve		41,241	46,728
Income and expenditure reserve		(64,220)	(65,490)
Total taxpayers' equity		**148,143**	**61,344**

The notes on pages 7 to 38 form part of these accounts.

The primary financial statements on pages 3 to 6 and the notes on pages 7 to 38 were approved by the Trust's Board of Directors on 9 June 2021 and signed on its behalf by Janelle Holmes, Chief Executive Officer.



Signed 14 June 2021

Janelle Holmes

Chief Executive Officer

Wirral University Teaching Hospital NHS Foundation Trust Annual Accounts 2020/21

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**80,106**	**46,728**	**(65,490)**	**61,344**
Surplus(deficit) for the year			440	440
Transfers between reserves		(797)	797	-
Impairments		(4,747)		(4,747)
Revaluations		61		61
Other recognised gains and losses	-	-	29	29
Transfer to retained earnings on disposal of assets	-	(4)	4	-
Public dividend capital received	91,016			91,016
Taxpayers' and others' equity at 31 March 2021	**171,122**	**41,241**	**(64,220)**	**148,143**

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**79,587**	**44,597**	**(49,302)**	**74,882**
Surplus/(deficit) for the year	-	-	(16,915)	**(16,915)**
Other transfers between reserves	-	(723)	723	**-**
Impairments	-	2,422	-	**2,422**
Revaluations	-	436	-	**436**
Transfer to retained earnings on disposal of assets	-	(4)	4	**-**
Public dividend capital received	519	-	-	**519**
Taxpayers' and others' equity at 31 March 2020	**80,106**	**46,728**	**(65,490)**	**61,344**

Information on reserves

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 expenditure, in which case they are recognised in operating expenditure - net impairments. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of this NHS foundation trust.

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 trust. In 2020/21 the Trust's loans with the DHSC were converted from borrowings into PDC.

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,114	(13,197)
Non-cash income and expense:			
Depreciation and amortisation	6.1	10,652	10,025
Net impairments	7	712	(231)
Income recognised in respect of capital donations	3	(902)	(194)
Amortisation of PFI deferred credit		(109)	(109)
(Increase) / decrease in receivables and other assets		7,085	(9,995)
(Increase) / decrease in inventories		(796)	(19)
Increase / (decrease) in payables and other liabilities		2,163	9,764
Increase / (decrease) in provisions		4,106	(218)
Other movements in operating cash flows			3
Net cash flows from / (used in) operating activities		**27,025**	**(4,171)**
Cash flows from investing activities			
Interest received		13	133
Purchase of intangible assets		(621)	(1,419)
Purchase of PPE and investment property		(13,574)	(8,631)
Sales of PPE and investment property		-	32
Receipt of cash donations to purchase assets		165	194
Net cash flows from / (used in) investing activities		**(14,017)**	**(9,691)**
Cash flows from financing activities			
Public dividend capital received		91,016	519
Movement on loans from DHSC		(84,899)	16,999
Capital element of finance lease rental payments		(64)	(61)
Interest on loans			(2,186)
Other interest		(487)	(1)
Interest paid on finance lease liabilities		(5)	(7)
PDC dividend (paid) / refunded		(3,207)	(1,985)
Net cash flows from / (used in) financing activities		**2,354**	**13,278**
Increase / (decrease) in cash and cash equivalents		**15,362**	**(584)**
Cash and cash equivalents at 1 April 2020 - brought forward		5,931	**6,515**
		21,293	**5,931**

Cash and cash equivalents at 31 March 2021 20.1

Note 1 Accounting policies

1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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

1.2 Going Concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.

After making enquiries, the directors have a reasonable expectation that the services provided by the Wirral University Hospital NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future.

1.3 Consolidation

NHS Charitable Fund
The Trust is the Corporate Trustee to Wirral University Hospital NHS Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The Trust has reviewed the value of the Charity's fund balances at 31 March 2021 and does not consider these to be material to the Trust. Consequently, consolidated financial statements, incorporating the accounts of both the Trust and the Charity ('group accounts') have not been prepared for the year ended 31 March 2021.

Joint operations
Joint operations (Note 16) are collaborative arrangements over which the Trust has joint control with one or more other entities, which typically involves the pooling of assets and the sharing of expenditures rather than the establishment of a separate entity. The Trust has the rights to particular assets or a share of certain assets, and obligations for particular liabilities or a share of certain liabilities, relating to the arrangement. Joint control is the contractually agreed sharing of control of an arrangement. Where material, the Trust includes within its financial statements its share of each operation's assets, liabilities, income and expenditure.

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.

Revenue from NHS contracts
The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

<u>2020/21</u>

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)
In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled 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.

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

Note 1.5 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 grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

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

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

Note 1.6 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
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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

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

National Employment Savings Trust (NEST)

NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. This alternative scheme is provided under the Trust's 'automatic enrolment' duties to the small number of employees who choose this scheme or do not contribute to the NHS pension schemes.

NEST levies a contribution charge and an annual management charge which is paid for from employee contributions. There are no separate employer fees levied by NEST. The Trust is legally required to make a minimum contribution for opted-in employees who earn more than the qualifying earnings threshold, and the cost to the Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. That is, employer's pension costs of contributions are charged to operating expenditure as and when they become due.

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.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where the following conditions are met:

- The item 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.
- The item is expected to be used for more than one financial year.
- The cost of the item can be measured reliably.
- The cost meets at least one of the following three criteria.
    - For single assets, the cost is at least £5,000, including irrecoverable VAT.
    - For grouped assets, where the assets are functionally interdependent (e.g. networked IT equipment), their collective cost is at least £5,000, they have broadly simultaneous purchase dates and anticipated disposal dates, are under single managerial control, and each individual cost exceeds £250, including irrecoverable VAT.
    - The cost forms part of the initial equipping and setting-up, or refurbishment, costs of a building, ward or unit, and each individual asset exceeds £250 including irrecoverable VAT, provided that the refurbishment work would qualify as subsequent expenditure in IAS 16 terms (described below).

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

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

Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, comprising borrowing costs where relevant, and all 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. The carrying amount in the period between initial recognition and any revaluation is this initial cost less any subsequent accumulated depreciation and impairment.

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

Property, plant and equipment assets comprising the Trust's estate (property and land) are professionally revalued 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 location requirements of the services being provided. From 2017, the Trust has opted to interpret the MEA basis as pertaining to a single combined hospital facility ('single site model') wholly located at the Trust's Clatterbridge site.

Surplus assets, which are non-operational assets with no clear plans to be brought back into use, are valued at *fair value – highest and best use* under IFRS 13 *Fair Value Measurement*, if they do not meet the requirements of IAS 40 *Investment Property* or IFRS 5 *Non-current Assets Held for Sale and Discontinued Operations*, and there are no restrictions on the Trust or the assets which would prevent access to the market at the reporting date. If access to the market is prevented, such assets are valued at *current value in existing use.*

Assets re-classified as held-for-sale under IFRS 5 are measured at the lower of their *carrying amount* or *fair value less costs to sell,* and are not depreciated.

Property, plant and equipment assets which are not part of the Trust's estate (neither property nor land assets, e.g. medical equipment, IT equipment, vehicles, furniture and fittings) should be held at *current value in existing use*. However, these equipment assets are not revalued, but are held at depreciated historical cost (DHC), net of impairments. This is because DHC is not considered to be materially different from *current value in existing use*, for short-life low-value assets.

Assets under construction, for service or administrative purposes, are measured at the cost of construction less any impairment loss. The cost of construction includes relevant professional fees, and, where capitalised in accordance with IAS 23 *Borrowing Costs*, borrowing costs. Assets are reclassified to the appropriate category when they are brought into use, and depreciation commences. For an asset that is newly-constructed, a formal revaluation should only be necessary if there is an indication that the initial cost is significantly different from the potential revalued amount. Otherwise, the asset is only revalued on the next occasion when all assets of that class are revalued.

Depreciation
Depreciation is charged to write down the costs or valuation of certain items of property, plant and equipment, less any residual value, over their remaining useful economic lives on a straight-line basis. It is an operating expenditure within the SOCI.

The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is an accounting estimate and may prove to be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Freehold land is considered to have an infinite life and is not depreciated. Property, plant and equipment which is reclassified as held-for-sale under IFRS 5 ceases to be depreciated at the point of reclassification. Assets under construction are not depreciated until the assets are brought into use.

Finance-leased assets are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term. If this is the case, the asset is depreciated in the same manner as owned assets.

Property is usually depreciated over the following useful economic lives.

- Buildings excluding dwellings 1 to 80 years.
- Dwellings 1 to 80 years.

Equipment is usually depreciated over the following useful lives.

- Plant and machinery 1 to 17 years.
- Transport equipment 1 to 10 years.
- Furniture and fittings 1 to 13 years.
- Information technology equipment 1 to 7 years.

These useful economic lives reflect the total life of an asset when it is recognised, and not its remaining life.

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
At each reporting period end, the Trust checks whether there is any indication that any of its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

In accordance with the *DHSC GAM*, impairments that arise from a clear consumption of economic benefits or service potential are charged to operating expenditure. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:

- the impairment charged to operating expenditure; and
- the balance in the revaluation reserve attributable to that asset before impairment.

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

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

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

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

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

Private Finance Initiative (PFI) transactions and service concessions
Certain PFI transactions are accounted for as 'on Statement of Financial Position' or 'on SOFP' by the Trust, when they meet the definition of a service concession, as defined by IFRS Interpretations Committee (IFRIC) 12 *Service Concession Arrangements*, interpreted in HM Treasury's *FReM*. In accordance with IAS 17 *Leases*, the underlying assets are recognised as property, plant and equipment when they come into use, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment.

There are no annual contract payments ('unitary fees') or service charges payable in relation to the Trust's single 'service concession' asset, as the operator's income derives from charges to users. As outlined in Note 21, a deferred income balance has been created which is released each year as income which offsets, but does not necessarily match, the straight line depreciation charge incurred over the asset's useful economic life.

1.9 Intangible assets

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

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

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

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

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

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

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

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits. Expected useful economic lives at point of first recognition are usually as follows.

Software	1 to 14 years.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method or the weighted average cost method.

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

1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from 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. These balances exclude monies held in the Trust's bank account belonging to patients.

1.12 Financial assets and financial liabilities

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

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

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

Classification and measurement
The classification of financial instruments is determined by their cash flow and business model characteristics, as set out in IFRS 9 *Financial Instruments*, and is determined at the time of initial recognition. The only categories of financial assets and financial liabilities held by the Trust are 'Financial assets/liabilities held at amortised cost'.

Financial assets held at amortised cost
These are financial assets which are held with the objective of collecting contractual cash flows, where the cash flows are solely payments of principal and interest. They are included in non-current assets and current assets.

The Trust's *financial assets held at amortised cost* comprise cash and cash equivalents, and parts of the Trust's trade receivables, accrued income and other receivables balances.

They are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method, less any impairment / loss allowance. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset to the gross carrying amount (before adjusting for any loss allowance) of the financial asset.
Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques. For current receivables, both fair value and amortised cost usually equate to invoice value.

Financial liabilities held at amortised cost
Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the expected life of the liability to the amortised cost of the financial liability.

The Trust's *financial liabilities held at amortised cost* comprise parts of the Trust's trade payables, accruals and other payables, provisions under contract, and DHSC loans balances for which the effective interest rate is the nominal rate of interest charged on the loan.

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

Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques. For current payables, both fair value and amortised cost usually equate to invoice value.

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).

The term 'impairment' refers both to the permanent 'write-off' of a debt, and the creation of a 'loss allowance' balance for a debt or group of debts. Other than ICR receivables (*Injury Cost Recovery (ICR) income*), the only financial assets impaired by the Trust, in this and the previous year, have been trade receivables.

The ICR allowance is calculated at a rate of 22.43% (21.79% 2019/20), and this percentage reflects the average value of claims withdrawn as advised to DHSC by the Compensation Recovery Unit (CRU) of the Department for Work and Pensions. This percentage is updated by the CRU, and reflects expected rates of collection across the NHS.

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.

De-recognition
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.

1.13 Leases

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

The Trust as lessee

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

1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation, as a result of a past event, of uncertain timing or amount, for which the following conditions are true.

- It is probable that there will be a future outflow of cash or other resources.
- A reliable estimate can be made of the amount of the obligation.

The amount recognised as a provision in the SOFP is the best estimate of the expenditure required to settle the obligation, taking into account risks and uncertainties. Where a provision is measured using the estimated risk-adjusted cash flows required to settle the obligation, and where the effect of the time value of money is significant, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

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

Clinical negligence costs
NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to NHSR, which, in return, settles all clinical negligence claims. This contribution is charged to expenditure. Although NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed in Note 24.2 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.

1.15 Contingencies

Contingent assets (that is, possible assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in Note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 25, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the Trust'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.

1.16 Public dividend capital (PDC)

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

1.17 Value added tax (VAT)

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. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets.

1.18 Climate Change Levy

Climate Change Levy Expenditure is recognised in line with the levy charged, based on the chargeable rates for energy consumption per the rates detailed in the Climate Change Levy documentation.

1.19 Corporation tax

As an NHS foundation trust, Wirral University Teaching Hospital NHS Foundation Trust is specifically exempted from corporation tax through the Corporation Tax Act 2010. The Act provides that HM Treasury may dis-apply this exemption only through an order via a statutory instrument (secondary legislation). Such an order could only apply to activities which are deemed commercial, and arguably much of the Trust's other operating income is ancillary to the provision of healthcare, rather than being commercial in nature. No such order has been approved by a resolution of the House of Commons. There is therefore no corporation tax liability in respect of the current financial year.

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in Note 19.2 as required by HM Treasury's *FReM.*

1.21 Foreign currencies

The functional and presentational currency of the Trust is pounds sterling, presented in thousands unless expressly stated otherwise. A transaction which is denominated in a foreign currency is translated into sterling at the spot exchange rate on the date of the financial transaction.

At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Exchange gains or losses (arising on settlement of the transaction or on retranslation on 31 March) are recognised in income or expenditure in the period in which they arise.

1.22 Losses and special payments

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

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.

1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value. The Trust has not issued any gifts with the exception of occasional ad hoc collaborative gestures with NHS partners of a trivial nature.

1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been 'early adopted' in 20/21.

1.25 Accounting standards issued but not yet adopted

IFRS16 Leases

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

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

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

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

IFRS 17 Insurance Contracts: this standard is not yet adopted by the FReM but is expected to be from April 2023. It is not expected to affect the Trust's accounts as it does not issue insurance contracts.

1.26 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions which create a risk of material uncertainty.

These judgements, estimates and assumptions are based on historical experience and other factors considered of relevance. Actual results may differ from those estimates, and underlying assumptions are regularly reviewed. Revisions to estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of revision and future periods if the revision affects both current and future periods.

Listed below are areas where management has made judgements, apart from those involving estimations (see 1.3.2), in the process of applying the Trust's accounting policies, which are deemed most significant to the amounts recognised in the financial statements.

Segmental reporting

IFRS 8 *Operating Segments* requires additional annual accounts disclosures for certain significant business streams ('reportable segments') which engage in distinct business activities and whose operating results are regularly and separately reviewed by the entity's 'chief operating decision maker' (CODM).

As the Trust's CODM, the Trust's Board of Directors does regularly review the performance of the Trust's operational divisions, whilst reviewing the financial position of the Trust as a whole, in its decision-making framework. However, these divisions are not judged to comprise distinct reportable segments, as they share similar economic characteristics, having similar locations, outputs and customers, and operating within the same funding and regulatory environment. At an operational level, the workforce is flexibly deployed and assets are shared across the divisions in providing services and delivering the Trust's objectives.

The accompanying financial statements have consequently been prepared under one single reporting segment, that is, 'the provision of acute healthcare'.

Interests in other entities and joint arrangements

Reporting bodies are required to assess whether they have interests in subsidiaries, associates, joint ventures or joint operations, prior to accounting for and disclosing these arrangements according to the relevant accounting standards. This assessment involves making judgements and assumptions about the nature of collaborative working arrangements, including whether or not the Trust has control over those arrangements per IFRS 10 *Consolidated Financial Statements.*

The Trust has assessed its existing contracts and collaborative arrangements for 2019/20, and has determined that the only arrangements which would fall within the scope of IFRS 10, IFRS 11 *Joint Arrangements* or IFRS 12 *Disclosure of Interests in Other Entities*, are the Trust's subsidiary charity and its joint operations (Note 16).

Consolidation

Wirral University Teaching Hospital NHS Foundation Trust is the corporate trustee of Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund ('the Charity'). The Trust has assessed its relationship with the Charity and determined it to be a subsidiary, as it has the power to both gain and affect economic returns and other benefits from the Charity.

The Trust has reviewed the value of the Charity's fund balances at 31 March 2021 and does not consider these to be material to the Trust. Consequently, consolidated financial statements, incorporating the accounts of both the Trust and the Charity ('group accounts') have not been prepared for the year ended 31 March 2021.

'Service concession' asset

In 2010, the Trust recognised one 'service concession' asset (as at 31 March 2008). A staff accommodation block, built and operated by Frontis Homes Limited (Your Housing Group Limited) on the Trust's Arrowe Park site, is an infrastructure asset used in the delivery of public services. The Trust controls the residual interest in the asset and the services to be provided.

Finance leases

The Trust has a number of different lease arrangements, and follows IAS 17 *Leases* in classifying those leases as either finance leases or operating leases at the point of recognition. This classification leads to different accounting treatments, and different transaction values and balances for each reporting period within the Statement of Comprehensive Income (SOCI) and the SOFP as outlined under *1.14 Leases*, below. In following the applicable lease standards, an element of judgement is required in deciding whether an arrangement is a lease, and, in particular, determining a lease's classification.

Sources of estimation uncertainty

Asset valuation, lives and depreciation

The *DHSC GAM* requires that the valuation of the Trust's specialised buildings is based on a modern equivalent asset (MEA) with the same productive capacity as the property being valued. The Trust has opted to interpret the MEA basis as pertaining to a single combined hospital facility ('single site model') wholly located at the Trust's Clatterbridge site, and this fundamentally affects valuation processes, generally reducing asset carrying values.

The Trust has judged that this single combined hospital model is effectively a single asset for the purposes of applying IAS 16 Property, Plant and Equipment, with each significant building 'sub-asset' as a separately depreciating component. The component parts of each building 'sub-asset' are not themselves judged to have sufficient cost in relation to the single combined facility to require separate depreciation under the standard. This judgement affects the overall depreciation of the Trust's estate.

Additionally, the valuation of buildings requires decisions as to whether assets or groups of assets are specialised or non-specialised, which can lead to significantly different valuations, as described under *1.8 Property, plant and equipment.*

Asset valuation and lives

The value and remaining useful lives of land and building assets are estimated by the Trust's valuers, Cushman & Wakefield. Valuations are carried out annually and are performed in accordance with the Royal Institute of Chartered Surveyors' *RICS Valuation - Professional Standards* (the 'Red Book'), primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property, as described under *1.8 Property, plant and equipment.*

Where assets are of low value and/or have short useful economic lives, such as operational equipment, they are carried at depreciated historical cost (cost less any accumulated depreciation) as this is not considered to be materially different from fair value. The lives of equipment assets are estimated using historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Intangible software licences are depreciated over the shorter of the term of the licence and the useful economic life.

The Trust undertakes annual revaluations of estate assets to reduce estimation uncertainty relating to asset lives and depreciation so as to minimise risk of material adjustments. However, the Trust's reliance on valuation methods does present a risk relating to the carry amount of non-current assets. Valuation methods assess alterations made to Trust estate since the previous valuation, building areas, location, physical condition and functional obsolescence and assessment of the current cost of replacement referencing previous valuations and using building cost indices such as the BCIS "All In" Tender Price Index.

The total balance of intangible and tangible fixed assets as at 31 March 2021 is £176m (31 March 2020 £176m), of which £134m relates to estate assets. The Arrowe Park Hospital site is valued at £103m and whilst operationally inseparable the remaining lives of significant elements of the site have been assessed in the range of 27 to 43 years. The Clatterbridge Hospital site is valued at £30m and whilst operationally inseparable the remaining lives of significant elements of the site have been assessed in the range of 24 to 36 years.

Provisions

The amount recognised as a provision is a best estimate at the end of the reporting period of the expenditure required to settle a present obligation, or a constructive obligation, taking into account risks and uncertainties.

Inventory balances

Inventory balances which are measured by counting stock, and attributing values to that inventory. There is an estimation uncertainty related to the timing of the Trust's stock counts, because they cannot operationally be undertaken simultaneously at close of play on 31 March.

Note 2 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 2.1 Income from patient care activities (by nature)

	2020/21	2019/20
	£000	£000
Block contract/system envelope income	341,012	220,787
High cost drugs income from commissioners	17,124	15,863
Other NHS clinical income *	1,477	93,439
Private patient income	60	294
Additional pension contribution central funding **	10,436	9,991
Other clinical income***	10,301	3,380
	380,410	**343,754**

* In 2020/21 other NHS clinical income includes income received in respect of critical care and neo-natal units, maternity care, rehabilitation and renal services, diagnostic services, community medicine and elderly care services. In 2019/20 this included a number of funding streams which were replaced by the block contract/system envelope arrangement in 2020/21.

** The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2020/21, 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.

*** Other clinical income includes central funding in relation to the annual leave accrual and Flowers of £6m.

Note 2.2 Income from patient care activities (by source)

	2020/21	2019/20
	£000	£000
NHS England	49,120	46,286
Clinical Commissioning Groups	325,834	291,238
NHS Foundation Trusts	1,045	755
NHS Trusts	2	378
Local Authorities	577	686
Department of Health and Social Care	1	-
NHS Other	378	103
Non-NHS Private Patients	60	290
Non-NHS: Overseas patients (chargeable to patient)	-	12
Injury cost recovery scheme	761	803
Non-NHS: Other	2,632	3,203
	380,410	**343,754**
Of which relates to continuing operations	**380,410**	**343,754**

Note 2.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2020/21	2019/20
	£000	£000

Income from services designated as commissioner requested services	348,597	313,254
Income from services not designated as commissioner requested services	31,813	30,500
	380,410	**343,754**

Note 2.4 Overseas visitors (relating to patients charged directly by the provider)

	2020/21 £000	2019/20 £000
Income recognised this year	-	12
Cash payments received in year (relating to invoices raised in current and previous years)	5	5
Amounts written off in year (relating to invoices in current and previous years)	7	-

Note 3.1 Other operating income

	2020/21 £000	2019/20 £000
Recognised in accordance with IFRS15:		
Research and development	581	650
Education and training	10,616	10,263
Non-patient care activities to other bodies	8,478	9,118
Provider sustainability fund / Financial recovery fund / Marginal rate emergency tariff funding	-	10,665
Reimbursement and top-up funding	21,996	-
Income in respect of employee benefits accounted on a gross basis	2,780	2,597
Other	2,921	6,996
Recognised in accordance with other standards:		
Education and training	-	528
Donated equipment from DHSC for COVID response (non-cash)	737	-
Cash donations for the purchase of capital assets	165	194
Charitable and other contributions to expenditure – received from NHS Charities	14	-
Charitable and other contributions received from other bodies	250	249
Contributions to expenditure – receipt of equipment donated from DHSC for COVID response	126	-
Contributions to expenditure – consumables (inventory) donated from DHSC group bodies for COVID response	6,020	-
Rental revenue from operating leases	518	400
Amortisation of PFI deferred income / credits	109	109
Total other operating income	**55,311**	**41,769**

Note 3.2 Analysis of other income

	2020/21 £000	2019/20 £000
Car parking income	148	1,510
Catering	789	1,638
Staff accommodation rental	126	29
Other income not already covered (recognised under IFRS15)	1,858	3,819
Total other income	**2,921**	**6,996**

Note 4 Additional information on contract revenue (IFRS15) recognised in the period

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous year end	594	1,475

Note 5 Fees and charges

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

	2020/21	2019/20
	£000	£000
Income	937	3,148
Full cost	(1,899)	(3,140)
Surplus/deficit	**(962)**	**8**

The figures above represent income and cost from car parking and catering operations within the trust. In line with all Trusts car parking charges were suspended as a result of the pandemic for most of the financial year. In addition, the reduction in visitor numbers onto our hospital sites resulted in a loss of income in our refreshment outlets.

Note 6.1 Operating expenditure

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,840	5,684
Purchase of healthcare from non-NHS and non-DHSC bodies	4,585	8,729
Staff and executive directors costs	299,778	273,696
Remuneration of non-executive directors	145	152
Supplies and services - clinical (excluding drugs costs)	31,813	34,549
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	5,438	-
Supplies and services - general	4,613	4,655
Supplies and services – general: notional cost of equipment donated from DHSC for COVID response	126	-
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	23,413	23,089
Inventories written down	38	78
Consultancy costs	691	425
Establishment	2,900	2,183
Premises [1]	15,143	11,748
Transport (including patient travel)	923	1,718
Depreciation on property, plant and equipment	9,404	8,867
Amortisation of intangible assets	1,248	1,158
Net impairments	712	(231)
Movement in credit loss allowance: contract receivables / contract assets	983	60
Change in provisions discount rate	171	120
Audit fees payable to the external auditor:		

[1] Premises costs in 2020/21 included £5m relating to recognition of future contractual obligations from the operation of two accommodation blocks on the Arrowe Park hospital site.

audit services- statutory audit	134	61
Internal audit costs	110	98
Clinical negligence [1]	12,947	12,921
Legal fees	474	174
Insurance	516	407
Research and development	7	10
Education and training	975	1,259
Operating lease expenditure	1,756	1,810
Redundancy	-	313
Other [2]	6,724	4,987
Total	**431,607**	**398,720**

[1] Clinical negligence costs relate to the Trust's annual contribution to NHS Resolution (formerly NHS Litigation Authority) under its risk-pooling scheme.

[2] Other expenditure of £6.7m (£4.9m 2019/20) includes IT contracts, professional fees and other miscellaneous expenditure.

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2019/20: £2m).

Note 7 Impairment of assets

	2020/21 £000	2019/20 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	89
Changes in market price	712	(320)
Total net impairments charged to operating surplus/deficit	**712**	**(231)**
Impairments charges to the revaluation reserve	4,747	(2,422)
Total net impairments	**5,459**	**(2,653)**

In 2020/21 the charge to the revaluation reserve (£4.7m) represented the value of impairments due to the desktop revaluation of the Trust's estate as at 31 March 2021.

In 2019/20, the net credit to the revaluation reserve (£2.4m) represented the reversal of prior-year impairments, and was due to the full revaluation of the Trust's estate as at 31 March 2020.

Note 8.1 Employee benefits

	2020/21 £000	2019/20 £000
Salaries and wages	217,751	198,749
Social security costs	19,566	18,706
Apprenticeship levy	943	937
Employer's contributions to NHS pension scheme	34,077	32,739
Pension cost - other	75	65
Termination benefits	-	313
Temporary staff (including bank and agency)	27,559	23,177
Total gross staff costs	**299,971**	**274,686**
Of which:		
Staff costs capitalised as part of assets and therefore not included in operating expenditure	193	677
Total employee benefits shown in the analysis of operating expenditure	**299,778**	**274,009**

The 2019/20 comparative figures are amended to reflect the movement of agency costs into temporary staff costs. This amounted to £15.4m.

Details regarding the remuneration of senior managers can be found in the remuneration section of the Annual report.

Note 8.2 Retirements due to ill-health

During 2020/21 there were 4 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2020). The estimated additional pension liability of these ill-health retirements is £125k (£49k in 2019/20).

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

Note 9 Operating leases

Note 9.1 Wirral University Teaching Hospital NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Wirral University Teaching Hospital NHS Foundation Trust is the lessor.

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	518	400
Total	**518**	**400**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year;		110
- later than one year and not later than five years;	-	
- later than five years.	-	-
Total		**110**

Operating lease income is derived from retail and other service providers who occupy premises at the Trust's sites. Not included in the above note are the following 'peppercorn' (minimal) leases, which have been entered into to create service benefit.

	From	To
Frontis Homes Ltd - underlying land related to staff accommodation blocks	June 2006	June 2046
Ronald McDonald House	December 2009	December 2034
Wirral Limb Centre - used by Ottobock in providing an outsourced prosthetics service	July 2018	July 2021

Note 9.2 Wirral University Teaching Hospital NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Wirral University Teaching Hospital NHS Foundation Trust is the lessee.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	1,756	1,810
Total	**1,756**	**1,810**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	1,040	1,117
- later than one year and not later than five years;	3,248	3,350
- later than five years.	4,503	5,288
Total	**8,791**	**9,755**

The Trust holds a long-term lease for the use of car parking land at the Arrowe Park Hospital site, rents off-site premises to accommodate clinics, and also leases complex medical equipment used in the delivery of healthcare for periods not exceeding 10 years. Where applicable, break clauses in the Trust's lease contracts have been taken into account in the calculation of future minimum lease payments.

The Trust is also committed to a 15 year contract, which commenced in 2014/15, with the Carbon and Energy Fund, for the provision of a maintained energy service, including the installation of infrastructure assets at the Trust's main hospital sites. A 'lease' of the infrastructure

assets in deemed to be embedded in the main service contract, through IFRIC 4 *Determining whether an Arrangement Contains a Lease.* Therefore, figures for these assets are included in the tables above.

Note 10 Finance income

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

	2020/21 £000	2019/20 £000
Interest on bank accounts	-	130
Other	2	-
Total finance income	**2**	**130**

Other finance income in 2020/21 relates to late payment interest on legal cases.

Note 11.1 Finance expenditure

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

	2020/21 £000	2019/20 £000
Loans from the Department of Health and Social Care	225	2,253
Finance leases	5	7
Interest on late payment of commercial debt	-	2
Total interest expense	**230**	**2,262**
Other finance costs	(9)	(38)
Total finance costs	**221**	**2,224**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2020/21 £000	2019/20 £000
Amounts included within interest payable arising from claims under legislation	-	2

Note 11.3 Other gains and losses

	2020/21 £000	2019/20 £000
Gains on disposal of property, plant and equipment	5	14
Losses on disposal of property, plant and equipment	(99)	(78)
Total gains/losses on disposal of assets	**(94)**	**(64)**

Gains and losses in both 2020/21 and 2019/20 result from individual disposals of equipment assets.

Note 12.1 Intangible assets – 2020/21

	Software licences	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000
Gross cost at 1 April 2020 – brought forward	**25,848**	**1,152**	**30**	**27,029**
Additions	8	75	-	83
Reclassifications	223	(223)	-	-
Gross cost at 31 March 2021	**26,079**	**1,004**	**30**	**27,112**
Amortisation at 1 April 2020 – brought forward	**13,000**	**-**	**-**	**13,000**
Provided during the year	1,248	-	-	1,248
Accumulated amortisation at 31 March 2021	**14,248**	**-**	**-**	**14,248**
Net book value at 31 March 2021	**11,831**	**1,004**	**30**	**12,864**

Note 12.2 Intangible assets – 2019/20

	Software licences	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000
Gross cost at 1 April 2019 – brought forward	**24,438**	**1,600**	**30**	**26,067**
Additions	**603**	**359**	**-**	**962**
Reclassifications	**807**	**(807)**	**-**	**-**
Gross cost at 31 March 2020	**25,848**	**1,152**	**30**	**27,029**
Amortisation at 1 April 2019 – brought forward	**11,842**	**-**	**-**	**11,842**
Provided during the year	1,158	-	-	1,158
Accumulated amortisation at 31 March 2020	**13,000**	**-**	**-**	**13,000**
Net book value at 31 March 2020	**12,848**	**1,152**	**30**	**14,029**

The useful economic lives of software licence assets at 31 March 2021 ranges from 1 year to 14 years. Other purchased assets comprises a perpetual operating licence.

£1.0m of the balance held as intangible assets under construction relates to IT projects undertaken as part of the *Digital Wirral (Global Digital Exemplar)* programme. The other £0.1m relates to remote communication systems.

Note 13.1 Property, plant and equipment – 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**1,497**	**132,337**	**4,147**	**2,432**	**39,019**	**122**	**16,412**	**1,398**	**197,364**
Additions	-	1,342	-	6,624	6,947	-	2,059	-	16,972
Impairments	-	(4,747)	-	-	-	-	-	-	(4,747)
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	(4,944)	(154)	-	-	-	-	-	(5,098)
Reclassifications	-	4,992		(6,749)	557	-	1,200	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(1,581)	-	(146)	-	(1,746)
Valuation/gross cost at 31 March 2021	**1,497**	**128,980**	**3,993**	**2,307**	**44,942**	**122**	**19,525**	**1,379**	**202,745**
Accumulated depreciation at 1 April 2020- brought forward									
Provided during the year	**-**	**-**	**-**	**-**	**23,705**	**83**	**11,084**	**1,001**	**35,872**
Impairments	-	4,353	94	-	2,932	8	1,946	71	9,404
Reversals of impairments	-	651	61	-	-	-	-	-	712
Revaluations	-	-	-	-	-	-	-	-	-
Reclassifications	-	(5,004)	(155)	-	-	-	-	-	(5,159)
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(1,479)	-	(146)	(19)	(1,644)
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**25,158**	**91**	**12,884**	**1,053**	**39,185**
Net book value at 31 March 2021	**1,497**	**128,980**	**3,993**	**2,307**	**19,784**	**32**	**6,642**	**326**	**163,560**
Net book value at 1 April 2020	**1,497**	**132,337**	**4,147**	**2,432**	**15,314**	**40**	**5,329**	**397**	**161,492**

Note 13.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**1,497**	**129,959**	**4,062**	**3,890**	**39,483**	**122**	**14,562**	**2,068**	**195,643**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	811	-	2,563	736	-	2,043	-	**6,153**
Impairments	-	(176)	-	-	-	-	-	-	**(176)**
Reversals of impairments	-	2,598	-	-	-	-	-	-	**2,598**
Revaluations	-	(3,612)	85	-	-	-	-	-	**(3,527)**
Reclassifications	-	2,757	-	(4,021)	1,172	-	92	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(2,372)	-	(285)	(670)	**(3,327)**
Valuation/gross cost at 31 March 2020	**1,497**	**132,337**	**4,147**	**2,432**	**39,019**	**122**	**16,412**	**1,398**	**197,364**
Accumulated depreciation at 1 April 2019 - as previously stated	**-**	**(0)**	**-**	**-**	**23,019**	**75**	**9,746**	**1,591**	**34,430**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	4,193	90	-	2,908	8	1,593	75	**8,867**
Impairments	-	27	-	-	69	-	20	-	**116**
Reversals of impairments	-	(172)	(175)	-	-	-	-	-	**(347)**
Revaluations	-	(4,048)	85	-	-	-	-	-	**(3,963)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(2,291)	-	(275)	(665)	**(3,231)**
Accumulated depreciation at 31 March 2020	**-**	**(0)**	**-**	**-**	**23,705**	**83**	**11,084**	**1,001**	**35,872**

During the year £2.5m of assets previously classified as assets under construction were commissioned. The most significant item within this was £1.1m relating to telephony. Of the £3.3m classified as assets under construction at 31 March 21 the most significant items are £0.6m relating to the ICU refurbishment and £0.9m relating to IT software implementation.

The dwellings balance entirely comprises staff accommodation blocks at the Trust's Arrowe Park site which are owned and operated by Frontis Homes Limited, which is part of Your Housing Group. This accommodation is situated on land owned by the Trust, and leased to Frontis through a 'peppercorn' operating lease. The accommodation block is included in this note and accounted for as 'on-Statement of Financial Position' by the Trust, as it meets the definition of a service concession contained within IFRS Interpretations Committee (IFRIC) 12 *Service Concession Arrangements.* The impairment under *Dwellings* in 2020/21 reflects the under-occupancy of staff accommodation blocks at Arrowe Park.

Note 13.3 Property, plant and equipment financing - 2020/21

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	£000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2021										
Owned - purchased	1,497	127,229		2,307		17,913	32	6,556	308	155,841
Finance leased								67		67
On-SoFP PFI contracts and other service concession arrangements			3,993							3,993
Owned – donated/granted		1,751				1,134		19	18	2,922
Owned – equipment donated from DHSC and NHSE for COVID response						737				737
NBV total at 31 March 2021	**1,497**	**128,980**	**3,993**	**2,307**		**19,784**	**32**	**6,642**	**326**	**163,560**

Note 13.4 Property, plant and equipment financing - 2019/20

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2020									
Owned - purchased	1,497	130,466	-	2,432	14,142	40	5,164	375	**154,115**
Finance leased	-	-	-	-	-	-	134	-	**134**
On-SoFP PFI contracts and other service concession arrangements	-	-	4,147	-	-	-	-	-	**4,147**
Owned - government granted	-	-	-	-	49	-	15	-	**64**
Owned - donated	-	1,871	-	-	1,123	-	16	22	**3,032**
NBV total at 31 March 2020	**1,497**	**132,337**	**4,147**	**2,432**	**15,314**	**40**	**5,329**	**397**	**161,492**

Note 14 Donations of property, plant and equipment

In 2020/21 the Trust recognised donated asset additions of £902k (£194k 2019/20). £737k of this represents the equipment donated from DGSC for COVID response. The remaining £165k related to cash additions (£194k 2019/20).

Note 15 Revaluations of property, plant and equipment

The value and remaining useful lives of land and building assets are estimated by the Trust's valuers Cushman & Wakefield. Their independent valuations are carried out in accordance with the Royal Institute of Chartered Surveyors' *RICS Valuation - Global Standards* (the 'Red Book'), and other relevant RICS guidance notes, by RICS-qualified valuers. Valuations are carried out primarily on the basis of depreciated replacement cost (modern equivalent asset (MEA) basis) for specialised operational property. The Trust has opted to interpret the MEA valuation basis, which estimates the cost of a modern replacement asset with equivalent productive capacity to the asset being valued, as pertaining to a single combined hospital facility.

Revalued assets are written down to their recoverable amount within the Statement of Financial Position, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for that asset. Thereafter, the loss is charged to operating expenditure - net impairments. Increases in value are credited to the revaluation reserve unless circumstances arise whereby a reversal of impairment is necessary. In these circumstances this has been credited to operating expenditure - net impairments.

A desktop revaluation of the Trust's estate was undertaken as at the valuation date of 31 March 2021. The last full revaluation of the Trust's estate was undertaken as at 31 March 2019. This resulted in a net revaluation loss recorded in the revaluation reserve (within the Statement of Financial Position) of £4.6m, which is also disclosed within *Other comprehensive income* , and a net impairment charged to income and expenditure (within the Statement of Comprehensive Income) of £0.7m.

The Trust continues to place reliance on the valuation which has been produced to the same professional standards and regulations as in prior years. It will further mitigate the risk of material misstatement of asset values by maintaining the existing annual revaluation cycle of Trust properties. The useful economic lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. The lives of assets determined at recognition are disclosed within the accounting policies. The remaining useful economic lives of non-land property assets as at 31 March 2021 are as follows:

Buildings excluding dwellings	8 to 48 years.
Dwellings	43 years.

Note 16 Joint operations

The Trust has determined that, in addition to its subsidiary charity, it has interests in two joint operations. Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to assets, and obligations for liabilities relating to the arrangement. The Trust therefore includes within its financial statements, where material, its share of the assets, liabilities, income and expenditure relating to its joint operations.

The Trust does not attribute levels of risk significantly above 'business as usual' with these arrangements, as its joint operator is a partner NHS body, working together with the Trust within the same healthcare operating environment. In practical terms, this translates to a longstanding related party relationship based on contracts and transactions, collaborative working, shared objectives and common policies. In addition, the 'going concern' risk and credit risk associated with other NHS bodies is very low.

The Trust has no material joint operations, but collaborates in two lesser operations,:

Cheshire and Wirral Microbiology Service (CWMS)

The Trust works collaboratively with Countess of Chester Hospital NHS Foundation Trust to provide microbiology laboratory services to both trusts. CWMS was established in 2012, and the intention of the arrangement is to reduce running costs through joint use of a modern site and laboratory facilities, to provide resilience in each trust's microbiology service, and to enable both trusts to respond to future market opportunities.

The majority of CWMS activity is carried out in the main combined laboratory in Bromborough, which is jointly and equally owned by the two trusts. The carrying value of the Trust's half of this asset in its Statement of Financial Position is £1.0m. Additionally, there are small satellite laboratories at each hospital site for urgent out-of-hours specimens.

The Trust retains the rights to assets contributed at the start of the arrangement. The Trust is responsible for the administration of CWMS payroll costs, and wholly recharges these costs to Countess of Chester Hospital NHS Foundation Trust.

As the financial 'host' partner, Countess of Chester Hospital NHS Foundation Trust retains the obligation to pay other suppliers' invoices, and offsets all direct and recharged costs against the income generated by CWMS for tests performed for both the trusts and new customers, using a tariff of prices. In 2020/21, the Trust's net expenditure on CWMS services was £1.6m (2019/20 £2.7m)

HR and Wellbeing Business Services (HRWBS)

This arrangement was created in 2011 and is jointly operated by the Trust and Countess of Chester Hospital NHS Foundation Trust (the 'host' operator). This collaboration was designed to create savings through scale efficiencies, and provide resilience to each of the operators' HR functions, including payroll and recruitment.

Activities are carried out at the Countess of Chester Health Park, and end-user services can be accessed via intranet portal. In 2020/21, HRWBS has additionally sold services to Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Clinical Commissioning Group, and Wirral Community NHS Trust.

Assets purchased are owned by the purchasing trust, with the further possibility of joint procurement of future assets. As the 'host' operator, Countess of Chester Hospital NHS Foundation Trust is responsible for HRWBS staff, and administering the payment of staff and suppliers in the first instance. Each trust is ultimately responsible for its share of HRWBS's costs, and the net charge to the Trust for 2020/21 is £0.4m (2019/20 £0.5m)

Note 17 Inventories

	2020/21 £000	2019/20 £000
Drugs	1,332	1,374
Consumables	2,848	2,589
Consumables donated from DHSC group bodies (PPE)	582	-
Energy	26	29
Total stock held at net realisable value	**4,788**	**3,992**

Inventories recognised in expenditure for the year totalled £51.3m (£49.4m 2019/20). In 2020/21 this expenditure includes the centrally procured PPE consumables.

Write-down of inventories recognised as expenditure for the year totalled £38k (£78k 2019/20).

Due to the operational pressure the Trust has faced throughout the year as a result of the COVID pandemic it has not been possible to undertake physical stock counts in all areas. Consequently the Trust undertook alternative procedures which included estimation of stock levels based on stock levels from previous years. This estimation applied to only 10.5% of the overall stock value so is therefore not material.

Note 18.1 Receivables

	2020/21 £000	2019/20 £000
Current:		
Contract receivables	14,692	21,306
Allowance for impaired contract receivables / assets	(1,468)	(584)
Deposits and advances	58	102
Prepayments (non-PFI)	2,574	2,422
Interest receivable	-	11
PDC dividend receivable	371	525
VAT receivable	1,036	589
Other receivables	-	5
Total current receivables	**17,263**	**24,376**
Non-current:		
Contract receivables	740	924
Allowance for impaired contract receivables / assets	(166)	(201)
Other receivables	295	251
Total non-current receivables	**869**	**974**
Of which is receivable from NHS and DHSC group bodies:		
Current	10,737	16,662
Non-current	295	251

Note 18.2 Allowances for credit losses

	2020/21 £000	2019/20 £000
Allowances as at 1 April - brought forward		
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	785	728
New allowances arising	983	79
Reversals of allowances	-	(19)
Utilisation of allowances (write offs)	(134)	(3)
Allowances at 31 March	**1,634**	**785**

Note 19.1 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.

	2020/21 £000	2019/20 £000
At 1 April 2020	5,931	6,515
Net change in year	15,362	(584)
At 31 March	**21,293**	**5,931**
Broken down into:		
Cash at commercial banks and in hand	39	98
Cash with the Government Banking Service	21,254	5,833

Note 19.2 Third party assets held by the trust

During the year the Trust held cash relating to monies held on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	2020/21 £000	2019/20 £000
Bank balances	10	10
Total third party assets	**10**	**10**

Note 20 Trade and other payables

	2020/21 £000	2019/20 £000
Current:		
Trade payables	1,386	2,174
Capital payables	4,288	2,165
Accruals	29,762	28,848
Receipts in advance and payments on account	83	87
Social security costs	3,040	2,515
Other taxes payable	5,731	2,854
Other payables	247	3,229
Total current trade and other payables	**44,537**	**41,873**
Of which payable to NHS and DHSC group bodies:		
Current	4,151	12,459

Other taxes payables includes amounts owed to HMRC which relates to both employee salary deductions and employer contributions.

The Better Payment Practice Code (BPPC) gives NHS organisations a target of paying 95% of undisputed invoices within 30 calendar days of the receipt of either goods or a valid invoice (whichever is later), unless other payment terms have been agreed. Information regarding the Trust's BPPC performance is within the Annual Report's Directors' report.

Note 21 Other liabilities

	2020/21 £000	2019/20 £000
Current:		
Deferred income: contract liabilities	4,513	2,891
Deferred PFI income	109	109
Total other current liabilities	**4,622**	**3,000**
Non-current:		
Deferred PFI income	2,479	2,588
Total other non-current liabilities	**2,479**	**2,588**

The non-current deferred income balance above is wholly attributable to the staff accommodation blocks which are owned and operated by Frontis Homes Limited, and which are accounted for as 'on-Statement of Financial Position' in accordance with IFRIC 12. The deferred income balance represents the benefit to the Trust of the arrangement's future 'service potential' and is released to the Statement of Comprehensive Income (SOCI) over the period of the concession. Therefore, there is a corresponding balance in current PFI deferred income which represents next year's income release.

Note 22.1 Borrowings

	2020/21 £000	2019/20 £000
Current:		
Loans from the Department of Health and Social Care	1,024	85,170
Obligations under finance leases	66	64
Total current borrowings	**1,090**	**85,234**
Non-current:		
Loans from the Department of Health and Social Care	5,193	6,208
Obligations under finance leases	-	66
Total other non-current liabilities	**5,193**	**6,274**

In April 2020 the Department of Health announced its intention to issue new Public Dividend Capital (PDC) for the purpose of funding repayment of all NHS provider's interim revenue support and working capital loans. The new PDC does not require repayment of principle and therefore the swap of loan to PDC funding removes a material uncertainty over the Trust's ability to repay its loan balances. This transaction took place on 30 September 2020 and £83.9m of interim revenue support was converted to PDC.

Note 22.2 Reconciliation of liabilities arising from financing activities – 2020/21

	Loans from DHSC £000	Finance leases £000	Total £000
Carrying value at 1 April 2020	91,378	130	91,508
Cash movements:			
Financing cash flows – payments and receipts of principal	(84,899)	(64)	(84,963)
Financing cash flows – payment of interest	(487)	(5)	(492)
Non-cash movements:			
Application of effective interest rate	225	5	230
Carry value at 31 March 2021	**6,217**	**66**	**6,283**

Note 22.3 Reconciliation of liabilities arising from financing activities – 2019/20

	Loans from DHSC £000	Finance leases £000	Total £000
Carrying value at 1 April 2019	74,308	191	74,499
Cash movements:			
Financing cash flows – payments and receipts of principal	16,999	(61)	16,938
Financing cash flows – payment of interest	(2,186)	(7)	(2,193)
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2019	2,257	7	2,264
Carry value at 31 March 2020	**91,378**	**130**	**91,508**

Note 23 Finance leases

Obligations under finance leases where the Trust is the lessee:

	2020/21 £000	2019/20 £000
Gross lease liabilities	**66**	**138**
Of which liabilities are due:		
Not later than one year	66	69
Later than one year and not later than five years	-	69
Later than five years	-	-
Finance charges allocated to future periods	-	(8)
Net lease liabilities	66	130
Of which liabilities are due:		
Not later than one year	66	64
Later than one year and not later than five years	-	66
Later than five years	-	-

As lessee the Trust holds a single finance lease for digital data storage, with a whole-life duration of 5 years. The Trust has the option to purchase the equipment for a nominal amount at the end of the lease term.

Note 24.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	**£000**	**£000**	**£000**	**£000**
Opening balance	1,672	1,142	669	6,998	10,481
Transfers by absorption	-	-	-	-	-
Change in the discount rate	44	80	-	47	171
Arising during the year	242	746	1,637	2,925	5,550
Utilised during the year	(169)	(99)	(162)	(877)	(1,307)
Reversed unused	(67)	(115)	(126)	-	(308)
Unwinding of discounts	(8)	(6)	-	-	(14)
	1,714	1,748	2,018	9,093	14,573
Expected timing of cash flows					
- not later than one year	171	104	1,733	4,656	6,664
- later than one year and not later than five years	726	443	285	3,578	5,032
- later than five years	817	1,201	-	859	2,877
Total	**1,714**	**1,748**	**2,018**	**9,093**	**14,573**

Legal claims are primarily made up of employee tribunal and employer liability claims.

The amount provided for employer's / public liability claims is based on assessments received from NHS Resolution (NHSR) as to their value and anticipated payment date, plus local assessments on a small number of other employee related legal cases.

Other provisions largely comprise of contractual obligations (£5m) to compensate the operator for foregone rental income, resulting from ongoing under-occupancy of the staff accommodation blocks at the Trust's Arrowe Park site which are owned and operated by Frontis

Homes Limited (within Your Housing Group). In addition, a further £1.7m in relation to Flowers and £1.1m is held in respect of contractual VAT obligations which the Trust became aware of in February 2019, for which there is a corresponding contingent liability of £0.380m (£0.380m 2019/20).

Note 24.2 Clinical negligence liabilities

At 31 March 2021 £294,675k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Wirral University Teaching Hospital NHS Foundation Trust (31 March 2020 £288,353k).

Note 25 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(116)	(175)
Employer tribunal and other employer related litigation	-	(95)
Other	(380)	(380)
Gross value of contingent liabilities	**(496)**	**(650)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(496)**	**(650)**

The Trust has been informed of its contingent liability of £116k (31 March 2020 £175k) in respect of NHS Resolution legal claims.

Note 26 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	1,666	3,147
Intangible assets	257	199
Total	**1,923**	**3,346**

Capital commitments at 31 March 2021 relate to infrastructure and upgrade projects.

Note 27 Financial instruments

Note 27.1 Financial risk management

Liquidity risk

The Trust's net operating costs are incurred in delivering healthcare under annual contracts with Clinical Commissioning Groups (CCGs), which are ultimately funded from resources voted annually by Parliament. The Trust usually receives this CCG income through a combination of 'block' (fixed) payments and the Payment by Results (PbR) mechanism, which bases the income received each year on the activity delivered in that year by reference to the National Tariff. Monthly payments are received from CCGs based on annual service contracts, and this national framework reduces the Trust's exposure to liquidity risk.

The Trust borrows from the Department of Health and Social Care (DHSC) for operating purposes, and actively mitigates liquidity risk by daily cash management procedures incorporating the timely initiation of loans, keeping all cash balances in an appropriately liquid form. Liquidity is monitored by the Trust's Board on a monthly basis through monthly reports on movements, variances and trends in cash-flows, and the liquidity metric measured within the NHSI's Use of Resources (UoR) Rating.

The Trust may borrow from commercial organisations to support liquidity, but currently has no commercial borrowings.
The Trust also holds two fixed interest rate loans with DHSC which have funded past capital developments, as follows:

25 year loan of £6.5m at 4.32%, drawn down in 2009/10.
10 year loan of £7.5m at 1.96%, drawn down in 2014/15.

Repayments on the capital loans have commenced, and are paid according to a set schedule over the period of the loans. To date, £6.8m has been repaid.

In April 2020 the Department of Health announced its intention to issue new Public Dividend Capital (PDC) for the purpose of funding repayment of all NHS provider's interim revenue support and working capital loans. The new PDC does not require repayment of principle and therefore the swap of loan to PDC funding removes a material uncertainty over the Trust's ability to repay its loan balances. PDC was issued on 30 September 2020 allowing the Trust to repay its working capital and interim revenue support loans.
The loan repayment schedule is contained within the maturity of financial liabilities table in Note 27.4.

Credit risk
The Trust minimises its exposure to credit risk arising from deposits with banks and financial institutions through implementing its Treasury Management procedures. Cash required for day to day operational purposes is held within the Trust's Government Banking Services (GBS) account. GBS balances are swept into the Bank of England overnight, with the specific aim of reducing credit risk exposure for bodies within government.

The Trust regularly reviews debtor balances, and has a comprehensive system in place for pursuing past-due debt. Aged debts are regularly assessed and proactive credit control is in place, including referral to debt recovery agents when internal efforts are exhausted and it is deemed potentially cost-effective to pursue. Every quarter, aged debts are individually presented to the Trust's Audit Committee for further scrutiny.

The main source of income for the Trust is from CCGs in respect of healthcare services provided under contractual agreements. The credit risk associated with such customers is minimal. Non-NHS customers (for example, private patients and prescription charges) typically have a higher rate of write-off, but represent a small proportion of income. Therefore, the Trust is not exposed to significant credit risk from its customers.

The movement in the Allowance for credit losses during the year is disclosed in Note 18.2. The Trust's approach to the impairment of financial assets is detailed in Note 1 Accounting Policies.

The carrying amount of financial assets represents the Trust's maximum level of credit exposure. Therefore, the maximum exposure to credit risk at the Statement of Financial Position date was £35.3m (£27.3m 2019/20), being the total of the carrying amount of financial assets excluding cash (Note 27.2). There are no amounts held as collateral against these balances.

Market risk

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

The Trust does not invest for capital appreciation. All of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest other than the Trust's bank accounts which earn interest at a floating rate; the Trust is not exposed to significant interest rate risk.

Note 27.2 Carrying values of financial assets

In the following notes, non-financial assets and non-financial liabilities are excluded. Therefore, the receivables and payables figures are lower than their respective balances within the Statement of Financial Position (SOFP).

	Held at amortised cost £000
Carrying values of financial assets at 31 March 2021	
Trade and other receivables excluding non-financial assets	14,093
Cash and cash equivalents	21,293
Total at 31 March 2021	**35,386**
Carrying values of financial assets at 31 March 2020	
Trade and other receivables excluding non-financial assets	21,445
Cash and cash equivalents	5,931
Total at 31 March 2020	**27,376**

Note 27.3 Carrying values of financial liabilities

	Held at amortised cost £000
Carrying values of financial liabilities at 31 March 2021	
Loans from the Department of Health and Social Care	6,217
Obligations under finance leases	66
Trade and other payables excluding non-financial liabilities	29,476
Provisions under contract	7,672
Total at 31 March 2021	**43,431**

	Held at amortised cost £000
Carrying values of financial liabilities at 31 March 2020	
Loans from the Department of Health and Social Care	91,378
Obligations under finance leases	130
Trade and other payables excluding non-financial liabilities	36,417
Provisions under contract	6,747
Total at 31 March 2020	**134,672**

Note 27.4 Maturity of financial liabilities

	31 March 2021 £000	31 March 2020 £000
In one year or less	33,537	123,861
In more than one year but not more than five years	7,825	7,910
In more than five years	3,239	4,304
Total	**44,601**	**136,075**

As per note 27.3 £83.9m of working capital and interim revenue support loans from the Department of Health & Social Care were repaid on 30 September 2020 following the issue of new Public Dividend Capital for that purpose.

Note 27.5 Fair values of financial assets and liabilities

The Trust has two capital loans and a number of revenue support loans with the Department of Health and Social Care. The carrying value of the borrowings liability is considered to approximate to fair value, the interest rate not being significantly different from market rate. All other financial assets and liabilities have carrying values which are not significantly different from their fair values.

Note 28 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.
The Trust made the following losses and special payments, on an accruals basis (with the exception of provisions for future losses), during the financial year.

	2020/21		2019/20	
	Total number of cases No.	Total value of cases £000	Total number of cases No.	Total value of cases £000
Losses				
Cash losses	23	32	14	2

Bad debts and claims abandoned	26	103	22	2
Stores losses and damage to property	6	138	5	77
	55	**273**	**41**	**81**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	36
Ex-gratia payments	45	143	44	172
Total	**45**	**143**	**45**	**208**
Total losses and special payments	**100**	**416**	**86**	**289**

No losses or special payments of any type, over the disclosure threshold of £300k were recorded in 2020/21 and 2019/20.

Note 29 Related parties

Whole of Government Accounts (WGA) and consolidation

Wirral University Teaching Hospital NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. Monitor (operating as NHS Improvement) does not prepare group accounts, but rather, it prepares *NHS foundation trusts: consolidated accounts* , for further consolidation into the Department of Health and Social Care's accounts, and, ultimately, the Whole of Government Accounts. Monitor (operating as NHS Improvement) has powers to control NHS foundation trusts, but its financial results are not incorporated within the consolidated accounts, and it cannot be considered to be the parent undertaking for foundation trusts. The Department of Health and Social Care (DHSC) is the parent department of the foundation trust sector. Although there are a number of consolidation steps between the Trust's accounts and Whole of Government Accounts, the Trust's ultimate parent is HM Government.

WGA bodies

All bodies within the scope of the Whole of Government Accounts are considered to be related parties as they fall under the common control of HM Government and Parliament. The Trust's related parties therefore include other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies, non-departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Trust has had a number of transactions with WGA bodies. Listed below are those entities other than DHSC for which the total transactions or total balances with the Trust have been collectively significant or potentially material to the other body.

Betsi Cadwaladr University Local Health Board	NHS Wirral CCG
Countess of Chester Hospital NHS Foundation Trust	NHS England (including sub-entities)
The Clatterbridge Cancer Centre NHS Foundation Trust	Health Education England
Wirral Community NHS Foundation Trust	NHS Pension Scheme
NHS Cheshire CCG	NHS Resolution (formerly NHS Litigation Authority)
NHS Liverpool CCG	NHS Professionals

Public dividend capital (PDC) transactions with DHSC

The Trust made PDC dividend payments to DHSC totalling £3.3m (£2.0m 2019/20), received additional PDC of £91m which includes the loan conversion (£0.5m 2019/20). There is a year-end receivable for PDC dividend of £0.4m (£0.5m 2019/20).

Allowance for credit losses - related parties

No related party debts have been written off by the Trust in 2020/21 (none in 2019/20). The Trust's *Allowance for credit losses* is calculated such that it includes no balance in relation to its related parties.

Charitable related parties - WUTH Charity

Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund (registered charity number 1050469, known as 'WUTH Charity') is a subsidiary of the Trust and therefore a related party. The Trust is the Charity's corporate trustee, which means that the Trust's Board of Directors is charged with the governance of the Charity. The Charity's sole activity is the funding of capital and revenue items for the benefit of the Trust's patients. Further details can be found at https://www.wuthcharity.org/.

The Charity's total funds balance as at 31 March 2021 was £1m (£1.0m 2019/20) with net income of £0.1m (£0.1m net income 2019/20). During the year the Charity incurred expenditure of £0.3m (£0.5m 2019/20) in respect of goods and services for which the Trust was the main beneficiary.

Other related parties

Aside from the Trust's Charity, the Trust has no subsidiaries or associates.

Key management personnel

Key management personnel are *related parties* to the Trust, and are defined in IAS 24 *Related Party Disclosures* as 'those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any director (whether executive or otherwise) of that entity.' They are identified by the Trust as being the same individuals as the 'senior managers' which are disclosed in the remuneration section of the Annual Report, which contains details of their remuneration and other benefits.

In 2020/21, the Trust had expenditure as follows:

- £5k with Edge Hill University, at which Steve Igoe, a non-executive director of the Trust, is the Deputy Vice Chancellor
- £10k with the Healthcare Financial Management Association, at which Claire Wilson, Chief Finance Officer of the Trust, is a Trustee.

These expenditures are not believed to be in any way material to either party an all dealings were undertaken on an arms-length basis.

During the financial year under review, no other member of key management personnel, and no other party closely related to these individuals outside of the NHS, has undertaken transactions with Wirral University Teaching Hospital NHS Foundation Trust.

Note 30 Events after the reporting date

The Trust has not identified any events that occurred after the reporting year that would require disclosure as non-adjusting events in accordance with IAS10.