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Annual Report and Accounts 2012-13

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Trust Overview

Trust Overview

Wirral University Teaching Hospital NHS Foundation Trust is one of the largest and busiest acute trusts in the North West of England.

The Trust 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) and received its' Terms of Authorisation from Monitor, the independent regulator of NHS Foundation Trusts on 1 July 2007.

Our Foundation Trust (FT) status 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. We are also accountable to our commissioners (through contracts), Parliament and Monitor, which is the independent regulator of FTs.

Providing a comprehensive range of high quality acute care services, our 5,600-strong workforce 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 2012/13 centred on contracts placed by primary care organisations and specialist commissioning bodies.

We aim to provide excellence in healthcare over five clinical divisions:

1. Acute Care

2. Diagnostic and Clinical Support

3. Medical Specialties

4. Surgery

5. Women and Children's.

Each is led by a Clinical Head of Division, Associate Director of Operations, and a Divisional Lead Nurse and includes relevant clinical directorates.

We operate from two main sites (Arrowe Park Hospital and Clatterbridge Hospital), while also providing a range of services in community settings:

1. Arrowe Park Hospital, Upton – delivering a full range of emergency and acute services for adults and children, plus maternity services

2. Clatterbridge Hospital, Bebington – undertaking the majority of planned surgical services and some specialist rehabilitation services

3. St Catherine's Community Hospital, Birkenhead – providing X-ray and some outpatient services

4. Victoria Central Health Centre, Wallasey – providing X-ray and some outpatient services.

The full range of our service for local people includes:

❯ Accident & Emergency services for adults and children

❯ A diverse range of acute and non-acute specialties

❯ Outpatients services

❯ Day surgery services

❯ Maternity

❯ Level 3 neonatal services

❯ Specialist services, such as:

- renal

- dermatology

- orthopaedics (hip & knee revisions)

- ophthalmology (retinal)

- urology (cancer centre)

- stroke and gynaecology (advanced laparoscopic endometriosis centre).

Our clinical work is also complemented by corporate services, which comprises of:

❯ Executive office

❯ Operations

❯ Finance and Procurement

❯ Human Resources and Organisational Development

❯ Information

❯ Quality and Safety

❯ Facilities and Estates Management

❯ Corporate Nursing and Midwifery.

"In so far as it impacts on education, the Trust has an excellent and highly effective management structure.

Good working relationships between senior staff promote good education and this is very evident at all levels."

Extracts from the Deanery Annual Assessment Report 2012

Trust Overview

As one of the largest employers on the Wirral, we've had significant recognition from external organisations for our support for staff through effective policies, initiatives and partnership working approach.

This commitment to our staff reflects our wider commitment to improve internal efficiencies and develop high quality, people-centred care.

Our position as a leader in the development and use of clinical Information Technology (IT) has been strengthened by the ongoing implementation of the Wirral Millennium system, in partnership with providers Cerner Ltd, and its increased usage across the hospital.

Wirral Millennium is now established as our core clinical system and is supporting the effective delivery of patient care in several key areas.

As a teaching hospital of the University of Liverpool, we are also renowned as a leader in the region for high quality education and training for a wide range of staff including doctors, nurses and other clinicians.

We are also a tertiary centre providing specialist services to a wider population in Merseyside, Cheshire and North Wales.

> "I would like to thank the dedicated staff who worked very hard and showed so much compassion when saving the life of my severely disabled daughter.
>
> The dedication, respect and care they all showed towards me and my daughter was amazing."
>
> Helen Morris, Hoylake

290,654 diagnostic examinations performed

95,194 new outpatient attendances

91,161 A&E attendances

37,396 elective day case admissions (excluding nephrology)

3,672 births

Statements

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Chairman's Statement

As with the wider NHS, this has been a very challenging year for all involved in the work of this Trust.

Our determination to provide the best possible healthcare for our patients is undiminished, but we are also having to face the reality of increasing financial austerity and a growing demand for our services.

We can therefore take great pride that at year end we have achieved a green governance rating, that we have met our financial duties, and most importantly that our Regulators have confirmed the high quality of the care we provide.

This is a fitting tribute to the work and dedication of everyone in the organisation – our staff, our volunteers, our Council of Governors and our Board of Directors.

Yet we have no intention of resting on our laurels. This coming year will be just as difficult, but looking forward as a Trust we want to work closely with our Commissioners, our Partners, and our Members to ensure that we can plan to provide the kind of services that can best meet the current and future needs of the populations we serve.

To that end, we are working hard on a new five year strategy for the Trust and as part of that process we are developing new forms of engagement with our stakeholders. I hope to be able to report next year on the fruits of that work.

And, of course, the year has had its particular highlights, including the work to make better use of improved facilities at Clatterbridge Hospital, the acquisition with the help of Wirral Clinical Commissioning Group of a Da Vinci Robot in surgery, and the appointment of a number of excellent new consultants across the Trust.

This has also been a year of very considerable administrative change.

We have fully revised our Constitution to meet the requirements of the Health and Social Care Act 2012, have revised the size and composition of our Council of Governors – including the introduction of a new North West and North Wales Constituency to reflect our clinical reach, have introduced new governance and management structures, and have taken the opportunity of natural turnover to create a new Executive Team.

As a Trust we seek to serve both the people of the Wirral in their health needs generally, and also that wider population drawn from across England and Wales who depend upon our many specialist services.

To do so we rely on the help and commitment of our many stakeholders, both internal and external, and I should like to record our thanks to them all for their continuing support.

Michael Carr

Chief Executive's Statement

Looking back over my first twelve months in post as Chief Executive, I see many achievements and much that we can be proud of.

In terms of compliance and accreditations we have been fully compliant with all CQC standards; achieved NHSLA Level 2; attained Level 3 GMC/Deanery accreditation for our medical teaching; maintained Investors in People accreditation and achieved top marks in all areas in PEAT (Patient Environment Action Team) rating in respect of environment, food and privacy and dignity.

Our midwives, and the excellent service they provide to mothers in Wirral, were viewed by almost three million people in a BBC documentary; our wonderful new Wirral Breast Centre housing the latest in medical technology in a newly refurbished unit opened to patients and as part of our drive to create a great first impression for every person who visits our hospitals, major refurbishment works have commenced at our Arrowe Park site.

This will result in the sort of bright and modern entrance and public areas that patients have come to expect from a 21st century health service and which reflect the high standard of health care we provide.

The past twelve months has also seen individuals and teams across the Trust receive awards from external organisations. These include the Efficiency Award presented to our Micropath Laboratory Services at the National Healthcare Financial Management Awards; our COPD (Chronic Lung Disease) team were awarded the prestigious national 'Vision' award for their work with the Wirral Health Commissioning consortium on an initiative to support patients to manage their own condition.

Health Care Assistant Beverly Jackson was the NHS North West Apprentice of the Year; our hand and upper limb Consultant Surgeon was presented with the Mersey Trainer of the Year Award and our Trust was awarded a Gold Ribbon accreditation by the NHS Sport and Physical Activity Challenge for its' commitment to improving staff health and wellbeing.

Since I joined the Trust in April 2012 I have devoted a considerable amount of time to meeting and talking with staff across the organisation and with our partners and other healthcare providers, learning about the challenges they face in delivering high quality health care and how together we can improve the service we provide.

This ongoing engagement with colleagues, both within the Trust and externally, will continue to be central to shaping and implementing our Five Year Strategy and help us to meet our goal of transforming our organisation by building on our considerable clinical capabilities and placing our patients and customers at the heart of everything we do.

There is a huge level of commitment and this gives us a great platform to build on going forward. I am confident that with this commitment and the continuing and much valued support of our partners, commissioners, governors and volunteers we have the capability to achieve our vision of being the first choice healthcare partner to the communities we serve.

David Allison

Our
Performance

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Our Performance

Our Vision, Values and Goals

Our vision is to provide Excellence in Healthcare for the communities we serve.

This means excellence in everything we do, whether in the experience of patients, the quality of our services, our position as a major employer, or in our role in working with other organisations to improve public health in the widest sense of the word.

In pursuing the Trust's vision of Excellence in Healthcare, a number of goals have been established. These goals are used to establish annual objectives across each of our six Divisions through the annual planning process.

To achieve our vision we are committed to continually improving:

❯ the quality and safety of care provided for our patients

❯ access to the care we provide for our patients and the communities we serve

❯ the journey for our patients by improving flow through the Trust and local health system

❯ the experience of our patients whilst under our care

To enable the achievement of these over-arching goals we've developed a comprehensive set of system wide imperatives, enabling goals and Divisional specific objectives.
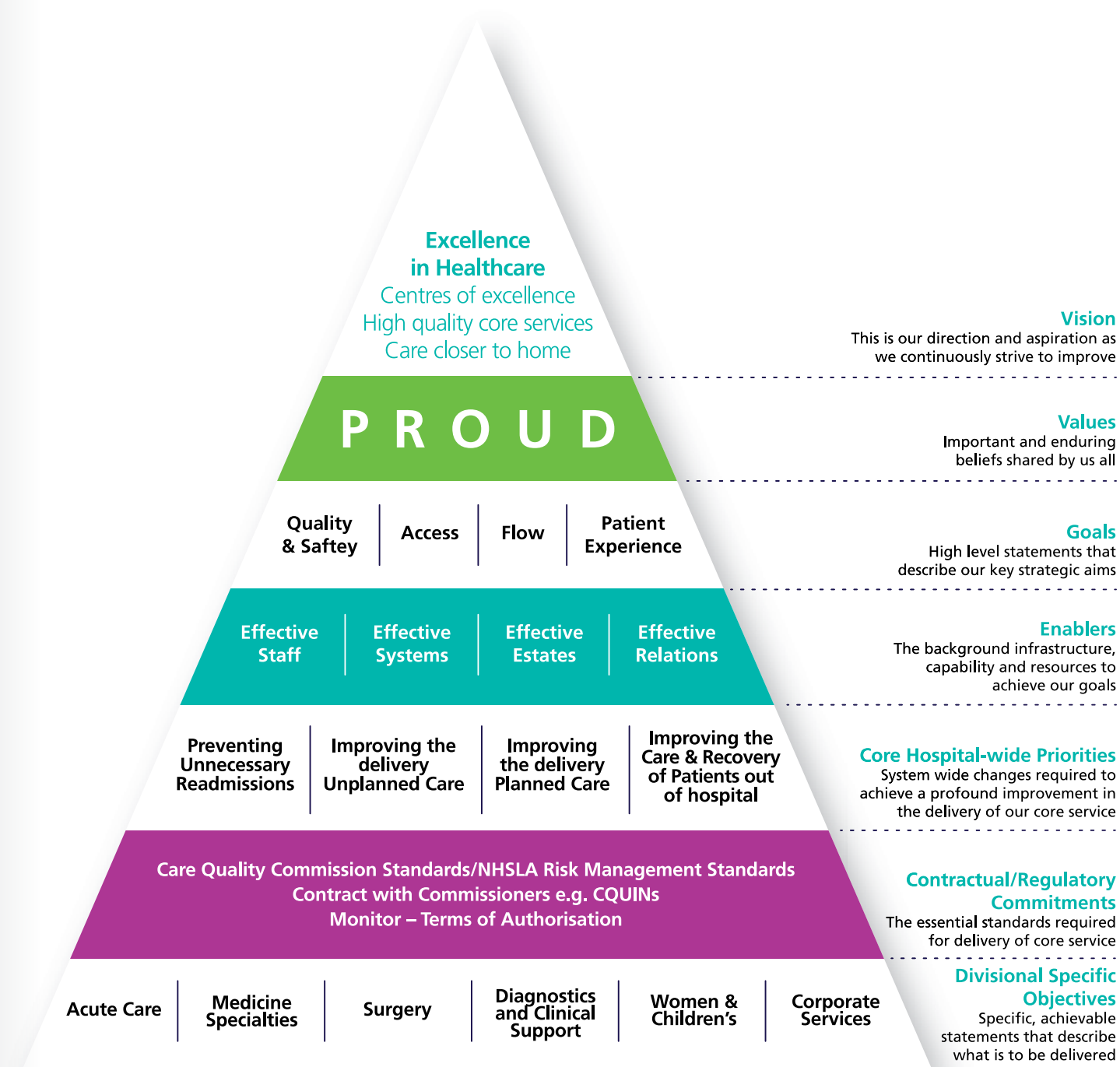
This is reflected in the pyramid diagram:

"Yesterday was my grandma's 91st birthday. During the visiting time around 10-15 nurses came over the gran's bed singing 'Happy Birthday' and carrying a giant cake!

It was such a lovely, kind thing to do."

Eleri Clare King, Wirral

Excellence in Healthcare
Centres of excellence
High quality core services
Care closer to home

PROUD

| Quality & Saftey | Access | Flow | Patient Experience |

| Effective Staff | Effective Systems | Effective Estates | Effective Relations |

| Preventing Unnecessary Readmissions | Improving the delivery Unplanned Care | Improving the delivery Planned Care | Improving the Care & Recovery of Patients out of hospital |

Care Quality Commission Standards/NHSLA Risk Management Standards
Contract with Commissioners e.g. CQUINs
Monitor – Terms of Authorisation

| Acute Care | Medicine Specialties | Surgery | Diagnostics and Clinical Support | Women & Children's | Corporate Services |

Vision
This is our direction and aspiration as we continuously strive to improve

Values
Important and enduring beliefs shared by us all

Goals
High level statements that describe our key strategic aims

Enablers
The background infrastructure, capability and resources to achieve our goals

Core Hospital-wide Priorities
System wide changes required to achieve a profound improvement in the delivery of our core service

Contractual/Regulatory Commitments
The essential standards required for delivery of core service

Divisional Specific Objectives
Specific, achievable statements that describe what is to be delivered

Our Performance

Excellence in Healthcare isn't just about the clinical treatment we provide. It's about the way we behave as individuals and as an organisation, towards each other, our patients, people who care for (or about) them, and our key stakeholders.

It's also about rising to the challenge to create a great first impression for everyone that comes into contact with us at any point in their healthcare journey.

The following values are therefore inherent in everything we do, right across the Trust:

Patients are at the heart of everything we do

Respect each other every day

Our hospitals are your hospitals

United to provide the best possible patient care

Dedicated to excellence in all we do

These values shape the culture and character of our organisation and guide the decisions that we make. They underpin all the work presented in this report.

By keeping these values at the heart of everything we do we continue to guide our journey towards our vision of achieving Excellence in Healthcare.

They show that fundamentally, we are a **PROUD** organisation:

❯ Proud of our staff and our work

❯ Proud of our facilities and our workplaces

❯ Proud of the trust our patients place in us

Rising to the Challenge

Sister Gail Auchinleck,
Children's Emergency Department

"She is a highly respected and admired person and truly embraces the trust PROUD core values at every turn. She always ensures that patients and relatives come first and always strives to ensure that excellent care is given. She demonstrates respect for all and always treats everyone as equals.

I have never before worked alongside someone who is as dedicated to her work and she is someone that takes pride in rising to the challenge every day!"

Extract from Foundation Award nomination

Our Performance

Key Achievements Against Our Goals

All our activities are linked to our goals and a summary of our substantial progress, measured against specific actions in2012/13 is given below:

Goal: Deliver excellence in quality, safety and patient experience	***RAG Rating**	**Short Comment**
Reduce hospital acquired infections	Amber	❯ 2 MRSA bacteraemia (blood borne infection) (against a tolerance of 0) ❯ Only 27 C Diff cases (out of a tolerance of 50 maximum)
Achieve NHSLA Level 2	Green	❯ Passed 48/50 criteria in July 2012.
Establish Patient Safety Alert system and improve incident reporting	Green	❯ Safety Alert System of incidents agreed for high risk incidents. Process agreed and currently being implemented.
Progress Safety Express initiative	Amber	❯ All wards submitting safety thermometer data monthly. Consistently maintained over 93% harm free care.
Deliver CQUIN improvements	Green	❯ Initial VTE (venous thromboembolism) risk assessments – 95% of inpatients were assessed (exceeding the national target of 90%).
Reduce the in-hospital risk adjusted mortality rate (HSMR)	Green	❯ Target of 10% achieved in year; expected to be maintained to year end.
Deliver the Advancing Quality initiative	Green	❯ Validated data is available for the first six months of 12/13; all areas have achieved their targets.

RAG*-Red, Amber, Green

Reduce number of patients coming to harm from anticoagulant treatment	Amber	❯ For target on *APTT we are achieving the maximum target. ❯ For *INR > 8 the target has not been reached but a reduction in the number of patients with an INR > 8 has been seen. ❯ A review of every patient under our care occurs and lessons learned are shared. There has been an improvement in the management of INR greater than 8 in the Trust with an action plan documented in each individual medical record ❯ There has been a big focus on training in 2012/13 and it is anticipated that the benefits of this will be seen in 2013/14
Reduce number of patients receiving medicines they are allergic to	Red	❯ Target for the year was 15. Cases to end of February was 28. ❯ All of these patients were managed appropriately and none suffered long term harm. ❯ A multidisciplinary group has been established to review each occasion when a patient is given medicines to which they are allergic ❯ If staff are involved in an incident then they will receive written notification when they are identified from the electronic record and are required to complete a reflective statement to identify how they will prevent this from occurring in the future ❯ The electronic prescribing system used in the Trust will be amended in 2013/14 to ensure that allergies print out on the nurse administration record in order to alert them to the allergy status.
Percentage of patients stating that they would recommend the hospital	Green	❯ During 2012/13, 96% of patients said they would recommend the hospital to their family and friends.

APTT*-Activated Partial Thromboplastin Time

INR*-Internal Normalised Ratio

Our Performance

Goal: Improve patient flow	RAG Rating	Short Comment
Reduce Length of Stay and overall bed requirements	Amber	❯ There have been some reductions in length of stay in specific areas, but not overall due to the high volume of emergency admissions with complex needs. The high volume of emergency admissions has resulted in the opening of additional beds on a temporary basis.
To ensure that reductions in Length of Stay do not significantly reduce the quality of patient flow	Green	❯ A number of new enhanced recovery pathways implemented over the year with positive patient feedback.
Implement eight Model Wards	Green	❯ A two year programme to improve patient and staff experience, by developing standards in our inpatient areas, commenced in August 2012 ❯ More than 30% of inpatient areas, are now developed to the defined standards, considering statutory and regulatory requirements ❯ Specific elements of the programme have also been rolled out across all wards ahead of the programme, to support Trust-wide safety, quality and flow initiatives ❯ Practitioners from the wards are appointed to work alongside the WEHS* leaders to increase the pace and promote sustainment of this programme ❯ Post-implementation audit, conducted by learning with patients and volunteers, and also external audit has confirmed significant improvements in staff and patient experience

WEHS* Wirral Excellence In Healthcare System

Goal: Improve patient access	RAG Rating	Short Comment
Meet the Accident & Emergency waiting time standards	Red	❯ We successfully delivered this standard for the first three quarters of the year, but did not do so in quarter four due to the pressure of high levels of emergency admissions and the impact of norovirus.
Meet compliance standards with 18 weeks Referral to Treatment	Green	❯ This standard was met all year.
Meet compliance standards for cancer treatment	Green	❯ Cancer targets for the year were achieved.

Goal: Develop excellent staff	RAG Rating	Short Comment
Develop excellent staff Implementation of year three of the Workforce Strategy. Workforce profile	Green	❯ Workforce reviews have been undertaken in the majority of areas and investment in staffing has been considerable with circ 100 additional nurses and 20 additional Consultants. The focus for the year has been on increasing our core staffing and improving our recruitment processes to minimise gaps.
Health and Wellbeing	Green	❯ The Health and Wellbeing work has continued and a number of health promotion campaigns have been implemented including Stop Smoking, and Flu vaccinations. ❯ Fitter for Health continues to be a popular programme and the Treating Yourself Well event in July 2012 was extremely successful.
Maximising knowledge and talent	Green	❯ The Senior Multidisciplinary Leadership and Management Programme was reviewed in order to make it more relevant and accessible to those who needed it ❯ The Knowledge and Talent Strategy implementation commenced and the first report on "talent" across the organisation produced ❯ Clinical leadership continues to be a priority and has progressed considerably in the last 12 months both in volume and impact.

Our Performance

	RAG Rating	Short Comment
Nursing excellence	**Green**	❯ Significant progress made in nursing leadership, development and involvement. ❯ Lead Nurses are properly embedded as part of the senior leadership team of the clinical divisions and this has been demonstrable in the quality of our care and experience
Excellence in Teaching	**Green**	❯ Three year plan developed and implemented with support from divisions and education/commissioning. Initiative not only addresses gaps in provision with reduction of Doctors in training but also supports the development of seven day working where needed.

Goal: Develop collaborative relationships and partnerships	RAG Rating	Short Comment
Develop the collaboration with the Countess of Chester	**Amber**	❯ We've made significant progress in developing both clinical and nonclinical shared services, for example, in microbiology services, however the vascular services collaboration has not progressed as quickly as planned.
Engage with Clinical Commissioning Groups and GPs	**Amber**	❯ We've made significant progress working with CCGs* but still need to improve joint working with GPs.

Goal: Enhance site infrastructure, safety, effectiveness and efficiency of facilities	RAG Rating	Short Comment
Develop and implement Site Strategy	**Green**	❯ The Site Strategy was progressed in accordance with our plans.

CCGs* Clinical Commissioning Groups

Goal: Provide excellent trust systems	RAG Rating	Short Comment
Implementation of Wirral Millennium	**Amber**	❯ Plan for the 2012/13 roll out of Wirral Millennium had to be revised following problems with the implementation of medicines management ❯ Phase 2 was split into two parts with the first part, Phase 2a, planned to go live in Q2 of 2013 ❯ Phase 2b which will include medicines management will now go live in 2014/15 ❯ All plans have been agreed with the Trust Board.
Revise Wirral Excellence in Healthcare System (WEHS) Strategic Plan to reflect changes in the Trust and operating environment	**Green**	❯ A three year plan was approved by the Board in February 2012 ❯ A progress report was presented to the Board in December 2012 to update on the work streams identified in that plan.

Goal: Strengthen excellent relationships with governors and members	RAG Rating	Short Comment
Strengthen purposeful relations with the Council of Governors	**Green**	❯ Representatives from the Council of Governors invited to all Formal Board Meetings ❯ Board members attend Council of Governors meetings and sub committees to update the Council on key activities within the Trust

Our Performance

Goal: Deliver strong financial performance	RAG Rating	Short Comment
Achieve Cost Improvement Programme (CIP) for 2012/13 and develop plans for 2013/14 and beyond	Amber	❯ Cost improvement in year will be achieved in 2012/13, however , there is a £2m recurrent shortfall to be carried over into 13/14. ❯ The Trust has engaged with KPMG to enhance its CIP development processes and to support achievement of plans for 2013/14 which will increasingly deliver in year. Longer term plans are being developed and the planning cycle brought forward.
*Monitor levels achieved	Green	❯ A financial risk rating of 3 has been achieved.
Supply Chain Excellence	Green	❯ £850k supply chain savings delivered against an annual target of £1.2m

*Monitior is the indipendent regulator for NHS Foundation Trusts

"My four night stay was made so much easier by the warm and informative welcome from all staff. The friendly atmosphere created on the ward, to the advice and reassurance given at all stages and on discharge, and the food was excellent.

I was most grateful for all the time and trouble taken by so many people, which ensured that what could have been an extremely stressful experience was in fact a relaxed and positive one."

Letter to the Editor – Wirral Globe

Principal Risks

In assessing the principal risks facing the Trust, the factors likely to impact on the organisation's operation were reviewed.

The key drivers of change, which the Trust believed would present both challenges and opportunities for the organisation, were identified. These are outlined below:

❯ Balancing CIP and Quality

The Trust has again successfully delivered a challenging savings target without compromising either the quality of services or patient experience – a significant achievement.

Programmes have been developed in response to the financial challenges, driving improvements in productivity and efficiency while striving continually to improve the quality of services and patient care.

❯ Implementation of the Wirral Millennium System

The risk of failure of the existing IT system prior to replacement by Wirral Millennium was mitigated through robust implementation processes including a phased transfer.

At each stage, lessons were learned from the experience and applied on an on-going basis. The process was closely monitored by the organisation's senior clinical committee, the Hospital Management Board (HMB).

❯ Failure to deliver key targets

The Trust continued to focus on managing identified risks and on ensuring that it was in the best position to take advantage of all potential opportunities.

Risks were managed through the Risk Management Strategy, which was regularly reviewed and the principal risks of any failure to achieve Trust objectives were regularly considered by the Board within its' Board Assurance Framework.

In line with national practice, risks were scored and ranked on their potential impact and the likelihood of occurrence.

The Trust adopted a proactive risk management culture and assurances were required by the Board that executive and management teams were actively mitigating risks.

Operational expenditure

Financial risks relate to:

❯ Income from activity being less than planned

❯ Expenditure being higher than planned without achieving compensating income gain

❯ Failure to deliver the CIP

❯ Processes to manage income and control expenditure and a focus on delivery of the Trust's CIP mitigated these risks. In overall terms, this was achieved for 2012/13.

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Improving Excellence

Improving Excellence in Quality, Patient Experience and Safety

Infection Prevention and Control

During 2012/13 we continued to perform well in relation to infection prevention and control by ensuring excellence in clinical practices and by maintaining a safe, clean environment at all times to prevent avoidable infections.

Having demonstrated a reduction in the number of patients acquiring Clostridium difficile in 2011/12, we focused on improving this reduction even further in 2012/13.

This year, we have reported 27 cases, demonstrating a significant reduction compared to 68 cases the previous year.

Having had no MRSA bacteraemias for a 15 month period, we were presented with the challenge of zero MRSA bacteraemias.

Unfortunately, we reported two hospital-attributed cases of MRSA in 2012/13 - one of which was deemed to be unavoidable by the group investigating the case.

The second however, was deemed avoidable and the investigation highlighted learning outcomes, which we have shared and acted on toprevent such an infection occurring in the future.

This year we have implemented a new programme of installing bay doors on many wards throughout the hospital, to minimise the risk of transmitting infections, in particular norovirus.

Whilst we did have a norovirus outbreak, potentially due to the circulation of the new strain throughout the community, fewer patients became affected than in previous years. Wards were closed for shorter periods, which meant that fewer bed days were lost across the Trust.

All inpatient and outpatient clinical areas received a full Infection Prevention and Control audit which focused on monitoring environmental issues to include cleanliness, compliance with policies, and clinical practices. 89% of areas received a green light status, with a small percentage (10%) receiving an amber status which once reaudited, were worthy of a green light. One outpatient area failed the audit, and the Directorate is currently working with the Infection Prevention and Control team to rectify the issues identified.

The Infection Prevention and Control Team have remained extremely proactive to ensure that all patients, staff and visiting public are provided with the necessary support and advice to protect themselves and others from any infection.

National targets and regulatory requirements	Target	Q1	Q2	Q3	Q4
Clostridium Difficile – maximum number of cases	Max 50	7	7	5	8
MRSA – maximum number of cases	Max 0	0	1	1	0

Improving Excellence in Quality, Patient Experience and Safety

Nursing and Performance Quality

During this year we reviewed nurse staffing levels, the result of which was an increase in resources for front line nursing; meaning we're able to continue to improve the nursing care we provide to patients.

In anticipation of the publication of the Francis Report into Mid Staffordshire Hospital, we continued to develop and promote the role of the ward sister and matron to inspire confidence in patient care.

Quality and Performance at ward level is monitored using a Nursing and Midwifery audit tool and is undertaken monthly.

The information generated provides assurance about the delivery of patient care and allows us to focus on further improvement.

We will be continuing and building on this work during 2013/14.

Improvements in Nursing and Maternity Audits

We've changed how we present the results and monitor Nursing and Midwifery audits to ensure better quality assurance for the organisation.

The changes we have made make it easier for our senior nurses to clearly identify any improvement areas that require action.

We have also taken the opportunity to raise the attainment levels of our audit activity; we have done this to ensure that our drive is for continual quality improvement.

We've streamlined our data collection tool to make the audit process more efficient. The reports have been redeveloped to include Red/Amber/Green (RAG) ratings so that visually the reports are easy to understand.

We've also made our scoring system for the RAG rating more stringent to drive improvements.

Nursing audit remains an important quality work stream and when compared with other quality indicators provide an ongoing view of performance.

These changes will help to ensure that challenges in the delivery of safe and effective nursing care are monitored openly and collectively across the organisation.

Safety Express

The Safety Express Programme is about learning and improvement in the prevention of avoidable hospital falls, hospital-acquired pressure ulcers, venous thrombo-embolic (VTE) events (or "blood clots"), and urinary tract infections associated with the use of catheters.

The aim of the programme is to achieve:

❯ 50% reduction in serious harm and death from falls in the hospital

❯ 80% reduction in stage 3 and 4 pressure ulcers developed in the hospital

❯ 50% reduction in venous-embolic events

❯ 50% reduction in urinary tract infections in patients with in-dwelling catheters.

"Came as a patient – left as a friend!"

Learning with Patients survey

Falls

Falls in hospital are very distressing for patients and carers.

A great deal of work has taken place within the Trust during the past year to reduce falls. We now use sensor pads on all of the Department of Medicine for the Elderly (DME) wards and on medical wards 32 and 34.

An evaluation of the effectiveness of the sensor pads is in progress. One to one observation is put in place where a patient is particularly vulnerable to fall.

A fall where a patient sustains a serious injury is subject to the 'Stop the Line' process where senior staff are alerted immediately and carry out an initial investigation.

After the incident has been fully investigated, a decision is made as to whether the fall was preventable.

Through all the work we have done and the commitment of our staff to preventing patients falling where possible, we have achieved the 50% reduction as planned.

Rising to the Challenge

Sister Tracey Whitby
Maternity Ward

More than 2.7m people tuned into 'The Midwives', a six part BBC documentary staring midwives from the Wirral Women and Children's Hospital showing the day-to-day, real-life experiences of midwives, mums-to-be and their families both in hospital and out in the community.

The two episodes gave an insight into what it's like to be a midwife in Wirral, the very varied range of responsibilities they have and challenges they are faced with every day.

Improving Excellence in Quality, Patient Experience and Safety

Pressure Ulcers

Pressure ulcers are painful and debilitating for patients, and resource-intensive in terms of nursing care and additional length of stay for patients.

All grade 1 and 2 pressure ulcers are reviewed by the Divisional Lead Nurse with the Ward Sister to identify the cause.. Every grade 3 or 4 pressure ulcer is subject to a Root Cause Analysis (RCA) investigation which is presented to the Deputy Director of Nursing by the Ward Sisters, and lessons learned are identified for action.

During Quarter (Q)3 an increase in Grade 3 pressure ulcers was observed from seven in Q2 to 15 in Q3. The outcome of the RCA investigations indicated that for many of these patients, the pressure ulcers were not hospital acquired, however, a lack of robust documentation meant that this could not be proven.

In response, a Pressure Ulcer Prevention Care Plan was launched in December 2012, which mandates specific interventions that all registered nursing staff must undertake on the admission or transfer of a patient.

The Tissue Viability Specialist Nursing Team hosted bespoke pressure ulcer prevention and treatment study days which all senior staff were required to attend. Matrons within Divisions are also undertaking daily checks on their respective wards to ensure that the nursing documentation supports care delivery.

Venous Thrombo-Embolic Events (Blood Clots)

We have achieved the targets in relation to deaths from Venous Thrombo-Embolic (VTE) disease on the Wirral and for patients who had been seen in hospital. We do not have year-end data yet for the morbidity indicators but the targets are expected to be delivered.

During Q3, we implemented a reminder system to wards to improve compliance with prophylaxis.

This was a pilot in areas where we can be confident about the need to prescribe because of guidelines built into the system.

Within a few weeks we achieved 100% compliance for the identified group and this was sustained for the next month.

We have suspended this pilot whilst we build in guidance in surgery, obstetrics, and gynaecology. The plan is to reintroduce the report once this is live to support best practice.

All patients who develop VTE disease whilst in our care, are readmitted with VTE disease; or have died are reviewed using a screening tool.

This tool identifies whether or not our clinical guidance has been used properly. If we establish any gaps, a further investigation (a RCA) is undertaken to establish what went wrong and what we can learn from this.

We have undertaken relatively few investigations during the year but it is clear that remembering to reassess patients and to act on those assessments is key to improving outcomes. We are currently consulting on a change in the process that will mean patients are reassessed every week. This will then be included in our guidance.

Catheter Associate Urinary Tract Infection (CAUTI)

The results of an audit performed by the Infection Prevention and Control Team in October 2012 to identify a Catheter Associate Urinary Tract Infection (CAUTI) rate has been compared with a baseline rate determined in a prevalence audit performed by the team two years earlier.

A 4.5% reduction has been demonstrated with only 5% of catheterised patients having an associated infection compared to a baseline of 9%. This reduction cannot be associated with a reduction in the number of catheters inserted, but is most likely due to other initiatives and the raised awareness throughout the Trust in relation to CAUTI.

The Infection Prevention and Control Team have considered the benefits of the weekly catheter counts currently being monitored and have pioneered a new approach that focuses on the reasons for catheterisation in individual cases.

This means that the catheter count now relates to those instances that are not clinically indicated. It will also clearly identify those areas where further education and training is required to avoid unnecessary catheterisation and encourage prompt removal as they are no longer indicated.

The information will continue to be shared with Ward Sisters, Matrons and Lead Nurses and any issues escalated through the Directorate Infection Prevention and Control assurance reports should they occur.

The patients' `Catheter passport` has been amended to include the risks and benefits of a urinary catheter as recommended by National Institute for Health and Care Excellence (NICE) guidelines. The passport will be available for use within the hospital and the wider community when it is approved.

A nurse-led protocol is currently being devised as a tool to assist and empower nurses in making the decision to remove a catheter.

The Infection Prevention and Control Team are working closely with supply staff and our suppliers to ensure appropriate supplies are available, and labelling improved on packs on all wards to enable staff to select the most appropriate catheter if they're required.

Improving Excellence in Quality, Patient Experience and Safety

Patients with learning disabilities

We've continued to improve the care pathways for patients admitted to hospital with a learning disability.

In particular, we've revised the planned care pathway to ensure that patients requiring operations have their care tailored to their needs so we can reduce the required visits to hospital before the day of surgery. This has been very well received by patients as well their families and carers.

We're continuing to work in collaboration with Cheshire and Wirral Partnership NHS Foundation Trust to make further improvements for this important patient group.

Patients with dementia

We've made significant progress over the past 12 months in how we provide care for patients with an existing diagnosis of dementia, and their relatives and carers.

On admission, nurses undertake and record a patient's needs assessment.

This includes a prompt for the nursing staff to check if the patient has a health passport or a 'This is Me' document recommended by the Alzheimers Society and the Royal College of Nursing.

The use of the 'Forget Me Not' symbol and laminated card outlines information about what name the patient prefers, and their eating and drinking preferences such as whether or not they take sugar in their tea!

The patient experience data we've gathered through the Learning with Patients questionnaire provides us valuable intelligence into how we provide assistance at mealtimes and how we attend to personal needs.

Where the patient has a health passport or a 'This is Me' document, there is a prompt on the discharge action plan to ensure that the documentation is returned to the patient on discharge.

The Matron for the Directorate of Medicine for the Elderly (DME) has led a project resulting in the introduction of movement sensor assistive technology to protect patient safety.

Signage on the wards has been improved as part of the model ward programme and delivering same sex accommodation requirements.

We successfully launched our 'Reminiscence Pods', which help to reassure patients who are admitted to hospital with dementia, in January 2012.

They include a pub scene, a 1950s style pop-up living room complete with authentic furniture and fully working 1950s television and radio, and a ballroom – all designed to evoke happy memories and make our patients feel comfortable and at home.

To minimise the number of bed moves for all patients, we have a policy and procedure for the transfer of patients within the organisation.

The policy has key performance indicators, which we closely monitor through annual audit and weekly incident report data.

Our safeguarding team works very closely with ward staff to develop a care plan for the management of patients admitted with dementia. We also sometimes request extra staff from the 'Flexibank' to cover the ward nurse who is providing one to one care for the patient with dementia.

We have also developed a comprehensive dementia training programme for staff, which has been developed in association with the Alzheimer's Society.

> "I attended Arrowe Park Hospital today and from the time I entered the main entrance, through to leaving a few hours later, I was extremely impressed with the high standard of care and attention provided by all members of staff.
>
> Nothing was too much trouble, we were greeted with smiles and helpful assistance."
>
> Letter to the Editor – Wirral News

Improving Excellence in Quality, Patient Experience and Safety

Listening to and Learning from Patients

1. 'Learning with Patients' Questionnaire

Throughout the last 12 months we have continued to develop our insight into what our patients think about their experiences when they're in our care or using our services. Over 10,000 patients have provided us with detailed feedback, helping to understand what our strengths are, as well as identifying the areas where we can do better.

Our patients said:

❯ 98% - 'My privacy was maintained when I was being examined'

❯ 95% - 'I was treated with courtesy and respect by staff'

❯ 97% - 'I was cared for in a clean environment'

❯ 95% - ' I got the care that mattered to me'.

These results are very pleasing and reflect the dedication of our staff to delivering consistently high standards of care.

There are, of course areas where our patients say we can do better, and these mainly relate to experiencing delays and waits. The feedback gained from patients is used to inform and focus service improvement activity within the Trust.

2. National Inpatient Survey

The annual National Inpatient Survey gives us an excellent indicator of overall patient satisfaction. The 2012 results reflect an improving position for the Trust in a number of areas as listed below. It is encouraging that improvements have been noted in communication and patient environment.

Some of the key improvements include:

❯ Patients reporting that they did not share a bathroom or shower area as patients of the opposite sex

❯ Patients not being bothered by noise at night from hospital staff (the Trust is now within the best performing range nationally for this indicator)

❯ Cleanliness of the hospital room or ward

❯ Rating of hospital food

❯ Patients getting understandable answers to important questions from Doctors and Nurses

❯ More patients stating that they receive copies of letters sent to their GP and that these were written in a way in which they could understand.

We will continue to build on these improvements thought the coming year.

3. Information for Patients

We are committed to improving the standard of information provided to Patients and Carers and have implemented several practical processes and held engagement events during 2012/13 in order to achieve this.

Some examples of these include:

❯ All patient information leaflets are reviewed by the "Reading Group", which involves patient representatives, to ensure that the information provided is "easy read" and in an accessible format for patients

❯ In association with Advancing Quality Alliance (AQuA) Enhanced Recovery Programme, we held an engagement event with former patients and carers. Here they were asked what information they required regarding their condition, treatment and recovery and at what stage in their patient journey they felt that they needed it

❯ We have also launched the distribution of ward bedside folders which provide practical information about the hospital, patient services and ward environment

❯ A review has commenced regarding the information currently available as part of the elective pathway programme to ensure better information is provided for patients coming in for planned surgery.

> "I found myself to be very emotional being in bed for ten days and being totally reliant on everybody.
>
> The emotional support constantly received during this time was 100 percent.
>
> From cups of tea to all the nursing care I received was fantastic. I found everybody to work incredibly hard but I always felt assured nothing was too much trouble and that is so very important."
>
> Learning with Patients survey

Improving Excellence in Quality, Patient Experience and Safety

Care Quality Commission

During the year, we received three unannounced inspections from the Care Quality Commission (CQC), all to the Arrowe Park site.

The first visit took place in April and focused on the management of medicines. They made a number of observations about the design and operation of the medicines reconciliation process, and the availability of bedside lockers to store patients' medicines.

CQC judged that we were non-compliant with Regulation 13 (Medicines Management), with a minor impact on people who use services.

However, in September we were re-inspected by CQC against this same regulation. On that occasion they were satisfied with the progress that we had made, and judged that we were now compliant.

They also revisited the Termination of Pregnancy service, which they had earlier visited in March 2012 when they found us non-compliant with Regulation 20 (Records). We were also found to be compliant on this occasion for this regulation.

Our main inspection took place over two days in January. The inspectors visited Ward 32, the Coronary Care Unit, and the Maternity Unit and inspected against the following outcomes:

- care and welfare of people who use services
- respecting and involving people who use services
- assessing and monitoring the quality of services
- safeguarding
- medicines management
- staffing.

The Trust was found to be compliant with all outcomes. The CQC made recommendations concerning clinical record keeping which the Trust has been working to address.

We have a number of methods of assuring ourselves of our compliance with the CQC Regulations:

- Our Divisional Lead Nurses undertake 'walk-arounds' of clinical areas using an inspection tool which is referenced to CQC's Essential Standards of Quality and Safety.

  These are organised so that the Lead Nurses do not inspect areas that fall within their line of responsibility, so that they are evaluated entirely objectively

- We hold review panel meetings with the Executive Directors and operational managers who lead on each regulation, and produce quarterly reports for the Quality and Safety Committee of the Trust Board

- We produce a monthly briefing summarising the Quality and Risk Profile. All risks with an implication for CQC compliance are recorded on the Corporate Risk Register

- Finally, we have delivered training for our Board members so that they are all familiar with the role of CQC and the standards it enforces.

NHSLA

We were successful in retaining our NHSLA Level 2 accreditation at our assessment in July 2012. This demonstrates that we have clear policies in place to manage risks facing the Trust, and that we are following those policies in practice.

We passed the assessment very comfortably, with a score of 96% (48 out of 50). We are now aiming to achieve Level 3 – the highest accreditation level – and have scheduled another assessment for December 2013. This will require a programme of audit of all our relevant policies, which is already underway.

2012/13 Incident Reporting

Reporting, investigation, and learning from incidents have continued to be of real importance to us, as they provide an opportunity to reduce risk and drive improvements in safety.

During the year we commenced a programme to allow electronic incident reporting which will help capture issues earlier and improve the use of the system. Nationally, we remain one of the highest reporters of incidents, with the majority of incidents not causing harm to patients.

We have progressed the rapid response system developed last year (where we quickly investigated a serious injury following a fall) to include other serious incidents. We also introduced an internal alert system where key learning from serious incidents can be rapidly disseminated throughout the Trust. This will be further developed in the coming year.

We recognise that high incident reporting levels, especially where the majority are low harm, are reflective of an open and transparent organisation with a positive safety culture – which is vital for patient confidence and the way we improve our services.

Quality and Safety Team

"The commitment and hard work of this team ensured that this trust was in a position to showcase the safe practice undertaken in the delivery of care for our patients. Spending many, many hours working on the organisation of the NHSLA Assessment, including weekends and late into the night, the team maintained a cheerful and professional demeanour.

I was proud to have been involved with such a positive team and delighted that they achieved what they set out to on behalf of the Trust."

Extract from Foundation Award nomination

Rising to the Challenge

Improving Excellence in Quality, Patient Experience and Safety

Improving Patient Flow

Improving the flow of patients in the Emergency Department and throughout the hospitals has the potential to deliver many benefits for patients, staff and the financial balance.

This year we have been planning and implementing improvement strategies that cover the end-to-end patient journey.

Our projects have included many participants from the clinical and operations staff inside the hospital and also representatives from the commissioners and community / social services.

The scope of our flow projects covers all of our 80,000+ patients / annum, whichever services they use.

At the start of our patient flows, a new Acute Admission Unit has been established in a collaborative pilot with the commissioners.

This has involved:

❯ A significant re-designation of the physical spaces

❯ Changes for the medical teams in both the hospital and the Community Trust

❯ An increased presence of specialty physicians at the start of the patient journey

❯ Increased capacity in ambulatory care clinics and urgent care slots in medical subspecialty clinics

❯ Streaming patients by acuity – with the intention of ensuring potential short stay patients are not admitted into the main hospital.

The number of discharges within 6hrs and 24hrs from the Acute areas have both increased in the first three months of this six month pilot.

For emergency patients, our programme covers the avoidance of inappropriate admissions, reduction of extended length of stay and assurance of the timely continuity of care provision at the point of discharge.

This involves processes which cross many boundaries with health and social care organisations, both within and outside the hospital.

In the early stages, the project has focused on:

❯ Developing a bed management system that ensures that every patient that needs a bed, gets the right bed with no unnecessary delay

❯ Our cohort of elderly patients, because the increased "winter" length of stay for these patients is a major operational challenge.

Immediate actions taken to date include the following:

❯ The introduction of seven day working for Consultants in order to increase capacity and smooth patient flow across the week

❯ The introduction of planned endoscopy lists at weekends

❯ The introduction of Rapid Access Clinics for elderly patients, which has received positive feedback from GPs

❯ Establishment of older people's short stay unit which has resulted in a shorter length of stay

❯ A Pre-Discharge Unit focusing on the remaining administrative steps required for patients who are no longer in need of Acute care

❯ Changes to discharge coordination and the information exchange between wards and the bed management process.

For Elective Patients, our programme started by mapping the many steps in the patient journey and how they are handed off from one person, function or department to another, in order to identify the waste in our current processes.

From this mapping, many opportunities were identified and some immediate actions were taken to improve information, patient access and staff handovers.

Six longer term work streams were developed to fundamentally improve our systems and processes for these patients.

> "I do not envy the things that these dedicated and highly skilled staff have to deal with on a daily basis, and the life changing/saving decisions that they must make.
>
> However, I will always be thankful that we have them!"
>
> Angela Basford, Prenton

Rising to the Challenge

Les Porter
WEHS Leader/Model Ward Development Manager

"I have had the privilege of working with Les on the Model Ward Improvement Programme and have been proud to witness his outstanding professionalism and unswerving commitment to improving the patient experience and safety, whilst simultaneously empowering clinical staff and supporting improvements in their working lives."
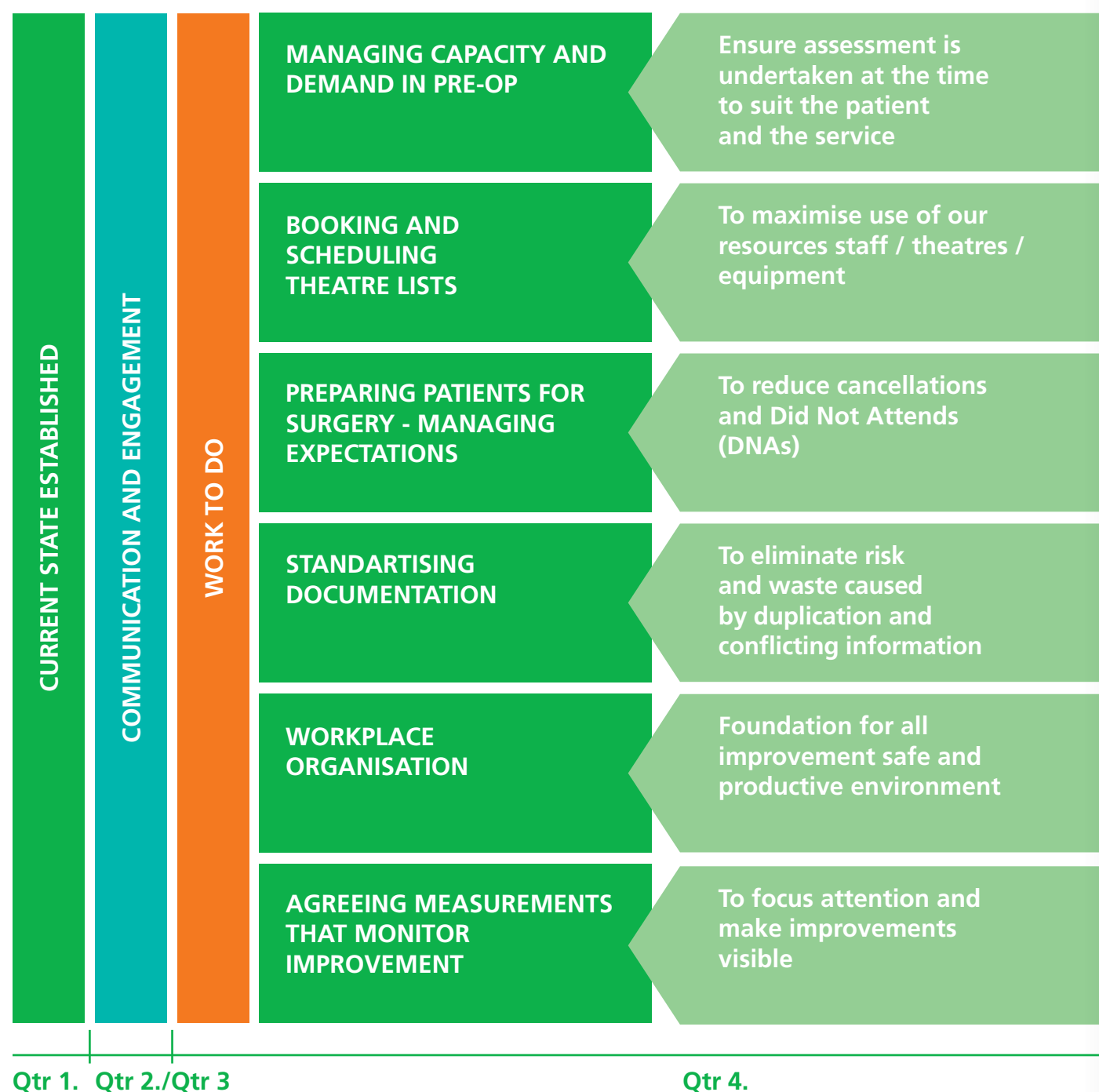
Extract from Foundation Award nomination.

Improving Excellence in Quality, Patient Experience and Safety

The diagram below summarises the sub-projects and aims.

Elective Surgical Patient Pathway

CURRENT STATE ESTABLISHED	COMMUNICATION AND ENGAGEMENT	WORK TO DO		
			MANAGING CAPACITY AND DEMAND IN PRE-OP	Ensure assessment is undertaken at the time to suit the patient and the service
			BOOKING AND SCHEDULING THEATRE LISTS	To maximise use of our resources staff / theatres / equipment
			PREPARING PATIENTS FOR SURGERY - MANAGING EXPECTATIONS	To reduce cancellations and Did Not Attends (DNAs)
			STANDARTISING DOCUMENTATION	To eliminate risk and waste caused by duplication and conflicting information
			WORKPLACE ORGANISATION	Foundation for all improvement safe and productive environment
			AGREEING MEASUREMENTS THAT MONITOR IMPROVEMENT	To focus attention and make improvements visible

Qtr 1.   Qtr 2./Qtr 3   Qtr 4.

Improvement in the number of cancellations, the utilisation of planned session time and the number of cases per theatre list were evident six months into the programme.

For outpatients, our programme to date has involved a multi-disciplinary team who have started work on:

❯ The potential for remote clinics nearer the patient's home

❯ Creating an urgent clinic Directory of Services

❯ Improving Patient Experience

❯ Reducing the number of patients who do not attend their appointment

❯ Reducing unnecessary review appointments

❯ Exploring new technologies

❯ Increasing the number of directly bookable clinics.

Our diagnostic division has introduced new processes and working patterns to improve the patient flow through the hospital by:

❯ Introducing seven day working in radiology with Consultant led lists in CT, MRI and ultrasound which not only improves access for acute inpatients, but also helps to facilitate the two week cancer pathway and the 18 week referral to treatment pathway

❯ Seven day working of Allied Health Professionals in our Surgical Division to facilitate the timely discharge of patients.

Other changes to improve access to services include giving direct access for GPs referrals and options for patients to attend outside working hours.

With other trusts in the North West we continue our participation in the Advancing Quality (AQ) service improvement programme with the aim of applying standards to ensure good and accurate monitoring of patients to reduce the likelihood of recurrent admissions. For example:

AQ nurses have ensured the timely and appropriate treatment of community acquired pneumonia by increasing the collection of real time data, which has assisted in improving the speed of treatment.

The AQ standard for heart failure focuses on discharge advice and ensuring that patients have a specialist nurse review pre-discharge, or access to outpatient clinics.

Improving Excellence in Quality, Patient Experience and Safety

Performance Against Compliance Framework Access Targets

2011/12	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%	95.4%	95.4%	97.8%	97.0%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all breast symptom referrals	Minimum 93%	95.8%	97.7%	95.6%	99.0%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	Minimum 96%	97.1%	97.7%	100%	97.9%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer (surgery)	Minimum 94%	96.6%	97.9%	100%	94.1%
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%	85.6%	86.0%	85.0%	87.1%
Maximum waiting time of 62 days from screening referral to treatment for all cancers	Minimum 90%	98.2%	98.2%	100%	92.4%
Referral to treatment time – admitted patients < 18 weeks	Minimum 90%	93.9%	92.6%	92.9%	92.8%
Referral to treatment time – non-admitted patients < 18 weeks	Minimum 95%	97.2%	96.6%	97.8%	97.8%
Referral to treatment time – incomplete pathways < 18 weeks	Minimum 92%	93.1%	92.3%	92.3%	92.1%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Minimum 95%	95.5%	95.4%	95.1%	91.4%

Improving Patient Access

Improving patient access is fundamental to our commitment to deliver the right treatment to the right people at the right time.

As an inclusive, patient-focused organisation, we continued to recognise the importance of offering a wide range of accessible services to local people throughout 2012/13. We also endeavoured to positively impact quality of life by minimising waiting times wherever possible.

Access to Cancer Care

We're pleased to report that we delivered against the full range of quarterly targets on cancer care. Historically, meeting the 62 day target for urgent referrals has proved to be a particularly challenging area, so this is a significant achievement for the Trust.

It can be attributed to both operational changes and decisions by individual staff.

The Trust has also made marked improvements in Cancer Services in 2012/13, including improving patient choices with the implementation and integration of robotic services, and increasing the number of surgeons in Breast, Colorectal and Urology services.

Looking to the future, the Trust is developing increased support for the Cancer Intelligence Strategy, responding to our patients' reported priorities, and considering succession planning for the vital Clinical Nurse Specialist Teams.

Emergency Patients

The key measure in this area focuses on admitting, transferring or discharging patients attending our Accident & Emergency department within four hours.

For the first three quarters of 2012/13 this standard was met for patients attending the emergency department at Arrow Park Hospital, including those attending the All Day Health Centre at the Arrowe Park site.

Although historically quarter four is busier than most other quarters, in 2012/13 the increase was exceptional.

There was greatly increased pressure on the Accidents & Emergency Department, and on the wards with a large rise in emergency admissions.

As a result the Trust was unable to meet the four hour standard for this last quarter.

This experience was replicated across many areas of the NHS, with most health economies in the North of England also not meeting the four hour standard in Q4.

A clear action plan is in place to ensure this important standard of patient experience is achieved in the first quarter of 2013/14 and sustained for the remainder of the coming year.

Improving Excellence in Quality, Patient Experience and Safety

Elective Patients

Another important measure of patient experience is in the standard that patients should commence treatment within 18 weeks of referral into a hospital service.

All the standards relating to Referral to Treatment within 18 weeks were met by the Trust throughout 2012/13. This includes patients that are both treated and those still waiting for treatment.

There is a continuing commitment at the Trust to ensure waiting times for patients are as low as possible and so minimise delays in accessing services.

It is not always easy balancing priorities, particularly when the Trust experiences greater pressure on other parts of the service such as the recent quarter four increased emergency demand.

However it is testament to the commitment of Clinical Divisions that elective waiting time standards were maintained through this difficult period.

The Trust is committed to ensuring patients in all specialties experience minimum delays at all stages of their healthcare pathway.

Developing Excellent Staff

❯ Working with Staff

During a challenging year, we've continued to recognise the importance of a highly engaged, flexible and competent workforce which brings about an improvement in the patient experience.

In order to control costs and modernise job roles, the organisation has developed a comprehensive change management programme. This has been underpinned by organisational change policy and partnership working at all levels.

Staff engagement and involvement, through the ongoing implementation of the internal communications strategy and the Trust's News Network, has been a priority.

The monthly briefing forum has allowed clinicians and managers to feed back to the executive team on issues or concerns, while the 'Ask the Chief Executive' portal on the staff intranet has continued to prove popular.

There are also robust procedures in place for staff to identify concerns through the traditional grievance, whistleblowing and incident reporting procedures.

The introduction of Listening into Action has been pivotal to achieving a step change in engagement of our staff in what makes a difference for them and the services we are able to provide for our patients and customers.

This work, led by the Chief Executive has been received really positively, engaging over 700 staff members from all areas and roles, in how can we improve things together.

"What matters to staff" has been an incredibly powerful tool in making sure we understand how best to motivate our staff and enable them to deliver the standard of service that we all aspire to.

In the latter part of the year work began on developing the new Workforce and Organisational Development Strategy for 2013-2016. The aim of this Strategy is to be a key enabler for the organisation to meets its new Vision and long term aspirations.

❯ Workforce

The average number of whole time equivalents employed by the Trust during 2012/13 was 4,773 and the total number of employees was 5,650.

We've worked hard to control workforce costs through natural staff turnover coupled with an effective vacancy control process, a voluntary severance scheme, skill mix redesign, redeployment and shared services working.

In terms of flexible working practices, some staff have chosen to reduce their hours to both support the organisation and themselves.

The shape of the workforce is also changing, with an increased number of highly skilled advanced nurse practitioners.

During the year, our focus on frontline services saw an increase of 121 additional nurses and clinical support workers and 20 Consultants. Further significant work is also planned for 2013/14 to support the new Workforce and Organisational Development Strategy.

❯ National Staff Survey

Understanding people's perceptions, ideas and concerns is absolutely fundamental to our core values. In response to the results of the 2011 National Staff Survey, we ran a number of successful drop-in sessions during 2012/13 and came up with five key focuses.

From this, we developed a range of actions and used a 'You said, we did' approach to share our progress with the wider team.

In addition, we introduced Listening into Action as part of the national Pioneers programme supported by Optimise Ltd.

The impact of this has been considerable and will no doubt build upon the improvements in Staff Satisfaction levels seen in the 2012 survey.

The National Staff Survey Report for 2012 has again demonstrated improvements and whilst there is still important work to be done, the Trust continues to move in the right direction. The full details of the 2012 Staff Survey Management Report can be accessed via the Trust's website however, the following provides an overview of key findings by work stream;

Rising to the Challenge

Bethan McGuigan,
A&E Consultant

Trust staff and their families turned out in their hundreds for the Treating Yourself Well Day, the second such event in the Trust's pioneering Fitter for Health campaign, which aims to support and encourage staff and their families to take part in regular sport or physical activity.

This campaign was recognised with the award of a Gold Ribbon accreditation by the NHS (2012) Sport and Physical Activity Challenge for its commitment to improving staff health and wellbeing.

A&E Consultant Bethan McGuigan led the field in a 2k run, proudly carrying the Torch she bore for the first time in the Olympic Torch Relay.

Bethan was nominated as a torch bearer because of her achievement in improving her own health and fitness and inspiring family and colleagues to get active.

Improving Excellence in Quality, Patient Experience and Safety

1. Response rate -

The response rate for the 2012 NHS Staff Survey was 43% for the core sample and 45% for the additional sample (as previously noted the response rate for 2011 was 42%). Only 35 Trusts achieved or exceeded their 2011 staff survey response rate.

2. Staff engagement -

The overall score for levels of staff engagement have increased from 3.48 to 3.59 (average 3.69) and there has been an improvement in willingness of staff to recommend their organisation as a place to work (3.48 in 2012 and 3.33 in 2011).

An increase in the proportion of staff saying they are satisfied with the extent to which the organisation values their work (39% compared to 31% in 2011 and 39% in the NHS staff generally).

There is an improvement in staff saying they are able to make suggestions on how they could improve the work of their team or department (69%, compared with 65% in 2011) and 66% felt that there were frequent opportunities to show initiative in role (57% in 2011 and 68% of NHS staff generally).

3. Quality of care -

The staff survey shows improved levels of staff confidence in the quality of care. 62% in our Trust (62% of NHS staff generally) said that if a friend or relative needed treatment they would be happy with the standard of care provided by their organisation.

This is an increase since 2011 at 57%. Staff were also asked whether or not they thought care of patients and service users was their organisation's top priority. 60% said that care of patients and service users was their organisation's top priority (52% in 2011 and 63% of NHS staff generally).

4. Job satisfaction -

Results for job satisfaction are up from last year. 78% of staff are satisfied with the support they receive from colleagues (77% of NHS staff generally).

There is though a slight drop in the number of staff satisfied with the amount of responsibility they are given (down 1% to 71% in 2012).

5. Staff appraisals -

Overall, 79% of staff had an appraisal, which is down from 86% in 2011 (82% of NHS staff generally).

Of those who had had an appraisal, 54% said it helped them improve how they do their job (51% in 2011), and 76% (72% in 2011) felt the appraisal helped them to agree clear objectives for their work.

6. Line management and supervisor support -

Overall 72% felt supported in a personal crisis (69% in 2011). 53% feel that their manager gives them clear feedback about their work (55% in 2011).

7. Health and wellbeing -

52% of staff reported that their organisation takes positive action on health and wellbeing (50% in 2011 and 52% of NHS staff generally). 37% of NHS staff overall reported during the last 12 months they have felt unwell as a result of work related stress (30% in 2011 and 37% of NHS staff generally).

8. Incident reporting -

The Trust continues to report positive figures in the number of staff who have reported an incident (93% in 2012 and 90% NHS staff generally).

> "The facilities were excellent – having a private room during every stage of labour, delivering and post delivery op was wonderful. I was very impressed with the level of care given and always felt informed and listened to. "
>
> Learning with Patients survey

Improving Excellence in Quality, Patient Experience and Safety

Summary of 2012 Key Findings for Wirral University Teaching Hospital NHS Foundation Trust

Top and Bottom Ranking Scores

❯ **Top Five Ranking Scores**

KF14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month
(the higher the score the better)
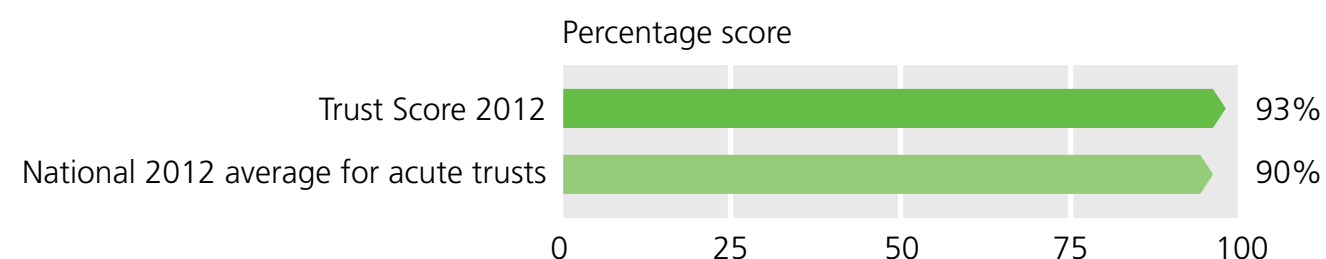
Percentage score

Trust Score 2012	93%
National 2012 average for acute trusts	90%

0　25　50　75　100

KF28. Percentage of staff experiencing discrimination at work in last 12 months
(the lower the score the better)

Percentage score

Trust Score 2012	9%
National 2012 average for acute trusts	11%

0　25　50　75　100

KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
(the lower the score the better)

Percentage score

Trust Score 2012	26%
National 2012 average for acute trusts	30%

0　25　50　75　100

KF19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
(the lower the score the better)

Percentage score

Trust Score 2012	23%
National 2012 average for acute trusts	24%

0　25　50　75　100

KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
(the lower the score the better)
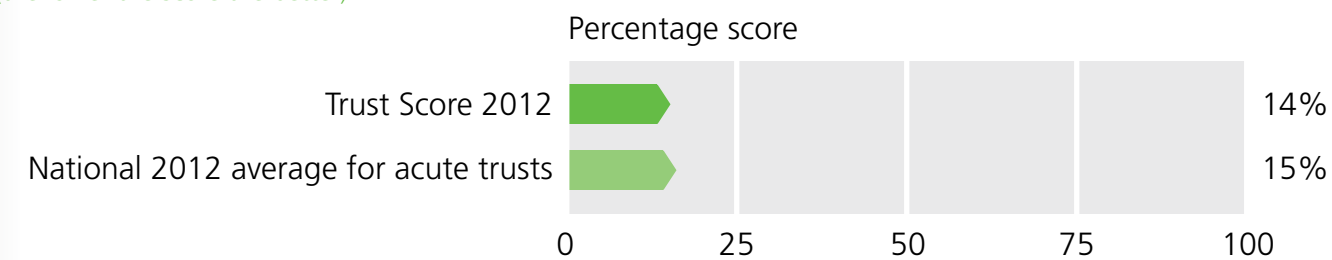
Percentage score

|	
Trust Score 2012	14%
National 2012 average for acute trusts	15%

0　25　50　75　100

Improving excellence in quality, patient experience and safety

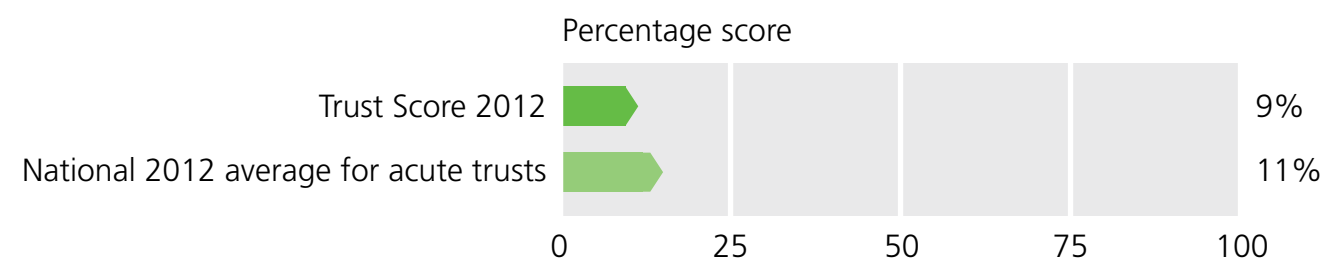**Summary of 2012 Key Findings for Wirral University Teaching Hospital NHS Foundation Trust**

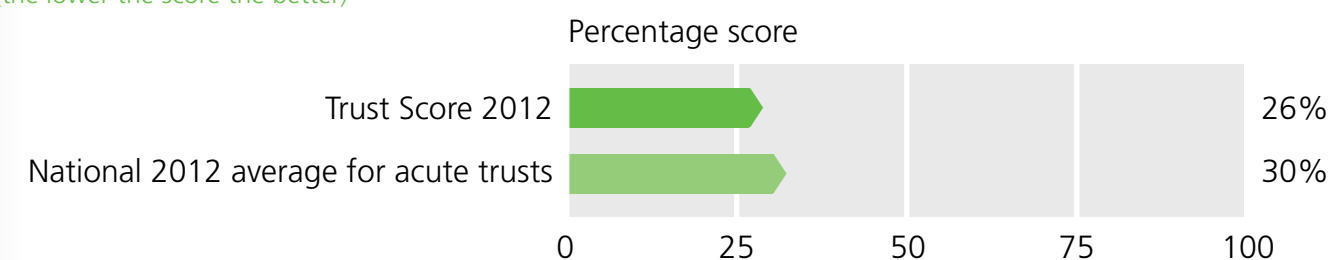**Top and Bottom Ranking Scores**

« Bottom Five Ranking Scores

KF2. Percentage of staff agreeing that their role makes a difference to patients
(the higher the score the better)
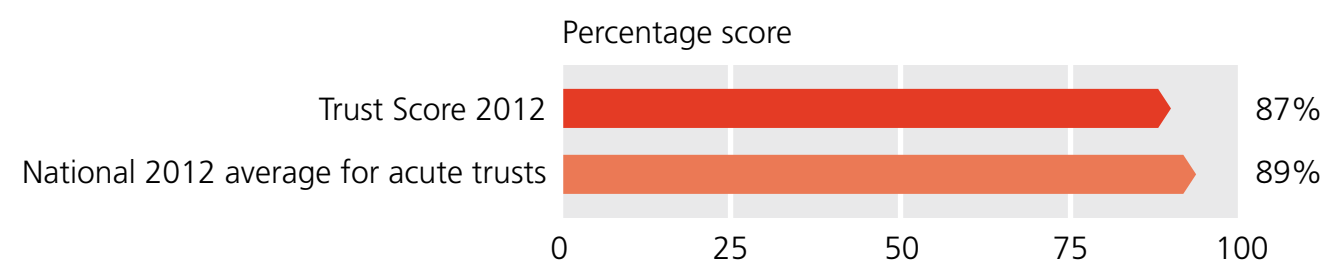
Percentage score

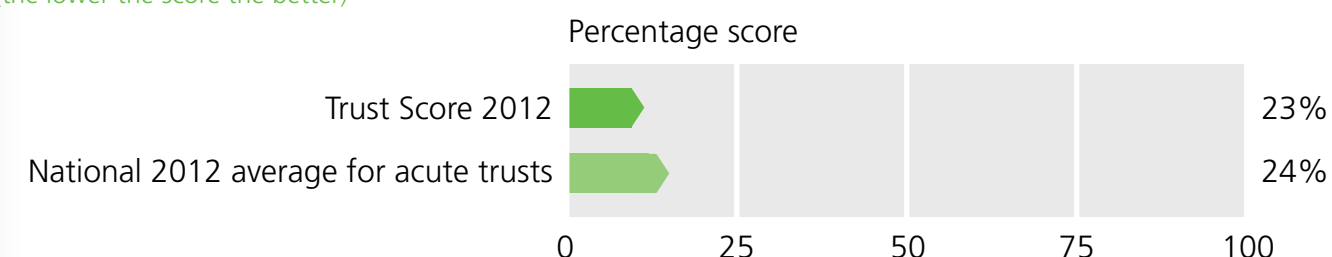|	
Trust Score 2012	87%
National 2012 average for acute trusts	89%

0   25   50   75   100

KF28. Percentage of staff experiencing discrimination at work in last 12 months
(the lower the score the better)

Percentage score

Trust Score 2012	62%
National 2012 average for acute trusts	68%

0   25   50   75   100
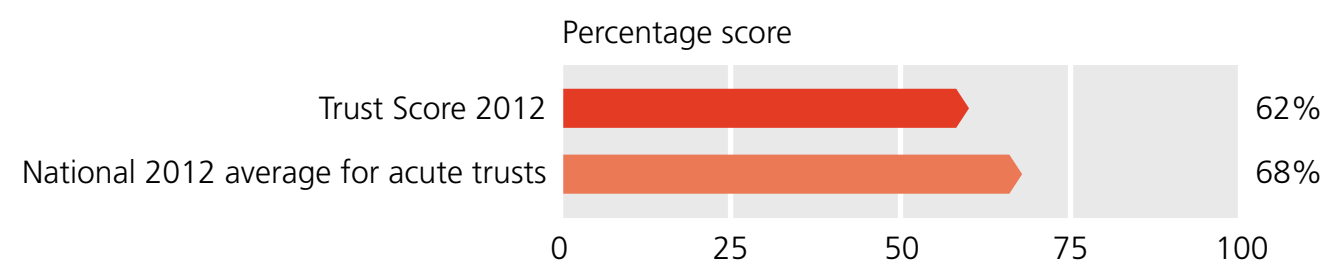
KF4. Effective team working
(the higher the score the better)

Percentage score

Trust Score 2012	3.64%
National 2012 average for acute trusts	3.72%

1   2   3   4   5
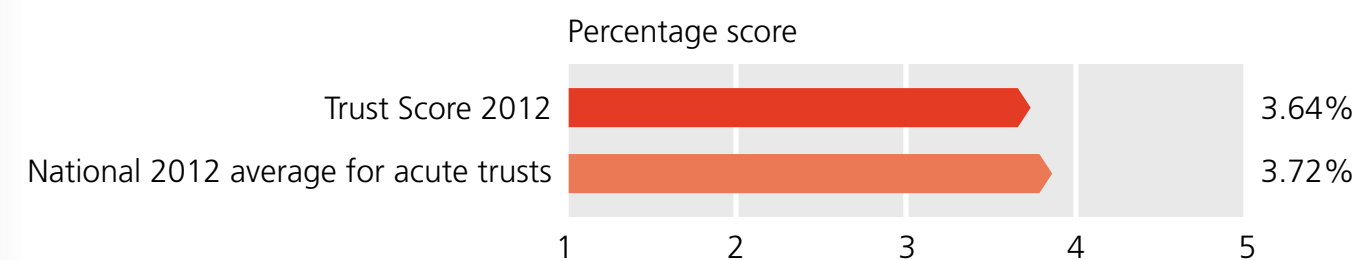
KF9. Support from immediate managers
(the higher the score the better)

Percentage score

Trust Score 2012	3.51%
National 2012 average for acute trusts	3.61%

1   2   3   4   5
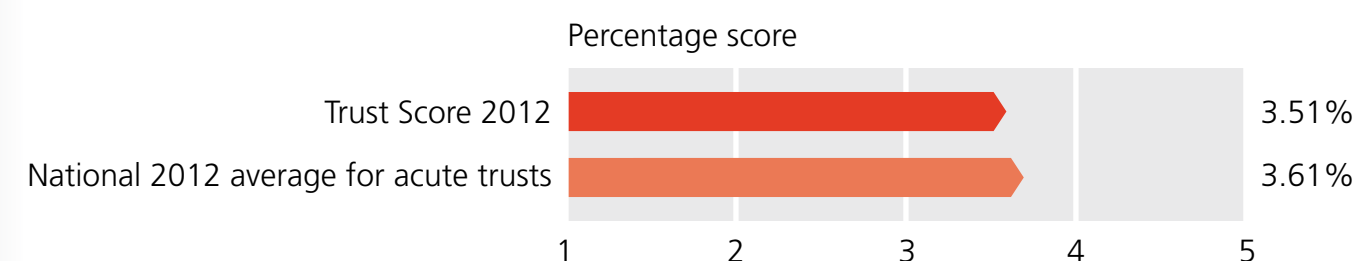
KF26. Percentage of staff having equality and diversity training in last 12 months
(the higher the score the better)

Percentage score

Trust Score 2012	44%
National 2012 average for acute trusts	55%

0   25   50   75   100
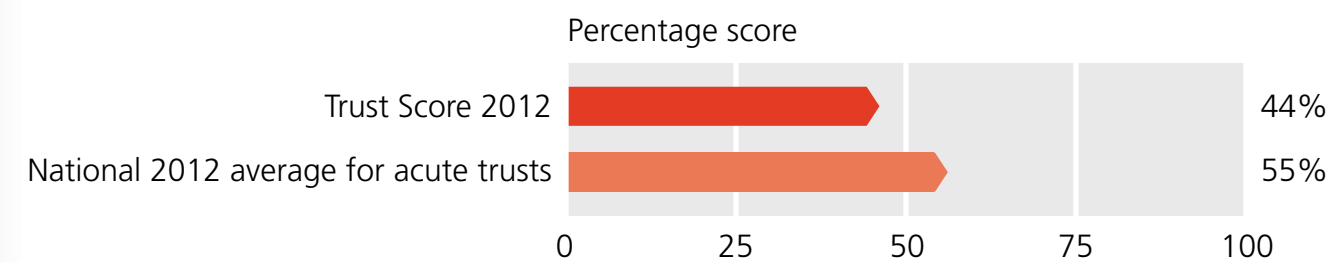
Rising to the Challenge

Vijay Bhalaik
Consultant Hand and Upper Limb Surgeon

Mr. Bhalaik was awarded the Mersey Trainer of the Year Award by the Mersey Orthopaedic Association. The award recognises his work in training surgical registrars in the north west region.

An extract from his nomination said: "He has worked hard to make Wirral the top choice for registrars to train in the Mersey region".

Improving Excellence in Quality, Patient Experience and Safety

❯ Promoting Staff Health and Wellbeing

Building on the Health and Wellbeing Strategy, we developed a range of initiatives to protect, promote and support the health and wellbeing of our staff.

This saw the Occupational Health Department working alongside divisions and senior Human Resources managers to provide a proactive service at all levels of the organisation.

The innovative Fitter for Health programme was one continuing success story. In its' third year, this social marketing campaign encouraged staff to take up a regular sport or physical activity, as well as signposting local facilities, activities and general lifestyle advice.

A 'Treating You Well Day' was also held for staff and their families in July 2011 and not only highlighted healthy eating but introduced participants to fun physical activities ranging from rounders and a walk-run race, to zumba and wii fit.

As part of the event's legacy, a marked walking route was created on both hospital sites which staff can now use to exercise during breaks and lunchtimes.

We also understand the importance of psychological wellbeing in reducing sickness absence, improving staff retention and productivity and boosting staff engagement and motivation. So, as part of our holistic approach, the emotional aspects of staff and wellbeing also remained high in the agenda during 2012/13.

❯ Sickness Absence

The sickness absence rate for the year was 4.78%; this was an increase when set against last years' figure of 4.53%.

Sickness absence management action plans were monitored at both Trust and divisional level and a reduction of the Trust's tolerance target to 4% will remain a high priority in the coming year.

❯ Staff Recognition

Recognising and celebrating the ongoing contribution of staff to the patient experience was an important feature of the year under review.

Senior and staff managers gathered in the lecture theatre at Arrowe Park Hospital to recognise individuals who had attained formal qualifications. In addition, the popular Foundation Awards this year introduced a number of new award categories and attracted the highest number of nominations to date.

Winners were presented with an engraved memento, a framed certificate and retail vouchers during a ceremony at New Brighton's Floral Pavilion attended by more than 600 staff and invited guests.

Following a successful review, the organisation was also re-awarded Investors in People accreditation.

❯ Learning & Development

As part of ongoing work to empower the Trust's leaders and unlock their wider potential, the multi-disciplinary senior leadership and management programme was reviewed during 2012/2013 and revised.

Using workshop-style 'action learning' the emphasis was on bringing clinical and management leaders together to develop peer-to-peer approaches based on direct experience. This aligns closely with the Wirral Excellence in Healthcare System (WEHS), which looks to identify and eliminate waste, and improve the quality of our internal processes.

Throughout the year, we reinforced our commitment to listening to – and acting on – patient feedback.

The first Celebrating Excellence Best Practice Day was held providing an opportunity for staff and teams to showcase best practice and innovation from their areas.

Across the workforce, particular attention was paid to embedding the Trust's core values and the new Knowledge and Talent Strategy within individual reviews.

The collective challenge for the future will be to make these sessions as meaningful as possible and demonstrate added value for both individual team members and the organisation as a whole.

During the year, there was also a focus on both supporting a number of existing staff through apprenticeships and recruiting trainees externally.

❯ Medical Education

Already renowned as a leader in the region for high quality education and training for doctors in every specialty, we again celebrated an exceptional report following a Deanery visit in 2012.

> "The Trust exemplifies strong educational leadership"
>
> The Education centre is a superb facility, with excellent resources and a team of committed and highly motivated staff.
>
> In so far as it impacts on education, the Trust has an excellent and highly effective management structure.
>
> Good working relationships between senior staff promote good education and this is very evident at all levels."
>
> Extracts from the Deanery Annual Assessment Report 2012

Rising to the Challenge

«

Mike Hughes,
Joiner
Winner of the Trust Employee of the Year Foundation Award

"I have had the privilege of observing him over his 21 years of employment for the Trust and have regularly been taken aback by his commitment, his pride in his work and his willingness to go beyond what is expected of him.

This was exemplified recently when he returned to work within 3 months of having a total hip replacement. In essence he is the embodiment of the Trust core values and a fantastic example of someone who rises to the challenge every day."

"He is widely acknowledged amongst patients, colleagues and Trust staff for his cheerful, helpful personality and this recognition is long overdue.

There are not enough superlatives to describe how widely he is appreciated by all spectrums of Trust staff."

Extract from Foundation Award nomination

»

treating you well

Developing Relationships

Developing Collaborative Relationships and Partnerships

Making the most of the opportunities presented by the challenging financial backdrop, we've made effective partnership working and collaboration at the heart of our approach to driving forward quality and service improvements while striving to maximise resources and achieve best value.

We've worked closely with a wide range of partners and stakeholders over the past 12 months, including other NHS Trusts, GPs, Clinical Commissioning Groups (CCGs), local authorities, social care and the voluntary and community sectors.

Working with Wirral LINk

We've continued to work in close partnership with Wirral LINk during 2012/13.

❯ 'Enter & View' Visits

We welcomed them to undertake a series of unannounced 'Enter & View' visits. These were based on a list of specific indicators for observation provided by the Corporate Nursing and Midwifery Team asking questions such as:

"Is the patient's call bell in reach?' They have since adopted these indicators to use in their visits within Nursing and Residential Care Homes.

The 'Enter & View' visits have benefited us in a variety of ways.

They have increased Wirral LINk's level of confidence in our transparency and openness and have provided an opportunity to understand many of our challenges and processes.

This has been used to provide an external view of an area within the Trust where it was recognised we were not achieving the standards we expected.

In light of the visits, any concerns were escalated to the Trust board and a full action plan and support structure put in place.

Wirral LINk has revisited this area and congratulated us on the improvements made. All areas that have had an 'Enter & View' visit have completed any actions identified, and where they felt they needed to revisit, they did.

In addition these 'Enter & View' visits have enabled us to showcase some of our areas of excellence and provided a practical perspective on the model ward system.

❯ Coffee Mornings and Regular Attendance at Wirral LINk Board Meetings

The Head of Patient Experience and Involvement regularly attends Wirral LINk's meetings and answers any queries raised.

We've also presented and provided promotional information on subjects such as infection prevention and control, and privacy and dignity for patients with dementia.

These events are a forum to discuss and consult with our wider community on how we can improve patient care.

In addition Wirral LINk hosted a successful "Care of the Dying" open public event where the Deputy Director of Nursing was asked to attend as a speaker and Trust Representative.

Throughout the last year we further developed our collaborative relationship with Wirral LINk.

They've continued to undertake regular 'Enter & View' visits. In particular, we were pleased that one particular unannounced visit resulted in LINk being assured in relation to sustained improvements made on a ward where they had previously highlighted concerns.

The 'Enter & View' visits recognise Wirral LINk's. statutory duties but also provide an opportunity to work in partnership to highlight areas of good practice as well as influencing change.

From April 2013, LINk will be replaced by the new Healthwatch organisation and throughout the last year we have worked as part of a strategic team, along with the local authority, LINk and other NHS bodies to facilitate a smooth transition to the new organisation.

We have valued our relationship with Wirral LINk and are confident that many of the attributes of this relationship will be apparent in our future work with Healthwatch Wirral.

Wirral Older People's Parliament

We have an active and valued relationship with the Wirral Older People's Parliament. The chair and members of the executive committee meet with the Director of Nursing and Midwifery and other senior managers on a quarterly basis to discuss issues or questions from members.

We were very pleased to participate in the 'Nifty after Fifty' event in May 2012 where we had the opportunity to present our vision for elderly care in the future as well as engaging directly with members of the public about our services.

Listening Directly to Patients

Working in partnership with patients and their relatives and carers has been a recurring theme in 2012/13. As part of an ongoing commitment to listening to patients and learning from their experiences, we invited a number of families to attend the Quality and Safety Committee and tell their 'story of care'.

We heard some very positive experiences, but equally, we heard of experiences which were not so positive for patients and we are using these to inform future service developments. We will strengthen the patient voice further by having a patient representative as a standing member of the Quality and Safety Committee.

Rising to the Challenge

COPD & Oxygen Service Team

The team was awarded the prestigious national 'Vision' award for their work with the Wirral Health Commissioning Consortium on the Wirral Self Care Initiative.

This initiative delivers intensive support for COPD (chronic lung disease) patients in Primary Care.

This nurse led service supports patients in managing their own condition and, where possible, avoid admission to hospital.

Developing Collaborative Relationships and Partnerships

Stakeholders

We remain committed to maintaining and developing partnerships with all of our stakeholders, in order to share best practice and ensure true joined up thinking and working for the benefit of our patients.

Highlights from the past 12 months include:

➤ Effective working relationships with individual GPs have proved invaluable during a time of change and uncertainty. We look forward to strengthening these links in 2013/04, working alongside GPs where difficult decisions need to be made and making holistic systems work for the benefit of patients and families

➤ The recently formed Clinical Commissioning Group (CCG) for Wirral is a key stakeholder, not only as the principal commissioner of the services we provide, but as a fundamental partner in establishing the right strategic approach to addressing the health issues highlighted in the Joint Strategic Needs Asessment (JSNA).

➤ Integrated working across organisational boundaries is vital if patients are to be effetively served and considerable effort has been expended to improve integrated work ingwith the Community Trust and Chester and Wirral Partnerships NHS Foundation Trust

➤ We've maintained a positive working relationship with Wirral Metropolitan Borough Council and in particular with Adult Services and Children's Services

➤ This partneship has enabled us to work in a truly integrated way at a challenging time for the NHS, to help minimise delays for patients moving from a hospital setting into social care. The Trust also continues to be an active member of the Wirral Health and Wellbeing Board.

Commissioners

The NHS has seen significant structural reorganisation across its commissioning systems in the last two years. In 2012/13 NHS Wirral, our key commissioning partner, secured its authorisation as a Clinical Commissioning Group (CCG). NHS Wirral accounts for 87% of our total income and is therefore the key partner in how we develop our services.

As the new team at the CCG has bedded-in, our relationships with them have developed. Elements of joint working are increasingly evident, with good systems and processes sitting behind these to ensure effective delivery.

In addition to Wirral's core commissioner the Trust is also working constructively with other English Commissioners as well as commissioning organisations in Wales to increasingly offer services, where appropriate, on a larger footprint than traditionally provided for. In the coming years the Trust's strategy includes extending the footprint of its provision.

Shared Services and Joint Working

In 2012/13 we further consolidated the development of a shared employment bureau service and microbiology service.

In addition to building on these established changes, we were also successful, in partnership with the Community Trust and Brooks Advisory Service in securing an end-to-end provision of GU Services following a tendering process managed by the local CCG.

This is a great example of how partnering with different providers from different sectors can help us to deliver streamlined and seamless services to the population of the Wirral.

This year has provided a sound platform for working into 2013/14 with other such joint ventures and delivery models.

Provider-To-Provider Working

In addition to the traditional and positive working relationship we have with the Countess of Chester NHS Foundation Trust, we have also seen an increase in the level and number of discussions we have had with other potential partners from the provider sector.

Engagement with Liverpool Heart and Chest NHS Foundation Trust is picking up pace with a focus on improving pathways and outcomes for patients in the Wirral suffering with conditions such as coronary heart disease.

These discussions have been specifically focused on how we can secure the best specialist input on a local basis. We'll continue this partnering approach into 2013/14 and it will be extended to incorporate a broader range of provider partners.

This is all about offering a series of different services to ensure that the Wirral population is best served with the highest quality clinical input delivered through partnership models and localised care.

> **"My son has learning disabilities and every effort had been made to ensure that his day case procedure went like clockwork.**
>
> **The staff on the ward, the surgeon and the operating theatre staff were aware of his special needs and they handled the whole thing wonderfully."**
>
> **Letter to the Editor – Wirral Globe**

Developing Collaborative Relationships and Partnerships

Supporting the Local Economy

The Trust is conscious that it has a responsibility to support local businesses and the local jobs market, and within the confines of ensuring the achievement of the highest level of value for money, it takes this responsibility seriously.

There are currently over thirty Wirral-based firms registered with the North West Consortium – which maintains and manages approved lists of contractors and consultants for services related to design, construction and maintenance for the NHS - covering a wide range of services, and a recent analysis has shown that, in relation to minor works contracts, approximately two-thirds of the Trust's expenditure is placed with Wirral based firms. The vast majority of the remaining expenditure is with contractors based in the immediately neighbouring areas, as shown in the table below:

Recognising that it would be desirable to further maximise the opportunities for locally based firms to tender and to support the employment of local people, a process has now been adopted for 2013/14 such that if a Wirral based contractor is included within the North West Consortium's Approved List of Contractors, and is authorised to undertake works within that value range, that firm will be given an opportunity to tender for the works.

This process has been followed in relation to the next significant contract to be let by the Trust, which is for the next phase of the refurbishment of the main entrance at Arrowe Park Hospital.

	% of Jobs	% of £ Spend
Contractors - Wirral Based	65%	63%
Contractors - Liverpool Based	18%	26%
Contractors - Chester / Ellesmere Port Based	14%	11%
Contractors - Other Areas	3%	<1%
	100%	100%

Developing Collaborative Relationships and Partnerships

Strengthening Excellent Relationships with Governors and Members

❯ Council of Governors

During 2012/13 the Council of Governors and Board of Directors appointed a joint working group to review the size and composition of the Council of Governors in light of the 2012 Health and Social Care Act and to reflect best practice.

This work resulted in the size and composition of the Council of Governors being amended, following approval by the Board of Directors, Council of Governors, Members voting and a Special Members' Meeting and Monitor.

The new composition of the Council of Governors now comprises of 13 public constituencies, five staff constituencies and six stakeholder organisations.

All elected governors, however will remain in post until their natural end of tenure.

As an organisation, we regard their input as invaluable in representing the local population and helping put the voice of patients into our decision-making processes.

During 2012/13, governors assisted in a number of key areas. This included setting our annual planning priorities, as well as shaping the development of our on-going Site Strategy.

The Council of Governors have played a key role in supporting the Trust in its vision, values and goals and the setting of a five year plan of strategic priorities.

Meeting with governors in a variety of settings has been key to further strengthening this important relationship during the year.

All governors are invited to attend the Trust's Board meetings and receive the minutes.

A number of governors have also been involved in visits to wards, talking to staff and ensuring services to patients offer the best quality care.

Members of the Trust

Alongside the review of the composition and size of the Council of Governors, the boundary of the public membership constituency was extended which now means that any member of the public living within Wirral, the North West and North Wales is eligible to become a member from the age of 11 and to stand to become a governor from the age of 16.

Our staff membership classes have also been amended slightly to better reflect our workforce (for further information, please see the Director's Report, page 128).

Our members continue to 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 9,020 public members, plus an additional 5,650 who are members of staff.

They have supported us in a variety of ways, including:

❯ Voting in governor elections (in 2012/13 elections were held for seven seats)

❯ Participating in questionnaires and surveys

❯ Acting as a yardstick of public opinion about our plans

❯ Receiving and giving feedback on newsletters and other documents

❯ Volunteering.

"I could not have asked for better treatment and always felt respected, cared for and treated really well. The ward was run with skill, organisation and professionalism. I felt that the staff were part of a good and effective team."

Learning with Patients survey

Rising to the Challenge

Micropath Team

The team, comprising staff from Wirral and Chester trusts, was a winner of a Wirral Trust Foundation Award, an Outstanding Achievements Award at the Countess of Chester's annual Celebration of Achievements Awards and was shortlisted for a Health Service Journal Efficiency Award.

treating you well

Care Infrastructure

Developing an Excellent Care Infrastructure

Enhancing Site Infrastructure, Safety, Effectiveness and Efficiency of Facilities

❯ Site Strategy

Our estate comprises well in excess of 100,000 square metres of floor area across our two sites at Arrowe Park and Clatterbridge Hospitals.

2012/13 has once again been a busy year for the Trust as we seek to develop and manage our sites and infrastructure safely, efficiently and effectively.

Our ongoing Site Strategy programme encompasses a number of key developments aimed at enhancing the safety and quality of patient care. During the past year we have completed and opened two significant new developments on the Clatterbridge site:

- **New Stroke and Neuro-Rehabilitation Centre**

In December 2012 a new £1.95 million specialist multidisciplinary assessment and rehabilitation centre was opened, which will enable the Trust to combine neurological and stroke rehabilitation services at the Clatterbridge site.

As well as the convenience of having services in one place, patients will benefit from the added privacy and comfort of ten single bed en-suite rooms alongside therapy areas.

- **New Breast Centre**

In October 2012, a new £1.25 million purpose-built breast care facility at Clatterbridge was opened, which consolidates existing services and brings them together in one place for the first time. The new centre will also give patients more space and enhance their personal privacy and dignity.

In addition to these developments, in September 2012 the Trust's Child Development Centre moved from its' old premises on the Clatterbridge site to newly completed facilities at St Catherine's Health Centre in Birkenhead.

This provides a 'one stop shop' for families by bringing the services into the heart of the local community, side-by-side with other service providers such as audiology, speech and language therapy.

The hydrotherapy pool remains on the Clatterbridge site and has been the subject of a major investment to upgrade and modernise the pool and its associated patient changing facilities to meet modern standards and improved disabled accessibility.

❯ Arrowe Park Hospital - Catering Improvements

In March 2012, a major upgrade of the Bowman's Restaurant at Arrowe Park Hospital was completed. This investment has created a modern, up to date dining environment for both patients and staff, and ensured ongoing compliance with the latest food hygiene legislation.

❯ Safe Storage of Medicines

Work has been completed to ensure that safe medicines storage facilities are available in all clinical areas to meet required standards for compliance.

❯ Norovirus Prevention

The first phase of a Trust-wide programme to install doors on multi-bed bays on all our inpatient wards has been undertaken.

There is evidence to show that this is a major factor in helping to eliminate the spread of infections within the hospitals, as well as improving privacy and dignity for our patients. The programme will continue on further wards during the coming year.

❯ First Impressions

The Trust has developed a programme called First Impressions, which looks to improve all aspects of the service we provide to our patients and visitors, and the hospital environment.

As part of this programme, a project to fully refurbish the main ground floor corridor at Arrowe Park Hospital got underway, which includes new ceilings, lighting, flooring, signage and redecoration throughout.

The programme will continue during the coming year with a major upgrade of the main hospital entrance and foyer area, to include new public toilet facilities, new reception and improved seating areas.

❯ Sustainability and Climate Change

We have continued to drive forward activity to improve energy efficiency and reduce carbon emissions and the Trust's impact on the environment.

The Trust has been working with the NHS Carbon & Energy Fund during 2011/12 to develop a scheme for a major investment in our energy infrastructure.

This scheme will provide new Combined Heat and Power plants at both Arrowe Park and Clatterbridge sites, together with improvements to insulation, energy efficient lighting and water-saving measures.

In total it is expected that when fully implemented during the coming year, the scheme will reduce the Trust's total carbon emissions by around one-third and also significantly reduce our energy bills, allowing funding to be released for reinvestment in patient services.

As a result of the new facilities provided by our Site Strategy investments, the opportunity has been taken to demolish some redundant buildings which are no longer suitable for providing clinical care.

This has improved the quality, efficiency and sustainability of our overall estate by reducing the cost of energy, utilities and maintenance associated with old buildings.

Developing an Excellent Care Infrastructure

The new buildings provided at Clatterbridge during 2012/13 as a result of the Stroke and Neuro-Rehabilitation and Breast Unit schemes meet modern environmental and energy performance standards and also include additional renewable energy initiatives such as solar panels.

We have made major strides during 2011/12 in managing our waste through a process known as "segregation at source". This has resulted in an increase in our recycling rate from 25% of domestic and offensive waste up to 35%, the equivalent of recycling an additional six tonnes of waste every month.

We have also introduced a new system of managing our confidential waste through the introduction of locked consoles throughout the Trust, which is both more efficient and provides greater security. Paper waste managed in this way is also recycled.

Our Travel Plan continues to be implemented and has been very successful in reducing reliance on single-occupancy car journeys and encouraging sustainable modes of travel to our hospitals.

A staff travel survey carried out by an independent external consultant during 2012 showed that 44% of those staff responding used a sustainable mode of travel to work (walking, cycling, public transport or car sharing), an increase from 35% in the previous survey.

The Trust continues to implement measures to increase sustainable travel, including:

❯ Providing improved facilities for cyclists, which in 2012 has included the opening of refurbished changing and showering facilities at Arrowe Park Site

❯ Maintaining a salary sacrifice scheme for staff wishing to purchase a bicycle

❯ Actively promoting public transport options to staff, patients and visitors in partnership with Merseytravel.

The Trust's Environmental Action Team and Transport Strategy Group will continue to meet to drive forward progress in these areas during the coming year.

"When the staff came on duty it was like putting an engine in motion. They worked like clockwork, they were a team, they never stopped from the start of their shift till the end. Nothing was too much for them."

Learning with Patients survey.

Reducing Carbon Emissions: Summary Peformance 2011/12 and 2012/13

Area		Non-financial data (applicable metric)	Non-financial data (applicable metric)	Financial data (£k)	Financial data (£k)
		2011/12	2012/13	2011/12	2012/13
Waste minimisation and management (types of waste produced and methods of disposal)	Absolute values for total amount of waste produced by the Trust Methods of disposal (optional)	1,744.90 tonne	2,051.85 tonne	250,464	362,996.13
	Clinical waste (incineration)	104.58 tonne	104.58 tonne	65,236	97,238.08
	Clinical waste (heat disinfection)	70.13 tonne	85.82 tonne	28,552	33,109.36
	Offensive waste (landfill)	476.10 tonne	474.76 tonne	60,294	90,295.35
	Domestic waste (landfill)	541.68 tonne	644.45 tonne	64,799	90,351.89
	Recovery/recycling	552.41 tonne	693.30 tonne	31,583	51,997.50
Total		1,744.90 tonne	2,051.85 tonne	250,464	362,996.13
Finite resources	Water	207,573 m3	217,028 m3	276,072	304,711
	Electricity	23,956,520 Kwh	17,493,205 Kwh	2,310,866	1,717,485
	Gas	48,557,480 Kwh	54,475,783 Kwh	1,530,955	1,653,337
	Other energy consumption				

Developing an Excellent Care Infrastructure

Providing Excellent Trust Systems

❯ Wirral Excellence in Healthcare System (WEHS)

The Wirral Excellence in Healthcare System (WEHS) has continued to identify and eliminate waste and inefficiency in our systems and processes.

The focus this year has been on the end-to-end patient journey. Large projects are in progress covering both our Elective and Non Elective systems and are targeted at our goals of improving patient access and patient flow.

The Ideas generated by staff through the Listening into Action initiative have also been supported by the WEHS methodology.

❯ Clinical IT Systems

We're now half way through the major replacement of our main clinical IT systems.

As part of this programme of work we've continued to introduce new technologies throughout the year and as a result have improved the patient experience and enhanced processes across many areas of the hospital.

The main highlights during 2012/13 include:

❯ Wirral Millenium

We've continued to work closely with our partners Cerner to develop a comprehensive clinical information technology system across the Trust.

Following the successful implementation of the system in key areas such as the Emergency Department (ED) and Outpatients we are currently working on the next phase of the programme.

This will include a replacement of our current laboratory information system, the development of a system to support the Maternity department, the roll out of electronic ordering, and results retrieval on Millennium to all inpatient areas and some improved ways of working for outpatient clinics.

This latest phase of the project includes some innovative technology which hasn't been used in the UK before, in particular the integration of foetal monitoring into the clinical record on Millennium and the use of technology to positively identify the patient and match them to the correct laboratory investigation request.

All of this functionality will be live within 2013 and will provide benefits for staff and patient care.

As part of the preparation work for this latest phase, we took the opportunity to review the involvement of clinicians and other key staff with the programme and have now created three Advisory Teams:

- ❯ Clinical Advisory Team for nursing staff and other healthcare professionals

- ❯ Medical Advisory Team for consultants and junior doctors

- ❯ Operational Advisory Team for clerical and other support staff.

These teams identify areas where the Millennium system could be improved and help to spread best practice in the use of the system across the organisation.

We've also established an eProgramme Group overseeing technology projects across the organisation, making sure that such projects deliver the expected benefits and help to transform the care provided to patients.

❯ PIEDW

Cerner's data warehouse and reporting system, know as PIEDW, has become the primary information reporting tool used for the majority of our performance monitoring including the monitoring of outpatient and inpatient waiting lists.

The Information Department have developed InfoView, a web based tool which makes information available to managers and staff whenever and wherever they need it.

This information is provided by an automated processes and is presented in a 'dashboard' view which makes it easy for users to see at a glance how the Trust is performing against its key targets.

❯ Message Centre

Message Centre is a part of the Millennium system which is used by Consultants and other clinicians to view and manage laboratory, radiology and other results. It's a bit like an e-mail system which makes results instantly available as soon as they have been released and records that the results have been seen and endorsed.

This has helped us to significantly reduce the numbers of results which are printed out onto paper and speed up patient care as clinicians no longer have to wait for the paper copy of a result.

For example, in our acute admissions areas where 60 to 70 patients are assessed and treated every day, the use of Message Centre has improved the management of the associated clinical information.

The consultants within these areas can see CT or MRI results as soon as they have been reported rather than waiting for the paper copy which could have taken up to a day to arrive previously.

❯ Emergency Department

We've continued to develop the system used in the Trust's ED areas providing electronic assessments for the See and Treat area.

Working with Cerner and third party instrument suppliers we have also integrated the machines used to capture patients observations - such as pulse, heart rate, and temperature – into Millennium so that these clinical details can automatically be captured directly into the ED system.

Although this has previously been done in the USA, this is the first time such work has been carried out in the UK.

As well as providing time savings this system will also reduce risk to patients and will act as a model for the roll out of this functionality to wards across the hospitals in future years.

Developing an Excellent Care Infrastructure

❯ Digital Breast Screening

During early 2012, digital breast screening went live in Radiology which included the integration of screening mammography with the National Breast Screening Service.

This has allowed the department to support the national extension of age range programme which offers breast cancer screening to women aged 47 to 49 and 71 to 73 (women in the 50 to 70 age group were already being called).

❯ Diabetes and Colposcopy

This year also saw the development of bespoke Millennium pathways within the main system to support the care provided by the Diabetes and Colposcopy services.

This has helped to streamline their processes, reduced the duplication of information recording within the patient record, and helped to support the accurate call and recall of patients to attend when necessary.

❯ Informatics

To enable us to continue to develop and enhance our IT systems, we've also taken the opportunity to establish our own 'in house' team who are responsible for maintaining the Millennium system and other clinical systems.

"The care I received was exceptional.

Not only were the staff professional, there was also a 'warmth' which immediately made me feel reassured.

Learning with Patients survey.

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Financial Performance

Delivering Strong Financial Performance

Headline Performance

The 2012/13 financial year has been another challenging one and is indicative of the difficult financial environment the Trust will face in the coming years.

During 2012/13 the Trust continued to demonstrate financial stability, with the underlying position broadly in line with the plan.

Inflationary and other pressures have been managed in year, together with tariff deductions and in year operational challenges relating to improvements in quality and safety and service provision, through the delivery of recurrent cost improvements of £13m.

The Trust has over performed against clinical service contracts, attracting additional income and incurring additional expenditure in the delivery of the activity.

The Trust's 2012/13 Financial Plan was for a surplus of £2.8m. The accounts show a year-end surplus of £1.95m which is 0.7% of turnover, however after excluding the impact of non-cash technical adjustments relating to estate impairments and asset disposals, the Trust's operating position was ahead of plan at £3.4m.

In 2012/13 the Trust made capital investments of £11.9m on buildings, software and equipment to maintain and improve the infrastructure of the organisation and facilitate and improve patient care.

This sound financial performance generated a provisional Monitor* score of 'three' in accordance with the planned risk score under the NHS Foundation Trust Compliance Framework assessment.

Overall, therefore, the results represent a satisfactory position with continued financial stability for the Trust alongside its service achievements.

The accounts cover the period 1st April, 2012 to 31st March, 2013.

Monitor* Ratings (including regulatory ratings)

› Regulatory Ratings Report

On Monitor's Financial Risk Rating of one to five, where one represents very high risk and five very low risk, the Trust planned and achieved a risk rating of three. The Trust was at all times compliant with its Prudential Borrowing Limit.

A summary of the Trust's annual and quarterly performance against the regulatory ratings for financial risk, governance risk and mandatory services is given in the following table:

Monitor* is the independent regulator for NHS Foundation Trust.

	Annual Plan 2012/13	Quarter 1 actuals 2012/13	Quarter 2 actuals 2012/13	Quarter 3 actuals 2012/13	Quarter 4 actuals 2012/13
Finacial risk rating	3	3	3	3	3
Governance risk rating	Green	Red	Red	Red	Amber-Green
Mandatory services	Green	Green	Green	Green	Green

Key:

Financial risk rating:

1. Highest risk – high probability of significant breach of authorisation in the short term, eg less than 12 months, unless remedial action is taken.

2. Risk of significant breach in the medium term, eg 12 to 18 months, in the absence of remedial action.

3. Regulatory concerns in one or more components; significant breach unlikely.

4. No regulatory concerns.

5. Lowest risk – no regulatory concerns.

Governance risk rating:

Red: Likely or actual significant breach of terms of authorisation.

Amber/red: Material concerns surrounding terms of authorisation.

Amber/green: Limited concerns surrounding terms of authorisation.

Green: No material concerns.

› Financial Risk

This remained as planned throughout the year. A more detailed series of metrics is used to assess financial risk, shown on page 107.

› Governance Risk

All standards under the Compliance Framework were achieved for the first three quarters of 2012/13. However, due to the previous failure against the Referal To Treatment (RTT) admitted standard in 2011/12, Monitor still considered our Trust to be in significant breach of it's Terms of Authorisation, and so the Governance Risk Rating remained Red for those quarters.

It was subsequently confirmed by Monitor in Q4 that, following a governance review and the sustained achievement of all standards, our Trust was no longer considered to be in breach.

The resultant risk rating for Q4 was amber-green, on the basis that the A&E four hour standard was the only target not achieved for that quarter.

Delivering Strong Financial Performance

❯ Mandatory Services

Mandatory services continued to be provided in line with the terms of the Trust's authorisation. There were no identified issues. Any that do arise will be approached, as required, via the variation of authorisation process.

❯ Financial Performance

The Trust signed its main Commissioner contract on time allowing for the new Acute Services contract to start on 1 April 2012.

The contract was with Wirral Primary Care Trust (NHS Wirral); however this also included nine other Associate PCTs, including North West Specialised Commissioning, for the renal and neonatal services elements.

The 2012/13 contract covered all key elements of the Department of Health's 'NHS Standard Contract' including all finance and activity requirements, specific 'Quality' requirements, the 'Nationally Specified Events' key performance indicators (KPIs) and Commissioning for Quality and Innovation (CQUIN) schemes.

As per the contractual requirements, regular monthly performance monitoring information was provided to the PCT in terms of financial performance, performance against Known Performance Indicators (KPIs), Quality requirements, Service Development Improvement Plans and CQUIN schemes.

The Trust also participated in the regular monthly performance management meetings, which allowed for more in-depth debate about quality and performance issues.
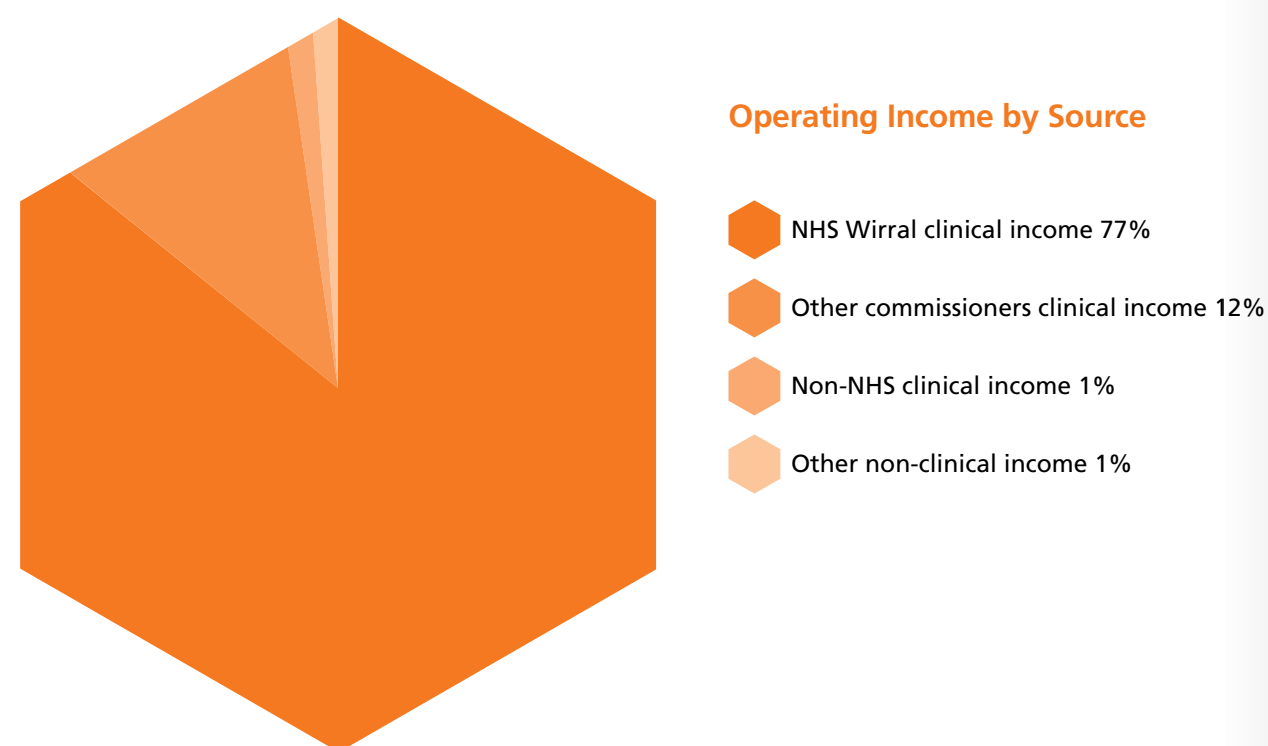
The Trust has historically had a good relationship with the local PCT and has a history of successful contract arrangements which ensured a high standard of service for local residents.

The introduction, in shadow form, of the newly established Clinical Commissioning Groups on Wirral in the last year has not changed this and has in fact allowed for stronger clinical debate on key contractual issues; further improving the contract outcomes for both parties.

❯ Statement of Comprehensive Income

Clinical income from NHS sources comprised 89% of total income and was largely generated by Payment by Results (PbR) for activity undertaken on the basis of agreed contracts.

Total Operating Income was £296.7m.

Operational expenditure within Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) to deliver this level of income and service, including performance against targets covered in this report, totalled £281.3m (excluding depreciation, Public Divident Capital (PDC) payable etc).

This gave an operational surplus (EBITDA) of £15.4m (5.2% turnover), £0.2m more than the planned figure of £15.2m.

Operating Income by Source

- NHS Wirral clinical income 77%
- Other commissioners clinical income 12%
- Non-NHS clinical income 1%
- Other non-clinical income 1%

Operational Expenditure

- Pay 72%
- Clinical supplies and services 10%
- Other 10%
- Drugs 6%
- Non-clinical supplies 2%
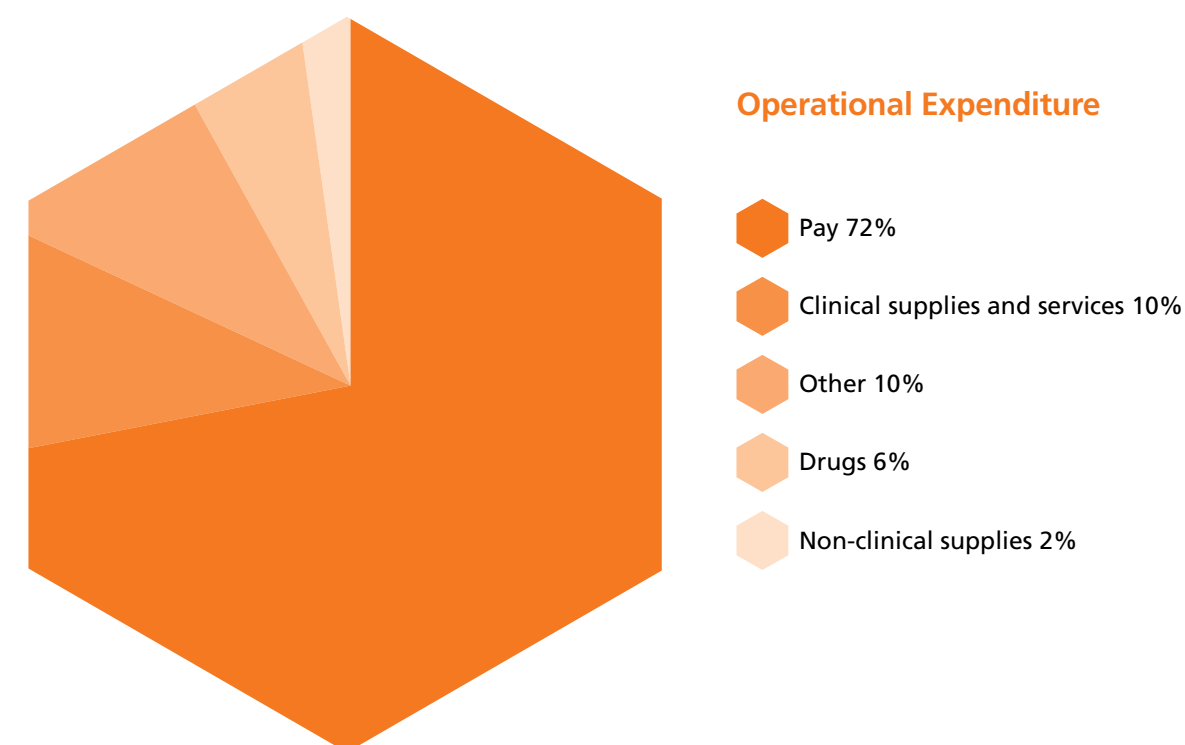
Delivering Strong Financial Performance

❯ Post EBITDA Items

This £13.4m net expenditure (including impairment of assets and losses on disposal of fixed assets of £1.5m) compared to a plan of £12.4m. The difference is largely due to impairing buildings as part of the continued modernisation of the Trust's site.

❯ Summary

The overall income and expenditure position was a surplus of £1.95m.

For the assessment of normalised earnings, impairment of assets and losses on disposals of assets were added back, giving a surplus of £3.4m.

❯ Capital Expenditure

The Trust used internally generated resource, resource generated by its surplus and resource brought forward from the previous year, to invest in its capital programme in 2012/13. Actual spend against this programme was £11.9m. The key schemes are outlined in the table below.

❯ Cash/Working Capital Facility/Liquidity

The Trust had a cash balance of £24.9m at the year end. The balance was higher than planned principally owing to slippage on the capital programme and higher creditor balances.

Including the working capital facility (£18m overdraft facility), which was not used during the year, the liquidity ratio for the Trust at the year end was good and assessed at low risk under the Monitor compliance regime.

❯ Statement of Financial Position

The key highlights for 2012/13 were:

❯ the achievement of the surplus for the year;

❯ small increase in creditors owing to the timing of charges due;

❯ small increase in debtors owing to the timing of monies receivable for over performance in the year.

Scheme	£m
Site strategy – 5 year project	3.3
Da Vinci Robot	1.8
Cerner Project to replace information system; total contract value £12.25 m (at 2008/09 prices) over 10 years	0.8
First Impressions Programme	0.7
Server virtualisation project	0.4

❯ Risk Ratio Financial Risk Metrics

Under Monitor's compliance regime, a series of metrics is used to assess financial risk. These are based on the Annual Plan for the year. The Trust's performance against these metrics is as outlined in the following table.

❯ Pension Liability

In 2012/13, there were seven (2011/12:7) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £418,954 (2011/12: £284,319). The cost of these ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

❯ Other Performance Indicators

❯ Management Costs
As defined for the accounts, these were 3.4% for the period (3.3% in 2011/12).

❯ Annual Governance Statement / Internal Audit Opinion
The Annual Governance Statement is included as part of the Annual Report Part 2.

This sets out the assurance process to the organisation and the Internal Audit Opinion provides 'significant' assurance to the overall process.

❯ Going Concern Basis
After making enquiries, the Trust's Board of Directors had a reasonable expectation that the Foundation Trust had adequate resources to continue in operational existence for the foreseeable future. For this reason, they continued to adopt the 'going concern' basis in preparing the accounts.

*1 = very high risk, 5 = minimal risk

	2012/13 Plan	2012/13 1* Provisional rating
Achievement of operational planned EBITDA	5	5
Underlying performance EBITDA margin compared to turnover	3	3
Financial efficiency • Return on assets • Income and expenditure surplus margin	3 3	4 3
Liquidity	3	3
Weighted average	3.2	3.4
Overall financial risk rating (rounded)	3	3

Delivering Strong Financial Performance

2012/13 Summary and Forward Look

Overall, the Trusts 2012/13 financial results are satisfactory, and are broadly in line with the planned position (excluding the impact of impairment in asset values).

This performance has been achieved alongside the delivery of service improvements, operational challenges faced during the year and within a complex and difficult financial environment.

Looking forward, it is clear that the Trust, along with the rest of the NHS, faces an immensely difficult future as demands on services continue to grow, alongside the continued need to deliver significant efficiencies.

The Trust will need to work closely with Commissioners in the management of limited resources within the health economy, and in understanding and managing the implications on the use of hospital services of national contracts / business rules, which with the development of KPIs / penalties are becoming ever more challenging for providers.

The following is a summary of financial issues that have been factored into the Trust's plans in order that financial stability is maintained. The Financial Plan for 2013/14 took into account:

❯ agreed contracts with commissioners within agreed timescales

❯ need to deliver national efficiencies to meet the cost of inflation and reductions in the national tariff

❯ assessment of financial risks faced in the coming year

❯ agreement of budgets within the organisation that, while tight, are realistic in terms of delivering planned activity.

The key objective is to provide the highest possible quality healthcare within the resources available. Necessary efficiencies need to be made so that there is no detrimental effect on the quality of frontline services.

One of the key financial challenges the Trust faces is to deliver an in year CIP in the region of £16m, in both recurring and cash releasing terms. On the basis of delivering these savings, a surplus of £2.8m is planned.

The Trust's planning assumptions are reflective of the national economic situation, recognising constraints on public sector funding and nationally set efficiency requirements.

This will mean constrained resource against a background of higher expectations of the quality of service to be delivered. As part of meeting this challenge, the Trust will work with commissioners on their strategic plans for the future.

These, together with the impact of the following key factors, have been taken into account in the Trust's planning process:

❯ demographic change, in particular the impact of an ageing population, on the demand for healthcare

❯ great patient choice, where the Trust's intention is to make services as attractive as possible

❯ quality and safety improvements;

❯ focus within the health service on a more preventative approach, and for more patients to be treated closer to home or in a community setting

❯ development of specialist services

❯ standards driven by DoH policy, the CQC, Monitor, NICE, etc.

Recognising this position, the Trust's longer term plans are based on realistic assumptions regarding resource. The implication is that, as a minimum, efficiency measures will need to generate up to £16m per annum for the remainder of this plan.

Summary

The dual challenges of the economic climate in the public sector and transition under NHS reforms over the next couple of years are recognised and factored into the Trust's longer term strategic plans.

These are built on the need to make efficient and effective use of resources to deliver on contracts and targets and respond appropriately to the changes in the commissioning environment.

The Trust remains committed to delivering high quality services and to achieving efficiency savings to address the future financial pressures and to protect our services.

❯ **Contributions for Political or Charitable Purposes**

The Trust did not make any political or charitable donations during the year.

❯ **Policy on the Payment of Suppliers**

It is the Trust's policy to follow the Better Payment Practice Code, seeking to pay 95% of invoices within contract terms or 30 days where no terms have been agreed.

The Trust endeavours to meet this target and is also a member of the prompt payment code (www.promptpaymentcode.org.uk), which monitors compliance by asking for feedback directly from the Trust's suppliers.

There has been no payment of interest under the Late Payment of Commercial Debts (Interest) Act 1998.

❯ **HM Treasury and Office of Public Sector Information Guidance**

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Delivering Strong Financial Performance

❯ Accounting Policies for Pensions and Senior Employees Remuneration

Accounting policies for pensions and other retirement benefits are set out in note 1.9 to the accounts and details of senior employees' remuneration can be found in page 151 of the remuneration report.

❯ Income for the Purposes of the Health Service

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 must be greater than its income from the provision of goods and services for any other purposes.

Wirral University Teaching Hospital NHS Foundation Trust can confirm that it has met this requirement for the 2012/13 financial year and is confident that it will continue to meet this requirement in future years.

Other income received is used to provide additional support and stability to the underlying financial position of the Trust.

This ensures the Trust can continue to afford to deliver a high standard of provision of goods and services for the purposes of the health service in England.

❯ Financial Instruments

An indication of the exposure of the entity to liquidity risk and interest rate risk is set out at Note 27.3 of the Trust's Accounts.

The Trust's investment policy is to hold funds in bank deposits and money funds, which are less vulnerable to market variations. Liquidity is managed via short to medium term deposits in the money market with highly rated banks.

❯ Statement of Disclosure to Auditors

Each of the 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 he/she ought to have taken as a Director in order to make him self / herself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

❯ Post Balance Sheet Event

There have been no post balance sheet events.

❯ Auditors

Following a competitive tender, the Trust replaced its external auditors, the Audit Commission, with KPMG on 1st December 2010.

"Last week I was admitted three times. Every time I was treated exceptionally well and with respect. My symptoms were extensively looked at until and answers were given.

I was discharged feeling well looked after and knowing I was given the best treatment possible."

Learning with Patients survey
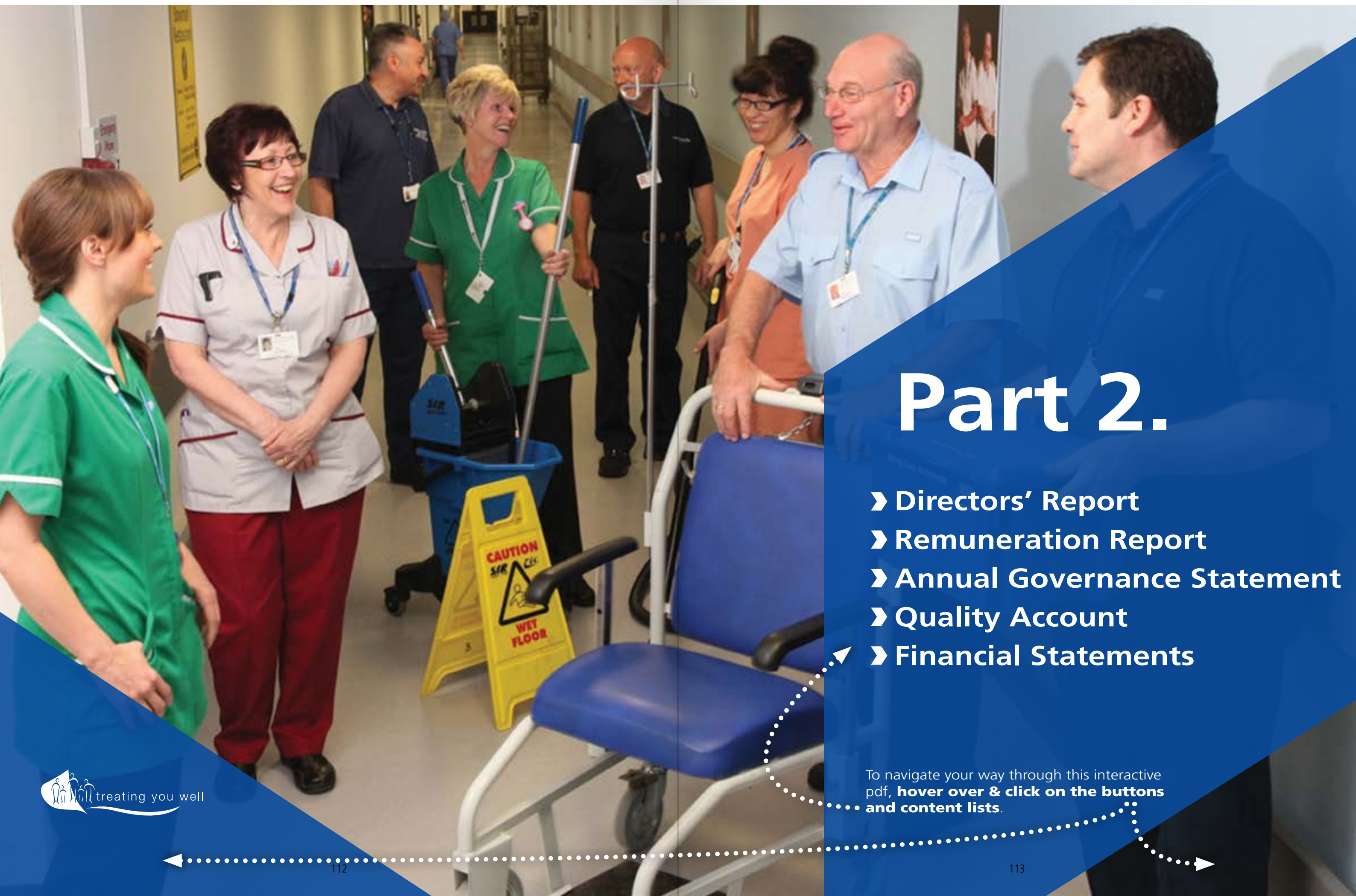
Part 2.

❯ **Directors' Report**
❯ **Remuneration Report**
❯ **Annual Governance Statement**
❯ **Quality Account**
❯ **Financial Statements**

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Directors' Report

Directors' Report

NHS Foundation Trust Code of Governance

The Board of Directors and Council of Governors are committed to continuing to operate according to the highest standards of corporate governance.

The Trust is compliant with the principles and provisions of the NHS Foundation Trust Code of Governance.

The Board of Directors met on nine occasions in 2012/13 in order to discharge its duties. In addition to developing the Trust's strategy, the Board regularly reviewed performance against all regulatory and contractual obligations and has established new governance structures to support its work. These new structures will be embedded in 2013/14.

During 2012/13 the Board redesigned its Board Assurance Framework and associated processes in a way that will support the new governance structure and add greater value to the work of the Board, enabling it to focus on regulatory requirements governing quality and safety and financial and operational performance; as well as delivery of the Trust's strategic plans.

All Directors have responsibility to constructively challenge the decisions of the Board; Non-Executive Directors scrutinise the performance of the Executive Directors on an ongoing basis and through a formal annual appraisal and objective setting process which is undertaken by the Chief Executive and reviewed by the Remuneration Committee, at least annually.

The Governors undertake an annual appraisal of the Chairman which is led by the Senior Independent Director.

The Chairman reviews the performance of the Chief Executive and of the Non-Executive Directors.

The Board regularly reviews its balance of skills to ensure that they are appropriate to the requirements of the Trust and has taken action to ensure that vacant Board positions are filled in a timely way, with consideration to succession planning, in order to mitigate risk associated with Board level turnover and the potential loss of organisational memory and continuity of leadership.

All Non-Executive Directors, including the Chairman, are considered independent in respect of the criteria for independence set out in the Code of Governance.

The Chairman has ensured that the Board of Directors and Council of Governors work effectively together, through the provision of timely and appropriate information; the convening of joint workshops; attendance of Board Members at Council of Governor meetings; and through a programme of joint workshop sessions. In particular, a joint Board and Council Working Group was established in 2012/13 to consider the implications of the Health & Social Care Act 2012. The Trust's constitution has been reviewed and the size and composition of the Council of Governors has been changed to reflect best practice and improve representation and effectiveness.

The Council of Governors represents the interests of public and staff members and of partner organisations.

The Council of Governors and Board of Directors have both reviewed and signed up to new Codes of Conduct in 2012/13.

Both the Board of Directors and Council of Governors have reviewed and discussed the findings and recommendations of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry and are exploring ways of further strengthening the patient voice and accountability to the wider public. These themes will be developed further in 2013/14.

The Council of Governors holds the Board of Directors to account through the receipt of quarterly performance reports on compliance targets, quality and safety and financial performance. Governors receive the agenda and minutes of all Board meetings and are invited to attend meetings of the Board of Directors.

Members of the Board attend the quarterly meetings of the Council of Governors in order to present information and respond to any 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.

The Council of Governors meets quarterly in public and in 2012/13, the Lead Governor was Paul Smyth, Staff Governor.

Governors have been actively engaged in developing the Trust's forward plans through the work of the Governors' Strategy and Development Committee and presentations and discussions with the Board at Governors' workshops. Governors gain an understanding of issues arising from patient feedback

Directors' Report

through participation in a programme of Board Walkabouts, involvement in the Council of Governors' Patient Experience Committee, receipt of assurance reports from the Care Quality Commission and other bodies; and through attendance at meetings of the Board of Directors.

The Council of Governors Membership and Communications Group has supported the delivery of the Membership Strategy and will work to further develop engagement plans in 2013/14 that will support the new wider duty of Governors to be accountable to and represent the views of the public as well as membership; in addition to ensuring engagement with the new wider public constituency area of North West and North Wales.

The Trust has facilitated training and development to enable Directors and Governors to update their skills and knowledge and to support their respective roles. Induction training and materials are provided for new Governors and Directors.

The effectiveness of the Board of Directors and its committee structure has been evaluated through an external governance review commissioned by the Trust in 2012/13. The Board of Directors also undertakes a regular self-assessment of its performance, through a process of informal evaluation at the end of each Board meeting. The Board Development plan has been informed through the findings and recommendations of the internal and external evaluation review.

In addition, the Board has accessed development programmes provided by the Foundation Trust Network, Cass Business School, Healthcare Finacial Managment Association (HfMA) and Mersey Internal Audit Agency. Several Board Members attended a 'Boards on Board' development programme in 2012/13 provided by AQUA and the North West Leadership Academy. This focused on quality and safety and the Board's responsibilities in respect of oversight.

Governors have participated in events and training provided by the Foundation Trust Network, the Foundation Trust Governors Association and the North West Governors' Forum. Specific development needs are addressed through the Governors' workshop and twice-yearly joint development sessions with the Board of Directors.

The Trust maintains a Register of Interests and the Board of Directors and Council of Governors review their respective registers on an annual basis to identify any potential conflicts of interests affecting their day to day responsibilities. No such conflicts of interest have been identified. In 2012/13, the Chairman had no significant commitments outside of the Trust that conflict or impact upon his ability to meet his responsibilities to the Trust.

At the start of each Board / Council meeting the Chairman routinely asks all members to declare any interests that relate to the scheduled agenda items, in order that they withdraw from discussion on any matter where there is a conflict. Any such declarations are recorded in the minutes.

The Registers of Interests for the Board of Directors and Council of Governors are available to the public and can be accessed on request by writing to the Associate Director of Governance, Executive Offices, Wirral University Teaching Hospital NHS Foundation Trust, Arrowe Park Hospital, Arrowe Park Road, Upton, Wirral CH49 5PE.

Directors' Report

Council of Governors

Role and Composition

The Council of Governors has responsibility for representing the interests of our members and partner organisations in discharging its statutory duties which are:

❯ To appoint and, if appropriate, remove the Chairman

❯ To appoint and, if appropriate, remove the other Non-Executive Directors

❯ To decide the remuneration and allowances, and other terms and conditions of office, of the Chairman and other Non Executive Directors

❯ To approve the appointment of the Chief Executive

❯ To appoint, and if appropriate, remove the auditor

❯ To receive the annual accounts, any report on these provided by the auditor, and the annual report.

In addition, in preparing the NHS Foundation Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors.

The Health and Social Care Act 2012, has brought additional powers and duties for the Council of Governors. Those that came into force on 1st October 2012 were:

❯ Governors must decide whether the Trust's private patient work would significantly interfere with the Trust's principal purpose, which is to provide goods and services for the health service in England; and

❯ The Council of Governors must approve any proposed increase in non–NHS income of 5% or more in any financial year.

The 2012 Act sets out some further powers and duties for Governors which have not in 2012/13 come into effect. These are summarised as follows and will come into force in 2013/14:

❯ holding Non Executive Directors, individually and collectively to account for the performance of the Board of Directors

❯ representing the interests of the members of the Trust as a whole and the interests of the public

❯ approval of 'significant transactions'.

The Trust's constitution sets out how the Council of Governors will discharge its duties and this includes processes for the appointment and removal of Non-Executive Directors.

Up until January 2013, our Council of Governors comprised 37 governors of which:

❯ 19 were elected by public members from 19 defined areas within the public constituency

❯ 5 were elected by staff from 5 defined classes

❯ 13 were nominated by specified partner organisations.

During 2012/13 the Council of Governors and Board of Directors appointed a joint working group to consider amendments required to the constitution in light of the 2012 Act and also to review the size and composition of the Council of Governors in accordance with published best practice; and also the boundary of the public constituency in the context of current patient flows.

This work resulted in the size and composition of the Council of Governors being amended, following approval of the Board of Directors, Council of Governors, Members voting and a Special Members' Meeting and Monitor.

The Council of Governors now comprises :

❯ 13 public governor seats (through the amalgamation of existing areas and creation of a new area 'North West and North Wales')

❯ 5 staff governor seats

❯ 6 seats assigned to nominated partner organisations (there were 9 seats up until 31st March 2013 as 3 seats were assigned to Primary Care Trusts which ceased to exist at the end of the financial year).

A transition plan is in place, enabling existing governors to remain in office until the end of their current three year tenure.

This ensured a majority of public governors on the Council, pending the reduction of seats assigned to partner organisations after 31st March 2013.

These changes were discussed with Members at a Special Members' Meeting held on 8th January 2013.

The names of those who served as Governor during 2012/13 are listed in the attendance report at the end of this section.

Our governors hold office for terms of three years and may serve up to a maximum of nine years if they are successfully re-elected / re-appointed and provided they continue to reside in the area of their constituency (public governors); continue to be in employment at the Trust (staff governors); and continue to be nominated by the organisation they represent (appointed governors).

Directors' Report

❱ Governor Elections

Elections were held for seven seats on the Council of Governors in 2012/13. The Board of Directors can confirm that elections for public and staff governors held in 2012/13 were conducted in accordance with the election rules as stated in the constitution and approved by Monitor.

The following governors were elected / re-elected for three years and their tenures will complete at the end of the 2015 Annual Members Meeting.

Constituency / Class	No. Seats	Governor elected
Public:		
Greasby, Frankby, Irby and Upton	1	Richard Agar Re-elected - 3rd term until AMM* 2015
Bebington and Clatterbridge	1	Brian Cummings Re-elected - 3rd term until AMM 2015
Oxton and Prenton	1	Donald Shaw Re-elected - 3rd term until AMM 2015
Heswall, Pensby and Thingwall	1	David Steele Re-elected - 3rd term until AMM 2015
Staff:		
Nurses and Midwives , Arrowe Park	1	Paula Clare 1st Term until AMM 2015
Medical and Dental	1	Rosemary Morgan 1st Term until AMM 2015
Other healthcare professionals	1	Iain Stenhouse 1st Term until AMM 2015

*AMM-Annual Members Meeting

❱ Governor attendance at Council of Governor Meetings 2012/13

The following tables list the governors who have served on the Council of Governors during 2012/13 and individual attendance by governors and directors at Council of Governors meetings.
Four meetings of the Council of Governors were held in 2012/13.

Governor	Constituency / Class	Meeting attendance Actual / Possible 1st April 2012 – 31st March 2013(% attendance)
Public:		
Richard Agar	Greasby, Frankby, Irby and Upton	4/4 (100%)
Brian Cummings	Bebington and Clatterbridge	4/4 (100%)
Katarzyna Miturska (Resigned November 2012)	Birkenhead	0/2 (0%)
Evelyn Hurren	Rock Ferry	2/4 (50%)
Robert Howell	West Wirral	4/4 (100%)
Bernie Howden	Seacombe	3/4 (75%)
Sue Hill	Claughton	2/4 (50%)
John Karran	Neston, Little Neston, Parkgate and Riverside	4/4 (100%)
Hazel Kelly (Resigned November 2012)	Leasowe, Moreton and Saughall Massie	0/2 (0%)
Jean McIntosh	Bidston	1/4 (25%)
Helena Eaton	Ellesmere Port and Neston	1/4 (25%)
Donald Shaw	Oxton and Prenton	4/4 (100%)
Jane Langsdale	Liscard	3/4 (75%)
Gwen Springall	Woodchurch	0/4 (0%)
David Steele	Heswall, Pensby and Thingwall	3/4 (75%)
Paula Williams	Burton, Ness, Willaston and Thornton	2/4 (50%)
Ian Ferguson	Bromborough and Eastham	3/4 (75%)
Barbara Kerr	New Brighton and Wallasey	4/4 (100%)

Directors' Report

Staff:		
Justine Brislen (Resigned May 2012)	Nurses and Midwives, Arrowe Park	0/0
Paula Clare	Nurses and Midwives, Arrowe Park	2/2 (100%)
Karen Hughes (Resigned May 2012)	Nurses and Midwives, Clatterbridge and other sites	0/0
Paul Smyth	Other Trust Staff	4/4 (100%)
Richard Stephenson (Term ended Sept 2012)	Medical and Dental	1/2 (50%)
Rosemary Morgan (Term commenced Sept 2012)	Medical and Dental	2/2 (100%)
Neil Wright (Resigned June 2012)	Other Healthcare Professionals	1/1 (100%)
Iain Stenhouse	Other Healthcare Professionals	2/2 (100%)

Stakeholder Governors:		
Phil Baldwin	Foundation Trust Partnership Steering Group	4/4 (100%)
Kenneth Davies (Resigned November 2012)	Wirral Chamber of Commerce	0/2 (0%)
Jeff Green	Wirral Metropolitan Borough Council	2/4 (50%)
Ed Davison	NHS Western Cheshire	0/4 (0%)
Mandy Duncan	Wirral Third Sector Assembly	2/4 (50%)
Helen Corteen (Resigned August 2012)	Wirral Third Sector Assembly	0/1 (0%)
Martin McEwan	NHS Wirral	4/4 (100%)
Irene Williams	Wirral Metropolitan Borough Council	0/4 (0%)
Dave Mitchell (Resigned October 2012)	Wirral Metropolitan Borough Council	2/2 (100%)
Norman Robinson (Resigned August 2012)	Foundation Trust Partnership Steering Group	1/1 (100%)
Derek Jones (Appointed September 2012)	Foundation Trust Partnership Steering Group	3/3 (100%)
Peter Kinderman (Appointed October 2012)	University of Liverpool	2/2 (100%)
Phil Davies	NHS Wirral	0/4 (0%)
Louise Gittins (Term ended January 2013)	Western Cheshire and Cheshire Council	3/3 (100%)

Individual Director Attendance at Council of Governor Meetings 2012/13:		
Michael Carr	Chairman	4/4 (100%)
Anne Parker	Non-Executive Director	4/4 (100%)
Richard Dutton	Non-Executive Director	4/4 (100%)
Jeff Kozer	Non-Executive Director	3/4 (75%)
Lyn Meadows	Non-Executive Director	4/4 (100%)
Jean Quinn	Non-Executive Director	4/4 (100%)
Nick Williams	Non-Executive Director	2/4 (50%)
Cathy Bond	Non-Executive Director	3/4 (75%)
David Allison	Chief Executive	3/4 (75%)
Gary Doherty	Chief Operating Officer / Deputy Chief Executive	2/4 (50%)
Russell Favager (Left January 2013)	Director of Finance	1/3 (33.3%)
Jill Galvani (Started March 2013)	Director of Nursing and Midwifery	1/1 (100%)
Sue Green	Director of Human Resources and Organisational Development	3/4 (75%)
Tina Long (Left March 2013)	Director of Nursing and Midwifery	2/3 (66.6%)
Alistair Mulvey (Started January 2013)	Director of Finance	0/1 (0%)
Luke Readman (Left August 2013)	Director of Information	1/1 (100%)
David Rowlands (Resigned as Medical Director 30.6.12)	Medical Director	0/1 (0%)
Evan Moore (Acting wef 1.7.12; Substantive wef 1.10.12)	Medical Director	3/3 (100%)

Directors' Report

Council of Governor Committees

❯ Nominations Committee

This is a statutory committee comprising the Chairman, three public governors, one staff governor and one appointed governor. Its' purpose is to identify appropriate candidates for Non-Executive Director posts as and when appointments or re-appointments are to be considered by open competition.

The committee also periodically reviews the composition of the Non-Executive Directors and receives the outcome of the annual appraisals of the Chairman and Non-Executive Directors.

There were no new appointments of Non- Executive Directors in 2012/13.

The Committee met on two occasions during the year to receive the appraisal summaries for the Chairman and Non-Executive Directors and to consider the succession plan. In 2012/13 the Committee made the following recommendations to the Council of Governors:

❯ The reappointment of Michael Carr, the Trust Chairman for a second term commencing 1.7.13

❯ The reappointment of Anne Parker for a further 12 months to 30.6.13, following a search process confined to Wirral residents that did not yield a sufficiently strong shortlist

❯ The reappointment of Richard Dutton for a further 12 months to 30.6.14 which will bring his length of service to seven years in total. The Committee gave careful consideration to the circumstances and risk of loss of continuity and organisational memory in the context of other Board changes before making this recommendation to the Council of Governors; and

❯ The recruitment process to support the appointment of two Non-Executive Director vacancies that will arise on 30.6.13 when Anne Parker and Nick Williams retire from their positions. It was decided that the posts would go to open competition and that the services of an external search consultancy be used to secure a strong shortlist of suitable candidates from within the new boundary of the public constituency which includes the North West and North Wales.

The above recommendations were approved by the Council of Governors.

❯ Nominations Committee Membership and attendance in 2012/13

Name	Role	Meeting attendance Actual / Possible 1st April 2012 – 31st March 2013(% attendance)
Michael Carr	Trust Chairman	2/2 (100%)
Bernie Howden	Elected Public Governor (Until Dec 2012)	0/1 (0%)
Peter Kinderman	Nominated Stakeholder Governor (from Dec 2012)	0/1 (0%)
Jane Langsdale	Elected Public Governor	2/2 (100%)
Dave Mitchell	Nominated Stakeholder Governor (Until Oct 2012)	1/1 (100%)
Rosemary Morgan	Elected Staff Governor (From Dec 2012)	1/1 (100%)
Donald Shaw	Elected Public Governor (From Dec 2012)	1/1 (100%)
Richard Stephenson	Elected Staff Governor (Until Dec 2012)	1/1 (100%)
David Steele	Elected Public Governor (from Dec 2012)	1/1 (100%)
Paula Williams	Elected Public Governor (Until Dec 2012)	0/1 (0%)

The Council of Governors has established three non-statutory sub-committees to support it in discharging its responsibilities. Each has an approved Terms of Reference and is chaired by a governor:

❯ Membership and Communications Sub-committee
This sub-committee is supported by our Membership Manager to shape communications between the Trust and its members. Committee members attended events across Wirral to engage with special interest groups in order to promote the benefits of membership and disseminate and collate feedback about the Trust's services. The committee also recruited new members targeting recruitment in order to improve representation.

❯ Patient Experience Sub-Committee
This sub-committee is supported by the Director of Nursing and Midwifery, and has regularly reviewed reports and data relating to patient experience and the quality of care provided at the Trust. In doing this, it considered a wide range of quality indicators including nursing audits, to assist in identifying core themes for focus such as assistance at mealtimes and overall patient dignity. The sub-committee also had the opportunity to feed back specific issues from members of the public for the Trust to consider.

❯ Strategy and Development Sub-Committee
This sub-committee met regularly with the Chief Operating Officer to discuss and review performance against strategy and to consider governor and community priorities for the Trust's development.

Directors' Report

Membership

We are committed to ensuring that our membership is representative of the population we serve.

In January 2013, the Trust changed the boundary and composition of its public constituency which now means that any member of the public living within Wirral, the North West and North Wales is eligible to become a member from the age of 11 and to stand to become a governor from the age of 16. The public constituency is now divided into 13 geographical areas:

❯ Bebington and Clatterbridge

❯ Bidston and Claughton

❯ Birkenhead, Tranmere and Rock Ferry

❯ Bromborough and Eastham

❯ Greasby, Frankby, Irby , Upton and Woodchurch

❯ Heswall, Pensby and Thingwall

❯ Leasowe, Moreton and Saughall Massie

❯ Liscard and Seacombe

❯ Neston, Little Neston, Parkgate and Riverside, Burton, Ness, Willaston and Thornton

❯ New Brighton and Wallasey

❯ North West and North Wales

❯ Oxton and Prenton

❯ West Wirral

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. In January 2013, the classes within the staff constituency were amended slightly to better reflect our workforce:

❯ Registered Medical Practitioners and Registered Dentists

❯ Registered Nurses and Registered Midwives

❯ Other Healthcare Professional Staff

❯ Other Trust staff

❯ **Membership Strategy**

We believe that our membership makes a real contribution to improving the health of our communities and now that we have recruited an optimum number of members, our emphasis will be upon ensuring good representation and encouraging an active and engaged membership.

Membership figures for the start and end of the period under review are shown in the following table. We have 9,020 members, representing approximately 2% of our local population (Wirral). We plan to maintain membership at around this optimal level during the year ahead, and will manage 'churn' by targeting recruitment activity towards our wider catchment area of North West and North Wales and to under-represented groups within the communities we serve.

Throughout 2012/13, we continued to maintain and improve our engagement with our members.

Members receive regular mailings, including 'Public Membership News' and are invited to events such as the Annual Members' meeting, Special Members meetings and the Council of Governors' meetings. Our Annual Members' Meeting, held in September 2012, provided an opportunity for members, local people, staff and other stakeholders to hear how the organisation performed during the year, and to meet members of the Board of Directors and Council of Governors.

Directors' Report

❯ Membership Profile

Membership size and movements		
Public constituency	2011/12	2012/13
At year start (1st April)	8,450	8,736
New members	523	605
Members leaving	237	321
At year end (31st March)	8,736	9,020
Staff constituency	2011/12	2012/13
At year start (1st April 2010)	5487	5557
New members	532	656
Members leaving	462	573
At year end (31st March)	5557	5650
Patient constituency	There is no Patient Constituency	

Analysis of membership 2012/13				
Public constituency	Number of members	%	Eligible membership	%
Age (years)	2011 figures collated by CACI Ltd, except for ethnicity, which is 2001 Census, ONS			
0 - 16	20	0.22	76,356	19.96
17 - 21	258	2.86	22,841	5.97
22+	7,687	85.22	283,197	74.05
Not stated	1,055	11.70	N/A	N/A
Total	9.020	100.00	382,394	100.00

Ethnicity				
White	8,596	95.30	382,194	98.36
Mixed	35	0.39	2,150	0.55
Asian or Asian British	63	0.70	1,600	0.41
Black or black British	22	0.24	611	0.15
Other	41	0.45	1,988	0.51
Not stated	263	2.92	N/A	N/A
Socio-economic groupings*				
ABC1	4,925	54.60	116,310	48.85
C2	1,690	18.74	45,271	19.01
D	1,841	20.41	50,379	21.16
E	564	6.25	23,980	10.07
Gender analysis	(2011 figures collated by CACI Ltd)			
Male	3,340	37.03	183,710	48.04
Female	5,483	60.79	198,684	51.95
Unspecified	197	2.18	N/A	N/A
Patient constituency	There is no patient constituency			

* Socio-economic data should be completed using profiling techniques (eg postcode) or other recognised methods.
To the extent socio-economic data is not already collected from Members, it is not anticipated that FTs will make a direct approach to members to collect this information. 'ABC' data is only available from 2001 census information and collected from the working population aged 16 - 64; therefore the 'eligible membership' numbers are significantly less than the total local population shown in the age profile.

Any member who wishes to communicate with Governors and / or Directors should contact:

The Membership Office
Arrowe Park Hospital
Arrowe Park Road
Upton
Wirral
CH49 5PE   **Call 0800 0121 356 or email wih-tr.foundation@nhs.net**

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 Terms of Authorisation, 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 Monitor, the Care Quality Commission, NHS Litigation Authority and other relevant bodies

❯ Setting and maintaining the Trust's vision, values and standards of conduct 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 has established a Governance Structure setting out how assurance and performance management is structured and this is supported by a Scheme of Delegation. This defines which decisions are reserved for the Board and which decisions are delegated to management.

The Board comprises a Non-Executive Chairman, seven independent Non-Executive Directors and seven Executive Directors. The composition of the Executive Directors has been reviewed during 2012/13 in light of turnover and to ensure the most appropriate mix of skills to deliver the Trust's ambitions for the future. There have been a number of changes to Board membership during 2012/13 due to a number of Executive Directors attaining promotions to other organisations. The Board has worked hard to manage the succession effectively and has successfully appointed a number of talented and experienced individuals to the Executive Director structure.

Non-Executive Directors are generally appointed to a three year term of office, with appointments staggered where possible, such that two or three expire on 30th June each year.
The unitary nature of the Board of Directors means that Non-Executive and Executive Directors share the same liability and have the same responsibility to constructively challenge decisions and help to develop proposals on strategy.

There is a clear division of responsibilities between the Chairman and the Chief Executive.

The Chairman 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 the Chairman's role to facilitate the effective contribution of all Directors, and for ensuring that constructive relationships exist between the Board 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 policy.

The Board of Directors has direct access to the advice of the Associate Director of Governance, whose role includes that of Company Secretary.

Directors' Report

Non Executive Directors

Michael Carr
Chairman

Michael Carr was appointed Chairman in July 2010, having previously been a Non-Executive Director of the Trust from July 2008. Michael was appointed for a second term as Chair during 2012/13 up until 30th June 2016. From 2004 to 2007, Michael was the inaugural Executive Director of the Russell Group of Universities, the primary association for the UK's leading research universities. He was Registrar of the University of Liverpool from 1988 to 2007. He is a Trustee of the Alliance House Foundation and Vice-Chairman of the Institute of Alcohol Studies, and from 1998 to 2007 was a Non-Executive Director of MIDAS Capital Partners Ltd. Michael was a Non-Executive Director and Vice Chairman of the Royal Liverpool and Broadgreen University NHS Trust for 10 years until 2006, where he also served as Chairman of its' Audit Committee.

Richard Dutton
Non-Executive Director
Deputy Chair and Senior Independent Director from 1st June 2012
Chair of Finance, Performance and Business Development Committee.

Richard has been a Non-Executive Director since July 2007, having been appointed to a second term of office in July 2010 and took on the roles of Deputy Chair and Senior Independent Director with effect from 1st June 2013. During 2012/13 his term of office was extended for a further 12 month period, to 30th June 2014.

Richard is currently Head of Strategy and Partnerships at Charities Trust, and Non-Executive Chairman of Wirral based Integrated Digital Services Ltd (iDS). He was previously Chief Executive of Livesmart from 2002 until 2008. Richard has extensive commercial experience, having worked for international blue chip companies such as Wellcome and Reebok International over the past 25 years in the UK, USA and Middle East. Richard has a law degree and is a Fellow of the Institute of Direct Marketing.

Cathy Bond
Non-Executive Director
Chair of Audit Committee

Cathy was appointed as a Non-Executive Director in July 2011 having taken early retirement in February 2010 from the position of Director of Finance at the Royal Liverpool and Broadgreen University Hospitals NHS Trust, a position she gained in 1992. As the Financial Director Cathy was responsible for commissioning and contracts with other Trusts. Cathy has a BSc (Hons) and full CIPFA membership.

Dr Jean Quinn
Non-Executive Director
Chair of Quality and Safety Committee

Dr Jean Quinn, was appointed Non-Executive Director in January 2011, having previously been a Stakeholder Governor. She is a former GP, university lecturer at the University of Liverpool Medical School and local councillor with Wirral Borough Council, where she was the Cabinet Member for Streetscene and Transport and spokesperson for the Social Care and Health Overview and Scrutiny Committee. She qualified MBChB in 1970 at Liverpool Medical School and is a Fellow of the Royal College of General Practitioners.

Directors' Report

Jeff Kozer,
Non-Executive Director

Jeff was appointed to the Board in July 2009 and re-appointed in 2012/13 for a second three year term up until 30/6/15. He brings a wealth of commercial expertise to his role, having spent eight years at United Utilities in roles including Operations Director, General Manager and Commercial Manager/Director, improving the subsidiaries by changing organisational management, performance management and commercial expertise. Four years ago, Jeff started his own consultancy, using his strategic skills to help start up and improve small and medium sized companies. Jeff chaired the Audit Committee up until October 2012.

Anne Parker,
Non-Executive Director

Anne Parker has been a Non-Executive Director since 2005. She is a member of the Riverside English Churches Divisional Board. Anne served as Director of Social Services for Berkshire County Council and subsequently chaired the National Care Standards Commission, Carers UK and the Audit Commission's Independent Complaints Panel. She was the first Independent Case Examiner for the Child Support Agency. Anne has a BA (Hons), a Diploma in Social Administration and is an Honorary Life Fellow of the National Institute for Social Work.

Anne was Deputy Chair and Senior Independent Director up until 31/5/12

Lyn Meadows,
Non-Executive Director

Lyn was appointed in July 2008 for a three year term of office which was renewed in 2011 for a further three years. She is employed as Director of Human Resources at Bangor University, having been appointed in March 2008. Lyn has a wealth of experience in the public sector specifically managing change and fostering good employment relations. Lyn has a Masters in Business Administration, a Law degree and is a Fellow of the Institute of Personnel and Development.

Nick Williams,
Non-Executive Director

Nick has been a Non-Executive Director since July 2008, having been appointed to a second term of office in July 2010. He runs his own ski company, Mountain Heaven Ltd, and is a Director of NMW Consulting Ltd, which provides advice to large organisations with regard to working capital management and cost reduction. Prior to this, he was National Working Capital Director for BDO Stoy Hayward, and Senior Director/European Purchase to Pay Practice Leader for Hackett-REL.

Directors' Report

David Allison
Chief Executive

David Allison joined the Trust as Chief Executive on 2nd April 2012 having formerly worked as Chief Operating Officer for Newcastle Hospitals NHS Foundation Trust. As an experienced leader, he has a record of delivering enhanced performance and introducing significant developments within an acute hospital setting. He has a degree in Physics, is qualified as a Chartered Engineer and Chartered Director and has over 25 years experience in both the public and private sectors. David recognises the commitment, skills and expertise that exist within the hospital and since joining the Trust has been building on the excellent foundations already in place to deliver the quality of healthcare that the communities we serve have a right to expect.

Gary Doherty
Chief Operating Officer and Deputy Chief Executive

Gary Doherty became the Chief Operating Officer and Deputy Chief Executive in June 2009, having been appointed Director of Strategic Development for the Trust in September 2006. Prior to joining the Trust, Gary had been the Director of Planning and Performance at North Cheshire Hospitals NHS Trust. He is a graduate of the NHS Management Training Scheme, has a degree in politics and economics and has worked in the NHS for 20 years. Gary has held senior positions in both large and small hospitals, and has worked at regional level for the Department of Health. He has experience in both operational and strategic positions, leading public consultations and developed business cases for major investment (both public and privately financed).

Evan Moore
Medical Director from 1.10.12
(Acting Medical Director 1.6.12.- 30.9.12)

Evan was appointed as Medical Director of the Trust in October 2012. He joined the Trust in 2002 as a Consultant Anaesthetist where his interest in Medical Leadership led him to be being elected to the Chairmanship of the Hospital Consultant Body, serving in this representative and negotiating role for several years. His first formal management role was as Clinical Director of the Theatres and Anaesthetics Directorate where he led a team of over 70 anaesthetists, introducing workforce and productivity efficiencies. Success in this role led to Evan being initially appointed as Deputy Medical Director where his interests included job planning, medical productivity and patient flow.

David Rowlands MB, ChB, FRCOG
served as Medical Director up until 31.5.12

Sue Green
Director of Human Resources and Organisational Development

Sue was appointed as Director of Human Resources and Organisational Development in March 2008, having previously held the position of Deputy Director of Human Resources in the Trust. Sue has 20 years experience in human resources, specialising during her earlier career in employment law, employee relations and workforce planning within the local authority and at the University of Liverpool. She is a graduate and a member of the Chartered Institute of Personnel and Development .

Directors' Report

Jill Galvani
Director of Nursing and Midwifery from 11.3.13

Jill was appointed as Director of Nursing and Midwifery in March 2013. She joined the Trust from North Wales where she gained extensive experience as a Director of Nursing and Midwifery in an integrated organisation which included acute and community services. She sees her role as putting nurses and midwives in the best position to deliver competent, professional and compassionate care for patients and their carers. She is particularly interested in the role of the Ward Sister and Matron in leading modern nursing based on traditional values.

Tina Long served as Director of Nursing and Midwifery until 10.3.13

Alistair Mulvey
Director of Finance from 1.4.13
(Interim Director of Finance 12.1.13 – 31.3.13)

Alistair was appointed as Director of Finance on 1st April 2013 having been working with the Trust as the Interim Director of Finance since December 2012. Alistair has joined the Trust from North Cumbria University Hospitals Trust where he was the Director of Finance / Deputy Chief Executive for three years. Prior to that Alistair was the Director of Finance / Deputy Chief Executive at St Helens and Knowsley Hospitals NHS Trust and has extensive knowledge of the Cheshire and Merseyside economy. Alistair has 20 years NHS experience and comes with a track record of achievement and a reputation for a balanced approach in delivery of financial and non-financial goals and targets for the organisations he has worked within.

Russell Favager served as Director of Finance until 11.1.13

Luke Readman served as Director of Information until 31.8.12

Directors' Report

❯ Attendance at Board of Director Meetings in 2012/13

Director	Details of Appointment / Service on Board in 2012/13	Meeting attendance Actual / Possible 2012/13
Non-Executive Directors		
Michael Carr Chairman	**Appointed as Non-Executive Director 1.11.08 (Designate from 1.7.08)** **Appointed as Chairman 1.7.10 (3 year term). Re-appointed for second term as Chairman in 2012/13 until 30.6.16.**	**9/9 100%**
Richard Dutton	**Appointed 1.7.07 (3 year term) Re-appointed for second 3 year term until 30.6.13** **Term of office extended in 2012/13 for a further 12 month period until 30.6.14** **Deputy Chair and Senior Independent Director from 1.6.12**	**9/9 100%**
Cathy Bond	**Appointed 1.7.11 (3 year term) Chair of Audit Committee from 1.10.12**	**9/9 100%**
Dr Jean Quinn	**Appointed 1.1.11 (3 year term)**	**9/9 100%**
Jeff Kozer	**Appointed 1.7.09 (3 year term) Re-appointed for a second 3 year term until 30.6.15.** **Chair of Audit Committee until 30.9.12**	**8/9 89%**
Lyn Meadows	**Appointed 1.7.08 (3 year term) Re-appointed for a second 3 year term until 30.6.14.**	**8/9 89%**
Anne Parker	**Appointed 1.6.05 (4 year term) Re-appointed for a second 3 year term until 31.5.12.** **Term of office extended in 2012/13 for a further 12 month period until 30.6.13.** **Deputy Chair and Senior Independent Director until 31.5.12**	**9/9 100%**
Nick Williams	**Appointed 1.7.08 (2 year term) Re-appointed for a second 3 year term until 30.6.13.**	**7/9 78%**

Executive Directors		
David Allison Chief Executive	**Appointed 1.4.12**	**8/9 89%**
Gary Doherty Chief Operating Officer / Deputy Chief Executive	**Appointed June 2009 Resigned 31.3.13**	**9/9 100%**
David Rowlands Medical Director	**Appointed 8.11.10 Resigned from Medical Director role 30.6.12**	**2/3 67%**
Evan Moore Medical Director	**Acting Medical Director 1.6.12 Medical Director 1.10.12**	**6/6 100%**
Tina Long Director of Nursing and Midwifery	**Appointed 20.9.10 Resigned 10.3.13**	**7/8 88%**
Jill Galvani Director of Nursing and Midwifery	**Appointed 11.3.13**	**1/1 100%**
Sue Green Director of Human Resources and Organisational Development	**Appointed March 2008**	**7/9 78%**
Russell Favager Director of Finance	**Appointed 29.11.10 Resigned 11.1.13**	**6/6 100%**
Alistair Mulvey Director of Finance	**Interim Director of Finance 12.1.13 Director of Finance 1.3.13**	**3/3 100%**
Luke Readman	**Appointed 1.12.09 Resigned 31.8.12**	**3/3 100%**

Directors' Report

Board Committees

The Board undertook a review of its' Governance Structure in 2012/13. During the year it established a new Finance, Performance and Business Development Committee and has reviewed the Terms of Reference of all Board Committees, ensuring a clear division between governance and assurance and performance management.

The Board has the following Committees

> Audit Committee

> Quality and Safety Committee

> Finance Performance and Business Development Committee

> Appointments Committee

> Remuneration Committee

> Charitable Funds Committee

Audit Committee

The Audit Committee comprises four independent Non-Executive Directors. Jeff Kozer chaired the Audit Committee up until October 2012. Cathy Bond has been Chair of the Audit Committee since November 2012.

The key responsibility of the Audit Committee is to assure the Board of Directors that there are effective systems of internal control (clinical, organisational and financial) across the organisation so as to ensure good governance in the delivery of the organisation's objectives. In order to do this the Audit Committee has scrutinised assurances provided by internal audit, external audit, the local counter fraud officer, Trust managers, finance staff and the quality and safety team along with reports and reviews from other external bodies.

An annual programme of work is set at the start of the year along with agreement of internal audit and counter fraud work plans, with provision to meet contingency requirements. A key priority for the Audit Committee this year has been to support the development of the new governance structure, risk management arrangements and Board Assurance Framework through a process of rigorous review and recommendation to the Board of Directors

The Audit Committee meets privately with the auditors on at least one occasion each year.

The Audit Committee reports to the Board of Directors through a regular Chair's report and Board members are provided with the minutes of each meeting.

The Chair of the Audit Committee has also reported to the Council of Governors during 2012/13 on the work of the Audit Committee.

The Audit Committee made the following recommendations to the Council of Governors during 2012/13:

i) That the appointment of the current external auditor, KPMG, be extended to 31st December 2015, subject to continued satisfactory performance and agreement of an acceptable annual fee

ii) That KPMG be appointed for a time-limited period to undertake non-audit work relating to the establishment of a Programme Management Office (PMO). In making this recommendation the Audit Committee gave careful consideration to the circumstances and safeguards in place to ensure that the independence and objectivity of the auditor would not be compromised. These included assurance that:

> there are no elements of the PMO work that will directly impact on the financial statements which would give rise to a risk of self-review

> the scale of the work is not sufficiently large, particularly for a firm of KPMG's size, to give rise to an independence threat

> there will be a clear separation between the advisory team and the audit team both internally within KPMG and at the Trust.

It was also recognised that the nature of the work should improve the governance of the organisation.

The Council of Governors approved both recommendations.

During the year the Audit Committee undertook a self-assessment of the effectiveness of the Committee through use of a questionnaire and workshop, following which a report was produced along with a revised cycle of business that will ensure that the Audit Committee's time is used to best value. A report was provided to the Board of Directors.

The Audit Committee met on five occasions during 2012/13.

Directors' Report

Attendance at Audit Committee Meetings in 2012/13

Role	Meeting attendance Actual / Possible 1st April 2012 – 31st March 2013
Jeff Kozer Chair until 31 October 2012	5/5
Cathy Bond Chair from 1 November 2012	5/5
Richard Dutton	5/5
Nick Williams	3/5

Quality and Safety Committee

This Committee is chaired by an independent Non-Executive Director and provides assurance to the Board of Directors on all quality issues including clinical effectiveness, safety and patient experience.

Finance, Performance and Business Development Committee

This Committee was established in 2011/12 to provide assurance to the Board of Directors on delivery of the Trust's financial plan, performance targets and business development strategy. It is chaired by an independent Non-Executive Director.

Appointments Committee

The Board of Directors maintains an Appointments Committee to consider the appointments of Executive Directors as their posts fall vacant.

Remuneration Committee

This Committee comprises the Non-Executive Directors and is chaired by the Trust Chairman. Its purpose is to decide the pay and allowances and other terms and conditions of the executive directors and of staff who are not on national terms.

The Committee receives the outcome of the annual appraisals of the Chief Executive and members of the Executive Team.

Members of the Committee had no financial interest in the matters to be decided. The Chief Executive, the Director of Human Resources and Organisational Development and /or the Associate Director of Governance normally attend Committee meetings, except where their own salaries or performance are discussed.

The Remuneration Committee met on four occasions during 2012/13.

Attendance at Remuneration Committee Meetings in 2012/13

Role	Meeting attendance Actual / Possible 1st April 2012 – 31st March 2013
Michael Carr Chair	4/4 100%
Cathy Bond	4/4 100%
Richard Dutton	3/4 75%
Jeff Kozer	3/4 50%
Lyn Meadows	3/4 75%
Jean Quinn	4/4 100%
Anne Parker	4/4 100%
Nick Williams	3/5 60%

Charitable Funds Committee

This Committee is chaired by the Trust Chairman to oversee the management of charitable funds

Remuneration Report

Remuneration Report

The Remuneration Committee determines the salaries of the Chief Executive and Executive Directors.

Membership of the Remuneration Committee wholly comprises Non-Executive Directors, who are viewed as independent. During 2012/13, the Committee was chaired by Michael Carr and its membership included all of the Non-Executive Directors. Members of the Committee had no financial interest in matters to be decided. The Chief Executive and Director of Human Resources and Organisational Development normally attended meetings of the Committee unless their own salaries were to be discussed or for some other reason determined by the Committee.

The Director of Human Resources and Organisational Development provided advice to the Committee concerning executive pay levels and terms and conditions of employment. Occasionally, professional advice is commissioned from external, unrelated consultants and peer review benchmarking advice is considered, as and when it is available, from the Foundation Trust Network and other sources.

❱ Remuneration Policy for Senior Managers

We use the definition of 'senior manager' to mean the members of the Board who are Directors of the Trust and those managers who are paid on Local Senior Manager rates believing that only these individuals direct or control the Trust's major activities.

There was no national pay award for 2012/13 as part of the two year national pay freeze for the public sector.

Executive Directors are employed on contracts of service and are substantive members of the Trust. Their contracts are open ended employment contracts, which can be terminated by either party with six months' notice.

The Trust's disciplinary policies apply to the Executive Directors and senior managers, including the sanction of summary dismissal for gross misconduct.

No Executive Director or senior manager is entitled to severance payments or termination payments beyond those accruing for redundancy, in line with Trust policy, or for pay in lieu of notice.

❱ Salary and Pension Entitlements of Senior Managers

A) Remuneration (AUDITED)

Name and Title	April 2012 to 31 March 2013 (2012/13)			1 April 2011 to 31 March 2012 (2011/12)		
	Salary (bands of £5000) £'000	Other Remuneration (bands of £5000) £'000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £'000	Other Remuneration (bands of £5000) £'000	Benefits in Kind Rounded to the nearest £100
Executive Directors						
Len Richards, Chief Executive (to August 2011) *1	N/A	N/A	N/A	70 - 75	85 - 90	3,000
Gary Doherty, Acting Chief Executive (from August 2011 to March 2012) *2	N/A	N/A	N/A	85 - 90	0	2,500
Gary Doherty, Chief Operating Officer / Deputy Chief Executive (from April 2011 to August 2011) & (from April 2012 to March 2013) *2	115 - 120	0 - 5	2,800	45 - 50	0	1,300
David Allison, Chief Executive (from April 2012)	190 - 195	0	21,500	N/A	N/A	N/A
Rod Jones, Director of Finance (to April 2011)	N/A	N/A	N/A	0 - 5	35 - 40	0
Russell Favager, Director of Finance (to January 2013)	85 - 90	0	4,200	110 - 115	0	5,000
Alistair Mulvey, Director of Finance (from January 2013)	25 - 30	0	0	N/A	N/A	N/A
David Rowlands, Medical Director (to May 2012)	15 - 20	10 - 15	2,000	105 - 110	80 - 85	1,000
Evan Moore, Medical Director (from June 2012)	145 - 150	0	1,300	N/A	N/A	N/A
John Foster, Director of Facilities & Estates (to June 2011) *3	N/A	N/A	N/A	25 - 30	0	300
Luke Readman, Director of Information (from August 2011 to August 2012)	40 - 45	0	1,100	70 - 75	0	2,300
Sue Green, Director of Human Resources & Organisational Development	100- 105	0	5,200	95 - 100	0	5,700
Tina Long, Director of Nursing & Midwifery (to March 2013)	100 - 105	0	3,300	90 - 100	0	3,300
Jill Galvani, Director of Nursing & Midwifery (from March 2013)	5 - 10	0	0	N/A	N/A	N/A

Remuneration Report

Name and Title	April 2012 to 31 March 2013 (2012/13)			1 April 2011 to 31 March 2012 (2011/12)		
	Salary (bands of £5000) £'000	Other Remuneration (bands of £5000) £'000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £'000	Other Remuneration (bands of £5000) £'000	Benefits in Kind Rounded to the nearest £100
Non-Executive Directors						
Michael Carr, Chairman	45 -50	0	0	45 - 50	0	0
Richard Dutton, Non-Executive Director	10 - 15	0	0	10 - 15	0	0
Catherine Bond, Non-Executive Director (from July 2011)	10 - 15	0	0	5 - 10	0	0
Anne Parker, Non-Executive Director	10 - 15	0	0	10 - 15	0	0
Jean Quinn, Non-Executive Director (from January 2011)	10 - 15	0	0	10 - 15	0	0
Alan Wilson, Non-Executive Director (to June 2011)	N/A	N/A	N/A	0 - 5	0	0
Nick Williams, Non-Executive Director	10 - 15	0	0	10 - 15	0	0
Lynda Meadows, Non-Executive Director	10 - 15	0	0	10 - 15	0	0
Jeff Kozer, Non-Executive Director	15 - 20	0	0	15 - 20	0	0

Ratio of Highest Paid Director to Median Staff Member

The Monitor Foundation Trust Annual Reporting Manual 2012/13 (FT ARM) requires the disclosure of the ratio of the pay of the highest paid executive directors to the median staff member.

The median staff member's pay is calculated based on the full time equivalent staff pay at the reporting period end date on an annualised basis as per the Hutton Review of Fair Pay Guidance.

This requires calculating the pay of each individual in March on the assumption that they all work on a full time equivalent basis and multiplying this by 12 months to get the annualised figure.

The estimated agency staff pay is also calculated on an annualised basis and added to the median pay calculation. The highest paid executive director's pay is removed from the median pay calculation for comparative purposes.

The highest paid executive is David Allison, the Chief Executive on a total remuneration basis. The report is represented in the table below for both the 2012/13 and 2011/12 financial years:

		2012/13		2011/12		
Band of Highest Paid Director's Remuneration		190 - 195		190 - 195		
Median Total Remuneration (FTE staff on an annualised basis)		25,284		25,207		
Ratio of Highest Paid Director to Median staff member		7.6		7.6		

In addition to the remuneration figures quoted in the above tables, the total combined amount that the executive and non executive directors incurred in additional expenses (training courses and travel) in 2012/13 was £3,788. The total combined amount that the governors incurred in expenses (training courses and travel) in 2012/13 was £1,071.

(NOT AUDITED)

Benefits in kind does not represent payments to the staff members listed but represents the perceived benefit by the HMRC for the provision of vehicles for staff use. The value is based on the set rate per the car x C02 vehicle emission level percentage (as specified by the HM Revenue and Customs).

*1 Len Richards left the Foundation Trust in the 2011/12 financial year. The other pay relates to payments in lieu of notice.

*2 Gary Doherty is shown twice on the remuneration report to reflect the fact that he changed posts mid-way though the 2011/12 financial year.

*3 John Foster left the Foundation Trust in the 2011/12 financial year via the Voluntary Severance Scheme. The purpose of the scheme is to reduce the current pay-bill of the Foundation Trust on a voluntary basis.

In accordance with the "Review of Tax Arrangements of Public Sector Appointees" published by the Chief Secretary to the Treasury on 23 May 2012; the foundation trust can confirm that it did not have any off payroll engagements in place during the 2012/13 financial year.

David Allison (Chief Executive)
29th May 2013

Remuneration Report

❯ **Salary and Pension Entitlements of Senior Managers**

B) Pension Benefits* (AUDITED)

Name and Title	Real increase in accrued pension at age 60 (bands of £2500) £000	Real increase in Lump Sum at age 60 related to real increase in pension (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5000) £000	Total lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real Increase in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension To nearest £100
David Allison, Chief Executive (from April 2012)	5 - 7.5	(180 - 182.5)	10 - 15	40 - 45	248	140	100	0
Gary Doherty, Chief Operating Officer / Deputy Chief Executive (to March 2013)	0 - 2.5	0 - 2.5	25 - 30	85 - 90	425	384	21	0
Russell Favager, Director of Finance (to January 2013)	(0 - 2.5)	(0 - 2.5)	40 - 45	120 - 125	657	620	3	0
Alistair Mulvey, Director of Finance (from January 2013)	0 - 2.5	0 - 2.5	25 - 30	85 - 90	465	420	5	0
David Rowlands, Medical Director (to May 2012)	(0 - 2.5)	(0 - 2.5)	65 - 70	205 - 210	1,273	1,182	5	0
Evan Moore, Medical Director (from June 2012)	0 - 2.5	2.5 - 5	30 - 35	100 - 105	475	416	31	0
Luke Readman, Director of Information (to August 2012)	(0 - 2.5)	(0 - 2.5)	40 - 45	125 - 130	837	821	(11)	0
Sue Green, Director of Human Resources and Organisational Development	0 - 2.5	2.5 - 5	5 - 10	15 - 20	92	71	18	0
Tina Long, Director of Nursing and Midwifery (to March 2013)	5 - 7.5	15 - 17.5	50 - 55	150 - 155	1,111	908	148	0
Jill Galvani, Director of Nursing and Midwifery (from March 2013)	(0 - 2.5)	(0 - 2.5)	50 - 55	150 - 155	952	922	(1)	0

(NOT AUDITED)

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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.

In the budget of 23rd March 2011, HM Treasury confirmed that they were to change the basis for the calculation of CETVs payable from public service schemes, including the NHS Pension Scheme.

* As disclosed in Note 1.9 Expenditure on Employee Benefits in the accounts, both employee and employer contribute to the NHS Pension Scheme. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

David Allison (Chief Executive)
29th May 2013

treating you well

Governance Statement

Annual Governance Statement

Annual Governance Statement

❯ Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 the 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.

❯ The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2013 and up to the date of approval of the annual report and accounts.

❯ Capacity to Handle Risk

I am responsible for risk management across all organisational, financial and clinical activities. I have delegated responsibility for the coordination of operational risk management to the Medical Director who manages the Risk Management Team. The Risk Management Strategy provides a framework for managing risks across the organisation and is consistent with best practice and Department of Health guidance.

The Strategy provides a clear, structured and systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, organisational and financial processes across the organisation.

The Strategy sets out the specific role of the Board and Standing Committees together with the individual responsibilities of the Chief Executive, Executive Directors and all staff in managing risk.

Divisional Management Teams are responsible for the operational management of risks and an escalation process is in operation that ensures that risks are escalated to the Operational Management Team, Executive Directors' Team and the Board of Directors, as detailed in the Strategy.

The Trust has mechanisms to act upon alerts and recommendations made by all relevant central bodies such as the National Patient Safety Agency (NPSA).

Risk Management training is provided via the corporate induction programme for new staff and provides details of the Trust's risk management systems and processes. This is augmented by local induction, as required and is organised by line managers. Annual mandatory training for existing staff reflects essential training needs and includes risk management processes relating to health and safety, manual handling , safeguarding, clinical risk management (for clinical staff) and information governance. The training programmes are available to hospital volunteers.

Root Cause Analysis training is provided to staff members who have direct responsibility for risk management within their area of work. Lessons learned are shared via Divisional governance systems with assurance provided to the Quality and Safety Committee.

The Board of Directors undertakes risk management training annually as part of its development programme.

Annual Governance Statement

> **The Risk and Control Framework**

Risk Management requires the participation, commitment and collaboration from all staff. Risks are identified and assessed proactively, at a corporate or local level, to identify actual or potential hazards or threats and to ensure that adequate control measures are in place to eliminate or reduce the risk of harm occurring.

Proactive risk assessment is informed by internal inspection processes (such as those relating to compliance with CQC standards, fire safety and infection control); Health and Safety workplace inspections; Nursing and Midwifery Audits; evaluation of National Reports (for example, safeguarding and National Inquiries); National Patient Agency Alert System; and self-assessment of risk. Risks are also identified and assessed reactively in response to Incident Reports; Near Miss Reports; Complaints reporting; claims; and external assessments and reviews.

All risks are scored using a risk matrix that takes account of likelihood of occurrence and impact and an ongoing review and escalation process ensures that all identified risks are eliminated or controlled to their lowest level.

The level of scrutiny and performance management is proportionate to the significance of the risk, but there is an expectation that all risks are proactively managed to minimise the impact. The process is clearly set out in the Trust's Risk Management Strategy and Policy.

The risk management process is embedded in the activity of the organisation and is fundamental to achieving the Trust's aims to improve the experience and safety of patients, visitors, staff and the public.

The roles and responsibilities for risk management are clearly defined and reinforced through induction and mandatory training. The Trust has adopted a positive, open and fair approach to incident reporting with a clear emphasis on learning.

This is fundamental to the reporting and effective management of incidents and near misses and thus to ensuring effective management of risks, spread of learning and minimisation of harm.

The mechanisms in place to ensure the communication and sharing of safety lessons include monthly reports on Complaints, Litigation, Incidents and concerns to Divisional Management Teams; quarterly trend reports to the Quality and Safety Committee; a monthly Quality and Safety Newsletter disseminated via team brief and sharing of Root Cause Analysis Reports with local commissioners.

The Board of Directors receives and reviews assurance reports from the Quality and Safety Committee.

Risks identified from serious incidents are managed with the involvement of public stakeholders, to ensure that those affected are satisfied with the investigation process and actions taken in respect of lessons learned.

The Trust subscribes to the Clinical Negligence Scheme for Trusts and other NHS Insurance schemes in order to mitigate financial impact on financial resources. The Trust's processes for managing risk and learning from incidents are externally assured by internal audit and through the NHSLA assessment process.

Information governance risks are managed as part of the processes described above and assessed using the Information Governance Toolkit. The risk register is updated with any identified information risks arising from assessment of compliance with the Toolkit.

The Audit Committee has received independent audit reports on compliance with the Information Governance toolkit.

Data quality and data security risks are managed and controlled via the risk management system. Risks to data quality and data security are continuously assessed and added to the IT risk register, which is reviewed by Information Governance Group, with assurances provided to the Finance, Performance and Business Development Committee.

In addition, independent assurance is provided by the Payment by Results Data Assurance Framework Review by external audit and the Information Governance self-assessment review by internal audit; both are scrutinised by the Audit Committee.

The Trust has in place a process for assessing compliance with the Care Quality Commission (CQC) Essential Standards of Quality and Safety across all services and at a corporate level. There is a well-developed assurance process for compliance with the CQC Essential Standards.

The most 'hands on' assurance comes from the Divisional Lead Nurses' walkarounds of clinical areas. They use an inspection tool which is referenced to CQC's Essential Standards of Quality and Safety, and covers all the patient-focused regulations over the course of a year.

These were introduced in 2012 and during 2013 there have been further improvements to the process for reporting the results of these inspections and ensuring appropriate follow up action. Panel meetings are held with the Executive Directors and operational managers who lead on each regulation, so that the self-assessed level of compliance using a red-amber-yellow-green rating can be reviewed and validated. Quarterly reports are provided to the Quality and Safety Committee.

There is a full portfolio of documentary evidence for each regulation, consisting of policies, audits, patient surveys, external inspection reports, training materials and other relevant items which is regularly updated. All risks with an implication for CQC compliance are recorded on the Trust Risk Register with an appropriate action plan as necessary.

In 2012/13, the Trust commissioned an external review of its' governance arrangements and has implemented new governance, assurance and performance management structures, including the establishment of a new Finance, Performance and Business Development Committee. The governance structure incorporates a number of Executive Director led Groups.

Annual Governance Statement

The Risk Management Group reviews risk on a trust-wide basis, monitors trends and refers issues as appropriate to the other Groups which in turn, provide assurance on organisation-wide learning from risks to the Quality and Safety Committee, and / or Finance, Performance and Business Development Committee. The Audit Committee oversees the systems of internal control and overall assurance process associated with managing risk.

The Quality and Safety Committee receives a quarterly report on Complaints, Litigation, Incidents, PALs and Patient Experience. Members of the Board receive the minutes of the Quality and Safety Committee and the Finance, Performance and Business Development Committee and the Chair of each of these Committees provides a report on assurances and risks to the Board following each meeting.

The Trust also developed its' Board Assurance Framework in 2012/13 and has re-designed it for 2013/14 such that it adds greater value to the work of the Board of Directors and drives its' programme of work, focusing the Board's time on principal strategic risks.

The Board Assurance Framework in place in 2012/13 comprised the following key elements:

❯ Principal risks to the achievement of the Trust's strategic objectives and to continued regulatory compliance

❯ Key controls by which these risks can be mitigated

❯ Sources of assurance (internal and external) that risks are being managed effectively

❯ Gaps in controls and assurances

❯ Current risk score

❯ Board action plans, including RAG rating on delivery of actions.

In 2013/14 the Board Assurance Framework will map the controls and assurances required by the Board to support the annual Corporate Governance Statement and principal strategic risks identified by the Board.

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

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.

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

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

❯ **Key In-Year Risks**

During 2011/12, the Trust experienced significant challenge in meeting its' Referral to Treat and A&E access targets. Also in this year, the Care Quality Commission identified shortfalls in the processes for documenting consent in relation to termination of pregnancy and the need to improve processes relating to the management of medicines.

Monitor found the Trust to be in significant breach of its Terms of Authorisation in March 2012, presenting a number of challenges for the Trust to overcome during 2012/13.

In 2012/13, the Trust commissioned an external governance review and has worked actively to address these risks to compliance and clinical management. Under the leadership of a new Chief Executive the Trust achieved de-escalation in February 2013, with its Monitor governance risk rating reverting to 'green'.

In addressing the breach of access targets, the Trust has worked actively with external partners to improve patient flow, and to continuously improve patient experience. Due to unprecedented demand on emergency care services, the Trust breached the A&E four hour waiting time target in Q4 but anticipates that sustained compliance will be achieved by the end of Quarter 1 2013/14, through a range of measures including the establishment of an integrated discharge team and improved multi-agency working.

During 2012/13 improvement work was undertaken in relation to the shortfalls identified by the Care Quality Commission and in January 2013, an unannounced inspection confirmed compliance with the six outcomes reviewed. The need to put in place some further actions to improve clinical record keeping was identified during this inspection.

Also during 2012/13, the Trust commissioned an external review of its' IT infrastructure. This highlighted the increased support costs and potential risks of failure of the Trust's ageing IT infrastructure and recommended the development of a clear programme of investment supported by a coherent IT Strategy. Work to develop this strategy is now well developed.

❯ Annual Governance Statement

❯ Future Risks

The Trust faces an ongoing challenge in relation to demand for emergency services and has embarked on a system-wide programme of transformational work to improve patient flow, manage patients safely without admission, where this is appropriate and to ensure effective integrated systems to support timely discharge, once there is no longer a clinical need for patients to remain in hospital.

Work is ongoing to ensure the Trust has the right capacity to meet demand and ensure patient continued safety in light of increasing levels of activity.

In the context of the financial climate and the need to generate sizeable recurrent cost improvements, whilst generating sufficient surplus funds to invest for the future in the estate and IT infrastructure, the Trust has recognised the need to review its clinical strategies and Five Year Strategic Plan. It has established a Programme Management Office in 2012/13 with new processes and governance structure to support the quality assurance, approval and risk management of cost improvement schemes.

These processes will be embedded in 2013/14 to support the delivery of cost improvements in a way that is aligned to the Trust's vision and strategy and avoids any adverse impact on quality and safety. In common with the NHS as a whole, the financial challenge associated with CIP delivery remains a significant future risk for the Trust.

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

The financial plan is approved by the Board of Directors and submitted to Monitor. The plan, including forward projections is monitored in detail by the Finance, Performance and Business Development Committee with key performance indicators and Monitor metrics reviewed by the Board. The Board also receives a written report of the Chair of the Finance, Performance and Business Development Committee following each Committee meeting.

There is a process in place for ensuring that a quality impact assessment is undertaken for all Cost Improvement Plans.

The Trust's resources are managed within the framework set by the Scheme of Reservation and Delegation and Standing Financial Instructions. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources.

During the year the Trust has continued to develop Service Line Reporting, supported by clinical engagement in cost management and service planning. It has also utilised benchmarking data and Dr Foster intelligence to measure its relative performance and identify priorities for improving the use of resources and clinical effectiveness.

Divisions are responsible for the delivery of financial and other performance targets and are monitored via a process of quarterly Executive-led Service Reviews.

The Audit Committee oversees the delivery of an agreed programme of work by internal audit and receives an annual value for money opinion provided by the external auditor.

❯ Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Annual Quality Report 2012/13 has been developed in line with national guidance, with regular reporting on the performance of key quality metrics to the Quality and Safety Committee and to the Board of Directors. The work is led by the Medical Director.

The Quality and Safety Committee, Chaired by a Non-Executive Director and comprising a number of Non-Executive and Executive Directors receives quarterly reports and assurances on the quality report metrics. All data and information within the Quality Report is reviewed through this Committee. The Committee is active in ensuring that quality remains at the heart of all Trust business.

The Quality Report within this Annual Report describes the quality improvements achieved in 2012/13 and the clinical governance arrangements in more detail. External audit assurance reports on the Quality Report are reviewed by the Audit Committee.

The Board of Directors is committed to developing a Quality Improvement Strategy in 2013/14 which will set out ambitions and milestones for further improvement of safety, clinical effectiveness and patient experience.

The Board of Directors has developed and introduced a new quality dashboard in 2012/13 that enables it to the measure trends in performance of key indicators that contribute to high level quality and safety metrics and identify improvement work.

The Trust has a dedicated Quality and Safety Team with the relevant skills and experience to identify, direct and measure quality improvement work across the organisation. Capability building in Quality Improvement techniques and skills continues to be a key objective. Members of the Board have completed the Advancing Quality Alliance (AQUA) 'Board on Boards' training programme in Quality Improvement awareness and skills in 2012/13.

The Quality Report has been reviewed through both internal and external audit processes and comments have been provided by local stakeholders including local commissioners, Wirral Local Involvement Network (LINk) and the Borough Council Overview and Scrutiny Committee.

Priorities for 2013/14 have been discussed with stakeholders and agreement reached to continue with the 2012/13 priorities to ensure that sustained progress is made.

Annual Governance Statement

❯ Review of effectiveness

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 Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. This is reviewed by the Board quarterly.

The Board commissioned a comprehensive external review of its governance arrangements during 2012/13 and as a consequence has put in place new governance structures and processes.

A follow up review of progress was undertaken in January 2013 and has provided me with further assurance in respect of governance arrangements and further developmental work in progress.

At the end of 2012/13 the Board has rigorously reviewed the findings and recommendations of the Report on Mid Staffordshire NHS Foundation Trust Public Inquiry which has given me assurance on the governance processes in place to support the quality of patient care. The Board is in the process of reviewing the Government's response to the Inquiry and will finalise its own response and action plan in 2013/14.

Internal audit provides me with an opinion about the effectiveness of the Assurance Framework and the internal controls reviewed as part of the internal audit plan. Work undertaken by internal audit is reviewed by the Audit Committee. The Director of Internal Audit has provided me with an overall Opinion of 'Significant Assurance' for 2012/13.

The Trust's programme of clinical audit work, which is agreed and monitored by the Quality and Safety Committee provides me with assurance on the quality and continuous improvement of clinical practice and patient care.

My review is also informed by External Audit Opinion, NHS Litigation Authority assessment, periodic assessments of compliance with the Essential Standards by the Care Quality Commission and other external inspections, accreditations and reviews.

❯ Conclusion

During 2012/13, the Board put in place mitigating actions to address all issues identified by Monitor and the Care Quality Commission in the previous year (2011/12) and to address the recommendations of an external review of governance arrangements.

As a result the Trust has in place strong foundations that will help in meeting the future challenges it faces in relation to patient flow and the increasing demand for emergency services and the transformation work required to ensure financial viability and clinical sustainability in the current financial climate.

David Allison (Chief Executive)
29th May 2013

treating you well

Quality Account

Contents

To navigate your way through this interactive pdf, **hover over & click on the buttons and content lists**.

Quality Account

Part 1:
Chief Executive's Statement

This is our fourth Quality Account. It is a yearly report that tells you what standard of care you can expect from us, how we measure those standards and how we plan to make improvements to the care we provide.

Wirral University Teaching Hospital is one of the largest and busiest acute Trusts in the North West of England, offering Accident & Emergency services and a diverse range of acute and non-acute specialties, together with outpatient and day surgery services.

We aim to be the first choice Healthcare provider to the communities we serve. This means we are striving to deliver high quality, patient centred care all day, every day.

One year on, since my appointment as Chief Executive, I am incredibly proud of the achievements and progress we have made; along with the Board we are committed to deliver year-on-year improvements in quality.

I hope this Quality Account describes those achievements and our plans for going forward.

When I first took up my post, the Trust had just been notified it was in breach of its terms of authorisation by Monitor (our regulator). In February 2013, we were notified that the Trust is no longer in breach and we are now rated green for governance.

This recognises the dedication of all our staff to delivering safe high quality care.

We have had a number of assessments in year with very positive outcomes including a Level 2 NHS Litigation Authority (NHSLA) assessment, reflecting the hospital's safety culture and shows we are implementing our guidance for safer care and our annual Patient Environment Action Team (PEAT) inspection where our hospitals were awarded an "excellent" rating for food and the environment.

Improvements in our national inpatient and staff surveys show more patients and staff would recommend the Trust to others.

We know that delivering healthcare does carry risks and unfortunately sometimes patients are harmed.

We are developing our three year strategy for quality improvement, based on reducing mortality, delivering best practice consistently, reducing harm and improving patient experience. This is building on the work reported in this Quality Account.

For example, our mortality rate has continued to reduce throughout 2012/13, and we are expecting a 10% reduction by year end. We have reduced harms from falls, blood clots, catheter acquired urinary tract infections and pressure ulcers.

We are using the national 'safety thermometer' to measure "harm free" care. We continue to have very low levels of hospital acquired infection, with one avoidable Methicillin Resistant Staphylococcus Aureus (MRSA) blood infection this year and a reduction in Clostridium Difficile, and we continue to promote high standards of hygiene to support this.

We are using the Advancing Quality initiative to ensure consistency in care and have seen improvements in care of patients with heart attacks, heart failure, pneumonia, and hip and knee replacements for the last four years.

We have had an increased focus on customer care and our systems to understand patient experience have developed further with improvements noted across a number of important indicators.

We have also started gaining insight into the experiences of relatives and carers which will support the introduction of the Friends and Family Test in April 2013.
All of these achievements are set against a very challenging financial setting and it is imperative that quality and safety are maintained whilst implementing significant changes in the way we deliver services. We are launching our new clinical quality improvement strategy later this year that will demonstrate the challenges and opportunities ahead.

I am pleased to confirm that the Board of Directors has reviewed the 2012/13 Quality Account and confirm that it is a true and fair reflection of our performance.

I hope this Quality Account provides you with a clear understanding of how important quality and safety improvement is to us at Wirral University Teaching Hospital.

David Allison
Chief Executive
May 2013

**Quality
Account**

Part 2.1:
Looking forward to 2013/14; what are our priorities?

We have actively sought the views of patients, relatives and carers, governors, staff, Wirral Local Involvement Network (LINks), the Local Authority Overview and Scrutiny Committee and our commissioners by asking what they thought of our services and what we should focus on when improving quality in 2013/14.

We have also analysed our risk management systems, patient experience feedback for the last year and asked our staff. We have used this information to identify areas for improvement to help determine our priorities for next year.

Part 2.1.1
Our priorities for improvement in 2013/14 are:

Recognising feedback from a number of internal and external sources it has been agreed by the Executive Directors to retain the five priorities from 2012/13 as whilst there has been progress made in all five priorities they require further focused work to ensure that the targets are achieved in some cases and there is continued improvement in others.

Quality Account

Patient Experience Priorities

a. Improve handling of complaints – during this last year we have often not responded to complaints within the timescales we have agreed; the reasons for this vary.

We recognise the importance of clear and timely responses to people who have complaints about our services and the need to demonstrate how we will act to avoid similar concerns.

The complaints process has been subject to a significant review but there has not been the opportunity to observe the benefit as yet therefore we identified this as a priority for 2013/14.

The target for 2013/14 is:

❯ 80% of complaints responded to within the timescale agreed with the complainant.

Lead: Mrs J Galvani, Director of Nursing and Midwifery (commenced March 2013)

b. Improve on the National Inpatient Survey Results - this has been a priority for the last two years. We want to achieve further improvement in the annual Care Quality Commission (CQC) National Inpatient Survey.

Whilst we have seen significant improvement this year, this priority needs further focused work to ensure that improvements are embedded across all relevant services.

The target for 2013/14 is:

❯ A composite score of 75% from 71.2% in the National Inpatient Survey.

In previous years we have used the National Inpatient Survey as a principle indicator of improved patient experience.

From April 2013 the Friends and Family Test (FFT) will be introduced across the NHS in England and this will provide a nationally benchmarked indicator for the public to compare hospitals.

Therefore we will use the three performance indicators of the NHS Friends and Family Test as our priorities for the coming year.

The targets for 2013/14 are:

❯ To implement the Friends and Family Test for Acute Inpatients and patients attending Emergency Department Minors (from April 2013) and users of Maternity Services (from October 2013)

❯ To ensure that response rates for the FFT are in the top 50% of Trusts across England

❯ To improve the score for staff stating that they would recommend the hospital to family and friends to 65% from 61%.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

Quality Account

Saftey Priority

c. Minimise unnecessary in-hospital bed moves – this has been a priority for the last two years. We are working with our partners in Wirral Community Trust, the Clinical Commissioning Group and the Department of Adult Social Services to ensure that a patient is in the most appropriate setting for their care.

We aim to reduce the number of patients in hospital who are medically fit but unable to leave hospital. However we still have more work to do to ensure that no patient is moved unnecessarily and therefore this will remain one of our priorities for 2013/14.

The target for 2013/14 is:

❯ No more than four bed moves unless it is clinically appropriate.

Lead: Mrs S Gilligan, Acting Director of Operations (since March 2013)

Clinical Effectiveness Priority

d. Reduce the hospital standardised mortality rate (HSMR) rate by 10% - the HSMR is a calculation that compares the observed deaths with those that could be expected, based on deaths in similar patients across similar hospitals (our peer group).

In deciding the expected rate, calculations are made using information such as age, gender and illnesses patients have, to risk adjust the chance of death.

We have achieved a reduction in our HSMR and expect to deliver the target for our patients in 2012/13 (final HSMR not available). However we think we can still do better. Maintaining this as a priority will enable us to ensure that the practice improvements are embedded across relevant services and any further improvements identified can be made.

The target for 2013/14 is:

❯ 10% from the baseline of 2012/13

e. Achieve goals set out in Safety Express Programme – this includes learning and improvement in the prevention of avoidable hospital falls, and hospital acquired pressure ulcers, venous thrombo-embolic (VTE) events (blood clots) and urinary tract infections associated with the use of catheters.

This was a priority for last year. The two year improvement programme closed in December 2012 but nationally it has been agreed to continue to work on improvements. The aim of the new programme is that this year we will have achieved:

❯ 50% reduction in serious harm and death from preventable falls in the hospital on 2012/13 figures

❯ 50% overall reduction in prevalence of new pressure ulcers developed in the hospital (grades 2-4) with an 80% reduction in new grade 3 and 4 pressure ulcers based on 2012/13 figures

❯ 50% reduction in preventable venous-embolic events based on 2012/13 figures

❯ A 50% reduction in unnecessary urinary catheterisation whilst maintaining the 50% reduction in urinary tract infections in patients with in-dwelling catheters based on the 2012/13 prevalence study.

Quality Account

Part 2.1.2 Monitoring of our Priorities for 2013/14

We will continue to provide a quarterly report on progress with our five priorities to the Board of Directors and internal committees.

The quarterly reports on progress will be shared with our local commissioners, Wirral Healthwatch and Wirral Borough Council Overview and Scrutiny Committee.

Individual priorities are managed and monitored by a range of groups in the Trust. All priorities will have a work programme in place.

2.1.3 Provision of Feedback

We welcome and wish to encourage feedback on our Quality Account. If you would like to comment on this report or if you want to make suggestions for future priorities please contact Dr M Maxwell, Associate Medical Director.

**Quality
Account**

Part 2.2:
Statements of Assurance from the Board of Directors

The information that follows is a mandatory requirement and all NHS trusts must include it within their Quality Account.

2.2.1
Service reviews

During 2012/13, the Trust provided and/or subcontracted 71 NHS services (see Appendix 1). The Trust has reviewed the data available to it on the quality of care in all of these services. The income generated by the NHS services reviewed in 2012/13 represents 100% of the total income generated from the provision of NHS services by the Trust for 2012/13.

Information covering all services and the three dimensions of quality is brought together in an Intelligent Board Report reviewed by the Board of Directors every month. During the year this report has further developed and includes trends in a wide range of quality indicators from all services such as Learning From Patients' surveys and staff feedback surveys.

Each Division has an internal quality and safety structure and processes and this has been reviewed and monitored on a quarterly basis by the Chief Executive and Executive Directors. The governance structure has been extensively reviewed during 2012/13 and new governance arrangements will be in place from April 2013. The new arrangements will strengthen the internal quality and safety structure.

2.2.2
Participation in National Clinical Audit and Confidential Enquiries

Clinical audit involves improving the quality of patient care by looking at current practice and measuring compliance with standards whether local or national. In 2012/13, 42 national clinical audits and 4 national confidential enquiries covered the NHS services that the Trust provides.

During 2012/13, the Trust participated in 79% (31) national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits which it was eligible to participate in during 2012/13, that the Trust participated in, for which data collection was completed during 2012/13 are listed in Appendix 2 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

In year, we received reports for 28 national audits of which nine have not completed the review process, four did not identify any specific actions. The remainder have been discussed and action plans are in place. Actions include development of care pathways (Inflammatory Bowel Disease; Dementia care); improving local documentation and data collection (National Joint Register, Bowel Cancer, Trauma Audit and Research Network); rehabilitation prescriptions for trauma patients; staff education (Trauma Audit and Research Network, Dementia care, Paediatric Asthma); additional multidisciplinary team meetings; new clerking proforma introduced to support safer care (Hip Fracture Database); improved mealtime assistance (Dementia care); improved patient/carer information (Dementia care, Neonatal care); Epilepsy care action plan working towards the best practice tariff; increased breastfeeding support (Neonatal care).

The national confidential enquiries which it was eligible to participate in during 2012/13 and that the Trust participated in are noted in table 1 on page 189.

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The reports of 27 national clinical audits were reviewed by the Trust in 2012/13 and we have taken or intend to take the actions noted in Appendix 2 to improve the quality of healthcare provided.

A number of the national clinical audits do not report in every financial year with some of the final reports of the audits noted as not being due until later in 2013 or 2014 because some audits are run on two or three yearly cycles.

The Trust continues to work to strengthen the clinical audit systems in place to ensure appropriate review of the reports of national audits and develop actions for improvement where required. This year the Trust wide clinical audit structure has been strengthened and additional staff will be recruited early in the new financial year.

In addition to the national clinical audits we undertake local clinical audits, a number of which are repeat audits in order to identify the level of improvement made as a result of earlier improvement actions.

The reports of 190 local clinical audits were reviewed by the provider in 2012/13 and the Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

❯ Improved staff awareness and education in relation to appropriate referral of malnourished patients with mandatory review of nutrition status and recognition of nutritional support on ward rounds

❯ Following results of the clinical record keeping audit and MEWS/DNR audit within the surgical division have developed NHSLA link nurses for each departament/ward to carry out health records check list to try and improve compliance with the standard. Clinical coding are also screening case notes to identify non compliance with the standards.

❯ Number of warfarin clinics increased to three per week to reduce waiting time for patients. Patients now given fixed appointment times and seen in order.

❯ Early identification of elderly trauma patients by senior staff to identify appropriate imaging

❯ Encourage use of a patient centred care plan for post-operative patients

❯ Recommendation to use alternative wound closure technique.

Table 1- National Confidential Enquiries

National Confidential Enquiries Title	Organisation Questionnaire	Case Requirement	Cases Audited
Subarachnoid Haemorrhage (audit is still ongoing)	1	3	2
Alcohol Related Liver Disease	0 Completed 2011/12	3	3
Bariatric Surgery (the Trust does not undertake planned bariatric surgery)	1	0	0
Cardiac Arrest Procedures	2	0	0

Part 2.2.3
Participation in Clinical Research

Clinical research includes both clinical trials (which involve studies to investigate new drug treatments or new 'implants' like hip replacements), and laboratory studies in which we look at new tests to help us diagnose illnesses earlier or more effectively.

All research must be approved by an NHS Research Ethics Committee, and studies with drug treatments or new implants also have to be approved by the Medicines & Healthcare products Regulatory Agency (MHRA).

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 338.

The Trust recruited patients to 42 National Institute for Health Research (NIHR) adopted studies covering a wide and varied portfolio including: Critical Care, Haematology, Medicines for Children, Musculoskeletal, Ophthalmology, Reproductive Health, Respiratory, Stroke and Surgery. Of these studies 24 were Clinical Trials of Investigational Medicinal Products.

In addition to this, 82 of our patients that were transferred to Clatterbridge Cancer Centre for treatment also participated in research approved by a research ethics committee.

Trust staff were involved in 42 publications being accepted in professional journals in the last year. This significantly increased level of participation demonstrates the continuing commitment the Trust has to improving the quality of care offered to our patients.

Quality Account

2.2.4 Commissioning for Quality and Innovation

Commissioning for Quality and Innovation (CQUIN) is a mandated sum of money put aside by Commissioners to fund quality improvement, with Providers earning the income by delivering agreed quality targets.

A proportion of Trust income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and local healthcare commissioners, and any person or body the Trust entered into a contract, agreement or arrangement with the provision of NHS services, through the CQUIN payment framework.

The targets for 2012/13 were developed by NHS Wirral and agreed with the Trust, and reflected areas of desired improvement identified nationally, regionally and locally. Further details of the agreed goals for 2012/13 and the following 12 month period are available at:

http://www.monitor-nhsft.gov.uk

Indicator for 2012/13	Threshold	Year-end Position
Reduce avoidable death, disability and chronic ill health from Venous-thrombo-embolism (VTE)	90% of admitted patients to have been risk assessed for VTE	**Achieved** Performance has been above 90% in every month throughout 2012/13
Patient Experience - improve responsiveness to personal needs of patients	Achieve a 4% improvement on 2011/12 levels (67.4%)	**Achieved** Published score for 2012/13 was 71.2%
Dementia - screening, risk assessment and referral for specialist diagnosis	90% of relevant patients to be screened, risk assessed and referred for specialist diagnosis for 3 consecutive months	**Achieved** Performance has been above 90% consecutively from November onwards in 2012/13
NHS Safety Thermometer - Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter and VTE.	Submission of data for 3 consecutive months in each quarter from Q2 onwards	**Achieved** Data submitted for more than 3 consecutive months in each relevant quarter in 2012/13
Advancing Quality – to promote clinical effectiveness, safety and patient experience in: • Acute myocardial infarction • Heart failure • Hip and knee replacement • Pneumonia • Stroke	Achieve a range of composite scores and patient experience measures	**Achieved all areas to date (month 8)** The definitive result will not be known until September 2013. However unvalidated data suggests the Trust is on track to achieve all clinical standards with the exception of Heart Failure where the performance to date has not been as good as expected following service reconfiguration; this is being addressed but the Trust may not meet the target. The Trust did not take part in the patient experience aspect.

TARN - improved trauma care for patients with better outcomes	Membership and data submission to the Trauma Audit and Research Network (TARN)	**Achieved** Data submission achieved the required standard for improvement
Lung Assessment Unit (LAU) – improve data collection to support the continued funding of the LAU	Data collection and presentation of business case	**Achieved** Data collected and Business case presented to the CCG in January 2013
Enhanced Recovery Programme (ERP) implementation across 5 pathways	Specific ERP pathways to be implemented and associated length of stay reductions to be agreed	**Achieved** Pathways implemented to plan, Length of Stay targets agreed and monitored
Non-elective flow – implement the principles of ERP in specific treatment pathways	Development and implementation of new treatment pathways and associated targets	**Achieved** Pathways agreed and Length of Stay reductions monitored
OPRA – Older Persons Rapid Assessment to be extended to Urgent Care areas	Minimum of 75% of OPRA patients to not have an emergency admission within 30 days of assessment	**Achieved** 90% of OPRA patients do not have emergency admission within 30 days
Patient Experience – Learning With Patients Questionnaire (LWPQ) on information, and assistance with eating, drinking and personal experience	LWPQs to return a minimum year-end average of scores and demonstrate incremental improvement	**Partially Achieved** Not all results at the required level although progress made
Patient Experience – CRT kiosk	Kiosks to be deployed and incremental improvement in scores achieved	**Achieved** Kiosks deployed and improvement scores achieved
Patient Experience – Dementia	Two focus groups to be established and a minimum of 70% of patients with dementia to complete the 'This Is Me' document	**Achieved** Focus groups established and 100% of patents with dementia complete 'This Is Me' document
Patient Experience – Paediatric	Develop and implement paediatric specific survey. Establish targets and achieve improvements	***Not yet confirmed** Methodology and baseline established
Foot care for Diabetic patients	Agree and implement new patient pathway, and achieve agreed treatment targets	**Achieved** Pathway established with patients reviewed as required within agreed time frames
Urgent Care - pathways	Implementation of timeliness pathways	**Partially Achieved** Trust-wide escalation plan adopted. Urgent Care services reconfigured in conjunction with Community Trust and Clinical Commissioning Group (CCG).
Urgent Care – See & Treat	Implementation of See and Treat	**Partially Achieved** Urgent Care services reconfigured in conjunction with Community Trust and CCG.
Alcohol – staff training	Agree baseline and achieve target for front-line staff training in alcohol screening tool and intervention / onward referral	**Achieved** Training levels achieved, effectivness of training monitored
Discharge Summaries/Improvement in communication	Agreement of target and demonstration of improvement	**Achieved** Milestones agreed, audits undertaken improvements evidenced
Smoking	Agreement and achievement of trajectory on offering smoking cessation support services	**Achieved** Pre-op documentation includes specifics on smoking and brief intervention, two audits to demonstrate compliance

Table 2. CQUINs for 2012/13

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The amount of income in 2012/13 conditional on achieving quality improvement and innovation goals was £5.76 million.
For the year 2011/12 the total associated payment was £3.47 million.

The CQUINs (table 3) for 2013/14 have been developed with NHS Wirral/GP Clinical Commissioning Groups and again reflect national, regional and local priorities.

*Goal/Strategic Aim 2013/14	Rationale for inclusion
Friends & Family Test	To improve the experience of patients
NHS Safety Thermometer	To reduce harm, focusing on reduced incidence of pressure ulcers, falls and urinary tract infections
Dementia	To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers.
VTE Prevention	To reduce avoidable death, disability and chronic ill health from venous thrombo-embolism (VTE)
Advancing Quality	To improve the quality of service for patients experiencing Acute myocardial infarction, Heart Failure, Hip and Knee Replacement, Pneumonia, Stroke and overall Patient Experience
Long Term Condition Management	To develop the Infrastructure to sustain integrated Long Term Condition Management delivering risk stratification, integrated teams and supporting self care project Pathways for Life. To deliver service integration supporting earlier discharge
Urgent Care	a) To reduce in emergency admissions for acute conditions that would not normally require hospital admission e.g. diabetic patients b) To redesign mental health assessment pathway in acute care
Dementia	To develop and implement an integrated Dementia assessment and support pathway across mental health & learning disability, community and acute sectors: leading and working on Trust elements of the pathway in partnership with all key stakeholders
Discharge	To improve the quality of discharge summaries from the Emergency Department
Seven-day Working	To introduce seven day working for Consultant/ Senior Medical staffing to provide a review of new and medically unstable inpatients across the Medical Specialties Division
Compassion in Care (Francis Report)	To ensure providers' Quality and Nursing strategies and frameworks are reviewed with a particular reference to nursing in line with the report of the Francis Inquiry and recommendations of Compassion in Practice

Table 3. CQUINs for 2013/14

Quality Account

2.2.5
Care Quality Commission Registration and Reviews

The Care Quality Commission is the organisation which regulates and inspects health and social care services. The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is that it is 'registered without conditions for the Health and Social Care Act 2008'.

The Care Quality Commission has not taken enforcement action against the Trust during 2012/13.

During the year the Trust has received three unannounced inspections from CQC, to the Arrowe Park site. There was one inspection of the Renal Unit at Clatterbridge Hospital (May 2012) where full compliance was found.

The first visit to the Arrowe Park site took place in April 2012, and the Inspectors looked at the management of medicines, this followed the moderate concern raised in January 2012.

They made a number of observations about the design and operation of the medicines reconciliation process and judged that we were still non-compliant with Regulation 13 (Medicines Management), however with a minor impact on people who use services. In response to this inspection, we amended and implemented a detailed action plan.

The action plan included; designating a lead clinician to champion medicines reconciliation; introducing spot checks of paperwork; additional training for junior doctors; reviewing

our guidelines for the process; and improving the method of our existing audit.

In September 2012 we were re-inspected by CQC against the medicines management regulation. On this occasion they were satisfied with the progress that we had made, and they judged that we were compliant with the regulation. Their report mentioned that the comments made by patients were very positive and that patients were happy that they had been given understandable information about their medicines. They did identify one instance where a patient was administering their own medicines and this was not in line with our own self-medication policy; we were piloting self-medication in certain parts of the hospital at the time.

They also revisited the Termination of Pregnancy service, which they had earlier visited in March 2012 and had found us non-compliant with Regulation 20 – Records. We were found to be compliant on this occasion, based on a sample check of the relevant forms.

Our main inspection took place over two days in January 2013. The inspectors visited Ward 32, the Coronary Care Unit and the Maternity Unit and inspected against the following outcomes: care and welfare of people who use services; respecting and involving people who use services; assessing and monitoring the quality of services; safeguarding; medicines management; staffing.

As at previous visits, the opinions expressed by patients to the inspection team were positive about the service which they were receiving. We were compliant with the six regulations, but during the visit it was noted that we were not compliant with Regulation 20 – Records.

This was because the inspectors were not satisfied with the standard of record keeping by clinicians in the case notes which they observed, and our own quarterly audits of clinical record keeping had failed to show any significant improvement since we failed the health record keeping standard at the Level 2 NHSLA assessment in July 2012 (even though we passed that assessment as a whole). They considered that this non-compliance would have a minor impact on patients. They had not originally planned to inspect us against this regulation but decided to expand the scope of the inspection after observing examples of poor record keeping in the random sample of notes which they were using to test compliance with other regulations.

Our action plan includes a range of measures to improve the standard of record keeping, such as a staff awareness campaign and frequent spot checks, with feedback to individuals whose record keeping needs to improve. The awareness campaign will highlight the potentially serious consequences for both patients and staff when proper records are not kept. Educational Supervisors will advise junior doctors of the importance of keeping comprehensive and accurate records, and for established medical staff, we are testing the feasibility of incorporating record-keeping into the appraisal and revalidation process.

In our action plan, we also address several issues which would improve our services that were mentioned in the inspection report. These include raising the visibility of the Safeguarding team across the organisation and revising their standard documentation, and providing more information to new mothers about infant feeding.

We have a well-developed assurance process for compliance with the CQC's Essential Standards. The most 'hands on' assurance comes from the Divisional Lead Nurses' walkarounds of clinical areas. They use an inspection tool which is referenced to CQC's Essential Standards of Quality and Safety, and cover all the patient-focused regulations over the course of a year. They are organised so that the Lead Nurses do not inspect areas that fall within their own area of managerial responsibility. These were introduced in 2012. During 2013, we are improving the process for reporting the results of these inspections and following up improvements. In addition to these walkarounds, the Quality and Safety Department undertook a mock inspection of the Children's ward looking at consent to treatment, and visited the Dialysis Unit at Countess of Chester Hospital, which is run as a partnership between our two Trusts.

We also hold review panel meetings with the Executive Directors and operational managers who lead on each regulation, so that they can self-certify their level of compliance using a red-amber-yellow-green rating, and produce quarterly reports for the Quality and Safety Committee of the Trust Board. There is a full portfolio of documentary evidence for each regulation, consisting of policies, audits, patient surveys, external inspection reports, training materials etc., and this is regularly updated. We also produce a monthly briefing which summarises the Quality and Risk Profile produced by the CQC. All risks with an implication for CQC compliance are recorded on the Trust Risk Register with an action plan. Finally, we delivered training for our Board members in June 2012 so that they are all familiar with the role of CQC and the standards it enforces.

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2.2.6
Data Quality

The Trust submitted records during 2012/13 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentages in table 4 below include the patient's valid NHS number. The results shown for GP Registration have a 'valid' GP Code assigned.

This includes all 'valid' codes so will include any records assigned as 'unknown'.

	2009/2010	2010/2011	2011/2012	2012/2013
NHS Coverage				
Admitted patient care	98.3 %	98.5%	97.8%	99.2%
Outpatients	98.9%	99.3%	98.7%	99.5%
A&E	96.2 %	96.3%	96.1%	98.6%
GP Registration				
Admitted patient care	99.5%	99.9%	99.9%	99.9%
Outpatients	99.9%	100.0%	100.0%	100.0%
A&E	95.6%	100.0%	100.0%	100.0%

Table 4. Data Quality

The Trust is committed to achieving and maintaining high levels of data quality across all areas of healthcare information. As part of the Information Governance assurance regime, a cross-Divisional Data Quality Group meets regularly to review data quality standards and to address issues.

The Trust will be taking the following actions to improve data quality for 2013/14:

❯ Embedding the revised patient demographics checking process into clerical pathways to reduce the rate of clinical communication addressed to incorrect GP practices

❯ Continue the improvements in quality of inpatient discharge summaries for GPs achieved through the CQUIN process in 2012/13

❯ Establish a joint Trust/CCG group to similarly improve the quality of A&E discharge summaries

❯ Creation of new data quality audit reports in preparation for the go-live of Phase 2a of Wirral Millenium (Trust IT system) in June 2013.

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2.2.7
Information Governance

Information governance ensures the necessary safeguards for, and appropriate use of, patient and person identifiable information. Risks relating to information governance are contained within the Trust monitoring and reporting mechanisms.

An Information Governance Committee facilitates the work programme that ensures the Trust maintains compliance with relevant information governance legislation and good practice. Highlights from the work programme this year include a review of internal and external data flows, a follow-up audit of corporate records and a review of the Trust's Information Assets ensuring that the appropriate safeguards are in place.

The Trust Information Governance Assessment report overall score for 2012/13 was 70% and was graded green in the grading scheme.

Information risks either reactive (following incidents) or proactive (following risk assessments), continue to be managed in the same way as all other risks identified in the Trust. Information risks are reviewed by the Information Governance Committee, which reported to the Clinical Governance Programme Board.

The Information Governance Committee also continues to report to the Audit Committee to increase the level of assurance on Information Governance systems.

2.2.8
Clinical Coding

High quality coded clinical data is essential to provide reliable and effective statistically meaningful data analysis.

The Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 8.9% primary diagnosis, 26.8% secondary diagnoses, 11.6% primary procedures and 19.2% secondary.

For 2012/2013 the audit had a national element and a random sample with each commissioner selecting the audit areas and proportions. The services audited were 50 finished consultant episodes from HRG chapter EB cardiac disorders, 50 finished consultant episodes from Stroke admissions and 80 finished consultant episodes from chapter FZ digestive system procedures and disorders.

These results should not be extrapolated beyond the actual sample taken as the audit reviews a small number of finished consultant episodes in a limited number of specialties.

The time period was July – September 2012. The key actions the Trust will take following this coding audit are:

❯ Continue the work to improve the quality of the discharge summaries

❯ To continue to roll out using case notes as the primary sourced document for clinical coding rather than the electronic record, whilst improving the quality of the case notes themselves

❯ To address issues raised with the coding during the audit with coders

❯ To continue with the audit programme.

Quality Account

Part 3:
Review of Quality Performance

This section of the report tells you how we performed against the five priorities that we set ourselves in 2012/13.

3.1
Our priorities for 2012/13 were:

Patient Experience Priorities

a. Improve handling of complaints – during the previous year we often did not respond to complaints within the timescales we agreed; the reasons for this vary.

We recognise the importance of clear and timely responses to people who have complaints about our services and the need to demonstrate how we will act to avoid similar concerns. We therefore identified this as a priority for 2012/13.

The targets for 2012/13 were:

❯ 80% of complaints responded to within the timescale agreed with the complainant

❯ 10% reduction in complaints about communication and staff attitude from the 2011/12 position.

This target was not reached.

Lead: Mrs T Long, Director of Nursing and Midwifery (left the Trust in March 2013)

The key actions undertaken during the year have been:

❯ We carried out a formal review of concerns and complaints handling. The proposals involve significant changes including the integration of the complaint and PALS functions to provide a clear management response to every complaint

❯ The review also included a review of the response timescales as the target did not take into account the complexity of the complaint.

❯ Medical Specialities Division trialled a process whereby the initial complaint was reviewed and an agreement made with the person making the complaint regarding response time. This is influenced by the content of the complaint and the complexity of the investigation required

❯ Continuation of training programme for staff who are responsible for investigating and responding to complaints

❯ The Trust has embarked on a major transformation programme with staff called *"Listening into Action"* which is about engaging with staff to drive change and improve things that matter to them. It is expected that a major part of the projects delivered as part of this programme will improve many of the underlying themes that feature in concerns and complaints.

Our compliance of complaints responded to within the timescale agreed with the complainant is 38% for the year.

However during the past year there has been a significant focus on the quality of the response to ensure that we address all the issues raised. It is expected that the implementation of the concerns and complaints review will be completed by May 2013 which will significantly improve the response times.

Unfortunately we did not achieve our target for reducing complaint themes relating to staff attitude and communication. However, the absolute numbers were the same as in 2011/12.

Due to the fact that the implementation of the review has not been completed, the response timescales are not yet achieving our target and the reduction in complaints involving communication and staff attitude has not been achieved, this priority is being retained as a priority for 2013/14.

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b. Improve on the National Inpatient Survey Results - this was a priority for 2011/12. We wanted to achieve improvement in the annual Care Quality Commission (CQC) National Inpatient Survey. Whilst we have seen some improvement, this needs further focused work to ensure that the practices and improvements are embedded across all relevant services.

The target for 2012/13 was:

❯ A composite score in the National Inpatient Survey of 71%.

This target was achieved

Lead: Mrs T Long, Director of Nursing and Midwifery

The key actions undertaken during the year have been:

❯ A continuation of a focus on the questions that form the National Patient Experience CQUIN (Commissioning for Quality and Innovation) and actions to improve these are integral to our Divisional patient experience action plans

❯ We needed better communication with patients about medication side effects. During this year we have focussed on supporting clinical staff on the wards to speak to patients about their medication. We have a medicines helpline leaflet that is being rolled out, and have reviewed the content and increased the provision of information leaflets. Medicines adherence has been embedded within all the Divisional patient experience action plans

❯ The return rates on the monthly Learning with Patients questionnaires are monitored monthly

❯ Services are provided with a quarterly dashboard relevant to all wards to help identify areas where more focus is required. Additional senior clinical input is provided to support the ward managers where required

❯ The action plans were monitored by the Clinical Governance Programme Board

❯ The expansion of the Model Ward programme (standardised ways of working to enable the ward to be more effective) has contributed to the consolidation of improvement activity

❯ The Learning With Patients questionnaire has been monitored on a ward by ward basis. This helps to focus actions at speciality level.

The Trust can report that our final CQUIN score for Patient Experience as measured by the National Inpatient Survey 2012 was 71.2% which represents a substantial improvement from 67.4% in 2011. This achievement reflects the significant focus the Trust affords to improving patient experience and the dedication of our staff in delivering a high standard of care and treatment.

In previous years we have used the National Inpatient Survey as a principle indicator of improved patient experience. From April 2013 the Friends and Family Test (FFT) will be introduced across the NHS in England and this will provide a nationally benchmarked indicator for the public to compare hospitals.

Actions to further improve on the National Inpatient Survey results and the Friends and Family Test include:

❯ Development of a Nursing Strategy 2013 -14

❯ Development of a Midwifery Strategy 2013 -14

❯ Development of a Quality Improvement Strategy 2013 -16.

Quality Account

c. Minimise unnecessary in-hospital bed moves – this has been a priority since 2011/12. We have undertaken a piece of work to understand why patients experience too many bed moves but we still have more work to do to ensure that no patient is moved unnecessarily and therefore this will remain one of our priorities. A key aim for the Trust is to ensure that every patient is treated in the right time, at the right place and by the right person with an improved patient experience.

This target was not achieved.

Lead: Mrs S Shannon, Director of Strategic Operations

The key actions undertaken during the year have been:

➤ The opening of a new Emergency Assessment Unit, (EAU) open 24 hours a day, 7 days a week. Patients who are referred by their GP or who present at the Emergency Department with urgent medical conditions are assessed in the EAU by a GP or Acute Physician and initial diagnostics and treatment commenced. The service provides clear alternatives to admission or re-admissions through rapid access to clinics and diagnostics. Patients requiring admission will be transferred to the Acute Medical Unit or direct to a specialty ward

➤ Multiple transfers for patients from one clinical area to another can lead to increased confusion for the patient. There is also a risk in relation to the timing and quality of handover of clinical care and information. A repeat audit of a sample of 20 patients who had moved on multiple occasions was undertaken to identify the reasons why patients are transferred from ward to ward to enable the identification of action that could be taken to reduce avoidable transfers. No patients were transferred on more than 4 occasions and all transfers were for clinical reasons involving transfer to and from critical care or an assessment unit. This review has highlighted a significant improvement from last year's audit, with the majority of patients being transferred within the hospital on 3 or less occasions and the moves being part of the planned clinical pathway

➤ A weekly report for multiple transfer or transfers out of hours, reported as clinical incidents, is monitored and enables rapid investigation to establish any reasons why patients have been subjected to multiple moves

➤ Improving discharge planning so that patients are aware of their expected date of discharge and fully involved in planning their safe and timely discharge. There has been a big focus on improving communication with patients and relatives regarding any post discharge social care support. This includes a number of new information leaflets providing guidance and advice on choosing a nursing and residential home or care packages

➤ Improving bed management processes with a revised capacity and demand management tool and new operational policy. The aim is to more accurately predict bed capacity requirements and reduce the number of times escalation areas are opened

➤ Work continues to redesign the Department of Medicine for the Elderly (DME) pathway which aims to more effectively manage the patient pathways so that all elderly patients experience a seamless flow of care that meets their needs thereby removing all avoidable delays in the patient journey and minimise length of stay. A number of wards are now using the discharge planning boards effectively and this will be rolled out across the Trust.

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d. Reduce the in-hospital risk adjusted mortality index (RAMI) rate by 10 points - the risk adjusted mortality index is a calculation that compares the observed deaths with those that could be expected, based on deaths in similar patients across similar hospitals (our peer group). In deciding the expected rate, calculations are made using information such as age, gender and illnesses patients have, to risk adjust the chance of death. We remain above our peer group average therefore we can still do better. Maintaining this as a priority will enable us to ensure that the practice improvements are embedded across relevant services.
The target for 2012/13 is:

❯ 10% from the baseline of 2011/12 and below our peer group for three successive months by year end.

We are on track to achieve this – full year data not yet available.

Lead: Dr E Moore, Medical Director

When we introduced this priority area the Trust used a monitoring tool called the RAMI, produced by a company called CHKS. During 2011, the Trust changed its contract to Dr Foster and now uses the Hospital Standardised Mortality Ratio (HSMR). The way in which these tools apply risk assessment is different; this means the end of year position has changed numerically. However, the desire to achieve a 10% reduction remains constant. To avoid confusion we have reported HSMR throughout this report.

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. Like all statistics, HSMRs are not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign that things are going wrong and that further investigation is required.

The key actions undertaken during the year have been:

❯ We have continued to embed the work started last year to identify the key areas where we might reduce mortality

❯ The multidisciplinary mortality audit work continues, with each Division providing a monthly report on progress and actions taken

❯ Identifying patients early who need rapid intervention to prevent further deterioration is a key area of work. We have been ensuring the early warning scores are being used and where escalation is required for more nursing or medical intervention, it is occurring. This is the subject of monthly monitoring and feedback to the wards

❯ Care of the dying patients and end of life care. There is a cross Wirral group working to implement the end of life pathway. This aims to identify people in their final year and work with them and local services to ensure they get the death they want. The Trust is currently piloting this work on two wards with a plan to roll it out over the coming year. In addition we have started initiating the care of the dying pathway within the Emergency Department to support patients requiring rapid palliation when needed. This supports better dignity in death for those patients and has been well received

❯ Communication issues; we have been working to enhance the medical and nursing handover in Acute Care to ensure there are no delays to treatment and staff are aware of any outstanding investigation or treatment actions required as patients transfer into and out of the unit. For example, we have seen improvements in early antibiotic treatment for pneumonia within the Advancing Quality programme

❯ The Audit Leads are using opportunities at Audit Meetings to give messages back to staff to reinforce their findings

❯ We have recently introduced 7 day Medical Specialty Ward rounds. This means patients will be reviewed by a relevant senior doctor whatever day they are admitted and within 24 hours. This should help to ensure patients receive the best care in a timely way and this consistency of practice should ensure better outcomes. Whilst this is relatively new we are monitoring the impact

❯ We have also implemented a system for additional review of deaths based on diagnosis or procedure. Information is presented to the Clinical Governance Programme Board monthly to ascertain if we are seeing significantly more deaths than anticipated in any specific group. We have agreed a process to follow to provide additional assurance if any concerns are raised that will focus on the clinical safety as well as a review of the clinical coding

❯ HSMR is only as good as the data that underpins it because the risk of death is dependent on a number of factors including other illnesses, whether the admission is planned or not, and in some cases the patients' age. We have also spent time improving our data quality to make sure it is as complete as possible so that the risk assigned is accurate and reflects the patients' true condition.

The HSMR for 2011/12 was 108 (range 103-114). For April 2012 to January 2013 the HSMR was 101 (95-107); we have seen a 7% reduction in the first 9 months and anticipate we will deliver the 10% reduction. This will however remain a priority for the Trust in 2013/14 as there remains more that we can do.

Clinical Effectiveness Priority

e. Achieve goals set out in Safety Express Programme – this includes learning and improvement in the prevention of serious avoidable hospital falls, hospital acquired pressure ulcers, venous thrombo-embolic (VTE) events (blood clots) and urinary tract infections associated with the use of catheters. This was a priority for last year. The two year improvement programme closed in December 2012 but nationally it has been agreed to continue to work on improvements. The aims of the programme were that we will have achieved:

> 50% (no more than 24) reduction in serious harm and death from falls in the hospital

> 80% reduction in stage 3 and 4 pressure ulcers developed in the hospital (no more than 21 and 4 respectively)

> 50% reduction in venous-embolic events (no more than 6 deaths/74 readmissions/172 new diagnoses in hospital)

> 50% reduction in urinary tract infections in patients with in-dwelling catheters (no more than 4.5% prevalence on re-audit).

This was partially achieved, grade 3 pressure ulcers did not meet the target.

Lead: Mrs T Long, Director of Nursing and Midwifery (left the Trust in March 2013)

Reduction in Serious Harm and Death from Falls in the Hospital

Falls in hospital create significant adverse patient experiences and significant additional costs in terms of patient mortality and morbidity, nursing and medical care length of stay.

A fall where a patient sustains a serious injury (usually a fracture of the femur or thigh bone or a head injury) is considered serious and is subject to the 'Stop the Line' process where appropriate senior staff are alerted immediately and carry out an initial investigation.

When the incident has been fully investigated a decision is made as to whether the fall was preventable. For example, the fall is seen as preventable if the falls risk assessment and corresponding actions have not been carried out, if medication has affected the patient or if call bells are not within reach etc. It is these preventable serious fall incidents that we have been working to reduce.

The key actions undertaken during the year have been:

> Raising staff awareness with information on ward board in the form of a Forget Me Knot symbol to indicate that a patient has dementia

> Dementia awareness training sessions for staff

> Planned Comfort Checks to reduce the need for patients to move about without appropriate supervision

> Grouping of patients at risk in order to observe patients more closely

> Alerts on the Patient Information System

> 'This Is Me' document helps to ensure that staff are aware of a patients individual needs

> Creation of clinical guidance for staff

> Cross Divisional Falls Sub-Group was formed

> Risk assessment for falls promoted and monitored via audit - the Trust monitors a number of clinical standards monthly and in a sample from each ward in the Trust compliance with completion of a falls assessment for patients on admission and when they are moved

> Use of assisted technology for patients on all of the Department of Medicine for the Elderly (DME) wards, ward 32 and 34 with additional sensor pads available as required. Ward staff have received training on the use of the technology.

Year	Tolerance level for preventable serious injury falls	Falls With Serious Injury	Preventable Falls With Serious Injury
2011/12 Year 1	32	31 (25% reduction achieved)	
2012/13 Year 2 – Quarter 1	24 (6 per quarter) Further 25% reduction	13	5
2012/13 Year 2 – Quarter 2		14	4
2012/13 Year 2 – Quarter 3		9	1
2012/13 Year 2 – Quarter 4		8 Total for year 44	3 Total for year 13

Table 5 - Falls with Serious Injury
The Trust has achieved a 54% reduction in preventable serious falls by the end of the year.

Reduction in Stage 3 and 4 pressure ulcers developed in the hospital

Pressure ulcers are a type of injury that break down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are incredibly painful, debilitating and can lead to additional length of stay for patients. They are resource intensive in terms of nursing care and the cost of consumables.

The key actions undertaken during the year have been:

➤ Establishment of a pressure ulcer working group, with representation from all Divisions

➤ Assessment of staff knowledge with training provided via 'drop in' sessions

➤ Investment into the Tissue Viability team

➤ The Tissue Viability service has hosted bespoke pressure ulcer prevention and treatment study days which significant numbers of senior nursing staff attended

➤ Increased availability of guidance on wards around determining the stage of pressure ulcers

➤ Initial amendments to documentation to support proactive prevention of pressure ulcers

➤ Discussions to review all nursing documentation as this issue has been identified as a trend following analysis of all serious incidents concerning pressure ulcers

➤ Raised awareness and expectations with all ward staff around the responsibility of the registered nurse in timely and comprehensive assessment of patients

➤ A weekly review of all stage 1 and stage 2 pressure ulcers by the Lead Nurses for Medicine and Surgery

➤ A pressure ulcer prevention care plan launched in December 2012 which mandates specific interventions that all registered nursing staff should undertake on admission/transfer of a patient

➤ Matrons undertaking daily checks on their respective wards to ensure that the documentation supports care delivery that is underway

➤ Introduction of a pressure ulcer prevention 'pyramid checklist' to be used on wards where systems are still being embedded.
This requires daily signing from staff nurses to ward sisters, and then by Matron and Lead Nurse to reinforce interventions required.

The organisation has made considerable progress with regard to reducing the numbers of stage 3 and 4 pressure ulcers (the most severe).

Peaks in quarter 3 appear commensurate with significant increases in demand which placed challenging demands on staffing levels.These were not seen in quarter 1 or quarter 2.

Year	Tolerance	Stage 3	Tolerance	Stage 4
2011/12 Year 1 (aim 30% reduction)		41		8
2012/13 Year 2 (aim 50% reduction) Quarter 1	20.5 (5 per quarter)	3	4 (aim for 0)	0
2012/13 Year 2 Quarter 2		7		0
2012/13 Year 2 Quarter 3		15		1
2012/13 Year 2 Quarter 4		19 Total for year 44		2 Total for year 3

Table 6 - Pressure Ulcer Reduction progress
The Trust is not on target to achieve its target of 80% reduction in stage 3 pressure ulcers developed in the hospital.

Reduction in venous-embolic events

Venous Thromboembolism (VTE) is a disease where a blood clot forms in a vein; Deep Vein Thrombosis (DVT) is commonly in the leg, it stops the blood flowing properly leading to damage to the tissues around the clot. Sometimes, a bit of clot may break off and be carried through the blood stream to the lungs causing a Pulmonary Embolus (PE). VTE includes both DVT and PE. The work we are doing to lower the incidence of VTE has reduced both the chronic illness VTE can cause, and deaths from PE by eliminating avoidable disease.

For example, since starting this work we would have expected approximately 44 deaths from PE on the Wirral; we have seen 28. For those who had been in hospital within 90 days prior to death we would have expected 22 deaths and we have seen 11 based on 2010 data.

The key actions undertaken during the year have been:

❯ We have continued to implement the changes we started last year. We have assessed the risk for over 95% of our inpatients to determine if they are at risk of VTE; which is above the national target of 90%

❯ We introduced a daily reminder to the wards for patients who were identified as requiring treatment where it had not been prescribed and saw a really good response. Within 4 weeks all patients were getting a timely prescription. This work could only be used in those areas where the treatment protocols are built into our electronic system and work is underway to progress this across all areas of the Trust

❯ In addition, Critical Care have implemented weekly audit to ensure appropriate prescribing for their patients and to date this has been 100% with no patient who required prophylaxis being denied it

❯ We have completed an audit of compliance with the guidance; for Deep Venous Thrombosis (blood clot in the legs) and Pulmonary Embolism (blood clot in the lungs) the results show low use of clinical scoring to determine the likelihood of disease and this led to more tests being carried out than were strictly necessary. However, in general the management was good and clinical guidance has been re-developed to ensure the latest evidence based care is used. These are being implemented and will be audited again next year

❯ We investigate all inpatients who develop VTE to see if it could be hospital acquired disease. We identify whether we followed our guidance and decide if the disease was avoidable; this helps us learn lessons to improve care. The overall compliance with this is 83%

❯ What these investigations have highlighted is that we need to ensure patients have a reassessment when their condition changes. Nationally the evidence does not indicate when this reassessment should be therefore we are introducing a reassessment at 7 days for all patients to supplement our current guidance. This will be implemented over the coming months.

Indicator	Target	Year to Date: 2012
Deaths from Pulmonary Embolism (clots in the lungs) for patients who have been discharged from hospital within 90 days of death	No more than 6 in year (50% reduction in 2 years)	7 (Jan – Dec)
Deaths on Wirral from VTE disease	No more than 11 (50% reduction in 2 years)	12 (Jan – Dec)
Readmission within 90 days with a primary diagnosis of VTE disease	No more than 74 (equates to last years endpoint; 50% reduction in 2 years=86)	71 (Jan – Oct)
Patients with VTE disease where it is not the primary diagnosis	No more than 172 (50% reduction in 2 years)	158 (Jan – Oct)

Table 7 – VTE progress
For 2012, we are on track to see a 50% reduction in patients readmitted with VTE within 90 days and patients who are admitted to hospital for another reason who also have VTE disease, some of which has developed during their stay as well as halving the deaths.

Catheter-associated urinary tract infection

A catheter-associated urinary tract infection (CAUTI) occurs when germs (usually bacteria) enter the urinary tract through the urinary catheter and cause infection. CAUTIs have been associated with increased morbidity, mortality, healthcare costs, and length of stay.

The presence of a urinary catheter, and the duration of its insertion, is a contributory factor to the development of a urinary tract infection.

The key actions undertaken during the year have been:

❯ Initiatives such as, daily reviews of patients with a urinary catheter by the Medical and Surgical surveillance nurses and members of the Infection Prevention and Control Team to heighten awareness relating to optimal catheter management and prompt removal of catheters reinforced at ward/ departmental level

❯ A weekly catheter count to highlight to each ward team the use of catheters compared to other areas with a view to week on week reduction. The Infection Prevention and Control Team have considered the benefits of the weekly catheter counts currently being monitored and believe that the data is not significant unless the reason for catheterisation is explored and deemed to be unnecessary

In doing so, the catheter count will relate to catheters that are not clinically indicated and will clearly identify those areas where further education and training is required to avoid unnecessary catheterisation and encourage prompt/early removal of catheters as they are no longer indicated

The information will continue to be shared with Ward Sisters, Matrons and Lead Nurses and any issues escalated through the Directorate Infection Prevention & Control assurance reports

❯ Promotion of continence products, where appropriate, to be used as an alternative to catheterisation thereby reducing the potential for infection

❯ The CAUTI group which includes staff from both the hospital and community have continued to meet bi monthly with the aim of discussing new initiatives which benefit patients throughout the whole health economy

❯ The patient `Catheter passport` which is given to all patients with a urinary catheter to inform them of how their urinary catheter should be cared for has been amended to include the risks and benefits of a urinary catheter as recommended by NICE guidance. The passport which has been approved will be available for use within the hospital and the wider community shortly

❯ A nurse led protocol has been discussed at a recent CAUTI group and is being amended to meet local needs. The nurse led protocol will guide and empower nurses in making the decision to remove a catheter

❯ The Infection Prevention and Control Team are working closely with supply staff and the company representative to ensure appropriate supplies are available on all wards to enable staff to select the most appropriate catheter for the patient requiring catheterisation.

This includes working with the company to review the content of the insertion packs to reduce the likelihood of infection and improved labelling will assist staff with correct product selection.

The results of an audit performed by the Infection Prevention and Control Team in October 2012 identified a 45% reduction in CAUTI since a baseline audit performed in 2010 (5% (2012) compared to 9% (2010)). The audit identified 6 patients to have a CAUTI. Three of these patients had acquired the infection prior to coming into hospital with 3 patients having acquired a CAUTI whilst in hospital. Several recommendations have been made based on the findings of the audit with the aim of making further reductions in CAUTI over the forthcoming year.

These include:

❯ A urinary catheter guideline/policy to be devised in order to guide the organisation in order to provide a basis for consistent decision making

❯ A review of the literature surrounding silver coated catheters for short term use

There is evidence that patients that perform intermittent self catheterisation (ISC) are less at risk of developing a urinary tract infection than those with a urinary catheter. Therefore, urinary nurse practitioners are to promote the use of intermittent self catheterisation (ISC) as an alternative to an indwelling catheter

❯ Bladder scanning accurately identifies whether a patient is retaining urine in their bladder. It is recommended that all wards should have access to a bladder scanner to enable urinary retention to be accurately diagnosed with the aim of preventing inappropriate catheterisation occurring

❯ All patients with a long term catheter and where a clear rationale for the catheter is not clearly documented are to be reviewed by a urology nurse practitioner

❯ A further audit is to be repeated during April 2013.

The repeat audit performed in April 2013 again identified a CAUTI of 4%, demonstrating that we have reduced CAUTIs by at least 50%. On this occasion, none of the infections were believed to have been acquired whilst in hospital, demonstrating that the initiatives introduced to further reduce CAUTIs in hospital have had a positive impact.

Whilst the target for pre and post 48 hr CAUTIs has been achieved, there is a little more work to be done to place more emphasis on the management of urinary catheters within the community including work to reduce the numbers of unnecessary catheterisations.

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3.2 External reviews

During the year the Trust has had a number of external reviews of its services, examples of which are set out below:

NHS Litigation Authority -

The Trust was successful in July 2012 in an external two day assessment by the NHS Litigation Authority where we maintained our Level 2 status which demonstrated that we are implementing the policies covered by the standards. The assessment went very well and we passed 48 out of the 50 standards. The assessors were very impressed with the wards visited and the standard of nursing documentation in particular. They commented on how helpful our staff had been and how well set out our evidence had been.

It is really important that the changes we made before the assessment are embedded into everyday practice as this will deliver safer care and help as we work towards level 3 accreditation in December 2013; level 3 organisations are those assessed at lowest risk in terms of patient safety.

Stroke Peer Review -

Cheshire and Merseyside Cardiac and Stroke Network have introduced a peer support visiting scheme, the purpose of which is to explore and share good practice among all the stroke units within the Network. The inaugural visit was conducted at Wirral University Teaching Hospital in April 2012. All members of the visiting team felt the visit had gone very well and were very impressed with the team work and very obvious commitment of all the people they met, to develop and deliver the highest quality services for stroke patients.The quality of stroke care is

reflected in the Sentinel Audit 2010 report and Wirral has maintained its position in the top quartile of performing Trusts.

There are challenges ahead due to increasing demand and expectation, staffing levels and increasing financial constraints, but the Wirral team are well placed to tackle these difficulties and ensure that services progress and high quality care is maintained.

National Cancer Patient Experience Survey -

This publication specifically identifies the experience of our patients who have cancer. There are 9 new questions in this year's survey, including an overarching question asking patients to rate their overall care. This came out with 88 per cent of patients rating their care 'excellent' or 'very good'. On most questions scores have improved, with the most significant increases in positive scores seen on information and communication issues. Areas where Trust results were below the national average were questions involving information on support groups, financial help, free prescriptions, trials and cancer research. Another area where improvements were required related to pain control for day care / outpatients. Each Multidisciplinary Team featured in the report will produce an individualised action plan to address the issues identified, which will be monitored as part of their annual review process.

PEAT Inspections Results -

An important national survey has recognised the quality of food, privacy and dignity and the clean environment at both of our hospitals.

The Patient Environment Action Team (PEAT) survey, which is carried out by the National Patient Safety Agency, assesses every hospital in the country to come up with an overall rating, ranging from 'excellent' to 'unacceptable'. The 2012 survey published in July awarded our hospitals an 'excellent' rating for providing the highest standards of food. This includes the choice, quality, quantity, nutritional value, presentation and temperature of food provided during protected meal times. For both hospitals, the survey also gave 'excellent' ratings for the environment in which care and treatment is provided for patients and for the Trust's role in maintaining patients' privacy and dignity.

Scores on the Doors -

This is a National Scheme run by all councils where the Environment Health Team visit and assess commercial catering outlets/services. This is the first time that the Trust has been assessed and we were awarded the highest score for Bowmans, Firtrees, Lite Bites, Annabelles and the League of Friends catering services.

The Microbiology Joint Laboratory Implementation Team -

Comprising of staff from Wirral and Chester Trusts was selected as a winner of an Outstanding Achievements Award at the Countess of Chester's annual Celebration of Achievement Awards. The team received the award in recognition of the hard work and dedication it demonstrated to successfully develop and implement the new single site microbiology laboratory, Micropath, within challenging targets and with minimal disruption to clinical users. Micropath won the Hospital Financial Management Association efficiency award for 2012.

Incident Reporting -

The latest National Patient Safety Agency figures on incident reporting show we are the second highest reporter in the large acute hospital group with fewer incidents causing harm (less than 1%). This is considered to be indicative of a better and more effective safety culture as we are informed about incidents and can respond and learn from them.

The COPD and Oxygen Service team -

Won the prestigious national 'Vision' award for their work with the Wirral Health Commissioning Consortium on the Wirral Self Care Initiative. The Self Care Initiative delivers intensive support for COPD (chronic lung disease) patients in Primary Care. This nurse led service aims to support patients to manage their own condition and avoid where possible, admission to hospital. As well as supporting a reduction in admissions to hospital, patients have felt empowered to manage their condition as a result of this service.

Integrated Library Service -

The Integrated Library Service has been awarded a score of 95% compliance against their recent submission for the national Library Quality Assurance Framework 2012 assessment. The Integrated Library Service team worked extremely hard to supply the evidence to match all the criteria required for the Library Quality Assurance Framework. This award demonstrates the commitment to support Trust staff to deliver the best most effective care.

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3.3   Local and National Quality Indicators

Advancing Quality

Advancing Quality includes improving care of people who have acute myocardial infarction (heart attack), community acquired pneumonia, stroke, hip and knee replacement and heart failure.

Advancing Quality is about ensuring we provide the right treatment to the right patients at the right time. It involves measuring key actions that are identified as good practice in the diseases concerned.

There is normally a 3-6 month time lag in the availability of reports on the key indicators in the Advancing Quality Initiative programme.

The most recent validated data available relates to 2011/12 and shows improvement in all areas. During 2012/13, new measures were piloted and these will be included for 2013/14.

These new measures are more challenging to deliver. The measure of success will also change in 2013/14 to reflect whether individual patients received all the care they were entitled to.

Indicator	2010/2011	2011/2012	2012/2013 (Apr - Dec)
Acute Myocardial Infarction	99.23	99.70	98.71
Heart Failure	82.89	84.59	87.76
Hip & Knee Replacement	97.62	97.46	96.53
Community Acquired Pneumonia	83.70	82.35	88.88
Stroke	89.59	93.35	97.56

Table 8 – Advancing Quality Results

National Quality Indicators

Wirral University Teaching Hospital NHS Foundation Trust considers that this data is as described due to the systems in place to collect accurate and reliable information, in a timely manner that is quality checked throughout the collection process.

Aspects of the data collection systems are subject to internal scrutiny and internal and external audit and where there are deficiencies actions are put into place to address the issues identified.

The trust would like to include national bench mark data to illustrate comparative performance. However the data publically available is not current enough to be meaningful.

We have taken action throughout the year to improve both data collection and the quality of our services and this is described in other sections of this Quality Account.

For example with regard to the Summary Hospital-level Mortality Indicator (SHMI) we have spent time improving our data quality to make sure it is as complete as possible so that the risk assigned is accurate and reflects the patients' true condition.

We introduced seven day Medical Specialty Ward rounds which means patients will be reviewed by a relevant senior doctor whatever day they are admitted, within 24 hours. This will help to ensure patients receive the best care in a timely way and this consistency of practice should ensure better outcomes.

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Local and National Indicators

The indicators in this section have been identified by the Board in consultation with stakeholders or are a national requirement and are monitored throughout the year.

In comparison to the published Quality Account for 2011/12 a number of the indicator values have changes:

❯ In 2011/12 serious incidents have reduced; this reflects the number of investigations that were completed after the Quality Account was published where there was no evidence that the care received caused serious harm or death

❯ In 2012/13, there has been a rise in the proportion of incidents reported that resulted in serious harm or death. Again the data has been extracted in advance of all the investigations being completed and this indicator may reduce further. However, due to the judgmental nature of this indicator it is difficult to be certain that all incidents are identified and reported and that all incidents are classified consistently within the organisation and nationally. One individual's view of what constitutes severe harm can differ from another's substantially. As a Trust we work very hard to ensure all our staff are aware of and comply with internal policies on incident reporting and standardisation in clinical judgements

❯ NPSA reporting rates: there was a printing error in the Quality Account 2011/12 where the data for April to September 10 and April to September 2011 were transposed

❯ The Trust has changed from CKHS to Dr Foster to monitor indicators. The way these are defined varies between the tools and so the data reported in 2011/12 for readmissions, average length of stay and mortality have changed. In this report all have been reported from Dr Foster to reduce confusion

❯ Staff respondents who would recommend the Trust to friends and family; we have replaced the measure with the percentage quoted in the National Staff Survey and this is a more meaningful figure than used previously.

❯

**The number of serious incidents reported may change as when the investigation is complete, if there are no issues of concern identified the incidents is regarded as not serious.

Table 9 Local and National Quality Indicators

	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013
Safety measures reported					
"Never events" that occurred in the Trust These are a national list of 25 applicable incidents that should never occur (March 2010).	0	1	0	1	2
Serious Incidents reported, investigated and remain serious (as of 31/03/2013)	42	57	94	88	96**
Reports made to the National Patient Safety Agency by the Trust and percentage of incidents reported that resulted in serious harm or death. (as of 31/03/2013)			8,280 0.1%	9,610 0.1%	13,120 0.2%**
National Patient Safety Agency Rate of patient safety incidents (per 100 admissions) and % resulting in severe harm (NB Figures relate to April – Sept 2012 only)			7.8 <1%	9.7 <1%	12.6 <1%
Clinical outcome measures reported					
Hospital Standardised Mortality Ratio (HSMR) - an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect (Dr Foster data)			102.8	108.4 (range 102.6–114.4)	101 (range 95–107) (Apr- Jan 2013)
Summary Hospital-Level Mortality Indicator SHMI value and banding (National Information Centre data) % of Admissions with palliative care coding % of Deaths with palliative care coding (Dr Foster data) (*Data period: Oct 2011-Sep 2012)				105.0 (range 89-112) Band = 2 as expected 0.59% 12.70%	110.0 (range 89-112) Band = 2 as expected *0.71% *16.03%
% of admitted patients risk assessed for VTE			45.6%	95.4%	95.0%
% of admitted patients who had risk assessment for malnutrition (MUST)					82.4%
% Emergency Readmissions within 28 days				7.7	8.0
Average length of stay (days)				4.4	4.6
Patient experience measures reported					
Number of complaints received by the Trust	356	362	401	422	515
% complaints responded to within agreed timescale	87%	90%	80%	59%	38%
% patients who felt they were treated with dignity and respect (from Learning with patients survey)	88%	90%	98%	99%	98%
Responsiveness to inpatients personal needs (from National Patient Survey)			65.1%	67.4%	71.2%
Staff respondents who would recommend the Trust to friends or family needing care (from National Staff Survey)				58%	61%

![Quality Account logo]

Quality Account

Serious Incidents

It is of great concern that the Trust has reported two Never Events during this year. One involved wrong site surgery (radiological procedure), one a retained swab and the other one a retained pack. In both cases the patient did not experience significant/serious harm. However it is recognised that the incidents were very serious and actions taken to prevent these incidents occurring again include specific raising awareness of the Never Events with relevant teams, changing theatre practice, ensuring robust use of the WHO surgical checklist and introducing visual cues, revising induction for radiographers and reduction of interruptions in the interventional suite.

Reducing Hospital Acquired Infection

The Trust has continued to follow a proactive focussed improvement programme to reduce hospital acquired infections.

The key actions undertaken this year to prevent hospital acquired infections have been:

❯ The Hydrogen Peroxide Vaporiser (HPV) programme continued intermittently due to bed pressures resulting in the loss of the decant ward on several occasions. HPV cleaning of dirty utility areas also continued on wards were cases of Clostridium difficile were identified.

❯ The Meticillin Resistant Staphylococcus Aureus (MRSA) strategy continued with all patients known to have MRSA previously or currently being reviewed each day to ensure that all precautions are in place to avoid MRSA transmission.

Unfortunately, we reported two hospital attributed bacteraemias, one of which was deemed to be unavoidable by the group investigating the case.

The second was avoidable and the investigation highlighted learning outcomes for the Trust which were shared Trust wide and acted upon to prevent such an avoidable infection occurring in the future.

The MRSA Medical Action Sheet was relaunched to ensure that the MRSA status of all patients is identified as near to admission as possible to make sure that the appropriate MRSA management has been initiated.

❯ A new strain of resistant organism known as Carbapenemase Producing Enterobacteriaceae (CPE) has been identified on some wards within the Trust. Key to the control of this organism is early identification and prompt isolation and control measures The Trust has a robust plan in place which has been successfully implemented.

❯ From November through to the end of March, Arrowe Park Hospital was affected with a new strain of Norovirus. Prior to the outbreak, bay doors had been installed on many wards throughout the hospital, to minimise the risk of transmission of this highly infections virus.

Whilst this was a prolonged norovirus outbreak, potentially due to the circulation of the new strain throughout the community, fewer patients became affected; wards were closed for shorter periods which resulted in fewer bed days lost.

Period	MRSA Bacteraemia Cases	Target	Clostridium Difficile Cases	Target
2008/2009	10	18*	209	358
2009/2010	8	18*	187	260
2010/2011	5	6	120	190
2011/2012	1	5	68	120
2012/2013	2	0	27	50

Table 10   Infection Control Maximum Targets for MRSA and Clostridium Difficile cases
*this was a combined target set for the Trust and the PCT services

Quality Account

National Targets

For the key infection control performance indicators, the Trust was well below the maximum number of cases allowed. There were two cases of MRSA bacteraemia all year, and the number of hospital acquired Clostridium Difficile cases was significantly lower than the maximum trajectory at 27 cases for the year.

Against the Cancer standards, the Trust has achieved all the requirements across every quarter of 2012/13, and in many cases performing better than the minimum expected.

The Trust delivered all three of the Referral to Treatment (18 week) standards in all quarters across 2012/13, including the new and challenging requirement that no more than 8% of patients awaiting treatment shall wait longer than 18 weeks.

For patients attending the Trust's Emergency Department, the waiting time standard of 95% within 4 hours was achieved for the first three quarters in 2012/13, in conjunction with the All Day Health Centre located at the Arrowe Park site.

However due to considerable pressures in quarter 4, particularly on beds, the target was not achieved in this final quarter of the year. Considerable work has gone into evaluating and improving the emergency patient pathways to ensure this important standard is achieved for quarter 1 of 2013/14 and beyond.

Achievement against national targets and indicators are set out in table 11 opposite.

National targets and regulatory requirements	Target	Q1	Q2	Q3	Q4
Clostridium Difficile – maximum number of cases	Max 50	7	7	5	8
MRSA – maximum number of cases	Max 0	0	1	1	0
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	Min 96%	97.1%	97.7%	99.0%	97.9%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer (two targets)	Min 94% or 98%	96.6% and 100%	97.9% and 100%	97% and 100%	94.1% and 100%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	Min 85%	85.6%	86.0%	85.6%	87.1%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	Min 93%	95.4%	95.5%	95.5%	97.0%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all breast symptom referrals	Min 93%	95.8%	97.7%	93.8%	99.0%
Referral to treatment time within 18 weeks – admitted patients	Min 90%	93.9%	92.6%	92.9%	92.8%
Referral to treatment time within 18 weeks – non-admitted patients	Min 95%	97.2%	96.6%	97.8%	97.8%
Referral to treatment time within 18 weeks – incomplete pathways	Min 92%	93.1%	92.2%	92.3%	92.1%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Min 95%	95.5%	95.4%	95.1%	91.4%

Table 11 National targets and regulatory requirements

It is also of note that although all national targets were met for the first three quarters of 2012/13, WUTH was still considered to be in breach of the Terms of Authorisation by Monitor due to the failure against the Referral to Treatment (RTT) admitted standard for three consecutive quarters of 2011/12. In quarter 4 (February 2013) it was confirmed by Monitor that due to the sustained improvement in performance and revised Governance arrangements, the Trust was no longer in breach of the Terms of Authorisation.

The Health and Social Care Information Centre is a relatively new development that provides comparative benchmarking for organisations against a range of indicators. These data are not always as timely as other data reported from local sources, and may not refer to this financial year. However, it does provide some information about how the Trust has performed relative to other organisations as it compared WUTH position with the national average, as well as the lowest and highest indicator values nationally. This section of the Quality Account will be expanded in future years as more data become available.

Quality Account

Summary Hospital Mortality Indicator

The SHMI is "as expected" for the Trust. Actions are ongoing to reduce deaths as noted in our priority areas. We would not anticipate that the work undertaken to date will impact until the SHMI reflects 2012/13 data. It should be noted that the palliative care coded deaths in the Trust are generally lower than average; given the local demographics this would suggest under recording and is an area of coding practise that has been reviewed this year:

	July 2011 – June 2012				October 2011 – Sept 2012			
	National Average	WUTH with banding	Low	High	National Average	WUTH with banding	Low	High
SHMI	1.0	1.098 (as expected)	0.710	1.256	1.0	1.10 (as expected)	0.685	1.211
% Deaths coded for palliative care	18.4%	13.0%	0.3%	46.3%	18.9%	16.0%	0.2%	43.3%

Table 12 Summary Hospital Mortality Indicator

Patient Reported Outcome Measures

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys. The data have been collected since 2009.

The adjusted average health gain looks at how much better patients' health is after their surgery than before; therefore the higher the figure the better the result. In 2012, we had above the national average adjusted average health gain for groin hernia repairs, and varicose veins with similar to national average values for hip and knee replacement. All indicators were improved on the previous year:

Adjusted Average Health Gain	April 2011 – March 2012				April 2012 – December 2012			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Groin Hernia	0.087	0.080	- 0.002	0.143	0.090	0.102	0.017	0.153
Hip Replacement	0.416	0.401	0.306	0.532	0.429	0.426	0.328	0.500
Knee Replacement	0.302	0.322	0.180	0.385	0.321	0.328	0.201	0.408
Varicose Vein	0.094	0.093	0.047	0.167	0.089	0.136	0.027	0.138

Table 13 Patient Reported Outcome Measures

Quality Account

Readmissions within 28 days

The emergency readmission rate to the Trust is higher than the national average and is an area we need to improve. There is a work stream in place to reduce avoidable admissions:

	April 2009 – March 2010				April 2010 – March 2011			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Readmissions (aged 0 – 15)	10.18	14.00	3.7	31.4	10.15	13.91	3.53	25.8
Readmissions (16 and over)	11.16	13.10	3.22	22.09	11.42	12.47	2.38	22.93

Table 14 Readmissions within 28 days **NB: these data do not reflect the age ranges stipulated in the national guidance; however the HSCIC does not use the age 15 split in the data available.**

Trust's responsiveness to the personal needs of its patients

Responsiveness to personal needs is a high level indicator bringing together patients responses from the national inpatient surveys.

The Trust is keen to learn from our patients experience and there is ongoing work to improve this. The 2012/13 survey has shown good improvement. However, in 2011/12 the performance was average:

	April 2010 – March 2011				April 2011 – March 2012			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Responsiveness to personal needs (indicator Value)	67.3	65.1	56.7	82.6	67.4	67.4	56.5	85

Table 15 Trust's responsiveness to the personal needs of its patients

Recommend the Trust to Family and Friends

In the National Staff Survey, staff rate whether they would recommend using the organisation to family and friends. Again, these data are historic and the 2012 survey shows an improved picture:

					Staff Survey 2011			
	National Average	WUTH (No's/Rate per 100 patient admissions)	Low	High	National Average	WUTH (No's/Rate per 100 patient admissions)	Low	High
Agree / Strongly Agree (%)					60	55	21	96

Table 16 Recommend the Trust to Family and Friends

VTE assessment – based on acute trusts

The Trust has maintained above average performance throughout the year in assessing patients for VTE disease; the latest two quarters are reported:

	Q2 2012/13				Q3 2012/13			
VTE Risk Assessment	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Compliance (%)	93.8	95.0	80.9	100	94.1	95.0	84.6	100

Table 17 VTE assessment – Based on acute trusts

C.difficile rates

The Trust has seen a significant reduction in C.difficile infection rate. In 2012/13, the absolute of infections has fallen further:

	April 2010 – March 2011				April 2011 – March 2012			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
C.difficile (rate per 100,000 bed days)	29.6	45.5	0.0	71.8	21.8	25.2	0.0	51.6

Table 18 C.difficile rates

Patient Safety Incidents Reported, based on large acute trusts

The Trust has one of the highest incident reporting rates nationally. This is associated with low levels of harm and NPSA consider this to be a sign of an open culture. We also actively encourage automated electronic reporting in some areas to ensure better coverage of incidents and support monitoring the impact of our safety work:

					April 2012 – Sept 2012			
	National Average	WUTH (No's/Rate per 100 patient admissions)	Low	High	National Average	WUTH (No's/Rate per 100 patient admissions)	Low	High
Patient Safety Incidents					4,060	6,259 (12.6)	859	6,485
					The Trust reported 8 incidents that resulted in severe harm or death			

Table 19 Patient Safety Incidents Reported, based on large acute trusts

Annex: Statements from Third Parties

Statement from Wirral Clinical Commissioning Group

As lead commissioner Wirral CCG is committed to commissioning high quality services from Wirral University Teaching Hospital. We take very seriously our responsibility to ensure that patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened and acted upon.

This is especially poignant with publication of the Francis report into Mid Staffordshire Hospital and the recommendations included within the report. This account reflects quality performance in 2012/13 and clearly sets out the direction regarding quality for the 2013/14.

Working in partnership with the Trust, a set of challenging local CQINs were developed during the last contracting round. We are pleased to see that the year-end position in relation to the CQUINs shows that the Trust has achieved both at a the national and local level. This demonstrates the attention that the Trust has shown in maintaining and improving quality in these areas.

We acknowledge that it has been a challenging year for the Trust by being in breach of the terms of authorisation by Monitor due to the failure against the referral to treatment target. Due to sustained improvement in performance and revised governance arrangements, it was confirmed in February 2013 the Trust was no longer in breach of the terms of authorisation.

There are still some areas of concern that have been highlighted by the CCG including: Grade 3 and 4 Pressure ulcer formation. We welcome the increased focus on preventing pressure ulcers and look forward to seeing the evidence of significant improvement in 2013/14.

We acknowledge the improvement programme that has been undertaken throughout the year to reduce hospital acquired infections and significant improvements have been made in this area. Hospital attributed MRSA remains a challenge to the Trust with 2 cases reported for this period against a target of zero.

Looking forward the CCG is reassured that the priorities for improving quality that have been identified by the Trust are priorities for the CCG and include;

Patient experience, including the improvement of responses to patient concerns and complaints; safety including reducing the number of unnecessary inpatient bed moves; clinical effectiveness including reducing the in hospital standardised mortality rate.

We believe that this quality account gives a high profile to continuous quality improvements in Wirral University Teaching Hospital and the monitoring of the priorities for 2013/14.

Wirral Clinical Commissioning Group looks forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2013/14.

Phil Jennings, Chair
Wirral CCG
May 2013

Quality Account

Commentary by Wirral LINk for WUTHFT Quality Account 2012/13

Report reviewed was Draft 3, dated 2 April 2013.

Wirral LINk would like to thank WUTHFT for the opportunity to comment on the Quality Account for 2012/13. On 1st April 2013 Healthwatch Wirral, a new Community Interest Company, was launched.

This organisation replaces LINk and is the local independent consumer champion for the public. A sub group of LINk, who look at Quality Accounts for NHS Trusts, met to discuss and compile this response.

The Quality Account for WUTHFT has been put together in a format that is relatively easy to understand. However, an Easy Read version produced before the deadline, for comment by Healthwatch Wirral, would be appreciated next year.

Over the last year WUTHFT have welcomed LINk's input on improving patient experience and have included LINk at a strategic, decision making level.

Chief Executive's Statement.

Wirral LINk were pleased to be informed that the number of assessments WUTHFT had during the year had positive outcomes including Level 2 NHS Litigation Authority assessment. This reflects the hospitals safety culture and implementation of guidance for safer care.

Patient Experience Priorities

❯ Improve Complaints Handling

It was noted that the number of complaints received by the trust this year had increased and the percentage of complaints responded to within the agreed timescales had fallen.

Therefore the Trust were not responding to complaints in the timescales that they had agreed. It was also noted that the figures for complaints in Table 9 for year 12/13 were yet to be validated. Because of this LINk cannot make a judgement at this time.

LINk agreed that improving the handling of complaints should be a priority for 2013/14. However, the 80% target to be achieved was thought to be low.

❯ Improve on the National Inpatient Survey Results

LINk agreed with this priority but thought that a copy of the Friends and Family test should be included in the document.

Safety Priority

❯ Minimise unnecessary in-hospital bed moves

LINk agreed with this priority and target for 2013/14. They were glad to see that there had been a significant improvement from the previous year's audit.

Clinical Effectiveness Priority

❯ Reduce the in-patient risk adjusted mortality index

It was noted that the Trust remains above their peer group and needs to do better. It is anticipated that the target will be met for 2013/14

❯ Achieve goals set out in Safety Express Programme.

50% reduction in serious harm and death from preventable falls in hospital on last years figures.

It was noted that there has been a reduction in preventable falls since the previous year and that the Trust is on track to achieve its target of a 50% reduction in preventable serious falls by the end of the year. However, the figures in this document were yet to be confirmed and validated. LINk welcomed the use of assisted technology in the key actions and would recommend that this is used in other wards.

80% reduction in stage 3 and 4 pressure ulcers developed in the hospital.

It was noted that there was a reduction in stage 4 ulcers developed in hospital. Stage 3 ulcers however had increased (documented in Table 6) the figures for Quarter 4 were yet to be confirmed and validated. Some figures include current investigations and may reduce when investigations are completed.

The Trust appears to be taking steps to prevent occurrences but LINK note with regret that they are not on target to achieve the target of 80% reduction in stage 3 pressure ulcers developing.

50% reduction in preventable venous embolic events.

LINk were pleased with the work being done to lower the incidence of VTE but were concerned about the readmission rates in table 7. The target and figures for Jan-Sep were not easy to understand so LINk felt unable to make an informed comment.

50% reduction in urinary tract infections in patients with in-dwelling catheters on 2012/13 prevalence study.
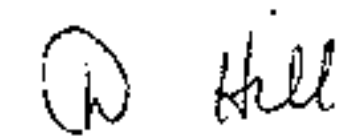
LINk were glad to be informed that the Trust is on target to achieve its target of 50% reduction in urinary tract infections in patients with in-dwelling catheters. This information will be confirmed in April or early May.

Local and National Quality Indicators.

❯ Advancing Quality

LINk note the improvements in the most recent validated data shown in table 8. It was also noted that the data for 2012/13 is yet to be confirmed.

Finally, Wirral LINk has had a very well established and respectful relationship with WUTHFT and looks forward to continuing this as Healthwatch Wirral in the future.

Diane Hill (Chairman)
29 April 2013

Quality Account

Glossary for Quality Account

Abbreviation / term	Definition
AQ	Advancing Quality
CAUTI	Catheter Associated Urinary Tract Infection
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease – chronic lung disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
Composite scores	Composite scores are calculated from data in multiple variables in order to form reliable and valid measures
Confidential enquiries	National reviews that assess the quality of care patients receive
CPE	Carbapenemase Producing Enterobacteriaceae – new strain of resistant organism
DASS	Department of Adult Social Services
DME	Department of Medicine for the Elderly
ECIST	Emergency Care Intensive Support Team
EAU	Emergency Assessment Unit
ERP	Enhanced Recovery Programme
FCE	Finished Consultant Episode
FFT	Friends and Family Test – a question contained within the national inpatient and staff survey
HPV	Hydrogen Peroxide Vaporiser
HES	Hospital Episode Statistics
HSMR	Hospital Standardised Mortality Rate
ISC	Intermittent self catheterisation
LAU	Lung Assessment Unit

LINK	Local Involvement Network forum (Wirral) to feedback from local community for the Trust to consider and completes specific projects relating to local health and social services. Healthwatch will take over this role from April 2013.
LWPQ	Learning with Patients Questionnaire – an internal patient survey
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
MEWS	Medical Emergency Warning Score
MHRA	Medicines and Healthcare-products Regulatory Agency
MUST	Malnutrition Universal Screening assessment Tool
MRSA	Meticillin Resistant Staphylococcus Aureus – bacteraemia; this is a blood stream infection
NCEPOD	National Enquiry into Patient Outcome and Death
NHSLA	NHS Litigation Authority
NICE	National Institute of Clinical Excellence
NIHR	National Institute of Health Research
OPRA	Older Persons Rapid Assessment
PCT	Primary Care Trust , NHS Wirral
PEAT	Patient Environment Action Team
RAMI	Risk Adjusted Mortality Index
RTT	Referral to Treatment – time taken from referral to treatment
Safety Express	Safety Express is a single programme which focuses on system re-design of fundamental care processes and behaviours.
SHMI	Summary Hospital-Level Mortality Indicator
TARN	Trauma Audit Research Network
VTE	Venous Thrombo-Embolism or blood clot in the vein
WUTH	Wirral University Teaching Hospital

Quality Account

Services Provided by the Trust

DIAGNOSTICS DIVISION (16)	
Radiology Plain Film Imaging Service	Laboratory Services Clinical Biochemistry
Radiology MRI	Laboratory Services Haematology and Blood Transfusion
Radiology CT Services	Laboratory Services Histopathology/Cytology/Mortuary/ Andrology/Immunology
Radiology Fluoroscopy	Laboratory Services Medical Microbiology
Radiology Interventional Services	Laboratory Services Point of Care Testing
Breast Screening and Symptomatic Mammography	Laboratory Services Phlebotomy
Radiology Ultrasound	Infection Control
Pharmacy	Allied Health Professional services

MEDICAL SPECIALTIES DIVISION (13)	
Cardiology	Diabetology and Endocrinology
Clinical Haematology	Respiratory Medicine
General Medicine	Rehabilitation
Gastroenterology	Medicine for the Elderly
Nephrology	Rheumatology
Palliative Care Consultant Service	Stroke Medicine
Genito-Urinary Medicine	

ACUTE CARE (3)		
Emergency Medicine	Childrens Emergency Medicine	Acute Medicine

SURGICAL DIVISION (13)	
Critical care	Vascular Surgery
Dermatology	Breast Surgery
Ear, Nose & Throat including Audiology	Upper and Lower Gastro-intestinal Surgery
Oral Surgery	Ophthalmology
Orthodontics	Pain service
Trauma & Orthopaedics	Limb Centre
Urology	

WOMENS' AND CHILDRENS' DIVISION (14)	
Gynaecology	General Paediatrics
Neonatology	Community Paediatrics
Obstetrics	School Nursing
Midwifery Led Unit	Paediatric audiology
Milkbank	Childrens Hospital at Home
Fertility Services	Child Health Surveilance
Pregnancy Counselling	Children's Continuing Care Team

CORPORATE SERVICES (12)	
Corporate Nursing and Midwifery includes Patient Experience	Quality & Safety Department includes Research and Development
Hotel Services	Human Resources and Organisational Development
Facilities Management	Finance and Procurement
Information Governance	Executive Management
Information Management and Technology	Kaizen Promotion Office
Bed Management	Outpatient Services

❯ Appendix 2

National Clinical Audits for Inclusion in Quality Accounts 2012/13
*Information for National Clinical Audits to be completed prior to approval
of the Quality Account in May 2013

	Name of audit / confidential enquiry	Latest report link	Data collection 2012/13	Participation Yes/No Number and Percentage	Report received and Reviewed Y/N/NA	Actions Taken and Comments
1	Adult community acquired pneumonia (British Thoracic Society)	Latest summary report (publ October 2011) >>	Yes	No	N/A	The Trust participates in the Advancing Quality initiative regarding adult Community Acquired Pneumonia.
2	Adult critical care (Case Mix Programme – ICNARC CMP)	Latest annual report (publ 2011) >>	Yes	Yes 1069 100%	Yes April 2013	Not yet reviewed
3	Emergency use of oxygen (British Thoracic Society)	Presentation of latest audits (publ 2011) >>	Yes	No	N/A	
4	Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Latest report (publ October 2012) >>	Yes	Yes	Yes	Reviewed with action plan at CGLN. Action plan now on the risk register.
5	National Joint Registry (NJR)	Latest annual report (publ Sep 2012) >>	Yes	Yes 898 100%	Yes	Dedicated member of staff identified to ensure data is completed and improved system of collecting information.
6	Non-invasive ventilation - adults (British Thoracic Society)	Latest summary report (publ October 2011) >>	Yes	Yes	No	
7	Renal colic (College of Emergency Medicine)	Link to summary report (publ April 2011) >>	Yes	Yes 50 100%	Yes Received March 2013	Not reviewed yet
8	Severe trauma (Trauma Audit & Research Network, TARN)	Reports sent quarterly direct to Trusts. To see 'performance comparisons', click here >>	Yes	Yes 155 (Apr-Dec 12) 53%. Expected a decrease in numbers due to the bypass of patients to the Trauma Centres and not reflected in HES data.	Yes Received March 2013	The Trust adopted London Trauma document to comply with the Trauma Network guidelines. This includes the rehabilitation prescription for trauma patients. Emergency Dept. Staff have been trained in completion of trauma documentation to collect the best possible info and most applicable data required.
9	Bowel cancer (NBOCAP) (Subscription funded from April 2012)	Latest annual report (publ December 2012) >>	Yes	Yes 190 100%	Yes	Audit showed low results for patients being seen by the Clinical Nurse Specialists (CNS) - the MDT felt that this was a documentation issue as the CNS acts as the patients' Key Worker. This data is now captured via the Somerset Database in the MDT meetings. Consultants record introduction of CNS to patients in OPD letters.
10	Head and neck oncology (DAHNO) (subscription funded from April 2012)	Latest annual report (publ June 2012) >>	Yes	Yes 53 100%	Yes	
11	Lung cancer (NLCA) (subscription funded from April 2012)	Latest annual report (publ December 2012) >>	Yes	Yes 325 100%	Yes	Action plan in place.
12	Oesophago-gastric cancer (NAOGC) (subscription funded from April 2012)	Latest annual report (publ July 2012) >>	Yes	Yes 113 100%	Yes	No actions required. Action plans led by Aintree Hospital.
13	Acute coronary syndrome or Acute myocardial infarction (MINAP) (subscription funded from April 2012)	Latest annual report (publ November 2012) >>	Yes	Yes 35 100%	Yes	No actions needed

#	Audit	Report				Comments
14	Cardiac arrhythmia (HRM)	Latest annual report (publ September 2011) >>	Yes	No	N/A	
15	Coronary angioplasty (subscription funded from April 2012)	Latest annual report (publ April 2012) >>	Yes	No	N/A	
16	Heart failure (HF) (subscription funded from April 2012)	Latest annual report (publ November 2012) >>	Yes	Yes 40 100%	Received Dec. 2012	Currently developing plan.
17	National Cardiac Arrest Audit (NCAA)	Publication date for first annual report scheduled for 2012 (date TBC)	Yes	No	N/A	
18	National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Latest annual report (publ 2009) >>	Yes	Yes CEA 58 100% AAA 36 100%	Yes	Results in line with national figures. No actions indicated.
19	Pulmonary hypertension (Pulmonary Hypertension Audit)	Latest annual report (publ 2011) >>	Yes	No	N/A	
20	Adult asthma (British Thoracic Society)	Latest summary report (publ May 2012) >>	Yes	No	N/A	
21	Bronchiectasis (British Thoracic Society)	Latest annual report (publ March 2012) >>	Yes	Yes	N/A	Not participated in previous years.
22	Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Latest reports (publ December 2012)>>	Yes	Yes 136 100%	Received March 2013	Not reviewed yet

#	Audit	Report				Comments
23	Diabetes (Paediatric) (NPDA)	Latest annual report (publ 2011) >>	Yes	Yes 102 100%	Yes	Error with data following download to NPDA this resulted in APH and other units being outliers. The error was not identified until the report was published. Concerns were escalated to the NPDA Team who acknowledges the error but is unable to amend the report.
24	Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services	Latest annual reports (publ 2012) >>	Yes	Yes 2 100%	Yes	Action plan on risk register (2042) from previous round - A Joint Colorectal Surgical and Gastroenterology IBD Multi-disciplinary Team has been in place since Jan 2011 where complex cases are discussed with the IBD team. Shared care pathways agreed.
25	National Review of Asthma Deaths (NRAD)	Publication date for annual report scheduled for Autumn 2013 (date TBC)	Yes	Yes	No N/A	Still collecting data
26	Pain database	Latest annual report (publ December 2012) >>	Yes	Yes 67 31%	Yes	No specific actions required
27	Renal replacement therapy (Renal Registry)	Latest annual report (publ December 2010) >>	Yes	Yes 100%	Yes	In top 10 of Trusts, no action required.
28	Carotid interventions audit (CIA) (subscription funded from April 2012)	Latest annual report (publ June 2011) >>	Yes	No	N/A	

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29	Fractured neck of femur	Latest annual report summary (publ 2009/10) >>	Yes	Yes 50 100%	Received March 2013	Not reviewed yet
30	Hip fracture database (NHFD)	Latest annual report (2010) >>	Yes	Yes 384 87%	Yes	The number of MDT meetings has been increased to 3 x weekly to improve capture of data prior to patient's discharge. New clerking proforma has been introduced.
31	National audit of dementia (NAD)	Latest annual report (publ December 2011) >>	Yes	Yes 40 100%	Yes Feb 2012	Dementia care pathway started Introduction of 'This is Me' document Production of a Dementia Awareness training video Use of the 'Forget-me-Not' symbol on ward boards Improved assisting mealtime assistance Reminiscence Pods on DME wards introduced Currently developing plan in response to recent re-audit

32	Parkinson's disease (National Parkinson's Audit)	Latest annual report (publ 2010) >>	Yes	Yes 28 100%	Yes	Action Plan awaited
33	Sentinel Stroke National Audit Programme (SSNAP)programme combines following audits, previously listed separately: a) Sentinel stroke audit (2010/11, 2012/13) b) Stroke improvement national audit project (2011/12, 2012/13)	Latest sentinel annual report (publ May 2011), Latest sentinel organisation of services report (publ December 2012), Latest SINAP annual report (publ March 2012)	Yes	Yes	Yes December 2012	Currently considering report and developing plan.
34	Elective surgery (National PROMs Programme)	Latest annual report (publ August 2011) >>	Yes	No	N/A	
35	Child health programme (CHR-UK)	Publication date for annual report scheduled for 2013	Yes	No	N/A	
36	Epilepsy 12 audit (Childhood Epilepsy)	Progress report (publ 2010) >>	Yes	Yes 330 100%	Yes	Working towards a best practice tariff.

37	Maternal, infant and newborn programme (MBRRACE-UK)*	Latest annual report (publ 2011) >>	Yes	Yes 27 100%	YUes	Action plan developed and placed on Risk Register.
38	Neonatal intensive and special care (NNAP) (subscription funded from April 2012)	Latest annual report (D65 2012) >>	Yes	Yes 406% 100%	Yes	Identified as an outlier for breastfeeding. Staffing numbers in the neonatal unit are below our target (with BAPM standards as our target). Awaiting a decision to recruit further staff. This will allow for increased time for breast feeding support. Recruited a midwife to lead on breast feeding for the Division, with two health care assistants to support her. This is with the aim to provide 24 hour cover for mothers requiring support to initiate and continue breast feeding on the postnatal ward and within the neonatal unit. We have partnered with another Trust to share good practice. The outcome of this was that while our breast feeding rates were low, all possible measures were being put in place. We have a five day (Monday to Friday) service with the Surestart breast feeding / expressing support team. Display outcomes of interest on our neonatal unit "high visibility board" for parents and staff. Includes rates of mother's milk given during the in-patient stay, as well as at discharge. This is reviewed weekly as part of our "care improvement meeting".

39	Paediatric asthma (British Thoracic Society)	Latest summary report (publ June 2011) >>	Yes	Yes 40 100%	Yes	Too many chest x-rays were being performed. An educational package has been put in place to address this issue.
40	Paediatric fever (College of Emergency Medicine)	Latest annual report summary (publ 2010) >>	Yes	Yes 50 100%	Received March 2013	Not reviewed yet.
41	Fractured Neck of Femur (College of Emergency Medicine	Latest annual report summary (publ 2010) >>	Yes	Yes 50 00%	Yes March 2013	Not reviewed yet.
42	Paediatric pneumonia (British Thoracic Society)	Latest summary report (publ October 2011) >>	Yes	No	N/A	

Quality Account

Statement of directors' responsibilities in respect of the quality report

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

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

❱ the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012-13;

❱ the content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2012 to May 2013

- Papers relating to Quality reported to the Board over the period April 2012 to May 2013

- Feedback from the commissioners dated May 2013

- Feeback from governors dated February 2013

- Feedback from LINks dated April 2013

- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2012

- The latest national patient survey (2012)

- The latest national staff survey (2012)

- The Head of Internal Audit's annual opinion over the trust's control environment dated May 2013

- CQC quality and risk profiles dated; April 2012 to March 2013.

❱ the Quality Report presents a balanced picture of the Trust's performance over the period covered

❱ the performance information reported in the Quality Report is reliable and accurate

❱ there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

❱ the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

Chairman
29 May 2013

David Allison (Chief Executive)
29 May 2013

Quality Account

2012 -13 Limited assurance opinion on the content of the quality report and mandated perormance indicators

Independent Auditor's Report to the Council of Governors of Wirral University Teaching Hospital NHS Foundation Trust on the Quality Report. We have been engaged by the Council of Governors of Wirral University Teaching Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Wirral University Teaching Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

❯ **Scope and subject matter**

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

❯ Clostridium Difficile – all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over   that are attributed to the Trust; and

❯ 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".

❯ **Respective responsibilities of the Directors and auditors**

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

❯ the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;

❯ the Quality Report is not consistent in all material respects with the sources specified below; and

❯ the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

❯ Board minutes for the period April 2012 to May 2013;

❯ Papers relating to Quality reported to the Board over the period April 2012 to May 2013;

❯ Feedback from the Commissioners dated May 2013;

❯ Feedback from local Healthwatch organisations dated May 2013;

❯ The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2012/13;

❯ The 2012/13 national patient survey;

❯ The 2012/13 national staff survey;

❯ Care Quality Commission quality and risk profiles 2012/13; and

The 2012/13 Head of Internal Audit's annual opinion over the Trust's control environment. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents").

Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics.

Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Wirral University Teaching Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Wirral University Teaching Hospital NHS Foundation Trust's quality agenda, performance and activities.

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Wirral University Teaching Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Quality Account

❯ Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

❯ Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;

❯ Making enquiries of management;

❯ Testing key management controls;

❯ Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

❯ Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report;

❯ Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

❯ Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability.

The precision of different measurement techniques may also vary.

Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time.

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Wirral University Teaching Hospital NHS Foundation Trust.

❯ Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

❯ the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;

❯ the Quality Report is not consistent in all material respects with the sources specified above; and

❯ the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Timothy Cutler for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants

St James' Square
Manchester
M2 6DS

29th May 2013

treating you well

Financial Statements

Financial Statements

Accounts for the 12 months April 2012 to March 2013

Independent Auditor's Report to the Council of Governors of Wirral University Teaching Hospital NHS Foundation Trust

We have audited the financial statements of Wirral University Teaching Hospital NHS Foundation Trust for the year ended 31 March 2013 on pages 252 to 319. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2012/13.

This report is made solely to the Council of Governors of Wirral University Teaching Hospital NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

❯ Respective Responsibilities of the Accounting Officer and the Auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 252 the accounting officer is responsible for the preparation of financial statements which give a true and fair view.

Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland).

Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

❯ Scope of the Audit of the Financial Statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error.

This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

❯ Opinion on Financial Statements

In our opinion the financial statements:

❯ give a true and fair view of the state of Wirral University Teaching Hospital NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended; and

❯ have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13.

❯ Opinion on other Matters Prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

❯ Certificate

We certify that we have completed the audit of the accounts of Wirral University Teaching Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Timothy Cutler for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants

St James' Square
Manchester
M2 6DS

29th May 2013

Financial Statements

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 the 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 Monitor.

Under the NHS Act 2006, Monitor has directed Wirral University Teaching Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction.

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, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

❯ observe the Accounts Direction issued by Monitor, 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 have been followed, and disclose and explain any material departures in the financial statements and;

❯ prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her 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 NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

David Allison (Chief Executive)
29th May 2013

Foreword To The Accounts

Wirral University Teaching Hospital NHS Foundation Trust

Wirral Hospital was authorised as an NHS Foundation Trust on 1 July 2007. These accounts for the twelve months ended 31 March 2013 have been prepared by Wirral University Teaching Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 in the form which Monitor, with the approval of the Treasury, has directed.

David Allison (Chief Executive)
29th May 2013

Financial Statements

Statement Of Comprehensive Income For The Year Ended 31 March 2013

	NOTE	2012/13 £000	Restated 2011/12 £000
Operating Income	2 & 3	296,992	284,374
Operating Expenses	4	(290,510)	(277,323)
Operating Surplus		6,482	7.051
Finance costs:			
Finance Income	9	281	114
Finance expense - financial liabilities	10	(425)	(488)
Finance expense - unwinding of discount on provisions		(68)	(78)
Surplus for the financial year		6,270	6.599
Public dividend capital dividends payable		(4,320)	(4.254)
Retained surplus for the year		1,950	2.345
Other comprehensive income / (expense)			
Reduction in reserves due to revaluation losses		(326)	(3,336)
Increase in reserves due to revaluation gains		0	2,162
Other Reserve movements		0	(276)
Total comprehensive income / (expense) for the year		1,624	895

The notes on pages 264 to 319 form part of these accounts.

The Statement of Comprehensive Income records the Trust's income and expenditure in summary form in the top part of the statement and any other recognised gains and losses taken through reserves under other comprehensive income.
All income and expenditure is derived from continuing operations. The foundation trust has no minority interest.

Monitor has restated the 2011/12 prior year comparator to improve disclosure quality. Finance lease income is now shown within "Operating Income" (Note 3) rather than "Finance Income" (Note 9), as a result there has been a recategorisation in both categories by £257k.

Financial Statements

Statement Of Financial Position As At 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current assets			
Intangible assets	13	9,572	10,061
Property, plant and equipment	14	156,745	153,872
Trade and other receivables	18	4,430	4,600
Total non-current assets		170,747	168,533
Current assets			
Inventories	17	4,056	3,583
Trade and other receivables	18	10,633	9,964
Cash and cash equivalents	19	24,918	26,196
Total current assets		39,607	39,743
Total assets		210,354	208,276
Current liabilities			
Trade and other payables	20	(32,948)	(31,788)
Borrowings	21	(521)	(493)
Provisions	24	(1,447)	(1,459)
Other liabilities	22	(2,991)	(2,896)
Net current assets / (liabilities)		1,700	3,107
Total assets less current liabilities		172,447	171,640

Statement Of Financial Position As At 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
Non-current liabilities			
Borrowings	21	(6,048)	(6,569)
Provisions	24	(2,716)	(2,578)
Other liabilities	22	(11,069)	(11,503)
Total assets employed		152,614	150,990
Financed by taxpayers' equity:			
Public dividend capital		68,627	68,627
Income and Expenditure reserve		36,311	33,630
Revaluation reserve	25	47,676	48,733
Total Taxpayers' Equity		152,614	150,990

The Statement of Financial Position lists the assets (everything the Trust owns or is owed) liabilities (money owed to external parties) and taxpayers' equity (public funds invested in the Trust). At any given time, the Trust's total assets less total liabilities must equal taxpayers' equity.

The financial statements on pages 252 to 319 were approved by the Board on the 29th May 2013 and signed on its behalf by:

David Allison
Chief Executive

Financial Statements

Statement Of Changes In Taxpayers' Equity For The Year Ended 31 March 2013

	Public dividend capital (PDC) £000	Revaluation reserve £000	Income and Expenditure reserve £000	Total £000
Balance at 1 April 2012	68,627	48,733	33,630	150,990
Surplus/(deficit) for the year	0	0	1,950	1.950
Transfers between reserves	0	(565)	565	0
Impairments	0	(326)	0	(326)
Revaluations - property, plant and equipment	0	0	0	0
Asset disposals	0	(166)	166	0
Public Dividend Capital received	0	0	0	0
Public Dividend Capital repaid	0	0	0	0
Other reserve movements	0	0	0	0
Balance at 31 March 2013	68,627	47,676	36,311	152,614

The Statement of Changes in Taxpayers' Equity shows the movements in reserves and public dividend capital within the current financial year.

Public dividend capital (PDC) is in effect the public's equity stake in the trust, it is similar to company share capital and as with company shares, a dividend is payable to the Department of Health. The dividend is currently 3.5% of average net relevant assets held by the Trust.

Financial Statements

Statement Of Cash Flows For The Year Ended 31 March 2013

	NOTE	2012/13 £000	Restated 2011/12 £000
Cash flows from operating activities:			
Operating surplus / (deficit) from continuing operations		6,482	7,051
Operating surplus / (deficit) of discontinued operations		0	0
Operating surplus / (deficit)		6,482	7,051
Non-cash income and expense			
Depreciation and amortisation		7,680	7,328
Impairments		1,321	1,138
Reversals of impairments		(30)	(285)
(Gain) / Loss on disposal		178	149
Dividends accrued and not paid or received		(132)	(206)
(Increase) / Decrease in Trade and Other Receivables		(499)	(1,667)
(Increase) / Decrease in Inventories		(473)	155
Increase / (Decrease) in Trade and Other Payables		1,160	2,287
Increase / (Decrease) in Other Liabilities		339	(1,718)
Increase / (Decrease) in Provisions		126	569
Other movements in operating cash flows		(749)	(760)
Net cash generated from / (used in) operations		15,403	14,041
Cash flows from investing activities:			
Interest received		281	341
Purchase of intangible assets		(952)	(2,112)
Purchase of Property, Plant and Equipment		(11,018)	(6,704)
Sales of Property, Plant and Equipment		39	4
Net cash generated from / (used in) investing activities		(11,650)	(8,471)

	NOTE	2012/13 £000	Restated 2011/12 £000
Cash flows from investing activities:			
Public dividend capital received		0	0
Public dividend capital repaid		0	0
Loans received from the Foundation Trust Financing Facility		0	0
Loans repaid to the Foundation Trust Financing Facility		(265)	(265)
Capital element of finance lease rental payments		(228)	(210)
Interest paid		(255)	(267)
Interest element of finance lease		(170)	(221)
PDC Dividend paid		(4,246)	(4,262)
Cash flows from (used in) other financing activities		133	224
Net cash generated from/(used in) financing activities		(5,031)	(5,001)
Increase / (decrease) in cash and cash equivalents		(1,278)	569
Cash and Cash equivalents at 1 April		26,196	25,627
Cash and Cash equivalents at 31 March	19	24,918	26,196

The Statement of Cash Flows summarises the cash flows in and out of the Trust during the financial year. It analyses these cash flows under the headings of operating, investing and financing cash flows. The Statement of Cash Flows differs from the Statement of Comprehensive Income by focusing on the cash implications of actions taken by the Trust during the financial year. The statement is useful in assessing whether the Trust has enough cash to be able to pay its bills as they fall due.

Monitor has restated the 2011/12 prior year comparator to improve disclosure quality. Finance lease income is now to be shown within "Operating Income" (Note 3) rather than "Finance Income" (Note 9), as a result there has been an increase in the "Operating surplus from continuing operations" by £257k but a reduction in "Other movements in operating cash flows" by £257k. Monitor have also added a separate working capital movement category for "Loss on disposal" and as a result this has increased by £149k and decreased "Other movements in operating cash flows" by £149k.

Financial Statements

Notes to the Accounts

1. Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012/13 NHS Foundation Trust Annual Reporting Manual issued by Monitor.

The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

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

1.2 Going Concern

International Accounting Standard (IAS)1 requires management to assess, as part of the accounts preparation process, the foundation trust's ability to continue as a going concern. After making enquiries, the directors can reasonably expect that the foundation trust has adequate resources to continue in operational existence for the foreseeable future.

For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.3 Segmental Reporting

Under IFRS 8: Operating Segments and service line reporting, the standard allows aggregation of segments that have similar economic characteristics and types and class of customer.

The operating results of the foundation trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes senior professional non-executive directors.

The Trust Board review the financial position of the foundation trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process implies a single operating segment under IFRS 8.

In addition, the large majority of the foundation trust's revenue originates with the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this service.

The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of "provision of acute care" is deemed appropriate.

Therefore, all the foundation trusts activities relate to a single operating segment in respect of the provision of acute care.

1.4 Consolidation

Subsidiaries

Subsidiary entities are those over which the foundation trust has the power to exercise control or a dominant influence so as to gain economic or other benefits.
The foundation trust has no subsidiaries other than its charitable funds. For 2012/13: NHS charitable funds considered to be subsidiaries are excluded from consolidation in accordance with the accounting direction issued by the Department of Health and subsequently Monitor.

Until 31 March 2013, NHS charitable funds considered to be subsidiaries are excluded from consolidation in accordance with the accounting direction issued by Monitor.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the foundation trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant.

Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6 Critical judgements in applying accounting policies

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

Finance leases in which the foundation trust acts as lessee

> As none of the leased assets are of a significant length or value, indexation is not considered material and has not been applied.

> It is assumed that the economic life is equal to the lease term and there is no residual value.

Finance leases in which the foundation trust acts as lessor

> It is assumed that the economic life is equal to the lease term and there is no residual value.

Financial Statements

1.7 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

❯ The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements as an expenditure accrual. As the calculation involves a large number of staff, sampling techniques are used to collate the results for the entire foundation trust.

❯ The level of partially completed clinical episodes not yet fully completed as at the end of the reporting period is recognised in the financial statements as an income accrual. As the calculation involves a wide variety of differing clinical episodes an average specialty specific tariff is utilised per episode.

❯ The useful economic life of each category of fixed asset is assessed when acquired by the foundation trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets.

❯ For early retirements that took place before the NHS pension scheme was modified in 1995, a provision is made in the accounts incorporating inflation and the discount rate. Inflation is estimated at 2.5% and where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.35% in real terms.

1.8 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the foundation trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Other income received from commissioners may be in the form of an investment in quality. Any quality investment income surplus may be used in subsequent years to supplement any major projects / capital schemes.

1.9 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State for England and Wales. It is not possible for the foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme. Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

Scheme Provisions as at 31 March 2013

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service.

A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

On death, a pension of 50% of the member's pension is normally payable to the surviving spouse. Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the foundation trust commits itself to the retirement, regardless of the method of payment.

The scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website **www.pensions.nhsbsa.nhs.uk.**

1.10 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.

1.11 Property, Plant and Equipment

❯ Recognition

Property, Plant and Equipment is capitalised where:

❯ it is held for use in delivering services or for administrative purposes;

❯ it is probable that future economic benefits will flow to, or service potential be provided to, the foundation trust;

❯ it is expected to be used for more than one financial year; and

❯ the cost of the item can be measured reliably.

Property, Plant and Equipment is also only capitalised where:

❯ it individually has a cost of at least £5,000; or

❯ it forms a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

❯ form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Measurement

❯ Valuation

Under IAS16 assets should be revalued when their fair value is materially different from their carrying value. Monitor requires revaluation at least once every 5 years.

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

Land and buildings used for the foundation trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of the revaluation less any subsequent accumulated depreciation and impairment losses.

All land and buildings are revalued using professional valuations in accordance with IAS16. Fair values are determined as follows:

❯ Land and non-specialised buildings – market value for existing use

❯ Surplus land – market value for existing use

❯ Specialised buildings – depreciated replacement cost

Until 31 March 2009, the depreciated replacement cost of specialised buildings had been estimated for an exact replacement of the asset in its present location.

HM Treasury has now adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury agreed that NHS trusts / foundation trusts had to apply these new valuation requirements by 1 April 2010 at the latest.

During the 2009/10 financial year Modern equivalent asset valuations were carried out by Debenham Tie Leung (DTZ), which is an independent valuation firm.

The land and buildings of the foundation trust were valued by DTZ using the modern equivalent assets approach as at the 1 April 2009 and any subsequent revaluations were reflected in the 2009/10 financial year.

Under this approach the Clatterbridge site was treated as two assets; the main hospital and the surplus land which has been identified as land sale area.

The Arrowe Park site has also been treated as two assets – the Main Hospital and the Accommodation Block.

DTZ reviewed the value of the land and buildings of the foundation trust as at the 31 March 2011. This updated valuation was considered necessary given the scale of the capital programme which had been undertaken in 2010/11.

The resulting valuation showed a material increase in value and it was considered necessary to reflect this change in the accounts.

DTZ also reviewed the value of the land and buildings of the foundation trust on an asset lives basis in the 2011/12 financial year. This meant that the remaining useful lives and value of the buildings were both re-assessed at the 1st April 2011. The subsequent revaluation and revised asset lives have both been incorporated in the 2011/12 accounts

DTZ have also informed the Foundation Trust that there has been no material changes in the indices in the period 1st April 2012 to the 31st March 2013 and hence no full scale revaluation has been carried out on land and buildings as at the 31st March 2013.

The foundation trust did not revalue its equipment in the 2012/13 accounts per IAS16 which states that NHS bodies may carry non-property assets at depreciated historic cost as a proxy for fair value, where the assets have short lives and their values are low.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss.

Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

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❯ Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value and asset life. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

❯ Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The estimated useful life of an asset is the period over which the foundation trust expects to obtain economic benefits or service potential from the asset. This is specific to the foundation trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed during the year, 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 has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the foundation trust, respectively.

❯ Revaluation gains and losses

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

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

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

❯ Impairments

In accordance with the FT Annual Reporting Manual, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses.

A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

❯ De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

❯ the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

❯ the sale must be highly probable i.e.:

- management are committed to a plan to sell the asset;

- an active programme has begun to find a buyer and complete the sale;

- the asset is being actively marketed at a reasonable price;

- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and

- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged 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 economic life is adjusted.
The asset is de-recognised when scrapping or demolition occurs.

❯ Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt

The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

❯ Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the foundation trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value.

An equivalent financial liability is recognised in accordance with IAS 17. The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The finance cost is calculated using the implicit interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

In the case of the foundation trust the Frontis accommodation block has moved on balance sheet as Property, Plant and Equipment at its fair value.

This is due to guidance under IFRIC 12 Service concessions; since the infrastructure is used to deliver public services, the foundation trust controls the residual interest in the asset and the foundation trust controls the services to be provided see disclosure note 14.1. No unitary fee is payable.

A deferred income balance relating to Frontis has been created which is uniformly released each year as income to exactly match and offset the straight line depreciation charge incurred over its useful economic life.

1.12 Intangible assets

❯ Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the foundation 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 foundation trust and for at least a year and where the cost of the asset can be measured reliably and is at least £5,000.

❯ Internally generated intangible assets

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

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

- ❯ the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;

- ❯ the foundation trust intends to complete the asset and sell or use it;

- ❯ the foundation trust has the ability to sell or use the asset;

- ❯ how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;

- ❯ adequate financial, technical and other resources are available to the foundation trust to complete the development and sell or use the asset; and

- ❯ the foundation trust can measure reliably the expenses attributable to the asset during development.

❯ 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 fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

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

❯ Amortisation

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

The estimated useful life of an asset is the period over which the foundation trust expects to obtain economic benefits or service potential from the asset. This is specific to the foundation trust and may 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.

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❯ Impairments

In accordance with the FT Annual Reporting Manual, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses.

A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

1.13 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.

1.14 Financial instruments and financial liabilities

❯ Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the foundation trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

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

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

❯ De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the foundation trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

❯ Classification and Measurement

Financial assets are categorised as Loans and Receivables.
Financial liabilities are classified as Other Financial Liabilities.

❯ Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets. The foundation trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method.

The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

❯ Other Financial Liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method.

The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs.

Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

❯ Impairment of financial assets

At the Statement of Financial Position date, the foundation trust assesses whether any financial assets are impaired.

Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

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

The loss is either recognised directly in the Statement of Comprehensive Income and the carrying amount of the asset is reduced or the bad debt provision can be utilised with the carrying amount of the asset similarly being reduced.

The bad debt provision should only be used to offset the fall in the carrying value of debtors in cases in which the applicable debtor has been specifically set up in the bad debt provision and when it has been formally assessed that the payment of the debtor is not likely.

In cases whereby, no specific provision has been made in the bad debt provision for the applicable debtor then the loss should be recognised directly in the Statement of Comprehensive Income.

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1.15 Leases

❯ Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the foundation 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 inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost.

The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

The following is the methodology used for the re-classification of operating leases as finance leases:

Finance leases in which the foundation trust acts as lessee

❯ the finance charge is allocated across the lease term on a straight line basis.

❯ the capital cost is capitalised using a straight line basis of depreciation.

❯ the lease rental expenditure that would otherwise have been charged to expenditure under an operating lease is removed from expenditure on a straight line basis.

Finance leases in which the foundation trust acts as lessor

❯ The present value of the minimum lease payments is calculated using the interest rate implicit in the lease. IAS 17 (4) defines this rate as the discount rate that, at the inception of the lease causes the aggregate present value of (a) the minimum lease payments and (b) unguaranteed residual value to be equal to the sum of (i) the fair value of the leased asset and (ii) any initial direct costs of the lessor.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

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.

1.16 Provisions

The foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.35% in real terms.

Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the foundation trust is disclosed at note 24.

Non-clinical risk pooling

The foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the foundation trust pays an annual contribution to the NHSLA 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.

1.17 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 26 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

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

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1.18 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.
A charge, reflecting the cost of capital utilised by the foundation 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 foundation trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General.

1.19 Value Added Tax

Most of the activities of the foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

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

1.20 Corporation Tax

The foundation trust does not have any corporation tax liability as HM Revenue and Customs has advised that no Corporation Tax will be charged for the financial year ending 31 March 2013, as envisaged by S519A(3) to (8) ICTA88. This has been further delayed until at least the 2013/14 financial year.

1.21 Foreign exchange

The functional and presentational currencies of the foundation trust are sterling.

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

Where the foundation trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

❯ monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;

❯ non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and

❯ non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.22 Cash, Bank and Overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the foundation trust's cash book. These balances exclude monies held in the foundation trust's bank account belonging to patients (see "third party assets" below).

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the foundation trust has no beneficial interest in them. However, they are disclosed in note 30 of the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.24 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

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1.25 Recently issued IFRS Accounting Standards

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

- ❯ IFRS 9 Financial Instruments

- ❯ IFRS 10 Consolidated Financial Statements

- ❯ IFRS 11 Joint Arrangements

- ❯ IFRS 12 Disclosure of Interests in Other Entities

- ❯ IFRS 13 Fair Value Measurement

- ❯ IAS 12 Income Taxes amendment

- ❯ IAS 1 Presentation of financial statements, on other comprehensive income

- ❯ IAS 27 Separate Financial Statements

- ❯ IAS 28 Associates and joint ventures

- ❯ IAS 19 (Revised 2011) Employee Benefits

- ❯ IAS 32 Financial Instruments: Presentation amendment (Offsetting financial assets and liabilities)

- ❯ IFRS 7 Financial Instruments: Disclosures amendment (Offsetting financial assets and liabilities)

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

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2. Revenue From Patient Care Activities

2.1 Analysis of revenue from patient care activities	2012/13 £000	2011/12 £000
Elective income	50,279	48,726
Non Elective income	77,751	76,334
Outpatient income	36,300	34,750
A&E income	9,290	8,713
Other NHS clinical income	90,745	83,081
Revenue from protected patient care activities	264,365	251,604
Private patient income	830	860
Other non-protected clinical income*	1,099	1,332
Total Revenue from patient care activities	1,929	2,192
Total	266,294	253,796

2.2 Analysis of revenue from patient care activities by source	2012/13 £000	2011/12 £000
Primary Care Trusts	261,091	248,310
NHS Trusts	551	309
Local Authorities	934	797
NHS Other	1,737	2,185
Non-NHS:		
Private patients	818	857
Overseas patients (non-reciprocal)	12	3
Injury costs recovery (was RTA)	1,099	1,332
Other	52	3
Total	266,294	253,796

The figures quoted for 2012/13 are based upon income received in respect of actual activity undertaken within each category. The Terms of Authorisation set out the mandatory goods and services that the Trust is required to provide (protected services). All of the income from activities before Private Patients and other clinical income shown above is derived from the provision of protected services.

*The Injury Costs Recovery Scheme income has been provided for impairment of receivables at 12.6% to reflect the expected rates of collection (2011/12: 10.5%).

All the foundation trusts' activities relate to a single operating segment in respect of the provision of healthcare services. The Trust does not consider that segmental reporting would be appropriate in the 2012/13 annual accounts as:

• The Trust Board reviews the financial position as a whole in its decision making process, rather than individual components included in the totals.

• The Trust shares it's assets across all areas to provide healthcare.

• The Trust workforce works flexibly across all areas to provide healthcare.

• IFRS 8: Operating Segments allows the aggregation of segments that have similar economic characteristics and types and class of customer. Therefore, all the foundation trusts activities relate to a single operating segment in respect of the provision of acute health care.

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2.3   Private patient cap

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012.
The financial statements disclosures that were provided in previous years are no longer required.

2.4 Operating lease income	2012/13 £000	2011/12 £000
Operating Lease Income		
Rental revenue from operating leases - minimum lease receipts	575	526
Rental revenue from operating leases - contingent rent	-	-
Rental revenue from operating leases - other	-	-
TOTAL	575	526
Future minimum lease payments due		
on leases of land expiring		
not later than one year;	-	-
later than one year and not later than five years;	-	-
later than five years.	-	-
TOTAL	-	-
on leases of buildings expiring		
not later than one year;	496	448
later than one year and not later than five years;	1.778	1,567
later than five years.	1,767	1,607
TOTAL	4,041	3,622
on other leases expiring		
not later than one year;	29	28
later than one year and not later than five years;	29	30
later than five years.	-	-
SUB TOTAL	58	58
TOTAL	4,099	3,680

Operating Lease income is derived from retail and other service providers who occupy premises on the foundation trust's sites.

Not included in the above note are the following peppercorn leases:
Ronald McDonald lease - lease started December 2009 and expires December 2034.
Frontis Homes lease of land - lease started June 2006 and expires June 2046.
Postgraduate Medical Centre - lease started May 1971 and expires April 2070

3. Other Operating Revenue	2012/13 £000	Restated 2011/12 £000
Research & Development	428	503
Education, training and research	9,065	9,157
Non-patient care services to other bodies	11,054	9,936
Reversal of impairments of property, plant and equipment	30	285
Rental revenue from finance leases	254	257
Rental revenue from operating leases - minimum lease receipts	575	526
Revenue to support Voluntary Severance Scheme Payments	429	704
Catering Income	1,352	1,260
Car Parking Charges	1,227	1,263
Income Generation	303	506
Facilities Management arrangements	743	655
Clinical Tests	229	376
Staff Recharges	4,133	3,963
Renal Recharges	171	167
Deanery Services	0	11
Other Revenue	705	1,009
Total	30,698	30,578

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4. Operating Expenses	2012/13 £000	2011/12 £000
Services from other NHS bodies	5,349	2,095
Executive Directors' costs	1,027	1,134
Non-executive Directors' costs	156	157
Staff costs	200,611	196,888
Drug costs (non inventory drugs only)	117	175
Drugs Inventories consumed	17,830	16,684
Supplies and services - clinical - Other Payments	26,761	26,318
Supplies and services - general	5,443	5,147
Establishment	3,004	2,910
Transport	432	412
Premises	11,425	9,261
Provision for impairment of receivables	40	(212)
Depreciation	6,538	6,307
Amortisation of Intangible Fixed assets	1,142	1,021
Impairments and reversals of property, plant and equipment	1,321	1,138
Audit fees - statutory audit	56	58
Other auditor's remuneration - audit-related assurance services	12	12
Loss on disposal of property plant and equipment	178	149
Clinical negligence	5,065	4,346
Insurance costs	361	302
Rentals under operating leases - minimum lease receipts	486	357
Accommodation costs	425	531
Waste disposal	373	343
Consultancy Costs	542	123
Legal fees	235	205
Training, courses and conferences	898	770
Patient travel	12	13
Car parking & Securityequipment	174	176
Other	497	503
Total	290,510	277,323

Clinical negligence costs relate to the Trusts contribution to the NHS Litigation Authority risk pooling scheme under which the Trust pays an annual contribution.

Included within the 2012/13 loss on disposal of property plant and equipment figure of £178k, is £121k in relation to the demolition of the pathology building at the Clatterbridge site. This building was demolished for no consideration within the 2012/13 financial year as part of the trust wide site strategy.

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5. Operating Leases

5.1 As lessee

Payments recognised as an expense	2012/13 £000	Restated 2011/12 £000
Minimum lease payments	486	357
Contingent rents	0	0
Sub-lease payments	0	0
Total	486	357

Total future minimum lease payments	2012/13 £000	Restated 2011/12 £000
Not later than one year	293	273
Between one and five years	662	394
After 5 years	1.577	1,605
Total	2,532	2,272

6. Limitation On Auditor's Liability	2012/13 £000	2011/12 £000
Limitation on auditor's liability	1,000	1,000
Total	1,000	1,000

7. The Late Payment Of Commercial Debts (Interest) Act 1998	2012/13 £000	2011/12 £000
Amounts included within other interest payable arising from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	0	0

8. Employee Costs and Numbers

8.1 Employee costs	2012/13			2011/12		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
Salaries and wages	167,399	167,399	0	165,545	165,545	0
Social Security Costs	12,681	12,681	0	12,109	12,109	0
Employer contributions to NHS Pension scheme	17,419	17,419	0	16,906	16,906	0
Agency / contract staff	4,139	0	4,139	3,462	0	3,462
Employee benefits expense	201,638	197,499	4,139	198,022	194,560	3,462

Included in the employer contributions to NHS Pension scheme is £31k on behalf of the directors of the foundation trust (2011/12 £41k)

8.2 Average number of people employed*	2012/13			2011/12		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
Medical and dental	503	369	134	537	408	129
Administration and estates	948	836	112	988	807	181
Healthcare assistants and other support staff	564	517	47	563	408	155
Nursing, midwifery and health visiting staff	2,028	1,877	151	1,954	1.852	102
Scientific, therapeutic and technical staff	685	633	52	639	629	10
Bank and agency staff	95	0	95	82	0	82
Total	4,823	4,232	591	4,763	4,104	659

*Whole Time Equivalent

8.3 Employee benefits	2012/13 £000	2011/12 £000
Employee benefits	0	0
Total	0	0

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8.4 Retirements due to ill-health

During the year there were 7 (2011/12: 7) early retirements from the foundation trust on the grounds of ill-health.

The estimated additional pension liabilities of these ill-health retirements will be £418,954 (2011/12: £284,319). The cost of these ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

8.5 Staff Exit Packages

Foundation trusts are required to disclose summary information of their use of staff exit packages agreed in the year.

In the 2012/13 financial year the foundation trust operated a Voluntary Severance Scheme. The purpose of the scheme was to reduce the current pay-bill on a voluntary basis.

All staff were informed of the scheme and the foundation trust received a number of applications. In deciding whether to approve each application, a critical consideration of how work would be undertaken in the future was carried out and whether the skills, expertise and role of an applicant could be adequately performed by the remaining members of staff in the team. In the 2012/13 year 29 (2011/12: 67) members of staff made use of this scheme at a cost of £622k (2011/12: £1,821k)

The tables below discloses the number of staff that has taken part in the scheme by differing cost ranges in the 2012/13 and 2011/12 financial years.

2012/13 Exit Package Cost	Compulsory Redundancies Number	Compulsory Redundancies £000	Voluntary Severance Scheme departures agreed Number	Voluntary Severance Scheme departures agreed £000
<£10,000	0	0	9	56
£10,001 - £25,000	0	0	11	187
£25,001 - £50,000	0	0	6	196
£50,001 – £100,000	0	0	3	183
£101,000 - £150,000	0	0	0	0
£150,001 - £200,000	0	0	0	0
>£200,001	0	0	0	0
TOTAL	0	0	29	622

2011/12 Exit Package Cost	Compulsory Redundancies Number	Compulsory Redundancies £000	Voluntary Severance Scheme departures agreed Number	Voluntary Severance Scheme departures agreed £000
<£10,000	0	0	23	115
£10,001 - £25,000	0	0	20	332
£25,001 - £50,000	0	0	17	626
£50,001 – £100,000	0	0	4	299
£101,000 - £150,000	0	0	1	104
£150,001 - £200,000	0	0	2	345
>£200,001	0	0	0	0
TOTAL	0	0	67	1,821

Any exit packages in relation to senior managers (should they arise) are not included in this note as these would be disclosed in the remuneration report.

"The cost of ill-health retirements falls on the relevant pension scheme, not the foundation trust, and would not be included in this disclosure but note 8.4.

8.6 Pensions

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales.

The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the 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 the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008.

However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership.

Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules.

This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

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9. Finance Income

9. Finance Income	2012/13 £000	Restated 2011/12 £000
Interest on bank accounts	281	114
Total	281	114

Monitor has restated the 2011/12 prior year comparator to improve disclosure quality. Finance lease income is now shown within "Operating Income" (Note 3) rather than "Finance Income" (Note 9), as a result there has been an increase and a decrease in both categories by £257k respectively.

10. Finance Costs - Interest Expense	2012/13 £000	2011/12 £000
Loans from the Foundation Trust Financing Facility	255	267
Finance leases	170	221
Total	425	488

11. Other Gains and Losses	2012/13 £000	2011/12 £000
Gain/(loss) on disposal of property, plant and equipment	(178)	(149)
Total	(178)	(149)

12. Impairment of assets	2012/13 £000	2011/12 £000
Other	0	6,521
Changes in market price	1,729	341
Reversal of impairments	(112)	(2,673)
Total	1,617	4,189

In the 2012/13 financial year, the £1,729k impairment relates to a downward valuation of buildings following the completion of the buildings and associated works. Of this amount £408k relates to a reduction in the revaluation reserve for the associated buildings and £1,321k relates to the impairment charged to the statement of comprehensive income.

In the 2012/13 financial year, the (£112k) reversal of impairment relates to the upward valuation of 2 small buildings that had been impaired in the previous financial year following a decision that these would be demolished. The demolition of these buildings is on hold. Of this amount (£82k) relates to an increase in the revaluation reserve for the associated buildings and (£30k) relates to the reversal of impairments income charged to the statement of comprehensive income.

In the 2011/12 financial year, the £6,521k impairment relates to a downward valuation of various buildings following the site strategy review which identified several buildings for demolition in future years. Of this amount £5,383k relates to a reduction in the revaluation reserve for the associated buildings and £1,138k relates to the impairment charged to the statement of comprehensive income.

In the 2011/12 financial year, the (£2,673k) reversal of impairment relates to the upward valuation of various buildings that had been previously impaired following a valuation of all buildings on the 1st April 2011 . Of this amount (£2,388k) relates to an increase in the revaluation reserve for the associated buildings and (£285k) relates to the reversal of impairments income shown in the statement of comprehensive income.

In the 2011/12 financial year, the £341k impairment relates to the downward valuation of a particular class of buildings following a valuation of all buildings on the 1st April 2011. The full £341k relates to a decrease in the revaluation reserve for the associated class of buildings.

13. Intangible Assets

	Software licences (purchased)	Intangible Assets Under Construction	Total
Gross cost at 1 April 2012	9,768	1,674	11,442
Additions - purchased	152	501	653
Additions - donated	0	0	0
Impairments	0	0	0
Reversal of impairments	0	0	0
Reclassifications	0	0	0
Revaluations	0	0	0
Disposals	0	0	0
Valuation/Gross cost at 31 March 2013	9,920	2,175	12,095
Amortisation at 1 April 2012	1,381	0	1,381
Provided during the year	1,142	0	1,142
Impairments	0	0	0
Reversal of impairments	0	0	0
Reclassifications	0	0	0
Revaluation surpluses	0	0	0
Disposals	0	0	0
Amortisation at 31 March 2013	2,523	0	2,523

Net book value			
NBV - Purchased at 31 March 2013	6,637	2,175	8,812
NBV - Finance leases at 31 March 2013	760	0	760
NBV - Donated at 31 March 2013	0	0	0
NBV total at 31 March 2013	7,397	2,175	9,572

All intangible assets are held at cost less accumluated amortisation based on estimated useful economic lives.

The amount held as an intangible asset under contruction was the cost to date of the implementation of the "Wirral Millenium" project for the replacement of the patient information system. Phase 1 of this asset was brought into use during 2010/11, the current asset under construction relates to phase 2 of this project.

13.2 Economic life of intangible assets

Intangible assets - purchased	Min Life Years	Max Life Years
Software	2	8

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14. Property, Plant and Equipment

14.1 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2012	2,012	124,485	12,372	578	35,007	107	10,102	3,501	188,164
Additions - purchased	0	5,212	0	1,090	3,902	0	778	128	11,110
Additions - donated	0	0	0	0	124	0	0	9	133
Impairments	0	(408)	0	0	0	0	0	0	(408)
Reversal of impairments	0	82	0	0	0	0	0	0	82
Reclassifications	0	575	(1)	(573)	1	1	(2)	(1)	0
Revaluations	0	0	0	0	0	0	0	0	0
Disposals	0	(149)	0	0	(1,646)	0	(1,454)	(352)	(3,601)
Cost or valuation at 31 March 2013	2,012	129,797	12,371	1,095	37,388	108	9,424	3,285	195,480

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
Accumulated depreciation at 1 April 2012	0	2,276	434	0	20,394	86	9,014	2,088	34,292
Provided during the year	0	2,513	434	0	2,882	4	443	262	6,538
Impairments	0	1,321	0	0	0	0	0	0	1,321
Reversal of impairments	0	(30)	0	0	0	0	0	0	(30)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0	0
Disposals	0	(28)	0	0	(1,558)	0	(1,454)	(346)	(3,386)
Accumulated depreciation at 31 March 2013	0	6,052	868	0	21,718	90	8,003	2,004	38,735

Net book value at 1 April 2012	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
NBV - Owned at 1 April 2012	2,012	120,010	11,938	578	13,870	21	1,072	1,365	150,866
NBV - Finance lease at 1 April 2012	0	0	0	0	17	0	0	0	17
NBV - Donated at 1 April 2012	0	2,199	0	0	726	0	16	48	2,989
NBV total at 1 April 2012	2,012	122,209	11,938	578	14,613	21	1,088	1,413	153,872

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2013									
NBV - Owned at 31 March 2013	2,012	122,282	11,503	1,095	14,948	18	1,409	1,234	154,501
NBV - Finance lease at 31 March 2013	0	0	0	0	7	0	0	0	7
NBV - Donated at 31 March 2013	0	1,463	0	0	715	0	12	47	2,237
NBV total at 31 March 2013	2,012	123,745	11,503	1,095	15,670	18	1,421	1,281	156,745

14.2 Analysis of property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
NBV - Protected assets at 31 March 2013	2,005	116,676	0	0	0	0	0	0	118,681
NBV - Unprotected assets at 31 March 2013	7	7,069	11,503	1,095	15,670	18	1,421	1,281	38,064
Total at 31 March 2013	2,012	123,745	11,503	1,095	15,670	18	1,421	1,281	156,745

The Dwellings figure represents the staff accommodation block at Arrowe Park which is owned and operated by Frontis Homes Limited. The accommodation is situated on land owned by the foundation trust and leased to Frontis. Under IFRIC12 Service Concessions the land is held on the balance sheet of the foundation trust.

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14.3 Economic life of property plant and equipment

Intangible Assets	Min Life Years	Max Life Years
Land	0	0
Buildings excluding dwellings	2	86
Dwellings	26	26
Assets under Construction & POA	0	0
Plant & Machinery	2	19
Transport Equipment	2	6
Information Technology	2	6
Furniture & Fittings	2	10

Freehold land is considered to have an infinite life and is not depreciated.
Assets under course of construction are not depreciated until the asset is brought into use.

15. Net Book Value of Assets Held Under Finance Lease

	Software licences (purchased)	Intangible Assets Under Construction	Total
Cost or valuation at 1 April 2012	1,013	439	1,452
Additions - purchased	0	0	0
Cost or valuation at 31 March 2013	1,013	439	1,452
Accumulated depreciation at 1 April 2012	0	422	422
Provided during the year	253	10	263
Accumulated depreciation at 31 March 2013	253	432	685
Net book value			
NBV - Purchased at 31 March 2013	760	7	767
NBV - Donated at 31 March 2013	0	0	0
NBV total at 31 March 2013	760	7	767

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16. Capital Commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2013 £000	31 March 2012 £000
Property, plant and equipment	873	2,367
Intangible assets	2,200	2,500
Total	3,073	4,867

The Trust has entered into a contract with Cerner for the provision of a replacement of the Patient Care Information System. The contract value is for £9.5 million, of which £7.3 million has occurred.

There are a number of other capital contracts which commenced in 2012/13 which are due to be completed in 2013/14 with a total value of £873k.
Total capital commitments as at 31st March 2013 are £3,073k (2011/12: capital commitments £4,867k).

17. Inventories

17.1. Inventories

	31 March 2013 £000	31 March 2012 £000
Drugs	1,470	1,065
Consumables	2,564	2,509
Energy	22	9
Total	4,056	3,583

17.2 Inventories recognised in expenses

	31 March 2013 £000	31 March 2012 £000
Inventories recognised as an expense in the period	36,089	44, 476
Write-down of inventories (including losses)	0	0
Reversal of write-downs that reduced the expense	0	0
Total	36,089	44,476

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18. Trade and Other Receivables

18.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 Restated £000	31 March 2013 £000	31 March 2012 £000
NHS Receivables - Revenue	6,210	4,545	0	0
Receivables due from NHS charities – Revenue	218	324	0	0
Other receivables with related parties - Revenue	0	52	0	0
Provision for impaired receivables	(135)	(231)	(375)	(239)
Prepayments (Non-PFI)	1,531	1,410	0	0
Accrued income	1,204	1,249	0	0
Interest Receivable	62	38	0	0
Finance Lease Receivables	44	41	3,078	3,122
PDC dividend receivable	132	206	0	0
VAT receivable	175	425	0	0
Other receivables - Revenue	1,192	1,868	1,727	1,717
Other receivables - Capital	0	37	0	0
TOTAL	10,633	9,964	4,430	4,600

The great majority of trade is with primary care trusts, as commissioners for NHS patient care services. As primary care trusts are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

Monitor has restated the 2011/12 prior year comparator to improve disclosure quality. "Receivables due from NHS charities" is a new category and as a result this has increased by £324k and "Other receivables - Revenue" has decreased by £324k.

18.2 Finance lease receivables

	31 March 2013 £000	Restated 31 March 2012 £000
Gross lease receivables	3,122	3,163
of which those receivable		
- not later than one year;	44	41
- later than one year and not later than five years;	210	196
- later than five years.	2,868	2,926
Unearned interest income	0	0
Net lease receivables	3,122	3,163
of which those receivable		
- not later than one year;	44	41
- later than one year and not later than five years;	210	196
- later than five years.	2,868	2,926
TOTAL	3,122	3,163

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18.3 Provision for impairment of receivables

	31 March 2013 £000	31 March 2012 £000
Balance at 1 April	470	701
Increase in provision	40	167
Amounts utilised	0	(19)
Unused amounts reversed	0	(379)
Balance at 31 March	510	470

As per note 2.1 the provision for the impairment of receivables includes a provision regarding the NHS Injury Scheme of 12.6% to reflect expected rates of collection (2011/12: 10.5%).

18.4 Analysis of impaired receivables

	31 March 2013 £000	31 March 2012 £000
Ageing of impaired receivables		
0 - 30 days	0	0
30 - 60 Days	2	0
60 - 90 days	4	74
90 - 180 days	24	109
over 180 days	480	287
Total	510	470

Ageing of non-impaired receivables past their due date		
0 - 30 days	1,546	1,328
30 - 60 Days	1,067	198
60 - 90 days	261	75
90 - 180 days	201	147
over 180 days	68	21
Total	3,143	1,769

19. Cash and Cash Equivalents

	31 March 2013 £000	31 March 2012 £000
Balance at 1 April	26,196	25,627
Net change in year	(1,278)	569
Balance at 31 March	24,918	26,196
Made up of		
Commercial banks and cash in hand	117	77
Cash with the Government Banking Service	24,801	26,119
Other current investments	0	0
Cash and cash equivalents as in statement of financial position	24,918	26,196
Bank overdraft	0	0
Cash and cash equivalents as in statement of cash flows	24,918	26,196

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20. Trade and Other Payables

20.1 Trade and Other Payables

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Receipts in advance	900	1,009	0	0
NHS payables - capital	0	98	0	0
NHS payables - revenue	3,600	2,138	0	0
Other trade payables - capital	1,944	2,088	0	0
Other trade payables - revenue	6,873	6,763	0	0
Social Security costs	1,888	1,868	0	0
Other taxes payable	1,988	2,115	0	0
Other payables	3,538	3,209	0	0
Accruals	12,217	12,500	0	0
TOTAL	32,948	31,788	0	0

Other payables includes: £2,273,497 outstanding pensions contributions at 31 March 2013 (£2,134,196 at 31 March 2012)

NHS payables includes: 7 early retirements from the NHS Trust on the grounds of ill-health (2011/12: 7). The estimated additional pension liabilities of these ill-health retirements will be £418,954 (2011/12: £284,319). The cost of these ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

21. Borrowings

21.1 Borrowings

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Loans from Foundation Trust Financing Facility	265	265	5,440	5,704
Obligations under finance leases	256	228	608	865
TOTAL	521	493	6,048	6,569

During 2009/10 the Trust arranged a £6.5m loan with the Foundation Trust Financing Facility to resource the building of the decontamination facility at Arrowe Park Hospital. The drawdown of the £6.5 million loan was completed in 2010/11 and the loan is repayable over 25 years and has an interest rate payable of 4.32%

The obligations under finance leases include the outstanding borrowings in relation to the Cerner Picture Archiving Communication System (PACS) finance lease of £857k.

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21.2 Finance lease borrowings

	31 March 2013 £000	31 March 2012 £000
Gross lease liabilities	1,093	1,302
of which those receivable		
- not later than one year;	256	228
- later than one year and not later than five years;	608	865
- later than five years.	0	0
Unearned interest income	0	0
Net lease receivables	864	1.093

of which those receivable		
- not later than one year;	256	228
- later than one year and not later than five years;	608	865
- later than five years.	0	0
TOTAL	864	1,093

The obligations under finance leases include the outstanding borrowings in relation to the Cerner Picture Archiving Communication System (PACS) finance lease of £857k.

22. Other Liabilities

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Deferred grants income	0	0	0	0
Other Deferred income	2,991	2,896	11,069	11,503
TOTAL	2,991	2,896	11,069	11,503

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23. Prudential Borrowing Limit

	31 March 2013 £000	31 March 2012 £000
Total long term borrowing limit set by Monitor	56,400	53,000
Working capital facility agreed by Monitor	18,000	18,000
TOTAL PRUDENTIAL BORROWING LIMIT	74,400	71,000
Long term borrowing at 1 April	7,062	7,537
Net actual borrowing/(repayment) in year - long term	(493)	(475)
Long term borrowing at 31 March	6,569	7,062
Working capital borrowing at 1 April	0	0
Net actual borrowing/(repayment) in year - working capital	0	0
Working capital borrowing at 31 March	0	0

The NHS Foundation Trust is required to comply and remain within a Prudential Borrowing Limit.

This is made up of two elements:

– the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.

– the amount of any working capital facility approved by Monitor.

Financial Ratios	2012/13		2011/12	
	Approved	Actual	Approved	Actual
Minimum dividend cover	> 1	3.6	> 1	3.5
Minimum interest cover	> 3	38	> 3	32
Minimum debt service cover	> 2	17	> 2	16
Maximum debt service to revenue	2.5%	0.3%	2.5%	0.3%

The Trust has £18 million of approved working capital facility. The Trust did not draw down any amounts under its working capital facility in 2012/13.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts - which is: http://www.monitor-nhsft.gov.uk/index.php

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24. Provisions

	Current		Non-current	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Pensions relating to other staff	276	254	2,716	2,578
Other legal claims	564	598	0	0
Other	607	607	0	0
TOTAL	1,447	1,459	2,716	2,578

	Pensions relating to other staff £000	Legal claims £000	Other £000	Total £000
At 1 April 2012	2,832	598	607	4,037
Change in the discount rate	(13)	0	0	(13)
Arising during the year	374	221	0	595
Utilised during the year - accruals	(64)	0	0	(64)
Utilised during the year - cash	(205)	0	0	(205)
Reversed unused	0	(255)	0	(255)
Unwinding of discount	68	0	0	68
At 31 March 2013	2,992	564	607	4,163

Expected timing of cash flows:				
not later than one year	276	564	607	1,447
later than one year and not later than five years	1,174	0	0	1,174
later than five years	1,542	0	0	1,542
TOTAL	2,992	564	607	4,163

Provisions for capitalised pension benefits are based on tables provided by the NHS Pensions Agency reflecting years to normal retirement age and the additional pension costs associated with early retirement.

The "Legal Claims" category consists of amounts due as a result of third party and employer liability claims. The values are based on information provided by the Trust's insurer, in this case , the NHS Litigation Authority. The amount shown here is the gross expected value of Wirral Hospital's liability to pay minimum excesses for outstanding cases under the Scheme rules. Provision has also been made for cases which are ongoing with the Trust's solicitors.

The "Other" Provision relates to staff.
The Contingent Liability for the maximum possible but not probable cost of claims is shown in Note 26.

The NHS Litigation Authority records provisions in respect of clinical negligence liabilities of the trust. The amount recorded as at 31 March 2013 was £80,949,400 (£62,441,333 at 31st March 2012).

25. Revaluation Reserve

	Revaluation Reserve -intangibles £000	Revaluation Reserve -property, plant and equipment £000
Revaluation reserve at 1 April 2012	0	48,733
Impairments	0	(326)
Revaluations	0	0
Transfers to other reserves	0	(565)
Asset disposals	0	(166)
Fair Value gains/(losses) on Available-for-sale financial investments	0	0
Recycling gains/(losses) on Available-for-sale financial investments	0	0
Other recognised gains and losses	0	0
Other reserve movements	0	0
Revaluation reserve at 31 March 2013	0	47,676

26. Contingencies

	2012/13 £000	2011/12 £000
Contingent Liabilities		
Equal pay	0	0
Other	(151)	(147)
Gross value of contingent liabilities	(151)	(147)
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	(151)	(147)
Contingent Assets		
Net value of contingent assets	0	0

A contingent liability of £151k exists in 2012/13 for potential third party claims in respect of employer's / occupier's liabilities and property expenses (2011/12 £146,619). The value of Provisions for the expected value of probable cases is shown in Note 24.

27. Financial Instruments

The carrying value and the fair value are equivalent for the financial assets and financial liabilities shown below in notes 27.1 and 27.2.

27.1 Financial assets by category

	2012/13 Loans and receivables £000	2011/12 Loans and receivables £000
NHS Trade and other receivables excluding non financial assets	6,210	4,545
Non-NHS Trade and other receivables excluding non financial assets	112	869
Cash and cash equivalents (at bank and in hand)	24,918	26,196
TOTAL	31,240	31,610

27.2 Financial liabilities by category

	2012/13 Other financial liabilities £000	2011/12 Other financial liabilities £000
Obligations under finance leases	864	1,093
NHS Trade and other payables excluding non financial assets	3,600	2,138
Non-NHS Trade and other payables excluding non financial assets	17,699	17,797
TOTAL	22,163	21,028

27.3 Financial Instruments

❯ Liquidity risk

The Trust's net operating costs are incurred under agency purchase contracts with local healthcare commissioners, which are financed from resources voted annually by Parliament. The Trust receives the majority of such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to a National / Local Tariff unit cost.

The Trust receives cash each month based on an annually agreed level of contract activity and there are periodic corrections made to adjust for the actual income due under the contract. The Trust has put in place an £18.0 million working capital facility, which to date, due to careful cash management, it has yet to draw on.

The Trust presently finances its capital expenditure mainly from internally generated funds and additional resources made available from Government, in the form of Public Dividend Capital.

Financing is drawn down to match the spend profile of the scheme concerned and the Trust is not, therefore, exposed to significant liquidity risks in this area. In addition, the Trust has also utilised funding from the Foundation Trust Financing Facility to finance specific capital schemes.

The Trust also has the option to utilise funding from commercial organisations to finance capital schemes. These funding arrangements ensure that the Trust is not exposed to any material credit risk.

❯ Interest rate risk

The only assets or liabilities subject to fluctuation of interest rates are cash holdings at the OPG and a UK high street bank. The Trust is not, therefore, exposed to significant interest rate risk.

28. Related Party Transactions

Wirral University Teaching Hospital NHS Foundation Trust is a body corporate established under the National Health Service Act 2006.

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Wirral University Teaching Hospital NHS Foundation Trust.

During the period Wirral University Teaching Hospital NHS Foundation Trust has had a significant number of material transactions with other NHS bodies.

Where the value of transactions is considered material, these entities are listed below:

2012/13

Organisation Category	Organisation	Income £000	Expenditure £000	Debtors £000	Creditors £000
Primary Care Trusts	NHS Wirral	230,980	173	2,350	155
	Western Cheshire PCT	29,252	19	1,008	155
NHS Foundation Trusts	Clatterbridge Centre for Oncology NHS Foundation Trust	4,947	251	2,146	947
	Cheshire & Wirral Partnership NHS Foundation Trust	1,162	17	365	2
	Countess of Chester Hospital NHS Foundation Trust	2,800	4,796	669	984
NHS Trusts	Northwest Ambulance Service NHS Trust	14	0	4	0
	Wirral Community NHS Trust	1,336	556	115	717
Strategic Health Authorities	NHS Northwest	9,227	1	7	0
Other NHS Bodies	NHS Litigation Authority	0	5,091	0	0
	NHS Business Services Authority (NHS Pensions Scheme)	0	17,423	0	2,274
Other Government Bodies	HM Revenue & Customs	0	37,154	175	3,876
Charitable Bodies	Wirral University Teaching Hospital NHS Foundation Trust Charitable Funds	370	0	218	0
TOTAL		**280,088**	**65,481**	**7,057**	**9,110**

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Organisation Category	Organisation	Income £000	Expenditure £000	Debtors £000	Creditors £000
Primary Care Trusts	NHS Wirral	217,988	25	1,529	46
	Western Cheshire PCT	25,855	1	271	104
NHS Foundation Trusts	Clatterbridge Centre for Oncology NHS Foundation Trust	4,037	247	1,662	934
	Cheshire & Wirral Partnership NHS Foundation Trust	1,189	27	172	4
	Countess of Chester Hospital NHS Foundation Trust	134	3,117	328	1,028
NHS Trusts	Northwest Ambulance Service NHS Trust	5	1	1	4
	Wirral Community NHS Trust	2,363	347	666	32
Strategic Health Authorities	NHS Northwest	9,104	55	28	0
Other NHS Bodies	NHS Litigation Authority	0	4,358	0	6
	NHS Business Services Authority (NHS Pensions Scheme)	0	16,910	0	2,134
Other Government Bodies	HM Revenue & Customs	0	36,525	425	3,956
Charitable Bodies	Wirral University Teaching Hospital NHS Foundation Trust Charitable Funds	325	0	324	0
TOTAL		261,000	61,613	5,406	8,248

The 2011 Health and Social Care Bill outlined a wide range of changes to the structure of the NHS, including the abolition of several types of organisation and the introduction of a number of new ones. Subsequent to this a number of additional new entities have been introduced as part of the process of designing the new service that has been undertaken by the NHS Commissioning Board. From the 1st April 2013 NHS Wirral PCT and Western & Cheshire PCT will no longer exist as the services that these organisations provided will be dispersed and managed between the new Clinical Commissioning Groups (CCG's), NHS Commissioning Board (NCB's), NHS Local Areas Teams (LAT's) and Public Health England (Local Authority).

29. Events After The Reporting Period

There are no events after the reporting period which require disclosure.

30. Third Party Assets

The Trust held £6,695 cash at bank and in hand at 31 March 2013 (£4,938 at 31st March 2012) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

The Trust held £3,262,934 of unused consignment inventories at the 31 March 2013 (£2,930,016 at 31st March 2012). Although the Trust is in physical possession of the unused consignment inventory it is still owned by the supplying organisations until the inventory is actually used. Unused consignment inventory is considered to be a third party asset and has been excluded from the inventories figure reported in the accounts.

31. Losses and Special Payments

During 2012/13 there were 88 cases, on an accruals not cash basis, of losses and special payments (2011/12: 79 cases) totalling £71,222 (2011/12: £70,499) .
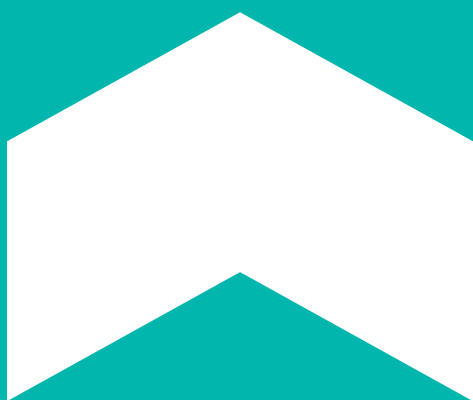
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