Wirral University Teaching Hospital NHS
NHS Foundation Trust

Annual Report and Accounts 2013-14

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

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1. Welcome Messages

1.1 Chairman's Message

This has been another very challenging year for the Trust. Demand for our services has only continued to rise whilst the financial pressures under which we are working are biting yet harder, and you will read later in this Annual Report how we are currently working with a financial deficit.

Notwithstanding these pressures, all of us at this Trust remain absolutely determined to provide the very best possible healthcare to meet the needs of our patients both on the Wirral and beyond, and therefore I am delighted to be able to report that external validation of our clinical services by the Care Quality Commission has confirmed our continuing compliance with all national healthcare standards, and that our patient feedback through the newly-introduced Friends and Family Test has shown a pleasing trend. These are notable achievements in difficult times.

Nevertheless, looking to the future both we and our health and social care partners locally all recognise that we cannot continue to provide sustainable high quality services without some radical changes in the way services are delivered and therefore through the Vision 2018 collaboration we are all working together to devise better 'joined up care' in order to improve outcomes and gain efficiencies.

Of course, as a Trust we also need to continue to change and adapt internally, and to that end we have developed our two-year and five-year strategies based around our vision of being 'Locally focused - Regionally significant', to help guide us through the next few years.

Among the specific highlights of a very busy year I might mention in particular:-

- The launch of our new Nursing and Midwifery Strategy, developed through the active involvement of nurses and midwives throughout the Trust, which combines the best of modern, patient focussed nursing and midwifery with the traditional nursing values of Care, Compassion, Competence, Communication, Courage and Commitment

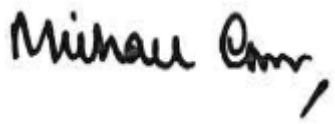
- The further confirmation of our regional role across the North West of England and North Wales, for example through our selection to extend our Neo-natal Intensive Care Services to North Wales and through the recognition of our Stroke Services as being the Best in the North West

- National recognition and support for our work with our industry partner Cerner to provide the Trust with world class computing and information systems in support of our clinical work

- In recognition of our role as a major provider of education and training, our identification in a GMC survey as being in the top six of over two hundred Trusts nationwide in junior doctor satisfaction with their training and supervision

- Our commitment as the largest employer on the Wirral to helping young people into careers in the health sector by our investment in apprenticeships and this year we launched a major initiative to recruit 50 young people into a range of clinical roles.

A successful Trust is the product of the hard work of so many different groups of dedicated people. Whether it be our staff, our army of wonderful volunteers, our Members and our Council of Governors, our Board of Directors or our external supporters and stakeholders, I would like to thank them all for their many contributions and support over the last year. By continuing to work closely together and by keeping a clear focus on the needs of the patient, I am confident that this Trust can navigate successfully the changing health landscape that lies ahead of us.



Michael Carr

1.2 Chief Executive's Message

Last year we declared a long-term vision for our Trust – Locally focused, regionally significant:

Locally focused – We will be the first choice healthcare partner to the communities we serve, supporting patients' needs from the home through to the provision of regional specialist services.

Regionally significant – we will be the top NHS Hospital Trust in the North West for patient, customer and staff satisfaction

Our intent is that all of our plans and actions will be aimed at achieving this vision and I am pleased to report that we have made significant steps towards this.

2013/14 has been a year of many challenges for our Trust but also one of significant success and achievements. We have introduced new and innovative services, achieved some excellent accreditations and maintained a quality of healthcare that we can all be truly proud of.

It has been a challenging year and the Trust completed it with a deficit of £3m. Towards the end of the year, Monitor conducted an investigation into financial planning and governance and concluded it with no regulatory action being required.

The annual unannounced inspection by the Care Quality Commission found us in compliance with all six of the standards they set for excellent patient care and all 16 of the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A survey conducted by the Care Quality Commission rated our maternity unit as one of the best in the country and best in the North West; the Royal College of Physicians ranked our Stroke Service as the best in the North West and the team reviewing our Trauma services as part of the reaccreditation process was so impressed that they want to replicate the work we are doing in other trauma units.

We opened our dedicated Frailty Unit - the first of its' kind in the North West - specifically designed to meet the needs of vulnerable older people with multiple, complex conditions. We carried out extensive work to reconfigure and refurbish our Emergency Department with the aim of improving the way in which patients are assessed and moved through the department to improve the overall patient experience and the formal opening of our Wirral Breast Centre took place. The Centre is the second largest in the North West and a centre of excellence for diagnosis and treatment of breast cancer.

These achievements have only been possible because of the commitment and calibre of the people who work in our organisation and so staff development and engagement has been a key focus for us.

Participation in the Listening into Action (LiA) programme has enabled us to engage our staff in our vision. More than 1,000 colleagues participated in LiA 'conversations' where they described what matters to them and what changes they would like to see to improve the patient experience and enable them to do their jobs and deliver great service. Work was undertaken to prioritise actions and act on them.

We are now working on a sustainability plan to ensure LiA becomes part of our organisation's culture as a means of creating rapid and effective improvements whilst engaging colleagues in the process.

Another key way in which we learn from staff about the things that matter to them in is through the annual NHS National Staff Survey. This gives us invaluable insight into the issues that concern our colleagues and so I was delighted that the last survey recorded the highest ever response rate.

As well as having high calibre, well trained people in place we also recognise the importance of providing them with good technology support to enable them to deliver the best possible healthcare and service. I am therefore pleased to report that the introduction of our Cerner Millennium IT software system is progressing well with staff and patients already experiencing many benefits as a result. Our Trust was also the recipient of government funded awards totalling £3.75 million for investment in technology which will have a direct impact on the patient experience. This further catapults our Trust in becoming one of Europe's leading IT enabled health organisations.

A highlight of the year was the refurbishment and reconfiguration of the main entrance and reception areas at our Arrowe Park Hospital, which was crowned winner of the 'public vote', winner of the 'small projects' category, and commended in the 'community' category at the Manchester Architects Design Awards 2014, in conjunction with the Manchester Society for Architects.

Arrowe Park sees thousands of patients, staff and visitors walk through its main entrance day in, day out. It had changed little since the hospital was opened in 1982 and it was fair to say that it had reached the end of its wear and tear shelf life and didn't provide the sort of public area that patients expect of a 21st century health service. We now have a 'front door' to our hospital that reflects the quality of the service and healthcare that is provided inside.

The other main 'shop window' on our services is our website and we also recognised that this wasn't a positive reflection of our services. We therefore created a new website which, as well as giving us a web presence that we can be truly proud of and reflects the quality of the services and care we provide, is also one which our

patients, visitors and partners will find genuinely useful as an essential part of their healthcare journey. And, for me, possibly the most appealing aspect of the new website is that it is fully mobile optimised for use on smartphones and tablets.

As part of our embracing digital communications and social media, we now also have a Twitter profile with an ever growing number of followers. Please follow us to learn about what we are doing to achieve our vision @wuthnhs.

Thank you to all my colleagues at WUTH for their magnificent efforts throughout the year and to our many stakeholders for their continued support in providing a public service of fundamental importance.

David Allison

2. Strategic Report

2.1 About us: Trust Overview

Wirral University Hospital NHS Foundation Trust (WUTH) 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 1st 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.

Providing a comprehensive range of high quality acute care services, our 5,785 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 2013/14 centred on contracts placed by primary care organisations and specialist commissioning bodies.

We operate from two main sites:

- **Arrowe Park Hospital,** Upton – delivering a full range of emergency (adults and children) and acute services for adults in the main hospital building. The Wirral Women's and Children's Hospital provides Maternity, Neonatal, Gynaecology, Children's inpatient, day case and outpatient units.

- **Clatterbridge Hospital,** Bebington – undertaking planned surgical services, dermatology services, breast care and specialist stroke and neuro-rehabilitation services.

We also provide a range of outpatient services from community locations:

- **St Catherine's Health Centre**, Birkenhead – providing x-ray, community paediatric services, paediatric audiology and a range of outpatient clinics

- **Victoria Central Health Centre**, Wallasey – providing X ray, some outpatient services and antenatal clinic

- **Other locations** – a range of outpatient services are provided from GP practices, schools and children's centres.

The full range of our services includes:

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

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

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

- patient and public involvement
- quality and safety
- corporate nursing and midwifery
- operations and performance
- strategy and partnerships
- finance and procurement
- human resources and organisational development
- executive office
- information
- facilities and estates management

As 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 care. In 2013-

14 the Trust expanded its apprenticeship portfolio for 16-23 year olds, to include roles in pharmacy, therapies and laboratories.

Our position as a leader in the development and use of clinical information technology (IT) has been strengthened by the on-going 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 in June 2013 phase 2a of the system was switched on incorporating the areas of inpatient spells, clinical coding, maternity and laboratory tests and results.

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.

In 2013-14 the Trust provided the following:

	2013-14
Total Births	3,312
A&E Attendances	93,046
Emergency Admissions *	52,975
New outpatient Attendances	107,606
Diagnostic examinations performed	339,331
Elective Day Case Admissions**	41,515
Elective Inpatient Admissions	8,114

*Including maternity emergencies but excluding births

**Excludes Nephrology

2.2 Our Strategy

In 2013/14, in the context of a changing and challenging external environment in which the NHS is being required to deliver higher levels of quality performance in a constrained financial climate and a strategic desire to see more care delivered closer to people's homes and out of hospital, the Trust agreed a new five year strategy – **'Locally focused - Regionally significant'**. This strategy is based upon a clear vision to be –

"The First Choice Healthcare partner to the communities we serve, supporting patients' needs from the home through to the provision of regional specialist services."

This strategy indicated that over the next five years we will work together to transform our organisation, building on our considerable clinical capabilities, to place our patients and our customers at the heart of everything we do. The focus on exceptional customer service will be delivered through integrated, seamless, continuous pathways of care enabled by innovation and leading edge technology and is underpinned by a set of clear strategic objectives, which have agreed annual milestones attached to them:

- to be the top NHS Hospital Trust in the North West for patient, customer and staff satisfaction
- to lead on integrated, shared pathways of care with primary, social and community care
- to deliver consistently high quality secondary care services enhanced through the provision of regional specialist services
- to ensure our people are aligned with our vision
- to maximise innovation and enabling technologies
- to build on partnering for value
- supported by financial, commercial and operational excellence.

These strategic objectives have been used to inform the development of divisional and corporate department plans and feed into the Trust's appraisal process to ensure that the delivery of these objectives is tied in to all department, team and individual objectives.

The delivery of high quality care is at the centre of our vision and values. The Trust has established its core values, PROUD, which sets out the expectations of our staff in providing an excellent service to our patients. These will be re-launched in 2014-15:

Patients focus

Respect

Ownership

Unity

Dedication

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.

3. Business Performance

3.1 Performance against Compliance / Risk Assessment Framework Targets

The primary process for foundation trusts to assure themselves on governance and performance was Monitor's Compliance Framework for the period April to September 2013, superseded by the Risk Assessment Framework from October 2013. Performance against the key Framework metrics is detailed below.

National targets and regulatory requirements	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	Minimum 93%	96.6%	96.7%	97.3%	95.7%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all breast symptom referrals	Minimum 93%	95.4%	98.0%	98.8%	98.6%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	Minimum 96%	97.5%	97.3%	97.3%	98.5%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer (surgery)	Minimum 94%	96.9%	98.4%	98.1%	96.1%
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%	87.4%	86.7%	85.0%	86.4%
Maximum waiting time of 62 days from screening referral to treatment for all cancers	Minimum 90%	100%	94.7%	95.4%	100%
Referral to treatment time – admitted patients < 18 weeks	Minimum 90%	93.2%	93.9%	93.6%	92.6%
Referral to treatment time – non-admitted patients < 18 weeks	Minimum 95%	97.8%	97.0%	97.0%	96.9%

Referral to treatment time – incomplete pathways < 18 weeks	Minimum 92%	92.6%	94.7%	94.3%	94.0%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Min 95%	95.4%	95.2%	95.2%	92.7%

The above table lists the Trust's performance on these key targets during 2013/14. The following commentary on these performances provides further information.

3.1.1 Access to cancer care

It is pleasing to report that the Trust consistently achieved the Cancer access targets for all quarters and for all metrics across the whole of 2013/14. This reflects the dedication of staff across many disciplines and departments in ensuring these most vulnerable patients experience as few delays as possible in accessing high quality treatment at every step of their clinical pathways.

3.1.2 Access to Elective Care

Another important measure of patient experience is in the standard that all patients should commence treatment within 18 weeks of referral into a hospital service. Again all the standards relating to Referral to Treatment (RTT) within 18 weeks were met by the Trust throughout 2013/14. This includes patients that are both treated and those still waiting for treatment. This performance was reflected at individual specialty level with very few exceptions in the year.

There is a continuing commitment at the Trust to ensure waiting times for all patients are as low as possible and so minimise delays in accessing services. There can be difficulties in 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 ability to directly book initial outpatient appointments at WUTH from GP surgeries ('DBS – Directly Bookable Services') was expanded through 2013/14. The Trust is committed to reducing waiting times in the outstanding specialties to the requisite maximum six weeks, thus enabling the further roll-out of this improved method of access for patients and GPs.

3.1.3 Access for Emergency Patients

The key measure in this area focuses on admitting, transferring or discharging patients attending our Accident and Emergency department within four hours. For the first three quarters of 2013/14 this standard was met for patients attending the

emergency department at WUTH, including those attending the All Day Health Centre at the Arrowe Park site.

Across the NHS historically, quarter four is busier than most other quarters, however in 2013/14 the increase was even more marked. There was greatly increased pressure on the 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.

A range of work streams are underway within the hospital to help improve patient flow. Discussions are also on-going with the wider health economy around a number of further key work streams which will help give a better understanding of demand and / or improve patient flow across partner organisations.

3.2 Performance against Strategic Objectives

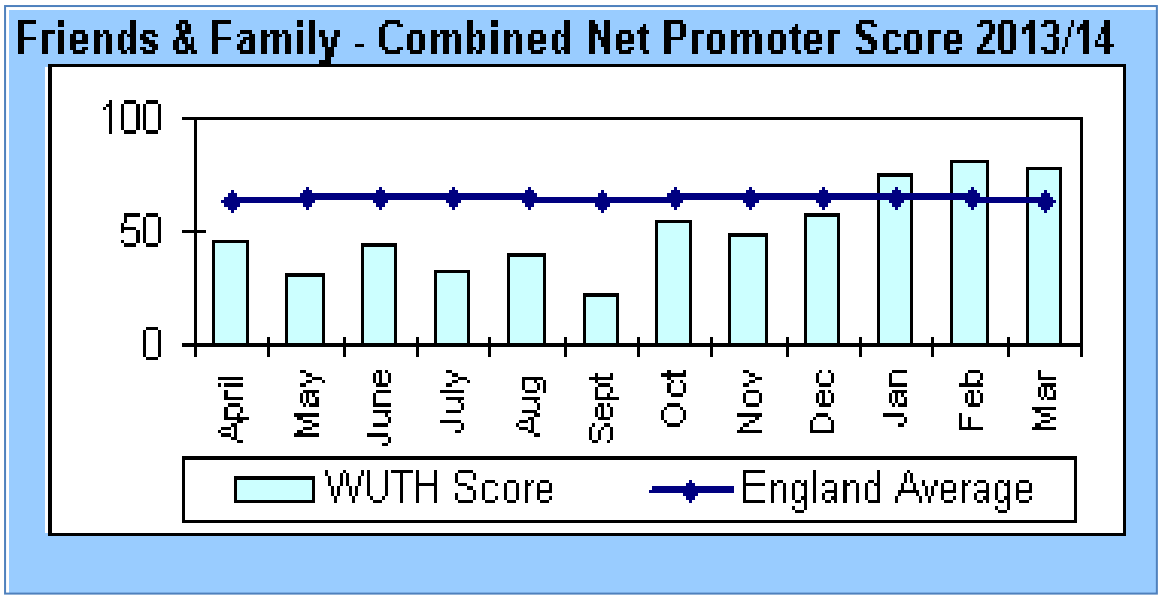
Alongside the above regulatory assessment on WUTH's performance, the Trust has set five-year milestones in support of the "Locally focused - Regionally significant" strategy to 2018. The strategic objectives and progress against the milestones are detailed below.

3.2.1 To be: The Top NHS Hospital Trust in the North West for Patient, Customer and staff satisfaction

This objective focuses on how we are judged by the patients that use our services and the staff we employ. Since April 2013 the following "Friends and Family Test" question has been asked in all NHS inpatient and A&E Departments:

"How likely are you to recommend our [ward/A&E department/maternity service] to friends and family if they needed similar care or treatment"?", with answers on a scale of extremely likely to extremely unlikely.

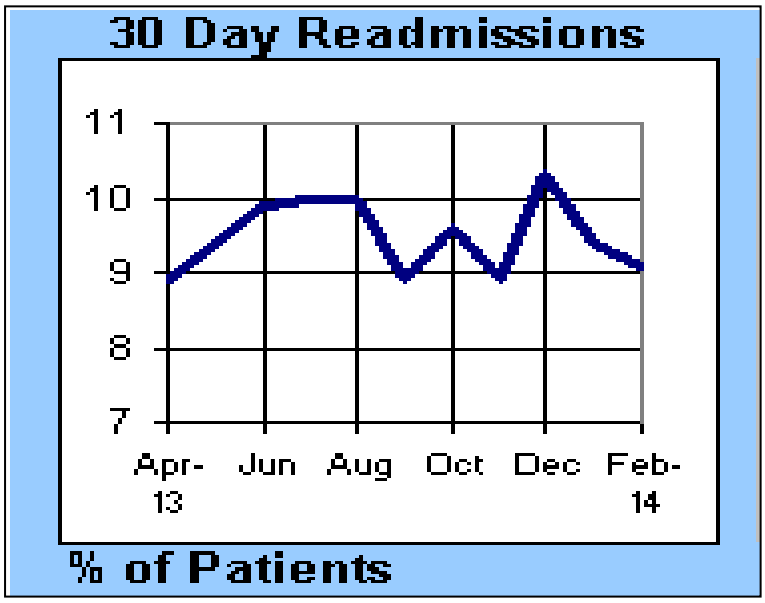
The chart below illustrates the greatly improved scores across the year, to the point where WUTH is exceeding the national average and for A&E scores ranks as one of the top Trusts in the country.


Friends & Family - Combined Net Promoter Score 2013/14
100
50
0
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
WUTH Score
England Average

3.2.2 To Lead on: Integrated, Shared Pathways of Care with Primary, Social and Community Care

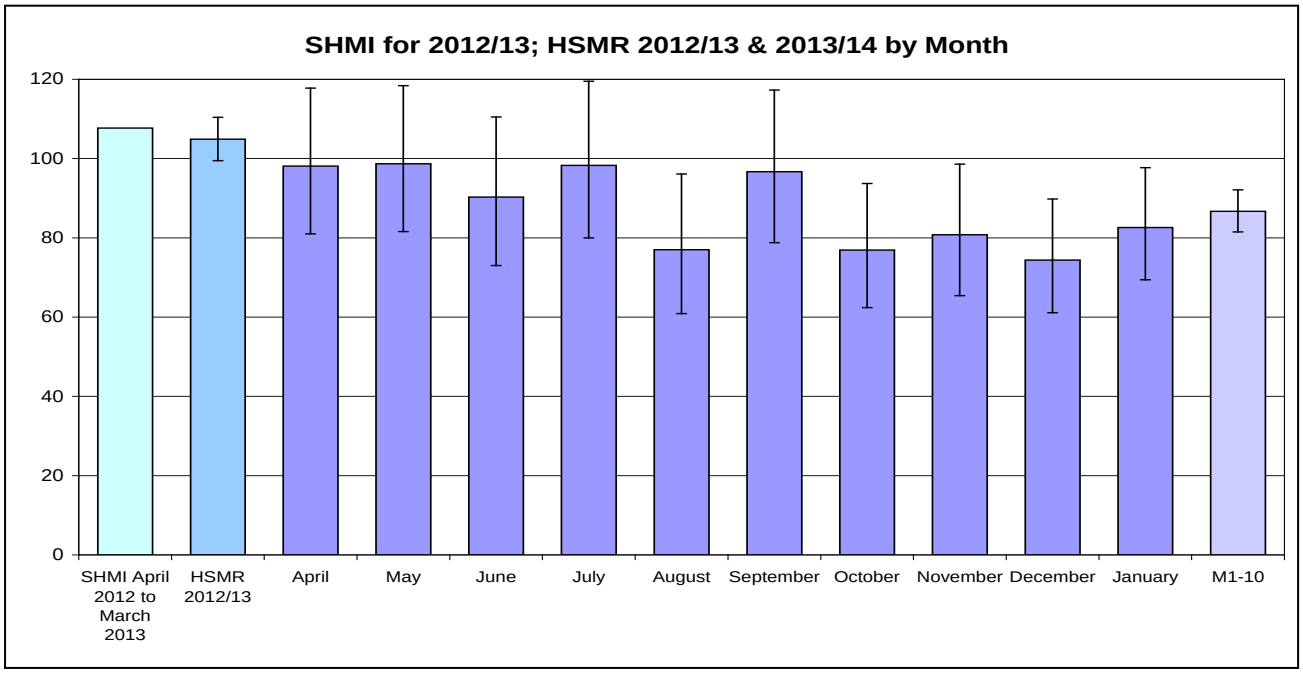
This objective recognises that many clinical pathways for patients cross organisational boundaries, requiring a commitment to co-ordination and co-operation.

A milestone against this objective is the aim of reducing the rate of patients readmitted within 30 days following a previous discharge. The chart below illustrates the rate across 2013-14, and illustrates the variability across the year, and the difficulties getting the rate down below the target of 8.4%.



3.2.3 To deliver: Consistently High Quality Secondary Care services enhanced through the provision of regional specialist services

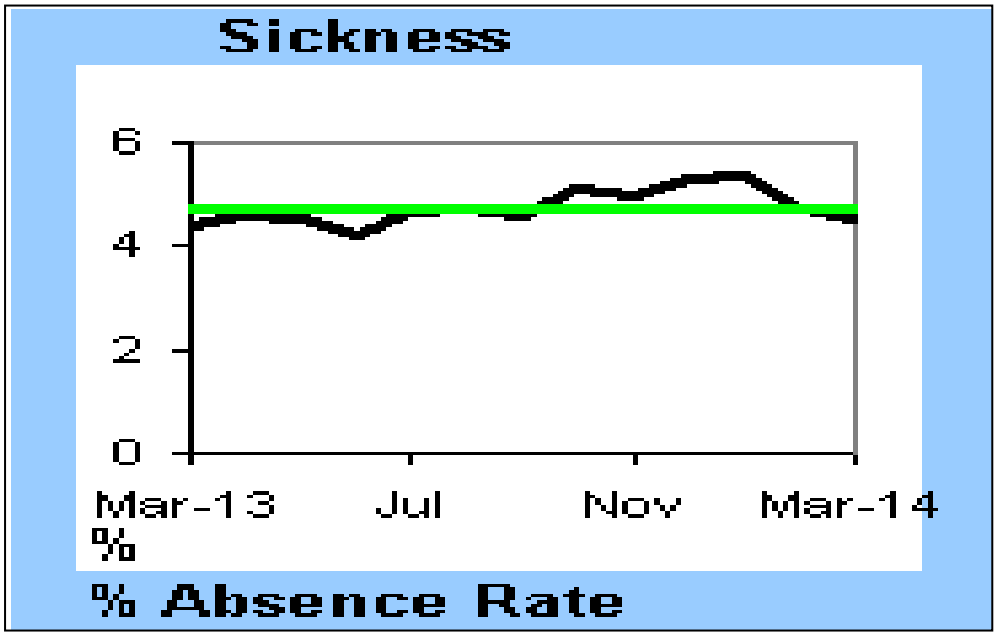
As a headline measure, mortality expressed in the Hospital Standardised Mortality Ratio (HSMR) can be considered an absolute measure of the quality of care. The improvement in the Trust's HSMR for 2013-14 is visible in the chart below, and to the end of January 2014 is ahead of the target set for the year as a maximum rate of 95.



3.2.4 To ensure: Our people are aligned with our vision

An engaged and motivated workforce is essential for delivering high quality services to patients. A simple metric of attendance is used in conjunction with other measures against this objective.

The chart below illustrates the sickness absence rate across 2013/14. The rate has fluctuated across the year, with the year-end rate being improved from the increases experienced in the winter months. The milestone rate of 95.3% attendance was met for the year.



3.2.5 To maximise: Innovation and Enabling Technologies

In June 2013 the Trust went live with the second major phase of its Cerner Clinical IT System 'Wirral Millenium'. The large-scale areas implemented covered Maternity, Pathology and Inpatients. Enhanced functionality within these areas helps to provide better services for patients with electronic pathways for most conditions. This allows patient information to be securely accessed from anywhere within the Trust and at any time, reducing duplication of information, replacing paper-based working practices, freeing up resources for patient care and ensuring patient services are more effective and efficient.

3.2.6 To build on: Partnering for Value

In support of the overarching strategy of being ‘Locally focused - Regionally significant’, the Trust has set an objective to increase its market share of referred patients from Wirral GPs. The target for 2013/14 was to achieve a 75.9% share. The most recent information available to the end of February 2014 shows WUTH exceeding this with a market share of 79.6%.

3.3 Development of the Trust during 2013/14

In 2013/14 Wirral University Teaching Hospital was proud to have delivered against its core vision of being the “first choice healthcare provider for the communities we serve”. Amongst many other achievements, the Trust was assessed as meeting all standards reviewed by the Care Quality Commission in their unannounced three day visit in November 2013. Our maternity and stroke services have been assessed as the best in the North-West and the Trust successfully delivered targets to manage MRSA and C. difficile infections.

In December 2013 the Trust launched its Nursing and Midwifery Strategy, which sets out the framework for delivering excellent care to our patients: care which will be delivered through modern, patient focused nursing and midwifery based on traditional values. The staff survey in 2013 saw a response rate of 60% (43% in previous years), and reported that the overall staff engagement level has also improved for the second year running. The Trust will review the 2013 survey results and identify measures for further improvement in 2014/15. In response to previous staff survey results the Trust focused on increasing staff appraisal rates and achieved its highest ever rate in 2013/14.

Recognising the challenges facing the Wirral health and care system over the next five years, the Trust joined partner agencies in Wirral to establish the Vision 2018 programme, which was launched in February 2014. A governance structure has been agreed and redesigned models of primary, secondary and integrated care will be considered. The Trust and its senior clinicians are engaged with this process.

The Trust has also worked in partnership with teams from Wirral Community Trust and Adult Social Services to establish an Integrated Discharge Team based on the Arrowe Park Hospital site. This has already contributed to a significant reduction in the numbers of patients experiencing a delayed discharge. Trust staff have actively participated in Wirral wide workstreams to develop integrated care co-ordination teams in the community that will support patients to manage their care in their own home and prevent unnecessary admission to hospital. WUTH, Wirral Community Trust and Brook were successful in bidding to run Sexual Health services in Wirral from April 2014. The Trust also has developed a primary care engagement strategy to build on its relationship with local GPs and their practices.

The Trust has continued to build on its collaboration with organisations in Cheshire. The Wirral and Chester human milk banks have come together with Chester University to establish a brand new facility, the north-west human milk bank on the main Chester University Campus. Work has been on-going with the Countess of Chester NHS Foundation Trust to explore further opportunities to build on existing collaborative services.

In 2013/14 the Trust worked with health partners on the HIE (health information exchange) system which enables Cerner Millennium to view primary care data which will support the safe and effective management of patients in secondary care.

A number of significant capital developments in 2013/14 will improve the care and experience our patients have at the Trust:

- the first phase of a £1.2m Emergency department remodelling was completed in November 2013 with new reception, waiting area, See and Treat capacity and mental health unit
- the therapy gym at Wirral Limb centre was reopened in November 2013 providing new facilities for patients from the Wirral and Cheshire areas who have had amputation or have a limb deficiency
- the Eden Suite, which will provide midwifery led care to women in labour, was opened in February 2014. It includes birthing pool facilities
- in March 2014 the refurbished main entrance of Arrowe Park Hospital created a clean, bright and confident environment to welcome patients and visitors to the Trust.

The Trust also invested in a £6.3m “green makeover” to further reduce the size of its carbon footprint on the Arrowe Park and Clatterbridge Hospital sites.

Specialist equipment was purchased by the Trust in 2013/14 to enable clinical teams to deliver improved diagnostic and surgical care:

- endo-bronchial ultrasound (EUS) will enable more rapid diagnosis of lung cancer
- the Da Vinci robot, which allows surgeons to perform complex laparoscopic procedures in specialities such as Urology and Gynaecology
- ultra sound imaging will enable nerve blocks to be performed on patients rather than having to undergo general anaesthetic.

Many of the above developments have already contributed to the Strategic objectives set by the Trust as part of its Business Strategy 2013-18, ‘Locally focused - Regionally significant’. The Trust will continue to build upon these successes in 2014/15 to realise its five year vision to transform our organisation, building on our considerable clinical capabilities, to place our patients and our customers at the heart of everything we do.

3.4 Financial commentary 2013/14

The Trust faced a difficult financial year in an increasingly challenging financial environment for the public sector, and the NHS specifically. Whilst the Trust planned for a surplus of £2.8m the financial statements highlight the delivery of a deficit of £3.0m. The financial performance was characterized by overspending in the first quarter of the year, followed by poorer income performance into the second quarter. The Board of Directors implemented a series of measures throughout the year to reduce costs and increase income. The poor performance in the first half of the year improved through the final two quarters, however Monitor opened a financial investigation into the Trust's financial planning, governance and performance in November 2013 concluding and closing the investigation, without formal regulatory action, in February 2014. Whilst no formal regulatory action was taken the Trust remained on monthly financial monitoring through 2013/14.

Additional costs in the early part of the year, and also in the final months, were incurred to support additional beds and staff capacity to ensure safe, high quality care was maintained against increased volumes of activity. Whilst some additional winter pressure monies were secured, these were insufficient to cover the costs associated with ensuring access for urgent care. The Trust is actively engaged with health economy partners in determining how the increase in unplanned inpatient care can be managed in different settings so that the Trust does not incur future costs in an unplanned way. The expectation of reduction in urgent care demand into secondary care forms a pivotal strand of Vision 2018, although the anticipated change in flow of patients is yet to be seen within the hospital setting.

Whilst the Trust's income achievement varied against its planned profile during the year, it marginally overachieved against planned income targets by year-end. Moving forwards, it is the Trust's expectation that income growth will be minimal and that any growth opportunities will be either through development of new services, potentially with partners, the repatriation of care currently provided to Wirral residents outside of the Wirral, or through provision of care across an extended geographical area. Specifically in year the Trust saw the development of agreements with North Wales Commissioners for the provision of specialist neonatal care services at Arrowe Park Hospital and it is anticipated that additional income associated with this service will be attracted.

A core element of the Trust's financial plan was the requirement to deliver efficiency savings totalling £16m on a recurrent basis. The Trust achieved £9.4m in year with a full year effect of £16m and applied reserves of £6m on a non-recurrent basis to bridge the in-year shortfall. Moving forwards, the Trust anticipates that an ongoing efficiency requirement of a minimum of 4% is likely to be required and this will pose a significant challenge to the provision of financially sustainable services. The Trust has a savings requirement for 2014/15 of circa £13m. Maintaining a balanced financial position in an environment of decreasing resources is likely to demand that

the Trust plans and delivers services differently into the future compared to its current service models.

Whilst the Trust's revenue position was challenging, in year the Trust maintained a level of investment in development and improvements to the hospital's facilities and equipment. These are essential investments, not only for the current period, but also for the future delivery of care. Whilst significant investment was made, the revenue position did mean that the investments made fell below those initially planned. The Trust planned to spend £13.2mon capital development and spent £9.9m. Although investment was maintained, it was not at the planned level and the in-year reduction had no impact on the provision of high quality patient care, however sustained reduction in capital investment will, over time, impact on the Trust's ability to maintain its estates, facilities and equipment. Significant capital investments in year included the redevelopment of the A & E department, continued maintenance of the Trust's estate and the redevelopment of the Trust's main entrance as part of a broader programme of "First Impressions". Additionally the Trust continued its investment in its leading edge IT system Cerner maintaining its position as a leading Trust in the UK and Europe for its application of IT solutions in the provision of health care. The Trust was allocated £3.75m of central government funding.

Internally the Trust also developed its understanding of income and costs for each of its specialties through a Service Line Management approach and this identified several opportunities for improvement which will continue to be explored in the coming financial periods.

Over the year the cash position fell £14.9m from £24.9m to £10.0m, against a planned level of £17.5m. The fall against plan was due to the financial performance and a delay in receipt of some commissioner payments due.

In conclusion 2013/14 was a difficult financial year for the organisation and one in which it did not achieve its overall financial plans. The future periods are likely to be equally challenging, however significant changes in planning, specifically in the development of cost saving delivery, have been implemented to support returning to the delivery of a surplus position in the medium term.

3.5 Future Outlook

The future financial outlook for the organisation will be challenging, as it will be for many medium to large district general hospitals. The Trust's financial plans recognise the pressures likely to be faced in the coming two financial years which identify deficits of £4.2m and £1.2m in 2014/15 and 2015/16 respectively. The Trust will seek some external support to underpin the necessary operational planning changes required to achieve a sustainable surplus position. The focus of the Trust's attention in the near term will be to address its internal operational issues to improve service and financial offering whilst engaging with local economy partners and neighbours to deliver strategic change to achieve operational, clinical and financial outcomes.

Specifically for 2014/15 the Trust has revised its approach to the achievement of savings having established a Programme Management Office (PMO) in the later part of the 2013 calendar year. The Trust has identified five key themes through which all savings proposals will be managed and a robust governance structure for the future identification, development, planning and delivery of savings proposals. In parallel with the development of all schemes a risk assessment process is undertaken to ensure that changes will not have a detrimental impact upon the provision of the highest quality care; the metrics associated with this are scrutinised by the Trust's Quality and Safety Committee. To date the Trust has identified in the region of 60% of its in-year savings requirements although it is recognised that there are delivery risks associated with this value. To supplement the in-year delivery the Trust has identified a further two main strands of activity for savings focused on the organisational structure and the operational capacity of the organisation. Cost Improvement Programme (CIP) achievement will be a critical success factor for the Trust in the coming years in maintaining financial balance.

The Trust continues to work closely with its Clinical Commissioning colleagues in agreeing a clinical contract for 2014/15; these negotiations have been challenging within the context of increasing volumes of care, decreasing levels of commissioner funding and the structural changes of funding transfers through the Better Care Fund to facilitate changes in the provision of health and social care services. The Trust is fully committed to playing the fullest part in supporting these changes recognising that within the overall strategic context individual organisations must ensure that they secure sufficient resources to meet the financial challenges they each face. In securing a balanced financial settlement for 2014/15 and beyond the Trust is exploring different contracting approaches and methodologies including elements of "block" contracting and "prime contractor" models. Agreement of emerging contracting models will only be reached where the Trust identifies that there is a balance in the risk, reward and economy wide responsibility for delivery of service change which sit behind each of these contracting models so that the Trust is not exposed to disproportionate risk or risk which it cannot influence or manage.

There was also an escalation in costs through 2013/14 which are, in part, likely to continue into 2014/15 and we are taking steps to address these. Escalating costs include those associated with the provision of additional nursing staff to ensure compliance with new national recommendations through the Francis report, the maintenance of additional capacity to ensure increased volumes of care associated with urgent and emergency admissions to hospital and costs of temporary staff specifically in areas where needed recruitment remains a challenge, such as medical staff within the Emergency Department. The Trust, in its planning for 2014/15, has recognised that some of these costs may persist in the short term and is therefore forecasting an in year deficit.

The above income and expenditure issues continue to place pressure on the Trust's cash and working capital balances which will require close management and greater organisational visibility throughout the financial period. The Trust has developed a specific programme of work to support an improved cash position, is planning to dispose of one of its buildings through the financial year and is also in negotiations to have an accessible overdraft facility in place throughout the financial year.

In managing the above financial outcomes, whilst the Trust has identified some headroom within its planning framework, this is less than in previous years and therefore the scope for the management of deviation from the plan is diminishing. To more closely manage adherence to the plan the Trust has enhanced its operational performance management regime, led on a monthly basis directly by the Executive Team.

Given the difficult revenue position, the Trust's capital investment in the coming years will be limited to the resource it internally generates. The key features of the capital investment will be to continue support of the Trusts Information Management and Technology (IM&T) development (Cerner), to maintain key equipment and estates backlog provisions and, where financial flexibility allows, to continue to refurbish patient facing areas.

The combination of challenging CIP targets, difficult contracting discussions, cost pressures, diminishing internal flexibility and a stretched cash position has resulted in the Trust forecasting a planned Continuity of Service risk rating (CoS) of 2 for each quarter of the coming financial year.

In recognition of these challenges the Trust is also proposing revisions to the structures through which it performance manages the organisation both operationally and financially and also how it ensures that the Board of Directors secure the appropriate assurances on delivery of the in year plan and achievement of strategic objectives.

The themes which run through 2014/15 are likely to continue into 2015/16 although the work the Trust is undertaking is aimed at mitigating these pressures and taking a step towards financial improvement through these periods from the forecast deficit of

£4.2m to £1.5m in 2015/16. The translation of these financial outcomes being reflected in quarterly CoS rating as described in the tables below.

Planned Continuity of Service (COS) Ratings:

2014/15:

	Annual Plan 2014/15	**Q1 2014/15 Plan**	**Q2 2014/15 Plan**	**Q3 2014/15 Plan**	**Q4 2014/15 Plan**
Under the Risk assessment framework					
Continuity of Service (COS) rating	2	2	2	2	2

2015/16:

	Annual Plan 2015/16	**Q1 2015/16 Plan**	**Q2 2015/16 Plan**	**Q3 2015/16 Plan**	**Q4 2015/16 Plan**
Under the Risk assessment framework					
Continuity of Service (CoS) rating	2	2	2	2	2

Whilst the above reflects a challenging financial position the Trust is taking internal actions, supported by external expert input as required, to ensure that there are operational improvements leading to a different financial outlook in the coming financial periods.

3.6 Trends and factors likely to affect future developments, performance and position of the Trust

There are a number of factors that may affect future developments, performance and position of the Trust. Wirral University Teaching Hospital is already in the process of establishing plans to manage or mitigate these factors:

3.6.1 Delivery of higher levels of quality, safety and patient experience in a constrained financial climate

Consistent with the national trend, the Wirral health and social care system is facing the dual challenge of continuing to improve levels of quality, safety and patient experience, combined with a challenging financial climate. Commissioners and Providers each face significant savings challenges over the next five years, ranging from £21million to £32million per year. Given the scale of this challenge, the traditional approach to delivering efficiencies will not be enough to ensure high quality and affordable health and social care services continue in the future. Partners in Wirral have recognised that they must work together to ensure the Wirral population continues to receive high quality services from the available health and social care budgets.

The partner agencies in Wirral have agreed that the significant challenges the local health economy faces are best resolved through partnership working and ensuring the views of clinicians, local people and partner agencies inform what we do to deliver sustainability going forward to 2018. Through the establishment of the 'Vision 2018' programme, a vision for the future of health and social care on the Wirral has been created.

A further financial factor that may affect the organisation is the delivery of a challenging Cost Improvement Plan (CIP). Significant improvements have been made in the development of a Programme Management Office and methodology to support the CIP. The Trust is working with colleagues to ensure wide and deep engagement in the development of plans to ensure that improvements in efficiency are delivered through improvements in quality – such as reducing waste or error.

3.6.2 Local health economy demographic context

Of the local population, those aged 65 years and above are projected to increase by 18% from the present level of 61,900 by 2021 (ONS 2011 based population projections, 2012). The population over 85 is projected to increase from 8,460 in 2011 to 10,985 in 2021, which equates to a 29.9% rise. This older population is also more likely to have a long term condition, with the 2011 census reporting that about

36,000 (57%) people living in Wirral aged 65 years and over reported a long term condition or disability that limited their daily activities.

Wirral also has the widest inequalities in Disability Free Life Expectancy (DFLE) of any Local Authority in England in 2012. Men living in the most deprived areas can expect to spend 20 more years of their lives living with ill-health or disability than men living in the most affluent areas. For women the difference is 17.1 years.

Lifestyle related issues such as smoking, drinking too much alcohol and obesity are all more prevalent in the most deprived areas of Wirral, with rates of breastfeeding lower than in comparable parts of the North-West. Alcohol is a significant problem and death rates from digestive diseases linked to alcohol are increasing rapidly in the most deprived areas. Numbers of looked after children in Wirral are higher than the national average and, amongst older people, dementia is a current concern and forecast to become a greater problem, with an estimated 4,443 people over 65 living on the Wirral with dementia in 2011. This is projected to rise to almost 5,300 within the next eight years (Wirral CCG prospectus 2013-14). Admissions to nursing homes in the Wirral are also higher than comparable areas of England.

The Trust takes into account these factors as it plans and delivers its services and is working with its patients, carers and partner agencies to mitigate the impact they may have.

3.6.3 Reduction in commissioned activity from the CCG and transfer of care from acute care to Primary and community care settings

The Better Care Fund presented to Wirral Health and Wellbeing Board in March 2014, describes an overall targeted reduction of 15% non-elective admissions (2014/15 and 2015/16), a targeted reduction of 3% of avoidable emergency admissions by March 2015 and a 20% reduction in planned care demand over the next 5 years. The Trust recognises that this direction of travel is in line with its own aspiration to deliver more integrated care outside of the acute setting but also that this is challenging and a “step change” in delivery for the health and social care economy. The Trust has sought assurance that this change will be thoroughly implemented and governance processes will quickly identify any deviance from the planned outcomes with a plan of appropriate mitigation taken immediately.

3.6.4 Reconfiguration of specialist services

NHS England has stated that specialised services must change, with fewer centres offering improved quality and sustainability more closely linked to research and

innovation. The Trust is committed to working in partnership with NHS England: Cheshire, Warrington and Wirral Area Team as it develops the North West five year strategic plan for Specialist Services Commissioning. The Trust's five year strategy, locally focused-regionally significant, demonstrates our intention to provide regional specialist services where we have the clinical capability and expertise to do so.

3.7 Environmental Matters

Our activities potentially impact on the environment in different ways; including consumption of energy and water, the production of waste and many vehicle journeys undertaken by staff and patients to and from our hospitals. In 2013/14 the Trust took a significant step towards reducing its environmental impact.

In August 2013, the Trust entered into a 15-year partnership with Ener-G Combined Power Ltd under the NHS Carbon & Energy Fund framework. Ener-G are investing £6.3 million in the energy infrastructure of both hospital sites, which will result in a reduction of the Trust's carbon footprint of approximately 6,200 tonnes per year. This represents a circa one-third reduction in carbon emissions and an annual saving on utility bills in excess of £200,000. The main elements of the investment are the provision of new combined heat and power (CHP) units at both hospital sites. The project also includes energy-efficient lighting, pumps, chillers and water-saving measures throughout both sites.

Other capital schemes undertaken during the year have also contributed to reduced energy consumption, including:

- improved insulation for flat roofs as part of a rolling programme of roof replacements
- introduction of water-saving measures as part of the refurbishment of a number of public toilets around the hospital
- replacement windows at Willow House on the Clatterbridge site
- vacation of the under-used C Block building at the Arrowe Park site, in preparation for demolition.

The Trust routinely reviews opportunities for including energy-saving measures within all planned capital projects, whether new build or refurbishment.

Travel to and from our hospital sites is a major contributor to carbon emissions. The Trust has a Travel Plan which is reviewed and updated bi-annually. It includes carrying out staff and visitor travel surveys and setting targets for increasing sustainable modes of travel to our hospitals in order to reduce dependence on the car. Our Travel Plan is supported by a transport strategy group, involving Trust staff and governors together with colleagues from Wirral Borough Council and Merseytravel, the local transport authority serving the Wirral.

Work with Merseytravel during 2013/14 has resulted in plans being agreed for major improvements to the bus interchange at the Arrowe Park site to improve the service for staff and visitors. The scheme includes new bus shelters and real-time information screens and is expected to commence in the summer of 2014.

In order to encourage more staff to cycle to work, we have continued to operate a salary sacrifice scheme for cycle purchase: 27 members of staff took advantage of

the scheme during the year. We have invested in additional security measures for the main cycle store at Arrowe Park Hospital.

Our hospitals are at the forefront in terms of waste management, reduction and recycling. In 2013/14 we reduced the total amount of waste we produced by more than 130 tonnes (6%) compared to the previous year and increased our overall recycling rate from 25% to 28%. An independent external review carried out during 2013 recognised that the Trust's waste management processes "*...have been well thought through and the environmental credentials must be among the best in the country."*

An Environmental Action Team comprising membership from across the Trust continues to take forward our Sustainable Development Management Plan. Our plan focuses on reducing the Trust's environmental impacts from energy, buildings, waste, transport and procurement. The Trust is also an active member of the Wirral Climate Change Group, together with representatives of all the other major public sector bodies serving the Wirral.

3.8 The Trust's Employees

The number of whole time equivalents (WTE) employed by the Trust during 2013/14 (at year end) was 4808.60 WTE and the total number of employees was 5785 (Head Count).

The following table provides a more detailed breakdown of our employees by WTE and Headcount for 2013/14 (year-end). This is broken down by staffing groups and by the number of male and female employees.

Staff Group	WTE	Headcount
Add Prof Scientific and Technic	189.90	210
Additional Clinical Services	829.57	993
Administrative and Clerical	967.88	1106
Allied Health Professionals	252.42	312
Estates and Ancillary	603.73	935
Healthcare Scientists	125.70	141
Medical and Dental	377.71	400
Nursing and Midwifery Registered	1446.09	1672
Students	0.60	1
Directors	6.00	6
Chief Executive	1.00	1
Chairman	1.00	1
Non Executive Director	7.00	7
Grand Total	**4808.60**	**5785**

Gender	WTE	Headcount
Female	3714.97	4599
Male	1093.63	1186
Grand Total	**4808.60**	**5785**

3.8.1 Male and Female Board Directors at year-end

	Male	Female
Director	3	2
Chief Executive	1	0
Chairman	1	0
Non-Exec Director	3	4
TOTAL	8	6

3.8.2 Male and Female Senior Managers

	Female		Male		Total WTE	Total Headcount
Payscale Description	Headcount	WTE	Headcount	WTE		
Band 8 - Range A	85	76.55	32	31.50	108.05	117
Band 8 - Range B	24	22.62	16	15.21	37.83	40
Band 8 - Range C	17	15.96	7	7.00	22.96	24
Band 8 - Range D	3	3.00	2	2.00	5.00	5
Band 9	1	1.00			1.00	1
Senior Manager	4	3.95	4	4.00	7.95	8
Grand Total	134	123.07	61	59.71	182.78	195

Given that our workforce is our greatest asset, significant work has been undertaken on delivering the Workforce / Organisational Development Strategy. Through the strategy, we have sought to create a working environment where highly engaged and professionally competent staff flourish in a “can do” culture of innovation, where the patient is always the primary focus. The strategy addresses the key workforce / organisational development issues arising out of the Francis report including staff working to the Trust’s values and behaviors in a culture of openness and candour, where staff are listened to and where the patient comes first.

Our focus on front line services has increased the consultant and nursing establishment and there is currently a further review of nursing establishment being conducted across the Trust. A robust development plan for Advanced Nurse Practitioners has been developed throughout the Trust, which is currently being implemented. Allied Health Professional reviews have been undertaken to ensure the services we provide are fit and sustainable with a focus on care in the community. The Trust has continued to undertake regular skill mix and grading reviews, the purpose of this being to ensure staffing levels remain safe and appropriate.

The Trust is committed to protecting front line services, however, we have worked hard to control workforce costs; measures include natural staff turnover coupled with an effective vacancy control process, skill mix redesign, redeployment, voluntary severance scheme and shared services working. All workforce cost improvement programmes are assessed against workforce implications, this ensures that we have safe staffing levels to maintain patient care and safety. Any change programmes which affect our workforce are underpinned by the Organisational Change Policy and effective Partnership working with our Trade Union colleagues.

Given the changing landscape, workforce profiling will continue to be a fundamental enabler to deliver the changes required in the coming years. The Trust has developed a Workforce Plan which projects the anticipated workforce movement by staffing group. The focus on frontline services will remain however, the size of the future workforce in particular staffing groups may reduce e.g. administration and

clerical, managerial. The Trust has identified a range of work programmes that will deliver the Workforce Plan, for example a full organisational workforce review planned for 2014/15.

3.9 Social, Community and Human Rights Issues

The Trust enjoys well established working relationships with a range of local stakeholder groups and organisations including the Older People's Parliament, the Carers Association and Wirral Multicultural Organisation. The Trust works with Healthwatch to ensure we are informed of the local public's views on health care issues and can take appropriate action.

Many stakeholder groups are standing members of the Trust's patient and family experience group which is integral to the organisations governance structure. We are able to send information to local 3rd sector organisations through Voluntary and Community Action Wirral (VCAW) who act as a network lead. The Trust also has representation on a number of Wirral wide boards, e.g. Carers partnership.

The Dementia steering group, which is chaired by WUTH, has representation from third sector organisations that are consulted in regard to delivery of care for dementia patients using the Trust's services.

The Trust is represented on the Maternity Services Liaison Group (MSLG), a statutory group which includes service providers, commissioners and local service users. Via the MSLG, local service users are consulted on the development of local maternity services and are able to comment on guidelines and policies being developed for the Trust's maternity service.

As we go forward, the Trust aspires to consult more comprehensively on our service with partners and stakeholders, and where it is more appropriate we will undertake consultation jointly with other health and Social care organisations, for example the development of the Vision 2018 strategy.

The Trust is also represented at local Public Service Boards where partner organisations, including Wirral Council, Health organisations, Police and Fire services proactively work together to identify opportunities for joint working that will benefit local communities.

3.9.1 Human Rights Issues

The Trust ensures that equality, diversity and human rights are embedded into its policies and practices. Processes exist to ensure that the Trust complies with its public sector equality duty; this includes an analysis of all policies, especially those relating to vulnerable patients. The Trust also has comprehensive engagement activity with groups who represent patients with protected characteristics including the Older People's Parliament Carers Association, Wirral Multicultural Organisation and the Alzheimers Society. Representatives from some of these groups are standing members of the Patient & Family Experience Group.

3.9.2 Risks and Uncertainties Facing the Trust

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:

3.10 Balancing CIP and Quality

The Trust has worked hard through 2013/14, with the support of an external partner, KPMG, to establish a Programme Management Office to support the identification, development, delivery and tracking of cost improvement programmes.

The Trusts holds, as a core belief, that the method of delivering sustainable change and cost improvement must be through changes in behaviours and care pathways which do not reduce the quality of care provided. An explicit component of each CIP scheme development is a risk assessment which includes: consideration of potential impacts on quality; mitigating actions for any identified risks; and how these actions would be implemented. The Trust has an established governance process for signing off higher valued or higher rated risk proposals which includes agreement through the Executive Directors Team of which the Director of Nursing and Midwifery and the Medical Director are members.

Each month the Trust's Quality and Safety Committee, a committee of the Board of Directors, receives a report on the levels of savings made in-month and cumulatively in year and maps the achievement of these savings against a series of metrics which consider qualitative issues, including: patient satisfaction, staff satisfaction and productivity and efficiency improvements. Through the established systems and processes the Trust builds quality and safety considerations into individual schemes and also monitors the impact of savings at an aggregate level. The Trust ensures that both at an operational and Board assurance level, CIP delivery does not impact upon the quality of care delivered.

3.10.1 Operational Expenditure

The Trust faced a challenging financial year in 2013/14 and the movement away from plan was largely driven by an in-year shortfall against CIP compounded with additional operational expenditure across a series of areas.

The features of operational over-spending were mostly associated with the maintenance of additional capacity to support capacity pressures from both planned and unplanned activity.

The Trust continued to incur significant costs for additional planned activity undertaken and is increasingly focused on accommodating this demand within its core activities, as well as making adjustments to the future rates of payment for additional activity.

Additional costs were incurred in the Trust's Emergency Department in caring for A & E attenders as well as in inpatient areas where emergency pressures required the Trust to maintain bed capacity above plan. Bed pressures were exacerbated through

a paucity of intermediate care beds for older patients meaning that in many cases patients who were medically well continued to be cared for in the hospital rather than in an alternative step-down facility, nursing home or their own home. Good work between economy partners in the later part of the year had been undertaken and it is hoped that the flow of patients out of the hospital, once their acute care has been completed, will be expedited.

3.10.2 Implementation of the Wirral Millennium System (phase 2a)

The risk of slippage to the delivery of phase 2a of the Millennium implementation programme was mitigated through robust programme and project management and by on-going monitoring of progress by the established governance arrangements. The engagement of colleagues across the whole organisation was critical to the success of the go live and the subsequent enhancement of the system. Delivery of phase 2a has helped mitigate against the risk of the Trust's legacy system failing before it is fully replaced by Wirral Millennium in November 2014.

3.10.3 Insufficient capacity to manage patient demand

The Trust has worked closely with partner organisations to create transformation workstreams which: i) reduce emergency admission and readmission rates through alternatives to admission, rapid access outpatient consultations and ambulatory care ii) reduce length of stay through seven day access to specialist care, enhanced recovery programmes and better discharge planning with partner organisations. In addition, there are regular acuity reviews in bedded areas to ensure the nursing compliment is safe and additional staff have been and are being appointed as required. This ensures the standard of care is high and facilitates speedy recovery and discharge.

3.10.4 Achieving the Trust's transformation programme whilst improving patient safety, clinical effectiveness and patient experience

The Trust believes there are opportunities to improve care, and in the process reduce cost. Our quality strategy aims to deliver consistent care in focused areas that should reduce length of stay, re-admissions and mortality. For example, the Safety Express initiative will continue to reduce hospital falls, venous thrombo-embolic disease, hospital acquired pressure ulcers and catheter acquired urinary tract infections. There are plans to implement a care bundle for Chronic Obstructive Pulmonary Disease from April 2014 recognising the high prevalence of long term conditions in the Wirral. And the Trust will continue to improve dementia care with measured improvement monitored by the national audit.

3.10.5 Infection prevention and control

During 2013/14 the Trust has implemented a range of mitigating actions including the availability of a C.difficile cohort unit to reduce the risk of C.difficile transmission in hospital. A decant ward is in place to allow a full ward decontamination programme to be provided. The rise in trends associated with Multidrug Resistant Organisms (namely CPE) has been placed on the Trust's risk register and the recommended actions will support the management of other MDROs such as VRE. The Trust is currently reviewing the policy and strategies around decontamination.

3.10.6 Failure to deliver key performance targets

Achievement of the 4 hour emergency access target is a whole-Trust and health economy responsibility. Despite achievement of the 95% target across the health economy in the first three quarters of 2103-14, challenges in the final quarter of the year resulted in a failure to meet the 4th quarter and overall target for 2013-14. The Trust is working closely with the Urgent Care Board on a range of demand schemes to ensure the delivery of the target in 2014-15. The Trust is further engaging with the Emergency Care Intensive Support Team (ECIST) to better understand the reasons for internal delays and external factors affecting the 4 hour performance. This has highlighted some clear areas that require additional work which will be implemented by the organisation.

3.10.7 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.

David Allison

Chief Executive

28th May 2014

4.0 Directors' Report

4.1 Board of Directors

4.1.2 Role and Composition

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

- setting the organisation's strategic aims, taking into consideration the views of the Council of Governors, and ensuring the necessary financial and human resources are in place to deliver the Trust's plans
- ensuring compliance with the Trust's Provider Licence, constitution, mandatory guidance and contractual and statutory duties
- providing effective and proactive leadership of the Trust within a robust governance framework of clearly defined internal controls and risk management processes
- ensuring the quality and safety of services, research and education, and application of clinical governance standards including those set by 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 organised, which is supported by the standing orders, standing financial instructions and a scheme of delegation. Together they define the governance arrangements and decisions reserved for the Board, its committees and those further delegated to management throughout the Trust.

In 2013/14, the Board comprised a non-executive chairman, seven independent non-executive directors and seven executive directors; although the latter was altered to six after the director of human resources &organisational development post was made redundant on 31st January 2014.

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 responsibility and engage 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. The chief executive is responsible for the performance of the executive directors, the day-to-day running of the Trust and the implementation of approved strategy and policies.

4.1.3 Non-Executive Directors

Michael Carr Chairman

Michael Carr was appointed chairman of Wirral University Teaching Hospital NHS Foundation Trust 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 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

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. He undertook roles of deputy chair and senior independent director from 1st June 2012 until 31st December 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, the second largest payroll giving and appeal management agency in the UK. Richard is also non-executive chairman of Wirral based connectivity and business communications specialist, 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 & Safety Committee

Dr Jean Quinn was appointed as a non-executive director in January 2011, having previously been a Stakeholder Governor; she was re-appointed in December 2013 for another three year term. 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.

Jeff Kozer

Non-Executive Director

Deputy Chair and Senior Independent Director

Jeff was appointed to the Board in July 2009 and re-appointed in 2012/13 for a second three year term up until 30th June 2015 and was appointed deputy chair and senior independent director on 1st January 2014.

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. Six 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.

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 extensive experience in the public sector specifically managing change and fostering good employment relations.

Lyn has a Master of Business Administration, a law degree and is a Fellow of the Institute of Personnel and Development.

Catherine Maddaford,

Non-Executive Director

Cathy qualified with the Wirral Health Authority as a Registered General Nurse in 1972 and as a Midwife in 1974. She retired in 2013 as director of nursing, performance and quality at NHS Cheshire, Warrington and Wirral.

During her career within the NHS, she has held, among other posts, ward sister, clinicalnurse teacher and nurse tutor, executive director of primary care services, director of nursing and quality, director of strategic partnerships and director of patient safety and governance and executive nurse for NHS Western Cheshire.

She also holds a BEd (Hons) and an MA in Health Service Management from the University of Manchester and an MA in Health Law from the University of Salford. Cathy has served as clinical reviewer for the Commission for Health Improvement and independent complaints reviewer for the Healthcare Commission.

Cathy was appointed as a non-executive director on 1st July 2013.

Graham Hollick,

Non-Executive Director

Graham began his career in 1964 when he joined the Central Africa Building Society, where he ultimately rose to chief executive and, in 1998, was appointed group chief executive at Old Mutual Central Africa.

Graham retired in 2004 and moved to the United Kingdom. He lectured in Management Science Methods and tutored in Quantitative Techniques and Operations Management at Aston University until 2012. He has been an executive and non-executive on numerous quoted and unquoted companies' boards.

In 2005 he was appointed to the Board of Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust where he was deputy chair and chair of the Finance and Performance Committee.

Graham was appointed as a non-executive director on 1st July 2013.

Anne Parker

Non-Executive Director

Anne Parker was a non-executive director from 2005 until 30 June 2013. 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.

Nick Williams

Non-Executive Director

Nick was a non-executive director from July 2008 until 30 June 2013. 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.

4.1.4 Executive Directors

David Allison

Chief Executive

David Allison joined the Trust as Chief Executive in 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.

On 23 October 2013, David also joined the NHS North West Leadership Academy Board as a representative member for chief executives in Cheshire and Merseyside.

Evan Moore,

Medical Director

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 lead 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 responsibilities included job planning, medical productivity and patient flow.

Jill Galvani,

Director of Nursing and Midwifery

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.

Alistair Mulvey,

Director of Finance

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.

Sharon Gilligan,

Director of Operations

Sharon was appointed as director of operations in July 2013 having previously held the position of Deputy Chief Operating Officer.

Prior to joining the Trust Sharon worked for Newcastle upon Tyne Hospitals NHS Foundation Trust in a number of key operational roles including assistant director of operations and assistant director of service improvement.

Sharon has also managed a number of complex services including the Regional Neurosciences Centre and Trauma and Orthopaedics. Sharon's 20 years of operational experience is supplemented by an MBA. Sharon has a strong track record of engaging with staff at all levels to ensure the delivery of high quality, cost effective care whilst achieving performance targets and enhancing patient experience.

Anthony Hassall,

Director of Strategy and Partnerships

Anthony Hassall was appointed to the role of Director of Strategy and Partnerships in September 2013.

Prior to this role, he was Director of Business Development at University Hospital of South Manchester NHS Foundation Trust, where he led a programme of transformational change over three years and was instrumental in securing a number of commercial sector partnerships.

Prior to this, Anthony has held a number of senior roles in hospitals, primary care, the Department of Health, Cheshire and Merseyside Strategic Health Authority and a secondment to a mental health organisation in Massachusetts, USA. Anthony has a strong record of establishing partnership arrangements across the public and private sector, together with a passionate belief in the power of employee engagement in delivering sustainable change.

Sue Green

Director of Human Resources and Organisational Development until role made redundant 31st January 2014

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 member of the Chartered Institute of Personnel and Development.

4.1.5 Attendance at Board of Director Meetings in 2013/14

Director	Details of Appointment / Service on Board in 2013/14	Meeting Attendance Actual/ Possible 2013/14
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.	6/6 100%
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 until 31.12.13	6/6 100%
Jeff Kozer	Appointed 1.7.09 (3 year term) Re-appointed for a second 3 year term until 30.6.15. Senior independent director from 1.1.14	3/6 50%
Cathy Bond	Appointed 1.7.11 (3 year term) Chair of Audit Committee from 1.10.12	6/6 100%
Dr Jean Quinn	Appointed 1.1.11 (3 year term)	6/6 100%

	Re- appointed for a second 3 year term until 30.12.16	
Lyn Meadows	Appointed 1.7.08 (3 year term) Re-appointed for a second 3 year term until 30.6.14.	5/6 83%
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	2/2 100%
Nick Williams	Appointed 1.7.08 (2 year term) Re-appointed for a second 3 year term until 30.6.13	1/2 50%
Cathy Maddaford	Appointed 1.7.13 (3 year term)	4/4 100%
Graham Hollick	Appointed 1.7. 13 (3 year term)	4/4 100%
Executive Directors		
David Allison Chief Executive	Appointed 1.4.12	6/6 100%
Sharon Gilligan Director of Operations	Acting director of operations 1.4.13 Director of operations 1.7.13	6/6 100%
Evan Moore	Acting medical director 1.7.12	6/6 100%

Medical Director	Medical director 1.10.12	
Jill Galvani Director of Nursing and Midwifery	Appointed 4.3.13	6/6 100%
Sue Green Director of Human Resources and Organisational Development	Appointed March 2008 until 31.1.14	3/5 60%
Alistair Mulvey Director of Finance	Interim director of finance 12.1.13 Director of finance 1.3.13	6/6 100%
Anthony Hassall Director of Strategy and Partnerships	Appointed 16.9.13	3/3 100%

4.1.6 Board Committees

The Board has the following Committees:

- Audit Committee
- Quality and Safety Committee
- Finance Performance and Business Development Committee
- Remuneration and Appointments Committee
- Charitable Funds Committee

4.1.6.1 Audit Committee

The Audit Committee comprises four independent non-executive directors. 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 had been to support the development of the governance structure, risk management arrangements and Board Assurance Framework (BAF) and reduce duplication of work between the committees.

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 2013/14 on the work of the Audit Committee. The Council of Governors was provided with a presentation on the role, responsibility and objectives of the Audit Committee.

In addition to receiving audit reports from the internal auditor, the committee discussed the Trust's financial performance in the context of it approving regular reviews of compliance to its provider licence and referred issues to the executive for further consideration. The Committee reviewed segmental reporting and, with advice from the external auditor, concluded that as it would not manage its affairs on a segmental basis. The committee noted the value of the intangible asset held in the balance sheet representing the Cerner asset and approved that no impairment was

needed. Late in the year, the committee requested an additional independent audit review of the management of establishments within the Trust.

The committee also regularly received updates on financial assurance including reports on losses and compensation, use of the seal and single tender waivers. It challenged the finance team on terms of payments from partners and the chasing of slow payments to the Trust as well as ensuring the payment process for private patients was reviewed. Writes off, such for pharmacy stock, were scrutinised. The committee also reviewed the annual report and annual accounts and ensured the internal and external auditors provided an opinion.

The committee monitored the internal audit and actions of safeguarding and requested follow up work, which is in progress. The committee had sought assurance relating to raising concerns in the context of process and culture. The committee monitored developments, through its regular licence review, of the Monitor financial investigation and discussed the risks related to maintaining the A&E target. On the basis that the value of the charitable fund is not material, the committee decided not to consolidate these funds and keep the matter under review.

The committee held a facilitated development session to review the principles for an effective Audit Committee and to develop a strategy to refocus the committee agenda to high impact issues. From this session, the agenda and cycle of business was developed; the assurance role in respect of clinical quality was defined and a development plan to improve the impact of the committee was produced.

The Trust has an active external audit function, provided by KPMG. They were appointed by the Council of Governors in January 2011 on a three-year contract with an option to extend for two years. The contract was extended with agreement of the Council of Governors for two years, until 31st December 2015. Their work is reviewed through an annual report they present to the Audit Committee and value is assessed when the Committee agrees the annual external audit plan. The external auditors provided additional, non-audit, services to the Trust on three projects: cash management review; RCA on governance of financial planning and performance monitoring; and RCA on annual plan process and related finances.

The Trust has an internal audit function, provided by Mersey Internal Audit Agency, who provide a team of auditors to fulfill the annual plan agreed by the Audit Committee. Throughout the year, they undertake audits on the Trust's financial systems, IM&T, performance, quality, workforce and governance, risk and legality.

The Audit Committee met on four occasions during 2013/14.

4.3.1.1 Attendance at Audit Committee Meetings in 2013/14

	Meeting Attendance Actual / Possible 1st April 2013 – 31st March 2014
Cathy Bond, Chair	4/4 100%
Richard Dutton	2/4 50%
Jeff Kozer	3/4 75%
Graham Hollick	3/3 100%
Nick Williams	1/1 100%

4.1.6.2 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. During the year, and among other achievements, the committee led on the Trust's response to the Francis II report, monitored the new friends and family test and quality dashboard and introduced a workforce quality dashboard. The committee also regularly received a patient's story, which gave further assurance that the committee was engaging in the right areas. As a result of triangulation, the Committee took interest in particular issues as they arose, such as outpatient appointment cancellations and workforce sickness levels.

4.1.6.3 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.

4.1.6.4 Remuneration and Appointments Committee

The operations of the Remuneration and Appointments Committee are detailed in the Remuneration Report, within this Annual Report.

4.1.6.5 Charitable Funds Committee

This committee is chaired by the Trust chairman to oversee the management of charitable funds.

4.2 Council of Governors

4.2.1 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 came 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.

The Council of Governors comprises of:

- 13 public governor seats

- 5 staff governor seats
- 4 seats assigned to nominated partner organisations

A transition plan is in place, due to the reduction of the size and composition of the Council of Governors in January 2013. This enables 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.

The names of those who served as Governors during 2013/14 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).

4.2.2 Governor Elections

Elections were held for four seats on the Council of Governors in 2013/14. The Board of Directors can confirm that elections for public and staff governors held in 2013/14 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 2016 Annual Members Meeting.

Constituency / Class	No. of Seats	Governor elected
Public:		
Birkenhead, Tranmere& Rock Ferry	1	**Evelyn Hurren** Re-elected - 3rd term until Annual Members Meeging (AMM) 2016
Leasowe, Moreton&Saughall Massie	1	**Beverly Ross** 1st Term until AMM 2016
Staff:		
Nurses and Midwives	1	**Carol Skillen** 1st Term until AMM 2016
Other Trust Staff	1	**Norman Robinson** 1st Term until AMM 2016

Governor attendance at Council of Governor Meetings 2013/14

The following tables list the governors who have served on the Council of Governors during 2013/14 and individual attendance by governors and directors at Council of Governors meetings. Four meetings of the Council of Governors were held in 2013/14.

Governor	Constituency / Class	Meeting attendance Actual / Possible 1st April 2013 – 31st March 2014 (% attendance)
Public		
Brian Cummings	Bebington and Clatterbridge	2/3 (66.6%)
Sue Hill	Bidston and Claughton	3/4 (75%)
Jean McIntosh	Bidston and Claughton	1/4 (25%)
Evelyn Hurren	Birkenhead, Tranmere and Rock Ferry	2/4 (50%)
Ian Ferguson (Resigned September 2013)	Bromborough and Eastham	1/1 (100%)
Richard Agar (membership ceased September 2013)	Greasby, Frankby, Irby, Upton and Woodchurch	1/2 (50%)
Gwen Springall	Greasby, Frankby, Irby, Upton and Woodchurch	0/2 (0%)
David Steele	Heswall, Pensby and Thingwall	4/4 (100%)
Beverly Ross	Leasowe, Moreton and Saughall Massie	2/2 (100%)
Bernie Howden	Liscard and Seacombe	1/2 (50%)
Jane Langsdale	Liscard and Seacombe	3/4 (75%)
John Karran	Neston, Little Neston, Parkgate and Riverside, Burton, Ness, Willaston and Thornton	4/4 (100%)
Paula Williams	Neston, Little Neston, Parkgate and Riverside, Burton, Ness, Willaston and Thornton	2/2 (100%)

Governor	Constituency / Class	Meeting attendance Actual / Possible 1st April 2013 – 31st March 2014 (% attendance)
Barbara Kerr	New Brighton and Wallasey	4/4 (100%)
Helena Eaton	North West and North Wales	0/4 (0%)
Donald Shaw (Lead Governor from September 2013)	Oxton and Prenton	4/4 (100%)
Robert Howell	West Wirral	3/4 (75%)
Staff		
Rosemary Morgan	Registered Medical Practitioners and Registered Dentists	4/4 (100%)
Paula Clare	Registered Nurses and Registered Midwives	3/4 (75%)
Carol Skillen (Term commenced September 2013)	Registered Nurses and Registered Midwives	0/2 (0%)
Iain Stenhouse	Other Healthcare Professional Staff	2/4 (50%)
Paul Smyth (Lead Governor: term ended September 2013)	Other Trust Staff	2/2 (100%)
Norman Robinson (Term commenced September 2013)	Other Trust Staff	1/2 (50%)

Governor	Constituency / Class	Meeting attendance Actual / Possible 1st April 2013 – 31st March 2014 (% attendance)
Stakeholder Governors		
Phil Baldwin (Term ended June 2013 – changes to composition of Council of Governors)	Foundation Trust Partnership Steering Group	1/1 (100%)
Derek Jones (Term ended June 2013 – changes to composition of CoG)	Foundation Trust Partnership Steering Group	1/1 (100%)
Peter Kinderman	University of Liverpool	1/4 (25%)
Mandy Duncan	Wirral Third Sector Assembly	4/4 (100%)
Jeff Green (Appointment ended September 2013)	Wirral Metropolitan Borough Council	0/2 (0%)
Irene Williams (Appointment ended September 2013)	Wirral Metropolitan Borough Council	0/2 (0%)
Kathy Hodson (Appointed September 2013)	Wirral Metropolitan Borough Council	2/2 (100%)

Governor	Constituency / Class	Meeting attendance Actual / Possible 1st April 2013 – 31st March 2014 (% attendance)
Anita Leech (Appointed September 2013)	Wirral Metropolitan Borough Council	1/2 (50%)

Director Attendance at Council of Governor Meetings 2013/14:

Michael Carr	Chairman	4/4 (100%)
Anne Parker	Non Executive Director	1/1 (100%)
Richard Dutton (Senior Independent Director until 31.12.13)	Non Executive Director	2/4 (50%)
Jeff Kozer (Senior Independent Director from 1.1.14)	Non Executive Director	1/4 (25%)
Lyn Meadows	Non Executive Director	2/4 (50%)
Jean Quinn	Non Executive Director	4/4 (100%)
Nick Williams	Non Executive Director	0/1 (0%)
Cathy Bond	Non Executive Director	3/4 (75%)

David Allison	Chief Executive	4/4 (75%)
Sharon Gilligan (Acting wef (needs to be in full – I don't know what this is1.4.13; substantive wef 1.7.13)	Director of Operations	2/4 (50%)
Alistair Mulvey	Director of Finance	3/4 (75%)
Jill Galvani	Director of Nursing and Midwifery	4/4 (100%)
Sue Green (director until 31.1.14)	Director of Human Resources and Organisational Development	2/3 (66.6%)
Cathy Maddaford (started 1.7.13)	Non Executive Director	3/3 (100%)
Graham Hollick (started 1.7.13)	Non Executive Director	2/3 (66.6%)
Anthony Hassall (started 16.9.13)	Director of Strategy and Partnerships	3/3 (100%)
Evan Moore	Medical Director	3/4 (75%)

4.2.3 Council of Governor Committees

4.2.3.1 Nominations Committee

Governors are invited to participate in the Nominations Committee, the membership of which is set out below. Its purpose is to identify appropriate candidates for non-executive director posts, including Trust chairman, as and when the terms of office provide, for appointment or re-appointment by open competition. The committee makes recommendations to the Council of Governors for appointment. The committee met three times during the year.

4.2.3.1.1 Nominations Committee Membership & Attendance 2013/14

Name	**Role**	**Meetings attended (maximum 3 and % attendance)**
Michael Carr	Trust Chairman	3/3 (100%)
Peter Kinderman	Nominated Stakeholder Governor	0/3(0%)
Jane Langsdale	Elected Public Governor (until December 2013)	1/1 (100%)
Rosemary Morgan	Elected Staff Governor	3/3 (100%)
Beverly Ross	Elected Public Governor (from January 2014)	2/2 (100%)

Donald Shaw	Elected Public Governor	3/3 (100%)
David Steele	Elected Public Governor	2/3 (66.6%)

In May 2013 the committee received and noted the performance and development review summaries for the chairman and non-executive directors. In particular the committee noted that the Board had successfully been through an intense period of scrutiny by Monitor and review by independent consultants McKinsey and expressed confidence that the new Board had put in place the foundations to embed the new governance arrangements. The committee recommended the re-appointment of Dr Jean Quinn for a second three year term and supported the recruitment process, led by external head-hunters, for two new non-executive directors with a recommendation to the Council of Governors that Mr Graham Hollick and Ms Cathy Maddaford be appointed for a three year term of office from 1st July 2013.

In January 2014 the committee commenced the process for the appointment of two new non-executive directors to replace Mr Richard Dutton and Ms Lyn Meadows who were not eligible for further appointment. It was noted that the Council of Governors in December 2013 had agreed not to use the services of headhunters again and to revert to the appointing procedure and advertising arrangements as used in the years up to 2012.

In March 2014 the committee recommended the re-appointment of Ms Cathy Bond for a second three year term of office. Candidates were shortlisted and final arrangements for the interview process for one new non-executive director after it was decided to reduce the overall number in line with the reduced number of executive directors. Interviews were to be held in May 2014 and appointment subsequently confirmed in due course.

The Council of Governors has established three non-statutory committees to support it in discharging its responsibilities

- ***Membership and Engagement***

  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.

- ***Editorial Panel***

  This panel was formed to assist in planning and reviewing the content of the membership newsletter and to oversee its production, such that it is produced to a high standard and on time; and aligned to a business cycle that meets the requirements of the membership strategy.

- ***Annual Plan Advisory Committee***

  This committee meets monthly with the director of strategy and partnerships.

  It has been involved in setting both, a two year and a five year plan of strategic priorities. The committee has a number of key roles which include providing feedback from fellow governors, Trust members and the general public. The committee also reviews strategic themes and objectives and the programme for completion of the annual plan.

4.2.4 Strengthening excellent relationships with governors and members

The Trust considers the input of the Council of Governors to be invaluable in representing the local population and helping put the voice of patients into our decision-making processes.

During 2013/14, governors assisted in a number of significant areas. This included the setting of our annual planning priorities and playing a key role in supporting the Trust in its ambition to be, “Locally focused – Regionally significant”

The Council of Governors has been involved in supporting the executive team in setting the two and five year plans. In addition to this, the Annual Plan Advisory Committee (APAC) was established. The Trust also dedicated a section of its Public Membership Newsletter to seeking the views of its members.

Meeting with governors in a variety of settings has been key to further strengthening this important relationship. A number of governors have also been involved in visits to wards, along with executive and non-executive directors.

4.3 Members of the Trust

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 8,997 public members plus an additional 5,785 staff members.

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

- voting in governor elections
- acting as a yardstick of public opinion about our plans
- receiving and giving feedback on newsletters and other documents
- volunteering.

4.3.1 Membership

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

The Trust welcomes members from the age of 11and they are eligible to stand in an election to become a governor from the age of 16.

The public constituency divided into 13 geographical areas:

- 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.

The classes within the staff constituency are as follows:

- Registered Medical Practitioners and Registered Dentists
- Registered Nurses and Registered Midwives
- Other Healthcare Professional Staff
- Other Trust staff

4.3.2 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.

We plan to maintain membership at around its current 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 2013/14, 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 2013, 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.

Membership Profile

Membership size and movements		
Public constituency	**2012/13**	**2013/14**
At year start (1st April)	8,736	8,963
New members	605	557
Members leaving	321	523
At year end (31st March)	9,020	8,997
Staff constituency	**2011/12**	**2013/14**
At year start (1st April)	5567	5655

New members	656	616
Members leaving	573	486
At year end (31st March)	5650	5785
Patient constituency	There is no Patient Constituency	

Note re: figures reconciled 1st April

Analysis of membership 2013/14				
Public constituency	**Number of members**	**%**	**Eligible membership**	**%**
Age (years)			2013 figures collated by CACI Ltd, except for ethnicity, which is 2011 Census, ONS	
0 - 16	26	0.28	1,561,647	20.00
17 - 21	257	2.85	498,143	6.3
22+	7,681	85.37	5,744,291	73.6
Not stated	1,033	11.48	N/A	N/A
Total	8,997	100.00	7,804,081	100.00
Ethnicity				
White	8,568	95.23	7,032,420	90.85
Mixed	37	0.41	115,841	1.49
Asian or Asian British	96	1.06	446,350	5.76
Black or black British	23	0.25	99,366	1.28
Other	8	0.08	46,137	0.59
Not stated	265	2.94	N/A	N/A
Socio-economic				

groupings*				
AB	2,353	26.32	465,188	19.17
C1	2,592	28.99	729,272	30.06
C2	1,930	21.59	511,110	21.07
DE	2,063	23.08	719,901	29.68
Gender analysis			(2013 figures collated by CACI Ltd)	
Male	3,339	37.11	3,841,501	49.22
Female	5,465	60.74	3,962,580	50.77
Unspecified	193	2.14	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 FoundationTrusts will make a direct approach to members to collect this information.

'ABC' data is only available from 2011 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

☎ 0800 0121 356 or email wih-tr.foundation@nhs.net

Arrangements to govern service quality

Governance and risk management processes are covered in more detail within the Annual Governance Statement, which is presented towards the end of this Annual Report. The Trust has an established and robust approach to monitoring service quality, with a 'Board to Ward' governance approach through which both executive directors and non-executive directors visit clinical areas regularly, utilising the 15-Step Challenge methodology. The Quality and Safety Committee supports the Board by gaining assurance on the development and monitoring of quality systems to ensure that clinical effectiveness, patient safety and patient experience are the key components of all activities of the Trust. The Quality Committee reviews internal and external reports and audits about the Trust's services and ensures appropriate action is planned and implemented; it also reviewed the Trust's self-assessment of the Quality Governance Framework in late 2013.

The Care Quality Commission has no outstanding quality concerns or conditions on the Trust's registration.

4.4 Statement of Disclosure to Auditors (s418)

Each of the above directors (excluding those who have resigned during the financial year):

- so far as the director is aware, there is no relevant audit information of which the Trust's auditors are unaware; and
- has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information

4.4.1 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 159 of the remuneration report.

4.4.2 Code of Governance Compliance

The Trust's Board of Directors supports and agrees with the principles set out in the 'NHS Foundation Trust Code of Governance', first published by Monitor in 2006 and updated in March 2010 and December 2013.

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

The Board of Directors met on six occasions in 2013/14 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.

All directors have responsibility to constructively challenge items at the Board. Non-executive directors scrutinise the performance of the executive directors on an on-going basis and through a formal annual appraisal and objective setting process which is undertaken by the chief executive.

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 annually.

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 manner, 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. These are structured opportunities particularly for the non-executive directors to gain the views of the governors and, through them, the membership.

Non-executives and governors are also in the same teams for the Board walkarounds, where they visit wards together. Non-executive directors usually attend public events, where they can meet members, such as the annual members meeting.

The Trust constitution contains a reference that sets out procedures for the removal of the chairman or another non-executive director, which is initiated by the governors and ultimately decided by the Council of Governors.

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 Codes of Conduct.

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 continue to explore ways of further strengthening the patient voice.

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 observe 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 met quarterly in public and in 2013/14, the lead governor was Paul Smyth, Staff Governor, until September 2013 and then succeeded by Donald Shaw, Public Governor from September 2014.

Governors have been actively engaged in developing the Trust's forward plans through the work of the Annual Plan Advisory Committee and presentations and discussions with the Board at Governors' workshops. Governors gain an understanding of issues arising from patient feedback through participation in a programme of Board Walkabouts, 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 Engagement Group has supported the delivery of the membership strategy.

The Trust has 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 Board of Directors undertakes a regular self-assessment of its performance, through a process of informal evaluation at the end of Board meetings. In addition, the Board has accessed development programmes provided by the Foundation Trust Network, North West Leadership Academy and Mersey Internal Audit Agency.

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

Executive directors are appraised annually by the chief executive and the non-executive directors are appraised annually by the chairman, which is reported to the governors Nominations Committee and Council of Governors. The chairman is appraised annually in a process led by the senior independent director.

The committees provide a report after each meeting to the Board and also complete an annual report on their activities, effectively providing an appraisal of their work to the Board.

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 2013/14, the chairman had no significant commitments outside of the Trust that conflict or impact upon his ability to meet his responsibilities to the Trust.

It is an agenda item at Board and Council meetings for the chairman to seek any declarations of 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 Trust, Arrowe Park Hospital, Arrowe Park Road, Upton, Wirral CH49 5PE.

The way in which the Board applies the principles and provisions is described within the various sections of the report and the directors consider that, for the 2013/14 year, the Trust has been compliant with the code as detailed for declaration within Monitor's Annual Reporting manual, however it wishes to note the following:

4.4.3 Code Provisions B.6.6

A governor of the Trust was removed from office in accordance with Paragraph 8.9 of Annex 5 of the Trust's Constitution in September 2013. Monitor's new Code of Conduct came into effect on 1st January 2014. This Code requires the Trust through its Council of Governors to have a clear policy and a fair process, including where appropriate independent assessment, for the removal of a Governor for a failure to attend at meetings, or where there is an actual or potential conflict of interest which prevents the proper exercise of their duties, or where the behaviours or actions of a Governor may be incompatible with the values and behaviours of the Trust. It is the Trust's view that a fair process was followed in this matter, led by the Council of Governors and culminating in the Council of Governors determining that the removal was appropriate.

Nevertheless, in view of Para 6.6.of the current Code, the Trust's Council of Governors has commenced the process of devising a policy for the removal of a Governor which complements the relevant provisions in the Trust's Constitution.

4.5 NHS Staff Survey

4.5.1 Staff Engagement

The Trust recognises that transformation will only be realised through passionate people. Listening into Action (LiA), which was introduced into the Trust in October 2012, has gone from strength to strength. Listening into Action has enabled us to engage and enthuse people, re-igniting the commitment our staff inherently have for the provision of exceptional healthcare. Since the launch of LiA the Chief Executive has personally worked with more than 1000 colleagues through our LiA Staff Conversations, where they have described what matters to them and what changes they would like to see. A further 600+ staff have attended team-level LiA Conversations to adopt this way of working for themselves – setting a clear mission, connecting all the right people around it, sharing ideas, taking ownership of the changes they want to see, and celebrating their successes. As we moved into our second year, we worked hard to identify priorities which would be achieved faster and better through LiA, with an absolute focus on quality and safety of care, improving the patient experience, and enabling our frontline teams to do their jobs and deliver great services.

4.5.2 Results from the NHS Staff Survey

The NHS Staff Survey 2013 has again demonstrated further 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 2013 Staff Survey management Report can be accessed via the Trust's web site homepage. It was very pleasing that the Trust showed a significant increase in the response rate in the NHS Staff Survey 2013 (60% from 43% in previous years), and the overall staff engagement level has improved for the second year running - improved from 3.59 to 3.64

The tables below set out the *Top five ranking scores* for 2013 with the national average for Acute Trusts and comparison to Trust in 2012

Key Findings	**2012**	**2013**	**National average acute Trusts 2013**
KF28 %staff experiencing discrimination in the last 12 months	9%	8%	11%
KF18 % staff experiencing harassment, bullying or abuse from patients, relatives or public in the last 12 months	27%	26%	29%
KF5 % staff working extra hours	70%	67%	70%

KF19 % staff experiencing harassment, bullying or abuse from staff in the last 12 months	24%	22%	24%
KF20 % staff feeling pressure in the last 3 months to attend work when feeling unwell	29%	27%	28%

The tables below set out the *Bottom five ranking scores* for 2013 with the national average for Acute Trusts and comparison to Trust in 2012

Key Findings	**2012**	**2013**	**National average acute Trusts 2013**
KF2 % staff agreeing their job role makes a difference to patients	87%	87%	91%
KF1 % staff feeling satisfied with the quality of work and patient care they are able to deliver	74%	74%	79%
KF % staff having E&D training in the last 12 months	44%	44%	60%
KF4 effective team working	3.64	3.66	3.74
KF22 % staff able to contribute towards improvement at work	62%	64%	68%

The Staff Satisfaction Steering Group (which is a subgroup of the Workforce & Communication Group) will continue to review the staff engagement plans at both a Trust and divisional level. This will include working with the communication department to ensure a consistent and levelled approach to the staff engagement agenda. The Friends and Family Test (FFT) will extend to all staff in 2014/15 with staff being asked two questions in relation to FFT: whether they would recommend the Trust to family and friends and whether they would recommend the Trust as a place to work. This will be included in the Workforce / Organisational Development Key Performance Indicators and will provide an important measure on staff satisfaction levels across the year.

The Trust remains committed to the Health & Wellbeing Agenda and whilst sickness remains above the Trust target of 4% (4.68% at March 2014 compared with 4.76% in calendar year 2013, average of 12 months) we are confident that with the measures we have put in place improvements will be made. The Trust's Occupational Health

service provides a proactive service for staff delivered by a team of qualified specialists including medical, nursing and psychology fields, the key aims are to immunise staff and screen them for occupational diseases through health surveillance, carry out pre-employment screening, assist with attendance management support, health promotion, rehabilitation, ill health retirement providing counselling support including cognitive behaviour therapy and managing accidents at work, particularly inoculation and sharps incidents. The Trust's Occupational Health team supported in the flu vaccination programme and achieved a take up rate of over 75%.

Statistics Produced by hscic from ESR Data Warehouse		Figures Converted by DH to Best Estimates of Required Data Items		
Quarterly Sickness Absence Publications	Monthly Workforce Publication			
Average of 12 Months (2013 Calendar Year)	Average FTE 2013	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
4.8%	4,894	1,101,108	52,430	10.7

A full review on compliance against Health & Safety legislation was undertaken in 2013/2014. This review was reported to the Trust Board for assurance that health andsafety within the Trust is being managed in an effective manner. The Trust has the appropriate mechanism for management of health and safety matters through the health and Safety Group. In carrying out our responsibilities, The Trust, will so far as is reasonably practicable, seek to achieve the following objectives:

- ensure the health, safety and welfare of all staff while they are at work. This will include taking all reasonable measures to remedy hazards, the undertaking of formal risk assessment procedures and bringing to the attention of staff any known major or general health and safety hazards
- arrange for activities for which The Trust is responsible for to be conducted so that persons not employed, but which may be affected by the activities, are not exposed to undue risks to their health and safety when using premises of

services under the control of the trust. This will include the undertaking of formal risk assessments
- ensure that procedures in respect of fire precautions are observed and adhered to
- conform to formal procedures for the reporting, investigating and monitoring of accidents and incidents
- fulfil the requirements of safety legislation concerning plant, machinery, processes, handling control of toxic and flammable substances, safe means of access and egress, protective equipment, training and the maintenance and cleanliness of property.
- Arrangements for such information to be distributed so as to ensure that the requirements stated above are safe and without risks to the health and safety of staff and others when properly used.
- Undertake monitoring for compliance on Health and Safety policies and procedures to ensure Health and Safety standards are maintained.
- That policies and procedures on Health and Safety issues will be reviewed and regularly updated as necessary to ensure at all times good working practices.

In order to bring about the transformation needed then the Trust has worked to ensure we have a trained and knowledgeable workforce which is aligned to the business strategy. The Trust made further progress on mandatory training rates at 93.81% as well as progressing appraisal levels to 85.65%. The Trust continues to be considered a pioneer organisation for Medical Appraisal and Revalidation and receives very positive feedback from the Deanery. The Trust ran a number of leadership programmes internally, which included an Institute of Leadership & Management (ILM) accredited Senior Multidisciplinary Leadership & Management programme for divisional and directorate medical, nursing and management leaders. The aim of the programme it to equip our clinical leaders for the Trust's future challenges and for senior teams to work as a triumvirate. In addition the Trust is committed to developing senior leaders through the North West Leadership Academy, with a number of senior staff having undertaken one or more programmes of the North West Leadership Programmes eg Transforming the NHS Leadership.

The Trust remains resolute in providing equality and opportunity for all employees and prospective employees within the Trust. The Trust has been awarded the Two Ticks Disability Symbol in recognition of meeting the five commitments regarding the employment of disabled people. By using the disability symbol, we can make it clear to disabled people that we welcome applications from them and are positive about their abilities. In addition it will show existing employees that their contribution is valued and will be treated fairly should they become disabled.

The Trust has a very strong focus on incident reporting and staff are actively encouraged to report incidents and concerns through our risk management systems. The Trust does not tolerate any form of intimidation or harassment and is committed to ensuring that no applicant for employment, employee or former employee suffers

discrimination, victimisation or harassment. The Trust is supportive of colleagues who have concerns over possible danger, risk, wrongdoing or malpractice and encourages all employees to act promptly and report their concern appropriately via the Trust's Raising Concerns Policy. The Trust has a Counter Fraud Policy and a Bribery Policy which apply in the case of suspected fraud or bribery. These policies are available on the Trust intranet. The policy gives details of how concerns may be raised and how they will be responded to.

4.6 Regulatory Ratings

The Trust is regulated by Monitor, which reviews the Trust's performance through a series of risk ratings.

For the first two quarters of the year the Trust was assessed under the Compliance Framework ratings. From the third quarter it was reviewed through the Risk Assessment Framework ratings.

Under both ratings, for finance, a Financial Risk Rating (FRR) or Continuity of Service (COS) rating of three or higher is deemed to be acceptable by Monitor.

For the Governance ratings, under the Risk Assessment Framework, a rating of Green indicates there are no evident concerns, whilst a Red rating indicates enforcement action is being taken. If a Trust is in between Green and Red it is unrated with a description of "Issues Identified" and the actions being taken. Previously, under the Compliance Framework, the ratings were Green through to Red.

The ratings for the year are shown below:

2013/14 ratings:

	Annual Plan 2013/14	**Q1 2013/14 Actual**	**Q2 2013/14 Actual**	**Q3 2013/14 Actual**	**Q4 2013/14 Actual**
Under the Compliance Framework					
Financial Risk Rating (FRR)	3	2	2		
Governance risk rating	Green	Green	Green		
Under the Risk assessment framework					
Continuity of Service (COS) rating				3	3

Governance rating				Green	Issues Identified

2012/13 ratings:

	Annual Plan 2012/13	**Q1 2012/13 Actual**	**Q2 2012/13 Actual**	**Q3 2012/13 Actual**	**Q4 2012/13 Actual**
Under the Compliance Framework					
Financial Risk rating (FRR)	3	3	3	3	3
Governance risk rating	Green	Red	Red	Red	Amber/Green

As outlined above, the Trust's financial performance in 2013/14 led to a fall in its financial risk ratings, both against the plan and against the previous year's performance. At the end of the year the Trust achieved a Continuity of Service rating of three compared to the planned level of four.

The governance risk rating issues from 2012/13 have been addressed for 2013/14. However, in quarter 4 of 2013/14 the Trust did not achieve the A&E 4 hour target. Discussions are on-going with the wider health economy around a number of key work streams which will help give a better understanding of demand and / or improve patient flow, to support the achievement of this standard. A range of plans are already in place, though they are not all within the gift of the Trust to deliver. Working closely with partners will be key to achieving this important indicator going forward.

4.6.1 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 2013/14 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 Foundation Trust. This ensures the Foundation 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.

4.6.2 Other Disclosures

4.6.2.1 Pension Liability

In 2013/14, there were six (seven in 2012/13) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £275,164 (£418,954 in 2012/13). The cost of these ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

4.6.2.2 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.

4.6.2.3 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.

4.6.2.4 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.

4.6.2.5 Data Loss

During 2013/14, there were three incidents where paper records were lost; in two cases they were retrieved outside of the hospital. All three incidents were closed in-year. There was also an incident where two computers went missing, however it was not known if these contained personal information or not. One incident, as required, was reported to the Information Commissioner's Office; they responded to confirm that no further action was needed. Learning outcomes from these incidents included: changes to the manner in which information is transferred; appropriate tracking of clinical information; and tracking and appropriate personnel only to move computers.

5Statement 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 28th May 2013

6. Annual Governance Statement

6.1 Scope of responsibility

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

6.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2014 and up to the date of approval of the annual report and accounts.

6.3 Capacity to handle risk

I am responsible for risk management across all organisational, financial and clinical activities at the Trust. I have delegated responsibility for the coordination of operational risk management to the Medical Director who leads the Risk Management Team. The Risk Management Strategy (RMS) provides a framework for managing risks across the organisation and is consistent with best practice and Department of Health guidance. The RMS 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. It sets out the specific role of the Board and assurance 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. An escalation process is in operation to ensure that, where necessary, risks are referred to the relevant senior team or senior management, as detailed in the RMS. The Trust also has mechanisms to act upon alerts and recommendations made by all relevant central bodies.

The Director of Informatics has been identified as the senior information risk owner (SIRO) and oversees risks relating to information governance, raising any relevant issues directly with the Board of Directors.
Risk management training is provided at the corporate induction programme for all new staff and provides details of the Trust's risk management systems and processes. This is augmented by local induction, which 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 also 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 through 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.

6.4 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 any potential consequences of the risk. Proactive risk assessment is informed by internal inspection processes, such as those relating to compliance with Care Quality Commission (CQC) standards, fire safety and infection control, Health and Safety workplace inspections, nursing and midwifery audits, evaluation of national reports, NHS England safety alerts, administered by the National Reporting and Learning 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. The Trust uses a generic risk assessment form and scoring system to support consistent risk assessment.

All risks are scored using a risk matrix that takes account of the likelihood of occurrence and the impact of it; actions and an ongoing review and escalation process ensures that all identified risks are either eliminated or controlled to their lowest level. The level of scrutiny and performance management is proportionate to the significance of the risk, however there is an expectation that all risks are proactively managed to minimise their potential impact. The process is set out in the Trust's risk management strategy.

The risk management process is embedded in the activity of the organisation and is fundamental to achieving the Trust's aims to improve the safety and experience of patients, visitors, staff and the public. 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, dissemination of lessons learned and minimisation of potential harm. Incident reporting is recorded on the Trust's risk management system, called Safeguard. The Trust is in the process of moving from paper-based reporting to web-based reporting, which will add efficiencies and greater use of risk related information.

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, the sharing of Root Cause Analysis reports and lessons learnt with divisions, as well as with local commissioners. The Board of Directors receives and reviews assurance reports from the Quality and Safety Committee as well as clinical performance reports on the Trust scorecard. 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 Litigation Authority (NHSLA) schemes to mitigate financial impact on any successful claims against the Trust. The Trust's processes for managing risk and learning from incidents are further assured by internal audit reviews and externally through the external auditor and various CQC assessment processes.

The management of risk is the responsibility of all staff employed by the Trust. The Trust acknowledges its legal duty to safeguard patients, staff and the public and while failure to manage risk effectively can lead to unacceptable harm to someone it can also result in damage to the Trust's reputation and financial loss. The Board of Directors have overall responsibility for corporate governance including quality, safety and risk management within the Trust and they have legal and statutory obligations, which demand that the management of risk is addressed in a strategic and organised manner.

The principles of risk identification, assessment, action planning and treatment apply at a local and corporate level and risks that cannot be managed at a local level are escalated as necessary to ensure they are controlled and mitigated for. Risks scoring 10 or above are escalated to the Risk Management Group (RMG) from the division, via the Risk Management Team so that mitigation can be monitored corporately. The responsibility for the risk management remains with the team that identified the risk, although corporate support for mitigation will be given as appropriate.

All new risks are initially reviewed by the executive directors team (EDT); they determine if a risk cannot be reduced or mitigated any further and whether it should be accepted as such or require further actions from the risk owners. Risks with a financial implication that cannot be mitigated locally will be escalated to EDT for

discussion and if a division considers that a risk cannot be mitigated further then it must refer it to EDT. Risks scoring 15 or above are presented to Quality and Safety Committee for assurance.

The Board of Directors will be notified of all risks which score 20 or above at the next meeting of the Board. The Board of Directors reviews all strategic risks to the organisation's strategic objectives through the Board Assurance Framework (BAF). The Board of Directors is also made aware of any serious incidents, as they occur, from the Quality & Safety Committee Chairs report.

The Trust's governance committee structure, work plans and terms of reference are reviewed annually. Changes to committee, or group, terms of reference are approved by the Board or related committee.

All committees and groups within the structure have 'Risks Identified' as a standing agenda item and have a responsibility for escalating risk issues discussed at their meeting through the chair, or divisional lead, in line with the Trust escalation process. However, the following committees and groups have specific functions pertaining to risk management: Board of Directors; Audit Committee; Quality and Safety Committee; Finance, Performance and Business Development Committee; Risk Management Group; Executive Director Team; operational management team; health and safety partnership and divisional management teams.

Information governance risks are managed as part of the processes described above and assessed using the Information Governance Toolkit and the risk register is updated with any identified information. The Audit Committee has received independent audit reports on compliance with the Information Governance toolkit; a mid-year assessment of the policies, systems and processes established to complete the Information Governance (IG) Toolkit provided significant assurance noting improvements the Trust IM&T has made in this area.

Data quality and data security risks are managed and controlled by 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 the Information Governance Group; it provides assurances directly to the Finance, Performance and Business Development Committee.

The Trust has in place a process for assessing compliance with the CQC Essential Standards of Quality and Safety across all services and at a corporate level. Panel meetings are held with the executive directors and operational leads to review and validate the self-assessed level of compliance and quarterly reports are presented 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 are regularly updated. All risks with an implication for CQC compliance are recorded on the Trust risk register with an appropriate action plan, as necessary. The Quality and Safety Committee also receive an analysis of CQC's new Intelligent Monitoring Report, which has replaced the Quality and Risk Profile, as well as briefing papers about new developments relating to CQC standards and inspection regimes. The quality

governance framework was self-assessment was completed and approve by the Quality and Safety Committee in November 2013.

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

The Trust has introduced and developed Board leadership walkarounds, using the NHS 15 Steps Challenge methodology. We currently have eight teams, each comprising of a director, a non-executive director and a member of the Council of Governors, who regularly visit wards and units. The 15 Steps Challenge is intended to review services and related experiences from a patient's perspective and assesses areas such as welcoming staff and environment, privacy and dignity and confidence in staff. The team members also take the opportunity to talk directly with patients to hear first-hand their views of being at patient at the Trust. The walkarounds are now well established and are proving a useful way for the Trust to gain a rich level of insight into patients' experiences of our services. The intention for the coming year is to conduct these visits unannounced and therefore provide a greater level of quality assurance.

In January 2014 the Trust commissioned an external review of its governance structures of the Finance, Performance and Business Development Committee and financial planning issues. The Board received the report and an action plan has been produced, which is being implemented. Among the recommendations were actions to ensure assurance is the focus of meetings, that operational issues should be managed by the subcommittees (i.e. groups), that the number of assurance committee meetings should be reduced, that tiered scrutiny be provided by reviewing the committee membership and ensure challenge is fostered and evidenced. The Trust, where relevant, extrapolated the recommendation to the Board and other committees to achieve over all improvements.

The Audit Committee is responsible for gaining assurance that financial, as well as risk management processes, within the organisation are being appropriately managed. It received reports from the internal and external auditors, as well as from the local counter fraud specialist. The Quality & Safety Committee receives a quarterly report on complaints, litigation, incidents, PALs and patient experience. Members of the Board receive the minutes of, and chair's report from, the Audit Committee, the Quality & Safety Committee and the Finance, Performance & Business Development Committee after each meeting.

The Trust redesigned its Board Assurance Framework (BAF) in 2013/14 and comprises the following key elements:

- principal risks to the achievement of the Trust's strategic objectives and to continued regulatory compliance, including compliance with the Trust's licence
- key controls by which these risks can be mitigated
- sources of assurance (internal and external) that risks are being managed effectively.

The BAF maps the controls and assurances required by the Board to support the annual Corporate Governance Statement and principal strategic risks identified by the Board. The BAF is linked to items and corresponding papers for the Board and assurance committees and is reviewed periodically by the Board as well as being referred to be Board members.

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.

The Trust has an established process to ensure that equality and diversity and human rights is embedded in its policy development process. All new, and reviewed, policies have an equality analysis completed, which is considered by the approving group within the Trust's governance structure. The Advancing Equality Steering Group reports to the Workforce and Communications Group and its work centres on progressing actions to advance equality using the principles of the NHS Equality Delivery System. The Trust reports its required information to comply with the public sector equality duty on an ongoing basis.

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.

6.5 Key In-Year Risks

In the earlier part of the year the Trust implemented an action plan to improve the quality of record-keeping following concerns identified by a CQC inspection in January 2013. We were asked to submit evidence to show progress and improvement in June 2013. CQC considered that this evidence was satisfactory and judged that the Trust was compliant. In November 2013 the Trust underwent a three-day unannounced CQC inspection of four clinical areas at the Arrowe Park Hospital site. We were judged compliant with all six of the standards inspected; an action plan has been developed to address a number of observations and suggestions that were made by the CQC inspection team.

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 an unprecedented demand on emergency care services, the Trust breached the A&E 4-hour waiting time target in Quarter 4 and it remains a challenge into Quarter 1 2014/15. Trend increases of 37% in GP admissions in January 2014 compared to January 2013 has been observed; this, with an increase in ambulance attendances and an increase in elderly patients being admitted, has placed significant pressure on the Trust, however, we are confident that with support

from the health economy on a range of transformational developments an improvement on delivery of the 4hour access target will be achieved.

6.6 Future Risks

As part of its strategic and operational planning process, which has been strengthened in 2013/14 with the creation of the new executive director role for Strategy and Partnerships, the Board has taken some time to review future risks to the clinical, operational and financial sustainability of the organisation. This process will be further strengthened through the process of submission of an organisational Strategic Plan to Monitor by 30 June 2014.

In a challenging external environment, the Trust faces a number of risks that have been identified in its operational plan and as part of its Board Assurance Framework. These include:

Commissioning and contracting – a large proportion of the Trust's activity is commissioned by Wirral Clinical Commissioning Group, which through its 'Vision 2018' strategic review process has an aspiration to reduce demand on hospital based services, which the Trust is involved in. As part of the change in the strategic shape of services going forward, including more services delivered outside of hospital and the implementation of the 'Better Care Fund', the Trust will need to reduce its current cost base and reduce its fixed overheads. This is a significant strategic challenge in the face of current funding constraints. At the same time, 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 appropriate discharge. 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.

Linked to the medium term contracting risk above, the Trust continues to face the challenge of safely reducing costs whilst at the same time improving levels of quality and patient experience. The Trust has catalysed its approach to the delivery of cost savings in 2013/14 with the establishment of a robust Programme Management Office, which has led a process of capturing and risk assessing opportunities for cost improvement, which do not impact on the quality of services being provided. This process will continue going forwards as the Trust continues to meet the financial challenges it faces.

Linked to the changing financial position, the Trust is faced with tightened availability of capital to invest in services going forward. However, the Trust does continue to invest heavily in new IM&T systems intended to help it deliver much more efficient and productive services.

6.7 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 and was recently reviewed by KPMG. The plan, including forward projections, is monitored by the Finance, Performance and Business Development Committee, with key performance indicators and Monitor metrics reviewed by the Board.

After a financial investigation conducted by Monitor, which closed in February without formal regulatory action, a review of the annual planning process for the annual plan 2014/15 was undertaken at Monitor's request; this review was conducted by KPMG and reviewed the financial aspects of the plan as well as the process undertaken by the Trust in forming and agreeing the annual plan.

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 by a monthly executive-led performance review.

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.

6.8 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 2013/14 has been developed in line with national guidance, with regular reporting on the performance of key quality metrics to the Quality & 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 2013/14. External audit assurance reports on the Quality Report are reviewed by the Audit Committee.

The Board of Directors agreed a quality improvement strategy in 2013/14 that sets out ambitions and milestones for further improvement of safety, clinical effectiveness and patient experience. The Board of Directors utilises a quality dashboard that enables it to the measure trends in performance of key indicators that contribute to highlevel 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.

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 Health Watch and the Borough Council Overview and Scrutiny Committee.

Priorities for 2014/15 have been discussed with stakeholders and agreement reached. Changes include a focus on dementia care, nutrition and hydration and readmissions; reduction in mortality and reducing pressure ulcers will continue to be priority areas.

6.9 Polices and Plans Ensuring Quality of Care Provided

The Trust has a robust system to review and update policies to ensure they support high quality care; this is managed by the quality and safety department. All new policies and revised policies that change process are subject to a two-week consultation process with staff prior to approval. Policies include key performance indicators that are audited in line with the policy requirements. Quality improvement plans are monitored in a number of ways primarily within the appropriate division. Plans to mitigate risk, to reduce the risk of a serious incident or complaint recurring, or the action plans from external reviews, are performance managed through the risk register until completion; this is overseen by the Risk Management Group.

Plans made in response to external inquiry such as the Francis II report are performance managed through the Clinical Governance Group. There are scheduled updates for other quality improvement plans including the quality improvement strategy to the Clinical Governance Group. This Group then provides assurance to the Board through the Quality and Safety Committee.

6.10 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 NHS foundation 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.

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 2013/14.

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 CQC and other external inspections, accreditations and reviews.

6.11 Conclusion

The Trust has a robust system of internal control that supports its aims and objectives, whilst safeguarding patients and the public funds and departmental assets. We have taken steps to mitigate and resolve issues that have risen in year and continue to work towards successful assurance outcomes. The Trust continues to report regularly to Monitor.

David Allison, Chief Executive.
28th May 2014

7. Quality Report 2013/14

Published June 2014

Report Date:

Compiled By: Dr M Maxwell, Associate Medical Director

Name of Approving Committee*: Quality and Safety Committee & Board of Directors*

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Part 1: Chief Executive's Statement

This Quality Account tells the story of a challenging, but successful year for Wirral University Teaching Hospital (WUTH).

A year ago, in the previous edition of this report, we set ourselves five priorities. We aimed to improve our clinical effectiveness by reducing our risk-adjusted mortality rate and implementing the Safety Express initiative to reduce harm to patients such as pressure ulcers, falls and venous thrombo-embolism. We have also worked to improve patient experience by reducing unnecessary bed moves, improving response times to complaints and implementing the Friends and Family Test. I am pleased to report that we have made strong progress with all these priorities, although we acknowledge that there is still work to do on improving our complaint response times.

In November we underwent an intensive, three-day unannounced inspection by the Care Quality Commission at our Arrowe Park site. They inspected us against six standards: care and welfare of people who use services; assessing and monitoring the quality of services; respecting and involving patients; staffing; supporting staff; and co-operating with other providers. They judged that we met all of these standards.

Earlier in the year, Robert Francis published his report into the management and regulation of the NHS, in response to the serious failures at Mid Staffordshire Foundation Trust. We have developed our own improvement plan to make Francis's recommendations a reality in our hospital. The actions come under five headings: quality is our highest priority; listening to patients; valuing our staff; being open; and delivering sustainable services. We have already done a great deal, and the rest of the actions are due to be completed by summer 2014 at the very latest.

Throughout the year, we have continued with the Listening into Action programme. This is a methodology which brings together staff at all levels to make changes to how we work, without the bureaucracy and delays that can affect large projects. Over the past year, over twenty teams have completed projects in their own areas that are already delivering better services and outcomes for patients and staff. They shared the lessons from their projects and celebrated their success with colleagues at 'Pass It On' events in June and December. Listening into Action has also delivered many 'quick wins' – for example improving the physical environment and making more computers available in clinical areas where they were needed; raising the profile of volunteers; making it easier to recruit to vacant positions; and providing more trolleys and chairs in the Emergency Department.

No organisation can succeed without the commitment and support of its staff. As part of Listening into Action, we conducted a simple 'Pulse Check' survey of staff across the Trust, and the results were encouraging. Compared to the year before, more staff believe they are encouraged to contribute to change, more thought that we are

providing high quality services, more feel valued for their contribution, and more understand how their role contributes to the wider organisational vision.

Looking ahead, we face many challenges. Like all Trusts, we must deliver further efficiency savings every year. Resources are static at best, whilst our population changes – such as people living longer – meaning that demand for many services is increasing. Rightly, scrutiny from regulators is becoming more intense and we must maintain, and improve, the quality of our services. We cannot meet the challenge by simply carrying on doing what we are doing, but in a more economical way. In the future, many health and social care services will have to operate in a radically different way, and they will also have to work much more closely with each other across organisational boundaries. In Wirral, Vision 2018 is how we plan to make this happen. It brings together local leaders of commissioners – who pay for the services – with leaders of provider organisations – who deliver the services. One of Vision 2018's key objectives is to bring care closer to the patient's home.

The Trust understands these challenges and stands ready to meet them. I would like to thank our staff for their efforts during the year, and our patients for choosing us to care for them and taking their time to provide invaluable feedback about how we can improve even further.

I am pleased to confirm that the Board of Directors has reviewed the 2013/14 Quality Account and confirm that it is a true and fair reflection of our performance.

David Allison, Chief Executive

28th May 2014

Part 2: Priorities for improvement and statements of assurance

Part 2.1: Looking forward to 2014/15; what are our priorities?

We have developed our quality improvement strategy based on the views of patients, relatives and carers, governors, staff, Wirral Healthwatch, the Family & Wellbeing Policy and Performance Group and our commissioners by asking what they thought of our services and what we should focus on when improving quality. We have also analysed our patient experience feedback, the risk management systems and our existing quality improvement work such as clinical audit, to help focus our activity. The strategy sets out clear expectations about quality improvement with measurable achievements to monitor our progress. In light of this, we have reviewed our Quality Account priorities for 2014/15 to support making that vision a reality.

2.1.1 Our priorities for improvement in 2014/15 are:

We have maintained the same priorities for the past two years and have seen considerable improvement for the majority (see part 3 for details). For 2014/15, we have agreed, through our Board, to introduce some new priorities; these are based on information gathered during the year where we believe focused activity will drive up quality for our patients.

The rationale for change:

- we have made major changes to the complaints handling process within the Trust and whilst we have not achieved our target for the year, we have seen significant and sustained improvement for the last four months. It requires the new process to embed and will be monitored through our governance mechanisms
- the Friends and Family test is now introduced in the organisation and will be monitored routinely through our patient experience work
- minimising bed moves is an important objective. We have shown that the work undertaken when audited has confirmed that appropriate moves occurred for patients having multiple transfers for two years successively. We are developing a way of monitoring the number of moves in a more timely way with an objective of this being a routinely monitored through our governance systems
- we will continue to report the Safety Thermometer. However, given the significant progress made with falls leading to serious harm, venous thromboembolic disease and catheter acquired urinary tract infection we no longer need to report these separately and we will focus on reducing pressure ulcers. Pressure ulcers are the main driver of harm as measured by this tool.

In 2014/15 the priorities are:

Patient Experience

1 Improving care for patients with dementia

Rationale: We are seeing more patients with dementia across all areas of the Trust. We know our population is ageing and therefore the prevalence if dementia is increasing; evidence suggests the care received is not always as good as it could be and this influences both the patient experience of our services as well as their clinical outcomes.

Delivering high quality care to these patients will be based on best practice standards as described by the National Institute for Health and Clinical Excellence (NICE). This year, we will focus on ensuring our staff are well trained across all areas of the organisation and that the information we provide to patients and their family both is appropriate to their needs at that time, robust and consistent.

Targets:

1a: People with dementia receive care from staff appropriately trained in dementia care.

In quarter 1 (Q1) we will undertake a baseline audit to identify how many staff require training, develop the training pack to reinforce the NICE standards and develop the educational plan. Milestones will be set for remainder of the year.

1b: People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.

In Q1 we will undertake a baseline audit to identify the information currently used within the organisation against the national recommendations. Milestones will be set for remainder of the year based in the findings.

Further standards may be included later in the year subject to progress against the targets set.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

2 Ensure patients are supported with eating and drinking based on their individual needs

Rationale: Eating and drinking are basic needs for our patients. Some patients require support and which can be as minimal as opening a sandwich packet or ensuring drink is in reach to more complex support for those with swallowing difficulties. Poor nutrition and hydration can increase the risk of poor healing and additional complications for our patients as well as causing distress. We monitor the

support we give patients and are not satisfied with the results. Therefore we think this should be a focus for improving our patients' experience.

Target:

2: 75% of patients will report receiving appropriate assistance with eating and drinking as measured by our Learning with Patients Survey.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

Safety Priority

3.1 Reduce harm to patients particularly in relation to newly formed pressure ulcers

Rationale: Health care is not without risk of harm. We have been measuring harm free care using the Safety Thermometer tool. This is based on a monthly audit of a sample of patients from across the Trust noting whether they have fallen, had a blood clot, a catheter acquired urinary tract infection and/or a pressure ulcer. We believe this is a helpful monitoring tool and will continue to report it; we have progress still to make, with the baseline being between 93-95% harm free care. The key harm is pressure ulcers and therefore we will continue to focus on this and reduce new pressure ulcers further.

Targets:

3.1a: Harm free care as measured by the safety thermometer monthly will be no lower than 93%, and above 95% for at least 6 months of the year.

3.1b: We will achieve an 80% reduction in avoidable new pressure ulcers grade 3-4 and a 30% reduction in new grade 2 pressure ulcers.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

3.2 Reduce the number of "missed medication" events

Rationale: Patients need to receive their prescribed medication in a timely way to speed recovery. During this year a pharmacy intervention monitoring audit has identified a number of missed medication doses and it is one of the main drivers for our medication error rate. Therefore we want to undertake targeted work to reduce the number of such events.

Target:

3.2: We will achieve a 50% reduction in missed medication events by Q4. The rate reduction will be based on the outcome of a monthly audit during quarter 1.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

Clinical Effectiveness Priority

4.1 Reduce the hospital standardised mortality rate (HSMR)

Rationale: A higher than expected mortality rate can be due to a number of factors, not just poor health care given within an organisation. However, it is accepted that it provides a good overall indicator of care; when high rates have been investigated various quality issues have been highlighted within hospitals. Our HSMR is currently better than the national average and we have seen significant improvement over the past two years. We are not yet in the top ten percent for our peer group and so want to continue to reduce this further.

Target: The HSMR reduces by at least 10 points over the year from the rebased position (2013/14).

Lead: Dr E Moore, Medical Director

4.2 Reduce emergency readmissions within 30 days

Rationale: Returning to the hospital for unplanned care is a measure of failure of the healthcare system. Quality issues that can underpin readmission include poor discharge processes, lack of communication and lack of community service provision. Some admissions will be completely unlinked. Our current readmission rate is “as expected” for the population we service; but one of the highest in the region. We believe we can reduce this to help us provide better patient experience and support acute care to deliver high quality services by freeing up time and resources to see new patients.

Target:

4.2 We will reduce our readmission rate by 1% during 2014/15 from the 2013/14 baseline.

Lead: Dr E Moore, Medical Director2.1.2 Monitoring of our priorities for 2014/15

We will continue to provide a quarterly report on progress with our priorities to the Board of Directors and internal committees; progress is shared with the governors biannually. The quarterly reports on progress are available to our local commissioners, Wirral Healthwatch, Wirral Borough Council Overview and Scrutiny Committee via the Families & Wellbeing Policy and Procedures Group and NHS England. Individual priorities are managed and monitored by a range of staff 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.

Part 2.2 Statements of assurance from the Board of Directors

The Trust uses a wide variety of information to provide the Board with assurance on the quality of our services. This information comes from a number of national and local initiatives:

2.2.1 Service reviews

During 2013/14, the Trust provided and/or subcontracted74 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 2013/14 represents 100% of the total income generated from the provision of NHS services by the Trust for 2013/14. Information covering all services and the three dimensions of quality is brought together in an Integrated Performance Report reviewed by the Board of Directors every month. This report enables the Board to triangulate quality data and monitor the impact of target delivery. In addition a clinical quality dashboard is monitored monthly through the Quality and Safety Committee (a subcommittee of the dashboard); this monitors trends in the safety, clinical effectiveness and patient experience and main drivers underpinning them.

Each division has an internal quality and safety structure and processes that support and performance manage the quality agenda.

2.2.2 Participation in National Clinical Audit and Confidential Enquiries

Clinical audit helps improve the quality of patient care by measuring compliance with best practice standards for care we give. This identifies areas for improvement that can be acted on prior to re-audit at a later date to show improvement. During 2013/14, participation in the relevant national clinical audits increased.

During 2013/14, the Trust took part in 32 national clinical audits and five national confidential enquiries covered relevant health services that the Trust provides.

During 2013/14, the Trust participated in 97% (32/33) national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. National audit participation has increased since 2012/13, when it was 79%.

The national clinical audits which the Trust was eligible to participate in during 2013/14, for which data collection was completed during 2013/14 are listed in Appendix 2. This table includes the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit and a summary of actions. In year, we received reports for 14 national audits of which five have not yet completed the review process, four did not identify any specific actions. The remainder have been discussed and action plans are either in place or development.

Examples of actions include working with services in other hospitals to provide more laser and endoscopic therapies and improving communication between services for patients with oesophageal and gastric cancers. Work has been done to improve the uptake of Patient Reported Outcome Measures within surgery and orthopaedics, as well as to improve the consent process for patients to be included on the National Joint Register – this will help ensure our audit data is robust. In some cases, whilst the audits help us understand our position against the national peer group, there are other workstreams that are improving care in that area so that actions are not directly attributable to the national audit. For example Myocardial Infarction National Audit Programme (MINAP) investigates care for patients with heart attacks; locally the service improvement has been driven by the Advancing Quality (AQ) programme.

From May 2013, the Trust invested in a small corporate audit team who are working with the clinical staff to improve the participation in the national clinical audits as one of their workstreams. They have captured data for the national heart failure audit and are currently supporting the national chronic obstructive airways disease audit.

There were five national confidential enquiries which the Trust was eligible to participate in during 2013/14 and that the Trust participated in (see table 1 below).

- the reports of two national confidential enquiries were received by the Trust in 2013/14. *Measuring the Units*: a comprehensive action plan has been put in place to address the issues raised. This includes reviewing the alcohol pathways currently in place and working with other local providers to ensure appropriate use of services for rehabilitation
- *Managing the Flow:* we are currently in the process of developing a Trust-wide action plan in response to the recommendations.

National Confidential Enquiries Title	Case Requirement	Cases Audited
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD): • Lower Limb Amputation Study • Tracheostomy Care Study • Subarachnoid Haemorrhage Study • Alcohol Related Liver Disease Study	7 2 2 3	100% (7) 100% (2) 100% (2) 100% (3)
Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRACE) *Formally known as Centre for Maternal and Child*	31	100% (31)

Enquiries (CMACE)		
National Confidential Inquiry into Suicide and Homicides for people with Mental Illness (CISH)	0	Not applicable

Table 1- National Confidential Enquiries

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 161 local clinical audits were reviewed by the provider in 2013/14 and the Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

- introduced a new process for managing heart failure patients including a method to identify patients which supports the referral of patients to the heart failure specialist nurses
- raised the profile of the cardiac rehabilitation service to ensure all appropriate patients are referred
- developed standardised cardiology documentation to ensure all patients are assessed appropriately
- introduced an acute kidney injury pathway leading to improved adherence to collecting of relevant daily blood tests, stopping drugs that adversely affect kidney function and initiating fluid balance charts
- improved the suitability of storage of medicines in ward areas across the Trust including the continuation of Matrons' monthly spot checks on the suitability of medicine storage
- improved the quality of discharge summaries for colorectal surgery and critical care patients
- appointed additional staff – for example a Specialist Nurse to support patients with fractured neck of femur
- we have purchased rempods (pop-up rooms set in bygone times to provide reassurance and calm to patients with dementia), developed dementia packs and introduced a dementia audit nurse to support the wards with assessments
- amendments to our observation charts to improve compliance with the delirium guidelines
- we want to introduce early supported discharge for patients with fractured neck of femur
- new and amended standard operating services within the Laboratory services to support the management of blood cultures, breast screening results and laboratory reporting
- review of the sepsis pathway, enhanced education and electronic decision support/prompting to improve the management of sepsis

- introduced a ward audit programme to improve compliance against areas such as blood transfusion, venous thrombo-embolism (VTE), consent to treatment, medicines management as well as a number of other areas
- education to improve staff awareness of protocols and pathways such as the fast track neck of femur pathway, and VTE prevention and treatment guidance.

2.2.3 Participation in Clinical Research

In 2013/14, 860patients receiving NHS services provided or sub-contracted by the Trust were recruited to participate in research approved by a research ethics committee. This reflects a significant increase of over 100% compared to last year's recruitment and demonstrates the Trust's continued commitment to research in order to provide evidence to improve treatment and the quality of care for our patients.

The Trust recruited participants to 44 National Institute for Health Research (NIHR) adopted studies; 41%of studies were clinical trials of investigational medicinal products (studies designed to test a new drug or to test a licensed drug in a different way). The research portfolio is clinically diverse with an increasing number of specialties able to offer research to suitable patients. This includes: cancer, cardiovascular, critical care, dermatology, elderly medicine, haematology, ophthalmology, paediatrics, reproductive health, respiratory, rheumatology, stroke and surgery.

Research within the Trust is supported by 15 Research Nurses and over 40 Trust clinicians and a small administrative team. Much of the research involves collaboration with key support services and the research department works closely with pharmacy, pathology and radiology to ensure that the Trust has the capacity and capability to set up and effectively run our studies. For the last two years the Trust has achieved the national key performance indicator for granting NHS permission (research and d approval) to all new studies within the 30 day target.

In addition to NIHR adopted studies the Trust approved five new WUTH consultant-led studies and 12 new WUTH student-led studies. During the last year, Trust staff were involved in 25 publications accepted in professional journals. This shows our commitment to improving outcomes for patients, staff professional development and also to making a wider contribution to healthcare on a national level.

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 2013/14

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 2013/14 were developed by NHS Wirral and agreed with the Trust, and reflected areas of desired improvement identified nationally and locally. Further details of the agreed goals for 2013/14 and the following 12 month period are available at:

http://www.monitor-nhsft.gov.uk/about-nhs-foundation-trusts/nhs-foundation-trust-directory/wirral-university-teaching-hospital-nhs-f

Indicator for 2013/14	Year-end position *Q3 position still to be agreed with WCCG
1. Friends & Family Test To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework - ensuring that people have a positive experience of care	*Not known – data awaited* We have improved our response rate for the patient questionnaire but the final position will not be known until May 2014. The friends and family test was successfully rolled out in Maternity Services in October 2013, as part of a phased expansion. The results of the staff Friends and Family Test (i.e. whether staff would be happy for their friends and family to be treated here) are included in the National Staff Survey, the report of which is still awaited.
2. NHS Safety Thermometer To improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter and VTE	*Partially achieved* We are on target to submit all the data required, although it appears that we may not achieve the improvements to the data required for the six-monthly report. The final data for this indicator will not be available until April 2014.
3. Dementia To improve pathway for dementia	*Partially achieved*

Indicator for 2013/14	Year-end position *Q3 position still to be agreed with WCCG
patients following emergency admission by ensuring that they are identified, assessed, investigated and referred on to a specialist service.	We achieved the first element of the indicator in the first three quarters of the year by scoring 90% compliance with our pathway. We have partially achieved the other elements of the indicator – our monthly audits commenced behind schedule due to a delay in recruiting a dementia specialist nurse.
4. VTE To reduce the incidence of VTE disease and ensure consistent care, learning from case reviews.	*On track to achieve* During the first three quarters of the year we achieved our target of risk-assessing all adult inpatients on admission using the clinical criteria of the national tool. We are on target to achieve the same in the final quarter. We also achieved our target for completing root cause analysis of hospital associated thrombosis in the first three quarters and are on track to do so in the final quarter as well.
5. Advancing Quality: To promote clinical effectiveness, safety and patient experience in • Acute myocardial infarction • Heart failure • Hip and knee replacement • Pneumonia • Stroke	*Partially achieved* The final results will not be available until later in 2014/15. However, the Trust is on target to deliver all but heart failure.
6. Integrated Long Term Condition Management Infrastructure Development To develop the infrastructure to sustain	*On track to achieve* During quarters 1 and 3 we achieved this indicator by developing work plans,

Indicator for 2013/14	Year-end position *Q3 position still to be agreed with WCCG
integrated long term condition management delivering risk stratification, integrated teams, supporting self-care project, Pathway for Life and to deliver service integration supporting earlier discharge.	workforce arrangements and agreeing key performance indicators with our partners. There was no target for Q 2 and we are on track to achieve again in Q 4.
7. Urgent Care Mental Health Assessment To improve the Pathway and environment in urgent and emergency care for patients in acute psychological distress and those who are under Section 36 of the Mental Health Act.	*On track to achieve* The start of the project was delayed and a revised timetable and target were agreed with WCCG (90% instead of 95%). We are on target to achieve these. They involve implementing operational plans for staffing and capital works, so that 90% of mental health patients should be ready to transfer into a Mental Health Assessment Unit within four hours.
8. A&E 4 hour target To achieve the 4 hour A&E target using only the attendance at the main A&E Department.	*Not achieved* During quarters 1, 2 and 3 we achieved the target of 93% of A&E attendees being identified, transferred or discharged within four hours of their arrival. However, we failed the indicator during Q 4 and therefore the whole of the CQUIN, as there is no payment for partial achievement.
9. End of Life Pathways To ensure that patients and their families are provided with the most appropriate pathway in the community if diagnosed as being in the last 6-8	*On track to achieve* We are on target to achieve our milestones for data collection and partnership working with other organisations in the local health economy to improve discharge by 31st

Indicator for 2013/14	Year-end position *Q3 position still to be agreed with WCCG
weeks of life.	March 2014.
10. Dementia – Local See 3 above	*On track to achieve* We are on target to achieve this target. Our actions include separating referral and review so that 90% of patients with dementia are referred for specialist review, and following agreed discharge protocols. We have also produced an audit and evaluation report to measure the impact of this CQUIN target on patients and other stakeholders.
11. A&E Discharge Summaries To improve the standard of discharge summaries for A&E to patients GP.	*Achieved* This has been achieved in full. During the year we undertook three audits which have shown a high level of improvement in the quality and discharge audit letters to GPs for inpatients and improvement in A&E letters.
12. Seven-Day Working – Consultant Physicians To introduce seven-day working for Consultant Medical Staff to provide a review of new and medically unstable inpatients across the medical specialities division and ultimately result in an increased number of discharges at weekends.	*On track to achieve* We had separate quarterly targets. These were a 3% increase in weekend discharges for Q1, a 5% increase in Q2, 8% increase in Q3 and 10% increase in Q4. We achieved the targets for Q1 and Q2. Q3

Indicator for 2013/14	Year-end position *Q3 position still to be agreed with WCCG
	appears on target for delivery and data is not yet available for Q4.
13. Compassion in Care (Francis Inquiry) To review quality and nursing strategies and frameworks in line with the Francis Inquiry, identify areas for improvement, challenges and action plan.	*On track to achieve* This is on target for delivery. We undertook a baseline assessment against the report's recommendations in August 2013, which we agreed with our commissioners. The actions in the improvement plan are all either completed, or on schedule for completion where they are not yet due.
14. Smoking To assist with reduction of smoking by patients by ensuring smoking statistics checked, brief intervention is given around the benefits of stopping smoking and appropriate referrals to NHS Staff Smoking Service.	We achieved our target in Q 1, partially achieved it in Q 2 and are on target to achieve in Q 3 (Q4 data not yet available). Our actions include establishing a system for collecting data from three wards on one day per quarter, training staff to deliver brief interventions for smoking cessation, and quarterly audits of patients.
15. Timely administration of total parenteral nutrition (TPN) for preterm infants To improve the preparation of pre-term babies who start timely administrating total parental nutrition by day two of life. To minimise weight loss and improve growth and neuro-developmental outcomes, to reduce the risk of mortally and later adverse outcomes such as necrotizing enterocolitis and broncho-pulmonary	We achieved the target in the first three quarters and are on track to achieve it for the whole year. The target was for 95% of qualifying babies to have had TPN, and for there to have been consistent improvement against the baseline for each quarter.

Indicator for 2013/14	Year-end position *Q3 position still to be agreed with WCCG
dysplasia.	
16. Improvement in monitoring of screening for retinopathy of prematurity Retinopathy of prematurity (RoP) is one of the few causes of childhood visual disability which is largely preventable. Many extremely pre-term babies will develop some degree of RoP although in the majority of babies this does not progress beyond mild disease which resolves spontaneously without treatment. A small proportion can develop potentially severe RoP which can be detected through retinal screening. If untreated severe disease can result in serious vision impairment and consequently all babies at risk of sight-threatening RoP should be screened (RCPCH 2008).	We have achieved our targets in the first three quarters of the year and are on track to achieve them for the year as a whole. We agreed performance improvements that were expected against the current baseline, provided exception reports and reviewed our action plan each quarter.
17. Reduction in incidence of preventable severe AKI (Acute Kidney Injury) requiring intermittent haemodialysis through targeted actions based upon data analysis To focus on reducing the incidence of preventable Acute Kidney Injury (AKI) and to support the AKI delivery group and the UK Renal Registry establish a new nationally consistent data set. To establish a working group responsible for developing an implementation plan to include	We have achieved the target in full for the first three quarters and are on track to achieve the target for the full year. We have had to submit the minimum data set to the Renal Registry, and to achieve reductions in the proportion of emergency admissions experiencing severe AKI, and the proportion of patients who receive intermittent haemodialysis to treat AKI where management to prevent progression of AKI was not undertaken in the first six months.

Indicator for 2013/14	Year-end position *Q3 position still to be agreed with WCCG
identifying causes of severe AKI for emergency admissions that were preventable and avoidable and specify actions to address and prevent reoccurrence.	
18. Increase use of Renal Patient View by patients under the care of a renal unit To place patients at the centre of decision making by enabling them to view a range of information about their care at a time and place that suits them. This information will be on line and will include their test results and information about their condition and its treatment and will enable patients to become more informed and involved in the management of their health. Also to allow other clinicians, with the patient's permission, to view their medical history should the patient be taken ill away from their home unit.	We have achieved the target in full for the first three quarters and are on track to achieve the target for the full year. We have been aiming for 40% of patients to have made use of Renal Patient View. We have submitted data every quarter and a working group has reviewed the current practice and pathways for renal patients.

Table 2: 2013/14 CQUINs

The amount of income in 2013/14 conditional on achieving quality improvement and innovation goals was £6,106,823 million subject to the final year income for 2013/14. For the year 2012/13, the total associated payment was £5,760,906

The 2014/15 CQUINs are currently under development with Wirral Clinical Commissioning Group and will reflect national, regional and local priorities. The

CQUINS listed below represent the National CQUINS and proposed themes for Local CQUINS; the local CQUINs will support achievement of the national CQUINS:

<table>
<tr><th>National:</th><th>Local:</th></tr>
<tr><td rowspan="4">Friends & Family Test

• Implementation of staff FFT
• Early Implementation
• Increased or Maintained Response Rate
• Reduction in Negative Responses in Acute Providers</td><td>Pressure ulcer zero tolerance approach</td></tr>
<tr><td>Dementia</td></tr>
<tr><td>Integrated Care</td></tr>
<tr><td>Compassion in Clinical Care</td></tr>
<tr><td>NHS Safety Thermometer – Reduction in prevalence of pressure ulcers</td><td>Local Authority Public Health:</td></tr>
<tr><td>Dementia:

• Find, Assess, Investigate and Refer
• Clinical Leadership
• Supporting Carers of People with Dementia</td><td>Smoking Cessation</td></tr>
</table>

Table 3 CQUINs for 2014/15

2.2.5 Care Quality Commission Registration and Reviews

The Care Quality Commission (CQC) is the organisation which regulates and inspects health and social care services. The Trust is required to register with the CQC and its current registration status is that it is '*registered without conditions for the Health and Social Care Act 2008'.*

The CQC has not taken enforcement action against the Trust during 2013/14. The Trust is currently considered level four risk for breaching CQC standards in a system where one is significant risk and six is considered the least risky.

The Trust was inspected in November 2013. The inspectors visited four clinical areas at the Arrowe Park site. The inspection involved a larger team than previous inspections – including practising clinicians from different professions and specialties

– as well as an 'expert by experience' (a lay person who provides a patient's perspective). It lasted for three days. As well as visiting the clinical areas they also interviewed executive directors and other senior managers in the hospital. They inspected us against six of the essential standards, namely:

9 - Care and welfare of people who use services	22 – Staffing
10 - Assessing and monitoring the quality of services	23 - Supporting workers
17 - Respecting and involving people who use services	24 - Co-operating with other providers

We were judged compliant with all six standards.

Earlier in the year, CQC asked us to provide evidence that we had made progress with the concerns about the standard of record keeping which were identified as part of their inspection in January 2013. We provided a fully updated action plan and a range of audit reports. CQC judged that we were now compliant with this standard.

During the year we have obtained assurance about our compliance by continuing to hold review panel meetings with the executive directors and operational managers responsible for each standard. Any gaps in compliance are recorded on the risk register. We have introduced the 'Fifteen Steps' programme. This is based on the idea that it should be possible to judge whether a service is caring and safe within fifteen steps of walking onto a ward.Developed by the NHS Institute for Innovation and Improvement and used nationwide, they are relevant to most of the CQC standards.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

2.2.6 Data Quality

The Trust submitted records during 2013/14 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 four 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'.

NHS Coverage	2010/2011	2011/2012	2012/2013	Apr2013/ Feb 2014
Admitted patient care	98.5	97.8	99.2	99.6
Outpatients	99.3	98.7	99.5	99.8
A&E	96.3	96.1	98.7	98.8
GP Registration				
Admitted patient care	99.9	99.9	99.9	100
Outpatients	100	100	100	100
A&E	100	100	100	99.9

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 Trust-wide data quality group meets regularly to review data quality standards, reports on data quality errors, and to address any ensuing issues.

The Trust will be taking the following actions to improve data quality for 2014/15:

- reinforce the patient demographics checking process in clerical pathways to reduce the rate of clinical communication addressed to incorrect GP practices
- maintain the improvements in quality of inpatient and Emergency Department (ED) discharge summaries to GPs achieved across the previous two years
- identify similar improvements to the quality of information provided to GPs on admission of their patients via the ED
- prepare data quality and assurance reports for the next go-live Phase (2b) of Wirral Millenium (Trust IT system) in late 2014.

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 group ensures the Trust maintains compliance with relevant information governance legislation and good practice.

The Trust information governance assessment report overall score for 2013/14 was 72% and was graded green in the grading scheme. This is an improvement on last years score.

Information risks are managed in the same way as all other risks identified in the Trust; they are reviewed by the information governance group, which reports to the finance, performance and business development committee. The information governance group also continues to report to the audit committee to increase the level of assurance on information governance systems.

Highlights from the work programme this year include a review and revision of the process of managing information sharing agreements and thirdparty/data processor agreements, establishment of a confidentiality audit procedure and audit schedule for the Trust's key information assets and development and implementation of information assessment management standards.

2.2.8 Clinical Coding

Accurate clinical coding is essential to the provision of effective healthcare at local and national level. It drives financial flows, informs payments and is critical to intelligent commissioning through the provision of epidemiology data which truly reflects the health and care needs of the nation.The Trust commissioned an external audit programme from the Clinical Coding Academy at Mersey Internal Audit Agency. Five audits have been conducted across the year. Specialties audited this year included cardiology, colorectal, vascular, gastroenterology, acute medicine and general surgery. Following these audits individual and team feedback has been given to enhance performance. These external audits and supplemented with additional internal audit.

The Trust was not subject to the Payment by Results clinical coding audit during 2013/14.

The Trust will be taking the following actions to improve data quality:

- continue to commission external clinical coding audits
- continue to undertake internal audits
- ensure coding staff receive feedback at individual and team level as appropriate
- provide education and training to all staff involved in the coding process

In 2014/15, the Trust is planning to review the whole coding process to ensure it is as cost effective as possible.

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 2013/14.

3.1.1 Patient Experience Priorities

3.1.1a.Improve handling of complaints

The target for 2013/14 was:

- 80% of complaints responded to within the timescale agreed with the complainant.

Lead: Mrs J Galvani, Director of Nursing and Midwifery

Compliance has improved significantly during the year and since December 2013 has been over 80% each month. However, the year end compliance was 70%overall compared to 38% last year; this reflects the challenges in achieving this target early in 2013/14.

Key actions this year are:

- completion of the Trust's concerns and complaints management review, this included engaging our local Healthwatch organisation in our review process and in relation to information sharing regarding concerns and complaints
- introduction of a revised policy and process
- weekly review with divisions of all ongoing complaints
- dedicated divisional staff responding to complaints to improve consistency and providing opportunity for targeted training
- monthly performance monitoring by the executive director team.

In future, this will continue to be included in the local indicators section of the report.

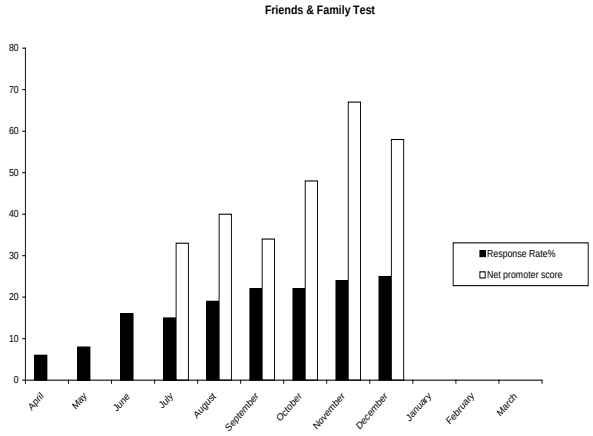
3.1.1b. The National Friends & Family Test

The targets for 2013/14 are:

- to implement the Friends and Family Test (FFT) 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 15% by end of Q1 rising to 20% by end of Q4
- 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

Performance in relation to the Friends and Family Test has continued to improve throughout
the year and the response rates for both the Emergency Department Minors and Inpatients are consistently above the required 20% target since Q1.



The Net Promoter Score (NPS) is a measure of patient loyalty to the organisation. The value is based on those patients who state they are extremely likely to recommend the Trust to their friends and family. To ensure the NPS is a valid measure it is important to have a good response rate.

Net Promoter scores have also continued to improve, especially in the Emergency Department.

Key actions undertaken in year include:

- awareness raising with staff to ensure they provide patients with the survey
- ensuring surveys are available in the relevant areas at all times
- triangulating the information with our Learning with Patients survey so we can identify areas for improvement
- introducing hourly rounding into the Emergency Department

There has been an increase in the staff recommending the Trust if a friend or relative needed treatment as reported by the national staff survey by 2%. However, the actual measure for 2012 as reported by CQC was 58%; in 2013 it rose to 60%. The improvement has not been as large as we would like to see and this will be a key measure going forward, reported in the key indicators section of this report.

3.1.1c. 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 Wirral Borough Council's 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, Director of Operations

Throughout 2013/14, we have worked to improve patient flow, ensuring beds are more readily available in specialist areas, as well as work to avoid unnecessary admissions and provide early supported discharge.

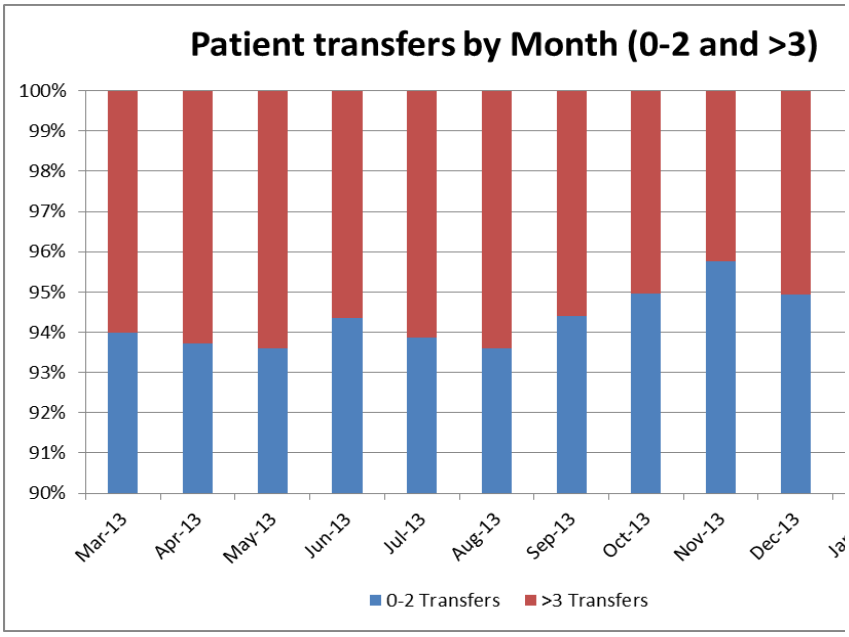
Key actions include:

- improved communication between the Bed Bureau and the Acute Assessment Unit by providing walkie-talkies; allowing instant updates on the bed status in wards and supporting flow of patients to the most appropriate bed in a timely manner
- fortnightly meetings with the Wirral Community Trust, the Clinical Commissioning Group and the Department of Adult Social Services to identify how we can best support patients to leave hospital after a protracted stay and also avoid admissions for patients with long term conditions. As a result, we have seen a significant reduction in patients with very long lengths of stay. This reduction in length of stay helps to safeguard against transfers to less acute wards and departments during the latter phase of the admission
- the development of an integrated discharge team, which incorporates staff from the Community Trust and Social Services, supports reduction in length of stay by actively managing discharge
- increased in-reach to the Emergency Department by specialty Consultants to avoid admission whenever possible and arrange direct admission to an appropriate ward when it is not
- the Trust invited the emergency and urgent care intensive support team to review the changes in our processes which resulted in the organisation receiving positive feedback. This also provided some external assurance that the changes made should support high quality patient care
- further developments to improve our bed management, including merging the acute and medical divisions in line with recent Department of Health Guidance " *Future Hospitals*" has be in place since the beginning of November 2013.

The annual multiple transfer of patients audit was undertaken to assess compliance with the number of times patients are transferred within the organisation. The audit demonstrated an improvement on the 2012 audit, with the majority of patients being transferred on two or three occasions. No patients included in the audit were transferred on more than four occasions. The deputy director of nursing receives a weekly report of any incidents reported in relation to multiple patient transfers so that early action can be taken.

This audit has proven that there has been a very positive outcome for patients as a result of the work carried out over the past year and also demonstrates that the Trust was successful in reaching its target for 2013/14 to have no more than four bed moves for individual patients unless it is clinically necessary.

This key performance indicator continues to be monitored to ensure compliance and will be supported by continued annual audits against this standard. We are developing a monitoring tool to track changes in the number of patients experiencing multiple transfers and intend to monitor this through our governance systems.



For the year March 2013 – February 2014, 4.7% of patients had three or more transfers, this reduced in the second half of the year:

3.1.2 Clinical Effectiveness Priority:

3.1.2 Reduce the hospital standardised mortality rate (HSMR)

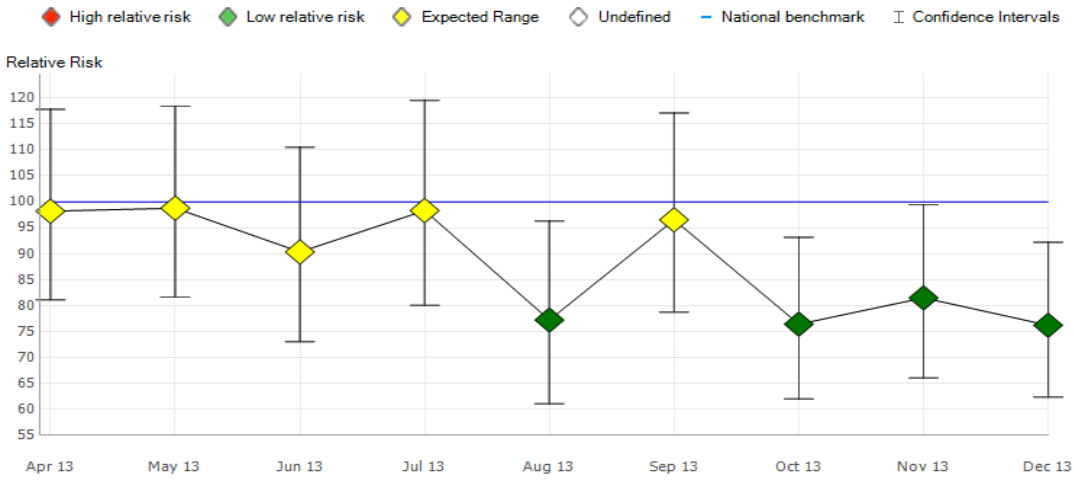
The Hospital Standardised Mortality Rate is a calculation that compares the observed deaths with the expected deaths based on national information; the national average is 100. In determining what is expected a number of factors are considered such as the reason for admission, the patient's age, other illnesses etc that may impact on the likelihood of death. Every year the number of deaths in hospital reduces and so to keep the national average at 100, the HSMR is reset. At the beginning of this financial year our HSMR was 105 (as expected). We want to be in the best performing Trusts and so reducing this is a priority for us.

The target for 2013/14 was:

A 10% reduction in HSMR i.e. HSMR no more than 95 (Information generated by Dr Foster Intelligence®)

Lead: Dr Evan Moore Medical Director

We have made good progress and should achieve the target:



The year to date (to February 2014) HSMR is 84.8 (80-90) this is significantly better performance than the national average and 200 less deaths than expected.

The key interventions undertaken this year include:

- work to improve compliance with the medical emergency warning system; recent audit has shown that we have high compliance for patients who are unwell and whose care potentially requires additional intervention. This means patients who are deteriorating are more likely to be recognised earlier and interventions given
- we have been working with our community partners to improve care of the dying and we have rolled out the Wirral End of Life project to a number of wards. This helps to identify patients in their last year of life, so that preparations can be made and should support patients dying in a dignified way where they want
- seven day specialty working has been introduced where a senior medical review is available every day. This ensures patients' care plans are developed in a timely way and enables additional support where required
- review of the nursing staff numbers and ward acuity with additional posts created in some wards. This work is ongoing. Lower mortality has been shown to be associated with higher nurse staffing levels.
- delivering consistent evidence-based healthcare through the Advancing Quality Programme and implementation of NICE guidance. Ensuring patients receive appropriate care to support their recovery
- a review of progress to date has led to an improvement plan based on reducing mortality in disease areas where there are high numbers of deaths
- continued the divisional mortality reviews with additional assurance in disease or procedure groups where we seem to be reporting higher-than-expected numbers of deaths over the preceding quarter
- we have also been ensuring that the data is as accurate as possible so that the risk adjustment process for HSMR is robust. For example we have improved our palliative care and co-morbidity coding, both were below the

expected levels for our population and we are now slightly below the national average in both measures.

3.1.3: Safer Care Priority

3.1.3 The Safety Express Initiative

This initiative identified four key harms from healthcare that we should address. Whilst the initiative completed in 2012/13, we decided to continue working on these areas to deliver safer care as we believed further improvement could be made.

The targets/tolerances are all based on a reduction from 2012/13 baseline:

a. 50% reduction in serious harm and death from preventable falls in the hospital
b. 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.
c. 50% reduction in preventable venous-embolic events based on 2012/13 figures.
d. A 50% reduction in unnecessary urinary catheterisation whilst maintaining the 50% reduction in urinary tract infections in patients with in-dwelling catheters

Lead: Mrs J Galvani, Director of Nursing and Midwifery

3.1.3a: Falls

Not all falls are preventable, however we aim to minimise the number and harm from falls. We have defined preventable falls as those where we did not follow our processes to ensure we have identified patients likely to fall and we have put in place measures to reduce the risk. We are on target to deliver a 50% reduction. We have seen a reduction in all falls both with and without harm.

Tolerance level for preventable serious injury falls	Falls With Serious Injury	Preventable Falls With Serious Injury
7	15	5

Table 5: Preventable falls with serious injury

A number of actions have been taken including:

- revision of the patient comfort checks with increased emphasis on falls prevention
- education sessions to support the roll-out in Medicine of assisted technology Assisted technology has been utilised on all of the older people's wards and two wards in the acute care and medical specialties division, and has helped reduce serious falls. This technology alerts staff to patients standing up or trying to walk when they need help to move around. Further use of the assisted technology has been identified from incident investigations
- launch of patient involvement questionnaire to assist nursing staff to identify problems faced by patients with a less serious falls
- we have strengthened our review process to ensure it is consistent and lessons learnt are shared.

A Falls Summit is arranged for March 2014 and will focus on next steps in recognition of significant reductions already and maintenance of improvements.

3.1.3b: New Pressure Ulcers

Not all pressure ulcers are avoidable. These are defined as those new pressure ulcers where the correct processes and procedures were undertaken in a timely fashion, fully documented and scrutinised through investigation (root cause analysis) and agreed with the director of nursing and midwifery. Whilst we have not achieved our targets, we have seen good improvement.

The prevalence of new grade 2-4 pressure ulcers is based on the sample data collected through the safety thermometer. For 2012/13, this was 1.06 new pressure ulcers per 100 patients sampled; the tolerance is therefore 0.53 new pressure ulcers per 100 patients sampled. The prevalence to date for 2013/14 is 0.76 per 100 patients sampled and whilst this represents a 39% reduction, the tolerance has not been achieved. Compared to national prevalence average, WUTH still continues to out-perform with a year-end prevalence of 3.7% compared to a national average of 5%. This has been achieved through establishment of partnership working and by also focusing on actual numbers of pressure ulcers.

We set a stretch tolerance this year; an 80% reduction in new grade 3 and 4 avoidable pressure ulcers. There have been no grade 4 pressure ulcers this year and no new grade 3 pressure ulcers in Q 4. Overall, the reduction was 62%. This represents a significant reduction in ‘actual’ numbers and progress during 2013/14 illustrates that this has been sustained.

Further collaborative events have now been agreed including a joint event in May 2014 to be attended by health economy partners from Wirral to agree together how best to further reduce pressure ulcer prevalence. Additionally, a ‘harm reduction collaborative’ has been established, also to commence in May, which will be jointly chaired by both WUTH and Wirral Community Trust to further reduce pressure ulcer prevalence and share practice, learning and expertise.

Tolerance level for preventable grade 3&4 pressure ulcers	Preventable grade 3 pressure ulcers	Preventable grade 4 pressure ulcers
10	18	0

Table 6: Grades 3&4 new pressure ulcers reported in 2013/14

Key improvement actions include:

- April 2012, apressure ulcer summit to engage all nursing staff about the improvements needed
- 'Check and Challenge' pressure ulcer prevention questions agreed and distributed for senior nurses to use when visiting wards
- a revised business case for increasing provision of electric profiling beds
- merging the tissue viability and the infection control teams to increase capacity by training infection control surveillance staff to also support surveillance of pressure ulcer prevention and education and to commence increased focus on stage 1 and 2 pressure ulcers
- establishment of a revised pressure ulcer summit and working group, in conjunction with our community partners to oversee the processes we use to manage patients skin.
- a "task and finish" group established to review/simplify documentation
- improved guidelines and education about deep tissue injury management
- a revised process for staging pressure ulcers which involves the associate director of nursing, a matron and a tissue viability nursing assessment
- root cause analysis process for stage 3 and 4 pressure ulcers reviewed and now involves the multi-disciplinary team. The key lessons learnt are the need to always complete a skin assessment on admission and/ or transfer; the need to elevate heels; implement the SSKIN bundle (prevention care plan) and ensure documentation is accurate.
- a '100 day challenge' was held in July to September 2013 whereby wards were monitored over a 100 day period. Four areas hadno pressure ulcers of any stage (wards 23, 36, gynaecology and surgical assessment wards), with 12 wards/departments had less than five (with no stage 3 or 4 pressure ulcers) and four wards/departments had less than 10, again with no stage 3 or 4 pressure ulcers.
- there is a review of provision of electric profiling beds in progress
- we have started departmental reviews of all new stage 2 pressure ulcers and wards have individual tolerances set.

3.1.3c: Venous thrombo-embolicevents (VTE)

VTE disease encompasses two conditions – deep vein thrombosis or DVT (blood clots, commonly in the legs) and pulmonary embolus or PE (where a small fragment of clot becomes dislodged and then trapped in the lungs; this can be fatal). VTE can also cause chronic disease and so preventing this is important. National guidance suggests that VTE disease happening within 90 days of discharge from inpatient care, or whilst in hospital is potentially avoidable.

We aim to improve this service in two ways, by trying to prevent disease and also making sure when it happens we manage it properly. Our actions to date are to identify gaps in our current service that could lead to inconsistent care.

We assess patients to see if their risk of clotting outweighs their risk of bleeding using a nationally developed assessment and then prescribe medication if needed. Over 95% of admissions have been assessed every month during 2013/14.

Key actions this year have been:

- to promote compliance with prescribing after assessment through ward based audit and awareness raising
- to strengthen education to the staff to highlight prescribing compliance, the use of compression stockings and reassessment for patients
- to introduce a seven day reassessment supported by an electronic prompt to remind staff
- to amend and update the policy to support the necessary changes
- to audit compliance with the treatment of established disease; diagnosis and treatment was prompt and compliant for the vast majority of patients.
- to continue the root cause analysis investigations and introduce a template assessment to determine whether the care given complied with our policies and procedures.

We have changed the way we identify patients with potentially hospital acquired VTE disease. We use hospital death notifications to identify any patient who died from pulmonary embolus. If the patient has been discharged within 90 days of admission or they have been in hospital more than 24 hours, they undergo a thorough investigation (a root cause analysis) to see if the disease was preventable and treated appropriately. Lessons learnt are shared to improve care. Of the five patients who fulfilled the criteria, three were deemed to have received less than perfect care. This is half the number reported last year.

We identify all patients who have been readmitted with VTE disease within 90 days, and use a locally developed audit form to see if we have managed the patient in accordance with our policies and processes. If we identify lapses in care that could have led to the disease this is considered preventable and a root cause analysis is undertaken to understand why. To increase the timeliness of this we now review patients discharged in month who had a previous admission.

We can also identify a group of patients who were admitted for another reason but have VTE coded within the discharge information. This allows us to identify patients will have developed new disease whilst in hospital and whether it was preventable.To increase the timeliness of this we now review patients discharged during each month who had a previous admission.

We are on track to meet our target of 50% reduction for deaths and readmissions from last year:

2013/14	Tolerance level for VTE events (total year)	VTE events reported		Preventable VTE events/ Nos reviewed
		Total reported	Nos reviewed	
Patients readmitted within 90 days	61 (total reported)	35	23	0 (Apr – Dec)
Patients who may have hospital acquired disease	120 (total reported)	122	78	1 (Apr – Dec)
Death from VTE disease	4 (preventable)	13	13	3

Table 7: VTE reduction in 2013/14

3.1.3d: Catheter Associate Urinary Tract Infection (CAUTI)

Building upon the success of 2012/13 where the Trust was able to demonstrate more than a 50% reduction in CAUTI over a two-year period, the Infection Prevention and Control Team have continued to promote a focused approach to achieve a further reduction.

The key actions undertaken during the year include:

- the ‘catheter passport’, was reviewed and amended. This provides all patients with an urinary catheter information about how to look after their catheter
- the 'Stop and Think' tool was successfully launched and evaluated extremely well with positive outcomes. This tool was designed to empower nurses using a criteria based approach to make a decision to remove urinary catheters at the earliest opportunity.
- the League of Friends approved the funding of two scanners which have been donated, one to the Orthopaedic Division and one to the emergency department. This will help reduce the number of catheter insertions and therefore reduce the risk of infection. A further application to the League of Friends for two more scanners will be made next year
- working with the supplies department, we have reviewed catheterisation products to ensure that the wards are provided with the most suitable product to support the prevention of infection associated with a urinary catheter
- promoting products and optimising practices associated with the management of continence has been beneficial in reducing unnecessary catheterisation. An audit was undertaken to investigate whether all wards had an appropriate supply of continence pads and whether there were any educational requirements for staff. The audit demonstrated an inconsistent approach to the management of continence which could result in unnecessary catheterisation. Ward based education on the correct use of continence pads was provided
- as part of the patient focused audits, all patients with a urinary catheter will be reviewed to ensure that there is a clinical requirement for a catheter and that the management of the catheter is optimised. The results of the audit will be included in the quarterly dashboard which will be reviewed by the senior nursing and midwifery audit team.
- catheter counts continue to be performed inall clinical areas. These identify catheters that are not clinically indicated and identify those areas where further education and training is required to avoid unnecessary catheterisation and encourage prompt/early removal of catheters. This count also identifies whether individual patients have an infection associated with their urinary catheter with the same surveillance definition being as for the CAUTI prevalence audit. This information is shared with ward sisters, matrons and lead nurses and any issues escalated through the directorate infection prevention andcontrol assurance report.

A repeat prevalence audit performed in April 2013 demonstrated that 4% of catheterised patients had an associated infection compared to 5% in 2012. In October 2013, this further reduced to 2%, thus achieving the target set.

This is a significant reduction and to achieve a further reduction will be extremely challenging. The work around CAUTI with the emphasis around avoiding catheterisation or prompt removal of catheter will continue to at the very least ensure that this reduction is sustained.

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.

Health Education Northwest (Annual Assessment Visit)

This visit, conducted by Mersey Deanery, is an annual assessment and reviews the quality of medical training within the Trust. The results are also used as part of the quality management processes which are monitored via the General Medical Council. The panel noted the improvement in emergency treatment within ophthalmology and IT provision and also concluded that, 'Wirral University Teaching Hospital provides a culture of support for education and training of its registrars. It is highly regarded by all of the trainees. A special note was the medical model for handover which provides an extremely safe forum for handing over patients, minimising any potential episodes of patient safety.'

Patient Led Assessments in Care Environments (PLACE)

PLACE assessments were introduced in April 2013 and are a new system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. Good environments matter and this assessment puts patients' views at the centre of the assessment process. Most importantly, patients made up at least 50%of the team who assessed how the Trusts environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. The local team awarded 'very good' or 'pass' in all areas for the following criteria:

- staff appearance
- overall cleanliness
- handwashing/hand hygiene facilities available
- pPrivacyanddignity
- food provision (presentation and access to food)

All scores were submitted (nationally) and the assessment process compares each hospital against a national average. The Trust (including both the Arrowe Park and Clatterbridge sites) were awarded higher than national average results.

National Cancer Patient Experience Programme

The Trust provides cancer care across a range of specialties and through all adult divisions, diagnosing around 2000 new cancer patients per year. Each area is subject to an annual peer review process to look at the structure and function of the services and more recently the national cancer patient survey.

Again the survey results are presented against a national average and each Trust results are provided indicating whether they are in the: bottom 20%, middle or in the top 20% of all Trusts. Overall care at WUTH is rated highly by patients and the results show that the hospital appears in the top 20% of all Trusts, with patients rating their care as excellent or very good. Patients also indicated that the Trust had listened to their comments and improved on providing both verbal and written communication.

3.3 Listening into Action

We joined the Listening into Action™ (LiA) National Pioneers Programme in October 2012, recognising that we wanted to achieve a fundamental shiftin the way we work and lead, putting clinicians and staff at the centre of change for the benefit of our patients, our staff and the Trust as a whole.

LiA is a comprehensive, outcome-oriented approach to engage all the right people behind quality outcomes. LiA creates a framework to change the way we do change associated with quality and safety of patient care, patient experience and improvement in working conditions, environment and culture. It is a systematic approach to engage and empower clinicians and staff around any challenge.

We began our LiA journey by talking to staff about what gets in the way of them delivering the best possible care and services for our patients and what changes they propose to address them. In 2013, we mobilised teams to take forward many of the priorities identified by staff and/or to adopt LiA as a way of working for themselves. Over 1000 staff have met with the chief executive and LiA sponsors through LiA “Big Conversations” and a further 600 staff have worked on the priorities for individual areas or on a trust wide basis. To date over 50 teams have now engaged in this way of working with many measurable improvements including:

- major refurbishment of our A&E department, introduction of a single triage process and developed integrated pathways of care with the orthopaedic teams
- improvements to the discharge planning process including speedier availability of take home medications
- introduction of a seven day neonatal community service
- joint working in physiotherapy and occupational therapy
- reduction in length of stay in the older peoples short stay unit
- improved storage and availability of case notes

- improved stroke data systems
- reduction in 'Did Not Attends' (DNAs) and waiting times in community paediatrics
- introduction of a breast cancer wellbeing and survivorship programme
- reduction in duplicated blood requests through alert triggers and education
- introduction of activities for dementia patients and improved staff education
- introduction of the Six C's standards of behaviour as part of the nursing and midwifery strategy
- established primary care engagement programme, improving communications, IT systems and improved patient pathways
- improved ways of working in the integrated discharge team
- improved staff morale in the microbiology team by addressing operational, environmental and training issues
- improved divisional visibility and communications
- introduce new easier appraisal system
- improved processes to ensure staff receive feedback after incident reporting
- improved access to and availability of equipment and linen
- established a social group and promotion of health and wellbeing to support staff
- reduced bureaucracy and paperwork in maternity and theatres
- improved Trust communications systems.

For 2014, we have prioritised some of our key challenges that would benefit from LiA and our teams are now working through these to enable them to deliver the best care and services to our patients.

3.4 Local and National Quality Indicators

3.4.1 Locally used 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 2012/13 some of the indicator values have changed:

HSMR updated to the year-end position for 2012/13

SHMI updated for the year end position for 2012/13

Friends and Family test from national staff survey for 2012/13 refreshed to reflect CQC reported outcome.

Safety measures reported	2009/10	2010/11	2011/12	2012/13	2013/14
"Never events" that occurred in the Trust *These are a national list of 25 applicable incidents that should never occur (March 2010).*	1	0	1	2	3
Serious Incidents reported, investigated and remain serious (as of 31/03/2013)	57	94	88	96	69*
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%	10,005 0.2%*
National Patient Safety Agency *Rate of patient safety incidents (per 100 admissions) and % resulting in severe harm.* NB: Data released in 2013/14 relates to Oct – Mar 2012/13		7.8 <1%	9.7 <1%	12.6 <1%	11.9 <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*) NB: Data for 2013/14 relates to Apr –Feb 2014.		102.8	108.4 (range 102.6 – 114.4)	105 (range 99 – 110)	85 range (80-90)
88Summary Hospital-Level Mortality Indicator *SHMI value and banding (National Information Centre data)* NB: Data released in 2013/14 relates to June 12-July 13 *%* of Admissions with palliative care coding % of Deaths with palliative care coding *(Dr Foster data)*			105.0 (range 89-112) Band = 2 as expected 0.59% 12.70%	107 (range 89 -112) Band 2 as expected 0.94% 19.02%	104 (range 89 – 112) Band 2 as expected 1.0% 19.96%
% of admitted patients risk assessed for VTE		45.6%	95.4%	95.0%	95.5%
% of admitted patients who had risk assessment for malnutrition (MUST)				82.4%	86.15%

Clinical outcome measures reported	2009/10	2010/11	2011/12	2012/13	2013/14
% Emergency Readmissions within 28 days *(Dr Foster data)* NB: Data for 2013/14 relates to Apr - Nov 2013 admissions.			7.7%	8.0%	9.0%
Average length of stay (days) *(Dr Foster data)* NB: Data for 2013/14 relates to Apr - Feb 2014.			4.4	4.6	4.5
Patient experience measures reported					
Number of complaints received by the Trust	362	401	422	515	482
% complaints responded to within agreed timescale	90%	80%	59%	38%	69.6%
% patients who felt they were treated with courtesy and respect (from Learning with Patients survey) **NB dignity replaced by courtesy in 2013/14**	90%	98%	99%	98%	95%
Responsiveness to inpatients personal needs (from National Patient Survey)		65.1%	67.4%	71.2%	67.2%
Staff respondents who would recommend the Trust to friends or family needing care (from National Staff Survey: CQC)			58%	58%	60%

Table 8 Local and National Quality Indicators

NB* this figure correct as of 4th April 2014 but may change as investigations are completed.

Never events

It is of great concern that the Trust has reported three never events reported during this financial year; no similar incidents have been reported before.

The first involved a patient who had retained a piece of glove following breast surgery in 2012/13 but was not reported until this year. The patient involved suffered an infection as a result of the retained foreign object, but made a full recovery following treatment; therefore no permanent harm has been caused. This is thought to have occurred when the surgeon was wearing two pairs of gloves and had therefore been unnoticed at the time. In response to this surgeons are now checking their gloves when wearing two pairs to ensure they are intact.

The second never event involved a tissue retrieval bag which had been retained in a patient following surgery. This error was highlighted whilst the patient was in theatre recovery. The patient was informed immediately and transferred back to theatre and the bag was removed and no permanent harm was caused to the patient. Several changes to practice have been made following investigation to prevent this incident from re-occurring.

The third incident involves an incorrect lens being placed in a patient. The error was recognised whilst the patient was still in theatre and the lens was replaced immediately and the situation explained to the patient. The root cause analysis is currently being completed and an action plan will result.

Serious Incidents

The number of incidents which have been investigated and remained as serious has reduced since the last financial year. This is positive and the largest improvement relates to the reduction in grade 3 and 4 pressure ulcers.

National Patient Safety Agency (NPSA)

The number of incidents reported to the NPSA via NRLS (needs to be in full) has reduced in the last financial year. There are two factors which have contributed to this; firstly incident reporting in the Trust overall has declined in the last financial year due to the implementation of web incident reporting and difficulties within the divisions with the uptake of the new system. In addition when incidents are reported on the web incident system these incidents are not submitted to NRLS until a web managers form has been completed, currently there is a Trustwide issue with the time taken for incidents to be managed on the web system; thus there has been a delay in the reporting of clinical incidents to NRLS.

Mortality

Our mortality has improved (see section 3.1). The SHMI is reducing at a similar rate to HSMR; however, reporting lags six months behind HSMR. There are slight improvements in coding for palliative care and co-morbidities.

Readmissions

There have been slight rises in length of stay and readmissions within 28 days although it is still within normal limits. These are both within the expected range for our organisation. However in 2014, the will be work undertaken to improve our position.

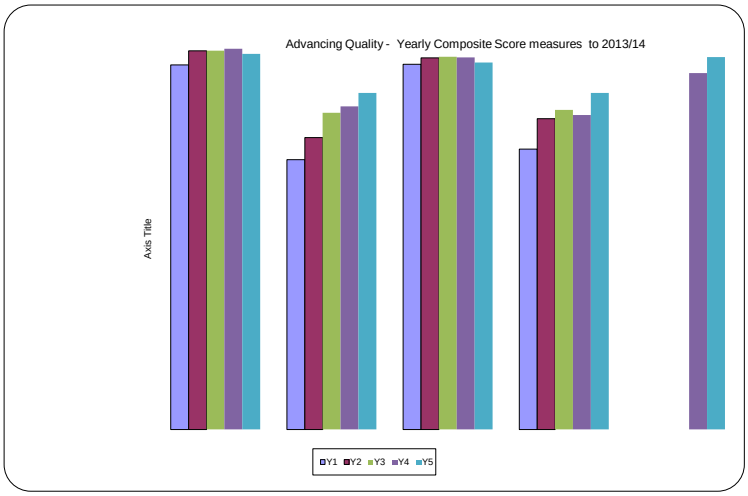
Complaints

Work is ongoing to improve our complaints system. We have seen a 6% reduction in the end of year total as we have tried to identify and address issues as they arise by being more visible and responsive to patients. This is conjunction with targeted work has reduced the overall number of formal complaints.

3.4.2 Advancing Quality

Advancing Quality (AQ) is an initiative to improve care for patients with acute myocardial infarction (heart attack), community acquired pneumonia, stroke, hip and knee replacement and heart failure. AQ is about ensuring we provide the right treatment to the right patients at the right time. It involves measuring key interventions that are identified good practice in the diseases concerned.

The most recent validated data available relates to 2012/13 and shows improvement for heart failure, community acquired pneumonia and stroke. There were changes to our antibiotic policy affecting patients having hip and knee surgery, and staff needed to remember to prescribe a different antibiotic to the one they were used to; this caused a drop in performance. For patients having a heart attack there was no specific measure that caused a problem, but care was not as consistent as it had been; additional awareness raising, brief intervention training for smoking cessation should support improvements. The stroke team was runner up in the AQ team of the year awards.



During 2013/14, there have been a number of changes to the AQ programme. New measures have been introduced that are more challenging to deliver; for example ensuring patients undergoing hip and knee replacement receive 28 days of medication to reduce the risk of blood clots.

The measure of success has also changed to reflect whether individual patients received all the care they were entitled to (appropriate care scores). These are generally lower than the composite score used to date (this reflects that when an opportunity arose to provide an intervention it was done). Key areas of improvement are: introducing a visual prompt for cardiac rehabilitation referrals (AMI); brief intervention training for smoking cessation; and employing a part time additional heart failure specialist nurse. This latter intervention should help ensure patients receive all the information about different aspects of their care at discharge. This is the usual cause of not achieving perfect care as defined by AQ:

Indicator	2013/14 Target	April - November 2013
Acute Myocardial Infarction (AMI)	79.87	76.51
Heart Failure	80.67	56.99
Hip & Knee Replacement	92.45	89.82
Community Acquired Pneumonia	61.07	69.08

Stroke	86.01	91.04

Table 8: Advancing Quality 2013/14

New areas are being piloted for a number of conditions. Sepsis and fractured neck of femur have clinical leadership from our Trust.

3.4.3 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 (C.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 re-launched 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 infectious 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	C.difficile cases	Target
2008/09	10	18*	209	358
2009/10	8	18*	187	260

2010/11	5	6	120	190
2011/12	1	5	68	120
2012/13	2	0	27	50
2013/14	2	0	28	33

Table 9 Infection control maximum targets for MRSA and C.difficile cases

**this was a combined target set for the Trust and the Primary Care Trust services.*

Whilst aiming to remain focussed in leading proactive strategies to reduce hospital acquired infection, it has been a particularly challenging year following the prolonged outbreak of norovirus which came to an end in March 2013. Bed pressures meant that the use of an empty ward to support the HPV programme to effectively remove norovirus and C.difficile from the environment was regularly interrupted. However it was still possible to HPV clean many of the areas that had been most affected by norovirus and during Q 2, the cleaning programme positively supported the further reduction in the number of patients acquiring C.difficile when in hospital. Unfortunately the increase in the number of positive cases witnessed during Q 3 and Q4 was likely due to the winter pressures, resulting again in the interruption of the HPV programme and in addition, the loss of the C.dificile cohort unit.

The 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 an MRSA bacteraemia occurring. Unfortunately we reported two MRSA bacteraemias during Q2. Full Root Causes Analyses (RCAs) performed on both these cases identified the first to be an unavoidable infection, however the second was believed to have been avoidable and highlighted several learning outcomes for the Trust which have been cascaded through the appropriate forums to ensure that lessons were learned across the organisation.

The infection prevention and control team took early action to provide direction regarding the management of newer organisms that are extremely resistant to many antibiotics e.g. CPE and Vancomycin Resistant Enterococci (VRE). Introducing screening strategies to proactively identify patients who are carrying these organisms and to support the prompt management of these patients has been successful in avoiding transmission and clinical infections associated with these extremely difficult to treat organisms.

Period	Tolerance for 2013/14	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
MRSA Bacteraemia Cases	0	0	0	0	1	1	0	0	0	0	0	0	0
C.difficile cases	33	3	4	1	1	1	1	2	3	3	4	3	2

Table 10: Hospital acquired infections reported in 2013/14

3.4.4 National Targets

For infection control, the Trust was considerably below the maximum number of 33 cases allowed for C.difficile – with 26 cases for the whole year. There were just two cases of MRSA bacteraemia within the year.

Against the Cancer standards, the Trust achieved all the requirements across each quarter in 2013/14, and in many cases performing better than the minimum expected. The Trust also delivered all of the Referral to Treatment (18 week) standards in all quarters across 2013/14 at a Trust total level.

For patients attending the Trust's Emergency Department and the All Day Health Centre located at the Arrowe Park site, the waiting time standard of 95% within 4 hours was achieved for the first three quarters of 2013/14. However this target was not achieved for Q4, with considerable increased emergency pressures on the Trust particularly in relation to beds. Achievement against national targets and indicators are set out in table 11 below.

National targets and regulatory requirements	Target	Q1	Q2	Q3	Q4
C.difficile – maximum number of cases	Max 33	8	3	8	9
MRSA – maximum number of cases	Max 0	0	2	0	0
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	Min 96%	97.5%	97.3%	97.3%	98.5%

National targets and regulatory requirements	Target	Q1	Q2	Q3	Q4
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer (two targets	Min 94% or 98%	96.9% & 100%	98.4% & 100%	98.1% & 100%	96.1% & 100%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	Min 85%	87.4%	86.7%	85.0%	86.5%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	Min 93%	96.6%	96.7%	97.3%	95.7%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all breast symptom referrals	Min 93%	95.4%	98.0%	98.8%	98.4%
Referral to treatment time within 18 weeks – admitted patients	Min 90%	93.2%	93.9%	93.6%	92.6%
Referral to treatment time within 18 weeks – non-admitted patients	Min 95%	97.8%	97.0%	97.0%	96.9%
Referral to treatment time within 18 weeks – incomplete pathways	Min 92%	92.6%	94.7%	94.3%	94.0%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Min 95%	95.4%	95.2%	95.2%	92.7%

Table 11 National targets and regulatory requirements

3.4.5 Core Indicators

The Health and Social Care Information Centre 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's position with the national average, as well as the lowest and highest indicator values nationally.

Summary Hospital Mortality Indicator

The SHMI is "as expected" for the Trust for both data sets:

	April 11 – March 12				April 12 – March 13			
	National Average	**WUTH with banding**	**Low**	**High**	**National Average**	**WUTH with banding**	**Low**	**High**
SHMI	1.0	1.05 (as expected)	0.71	1.24	1.0	1.07 (as expected)	0.65	1.16
% Deaths coded for palliative care	17.9	12.7%	0.2 %	44.2 %	19.9%	19.0%	0.2 %	43.3 %

Table 11: Summary Hospital Mortality Indicator

The Trust considers that this data is as described for the following reason – the data are historic and the Trust recognised the mortality indicators were higher than we would want although. We were also aware the coding for co-morbidities and palliative care was not reflecting the population; this has now been addressed using additional resources and by reviewing our coding process.

The Trust has taken steps to improve this score as described in the priority area "reducing HSMR" above.

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 2012/13, WUTH had above the national average adjusted average health gain for groin hernia

repairs, knee replacements and varicose veins with similar to national average values for hip replacement; all were as expected against the national average. In the first six months of 2013/14 both groin hernia and knee replacement scored as expected, with the trust average higher than the national one.

Adjusted Average Health Gain	April 2012 – March 2013				April 2013 – September 2013			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Groin Hernia	0.085	0.090	0.014	0.133	0.086	0.091	0.019	0.138
Hip Replacement	0.438	0.421	0.349	0.508	*	*	0.373	0.545
Knee Replacement	0.319	0.334	0.4	0.385	0.339	0.429	0.264	0.429
Varicose Vein	0.093	0.109	0.016	0.187	*	*	0.058	0.094

Table 12 Patient Reported Outcome Measures

**Casemix-adjusted figures not calculated where there are fewer than 30 modelled records*

The Trust considers that these data are as described for the following reason – the data are historic and the Trust works to ensure patients receive effective care that enhances their experience.

The Trust has taken steps to improve this score by ensuring the care given is patient centred. Work is ongoing to improve the response rates.

Readmissions within 28 days

	April 2010 – March 2011				April 2011 – March 2012			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Readmissions (aged 0 – 15)	10.15	13.91	3.53	25.8	10.1	13.60	6.4	14.94
Readmissions (16 and over)	11.42	12.47	2.38	22.93	11.45	11.75	9.34	13.8

Table 13 Readmissions within 28 days

The Trust considers that this data is as described for the following reason – the data are historic and the trust needs to consolidate work to reduce emergency readmissions to effect a change.

The Trust is taking steps to reduce this percentage and this will be a priority area for 2014/15. Actions already in place to avoid admissions and improve discharge are documented in the priority area to minimise bed moves.

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 2012/13 survey has shown good improvement with an above average score, an increase on the average score in 2011/12:

	April 2011 – March 2012				April 2012 – March 2013			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Responsiveness to personal needs (indicator Value)	67.4	67.4	56.5	85	68.1	71.2	57.4	84.4

Table 14 Trust's responsiveness to the personal needs of its patients

The Trust considers that this data is as described for the following reason – the data are historic and the Trust has been working to improve this score through our Learning with Patients survey which provides more timely information for actions to take place. The introduction of intentional rounding during this period is likely to have had an impact.

The Trust has taken steps to improve this score through work on a number of initiatives developed by the divisions in response to their local patient survey results. These vary by division. At a corporate level, introduction of the "fifteen steps" programme enables additional intelligence to be captured and support change as well as the use of patient stories at our Board and high-level committee meetings to provide a patient focus.

Recommend the Trust to Friends and Family Test

	Friends and Family Test, Feb 2014 (combined FFT rate)				Friends and Family Test, March 2014 (combined FFT rate)			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Recommend our services to Friends and Family	23.8%	24.4%	7.8%	100%	23.7%	25.2%	8.6%	100%

(%)								

The Trust considers that this data is as described for the following reason – whilst the Trust is not significantly different from the national average, we recognise that this is an area where we need to improve. The work that has started as a priority in 2013/14,will continue and we will strive to learn from the feedback we receive from patients and carers.

					Staff Survey 2013			
	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 (%)					67.1	59.85	39.5	93.9

Table 15 Recommend the Trust to Friends and Family

The Trust considers that this rate is as described for the following reason – whilst this is lower than the national average, it is an improvement compared to the response to similar questions asked in past staff surveys.

The Trust has taken steps to improve this score by educating staff about the importance of a high return rate, using the LiA initiative to ensure staff are able to articulate the changes needed locally to provide better care, listening to their concerns and acting on them.

VTE assessment – Based on acute trusts

The Trust met the national average performance for Q3 2013/14, a rise on the previous quarter, for assessing patients for VTE disease. The Trust continues to meet the target of 95% of patients being assessed for their risk of VTE throughout the year; the latest two quarters are reported. Details of actions taken are included in the priority area in part 3:

VTE Risk Assessment	Q2 2013/14				Q3 2013/14			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Compliance (%)	95.69	95.15	81.7	100	96	96	78	100

Table 16 VTE assessment – based on acute trusts

The Trust considers that this percentage is as described for the following reason – there has been extensive work over four years to ensure high compliance with VTE assessment including educational sessions for staff and prompts and reminders sent daily for those not assessed.

The Trust has taken steps to improve this score by educating staff about the importance of preventing VTE disease, widely publicising the reduction in mortality and readmissions.

C.difficile rates

The Trust has seen a significant reduction in C.difficile infection rate:

	April 2011 – March 2012				April 12 – March 2013			
	National Average	**WUTH**	**Low**	**High**	**National Average**	**WUTH**	**Low**	**High**
C.difficile (rate per 100,000 bed days)	22.2	27.8	0.0	58.2	17.3	9.6	0.0	30.8

Table 17 C.difficile rates

The Trust considers that this rate is as described for the following reason – the Trust has excellent systems in place to reduce hospital acquired infections (see section 3.4.3).

The Trust has taken steps to improve this score by the methods documented in 3.4.3, notably enforcing hand hygiene and the bare below elbows campaign as well as the HPV system used to clean wards on a rotational basis.

Patient Safety Incidents Reported, based on large acute trusts

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 12 – Sept 12				October 12 – March 13			
	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	4,427	5,930 (11.9)	1,761	7,835
	The Trust reported eight incidents that resulted in severe harm or death				The Trust reported nine incidents that resulted in severe harm or death			

Table 18 PatientsafetyiIncidents reported, based on large acute trusts

The Trust considers that this rate is as described for the following reason - the Trust continues to have 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. These data are historic. Whilst the national picture is of increased reporting between the periods, the Trust has reduced reporting. It is difficult to understand the reason; in part we would assume it is safer care, however during this period we introduced web based reporting and have noted a reduction in reporting as the new system embeds.

The Trust has taken steps to improve this score by educating staff about the importance of reporting incidents, providing additional support and education with the roll out of web based reporting. Incidents leading to severe harm and death and of great concern; a full root cause analysis is undertaken and actions to ensure this does not recur are monitored to completion through our risk systems. Lessons learnt are shared across divisions and departments as appropriate.

Annex: Statements from Third Parties

NHS
Wirral Clinical Commissioning Group

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 account reflects quality performance in 2013/14 and clearly sets out the direction regarding quality for the 2014/15.

Working in partnership with the Trust, a set of challenging local CQINs were developed during the last contracting round. The targets were developed by the CCG and agreed with the Trust, and reflected areas of desired improvement identified nationally and locally. Not all of these have been fully achieved this year, which demonstrates the challenging targets that both organisations committed to at the start of the year in order improve the quality of care for patients. Both organisations remain resolute to achieving these standards in the forthcoming year.

Ensuring patient safety is of paramount importance, and therefore it is a concern that there have been 3 never events during 2013/14. root cause analyses have been completed on all of these incidents in order to identify causative factors and emerging themes

Another area of concern is the increase in readmissions within 28 days. We welcome the increased focus in this area and the work that will be undertaken and look forward to seeing the evidence of significant improvement in 2014/15.

We acknowledge the improvement programme that has been undertaken throughout the year in relation to the reduction of pressure sore formation and infection prevention control

Hospital attributed MRSA remains a challenge to the trust with 2 cases reported for this period against a target of zero. However, there has been a significant reduction in C-difficle infection rate due to the steps and the actions that the trust has put in place.

Looking forward in 2014/15, 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
  - Improvements to complaints handling process
  - Family and Friends test
  - Improving care for people with Dementia
  - Ensure patients are supported with eating and drinking according to their individual needs
- Safety
  - Reduction in pressure sore formation
  - Reduce the number of “missed medication” events

- Clinical Effectiveness
  - Reduction in Hospital Standardised Mortality rate
  - Reduction in emergency readmissions within 30 days.

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 2014/15. Wirral Clinical Commissioning Group looks forward to continuing to work in partnership with the Trust to assure the quality of services commissioned over the forthcoming year.

Phil Jennings Chair

Wirral CCG

WIRRAL

Statement from Wirral Metropolitan Borough Council

2nd May 2014

Commentary on the draft Quality Account, 2013/14,

Wirral University Teaching Hospital

The Families and Wellbeing Policy and Performance Committee undertakes the health scrutiny function at Wirral Council. The Committee has established a Panel of Members (The Health and Care Performance Panel) to review the draft Quality Accounts received from health partners. Members of the Panel met on 29th April 2014 to consider the draft Quality Account and received a verbal presentation on the contents of the document. Members would like to thank Wirral University Teaching Hospital Foundation Trust for the opportunity to comment on the Quality Account 2013/14. Members provide the following comments:

Overview

Members acknowledge that 2013/14 has been a challenging year for the Trust but Members are pleased that genuine improvement is being made as demonstrated by the progress against the targets for the year. Members have concluded that the Quality Account describes the positive progress that has taken place during 2013/14 and highlights the continuous quality improvements being made by the Trust. In particular, the Trust has responded very positively to the outcomes of the Francis Enquiry by developing and implementing its local Francis Action Plan. Council Members look forward to working in partnership with the Trust during the forthcoming year.

Part 2.1.1 Priorities for Improvement in 2014/15

Care for patients with dementia

Members welcome the prioritisation of care for patients with dementia. In particular, the intention to ensure that patients with dementia receive care from staff who are appropriately trained in dementia care is appreciated.

Nutrition and hydration / Basic standards of care

Members welcome the priority being given to the nutrition and hydration of patients. It is recognised that this forms part of a wider nursing strategy. Members are aware of a WUTH document entitled ‘Proud to Care’ which sets out the ethos and care standards which nurses, midwives and health care support workers are expected to deliver. This document is based on the Strategy for Nursing ‘Compassion in Practice’.

Members recognise that, in order to ensure that the strategy has a direct impact on patient experience, a mechanism should be in place to measure the desired impacts. Although it is recognised that all activities at the Trust cannot be included within the document, a wider recognition for the nursing strategy within the priorities of the Quality Account would have been welcomed.

"Missed medication"

The prioritisation of reducing "missed medication" events is welcomed. However, Members are also aware of delays to discharge having, in the past, been caused by patients waiting for medication. It is hoped that this aspect will be included as part of the priority action planning.

Waiting times in A&E

Part 2.2.4 refers to the Commissioning for Quality and Innovation (CQUIN) targets for 2013/14. The document states that the A&E 4 hour target was not achieved in Quarter 4. Based on anecdotal evidence, Members regard this to be an issue of importance to patients and suggest that this issue is considered when setting future Quality Account priorities.

Part 3: Review of Quality Performance

Improve handling of complaints

Members note the considerable improvement in compliance during 2013/14 and also note the Chief Executive's comment that "there is still work to do on improving our complaint response times". The continued inclusion of this indicator as a Local Indicator in the future is, therefore, welcomed.

National Friends and Family Test

The significant improvement in the Net Promoter Score during the second half of 2013/14 is welcomed. In particular, the Trust is to be congratulated on the score in March 2013, achieving the third highest score in the country and the highest in the North West Region.

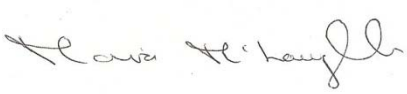
Minimise unnecessary in-hospital bed moves

Members particularly welcome the increased amount of integrated working between partners in the health and care sector, amply demonstrated by the actions put in place during 2013/14 to meet this target. It is anticipated that such integrated working will continue to develop as part of the Vision 2018 programme.

Factual Information

The health scrutiny function at Wirral is undertaken by the Families and Wellbeing Policy & Performance Committee. (Reference Part 2.1 on page 5 and Part 2.1.2 on page 7).

I hope that these comments are useful



Councillor Moira McLaughlin

Chair, Health and Care Performance Panel and

Deputy Chair, Families and Wellbeing Policy & Performance Committee

healthwatch wirral

Commentary by Healthwatch Wirral for Wirral University Teaching Hospital Foundation Trust Quality Account 2013/14

Report reviewed was Quality Account 2013/14 v2 to be published June 2014.

Healthwatch Wirral would like to thank WUTHFT for the opportunity to comment on the Quality Account for 2013/14. Over the last year WUTHFT have welcomed Healthwatch Wirral's input on improving patient experience and have included Healthwatch at a strategic, decision making level.

Healthwatch Wirral were pleased to learn that the Trust had made strong progress with the 5 priorities from last year and that they had identified one of Vision 2018 key objectives to bring care closer to the patient's home.

Healthwatch Wirral acknowledges the fact that the Trust faces challenges, and despite these, intends to maintain and improve the quality of the services provided.

Priorities for 2014/15

Healthwatch Wirral welcomes the focus on detecting and supporting people with dementia and would like to see further standards included following the baseline audit.

It was felt that the 75% target set for patients receiving support with eating and drinking was low. A quarter of patients reporting that they are not supported to eat and drink is a percentage to be taken seriously.

We were pleased to see the focus on preventing pressure ulcers and will monitor progress in the quarterly quality reports.

The Commissioning for Quality and Innovation (CQUIN) results were noted. It was disappointing to see that the A&E target for patients being identified, transferred or discharged within 4 hours had not been achieved.

Review of Quality Performance

Patient Experience – Healthwatch Wirral would like to see the inclusion of the impact of learning from complaints and concerns, not just response targets and would like to see concerns included in any trend analysis data.

Clinical Effectiveness – It was pleasing to read that seven day speciality working has been introduced where a senior medical review for patients is available every day.

External Reviews – Healthwatch Wirral were impressed that the National Cancer Patient Survey showed that the Trust were in the top 20% with patients rating their

care as excellent. It was commendable that the Trust had listened to patients comments and acted on them by improving both verbal and written communication.

Listening into Action – This is a positive initiative, however, staff views should be balanced against the impact on patients and their views. Healthwatch Wirral suggest that regular feedback should be obtained from patients to check that they feel appropriately supported and communicated with about planned changes.

Safety Measures- It was a concern to read that 'Never Events' had increased this year but it was gratifying to read that serious incidents had decreased. Healthwatch Wirral would be keen to find out how the Trust learn from the findings.

Advancing Quality – Healthwatch Wirral were pleased with the improvements noted and would like to congratulate the Stroke team for being runner up in the Advancing Quality team of the year awards.

Future Priorities – Healthwatch Wirral would like to see the Trust prioritise culture-attitudes, values and behaviours and improved communication/interaction with patients.

Finally, overall the report was honest and informative, but the document would benefit from the use of less technical terms making it easier for the general public to understand.

Healthwatch Wirral look forward to receiving reviews from the Trust on progress with the implementation of the Quality Account and also strategic plans for future End of Life/Palliative Care, particularly for patients with dementia or learning disabilities.

Healthwatch Wirral has had a very well established and respectful relationship with WUTHFT this year and looks forward to continuing this in the future.

Karen Prior

Healthwatch Wirral Manager

On behalf of Healthwatch Wirral

Glossary for Quality Account

Abbreviation / term	Definition
AKI	Acute Kidney Injury
AQ	Advancing Quality
Appropriate Care Score	A patient in the Advancing Quality Programme receives all the interventions they are entitled to
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	Calculation derived from data in multiple variables in order to form reliable and valid measures
CPE	Carbapenemase Producing Enterobacteriaceae – new strain of resistant rganism
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

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
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
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
OPRA	Older Persons Rapid Assessment
PEAT	Patient Environment Action Team
ROP	Retinopathy of Prematurity
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.
SDIP	Service Development and Improvement Programme – contractual obligation to improve care in a given area. These may be national or locally defined.
SHMI	Summary Hospital-Level Mortality Indicator – a measure of death within 30 days of discharge form hospital; not adjusted for palliative care
TARN	Trauma Audit Research Network
VRE	Vancomycin Resistant Enterococci
VTE	Venous Thrombo-Embolism or blood clot in the vein
WUTH	Wirral University Teaching Hospital

Appendix 1

Services Provided by the Trust

Diagnostics and Clinical Support Division (15)

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 Prevention and Control
Allied Health Professional services (Physiotherapy, Occupational Therapy, Dietetics)	

Acute and Medical Specialties Division (19)

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 / Sexual Health	

Acute Admissions Unit	Acute Assessment Unit
Accident and Emergency	Acute Oncology
Critical Care	Children's Emergency Department

Surgery Division (13)

Colorectal Surgery	Vascular Surgery
Dermatology	Breast Surgery
Ear, Nose & Throat including Audiology	Upper and Lower Gastro-intestinal Surgery
Oral Surgery	Ophthalmology
Maxillofacial Surgery and Orthodontics	Pain service
Trauma & Orthopaedics	Limb Centre
Urology	

Women and Children's 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 Division (13)

Corporate Nursing and Midwifery (includes Patient Experience and Complaints)	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
Pharmacy	

Appendix 2

National Clinical Audits Participation

	Name of audit / confidential enquiry	Data collection 2013/14	Participation Yes/No Number and %	Report received and Reviewed Y/N	Actions Taken and Comments
1	Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes 493 96%	No	Annual Report not available at time of writing. However interim reports have reinforced the need for monthly morbidity and mortality meetings to review individual cases in a more timely way.
2	National audit of seizures in hospital (NASH)	Yes	Yes 30 100%	Yes No	Report recently received – under review
3	National emergency laparotomy audit (NELA)	Yes	Yes 19 86%	No	Annual Report not available at time of writing
4	National Joint Registry (NJR)	Yes	Yes 1074 92%	Yes Yes	Consent rate for inclusion was lower than in previous reports. From January 2014 this has been completed when patients attend Joint School to improve compliance. WUTH hosted the 10th Anniversary Regional NJR Conference for the North of England.
5	Severe trauma (Trauma Audit	Yes	Yes	Yes	A “trauma champion” week has been arranged

	Name of audit / confidential enquiry	Data collection 2013/14	Participation Yes/No Number and %	Report received and Reviewed Y/N	Actions Taken and Comments
	&Research Network, TARN)		145 49%	Yes	for mid grade doctors to raise awareness of the activation criteria and protocol and the process for out of hospital transfers
6	Emergency Use of Oxygen	Yes	Yes 86 100%	No	Annual Report not available at time of writing
7	Bowel cancer (NBOCAP) (Subscription funded from April 2012)	Yes	Yes 223 104%	Yes Yes	No action required
8	Head and neck oncology (DAHNO) (subscription funded from April 2012)	Yes	Yes 34 100%	Yes Yes	Action plan led through regional centre at Aintree Hospital. The Trust is awaiting its data in order to review and implement an action plan if applicable.
9	Lung cancer (NLCA) (subscription funded from April 2012)	Yes	Yes 315 100%	No	Annual Report not available at time of writing
10	Oesophago-gastric cancer (NAOGC) (subscription funded from April	Yes	Yes 78 60-80%	Yes Yes	Regional Centre to lead action plan. Upper GI cancer nurse specialist now involved in supporting submission of

	Name of audit / confidential enquiry	Data collection 2013/14	Participation Yes/No Number and %	Report received and Reviewed Y/N	Actions Taken and Comments
	2012)				data so data capture and quality of data will be improved for the next report covering 2012 / 13 data. Closer links have been forged with Aintree Hospital to increase availability of laser and endoscopy treatments.
11	Acute coronary syndrome or Acute myocardial infarction (MINAP) (subscription funded from April 2012)	Yes	Yes 365 95%	Yes No	Report recently received – under review
12	National Cardiac Arrest Audit (NCAA)	Yes	Yes	No	Annual Report not available at time of writing
13	Heart failure (HF)	Yes	Yes 250 45.3%	No	Annual Report not available at time of writing
14	National Vascular Registry	Yes	Yes CEA 41 100% AAA 20 100%	Yes Yes	No actions required. Complex vascular surgery to be transferred to Countess of Chester Hospital – April 2014
15	Diabetes (Adult) ND(A), includes National	Yes	Yes	No	Annual Report not available at time of

	Name of audit / confidential enquiry	Data collection 2013/14	Participation Yes/No Number and %	Report received and Reviewed Y/N	Actions Taken and Comments
	DiabetesInpatient Audit (NADIA)		127 100%		writing
16	Diabetes (Paediatric) (NPDA)	Yes	Yes 117 100%	Yes No	Report recently received – under review
17	Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services	Yes	Yes	No	Annual Report not available at time of writing
18	National chronic obstructive pulmonary (COPD) audit programme	Yes	Yes Data collection in progress	No	Annual Report not available at time of writing Data collection to complete April 2014.
19	Renal replacement therapy (Renal Registry)	Yes	Yes 85 100%	Yes Yes	Historic data. Data quality needs to improve (been addressed but will not show until reporting 2012 data), No actions identified.
20	Rheumatoid and early inflammatory arthritis	Yes	Yes	No	Annual Report not available at time of writing
21	Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Yes 462	No	Annual Report not available at time of writing

	Name of audit / confidential enquiry	Data collection 2013/14	Participation Yes/No Number and %	Report received and Reviewed Y/N	Actions Taken and Comments
			100%		
22	Sentinel Stroke National Audit Programme (SSNAP))	Yes	Yes 534 (93%)	Yes Yes	No actions required
23	Elective surgery (National PROMs Programme)	Yes	Yes All procedures 534 (61.5%) Groin Hernias 85 (40.5%) Hips 145 (60.4%) Knee 230 (87.5%) Varicose Veins 62 (45.6)	Yes Yes	Hip forms now given out in Joint school to improve completion. Remaining forms given out in pre operative assessment to improve compliance. Work in progress to increase uptake of PROMS for hernia repairs.
24	Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes 9 100%	Yes No	Report recently received – under review
25	Maternal, infant and newborn programme (MBRRACE-UK)	Yes	Yes 31 100%	No	Triennial report not available at time of writing
26	Neonatal intensive and	Yes	Yes 374	Yes	Report recently received

	Name of audit / confidential enquiry	Data collection 2013/14	Participation Yes/No Number and %	Report received and Reviewed Y/N	Actions Taken and Comments
	special care (NNAP) (subscription funded from April 2012)		100%	No	– under review
27	Paracetamol overdose (Care provided in Emergency Dept)	Yes	Yes 50 100%	No	Annual Report not available at time of writing
28	Severe Sepsis and Septic Shock	Yes	Yes 50 100%	No	Annual Report not available at time of writing
29	Cardiac rhythm management (CRM)	Yes	Yes 313 100%	No	Annual Report not available at time of writing
30	Moderate or Severe Asthma in Children (Care provided in Emergency Dept)	Yes	Yes 50 100%	No	Annual Report not available at time of writing
31	Paediatric Bronchiectasis	Yes	Yes 46 85%	No	Annual Report not available at time of writing
32	Paediatric Asthma	Yes	Yes	No	Annual Report not available at time of writing
33	Child Health Clinical Outcome Review	Yes	Yes 50	No	Annual Report not available at time of

	Name of audit / confidential enquiry	Data collection 2013/14	Participation Yes/No Number and %	Report received and Reviewed Y/N	Actions Taken and Comments
	Programme (CHR-UK)		100%		writing
34	National Comparative Audit of Blood Transfusion Programme	No	No	No	This programme will resume in 2014/15

Appendix 3

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 2013-14

- 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 2013 to June 2014
    - Papers relating to Quality reported to the Board over the period April 2013 to June 2014;
    - Feedback from the commissioners dated May 2014
    - Feedback from governors dated February 2014
    - Feedback from local Healthwatch; dated May 2014
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2013;
    - The latest national patient survey (2012);
    - The latest national maternity survey (2013)
    - The latest national staff survey (2013);
    - The Head of Internal Audit's annual opinion over the trust's control environment dated May 2014
    - CQC intelligence monitoring report dated November 2013 and March 2014
    - the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

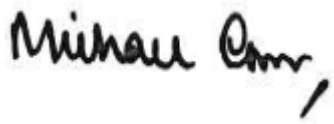
- the performance information reported in the Quality Report is reliable and accurate;

- 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.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.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



Michael Carr
Chairman

28th May 2014

David Allison
Chief Executive

28th May 2014

Appendix 4

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 2014 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 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 in the *Detailed Guidance for External Assurance on Quality Reports; 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 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;

- The 2013 national patient survey*;*
- The 2013 national staff survey*;*
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2013/14; and
- The 2013/14 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 2014, 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.

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 2014:

- 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.*

KPMG LLP

Chartered Accountants
St James' Square
Manchester
M2 6DS

29th May 2014

8. Remuneration Report

8.1 Remuneration and Appointments Committee

This committee comprises the non-executive directors, chief executive and is chaired by the Trust chairman. Its purpose is to decide the pay, allowances and other terms and conditions of the executive directors and of staff who are not on national terms as well as consider the appointments of executive directors as their posts fall vacant.

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 attended meetings in 2013/14, except where their own salaries or performance were discussed.

During 2013/14 the director of human resources and organisational development and the associate 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.

The Remuneration Committee met on five occasions during 2013/14.

Attendance at Remuneration and Appointments Committee Meetings in 2013/14

	Meeting Attendance Actual / Possible 1st April 2013 – 31st March 2014
Michael Carr, chair	5/5 100%
Cathy Bond	5/5 100%
Richard Dutton	4/5 80%
Graham Hollick	3/3 100%
Jeff Kozer	5/5 100%
Cathy Maddaford	3/3 100%
Lyn Meadows	4/5 80%
Jean Quinn	5/5 100%
Anne Parker	2/2 100%
Nick Williams	1/2 50%

8.2 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 a one per cent pay award for 2013/14 (in line with National Terms & Conditions).

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. The committee has no plans to introduce incentive payments or rewards to executive directors.

Salary and Pension entitlements of senior managers

A) Remuneration
(AUDITED)

Name and Title	1 April 2013 to 31 March 2014 (2013/14)						1 April 2012 to 31 March 2013 (2012/13)					
	Salary & Fees (in bands of £5,000) £'000	Taxable Benefits (total to the nearest £100)	Annual Performance related bonuses (in bands of £5,000) £'000	Long Term Performance related bonuses	Pension Related Benefits (*1) (to the nearest £)	Total (to the nearest £)	Salary & Fees (in bands of £5,000) £'000	Taxable Benefits (total to the nearest £100)	Annual Performance related bonuses (in bands of £5,000) £'000	Long Term Performance related bonuses	Pension Related Benefits (*1) (to the nearest £)	Total (to the nearest £)
Executive Directors												
David Allison, Chief Executive (from April 2012)	190 - 195	6,400	0	0	58,647	259,677	190 - 195	21,500	0	0	(66,509)	147,513
Gary Doherty, Chief Operating Officer / Deputy Chief Executive (from April 2012 to March 2013)	N/A	N/A	N/A	N/A	N/A	N/A	120 - 125	2,800	0	0	14,798	140,401
Russell Favager, Director of Finance (to January 2013)	N/A	N/A	N/A	N/A	N/A	N/A	85 - 90	4,200	0	0	(19,230)	74,837
Sharon Gilligan, Acting Director of Operations (from April 2013 to June 2013) *2	25 - 30	100	0	0	21,058	47,629	N/A	N/A	N/A	N/A	N/A	N/A
Sharon Gilligan, Director of Operations (from July 2013) *2	80 - 85	300	0	0	63,173	145,204	N/A	N/A	N/A	N/A	N/A	N/A
Alistair Mulvey, Director of Finance (from January 2013)	125 - 130	0	0	0	(6,079)	120,171	25 - 30	0	0	0	16,558	42,001
David Rowlands, Medical Director (to May 2012)	N/A	N/A	N/A	N/A	N/A	N/A	30 - 35	2,000	0	0	(6,740)	27,174
Evan Moore, Medical Director (from June 2012)	180 - 185	0	0	0	41,992	225,429	145 - 150	1,300	0	0	42,969	192,149
Sue Green, Director of Human Resources & Organisational Development (To January 2014) *3	200 - 205	3,000	0	0	27,478	233,361	100 - 105	5,200	0	0	24,863	130,814
Luke Readman, Director of Information (from August 2011 to August 2012)	N/A	N/A	N/A	N/A	N/A	N/A	45 - 50	1,100	0	0	(30,434)	15,421
Tina Long, Director of Nursing & Midwifery (to March 2013)	N/A	N/A	N/A	N/A	N/A	N/A	100 - 105	3,300	0	0	133,166	237,858
Jill Galvani, Director of Nursing & Midwifery (from March 2013)	125 - 130	0	0	0	53,479	179,729	5 - 10	0	0	0	(55,400)	(48,344)
Anthony Hassall, Director of Strategy & Partnerships (From September 2013)	50 - 55	3,000	0	0	49,548	107,136	N/A	N/A	N/A	N/A	N/A	N/A
Non-Executive Directors												
Michael Carr, Chairman	45 - 50	0	0	0	N/A	47,774	45 - 50	0	0	0	N/A	46,289
Richard Dutton, Non-Executive Director	10 - 15	0	0	0	N/A	13,649	10 - 15	0	0	0	N/A	13,286
Catherine Bond, Non-Executive Director	15 - 20	0	0	0	N/A	18,049	10 - 15	0	0	0	N/A	13,714
Anne Parker, Non-Executive Director (To June 2013)	0 - 5	0	0	0	N/A	3,355	10 - 15	0	0	0	N/A	13,286
Jean Quinn, Non-Executive Director	10 - 15	0	0	0	N/A	13,512	10 - 15	0	0	0	N/A	13,714
Nick Williams, Non-Executive Director (To June 2013)	0 - 5	0	0	0	N/A	3,355	10 - 15	0	0	0	N/A	13,286
Graham Hollick, Non-Executive Director (From July 2014)	10 - 15	0	0	0	N/A	11,705	N/A	N/A	N/A	N/A	N/A	N/A
Cathy Maddaford, Non-Executive Director (From July 2014)	10 - 15	0	0	0	N/A	10,345	N/A	N/A	N/A	N/A	N/A	N/A
Lynda Meadows, Non-Executive Director	10 - 15	0	0	0	N/A	13,419	10 - 15	0	0	0	N/A	13,286
Jeff Kozer, Non-Executive Director	10 - 15	0	0	0	N/A	13,563	15 - 20	0	0	0	N/A	16,731

Ratio of Highest Paid Director to Median staff member
The Monitor Foundation Trust Annual Reporting Manual 2013/14 (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 month's 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 2013/14 and 2012/13 financial years:

Financial Year	2013/14	2012/13
Band of Highest Paid Director's Remuneration	190 - 195	190 - 195
Median Total Remuneration (FTE staff on an annualised basis)	24,008	25,284
Ratio of Highest Paid Director to Median staff member	8.0	7.6

Governors & Directors Information
The Monitor Foundation Trust Annual Reporting Manual 2013/14 (FT ARM) requires the disclosure of the following information in relation to the governors and executive and non-executive directors of the trust.

Financial Year	2013/14	2012/13
Number of Governors in office	31	40
Number of Governors receiving expenses	9	8
Aggregate Expenses paid to Governors (to the nearest £100)	1,600	1,100
Number of Executive and Non-Executive Directors in office	18	18
Number of Executive and Non-Executive Directors receiving expenses	1	1
Aggregate Expenses paid to Executive and Non-Executive Directors (to the nearest £100)	5,000	2,200

(NOT AUDITED)

The Taxable Benefits 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 - The Pension related benefits shows the change in the annual rate of pension and lump sum that would be payable to the director if they became entitled to it at the end of the financial year. This calculation is adjusted for the relevant financial years inflation rate that is prescribed by the NHS Business Services Authority. If the increase in pension and lump sum is lower than that achievable by the increase in the rate of inflation then these figures appear as negative numbers.

*2 - Sharon Gilligan is shown twice on the remuneration report to reflect the fact that she was appointed as the Director of Operations on a permanent basis during the 2013/14 financial year.

*3 - In the 2013/14 financial year, the position of Executive Director of Human Resources and Organisational Development was made redundant and a redundancy payment is included within Salary & Fees.

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 2013/14 financial year.

Signed: …….. Date: ……..
Chief Executive

28th May 2014

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 £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5000) £000	Total lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Real Increase in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension To nearest £100
David Allison, Chief Executive	2.5 - 5	7.5 - 10	15 - 20	50 - 55	304	248	51	0
Alistair Mulvey, Director of Finance	(0 - 2.5)	(0 - 2.5)	25 - 30	85 - 90	484	465	8	0
Evan Moore, Medical Director	0 - 2.5	5 - 7.5	35 - 40	105 - 110	526	475	41	0
Jill Galvani, Director of Nursing & Midwifery	0 - 2.5	5 - 7.5	50 - 55	160 - 165	1,048	952	75	0
Susan Green, Director of Human Resources & Organisational Development (To January 2014)	0 - 2.5	2.5 - 5	5 - 10	20 - 25	115	92	17	0
Anthony Hassall, Director of Strategy & Partnerships (From September 2013)	0 - 2.5	2.5 - 5	15 - 20	50 - 55	238	200	18	0
Sharon Gilligan, Interim Director of Operations (From April 2013)	2.5 - 5	10 - 12.5	15 - 20	45 - 50	222	161	57	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.

The real increase in accrued pension, lump sum and CETV is adjusted for the relevant financial years inflation rate that is prescribed by the NHS Business Services Authority. If the increase in these categories is lower than that achievable by the increase in the rate of inflation then these figures appear as negative numbers.

* 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.

Signed: ……..

Date: ……..

Chief Executive

28th May 2014

9. Auditor's Report

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 2014 on pages 191 to 267. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2013/14.

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 74 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 and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. 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 the Trust's affairs as at 31 March 2014 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Strategic Report and 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 NHS Foundation Trustin 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 2014

Accounts for the 12 months April 2013 – March 2014

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

The National Health Service Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of 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 National Health Service Act 2006, Monitor has directed the 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;
- prepare the financial statements on a going concern basis;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance

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 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

28th May 2014

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 2014 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.

Signed:

David Allison
Chief Executive
Date: 28th May 2014

Statement of comprehensive income for the year ended 31 March 2014

			2013/14		2012/13
	NOTE		**£000**		£000
Operating Income	2 & 3		**300,889**		296,992
Operating Expenses	4		**(299,006)**		(290,510)
Operating surplus / (deficit)			**1,883**		6,482
Finance costs:					
Finance Income	9		**53**		281
Finance expense - financial liabilities	10		**(376)**		(425)
Finance expense - unwinding of discount on provisions			**(54)**		(68)
Surplus / (deficit) for the financial year			**1,506**		6,270
Public dividend capital dividends payable			**(4,494)**		(4,320)
Retained surplus / (deficit) for the year			**(2,988)**		1,950
Other comprehensive income / (expense)					
-Reduction in reserves due to revaluation losses			**(59)**		(326)
-Increase in reserves due to revaluation gains			**0**		0
-Other Recognised gains and losses			**0**		0
Total comprehensive income / (expense) for the year			**(3,047)**		1,624

The notes on pages 202 to 267 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 are taken through reserves under other comprehensive income.

All income and expenditure is derived from continuing operations. The foundation trust has no minority interest.

Statement of financial position as at 31 March 2014

			31 March 2014		31 March 2013
	NOTE		£000		£000
Non-current assets					
Intangible assets	13		**9,342**		9,572
Property, plant and equipment	14		**160,212**		156,745
Trade and other receivables	18		**4,273**		4,430
Total non-current assets			**173,827**		170,747
Current assets					
Inventories	17		**4,136**		4,056
Trade and other receivables	18		**15,279**		10,633
Cash and cash equivalents	19		**10,034**		24,918
Total current assets			**29,449**		39,607
Total assets			**203,276**		210,354
Current liabilities					
Trade and other payables	20		**(29,356)**		(32,948)
Borrowings	21		**(590)**		(521)
Provisions	24		**(753)**		(1,447)
Other liabilities	22		**(2,534)**		(2,991)
Net current assets / (liabilities)			**(3,784)**		1,700
Total assets less current liabilities			**170,043**		172,447
Non-current liabilities					
Borrowings	21		**(5,625)**		(6,048)
Provisions	24		**(2,549)**		(2,716)

Other liabilities	22		**(12,044)**		(11,069)
Total assets employed			**149,825**		152,614
Financed by taxpayers' equity:					
Public dividend capital			**68,885**		68,627
Revaluation reserve	25		**47,054**		47,676
Income and Expenditure reserve			**33,886**		36,311
Total Taxpayers' Equity			**149,825**		152,614

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 were approved by the Board on the 28th May 2014 and signed on its behalf by:

David Allison
Chief Executive

Signed :

Statement of changes in taxpayers' equity for the year ended 31 March 2014

	Public dividend capital (PDC)	Revaluation reserve	Income and Expenditure reserve	Total
	£000	£000	£000	£000
Balance at 1 April 2013	**68,627**	**47,676**	**36,311**	**152,614**
- Surplus / (deficit) for the year	0	0	(2,988)	**(2,988)**
- Impairments	0	(59)	0	**(59)**
- Revaluations - property, plant and equipment	0	0	0	**0**
- Asset disposals	0	(25)	25	**0**
- Public Dividend Capital received	258	0	0	**258**
- Other recognised gains and losses	0	0	0	**0**
- Other reserve movements	0	(538)	538	**0**
Balance at 31 March 2014	**68,885**	**47,054**	**33,886**	**149,825**

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 approximately based upon 3.5% of average net relevant assets less cash held by the Trust.

Statement of cash flows for the year ended 31 March 2014

				Restated
		2013/14		2012/13
	NOTE	**£000**		£000
Cash flows from operating activities:				
Operating surplus / (deficit) from continuing operations		**1,883**		6,482
Operating surplus / (deficit) of discontinued operations		**0**		0
Operating surplus / (deficit)		**1,883**		6,482
Non-cash income and expense				
Depreciation and amortisation		**8,285**		7,680
Impairments		**293**		1,321
Reversals of impairments		**(525)**		(30)
(Gain) / Loss on disposal		**103**		178
Non-cash donations/grants credited to income		**(324)**		(133)
(Increase) / Decrease in Trade and Other Receivables		**(4,678)**		(499)
(Increase) / Decrease in Inventories		**(80)**		(473)
Increase / (Decrease) in Trade and Other Payables		**(3,125)**		1,160
Increase / (Decrease) in Other Liabilities		**518**		339
Increase / (Decrease) in Provisions		**(915)**		126
Other movements in operating cash flows		**(1,465)**		(615)
Net cash generated from / (used in) operations		**(30)**		15,536
Cash flows from investing activities:				
Interest received		**110**		281

Purchase of intangible assets		**(1,389)**		(952)
Purchase of Property, Plant and Equipment		**(8,695)**		(11,018)
Sales of Property, Plant and Equipment		**21**		39
Net cash generated from / (used in) investing activities		**(9,953)**		(11,650)
Cash flows from financing activities:				
Public dividend capital received		**258**		0
Loans repaid to the Foundation Trust Financing Facility		**(266)**		(265)
Capital element of finance lease rental payments		**(270)**		(228)
Interest paid		**(245)**		(255)
Interest element of finance lease		**(131)**		(170)
PDC Dividend paid		**(4,247)**		(4,246)
Net cash generated from/(used in) financing activities		**(4,901)**		(5,164)
Increase / (decrease) in cash and cash equivalents		**(14,884)**		(1,278)
Cash and Cash equivalents at 1 April		**24,918**		26,196
Cash and Cash equivalents at 31 March	19	**10,034**		24,918

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.

The Statement of Cash Flows prior year comparator has been restated due to the introduction of additional categories by Monitor and the subsequent re-categorisation by the Trust. As a result, the prior year comparators of the following notes have also been re-categorised and labelled as restated:

- Note 3.1 - Other Operating Revenue
- Note 4.0 - Operating Expenses

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 2013/14 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 trust's 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 is the corporate trustee to the Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff. Prior to 2013/14, the FT ARM permitted the NHS foundation trust not to consolidate the charitable fund. In 2013/14 consolidated financial statements incorporating the Wirral University Teaching Hospital Charitable Fund have not been prepared because the results and assets and liabilities of this Charity are not considered to be material. This approach will be subject to review on an annual basis.

The foundation trust has no subsidiaries other than its charitable funds.

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.

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 1.80% 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 2014

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.

The National Employment Savings Trust (NEST) is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. NEST was set up specifically to help employers comply with automatic enrolment duties. NEST Corporation is the Trustee body that has overall responsibility for running NEST, it's a non-departmental public body that operates at arm's length from government and is accountable to Parliament through the Department of Work and Pensions.

NEST levies a contribution charge of 1.8% and an annual management charge of 0.3% which is paid for from the employee contributions. There are no separate employer charges levied by NEST and you do not have to enter into a contract to utilise NEST qualifying pension schemes.

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.

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 also informed the Foundation Trust that there had been no material changes in the indices in the period 1st April 2012 to the 31st March 2013 and hence no full scale revaluation was been carried out on land and buildings as at the 31st March 2013. DTZ have carried out a full scale revaluation of the land and buildings of the foundation trust as at the balance sheet date of 31st March 2014. This is to comply with Monitors requirement that foundation trusts perform a full scale revaluation at least once every 5 years

The foundation trust did not revalue its equipment in the 2013/14 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.

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.

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

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 IFRIC12 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.

1.13 Revenue government and other grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.14 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.

1.15 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.

1.16 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.

1.17 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 1.80% 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.

1.18 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 beconfirmed 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 probablethat a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.19 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS 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 (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) for 2013/14 only, net assets and liabilities transferred from bodies which ceased to exist on 1 April 2013, and (iv) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.20 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.

1.21 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 2014, as envisaged by S519A(3) to (8) ICTA88. This has been further delayed until at least the 2014/15 financial year.

1.22 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.

1.23 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).

1.24 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 31 of the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.25 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.

1.26 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 27 Separate Financial Statements
- IAS 28 Associates and joint ventures
- IAS 32 Financial Instruments

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.

2. Revenue From Patient Care Activities

2.1 Analysis of revenue from patient care activities	2013/14		2012/13
	£000		£000
Elective income	**54,315**		50,279
Non Elective income	**79,350**		77,751
Outpatient income	**35,080**		36,300
A&E income	**9,715**		9,290
Other NHS clinical income	**92,365**		90,745
Revenue from protected patient care activities	**270,825**		264,365
Private patient income	**914**		830
Other non-protected clinical income*	**896**		1,099
Total Revenue from patient care activities	**1,810**		1,929
	272,635		266,294

The figures quoted 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 (2012/13: 12.6%).

2.2 Analysis of revenue from patient care activities by source	**2013/14**		2012/13
	£000		£000
CCGs and NHS England	**264,805**		0
Primary Care Trusts	**0**		261,091
NHS Foundation Trusts	**431**		0
NHS Trusts	**1,256**		551
Local Authorities	**2,457**		934
NHS Other	**1,836**		1,737
Non-NHS:			
Private patients	**885**		818
Overseas patients (non-reciprocal)	**29**		12
Injury costs recovery (was RTA)	**896**		1,099
Other	**40**		52
	272,635		266,294

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. Since the 1st April 2013 onwards the Primary Care Trusts and Strategic Health Authorities have ceased to exist and the services that these organisations provided have been dispersed and managed between the new Clinical Commissioning Groups, Commissioning Support Units, NHS Regional Offices, NHS England, NHS Local Area Teams and Public Health England (Local Authority).

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 2013/14 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.

2.3 Operating lease income	**2013/14**	2012/13
	£000	£000
Operating Lease Income		
Rental revenue from operating leases - minimum lease receipts	**581**	575
Rental revenue from operating leases - contingent rent	**-**	-
Rental revenue from operating leases - other	**-**	-
Total	**581**	575
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.	**-**	-
	-	-
on leases of buildings expiring		
- not later than one year;	**501**	496
- later than one year and not later than five years;	**1,783**	1,778
- later than five years.	**1,673**	1,767
	3,957	4,041

on other leases expiring		
- not later than one year;	**29**	29
- later than one year and not later than five years;	**29**	29
- later than five years.	**-**	-
	58	58
Total	**4,015**	4,099

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.

			Restated
3.1 Other Operating Revenue	**2013/14**		2012/13
	£000		£000
Research & Development	**527**		428
Education, training and research	**9,201**		9,065
Non-patient care services to other bodies	**7,507**		11,054
Reversal of impairments of property, plant and equipment	**525**		30
Rental revenue from finance leases	**251**		254
Rental revenue from operating leases - minimum lease receipts	**581**		575
Receipt of Donated Assets Income	**324**		133
Revenue to support Voluntary Severance Scheme Payments	**0**		429
Catering Income	**1,382**		1,352
Car Parking charges	**1,200**		1,227
Income generation	**380**		303
Facilities Management arrangements	**230**		255
Clinical Tests	**117**		229
Staff recharges	**4,081**		4,133
Renal recharges	**175**		171
Release from Deferred Income - Frontis Accommodation Block	**434**		434
Continuing Care Income	**440**		356
Other revenue	**899**		270
	28,254		30,698

3.2 Commissioner Requested & Non-Commissioner Requested Services	**2013/14**		2012/13
	£000		£000
Commissioner Requested Services	**261,499**		254,061
Non Commissioner Requested Services	**39,390**		42,931
	300,889		296,992

NHS foundation trusts are required to disclose their income from Commissioner Requested Services and non-Commissioner Requested Services. The Income from Commissioner and Non Commissioner Requested Services equals the total value of income from activities in the SOCI and also notes 2 & 3.

4. Operating Expenses

			Restated
	2013/14	-	2012/13
	£000	-	£000
Services from other NHS bodies	**3,509**		3,126
Executive Directors' costs	**1,131**		1,027
Non-executive Directors' costs	**162**		156
Staff costs	**204,804**		200,611
Drug costs (non inventory drugs only)	**171**		117
Drugs Inventories consumed	**18,712**		17,830
Supplies and services - clinical - Other	**32,000**		28,984
Supplies and services - general	**5,802**		5,443
Establishment	**2,862**		3,004
Transport	**410**		432
Premises	**10,343**		11,425
Provision for impairment of receivables	**254**		40
Change in provisions discount rate	**(12)**		(13)
Inventories written down (net, including inventory drugs)	**15**		9
Depreciation	**6,870**		6,538
Amortisation of Intangible Fixed assets	**1,415**		1,142
Impairments of property, plant and equipment	**293**		1,321
Audit fees - statutory audit	**63**		56
Other auditor's remuneration - audit-related assurance services	**138**		12
Loss on disposal of property plant and equipment	**103**		178

Clinical negligence	**6,475**		5,065
Insurance costs	**411**		361
Rentals under operating leases - minimum lease receipts	**415**		486
Accommodation costs	**573**		425
Waste disposal	**440**		373
Consultancy Costs	**53**		542
Legal fees	**305**		235
Training, courses and conferences	**828**		898
Patient travel	**13**		12
Car parking & Security	**157**		174
Other	**291**		501
	299,006		290,510

The Clinical negligence costs relates to the Trusts contribution to the NHS Litigation Authority risk pooling scheme under which the Trust pays an annual contribution.

5. Operating Leases

5.1 As lessee

Payments recognised as an expense		**2013/14**		2012/13
		£000		£000
Minimum lease payments		**415**		486
Contingent rents		**0**		0
Sub-lease payments		**0**		0
		415		486
Total future minimum lease payments		**2013/14**		2012/13
Payable:		**£000**		£000
Not later than one year		**378**		293
Between one and five years		**702**		662
After 5 years		**1,495**		1,577
Total		**2,575**		2,532
6. Limitation On Auditor's Liability		**2013/14**		2012/13
		£000		£000
Limitation on auditor's liability		**1,000**		1,000
		1,000		1,000

7.The Late Payment Of Commercial Debts (Interest) Act 1998		**2013/14**		2012/13
		£000		£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
		0		0

8. Employee Costs and Numbers

8.1

Employee costs	2013/14			2012/13		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	169,989	169,989	0	167,399	167,399	0
Social Security Costs	13,122	13,122	0	12,681	12,681	0
Employer contributions to NHS Pension scheme	18,301	18,301	0	17,419	17,419	0
Agency / contract staff	4,523	0	4,523	4,139	0	4,139
Employee benefits expense	205,935	201,412	4,523	201,638	197,499	4,139

Included in the employer contributions to NHS Pension scheme is £117k on behalf of the directors of the foundation trust (2012/13 £128k)

8.2

Average number of people employed*			**2013/14**						2012/13		
	Total		**Permanently Employed**		**Other**		Total		Permanently Employed		Other
	Number		**Number**		**Number**		Number		Number		Number
Medical and dental	**524**		**385**		**139**		503		369		134
Administration and estates	**952**		**874**		**78**		948		836		112
Healthcare assistants and other support staff	**573**		**529**		**44**		564		517		47
Nursing, midwifery and health visiting staff	**2,072**		**2,010**		**62**		2,028		1,877		151
Scientific, therapeutic and technical staff	**719**		**689**		**30**		685		633		52
Bank and agency staff	**88**		**0**		**88**		95		0		95
Total	**4,928**		**4,487**		**441**		4,823		4,232		591
*Whole Time Equivalent											

8.3 Employee benefits	**2013/14**		2012/13
	£000		£000
Employee benefits	**0**		0
	0		0

8.4 Retirements due to ill-health

During the year there were 6 (2012/13: 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 £275,164 (2012/13: £418,954). 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 2013/14 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 2013/14 year 13 (2012/13: 29) members of staff made use of this scheme at a cost of £468k (2012/13: £622k)

In the 2013/14 financial year, the compulsory redundancy relates to the position of Executive Director of Human Resources and Organisational Development being made redundant following the Trust's Corporate Services review.

The tables below discloses the Voluntary Severance Schemes and compulsory redundancies, highlighting the staff numbers that fall within the differing cost ranges in the 2013/14 and 2012/13 financial years.

2013/14				
Exit Package Cost	Compulsory Redundancies	Compulsory Redundancies	Voluntary Severance Scheme departures agreed	Voluntary Severance Scheme departures agreed
	Number	£000	Number	£000
<£10,000	0	0	1	8
£10,001 - £25,000	0	0	3	56
£25,001 - £50,000	0	0	6	231
£50,001 – £100,000	1	85	3	173
£101,000 - £150,000	0	0	0	0
£150,001 - £200,000	0	0	0	0
>£200,001	0	0	0	0
Total	1	85	13	468

2012/13				
Exit Package Cost	**Compulsory Redundancies**	**Compulsory Redundancies**	**Voluntary Severance Scheme departures agreed**	**Voluntary Severance Scheme departures agreed**
	Number	**£000**	**Number**	**£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
£100,001 - £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

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. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 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.

9. Finance Income	**2013/14**	2012/13
	£000	£000
Interest on bank accounts	**53**	281
	53	281
10. Finance Costs - Interest Expense	**2013/14**	2012/13
	£000	£000
Loans from the Foundation Trust Financing Facility	**245**	255
Finance leases	**131**	170
	376	425
11. Other Gains and Losses	**2013/14**	2012/13
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	**(103)**	(178)
	(103)	(178)
12. Impairment of assets	**2013/14**	2012/13
	£000	£000
Changes in market price	**5,009**	1,729
Reversal of impairments	**(5,182)**	(112)
	(173)	1,617

In the 2013/14 financial year, the £5,009k impairment relates to a downward valuation of buildings following the mandatory revaluation of buildings and land at the 31st March 2014. Of this amount £4,716k relates to a reduction in the revaluation reserve for the associated buildings and £293k relates to the impairment charged to the statement of comprehensive income. These figures are shown net of an Impairment of the C Block Building at Arrowe Park Hospital due to this being scheduled for demolition early on in the next financial year.

In the 2013/14 financial year, the (£5,182k) reversal of impairment relates to the upward valuation of buildings that had been impaired in previous financial years. Of this amount (£4,657k) relates to an increase in the revaluation reserve for the associated buildings and (£525k) relates to the reversal of impairments income charged to the statement of comprehensive income.

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.

13.1 Intangible assets						
	Software licences (purchased)			**Intangible Assets Under Construction**		**Total**
	£000			**£000**		**£000**
Gross cost at 1 April 2013	9,920			2,175		**12,095**
Additions - purchased	690			495		**1,185**
Additions - donated	0			0		**0**
Impairments	0			0		**0**
Reversal of impairments	0			0		**0**
Reclassifications	2,454			(2,454)		**0**
Revaluations	0			0		**0**
Disposals	0			0		**0**
Valuation/Gross cost at 31 March 2014	**13,064**			**216**		**13,280**
Amortisation at 1 April 2013	2,523			0		**2,523**
Provided during the year	1,415			0		**1,415**
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 2014	**3,938**			**0**		**3,938**

Net book value						
NBV - Purchased at 31 March 2014	8,620			216		**8,836**
NBV - Finance leases at 31 March 2014	506			0		**506**
NBV - Donated at 31 March 2014	0			0		**0**
NBV total at 31 March 2014	**9,126**			**216**		**9,342**

All intangible assets are held at cost less accumulated amortisation based on estimated useful economic lives.

The amount held as an intangible asset under construction was the cost to date of the implementation of the "Wirral Millennium" project for the replacement of the patient information system. Phase 1 of this asset was brought into use during 2010/11, and phase 2a was brought into use during the 2013/14 financial year. The current asset under construction relates to phase 2b and phase 3 of this project.

13.2 Economic life of intangible assets				
	Min Life			**Max Life**
	Years			**Years**
Intangible assets - purchased				
Software	**2**			**7**

14.1

Property, plant and equipment	Land	Buildings excluding dwellings	Dwellings	Assets under construction and 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 2013	2,012	128,463	12,371	1,095	37,388	108	9,424	3,285	**194,146**
Additions - purchased	0	4,149	0	1,650	891	0	1,193	434	**8,317**
Additions - leased	0	0	0	0	181	0	0	0	**181**
Additions - donated	0	19	0	0	294	0	0	11	**324**
Impairments	0	(4,716)	0	0	0	0	0	0	**(4,716)**
Reversal of impairments	0	4,657	0	0	0	0	0	0	**4,657**
Reclassifications	0	1,358	1	(1,731)	373	(1)	0	0	**0**
Revaluations	0	(7,071)	164	0	0	0	0	0	**(6,907)**
Disposals	0	(2)	0	0	(1,034)	(6)	(577)	(44)	**(1,663)**
Cost or valuation at 31 March 2014	**2,012**	**126,857**	**12,536**	**1,014**	**38,093**	**101**	**10,040**	**3,686**	194,339
Accumulated depreciation at 1 April 2013	0	4,718	868	0	21,718	90	8,003	2,004	**37,401**
Provided during the year	0	2,572	434	0	3,069	4	517	274	**6,870**
Impairments	0	293	0	0	0	0	0	0	**293**
Reversal of impairments	0	(525)	0	0	0	0	0	0	**(525)**
Reclassifications	0	0	0	0	0	(1)	0	1	**0**
Revaluation surpluses	0	(7,071)	(1,302)	0	0	0	0	0	**(8,373)**
Disposals	0	(2)	0	0	(924)	(6)	(577)	(30)	**(1,539)**
Accumulated depreciation at 31 March 2014	**0**	**(15)**	**0**	**0**	**23,863**	**87**	**7,943**	**2,249**	34,127
Net book value at 1 April 2013									
NBV - Owned at 1 April 2013	2,012	122,282	11,503	1,095	14,948	18	1,409	1,234	**154,501**
NBV - Finance lease at 1 April 2013	0	0	0	0	7	0	0	0	**7**
NBV - Donated at 1 April 2013	0	1,463	0	0	715	0	12	47	**2,237**
NBV total at 1 April 2013	**2,012**	**123,745**	**11,503**	**1,095**	**15,670**	**18**	**1,421**	**1,281**	156,745
Net book value at 31 March 2014									
NBV - Owned at 31 March 2014	2,012	125,407	12,536	1,014	13,197	14	2,089	1,390	**157,659**
NBV - Finance lease at 31 March 2014	0	0	0	0	172	0	0	0	**172**
NBV - Donated at 31 March 2014	0	1,465	0	0	861	0	8	47	**2,381**
NBV total at 31 March 2014	**2,012**	**126,872**	**12,536**	**1,014**	**14,230**	**14**	**2,097**	**1,437**	160,212

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

14.2 Economic life of property plant and equipment				
	Min Life		**Max Life**	
	Years		**Years**	
Land	0		0	
Buildings excluding dwellings	2		81	
Dwellings	26		26	
Assets under Construction & POA	0		0	
Plant & Machinery	2		18	
Transport Equipment	2		5	
Information Technology	2		5	
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.

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15. Net Book Value of Assets Held Under Finance Lease					
	Software licences (purchased)		**Plant & Machinery**		**Total**
	£000		**£000**		**£000**
Cost or valuation at 1 April 2013	1,013		439		**1,452**
Additions - purchased	0		181		**181**
Cost or valuation at 31 March 2014	**1,013**		**620**		**1,633**
Accumulated depreciation at 1 April 2013	253		432		**685**
Provided during the year	254		16		**270**
Accumulated depreciation at 31 March 2014	**507**		**448**		**955**
Net book value					
NBV - Purchased at 31 March 2014	506		172		**678**
NBV - Donated at 31 March 2014	0		0		**0**
NBV total at 31 March 2014	**506**		**172**		**678**

16. Capital Commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements are:

	31 March 2014		31 March 2013	
	£000		£000	
Property, plant and equipment	**656**		873	
Intangible assets	**5,035**		2,200	
	5,691		**3,073**	

The Trust has entered into a contract with Cerner for the provision of a replacement of the Patient Care Information System. The contracted capital commitment regarding Cerner is £5,035k, however, this will be reviewed in the new financial year following the anticipated receipt of Public Dividend Capital from the Department of Health to support the future implementation of the project.

There are a number of other capital contracts which commenced in 2013/14 which are due to be completed in 2014/15 with a total value of £656k.

Total capital commitments as at 31st March 2014 are £5,691k (2012/13: capital commitments £3,073k).

17.1 Inventories	**31 March 2014**		31 March 2013
	£000		£000
Drugs	**1,355**		1,470
Consumables	**2,760**		2,564
Energy	**21**		22
	4,136		4,056
			Restated
17.2 Inventories recognised in expenses	**31 March 2014**		31 March 2013
	£000		£000
Inventories recognised as an expense in the period	**47,808**		44,903
Write-down of inventories (including losses)	**(15)**		(9)
Reversal of write-downs that reduced the expense	**0**		0
	47,793		44,894

18.1

Trade and other receivables	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
NHS Receivables - Revenue	**9,487**	6,210	**0**	0
Receivables due from NHS charities – Revenue	**166**	218	**0**	0
Provision for impaired receivables	**(504)**	(135)	**(260)**	(375)
Prepayments (Non-PFI)	**1,851**	1,531	**0**	0
Accrued income	**1,264**	1,204	**0**	0
Interest Receivable	**5**	62	**0**	0
Finance Lease Receivables	**47**	44	**3,031**	3,078
PDC dividend receivable	**0**	132	**0**	0
VAT receivable	**665**	175	**0**	0
Other receivables - Revenue	**2,298**	1,192	**1,502**	1,727
	15,279	10,633	**4,273**	4,430

The great majority of trade is with clinical commissioning groups, as commissioners for NHS patient care services. As clinical commissioning groups are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Finance lease receivables	31 March 2014		31 March 2013
	£000		£000
Gross lease receivables	3,078		3,122
of which those receivable			
- not later than one year;	47		44
- later than one year and not later than five years;	226		210
- later than five years.	2,805		2,868
Unearned interest income	0		0
Net lease receivables	3,078		3,122
of which those receivable			
- not later than one year;	47		44
- later than one year and not later than five years;	226		210
- later than five years.	2,805		2,868
	3,078		3,122

18.3 Provision for impairment of receivables	31 March 2014		31 March 2013
	£000		£000
Balance at 1 April	510		470
Increase in provision	254		40
Amounts utilised	0		0
Unused amounts reversed	0		0
Balance at 31 March	764		510

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 (2012/13: 12.6%).

18.4 Analysis of impaired receivables	31 March 2014		31 March 2013
	£000		£000
Ageing of impaired receivables			
0 - 30 days	0		0
30-60 Days	2		2
60-90 days	16		4
90- 180 days	64		24
over 180 days	682		480
	764		510
Ageing of non-impaired receivables past their due date			
0 - 30 days	610		1,546
30-60 Days	1,397		1,067
60-90 days	1,549		261
90- 180 days	436		201
over 180 days	625		68
	4,617		3,143

19. Cash and Cash Equivalents	31 March 2014		31 March 2013
	£000		£000
Balance at 1 April	24,918		26,196
Net change in year	(14,884)		(1,278)
Balance at 31 March	10,034		24,918
Made up of			
Commercial banks and cash in hand	113		117
Cash with the Government Banking Service	9,921		24,801
Other current investments	0		0
Cash and cash equivalents as in statement of financial position	10,034		24,918
Bank overdraft	0		0
Cash and cash equivalents as in statement of cash flows	10,034		24,918

20.1

Trade and Other Payables	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Receipts in advance	**900**	900	**0**	0
NHS payables - revenue	**6,260**	3,600	**0**	0
Other trade payables - capital	**1,362**	1,944	**0**	0
Other trade payables - revenue	**5,930**	6,873	**0**	0
Social Security costs	**1,923**	1,888	**0**	0
Other taxes payable	**1,945**	1,988	**0**	0
Other payables	**2,775**	3,538	**0**	0
Accruals	**8,146**	12,217	**0**	0
PDC dividend payable	**115**	0	**0**	0
	29,356	32,948	**0**	0

Other payables includes: £2,455,886 outstanding pensions contributions at 31 March 2014 (£2,273,497 at 31 March 2013)

NHS payables includes: 6 early retirements from the NHS Trust on the grounds of ill-health (2012/13: 7). The estimated additional pension liabilities of these ill-health retirements will be £275,164 (2012/13: £418,954). The cost of these ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

21.1

Borrowings	Current				Non-current			
	31 March 2014		31 March 2013		**31 March 2014**		31 March 2013	
	£000		£000		**£000**		£000	
Loans from Foundation Trust Financing Facility	**265**		265		**5,174**		5,440	
Obligations under finance leases	**325**		256		**451**		608	
	590		521		**5,625**		6,048	

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 £608k (2012/13 £857k).

21.2 Finance lease borrowings

	31 March 2014		31 March 2013
	£000		£000
Gross lease liabilities	1,093		1,302
of which liabilities are due:			
- not later than one year;	325		256
- later than one year and not later than five years;	451		608
- later than five years.	0		0
Finance charges allocated to future periods	0		0
Net lease liabilities	776		864
of which those due:			
- not later than one year;	325		256
- later than one year and not later than five years;	451		608
- later than five years.	0		0
	776		864

The obligations under finance leases include the outstanding borrowings in relation to the Cerner Picture Archiving Communication System (PACS) finance lease of £608k (2012/13 £857k).

22.

Other Liabilities	Current				Non-current		
	31 March 2014		31 March 2013		31 March 2014		31 March 2013
	£000		£000		£000		£000
Other Deferred income	2,534		2,991		12,044		11,069
	2,534		2,991		12,044		11,069

The deferred income balances within the 2013/14 financial year are inclusive of a £1,466k increase due to the revaluation increase of the Frontis Accommodation block. This is in accordance with IFRIC12 Service Concessions as per note 14.1.

23. Prudential Borrowing Limit

The Prudential Borrowing Code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

24. Provisions	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Pensions relating to other staff	**273**	276	**2,549**	2,716
Other legal claims	**480**	564	**0**	0
Other	**0**	607	**0**	0
	753	1,447	**2,549**	2,716

	Pensions relating to other staff	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
At 1 April 2013	2,992	564	607	**4,163**
Change in the discount rate	(12)	0	0	**(12)**
Arising during the year	141	156	0	**297**
Utilised during the year - accruals	(69)	0	0	**(69)**
Utilised during the year - cash	(197)	0	0	**(197)**
Reversed unused	(87)	(240)	(607)	**(934)**
Unwinding of discount	54	0	0	**54**
At 31 March 2014	2,822	480	0	**3,302**
Expected timing of cash flows:				
- not later than one year	273	480	0	**753**
- later than one year and not later than five years	1,161	0	0	**1,161**
- later than five years	1,388	0	0	**1,388**
	2,822	480	0	**3,302**

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 on-going with the Trust's solicitors.

The "Other" Provision related 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 2014 was £80,510,010 (£80,949,400 at 31st March 2013).

25.

Revaluation Reserve			
	Intangibles		**Property, plant and equipment**
	£000		**£000**
Revaluation reserve at 1 April 2013	**0**		47,676
Net Impairments and reversal of Impairments	**0**		(59)
Asset disposals	**0**		(25)
Other recognised gains and losses	**0**		0
Other reserve movements	**0**		(538)
Revaluation reserve at 31 March 2014	**0**		**47,054**

26.

Contingencies			
	2013/14		2012/13
Contingent Liabilities	**£000**		£000
Equal pay	**0**		0
Other	**(196)**		(151)
Gross value of contingent liabilities	**(196)**		(151)
Amounts recoverable against liabilities	**0**		0
Net value of contingent liabilities	**(196)**		(151)
Contingent Assets			
Net value of contingent assets	**0**		0

A contingent liability of £196k exists in 2013/14 for potential third party claims in respect of employer's / occupier's liabilities and property expenses (2012/13 £151k). 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			
	2013/14		2012/13
	Loans and receivables		Loans and receivables
	£000		£000
Trade and other receivables excluding non financial assets	**10,664**		6,322
Cash and cash equivalents (at bank and in hand)	**10,034**		24,918
	20,698		31,240
27.2 Financial liabilities by category	**2013/14**		2012/13
	Other financial liabilities		Other financial liabilities
	£000		£000
Borrowings excluding Finance lease and PFI liabilities	**5,439**		5,705
Obligations under finance leases	**776**		864
Trade and other payables excluding non financial liabilities	**18,543**		21,299
	24,758		27,868

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 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 on the following pages:

2013/14

Organisation Category	Organisation	Income £000	Expenditure £000	Debtors £000	Creditors £000
Clinical Commissioning Groups	NHS Wirral Clinical Commissioning Group	220,828	0	6,489	976
	NHS West Cheshire Clinical Commissioning Group	16,327	0	282	16
Health Education England	Health Education England	9,453	10	74	0
NHS Foundation Trusts	Clatterbridge Centre for Oncology NHS Foundation Trust	4,938	45	983	921
	Cheshire & Wirral Partnership NHS Foundation Trust	1,080	42	2,600	36
	Countess of Chester Hospital NHS Foundation Trust	2,738	5,030	367	1,235
NHS Trusts	Northwest Ambulance Service NHS Trust	10	0	3	0
	Wirral Community NHS Trust	1,920	981	1,172	882
NHS England	NHS England (inclusive of Commissioning Support Units & Local & Regional Area	24,511	1,193	528	1,205
Other NHS Bodies	NHS Litigation Authority	0	6,719	0	0
	NHS Business Services Authority (NHS Pensions Scheme)	0	18,301	0	2,456
Other Government Bodies	HM Revenue & Customs	0	31,423	665	3,868
Charitable Bodies	Wirral University Teaching Hospital NHS Foundation Trust Charitable Funds	307	0	166	0
		282,112	**63,744**	**13,329**	**11,595**

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
		280,088	**65,481**	**7,057**	**9,110**

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. Since the 1st April 2013 onwards the Primary Care Trusts and Strategic Health Authorities have ceased to exist and the services that these organisations provided have been dispersed and managed between the new Clinical Commissioning Groups, Commissioning Support Units, NHS Regional Offices, NHS England, NHS Local Area Teams 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 £35,121 cash at bank and in hand at 31 March 2014 (£6,695 at 31st March 2013) 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 £2,863,462 of unused consignment inventories at the 31 March 2014 (£3,262,934 at 31st March 2013). 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 2013/14 there were 72 cases, on an accruals not cash basis, of losses and special payments (2012/13: 88 cases) totalling £66,201 (2012/13: £71,222).

Wirral University Teaching Hospital

NHS Foundation Trust

Arrowe Park Hospital

Upton

Wirral

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