

Annual Report and Accounts 2015/16



**Wirral University Teaching Hospital NHS Foundation Trust
Annual Report and Accounts 2015/16**

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

Contents

	Page
Performance Report	6
• Message from the Chairman and Chief Executive	6
• Overview of Performance	9
• Performance Analysis	20
Accountability Report	32
• Director's Report	32
• Remuneration Report	41
• Staff Report	48
• NHS Foundation Trust Code of Governance Disclosures	58
• Regulatory Ratings	81
• Statement of Accounting Officer Responsibilities	82
• Annual Governance Statement	83
Quality Report	102
Annual Accounts 2015/16, including Independent Auditor's Report	165

Performance Report

Message from the Chairman and Chief Executive

Welcome to our review of 2015/16; a year of significant progress despite a very difficult climate for the whole of the NHS.

Increasing pressures on services mean that every trust across the country is striving to overcome major financial and operational challenges. Here at Wirral University Teaching Hospital, we are pleased to report that we have made major strides forward this year, and whilst we are realistic about the demands and expectations upon us, we also believe that our journey of improvement is progressing along the right path.

We are enormously proud that we continue to have low mortality rates, impressive results in national audits such as for stroke, children's inpatient services and maternity and breast services; as well as some outstanding patient feedback. The Trust has been recognised with numerous national awards this year in areas such as dermatology, dementia, patient experience and patient safety.

There has been a significant amount of work undertaken to improve staff engagement and morale and this year's NHS Staff Survey results were extremely encouraging, with one of the biggest improvements ever in a single year by any trust. Our employees are feeling much more positive and enthusiastic and several of the survey's key findings were in the top 20% of acute trusts nationally. We will continue to build on this good work as we progress with year 2 of our Workforce and Organisational Development Plan.

In recognition of the crucial role that nurses play in delivering the best possible patient experience, we have invested significantly in nurse recruitment, and now have one of the lowest nurse vacancy rates nationally. We are also nurturing existing staff to develop further their own nursing skills so we can meet the demands of modern healthcare, and our successful 'Return to Practice' programme has resulted in experienced nurses returning to work delivering patient care on wards at both Clatterbridge and Arrowe Park Hospitals.

As Wirral's biggest employer, our workforce is at the forefront of our journey of transformational improvement. In March 2016, the Care Quality Commission published its inspection report on Wirral University Teaching Hospital and in line with most other health and social care organisations across the country, we were given an overall 'requires improvement' rating against the highest possible standards. Reassuringly, the results did not come as a surprise and were in line with our own self-assessment carried out before the inspection. However a number of improvements were highlighted by the CQC. We had already started to address these areas and are pleased to confirm that we have made

significant further progress since the inspection. We are particularly proud that the CQC highlighted the 'dedicated' and 'caring' staff and our commitment to continuing to provide the support that they need to further improve performance.

We continue to liaise closely with NHS Improvement, formerly Monitor (the regulator of NHS funded healthcare), following our financial governance breach in 2015 as we work towards a position of sustainable financial stability. Our recovery plan has been acknowledged as "credible" and "robust" and we remain committed to achieving the strong financial footing needed to provide the best possible standards of patient safety and quality of care. As with so many other acute trusts, full financial recovery will take longer to achieve, but we will not become complacent and will continue to work with NHS Improvement and ensure that the efficiencies we are required to make do not compromise the excellent care our staff provide. The Trust already has a reference costs index (RCI) of 91 which indicates that our costs are 9% less in total than the national mean for like services.

We are maintaining our efforts to reduce pressures on our Emergency Department and improve waiting times to meet the '4-hour' standard as set by government. As part of NHS England's Emergency Care Improvement Programme, we have strengthened partnerships with external health and social care agencies to better understand where delays occur during a hospital stay and transition to alternative provision or return home in order to make the necessary improvements. Recent initiatives have focussed on making sure that patients who are ready for discharge are able to leave hospital and return home quickly and safely and we are starting to see some positive results. Our NHS Friends and Family Test results for the Emergency Department (Minors) have shown consistency over the year and often indicate that between 98% and 100% of patients completing their discharge survey would recommend the service to others to receive care.

Continued demand for our elective services and the cancellation of activity, albeit limited, has led to non-compliance with referral to treatment times. The Trust continues to make improvements against improvement trajectories and is hopeful of compliance shortly.

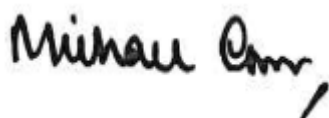
The Trust is enormously proud of the work of our infection prevention and control team this year; they have led the way in managing the impact of bacteraemia such as CPE which are resistant to antibiotics and are now advising other trusts in this area. The issues experienced earlier in the year by the Trust with the number of reported cases of C difficile have now been effectively managed with no new avoidable cases reported since the middle of January 2016.

We have been working ever closer with our partners in Wirral to develop the new economy-wide approach to healthcare to make sure that it is sustainable and meets the needs of the populations we serve. Although the national financial support for the Vanguard project has now ceased, the commitment from partners to implement the changes necessary to bring services closer together and to create a local health

economy that can both meet the financial challenge and deliver the high standards of care that residents so rightly expect continues as part of “Healthy Wirral”.

As a trust, we have developed a strong reputation for innovation, both nationally and overseas, and are proud to be involved with pioneering programmes to improve healthcare. With further developments to our electronic health record system, Wirral Millennium, we are well on the way to being the first acute hospital trust in the UK to be truly digital. The Trust was ranked by the HSJ as the 4th nationally in the Digital Maturity Index. This is bringing major benefits for staff and patients, not just by streamlining processes but by improving the quality and safety of care we provide. We recently hosted the 6th Annual BIARGS (British and Irish Association of Robotic Gynaecological Surgeons) Conference, where doctors, nurses and surgeons learnt about the latest in surgical technology and we have joined the world’s largest ever clinical trial looking at whether taking aspirin every day prevents common cancers from returning.

We would like to take this opportunity to emphasise that the progress we have made this year has only been possible thanks to the hard work, support and commitment of our workforce, who are the beating heart of the organisation. In addition, our Board, our Directors, our Council of Governors, our Members and the support of our external stakeholders has, and will continue to be, a vital part of our journey, along with the hundreds of dedicated volunteers who kindly donate their skills, time and assistance to our hospitals. It has been a difficult year, yet as a trust we have achieved a great deal. We are well prepared for the challenges that 2016/17 will bring and are confident that we have gathered the momentum to drive further improvements and to achieve our goals.



Michael Carr
Chairman



David Allison
Chief Executive

Overview of Performance

The purpose of the Trust and its key activities

Wirral University Hospital NHS Foundation Trust (WUTH) is not only the largest employer in Wirral but is also one of the largest and busiest acute Trusts in the North West of England. It was formed under the provisions of the Health and Social Care (Community Care and Standards) Act 2003 (consolidated in the National Health Service Act 2006). The Trust received its Terms of Authorisation from Monitor, the regulator of NHS funded healthcare, on 1st July 2007.

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

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

We are also accountable to our commissioners (through contracts), Parliament and Monitor. Providing a comprehensive range of high quality acute care services, our 5871 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 2015/16 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
 - 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 employer on the Wirral, we have had significant recognition from external organisations for our support for staff through effective policies, initiatives and a partnership working approach. We have continued our commitment to developing the talents of young people in Wirral through our apprenticeships. We were also recognised in this year’s Patient Experience Network National Awards (PENNA) for our work around staff engagement and patient experience.

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, enabling the vast majority of the Trust's electronic patient record including virtually all nursing, Allied Health Professional and medical documentation outside theatres and our Intensive Care Unit (ICU).

As a teaching hospital of the University of Liverpool and University of Chester, 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 2015-16 the Trust provided the following:

	2015-16
Total Births	3,382
A&E Attendances	93,247
Emergency Admissions *	55,057
New Outpatient Attendances	113,350
Diagnostic examinations performed	335,804
Elective Day Case Admissions**	43,447
Elective Inpatient Admissions	7,841

*Including maternity emergencies but excluding births

**Excludes Nephrology

Key Issues and Risks

The table below sets out risks to delivery of this Operational Plan for 2016/17 and an assessment of likelihood and impact together with mitigating actions:

Risk & Effect	Likelihood (1-5)	Impact (1-5)	Score (2-25)	Mitigation
Initiatives to suppress demand or develop community substitute services fail to deliver a reduction in emergency demand: non-delivery of ED trajectory.	4	4	16	Active participation within the Urgent Care Recovery Group and System Resilience Group. The Trust will continue to improve patient pathways in line with the Emergency Care Improvement Programme. On-going development of Healthy Wirral programme.
Capacity hotspots (e.g. therapies and community paediatrics) and/or growth in non-elective admissions: non-delivery of RTT target.	3	4	12	Through the System Resilience Group actively champion robust workforce plans across organisational boundaries and the introduction of pathway coordinators will enable early notification of constraints within specialties so robust corrective action can be initiated.
Failure to reduce emergency demand and capacity hotspots and/or growth in non-elective admissions: increased (unplanned) expenditure and/or loss of income.	4	4	16	Active participation within the Urgent Care Recovery Group and System Resilience Group. To ensure sufficient step up & down capacity across the economy, with the Trust taking an active lead.
Delivery of the required financial position.	3	5	15	Existing financial governance framework and policies. Non recurrent support from Health Economy.
Size of change management agenda greater than organisational capacity.	4	4	16	Development of leadership capabilities to support the change management agenda through decentralisation, HR and OD Strategy. Positioning of Senior Leadership Team to be able to support delivery of the change management agenda, e.g. COO appointment.

Financial Overview 2015/16

The 2015/16 financial year has been one of the most challenging for the NHS, with the provider sector carrying the most of the financial burden. Within this challenging landscape, the Trust has reported a year end deficit of £15.4m compared with an initial planned deficit of £13.5m. Despite the deficit, the Trust's cash balances remained positive, with the Trust finishing the financial year with a cash balance of £3.5m.

The Trust's budgets are expressed in a single document held and reviewed by Monitor, the sector regulator for foundation trusts in 2015/16, and this is known as the Trust's plan.

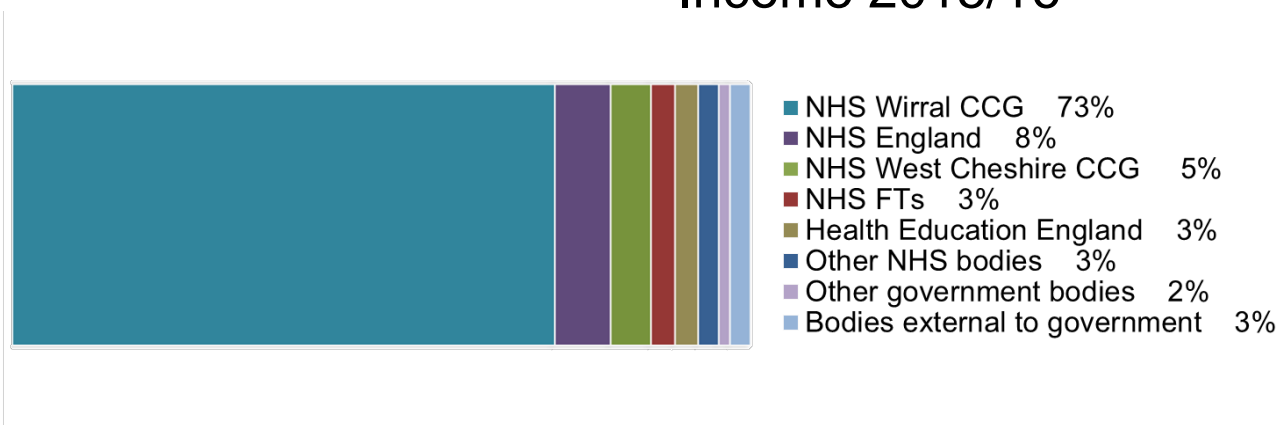
The following commentary provides more detail on the Trust's key financial results, which are formally reported in the Trust's annual accounts, with reference to the 2015/16 plan.

Income

The Trust has generated income of £306.5m in the year, which is £0.6m lower than planned. Wirral Clinical Commissioning Group (WCCG) remains the largest commissioner of services from the Trust, generating 73% of the Trust's overall income, which is consistent with 2014/15.

The chart below depicts the Trust's income by customer type.

Income 2015/16



Elective activity was below plan in 2015/16, whereas Accident & Emergency (A&E) attendances exceeded plan. The elective activity variance was driven by the displacement of planned activity as a result of unplanned activity pressures, and staffing pressures, including the impact of junior doctors' industrial action during the last quarter of the financial year.

The Trust experienced a higher number of A&E attendances than in each of the previous two years. Potential A&E sanctions against the Trust were reinvested in the Trust by Wirral CCG, helping to mitigate the cost of providing additional capacity for unplanned care.

The table to the right details the Trust's 2015/16 income, split by the broad admission type, known as 'point of delivery'.	Clinical income by point of delivery		
	2015/16 £000	2014/15 £000	
	Elective income	49,997	52,054
	Non elective income	79,846	79,705
	Outpatient income	36,550	35,964
	A & E income	10,757	10,592
	Other NHS clinical income	97,578	97,864
	Private patient income	560	742
	Other clinical income	1,059	870
	Total income from activities	276,347	277,791

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

Expenditure

Total expenditure is £321.9m, which is an increase of £10.8m or 3.5% on 2014/15. Pay is the largest expenditure category at £212.5m, which is 67% of the Trust's total expenditure. Within this pay figure, the amount spent on nursing staff remains the most significant, at £79.5m. In non-pay costs, £32.8m was spent on clinical supplies, and £21.9m was spent on drugs, which is an increase of £1.9m on last year.

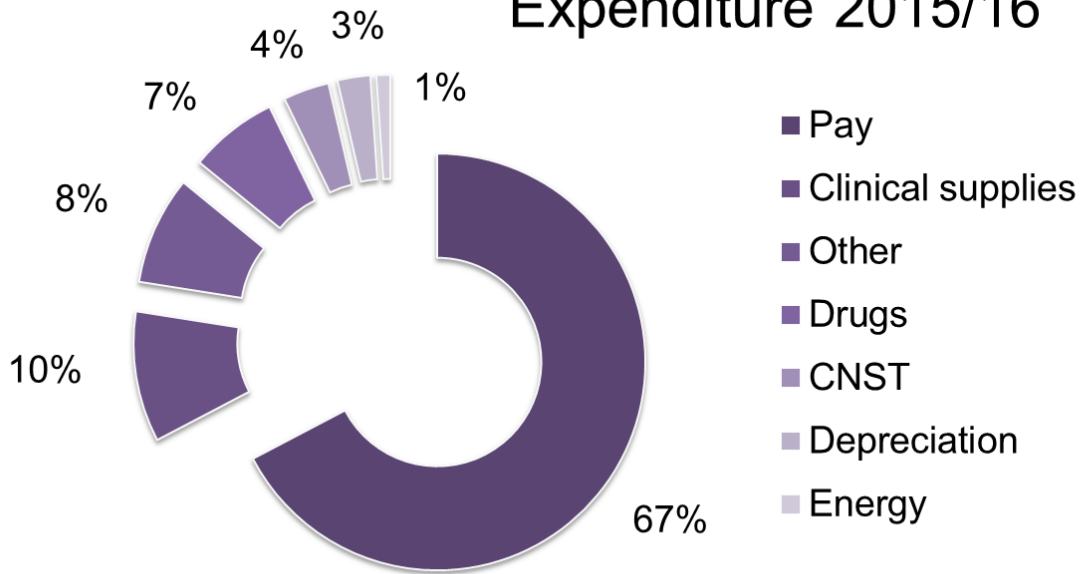
Other notable expenditure items in 2015/16 are as follows.

- £11.3m for the Trust's clinical negligence insurance (CNST) premium.
- £13.9m for medical / surgical equipment.
- £3.9m on orthopaedic implants.
- £3.5m on utilities.

Depreciation of £8.1m is included in the overall expenditure figure. This is a non-cash item, which is charged annually to reflect the usage and consumption of capital assets which were purchased in this and previous years.

The following chart (overleaf) depicts the main categories within total reported expenditure for 2015/16.

Expenditure 2015/16



Pay expenditure was £0.9m higher than the plan, reflecting winter challenges and the junior doctors' industrial action, and mitigated by the active management of agency spend in line with central initiatives regarding agency caps. Investment in nursing continued, with a further hugely successful drive on nurse recruitment during the year, together with further nursing investment for a new infection control isolation facility.

Non-pay expenditure was £2.1m higher than plan, but is offset largely by income in relation to funded drug spend, and further IT development.

Cost improvement plans (CIPs)

The CIP requirement is a national Department of Health strategy involving all NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs.

The Trust set a challenging CIP target for the year and managed to deliver this target after the application of non-recurrent resources, as detailed in the following table (overleaf).

	Actual £m	Plan £m	Variance £m	Variance %
2015/16	13.3	13.0	0.3	2.3%
Percentage of total income	4.3%	4.2%		
2014/15	9.6	13.0	-3.4	-26.2%
Percentage of total income	3.1%	4.3%		

Capital expenditure

Capital investment for the year totalled £9.7m (£8.0m in cash terms), which is in line with the Trust's plan to invest in its estate and infrastructure, as well as leading-edge technologies. This expenditure underpins patient experience, service delivery, and the achievement of efficiencies in the medium and long-term.

The Trust's main schemes for 2015/16 were as follows.

- Continued investment in the Trust's IT infrastructure and patient care systems (£2.3m).
- The redevelopment of an isolation ward (£0.9m) as part of a wider £1.7m ward upgrade program.
- Installation of a new pharmaceutical robot to support and improve the service provided by the Trust's pharmacy department (£0.5m).

Cash

The cash balance held at 31 March 2016 was £3.5m. This is £1.9m higher than planned, in spite of the deficit, mainly due to favourable movements in the Trust's working capital balances (debtors and creditors).

Although the Trust has experienced diminishing liquidity, prompt supplier payments have been maintained. Note 9.3 to the accounts - *Better Payment Practice Code (BPPC)* – evidences the Trust's strong performance in 2015/16, although the 95% targets were not met. The Trust has established a borrowing facility for 2016/17 through Monitor and the Department of Health, in order to secure future liquidity.

Financial sustainability risk rating (FSRR)

The Trust is regulated by Monitor, which assesses the Trust's performance. With effect from August 2015, the financial rating system in Monitor's Risk Assessment Framework was adjusted to reflect Monitor's current views on areas of financial risk faced by foundation trusts. Two new financial efficiency metrics were introduced, alongside the two existing continuity of services (CoS) metrics. This new overall

rating is the financial sustainability risk rating (FSRR).

Both CoS and FSRR are measured from 1 to 4, with 4 being the highest rating achievable. Under both rating systems, the Trust achieved an overall rating of 2 for 2015/16, which matched the Trust's plan, although this result is viewed by Monitor as indicative of financial risk. The Trust is not alone in achieving this rating, which partly expresses sector-wide pressures, and mirrors the downward trend in ratings for providers nationally.

The Trust's FSRR performance for 2015/16 is detailed in the table below.

		2015/16 Plan	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual
Continuity of Services	Liquidity	1	2	1	1	1
	Capital servicing capacity	2	1	1	1	1
	CoS rating	2	2			
Financial Efficiency	I&E margin	1	1	1	1	1
	I&E margin variance	3	3	3	3	3
Overall FSRR		2	2	2	2	2

Following a period of investigation by Monitor, the Trust was found to be in breach of its provider licence in August 2015. This breach was in relation to financial governance concerns. Although financial challenges remain, the Trust continues to work with the regulator to meet requirements and Monitor has recognised the Trust's direction of travel, and progress in key areas.

Reference costs

The Trust's reference cost index, which measures the relative efficiency of trusts in England, continues to be positive, with the Trust scoring 91 for the return submitted in July 2015. In essence, this means that the Trust is 9% more efficient than the national average, and demonstrates the Trust's commitment to deliver value for money in a challenging health economy.

Countering fraud and corruption

The Trust's Bribery Policy and Fraud & Corruption Policy, as well as the Standards of Business Conduct policy document, are available to, and binding on, all Trust staff. Through Mersey Internal Audit Agency, the Trust receives a local counter fraud

service which prevents and detects fraud, and reports activities and findings to the Trust's Audit Committee.

Future outlook

During 2016/17, the Trust will continue on its journey to achieve financial sustainability. As part of that journey, the Trust has agreed a 'financial envelope' with its main commissioner, Wirral CCG. This will allow the Trust and the CCG to work more closely together on innovative new ways of controlling and dealing with demand within the Wirral peninsula, whilst giving financial certainty for both parties.

The Trust has also agreed to a control total which has been set by NHS Improvement. This will allow the Trust to access £9.9m of additional income which will support the transition towards sustainability.

The following factors will be critical in the delivery of the Trust's forward plan.

- Control of service demand, to ensure that services can be safely delivered within the agreed 'financial envelope'.
- Tight management of costs across the Trust, to deliver the activity required in line with agreed budgets.
- Development and delivery of detailed efficiency plans which achieve in-year savings of £11.2m, and which lay the foundations for further savings into future years.
- Development and delivery of an additional £5m of savings through the wider health economy.
- Securing £9.9m of funding from the Sustainability and Transformation Fund.
- Access to interim financial support from the Department of Health.

Outlined below are the key elements of the Trust's 2016/17 plan.

2016/17 Plan		£m
Surplus		0.2
	Assumed CIP achievement within the above surplus	11.2
	Health economy financial challenge, also included in the above surplus	5.0
Capital expenditure		6.8
	Capital expenditure on a cash basis	8.9
Closing cash balance		7.9
	Department of Health facility drawn down to support liquidity	8.2
Overall FSRR		2
FSRR comprises the following planned ratings		
Continuity of Services	Liquidity	1
	Capital servicing capacity	3
Financial Efficiency	I&E margin	3
	I&E margin variance	3

Going Concern Disclosure

The Trust is judged to be a going concern if it is to continue in operation for the foreseeable future. There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows.

In forming a view, the directors have considered the financial factors captured in the Trust's 2016/17 plan, including any projected losses or liquidity risks, alongside any other foreseeable operational and compliance matters. This assessment covers a period of at least 12 months from the date of approval of the financial statements.

In particular, the directors have noted the following indicators of going concern status.

- The Trust's 2016/17 plan has been submitted to the regulator, NHS Improvement, and no queries or issues have been brought to the Trust's attention by the regulator subsequent to that submission.

- No major losses of commissioner income are anticipated. The Trust has agreed a 'financial envelope' with its main commissioner for 2016/17, which will allow both parties to innovate and work more closely together, whilst offering a degree of financial certainty.
- No deterioration in the overall Financial Sustainability Risk Rating (FSRR) is forecast, with planned improvements in both the Capital Servicing Capacity and I&E Margin ratings.
- Planned operating cash-flows for 2016/17 are positive.
- Regulator approval of a working capital facility for 2016/17 has been secured, supporting liquidity, with no anticipated problems in complying with the terms of the facility.
- The Trust has not identified any risk of an inability to repay borrowings when they fall due – all treasury activity is included in the Trust's planning models and all borrowings are intra-governmental – ultimately, if required, terms may be renegotiated.
- Key management vacancies have been, and will be, filled, and the Trust's general vacancy rates are low compared with comparator trusts.
- Robust plans are in place to support the Trust's governance risk rating.
- The Trust is actively engaged in local strategic transformation planning with health economy partners, to develop models to deliver sustainable healthcare from 2016/17 onwards.

Based on their detailed assessment, the directors have a reasonable expectation that the NHS 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.

Performance Analysis

Performance against Risk Assessment Framework Targets

The primary process for foundation trusts to assure themselves on governance and performance is the NHS Improvement (formerly Monitor) Risk Assessment Framework. Performance against the key Framework metrics is detailed below.

The table lists the Trust's performance on these key targets during 2015/16.

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%	94.9%	97.4%	94.6%	98.4%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all breast symptom referrals	Minimum 93%	97.7%	100%	100%	98.8%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	Minimum 96%	97.6%	96.2%	97.8%	97.8%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer (surgery)	Minimum 94%	94.3%	98.2%	100%	100%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer (drugs)	Minimum 98%	100%	100%	100%	100%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	Minimum 85%	85.0%	85.4%	85.3%	86.1%
Maximum waiting time of 62 days from screening referral to treatment for all cancers	Minimum 90%	100%	100%	91.5%	100%
Referral to treatment time – incomplete pathways < 18 weeks	Minimum 92%	93.0%	92.1%	91.7%	90.3%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Minimum 95%	87.6%	93.3%	88.0%	80.9%
Maximum number of avoidable cases of C difficile	Maximum 29 for the year	11	11	11	2

Access to cancer care

The Trust again consistently achieved the Cancer access targets for all quarters and for all metrics across the whole of 2015/16. The continued 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 is to be commended.

Access to Elective Care

Ongoing achievement of the Referral to Treatment RTT standard is directly linked to demand and capacity. Both increased demand and reduced capacity in a number of services has meant that the Trust ability to meet the 92% RTT standard was challenging in Quarters 3 and 4.

The specialties that did not achieve continue to be General Surgery (with the failing areas in colorectal, upper gastrointestinal surgery, and vascular), Urology, Trauma and Orthopaedics and “Other” which includes numerous specialties but notably Community Paediatrics.

The Trust is focussing on current practice for managing elective care against best practice guidance from the NHS Interim Management & Support Group using their elective care guide and developing an action plan for improvement. Reviews will be undertaken at specialty level to ensure full understanding of capacity and demand together with a review of reporting structures to provide assurance that there is proactive management and waiting time tracking at patient level. The Trust is also reviewing and developing its reporting and performance metrics to be able to track the impact of any changes and monitor improvement.

Access for Emergency Patients

Despite the range of actions being put in place, performance against the Emergency Access Standard remained below the minimum 95% for 2015/16.

The Trust is working with external experts and health and social care economy partners to improve patient flow. The Trust has also established internal mechanisms to prioritise key actions to see measurable improvement within the Emergency Department. The Trust has agreed a trajectory of improvement with Commissioners and performance against this will be tracked by the Board.

Avoidable Cases of C difficile

The Trust now has a robust programme for managing and monitoring C difficile. The HPV programme has continued with the Infection Prevention and Control Team prioritising the wards at greatest risk of C.difficile acquisition.

Ongoing monitoring of side room usage, documentation and the management of patients with diarrhoea continues to ensure all mitigating actions are consistently in place to prevent C.difficile infection against a trajectory of no more than 29 cases by the end of 2016/17. The Trust has not reported an avoidable case of C difficile since the middle of January 2016.

Performance against strategic objectives 2015/16

Set out below is a table illustrating the Trust's current strategic aims and the operational objectives for 2015/16:

Strategic Aim	2015/16 Operational Objective
To be the top NHS hospital trust in the north west for patient, customer and staff satisfaction	Continually improve our patient experience to deliver a Friends & Family Test result where over 95% would recommend our care Create a strong culture of empowered employees, delivering an improved overall score in the NHS staff survey
To lead on integrated shared pathways of care with primary, community and social care	Work with partners in Wirral to reduce delayed transfers of care to no more than 3.5 a month Reduce readmissions to 7% of total admissions by developing a range of plans to deliver care closer to home
To deliver consistently high quality secondary care services enhanced through the provision of regional specialist services	Implement our quality improvement strategy to reduce mortality to a score of 85 Ensure that our harm free score is no lower than 95% for each month of the year
To ensure our people are aligned with our vision	Relaunch our values and behaviours strategy Improve attendance rates to 96.3% and appraisal rates to 91%

<p>To maximise innovation and enabling technologies</p>	<p>Implement the next stage of our Wirral Cerner Millennium IT systems: deliver full electronic nursing documentation; pilot paper free outpatients and the sharing of documents with primary care</p> <p>Ensure that in 80% of research studies the time to recruiting the first patient will be within 30 days of the study opening</p>
<p>To build on partnering for value</p>	<p>Deliver an increased market share to 86% of Wirral CCG referrals through engagement with local GPs</p> <p>Continue to develop a range of partnerships with NHS and non NHS providers to secure clinical sustainability particularly in relation to our regionally significant services</p>
<p>To achieve financial, commercial and operational excellence</p>	<p>Fully comply with the requirements of CQC registration</p> <p>Continue to deliver a Monitor Continuity of Services rating of 1 whilst working towards improving our financial sustainability in the long term</p> <p>Achieve a Monitor Green governance rating meaning that we have met all our performance targets – including the 4 hour A&E, 18 weeks and cancer waiting targets</p>

Set out below is a table illustrating performance against objectives:

<p>2015/16 Operational Objective</p>	<p>Year End Position</p>
<p>Continually improve our patient experience to deliver a Friends & Family Test result where over 95% would recommend our care</p>	<p>Since May 2015 the Trust has consistently achieved over 95% with a score of 98% in January 2016</p>

<p>Create a strong culture of empowered employees, delivering an improved overall score in the NHS staff survey</p>	<p>Significant achievements have been made. The NHS Staff survey shows engagement score at 3.79 (national average). This is an increase from last year when the Trust was in the bottom 20%. Achieve of 88% compliance with Appraisal rates and good performance against the 96% attendance rate</p>
<p>Work with partners in Wirral to reduce delayed transfers of care to no more than 3.5 a month</p>	<p>The Wirral economy has sought to care for patients in the most appropriate environment once they are medically discharged from acute care. A range of schemes has been put in place to reduce the duplication of assessments and ensure the appropriate capacity is commissioned within the community for domiciliary care and short term placements.</p> <p>Average Delayed Transfer of Care for April 2015 to March 2016 was 3.4. This is based on the position at each month-end and is consistent with the target of reducing below 3.5.</p>
<p>Reduce readmissions to 7% of total admissions by developing a range of plans to deliver care closer to home</p>	<p>The current position for readmissions is at 8.9% versus the highest point in 15/16 of 10%</p>
<p>Implement our quality improvement strategy to reduce mortality to a score of 85</p>	<p>HSMR=89.2 (83.5-95.3) April – Nov 2015.</p> <p>On trajectory to remain below expected for 2015/16.</p>
<p>Ensure that our harm free score is no lower than 95% for each month of the year</p>	<p>The Trust has achieved a score of 95% or above for each month with the exception of August 2015 (94%). The Trust score for January 2016 is 96%.</p>

<p>Relaunch our values and behaviours strategy</p>	<p>Refreshed approach introduced. The results of the NHS Staff Survey shows considerable improvements in linked questions e.g. "Care of patients / service users is my organisation's top priority" has increased from 53% to 66%.</p>
<p>Improve attendance rates to 96.3% and appraisal rates to 88%</p>	<p>Significant reductions in sickness absence have been achieved. The rolling 12 months sickness rate is now 4.21%, compared to 4.93% last year.</p> <p>The Trust achieved the appraisal rate target</p>
<p>Implement the next stage of our Wirral Cerner Millennium IT systems: deliver full electronic nursing documentation; pilot paper free outpatients and the sharing of documents with primary care</p>	<p>Phase 2b implemented. Millennium moved into the Cerner data centre.</p> <p>Achieved digital maturity index placing Trust one of the highest in the country</p>
<p>Ensure that in 80% of research studies the time to recruiting the first patient will be within 30 days of the study opening</p>	<p>For studies approved from April 2015 - 4/8 achieved recruitment within 30 days.</p> <p>The studies that missed target were all medical products with low recruitment aims (3 less than 6); so few patients were expected to match criteria.</p>
<p>Deliver an increased market share to 86% of Wirral CCG referrals</p>	<p>Market share 15/16</p> <p>Q1 82.51 %</p> <p>Q2 83.06 %</p> <p>Q3 83.82 %</p>

<p>Continue to develop a range of partnerships with NHS and non NHS providers to secure clinical sustainability particularly in relation to our regionally significant services</p>	<p>An Acute Care Alliance has been proposed by the Boards of this Trust and the Countess of Chester between the 2 organisations</p> <p>The Trust is a key partner in Healthy Wirral.</p> <p>The Trust is a key partner in the emerging Cheshire and Merseyside Women and Children’s Vanguard</p>
<p>Fully comply with the requirements of CQC registration</p>	<p>The CQC undertook its comprehensive inspection in September 15 to which the overall rating was “requires improvement”. The Trust has now submitted an action plan to address the areas of non-compliance as outlined in the requirement notices. Many of the actions have already been undertaken.</p>
<p>Continue to deliver a Monitor Continuity of Services rating of 1 whilst working towards improving our financial sustainability in the long term</p>	<p>The Trust achieved a Financial sustainability Risk Rating of 2 as planned</p>
<p>Achieve a Monitor Green governance rating meaning that we have met all our performance targets – including the 4 hour A&E, 18 weeks and cancer waiting targets</p>	<p>The Trust currently has a RED governance rating attributed to non-compliance with the 4 hour A & E standard. The Trust has agreed a trajectory of improvement for 16 17 but without transformational change across the health economy this will not meet the 95% standard</p> <p>Referral to Treatment Time performance for the end of 15/16 was 90.46% against a target of 92%</p>

Development of the Trust

Any consideration of the Trust's future development, performance and position needs to be placed in the context of the current reshaping of the health (and social) care policy landscape: roll out of the Five Year Forward View entails the dismantling of the internal market and its replacement with place based integrated care systems funded on a population basis.

In the period to Christmas 2015, the Trust undertook a fundamental review of its long term strategy up to the end of the decade. The Trust's future development, performance and position will be determined by the extent to which this strategy is successful. The three key themes upon which the strategy is based are as follows:

1. WUTH 2020: Clinical Model and Service Portfolio

- The Trust will retain its underpinning clinical model and will continue to ensure local access to the current range of acute and secondary care services available to patients on the Wirral. That said, in many instances, how these services are provided, where and by whom will change
- The Trust will become part of a network of networks
- The most significant of these networks are
 - A strategic alliance with the Countess of Chester NHSFT (CoCH) i.e. horizontal integration
 - Healthy Wirral i.e. vertical integration
- The alliance with CoCH will enable the continued provision locally of services which otherwise would not be clinically or financially viable
- Healthy Wirral's emphasis on prediction/ prevention rather than diagnosis/ treatment and on the delivery of care in a community/ domiciliary setting should reduce the overall quantum of hospital/bed based acute and secondary care (especially unscheduled care) needed by patients
- Changes in how services are provided, where and by whom will focus on
 - the unscheduled care system
 - care of older people
 - elective care
 - women's and children's services
- The Trust will use its investment in IT and its relationship with Cerner to support the development and implementation of standard (best practice) care pathways
- The Trust will maximise the use of telemedicine
- The Trust will review how to retain local provision of financially challenged District General Hospital+ and non-core services.

2. WUTH 2020: The South Mersey Acute Alliance

- The Trust will explore with CoCH the potential for the development of a single Acute General Hospital covering Wirral and west Cheshire within the next 10-15 years
- The Trust expects that the strategic alliance with CoCH will deliver material financial and clinical benefits in the short to medium term
- The first priority is the exploration of merging of back office functions
- The scope of improvements in cost and quality/viability will be tested through joint work on the LCR review of gynaecology, obstetrics, neonatology and paediatrics and on the integration of ENT, maxillo-facial and ophthalmology services
- Assuming a positive feasibility study, the two organisations will look to centralise their elective care on the Clatterbridge site (Arrowe Park Hospital becoming a 'hot' site)
- The two Trusts will collaborate on the implementation of IT enabled standardised care pathways.

3. WUTH 2020: Healthy Wirral

- In line with the emerging lessons from other health and social care systems in England, the Trust expects Healthy Wirral to deliver material financial and clinical benefits only in the medium to long term
- The Trust recognises that the potential exists for reductions in activity to result in corresponding reductions in its bed base. The Trust will work with partner organisations to model the 'how and when' of this and will flex its bed base to meet changes in demand
- The initial focus of Healthy Wirral on the functioning of acute/secondary care services will be diabetes, respiratory medicine services and the establishment of population health registries. The Trust will look to expand the scope of Healthy Wirral to include the reengineering of unscheduled care and care of older people
- The Trust will also work with partner organisations to model and deliver the decentralisation of ambulatory care services to the four integrated community care hubs
- Finally, the Trust will work with partner organisations to develop real time system management in support of the optimum functioning of the local integrated care network to improve hospital throughput and reduce length of stay.

Risks, uncertainties and other factors which will potentially compromise execution of the Trust's strategy include

- The current lack of effective strategic and operational system management structures and processes
- A potential mismatch between the speed of cost improvement required and the speed with which fundamental service redesign and reconfiguration can be delivered

- The lack of dedicated programme/ project and change management resource to support service redesign and reconfiguration
- Macro-pressures on the NHS/ DoH budget resulting in central initiatives/actions which do not 'fit' with local plans
- The Industrial Relations environment and the potential for continued and more damaging industrial action coupled with limited clinical enthusiasm for service redesign and reconfiguration.

Social, Community and Human Rights Issues

The Trust is committed to encourage both knowledge and implementation of human rights approaches in health. The Trust is committed to ensuring that equality and diversity is at the heart of all we do. This means ensuring that equality and fairness is embedded in the delivery of services to our service users and local community. It also means ensuring our employment practices are fair, flexible and enabling so that each member of staff can reach their full potential.

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 the Trust, 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 New Models of Care Programme.

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.

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 Alzheimer's Society. Representatives from some of these groups are standing members of the Patient and Family Experience Group.

Environmental Matters

During 2015/16 the Trust continued reducing its environmental impact and is PROUD of the achievements made including:

- A reduction of imported Electricity from 23,906,953kwh to 11,865,701kwh
- On site generation of electricity of more than 50%
- Delivery of increased energy and carbon savings in regards to a 15-year partnership with Ener-G Combined Power Ltd
- The energy infrastructure of both hospital sites continues to be upgraded, delivering significant reductions in the Trust's carbon consumption
- The combined heat and power (CHP) units are operating at increased performance levels
- Energy-efficient motors have been installed on plant throughout both sites.

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

- Improved insulation on exposed ventilation ductwork
- Refurbishment of two wards as part of a first impression improvement project
- Installation of Decontamination steriliser chiller reducing water consumption
- Insulated roof on Histopathology building at the Arrowe Park site.

All Trust planned capital projects are routinely reviewed for inclusion of energy-saving measures, whether new build or refurbishment.

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.

Completion of the bus interchange at the Arrowe Park site has improved the service for staff and visitors. The scheme includes new bus shelters and real-time information screens and has supported increased services encouraging greater usage of public transport.

The Trust have continued to operate a salary sacrifice scheme for cycle purchase and a number of staff took advantage of the scheme during the year. In partnership with Wirral Borough Council the Trust ran 'Cycling to Work' promotional events at both Arrowe Park and Clatterbridge sites which included a cyclists breakfast and free bicycle maintenance.

The Trust held a Listening in Action 'Big Conversation' for staff about energy awareness which encouraged ideas about savings on both energy and carbon consumption.

Accountability Report

Director's Report

Board of Directors

Role and Composition

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

- Setting the organisation's strategic aims, taking into consideration the views of the Council of Governors, and ensuring the necessary financial and human resources are in place to deliver the Trust's plans
- Ensuring compliance with the Trust's Provider Licence, constitution, mandatory guidance and contractual and statutory duties
- Providing effective and proactive leadership of the Trust within a robust governance framework of clearly defined internal controls and risk management processes
- Ensuring the quality and safety of services, research and education, and application of clinical governance standards including those set by 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 2015/16, the Board comprised of a non-executive chairman, six independent non-executive directors and six executive directors.

Non-executive directors are generally appointed to a three-year term of office, with appointments staggered where possible, such that two or three terms 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.

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. In September 2015, the Council of Governors extended this for a further one year in view of the changes in the Executive Team. 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.

Cathy Bond

Non-Executive Director Deputy Chair, Senior Independent Director and Chair of Audit Committee



Cathy Bond 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. Cathy was re-appointed in June 2014 for another three year term. 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.

Graham Hollick

Non-Executive Director, Chair of Finance Business Performance and Assurance Committee



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. Graham was appointed for a second term during 2015/16 up until 30th June 2019.

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, Clinical Nurse 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. Cathy was appointed for a second term during 2015/16 up until 30th June 2019.

Andrea Hodgson
Non-Executive Director



Andrea is a qualified finance professional with extensive business experience gained across the financial services industry focussing on delivering changes to processes, procedures and culture change programmes in a complex and highly regulated environment.

She has held a variety of senior executive leadership positions throughout her career at KPMG, National Australia Group Plc, Lloyds Banking Group and USS Ltd including Finance Director, Change Director and CFO.

Andrea was appointed as a Non-Executive Director on 1st July 2014.

John Sullivan
Non-Executive Director



John has extensive international manufacturing, business change and HR experience at senior levels in ICI, Texaco Canada Inc, Ineos Chlor Ltd, Sanofi Aventis Ltd and Novartis Vaccines & Diagnostics Ltd. Recently he also founded ICTAN Limited, providing management consultancy and executive coaching support to senior manufacturing and general management leaders in various industries.

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

John was appointed Non-Executive Director in July 2015.

Jeff Kozer,
Non-Executive Director



Jeff was a Non-Executive Director from July 2009 until 30 June 2015. He undertook the role of Deputy Chair, Chair of Audit Committee and Senior Independent Director. He brought 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.

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 led him to be 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.

Gaynor Westray
Director of Nursing and Midwifery



In February 2016 Gaynor was appointed as Director of Nursing and Midwifery and Director of Infection Prevention and Control. Gaynor joined the Trust as a student nurse back in 1984 and has spent her entire NHS career dedicated to caring for people at Wirral hospitals. After three years of nurse training, Gaynor became a Staff Nurse on the orthopaedic wards here at Arrowe

Park Hospital. Her hard work and commitment to patient care resulted in her being promoted to Ward Sister initially at Arrowe Park Hospital, then transferring to Clatterbridge Hospital. In 2002, Gaynor had the privilege of becoming the Trust's first ever Matron. This progressed into a general management role, managing clinical services within Critical Care, Orthopaedics, Surgery and Special Surgery, as well as the theatres at both Clatterbridge and Arrowe Park hospitals. She was later promoted to Associate Director of Nursing within Surgery, Women and Children's, and then in 2014 as Deputy Chief Nurse.

Having been a member of the Wirral community for many years and with more than three decades of nursing experience, Gaynor aims to ensure the best possible care and has pledged to continue and build on the current Nursing and Midwifery Strategy which focuses on care, compassion, competence, communication, courage and commitment.

Gareth Lawrence
Acting Director of Finance



Gareth was appointed Acting Director of Finance in November 2015, after previously being Deputy Director at the Trust since July 2015.

Gareth has over 12 years NHS experience and previously spent five years working at St Helens and Knowsley NHS Trust in senior finance positions. He sees the role as ensuring that the Trust has the right controls and processes in place to manage the public finances as well as working with our clinical services to seek out continuous improvements for the patients that we serve.

Jill Galvani
Director of Nursing and Midwifery



Jill was the Director of Nursing and Midwifery from March 2013 until February 2015. 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 saw her role as putting nurses and midwives in the best position to deliver competent, professional and compassionate care for patients and their carers. She was 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 the Director of Finance from 1st April 2013 until November 2015. Alistair 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.

Sharon Gilligan
Director of Operations



Sharon was the Director of Operations from July 2013 until November 2015 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 had also managed a number of complex services including the Regional Neurosciences Centre and Trauma and Orthopaedics.

Anthony Hassall
Director of Strategic and Organisational Development



Anthony Hassall was the director of Strategic and Organisational Development from September 2013 until August 2015. 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 had 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.

HM Treasury cost allocation and charging guidance

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

Policy on the payment of suppliers

It is the Trust's policy to follow the Better Payment Practice Code (BPPC), seeking to pay 95% of invoices within contract terms or 30 days where no terms have been agreed. Performance against this target is offered in Note 9.3 to the accounts.

There have been no payments of interest in 2015/16 under the Late Payment of Commercial Debts (Interest) Act 1998.

Compliance with Monitor's Quality Governance Framework

The Trust has a formal Board approved clinical governance and assurance structure. The Quality and Safety Committee is the key Board sub-committee that monitors improvements in quality, safety and patient experience. Full details of the work of the Quality and Safety Committee are outlined in this Report. This Annual Report also outlines how the Trust has managed a range of quality and safety issues/initiatives as follows:

The Annual Governance Statement – this outlines the findings of the CQC comprehensive inspection undertaken in September 2015 which was supported by a full action plan which is being progressed at pace.

The Staff Report – this section highlights how the Trust has improved staff engagement and organisational development and the impact this has had on staff morale, vacancy rates, attendance and appraisal levels.

The Quality Report – this outlines the quality priorities the Trust agreed for 2015/16 and how the Trust performed against these. It also articulates the focus of attention for 2016/17 and the rationale for this.

Performance Analysis – this section outlines how the Trust performed against key access targets and where this was not achieved, the actions being taken to improve this in 2016/17.

Future development of the Trust – this section outlines the partnerships/strategic alliances and collaborations the Trust is embarking upon to improve financial sustainability and patient care. The Trust has engaged a wide range of external stakeholders as part of the developing strategy to ensure clinical buy-in and partnership support. This activity will continue as the emerging strategies progress.

Income for the purposes of the health service in England

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England (principal) must be greater than its income from the provision of goods and services for any other purposes (non-principal). The Trust has met this statutory requirement.

Non-principal income is used to provide additional funding for the Trust. It is directly reinvested in the delivery of high quality NHS services.

Statement of disclosure to auditors

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

- are not aware of any relevant audit information of which the Trust's auditors are unaware; and

- have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

Remuneration Report

Annual Statement on Remuneration

The Remuneration Committee met on 9 occasions during 2015/16 as a result of significant turnover in the Executive Team. The Committee supported the Chief Executive's proposal to re-structure the Executive Team to include the role of a Chief Operating Officer and the wider membership from senior managers. The Senior Management Team structure has been in place now for some months and provides the Trust with improved influence and decision making.

The section in the Annual Report on the role and composition of the Board describes the key changes in personnel during the reporting period. The Chief Operating Officer commenced employment on the 1st April 2016 and the substantive Director of Finance is due to commence employment at the beginning of June 2016.

Senior Managers' remuneration policy

We use the definition of Senior Manager to mean the members of the Senior Management Team 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.

Executive Directors of the Trust 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 (Directors who are not at the executive level have a three month notice period). 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.

Annual Report on remuneration

Remuneration and Appointments Committee

This committee comprises of the non-executive directors, 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, Director of Workforce and the Director of Corporate Affairs normally attended meetings in 2015/16, except where their own salaries or performance were discussed.

During 2015/16 the Director of Workforce 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 9 occasions during 2015/16.

Attendance at Remuneration and Appointments Committee Meetings in 2015/16

	Meeting Attendance Actual / Possible 1st April 2015 – 31st March 2016
Michael Carr, Chair	9/9
Cathy Bond	8/9
Graham Hollick	8/9
Cathy Maddaford	7/9
Jean Quinn	9/9
John Sullivan	7/7
Jeff Kozer	2/2

Directors' and governors' expenses

Expenses paid to executive and non-executive directors and governors include all business expenses arising from the normal course of business of the Trust and are paid in accordance with Trust policy. The total amount of expenses reimbursed to six directors during the year was £3,150 (5, £4,800 in 2014/15). In 2015/16, 16 executive and non-executive directors were in office (15 in 2014/15).

The total amount of expenses reimbursed to four governors during the year was £340 (8, £710 in 2014/15). In 2015/16, 25 governors were in office (30 in 2014/15).

Remuneration disclosures which are subject to audit

The following disclosures are subject to audit.

Salaries and benefits of senior managers 2015/16

	Salary & fees (in bands of £5,000) £'000	Taxable benefits (to the nearest £100) £	Pension-related benefits (in bands of £2,500) £'000	Total (in bands of £5,000) £'000
David Allison Chief Executive	190 - 195	5,200	30 - 32.5	230 - 235
Evan Moore Medical Director	185 - 190	5,400	30 - 32.5	225 - 230
Gaynor Westray Director of Nursing and Midwifery (from February 2016)	15 - 20	0	145 - 147.5	160 - 165
Gareth Lawrence Acting Director of Finance (from November 2015)	40 - 45	3,000	67.5 - 70	110 - 115
Jill Galvani Director of Nursing & Midwifery (to February 2015)	105 - 110	0	0	105 - 110
Alistair Mulvey Director of Finance (to November 2015)	140 - 145	0	7.5 - 10	150 - 155
Chris Oliver Interim Director of Operations *	25 - 30	2,000	42.5 - 45	70 - 75
Mark Blakeman Director of Infrastructure & Informatics *	30 - 35	1,200	10 - 12.5	45 - 50
James Mawrey Director of Workforce *	30 - 35	1,100	32.5 - 35	60 - 65
Carole Self Director of Corporate Affairs *	25 - 30	100	30 - 32.5	55 - 60
Pippa Roberts Director of Pharmacy and Medicines Management *	30 - 35	0	0	30 - 35
Mike Coupe Director of Strategy *	30 - 35	0	12.5 - 15	45 - 50
Sharon Gilligan Director of Operations (to November 2015)	80 - 85	4,600	25 - 27.5	110 - 115
Anthony Hassall Director of Strategy & Partnerships (to August 2015)	40 - 45	1,500	77.5 - 80	120 - 125
Michael Carr Chairman	45 - 50	0	n/a	45 - 50
Catherine Bond Non-Executive Director	15 - 20	0	n/a	15 - 20
Dr Jean Quinn Non-Executive Director	10 - 15	0	n/a	10 - 15
Graham Hollick Non-Executive Director	10 - 15	0	n/a	10 - 15
Catherine Maddaford Non-Executive Director	10 - 15	0	n/a	10 - 15
Andrea Hodgson Non-Executive Director	10 - 15	0	n/a	10 - 15
John Sullivan Non-Executive Director (from July 2015)	10 - 15	0	n/a	10 - 15
Jeff Kozer Non-Executive Director (to June 2015)	0 - 5	0	n/a	0 - 5
Richard Dutton Non-Executive Director (to June 2014)	n/a	n/a	n/a	n/a
Lynda Meadows Non-Executive Director (to June 2014)	n/a	n/a	n/a	n/a

* Within 2015/16, the structure of the senior management team was reviewed to strengthen capacity at a senior level for the delivery of the very best standards of patient safety and quality of care. The changes came into effect from 1 December 2015.

The above figures reflect remuneration only for the period during which each individual was deemed to be a senior manager.

Unless otherwise indicated all of the above directors were in post for the twelve month period to 31 March 2016. No annual performance-related bonuses or long term performance-related bonuses were paid during the period.

Taxable benefits relate to a vehicle scheme which forms part of executives' remuneration. No senior manager has received a payment for loss of office, and there have been no payments to past senior managers.

Salaries and benefits of senior managers 2014/15

	Salary & fees (in bands of £5,000) £'000	Taxable benefits (to the nearest £100) £	Pension-related benefits (in bands of £2,500) £'000	Total (in bands of £5,000) £'000
David Allison Chief Executive	195 - 200	5,600	50 - 52.5	250 - 255
Evan Moore Medical Director	180 - 185	0	47.5 - 50	230 - 235
Gaynor Westray Director of Nursing and Midwifery (from February 2016)	n/a	n/a	n/a	n/a
Gareth Lawrence Acting Director of Finance (from November 2015)	n/a	n/a	n/a	n/a
Jill Galvani Director of Nursing & Midwifery (to February 2015)	125 - 130	0	2.5 - 5	130 - 135
Alistair Mulvey Director of Finance (to November 2015)	125 - 130	0	17.5 - 20	145 - 150
Chris Oliver Interim Director of Operations *	n/a	n/a	n/a	n/a
Mark Blakeman Director of Infrastructure & Informatics *	n/a	n/a	n/a	n/a
James Mawrey Director of Workforce *	n/a	n/a	n/a	n/a
Carole Self Director of Corporate Affairs *	n/a	n/a	n/a	n/a
Pippa Roberts Director of Pharmacy and Medicines Management *	n/a	n/a	n/a	n/a
Mike Coupe Director of Strategy *	n/a	n/a	n/a	n/a
Sharon Gilligan Director of Operations (to November 2015)	110 - 115	7,200	32.5 - 35	150 - 155
Anthony Hassall Director of Strategy & Partnerships (to August 2015)	105 - 110	6,100	70 - 72.5	180 - 185
Michael Carr Chairman	45 - 50	0	n/a	45 - 50
Catherine Bond Non-Executive Director	15 - 20	0	n/a	15 - 20
Dr Jean Quinn Non-Executive Director	10 - 15	0	n/a	10 - 15
Graham Hollick Non-Executive Director	10 - 15	0	n/a	10 - 15
Catherine Maddaford Non-Executive Director	10 - 15	0	n/a	10 - 15
Andrea Hodgson Non-Executive Director	10 - 15	0	n/a	10 - 15
John Sullivan Non-Executive Director (from July 2015)	n/a	n/a	n/a	n/a
Jeff Kozar Non-Executive Director (to June 2015)	10 - 15	0	n/a	10 - 15
Richard Dutton Non-Executive Director (to June 2014)	0 - 5	0	n/a	0 - 5
Lynda Meadows Non-Executive Director (to June 2014)	0 - 5	0	n/a	0 - 5

Pension benefits of senior managers 2015/16

	(a)	(b)	(c)	(d)	(e)	(f)	(g)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
David Allison Chief Executive	2.5 - 5.0	2.5 - 5.0	20 - 25	65 - 70	361	39	405
Evan Moore Medical Director	2.5 - 5.0	0	40 - 45	115 - 120	588	26	620
Gaynor Westray Director of Nursing and Midwifery (from February 2016)	0 - 2.5	2.5 - 5.0	30 - 35	90 - 95	387	19	519
Gareth Lawrence Acting Director of Finance (from November 2015)	0 - 2.5	2.5 - 5.0	5 - 10	25 - 30	71	17	113
Jill Galvani Director of Nursing & Midwifery (to February 2015)	0 - 2.5	0 - 2.5	55 - 60	165 - 170	1,110	14	1,140
Alistair Mulvey Director of Finance (to November 2015)	0 - 2.5	0	30 - 35	90 - 95	524	7	541
Chris Oliver Interim Director of Operations *	0 - 2.5	0 - 2.5	10 - 15	35 - 40	136	9	163
Mark Blakeman Director of Infrastructure & Informatics *	0 - 2.5	0	30 - 35	85 - 90	460	4	477
James Mawrey Director of Workforce *	0 - 2.5	0 - 2.5	15 - 20	45 - 50	190	8	217
Carole Self Director of Corporate Affairs *	0 - 2.5	0 - 2.5	10 - 15	30 - 35	155	13	195
Pippa Roberts Director of Pharmacy and Medicines Management *	0 - 2.5	0 - 2.5	20 - 25	70 - 75	360	5	379
Mike Coupe Director of Strategy *	0 - 2.5	0	30 - 35	55 - 60	518	6	490
Sharon Gilligan Director of Operations (to November 2015)	0 - 2.5	0 - 2.5	15 - 20	50 - 55	256	14	280
Anthony Hassall Director of Strategy & Partnerships (to August 2015)	0 - 2.5	0 - 2.5	25 - 30	65 - 70	294	13	338

- (a) Real increase in pension at pension age (bands of £2,500)
(b) Real increase in pension lump sum at pension age (bands of £2,500)
(c) Total accrued pension at pension age at 31 March 2016 (bands of £5,000)
(d) Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)
(e) Cash equivalent transfer value (CETV) at 1 April 2015 (to the nearest £1,000)
(f) Real increase in CETV (to the nearest £1,000)
(g) CETV at 31 March 2016 (to the nearest £1,000)

Non-executive directors do not receive pensionable remuneration. The element of the Medical Director's remuneration which relates to their clinical role is not currently separable from the remuneration for their management role.

Pension benefits of senior managers 2014/15

	(a)	(b)	(c)	(d)	(e)	(f)	(g)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
David Allison Chief Executive	0 - 2.5	5 - 7.5	20 - 25	60 - 65	304	49	361
Evan Moore Medical Director	0 - 2.5	5 - 7.5	35 - 40	115 - 120	526	47	588
Gaynor Westray Director of Nursing and Midwifery (from February 2016)	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Gareth Lawrence Acting Director of Finance (from November 2015)	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jill Galvani Director of Nursing & Midwifery (to February 2015)	0 - 2.5	0 - 2.5	55 - 60	165 - 170	1,048	33	1,110
Alistair Mulvey Director of Finance (to November 2015)	0 - 2.5	0 - 2.5	30 - 35	90 - 95	484	27	524
Chris Oliver Interim Director of Operations *	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mark Blakeman Director of Infrastructure & Informatics *	n/a	n/a	n/a	n/a	n/a	n/a	n/a
James Mawrey Director of Workforce *	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Carole Self Director of Corporate Affairs *	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Pippa Roberts Director of Pharmacy and Medicines Management *	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mike Coupe Director of Strategy *	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sharon Gilligan Director of Operations (to November 2015)	0 - 2.5	2.5 - 5.0	15 - 20	50 - 55	222	28	256
Anthony Hassall Director of Strategy & Partnerships (to August 2015)	2.5 - 5.0	7.5 - 10	20 - 25	60 - 65	238	49	294

- (a) Real increase in pension at pension age (bands of £2,500)
- (b) Real increase in pension lump sum at pension age (bands of £2,500)
- (c) Total accrued pension at pension age at 31 March 2015 (bands of £5,000)
- (d) Lump sum at pension age related to accrued pension at 31 March 2015 (bands of £5,000)
- (e) Cash equivalent transfer value (CETV) at 1 April 2014 (to the nearest £1,000)
- (f) Real increase in CETV (to the nearest £1,000)
- (g) CETV at 31 March 2015 (to the nearest £1,000)

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

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.

Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension Scheme are based on the previous discount rate and have not been recalculated.

Hutton review of fair pay

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. In this context the median is defined as the total remuneration of the staff member who lies in the middle of the linear distribution of staff, excluding the highest paid director. The median is based on the annualised, full time equivalent remuneration for the year excluding employers' costs.

The banded remuneration of the highest paid director of Wirral University Hospital NHS Foundation Trust in the financial year 2015/16 was £190k to £195k (2014/15 £195k to £200k). This was 7.5 times (2014/15 7.7 times) the median remuneration of the workforce, which was £25,818 (2014/15 £25,783).

In 2015/16, 6 employees received remuneration in excess of the highest paid director (2014/15 4 employees). Their remuneration in 2015/16 ranged from £198k to £219k (2014/15 £212k to £218k).

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

The year-on-year change in the ratio is considered negligible. The decrease is driven by the reduction in the highest paid director's pay band.

As in previous years, temporary agency staff are excluded from the calculations. The calculation methodology is kept the same so that the 2015/16 results are comparable with those in previous years. Summary results are included in the table below.

	Financial year 2015/16	Financial year 2014/15
Band of highest paid director's remuneration (£'000)	190 - 195	195 - 200
Median total (£)	25,818	25,783
Ratio	7.5	7.7



David Allison
Chief Executive
Date 25.05.16

Staff Report

The Trust agreed the Workforce and Organisation Development Strategy in April, 2015. The Workforce and Organisational Development Strategy articulates our vision which is to have a healthy organisational culture, a sustainable and capable workforce, working in an integrated manner with partners and where the leadership and management of our people is effective and conducted in a manner that improves staff experience and lets us demonstrate that we have put our values into action.

The Trust has already made significant progress in delivering the Workforce and Organisational Development Strategy and the Year 1 monitoring of the Strategy has been considered within the Trust's governance framework. The Human Resources & Organisational Development department continue to monitor the key characteristics of the workforce such as proportions in different staff groups, pay band, age, length of service, turnover in order to inform the workforce strategy and departmental planning. Further developments have been made in aligning our clinical workforce to the delivery of care, based on both demand/flow and demographics/acuity. Building on this work, further developments will be rolled out in terms of multidisciplinary workforce planning, integration of new/developing roles and team job/planning; Optimising leadership skills and potential is essential and as such we have implemented an improved Leadership and Management framework. The

Joint Clinical Leadership Development Programme with Mid-Cheshire Hospitals and the Countess of Chester Hospital now in its second year and the second cohort of the Consultant Development Programme commenced in December 2015. We achieved a Trust appraisal rate of over 88% which demonstrates our ongoing commitment to developing our workforce. The Trust's values continue to be embedded in HR processes including recruitment, appraisal, remuneration and training. A clear commitment to the wellbeing of our workforce has resulted in significant improvements in staff sickness levels. In line with the Health and Wellbeing Plan, the Trust's flu vaccination rate for front line staff continues to improve (despite a national downward trend) and 79.1% of our frontline staff received the vaccination. The Trust's vacancy rate is reported to the Quality and Safety Committee and our rates remain low when compared with peer NHS organisations.

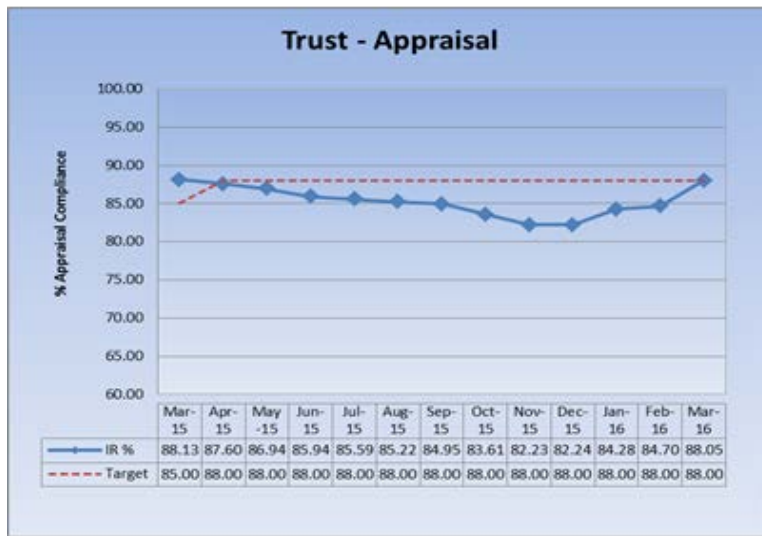
The main anticipated changes to the shape of the Workforce are as follows:

1. Non-medical staffing is projected to reduce with reductions in administrative staff as systems and efficiencies become leaner and more streamlined, taking advantage of enabling technologies.
2. Medical staffing levels have increased over recent years, specifically within the Consultant level positions. Whilst this increase has slowed down it is anticipated that there will be slight increases in Consultant level positions over the time period. Generally, the Trust does not have significant problems in recruiting into senior positions although bespoke plans are in place in 'hard to fill' areas. The Trust has a range of measures in place in order to mitigate the anticipated reduction in Junior Doctors in this time period.
3. Ward nurse staffing levels have increased and the nurse vacancy rate remains low when compared to peer organisations. Recruitment of nurses has not traditionally been a problem for the Trust and with an innovative approach the Trust does not anticipate significant nurse recruitment problems moving forward.

The chart below illustrates the attendance absence rate across 2015/16. As the graph demonstrates significant progress has been made in 2015/2016.



The charts below illustrate the appraisal and mandatory training rates across 2015/16.



The Trust's Employees

The number of whole time equivalents (WTE) employed by the Trust during 2015/16 (as at March, 2015) was 4485.84 WTE and the total number of employees was 5871 (Head Count).

The following table provides a more detailed breakdown of our employees by WTE and Headcount for 2015/16 (as at March, 2015). 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	193.22	215
Additional Clinical Services	949.97	1125
Administrative and Clerical	923.01	1065
Allied Health Professionals	252.97	308
Estates and Ancillary	588.58	926
Healthcare Scientists	122.68	140
Medical and Dental	390.42	416
Nursing and Midwifery Registered	1465.00	1676
Grand Total	4885.84	5871

Gender	WTE	Headcount
Female	3756.75	4632
Male	1129.09	1239
Grand Total	4885.84	5871

	Female		Male		Total Headcount	Total WTE
Payscale	Headcount	WTE	Headcount	WTE		
Band 8 - Range A	101	91.38	33	32.30	134	123.68
Band 8 - Range B	29	26.78	10	9.01	39	35.79
Band 8 - Range C	18	17.23	4	4.00	22	21.23
Band 8 - Range D	3	3.00	2	2.00	5	5.00
Band 9	1	1.00			1	1.00
Senior Manager	5	5.00	7	7.00	12	12.00
Grand Total	157	144.39	56	54.31	213	198.70

Male and Female Board Directors at year-end

Staff engagement and satisfaction

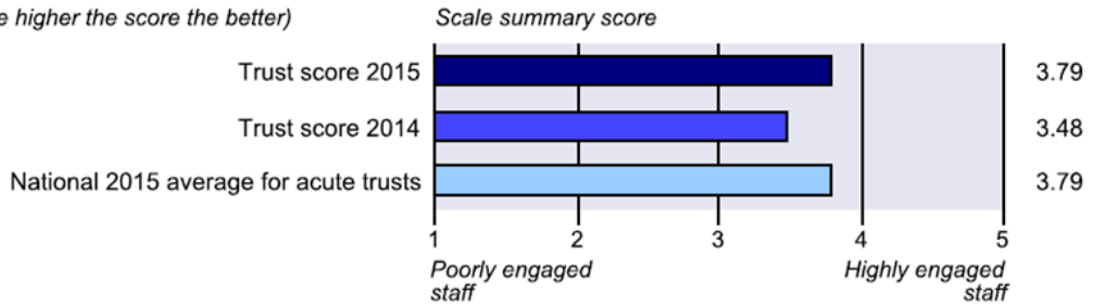
The Trust recognises that staff satisfaction and engagement is essential in improving quality and productivity and helping us to meet our significant financial and future challenges. Staff satisfaction and Staff engagement are key elements of the Workforce and Organisational Development Strategy, which was agreed at the Trust Board in April, 2015.

Following the disappointing 2014 staff survey results, which placed the Trust in the bottom 20% nationally, a high level staff satisfaction action plan was put in place to create focus to the areas that needed improvement, adopting and building on the success of Listening into Action as a way of working. This action plan was supplemented by divisional plans that have been acted upon and monitored throughout 2015.

The National Staff Survey 2015 took place in Quarter 3 2015/16 between 27th September and 27th November 2015. The results of the NHS Staff Survey 2015 were published by NHS England on 23rd February, 2016. The Trust has shown significant progress and the results for overall staff engagement have confirmed that Wirral University Teaching Hospital overall staff engagement scores have increased from 3.48 to 3.79. The table below provides an overview of the measurable improvements during the year (measured by the National Staff Survey 2015).

OVERALL STAFF ENGAGEMENT

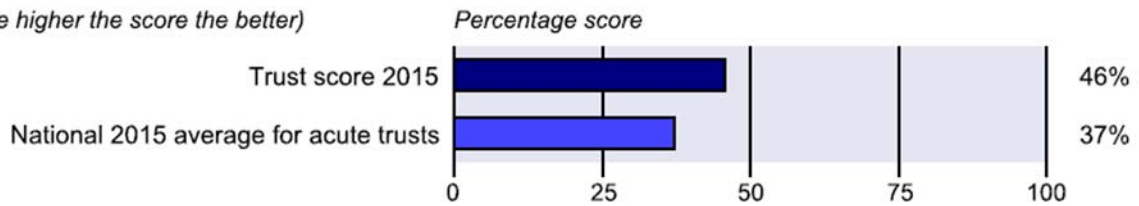
(the higher the score the better)



TOP FIVE RANKING SCORES

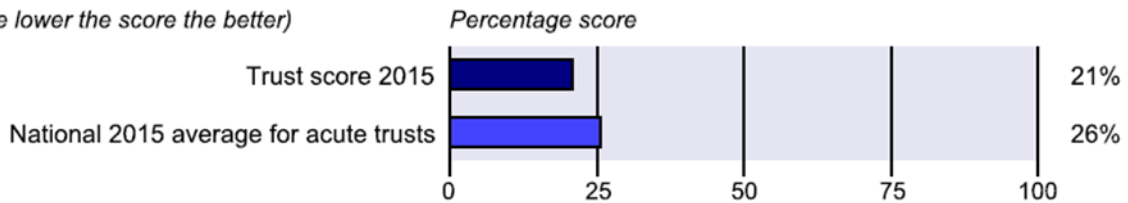
✓ KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



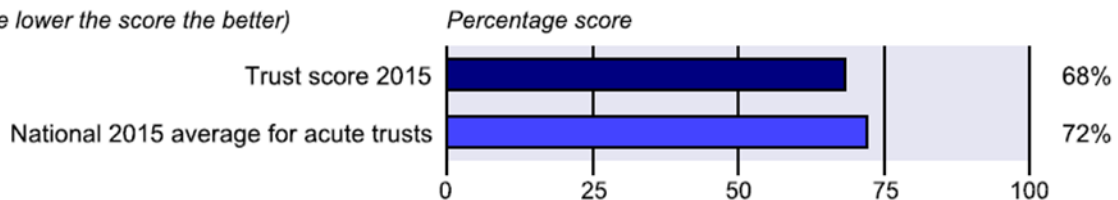
✓ KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



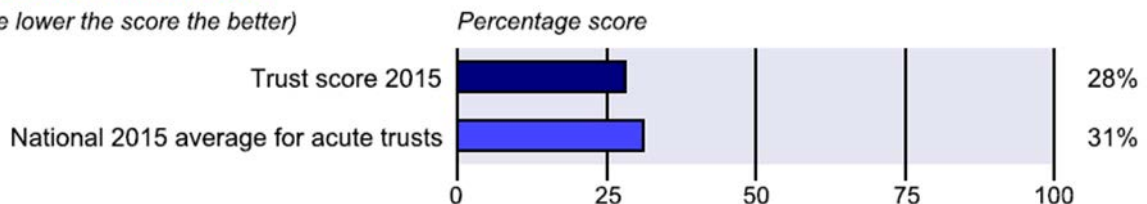
✓ KF16. Percentage of staff working extra hours

(the lower the score the better)



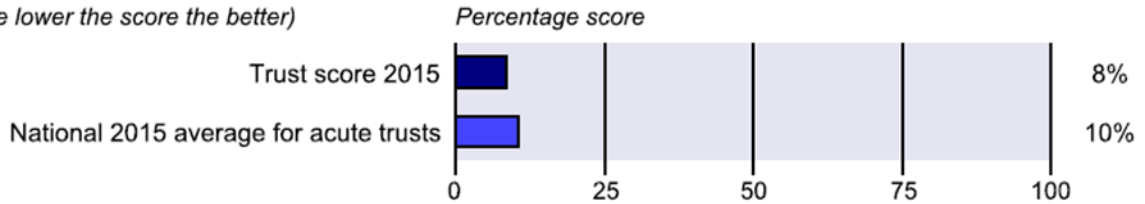
✓ KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



✓ **KF20. Percentage of staff experiencing discrimination at work in last 12 months**

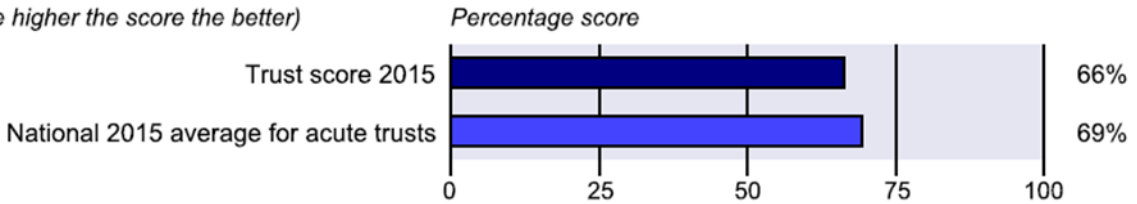
(the lower the score the better)



BOTTOM FIVE RANKING SCORES

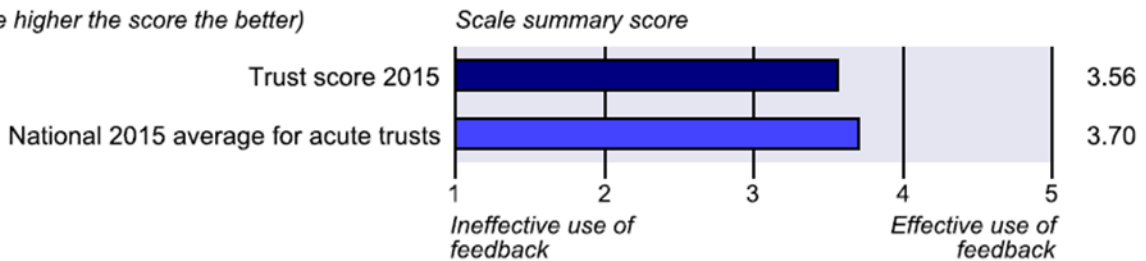
! **KF7. Percentage of staff able to contribute towards improvements at work**

(the higher the score the better)



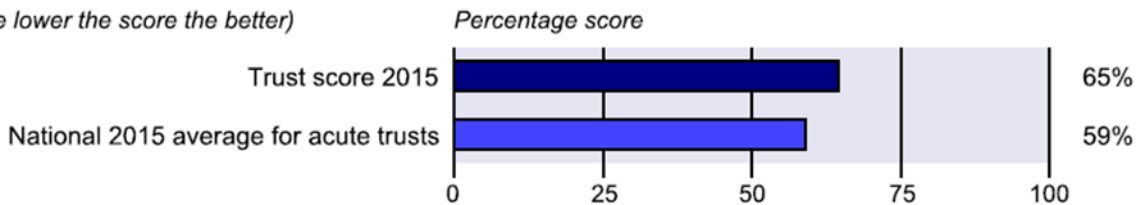
! **KF32. Effective use of patient / service user feedback**

(the higher the score the better)



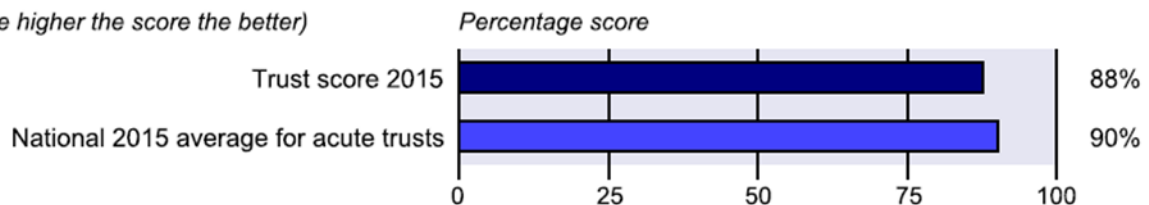
! **KF18. Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell**

(the lower the score the better)



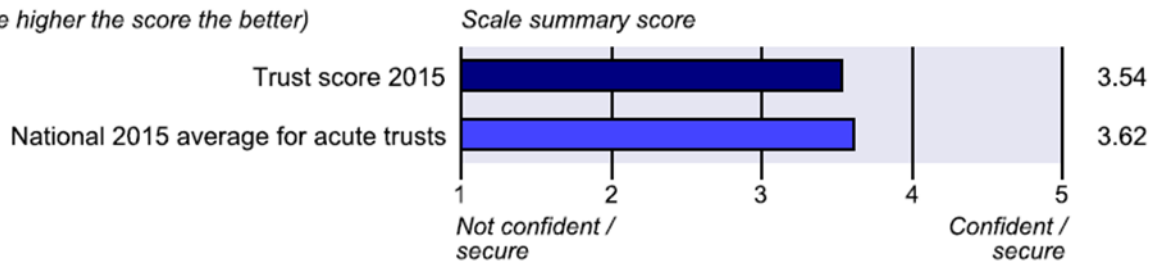
! **KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month**

(the higher the score the better)



! KF31. Staff confidence and security in reporting unsafe clinical practice

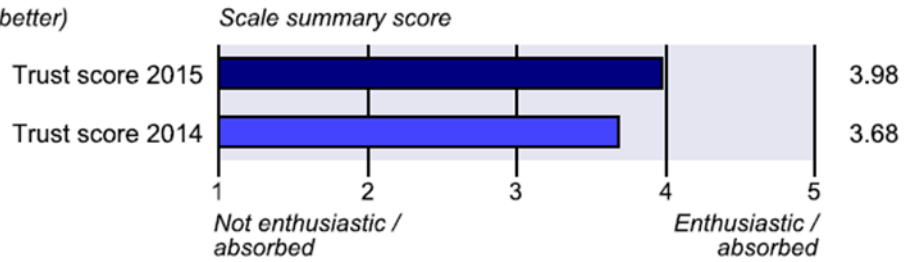
(the higher the score the better)



WHERE STAFF EXPERIENCE HAS IMPROVED

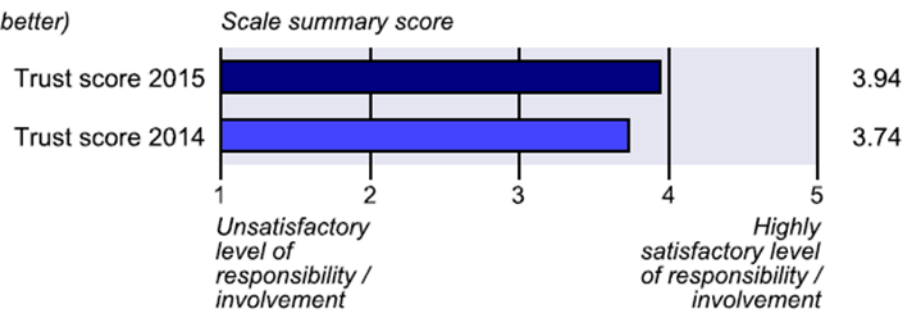
✓ KF4. Staff motivation at work

(the higher the score the better)



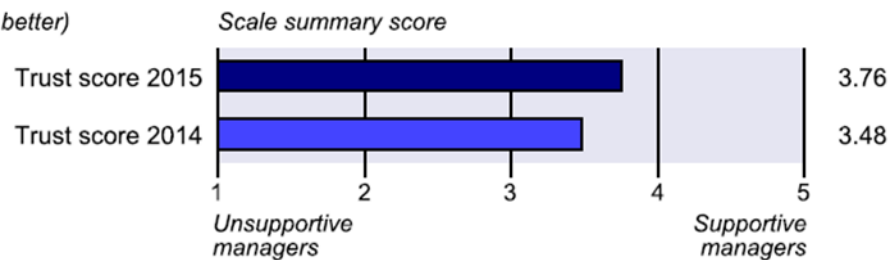
✓ KF8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



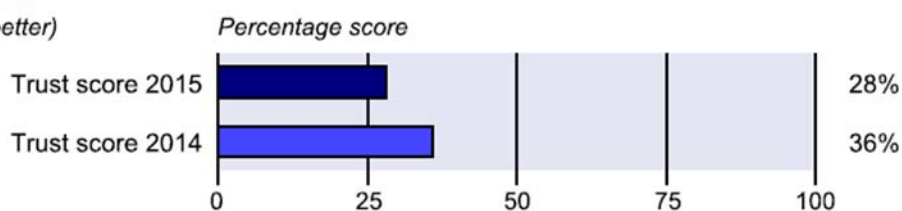
✓ KF10. Support from immediate managers

(the higher the score the better)



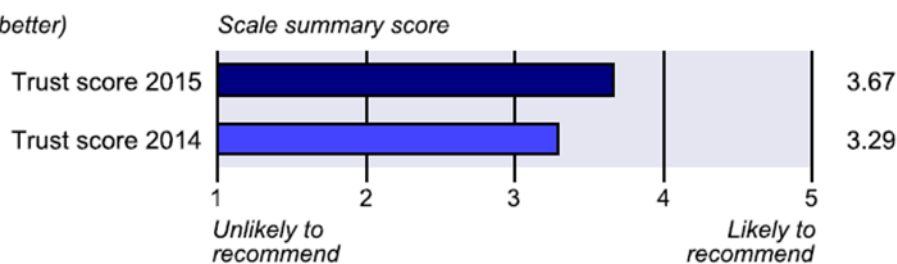
✓ **KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month**

(the lower the score the better)



✓ **KF1. Staff recommendation of the organisation as a place to work or receive treatment**

(the higher the score the better)



The results of the 2015 National Staff Survey have shown significant improvement and suggest that the staff engagement work programme has been effective. This has been due to a huge amount of effort right across the organisation. It is important that this focus and commitment needs to be maintained to sustain this level of improvement, as detailed within the Culture and Engagement Plan that underpins the Workforce and Organisational Development Strategy 2015-2018.

Expenditure on consultancy

Total expenditure on consultancy for 2015/16 has been £1.6m (£1.1m 2014/15).

Tables 1 and 2 address engagements which have lasted for more than six months, and which exceed £220 per day.

Table 1: For all off-payroll engagements as at 31 March 2016

Number of existing engagements as at 31 March 2016.	8
The following figures pertain to the above existing engagements.	
Number that have existed for less than one year at time of reporting.	3
Number that have existed for between one and two years at time of reporting.	5
Number that have existed for between two and three years at time of reporting.	-
Number that have existed for between three and four years at time of reporting.	-
Number that have existed for four or more years at time of reporting.	-

All off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016

Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016.	6
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations.	-
Number for whom assurance has been requested.	6
The following figures pertain to the above.	
Number for whom assurance has been received.	3
Number for whom assurance has not been received.	3
Number that have been terminated as a result of assurance not being received.	-

The Trust does not currently seek assurance directly from individuals who are contracted as staff solely through an employment agency on the basis that these organisations have existing arrangements in place for ensuring appropriate deductions are made for the individual and therefore these have been identified as low risk.

Of the three engagements for whom assurance has not been received, one left the Trust before assurance could be gained. Assurance has been received for the remaining two, although the Trust is currently requesting additional information for the purposes of due diligence. There is no current indication of any irregularity.

There have been no off-payroll engagements of Board members in 2015/16.

Table 3: For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016

Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
Number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year. This figure includes both off-payroll and on-payroll engagements.	16

Exit packages

Foundation trusts are required to disclose summary information of staff exit packages which have been agreed in the year. Exit costs in this note are accounted for in full in the year of departure.

Exit package cost band (including any special payment element)	2015/16	2015/16	2015/16	2014/15	2014/15	2014/15
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
< £10,000		24	24	2	2	4
£10,001 - £25,000		2	2	1	6	7
£25,001 - £50,000		1	1		2	2
£50,001 - £100,000		1	1		1	1
Total number of exit packages by type	0	28	28	3	11	14
Total resource cost	0	230	230	29	262	291

In 2015/16, 14 of the 'other departures' were as a result of dismissal, and a further nine were as a result of voluntary resignation. In 2014/15, all exit packages were via a voluntary severance scheme. Ill-health retirement costs are met by NHS Pensions and are not included in the table.

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

	2015/16	2015/16	2014/15	2014/15
	Payments agreed Number	Total value of agreements £'000	Payments agreed Number	Total value of agreements £'000
Voluntary redundancies including early retirement contractual costs	1	34	11	262
Mutually agreed resignations (MARS) contractual costs	2	13		
Contractual payments in lieu of notice	24	163		
Non-contractual payments requiring HM Treasury approval	1	20		
Total	28	230	11	262

No non-contractual payments were made requiring HM Treasury approval which exceeded twelve months of an individual's salary.

NHS Foundation Trust Code of Governance Disclosures

Wirral University Teaching Hospital NHS Foundation Trust has applied the principles of the NHS Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance most recently revised in July 2014 is based on the principles of the UK Corporate Governance Code issued in 2012.

The 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 12 occasions in 2015/16 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 are considered independent in respect of the criteria for independence set out in the Code of Governance. The Council of Governors, with the support of the Board of Directors, agreed to extend the tenure of the Chairman for a further year beyond his 6 year tenure which was due to expire on 30th June 2016. This decision was taken in the full knowledge that the Trust would need to explain its action in the Annual Report as per the NHS Foundation Trust Code of Governance. The risks and benefits with this extension were fully explored, agreed and supported by Monitor as this provided continuity and consistency during a period of significant Executive Director turnover.

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 walkabouts, 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.

The Council of Governors approved the process for the removal of a Governor in 2014/15 which complements the relevant provisions in the Trust's Constitution.

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 2015/16 the lead governor was Donald Shaw, Public Governor until September 2015 and Robert Howell from September 2015 to date.

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.

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.

In February 2016 the Trust undertook a procurement exercise to identify an external consultancy to facilitate Monitor's Well-led Governance Review. The preferred bidder was determined as Deloitte and the review will be finalised in June 2016.

The committees provide a report after each meeting 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 2015/16, 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 Director of Corporate Affairs, 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 2015/16 year, the Trust has been compliant with the code as detailed for declaration within Monitor's Annual Reporting manual.

Attendance at Board of Director Meetings in 2015/16

Director	Meeting Attendance Actual/ Possible 1st April 2015 – 31st March 2016 (% Attendance)
Michael Carr Chairman	12/12 100%
John Sullivan (commenced 1 st July 2015)	7/7 100%
Cathy Bond	11/12 91.6%
Cathy Maddaford	11/12 91.6%

Graham Hollick	10/12 83.3%
Dr Jean Quinn	12/12 100%
Andrea Hodgson	11/12 91.6%
Jeff Kozer (tenure expired 30 th June 2015)	2/4 50%
David Allison Chief Executive	11/12 91.6%
Evan Moore Medical Director	11/12 91.6%
Gaynor Westray Director of Nursing and Midwifery (from 5 th February 2016)	2/2 100%
Gareth Lawrence Acting Director of Finance (from 1 st November 2015)	5/5 100%
Jill Galvani (retired February 2016) Director of Nursing and Midwifery	8/9 88.8%
Alistair Mulvey (left November 15) Director of Finance	5/7 71.4%
Anthony Hassall (left August 15) Director of Strategy and Partnerships	4/5 80%
Sharon Gilligan (left November 15) Director of Operations	7/8 87.5%

Board Committees

The Board has the following Committees:

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

Audit Committee

The Audit Committee comprises three 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.

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 Audit Committee members met in private with the Internal and External Auditor prior to the Audit Committee meeting in February 2016.

The Chair of Audit Committee reports to the Council of Governors each year on the duties of the audit Committee. In addition, given the specific duties of the Governors in respect of the Appointment of External Audit the chair of Audit Committee refers to the council of Governors any matter relating to the External Audit.

The Director of Finance, Assistant Director of Finance – Financial Services, Deputy Director of Finance, Director of Corporate Affairs, Representatives from Internal and External Audit and the Local Counter Fraud Specialist have been in regular attendance

Executive Directors, Corporate Directors and other colleagues are invited to attend as required.

Audit Provision

Internal Audit has been provided by Mersey Internal Audit Agency

External Audit has been provided by KPMG up until December 2015. Following a full procurement exercise, the Council of Governors approved the recommendation from the Audit Committee to award the contract for external audit services to Grant Thornton for a period of 3 years.

Assurance

The Audit agenda is constructed in order to provide assurance to the Board of Directors across a range of activities including corporate, clinical, financial and risk governance and management.

The Audit Committee's Work Programme for 2015/16 covered the following:

- Review of the Board Assurance Framework

- Review of the Risk Management System including particularly focus on the incident web-holding file
- Review and recommendation of the Annual Governance Statement, Annual Report and Account Accounts to the Board
- Review of the Scheme of Delegation
- Review of Compliance against the Trust's Provider Licence
- Review of risks and controls around financial management including losses' special payments and financial assurance
- Review of changes to accounting policies
- External Audit reports
- Internal Audit Report
- Counter Fraud Reports
- Review of Clinical Audit

Review of the Work and Performance of the Committee during 2015/16

Terms of Reference 2015/16

The Audit Committee has adhered to its terms of reference which were reviewed in December 2015 and approved by the Board in January 2016.

External Audit

The 2015/16 accounts were audited by Grant Thornton and the findings presented to the Audit Committee in May 2016 and recommended to the Board of Directors later in May 2016. An unmodified opinion on the accounts was given.

Having reviewed the financial statements, operations and compliance the Committee focussed on the following issues as highlighted in the External Audit Plan:

- The Valuation of Property Plant and Equipment – the committee took assurance from the interim “desk top” revaluation of all the Trust's land and buildings undertaken during 2014/15 particularly in view of the competence, capability, objectivity and independence of the Trust's external valuer.
- The revenue cycles (revenue from patient care activities and other operating revenue) including fraudulent transactions - The Committee took assurance from the testing of material revenue streams for periods 1-10 via agreement back to the main contracts with commissioning bodies.
- Management override of controls – The Committee took comfort on this risk through the Internal Audit Reports received in year and some of the detail on internal control discussed within the AGS

The Committee also considered other areas of risk in the year as follows:

- Segmental Reporting – the Committee reviewed the options as outlined in the paper reported to the Committee in February 2016 and concluded that as in previous years that this was not appropriate for 2015/16
- Charitable Funds Non-Consolidation – The committee reviewed the option available to the Trust at its meeting in February 2016 and concluded that it was not appropriate to consolidate as the value of the charitable funds was not material.
- Going Concern statement – the Finance Business Performance and Assurance Committee reviewed the technical statement at its meeting in April 2016 and recommended this to the Board on 27th April 2016.

The Committee reviewed the changes proposed by the National Audit Office to the Value for Money conclusion for 2015/16 at its meeting in February 2016 to understand how the Trust would be assessed against the new criteria.

The Council of Governors will receive the report on the accounts from the Independent Auditor in Autumn 2016.

The annual external audit plan, which was risk based, was approved together with the associated costs in March 2016.

KPMG and Grant Thornton have both provided regular technical updates to the Audit Committee throughout the year.

The Audit Committee has not as yet reviewed the work of Grant Thornton formally in view of the short period of tenure favouring instead to rely on the numerous external references undertaken as part of the procurement exercise.

Internal Audit

The Audit Committee received and approved the Internal Audit Plan for 2016/17 in April 2016.

The Head of Internal Audit Opinion 2015/16 was presented to the Audit Committee in April 2016 and a significant assurance opinion was given on the adequacy of the system of internal control.

The following Internal Audit Reports have been received by the Audit Committee throughout the year:

Report	Assurance Rating
Accounts Payable	Significant Assurance
Treasury Management	Significant Assurance
Asset Management	Significant Assurance
Estates Maintenance	Significant Assurance
Facilities Time Recording	Significant Assurance
Friends and Family Test: Systems and Processes	Significant Assurance
Clinical Audit Arrangements	Significant Assurance

Medicines management	Significant Assurance
Payroll/Human Resources ESR	Significant Assurance
Sickness Absence	Significant Assurance
Mandatory Training	Significant Assurance
Emergency Preparedness	Significant Assurance
Health and Safety	Significant Assurance
IM&T: Information Governance (IG) Toolkit	Significant Assurance
IM&T: service continuity	Significant Assurance
IM&T: Threat and Vulnerability Management	Limited Assurance

The Audit Committee requested additional assurance on the status of outstanding recommendations following audits. This process is now undertaken by the Director of Corporate Affairs and presented to each meeting.

The Audit Committee focussed on audit reports which had received a limited assurance rating and actions representing high risk values. Where appropriate the Committee would request the presence of key individuals to present their actions plans to fulfil the recommendations.

The committee noted the quality standards obtained by MIAA in their Audit Approach, noted that the External Auditors placed reliance on the work of Internal Audit in conducting the External Audit of the Trust; questioned the External Auditors on their opinion of the standard of IA and concluded that the service provided by MIAA complied with IA guidance and best practice.

Compliance with Provider Licence

The Audit Committee agreed to widen its scope for monitor compliance following the financial governance breach in August 2015 this allowed the Committee and subsequently the Board to monitor progress towards removal of enforcement action. The Trust has now secured the removal of some of the enforcement action in relation to interim support following the successful recruitment and appointment of substantive Executive appointments.

Counter Fraud

The Counter Fraud Service to the Trust is currently provided by MIAA having previously been supplied by Cheshire and Merseyside Commissioning Support Unit. The Trust utilised the services of two fully accredited Counter Fraud Specialists.

The Audit Committee received regular progress reports at every meeting.

The Audit Committee approved the Counter Fraud Annual Report 2015/16 in April 2016 which provided a summary of the counter fraud work undertaken based on the annual work plan.

Key referrals during 2015/16 have included:

- False representation
- Salary overpayments

The Audit Committee noted that the resource allocated for Counter Fraud Work was focussed on a mixture of awareness training, supporting national fraud initiatives and investigations work. The work plan follows the National guidance best practice for Counter Fraud work, within the resources made available by the Trust.

Clinical Audit

The Audit Committee reviewed the effectiveness of Clinical Audit in December 2015. This included how the audit programme was developed in terms of mandated audits; nursing audits and the prioritisation of key areas.

The Audit Committee sought to establish how the Trust was learning from external clinical audits to improve clinical practice which was through the Advancing Quality Work although it was acknowledged that the benchmarking work was not as visible as the Trust would like although this was improving.

The Audit Committee concluded that an adequate process for Clinical Audit existed within the Trust, there were appropriate systems of review, that change in practice was evidenced through the Advancing Quality programme although it was recognized that the learning was more variable in other areas with further work required to capture this. It was also noted that the Clinical Audit Plan was driven largely by mandatory external requirements and the advancing quality programme leaving little scope for locally determined areas of specific interest.

Board Assurance Framework (BAF)

The Board Assurance Framework has undergone extensive review and development during 2015/16 with the support of Mersey Internal Audit. The Board of Directors approved the revised framework in July 2014 which now incorporates the Trust's strategic objectives and the key risks associated with the achievement of these objectives.

The Audit Committee has undertaken reviews of the Board Assurance Framework at each meeting throughout the year and recommended improvements as follows:

- The inclusion of the quality impact risk of the CIP programme
- A review of the internal audit programme and the BAF to identify any potential gaps
- Review of all residual risk ratings in light of action being taken
- BAF references in Committee and Board reports to be in narrative form as opposed to numerical to aid with triangulation
- Further consideration be given to the risks associated with the NHS staff survey, activity levels and the overall Use of Resources in the Trust
- Inclusion of the risk of failing to comply with the Monitor Enforcement Undertaking as a result of the breach in the Trust's provider licence

- Inclusion of risks associated with partnership governance and sustainability arising from the Vanguard project
- The inclusion of the risk of further enforcement action should the Trust not respond appropriately to the requirement notice on nurse staffing
- Reviews to be more forward looking in terms of forecasting the impact of known events such as winter
- Recommendation that the Board undertakes a review of its risk appetite which is now planned for May 16.

All Board and Committee Reports now have a stronger alignment to the BAF as recommended by the Audit Committee and require authors to detail the action to be taken to mitigate any gaps in assurance. All Assurance Committee agendas highlight the gaps in assurance/control.

The Audit Committee concluded at its meeting in March 2016 that the BAF now provided them with a holistic overview of the risk profile of the Trust which informed the work of the Trust and the Board of Directors.

Priorities for 2016/17

- Business continuity of IT systems
- Legislation that impacts on the work of the Committee
- Compliance with the Provider Licence
- Partnership Governance
- Arrangements to secure financial sustainability
- Risk management and risk appetite
- The Value for Money Conclusion and Use of Resources
- Key aspects from the Internal Audit Programme

Developing the role and skills of the Audit Committee

The Audit Committee undertook a review of the Board Assurance Framework in November 2014 facilitated by Mersey Internal Audit.

The Chair of Audit Committee attends regular meetings of the Audit Chairs forum and Audit Committee members are encouraged and have attended workshops arranged by Internal and External Auditors.

The Audit Committee met on five occasions during 2015//16

Attendance at Audit Committee Meetings in 2015/16

	Meeting Attendance Actual / Possible 1st April 2015 – 31st March 2016 (% Attendance)
Cathy Bond, Chair	4/5 80%

Cathy Maddaford	5/5 100%
Andrea Hodgson	5/5 100%

Quality and Safety Committee

The Committee is established as an Assurance Committee of the Board of Directors, it is chaired by a Non-Executive Director, in order to provide the Board with assurances in respect of delivery of the Trust's Quality Improvement Strategy and service delivery in respect of clinical effectiveness, safety, and patient and staff experience. This will incorporate measures of performance and compliance with national and local requirements. During the year, and among other achievements, the committee continues to monitor the Trust's response to the Francis II report, the friends and family test and quality and workforce dashboards. 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 end of life care, community paediatrics, nurse staffing levels, culture in maternity services, winter planning and CQC compliance and improvement.

The Committee met 6 times during 2015/16

Attendance at Quality and Safety Committee meetings in 2015/16

	Meeting Attendance Actual / Possible 1st April 2015 – 31st March 2016 (% Attendance)
Jean Quinn, Chair	7/7 100%
Cathy Maddaford	7/7 100%
John Sullivan (from July 2015)	5/5 100%
Evan Moore	7/7 100%
Gaynor Westray (from February 2016)	1/1 100%
Jill Galvani (until February 2016)	5/6 83.3%

Anthony Hassall (until August 2015)	3/3 100%
Donald Shaw - Lead Governor (until October 2015)	4/4 100%
Robert Howell - Lead Governor (from January 2016)	2/2 100%
Jeff Kozer (until June 2015)	0/2 0%

Finance Business Performance and Assurance Committee

The Committee is established as an Assurance Committee of the Board of Directors, it is chaired by a Non-Executive Director, in order to provide the Board with assurance on delivery of the Trust's financial plan, performance targets and business development strategy. During the year, the Committee has focussed attention on the cost improvement programme; improvement to cash forecasting and the implementation of service line reporting.

The Committee met 8 times during 2015/16

Attendance at Finance, Business Performance and Assurance meetings in 2015/16

		Meeting Attendance Actual / Possible 1st April 2015 – 31st March 2016 (%Attendance)
Graham Hollick	Non- Executive Director	7/8 87.5%
Andrea Hodgson	Non- Executive Director	8/8 100%
John Sullivan (from July 2015)	Non-Executive Director	5/6 83.3%
Evan Moore	Medical Director	4/8 50%
Gaynor Westray (from February 2016)	Director of Nursing and Midwifery	2/2 100%
Alistair Mulvey	Director of Finance	3/5 60%

(until November 2015)		
Sharon Gilligan (until November 2015)	Director of Operations	5/6 83.3%
Jeff Kozer (until June 2015)	Non- Executive Director	1/2 50%

Remuneration and Appointments Committee

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

Charitable Funds Committee

This committee is chaired by the Trust chairman to oversee the management of charitable funds. The Committee met twice during the year.

Council of Governors

Role and Composition

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

- to appoint and, if appropriate, remove the chairman
- to appoint and, if appropriate, remove the other non-executive directors
- to decide the remuneration and allowances, and other terms and conditions of office, of the chairman and other non-executive directors
- to approve the appointment of the chief executive
- to appoint, and if appropriate, remove the auditor
- to receive the annual accounts, any report on these provided by the auditor, and the annual report.

In addition,

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

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

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

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

The 2012 Act sets out some further powers and duties for governors which 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:

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

The names of those who served as Governors during 2015/16 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).

Governor Elections

Elections were held for two seats on the Council of Governors in 2015/16. The Board of Directors can confirm that elections for public and staff governors held in 2015/16 were conducted in accordance with the election rules as stated in the constitution and approved by Monitor.

Constituency / Class	No. of Seats	Governor elected
Public:		
Greasby, Frankby, Irby, Upton and Woodchurch	1	Eileen Hume 1 st Term of office

Constituency / Class	No. of Seats	Governor elected
Heswall, Pensby and Thingwall	1	Fleur Flannagan 1 st Term of office

Governor attendance at Council of Governor Meetings 2015/16

The following tables list the governors who have served on the Council of Governors during 2015/16 and individual attendance by governors and directors at Council of Governors meetings. Four meetings of the Council of Governors were held in 2015/16.

Governor	Constituency / Class	Meeting attendance Actual / Possible 1st April 2015 – 31st March 2016 (% attendance)
Public		
Brian Cummings	Bebington and Clatterbridge	1/2 (50%)
Rohit Warikoo	Bidston and Claughton	2/4 (50%)
Evelyn Hurren	Birkenhead, Tranmere and Rock Ferry	3/4 (75%)
Steve Evans	Bromborough and Eastham	4/4 (100%)
Brian Beechey	Greasby, Frankby, Irby, Upton and Woodchurch	1/2 (50%)
Eileen Hume	Greasby, Frankby, Irby, Upton and Woodchurch	2/2 (100%)
David Steele	Heswall, Pensby and Thingwall	2/2 (100%)
Fleur Flannagan	Heswall, Pensby and Thingwall	0/2 (0%)
Beverly Ross	Leasowe, Moreton and Saughall Massie	0/1 (0%)
Sue Mitchell	Leasowe, Moreton and Saughall Massie	2/2 (100%)
Derek Hampson	Liscard and Seacombe	3/4 (75%)

Governor	Constituency / Class	Meeting attendance Actual / Possible 1st April 2015 – 31st March 2016 (% attendance)
Len Smith	Neston, Little Neston, Parkgate, Riverside, Burton, Ness, Willaston and Thornton	4/4 (100%)
Paul Harris	New Brighton and Wallasey	3/4 (75%)
Angela Tindall	North West and North Wales	4/4 (100%)
Donald Shaw	Oxton and Prenton	2/2 (100%)
George Wadham	Oxton and Prenton	2/2 (100%)
Robert Howell	West Wirral	4/4 (100%)
Staff		
Rosemary Morgan	Registered Medical Practitioners and Registered Dentists	4/4 (100%)
Paula Clare	Registered Nurses and Registered Midwives	3/4 (75%)
Carol Skillen	Registered Nurses and Registered Midwives	3/4 (75%)
Vacant	Other Healthcare Professionals	N/A
Norman Robinson	Other Trust Staff	4/4 (100%)
Stakeholder Governors		
Fadil Hannan	University of Liverpool	1/4 (25%)
Mandy Duncan	Wirral Third Sector Assembly	3/4 (75%)
Kathy Hodson	Wirral Metropolitan Borough Council	1/4 (25%)
Christina Muspratt	Wirral Metropolitan Borough Council	1/4 (25%)

Director Attendance at Council of Governor Meetings 2015/16

Michael Carr	Chairman	4/4 (100%)
Jeff Kozer	Non- Executive Director	1/1 (100%)
Cathy Bond (Senior Independent Director from 1.7.15)	Non- Executive Director	2/4 (50%)
Andrea Hodgson	Non- Executive Director	3/4 (75%)
Graham Hollick	Non- Executive Director	3/4 (75%)
Cathy Maddaford	Non- Executive Director	3/4 (75%)
John Sullivan	Non- Executive Director	2/3 (66.6%)
Jean Quinn	Non- Executive Director	3/4 (75%)
David Allison	Chief Executive	3/4 (75%)
Mark Blakeman	Director of Infrastructure and Informatics	2/4 (50%)
Mike Coupe	Director of Strategy	3/3 (100%)
Jill Galvani	Director of Nursing and Midwifery	3/3 (100%)
Sharon Gilligan	Director of Operations	2/2 (100%)
Anthony Hassall	Director of Strategic and Organisational Development	1/1 (100%)
Gareth Lawrence	Acting Director of Finance	2/2 (100%)
Evan Moore	Medical Director	4/4 (100%)
Alistair Mulvey	Director of Finance	2/2 (100%)
Gaynor Westray	Director of Nursing and Midwifery	0/1 (0%)

Council of Governor Committees

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.

Nominations Committee Membership & Attendance 2015/16

Name	Role	Meetings attended (maximum 3 and % attendance)
Michael Carr	Trust Chairman	2/2(100%)*
Anita Leech	Nominated Stakeholder Governor	0/1 (0%)
Rosemary Morgan	Elected Staff Governor	0/3 (0%)
Beverly Ross	Elected Public Governor	0/2 (0%)
Donald Shaw	Elected Public Governor	2/2 (100%)
David Steele	Elected Public Governor	2/2 (100%)
Kathy Hodson	Nominated Stakeholder Governor (Nominations Committee member since Council of Governors approval, 16.09.2015)	0/1 (0%)
Robert Howell	Elected Public Governor (Nominations Committee member since Council of Governors approval, 16.09.2015)	1/1 (100%)
Steve Evans	Elected Public Governor (Nominations Committee member since Council of	1/1 (100%)

	Governors approval, 09.12.2015)	
Angela Tindall	Elected Public Governor (Nominations Committee member since Council of Governors approval, 09.12.2015)	1/1 (100%)

*indicates the number of available Committees the Chairman was required to attend

In May 2015 the Committee received and noted the performance and development review summaries for the non-Executives together with a review of the recommendation for the appointment of a new Deputy Chairman and Senior Independent Director as a result of Jeff Kozer leaving at the end of June 2015. The Committee also undertook a review of the fit and proper persons test for Non-Executive Directors.

A review of the performance and appraisal for the Chairman was undertaken by the Council of Governors at its private meeting in June 2015 in line with its terms of reference.

The Council of Governors has established two 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.

- ***Annual Plan Advisory Committee***

This committee meets monthly with the Director of Strategic and Organisational Development

It has been involved in setting both, a one 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.

Strengthening excellent relationships with governors and members

Council of Governors

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 2015/16 as well as Governors being instrumental in membership and engagement and the development of the annual plan they have also been involved in a range of Governor workshops, the topics for which have been determined by the Council. The workshops this year have included Cardiovascular Out Patients Department, Diagnostics and the Combined Heat and Power (CPH) Plant.

Governors took an active role in the Annual members meeting in October 2015 which included an “active market place” showcasing the work of the Trust as well as taking questions before and during the meeting from members.

The Trust continues to seek the views of Governors and members and to this end has introduced the concept of Ambassadors for both specialist cohorts of our population as well as young people. The Ambassador role is designed to continually engage with ex Governors who have shown a positive interest in working together with the Trust.

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 9,063 public members plus an additional 5,871 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.

Membership

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

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

The public constituency divided into 13 geographical areas:

- 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

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 under-represented groups within the communities we serve.

Throughout 2015/16, 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 October 2015, 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	2014/15	2015/16
At year start (1 st April)	8,997	9,230
New members	629	217
Members leaving	396	384
At year end (31 st March)	9,230	9,063
Staff constituency	2014/15	2015/16
At year start (1 st April)	5785	5520
New members	430	811
Members leaving	695	460
At year end (31 st March)	5520	5871
Patient constituency	There is no Patient Constituency	

Analysis of membership 2015/16				
Public constituency	Number of members	%	Eligible membership	%
Age (years)			2014 figures collated by CACI Ltd, except for ethnicity, which is 2011 Census, ONS	
0 - 16	10	0.11	1,560,359	19.91
17 - 21	196	2.16	492,266	6.28
22+	7,865	86.78	5,785,080	73.81
Not stated	992	10.95	N/A	N/A

Total	9,063	100.00	7,837,705	100.00
Ethnicity				
White	8,548	94.32	7,032,420	90.86
Mixed	39	0.43	115,841	1.51
Asian or Asian British	94	1.03	446,350	5.76
Black or black British	25	0.28	99,366	1.28
Other	11	0.12	46,137	0.59
Not stated	346	3.82	N/A	N/A
Socio-economic groupings*				
AB	2,375	26.01	465,188	19.18
C1	2,594	28.62	729,272	30.07
C2	1,945	21.46	511,110	21.07
DE	2,114	23.33	719,901	29.68
Gender analysis			(2014 figures collated by CACI Ltd)	
Male	3,343	36.89	3,863,791	49.30
Female	5,508	60.77	3,973,909	50.70
Unspecified	212	2.34	N/A	N/A
Patient constituency	There is no patient constituency			

*Socio-economic data should be completed using profiling techniques e.g. postcode or other recognised methods. To the extent socio-economic data is not already collected from Members, it is not anticipated that Foundation Trusts 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

Regulatory ratings

The Trust is regulated by Monitor, which reviews the Trust's performance through a series of risk rating called the Risk Assessment Framework ratings. Monitor's assessment of a Foundation Trust under this framework aims to identify:

- Significant risk to the financial sustainability of a provider of key NHS services that endangers the continuity of those services and /or
- Poor governance at an NHS Foundation Trust, including poor financial governance and inefficiency

Monitor replaced the previously used "continuity of service risk rating" with the "financial sustainability risk rating" in August 2015. The risk rating represents Monitor's view of the likelihood that a licence holder is, will be, or could be in breach of the continuity of service licence condition 3 and/or provisions of the NHS Foundation Trust licence condition 4 (governance) which relates to finance.

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. For the financial sustainability risk ratings, the range is from 1, the most serious risk, to 4, the lowest risk.

The Trust was found to be in breach of its Provider licence in August 2015 for financial governance concerns. The Trust formally responded to the enforcement notice and developed a 2 year financial recovery plan. The Trust delivered a financial deficit out-turn of £15.4M against a deficit target of £13.5M. This was considered to be a significant achievement in light of the increased demand on the

hospital; the junior doctors' industrial action and the national initiative to reduce occupancy during the Christmas and New Year Period. The Trust has managed to remove some aspects of the enforcement undertakings during the year relating to interim positions as a result of appointing to substantive posts and continues to provide formal updates to Monitor through the progress review meetings.

The ratings for the year are shown below:

2015/16 ratings:

	Annual Plan 2015/16	Q1 2015/16 Actual	Q2 2015/16 Actual	Q3 2015/16 Actual	Q4 2015/16 Actual
Continuity of Service (COS) rating	2	2			
Financial sustainability risk rating			2	2	2
Governance risk rating	Issues identified	Red	Red	Red	Red

Statement of Accounting Officer responsibilities

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

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and the 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.

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.
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance 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

Date: 25th May 2016

Annual Governance Statement

Scope of responsibility

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

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 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

I am responsible for risk management across all organisational, financial and clinical activities 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 and Infrastructure 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.

The national expectation for NHS bodies to work as part of a single footprint; in collaboration with other organisations or as part of a Vanguard site has seen the emergence of a series of risks associated with these partnership arrangements. The Trust currently monitors these risks through the Board Assurance Framework and reporting papers to the Board but is looking for partners to strengthen the governance arrangements going forward.

A variety of risks during this reporting period have been identified through the Trust's performance management structure as opposed to the governance structure. The Trust has acknowledged that a change was required to the performance management framework and the subsequent reporting from this and has now enacted this change. The wider Senior Management Team is now in attendance at the Performance Reviews and the recording of the meeting is undertaken by the Director of Corporate Affairs.

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. The Trust has recognised that compliance against mandatory training targets is impacted on by operational pressures experienced over the winter and has agreed therefore to stagger the training provided to allow staff to attend outside this busy period.

The Board of Directors undertakes risk management training annually as part of its development programme and through the Assurance Committees also undertakes a review of its risk profile as part of the review of the Board Assurance Framework. The Board has agreed to undertake a review of its risk appetite as part of its continued development in this area.

The Quality and Safety Committee receive bi-monthly reports which provide information on new and up-scored risks; the number of patients who have experienced actual harm as a result of a serious incident and a serious incidents trend report. The Trust has agreed a series of developments to improve the reporting of incidents; the management of RCAs and embedding the lessons learned from incidents and investigations, this includes:

- A revised RCA training programme for all staff responsible for completing investigations
- The introduction of new RCA templates to improve the consistency and quality of reports
- The adoption of an action logic model to identify trends and actions highlighted through the RCA
- Communication and information sharing via a dedicated site on the Trust's intranet and through the reintroduction of a newsletter.

Further work is also being progressed following concerns highlighted in the CQC Inspection Report September 15 to ensure that all staff are aware of how to report incidents and raise risks and that the Trust's feedback mechanisms are improved in terms of timely response and content.

Both the Audit Committee and Quality and Safety Committee raised concerns with the number of risks being held in the incident web-holding file and have sought assurance at each meeting on progress to address this. The actions being taken have begun to address the backlog numbers significantly in the file however there is recognition that there is more work to do in this area, particularly in light of the findings in the “Learning from Mistakes” league table which triangulated specific questions from the NHS Staff Survey to openness, transparency and responsiveness of the management of incidents. This is being addressed through a series of Listening into Action events and additional training programmes.

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 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 (NHS LA) 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 Trust is focusing attention in the following three areas as part of the NHS LA "Sign up to Safety" Campaign the aim being to target high value high volume claims.

- Pressure ulcers
- Missed fractures in A&E
- Sepsis

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 has overall responsibility for corporate governance including quality, safety and risk management within the Trust and it has 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. Risks scoring 10 or above are escalated to the Operational Management Team (OMT) from the divisions, via the Risk Management Team so that mitigation can be monitored corporately. The responsibility for risk management remains with the team that identified the risk, although corporate support for mitigation will be given as appropriate.

All new risks that score 15 or above undergo first line approval from the Medical Director, then are escalated for second line approval in the Quality and Safety Committee.

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 has an established a process for alerting the Board of Directors, Council of Governors and Senior Management Team to any reputational risks facing the Trust.

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 Business Performance and Assurance Committee
- Operational Management Team
- Health and safety partnership
- Divisional management teams

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 Business Performance and Assurance Committee.

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 Board Assurance Framework

The review of the BAF is a standing agenda item for each of the Assurance Committees. The Committee's agendas are focussed on the gaps in assurance/control and the Chair's reports to the Board outline where these gaps in assurance/control have been successfully mitigated or where further support is required. The Committee's also reviews the Trust's risk profile as a consequence of the action taken during the reporting period.

The Trust has continually reviewed the impact of the BAF during 2015/16 following the significant change in reporting agreed in 2014. Key changes include:

- The alignment of the internal audit plan with the BAF
- The triangulation with key work streams including partnership working
- The inclusion of risk profiling to aid with review
- The amendment to Assurance Committee agendas to focus on gaps in assurance/control

In October 2015, the Board of Directors undertook an annual review of the BAF which highlighted the key movement in risk during the reporting period; new risks identified and those risks which had been closed following appropriate mitigation.

Monitor Licence Breach

The Trust was found to be in breach of its Provider licence in August 2015 following a period of investigation. The breach was in relation to financial governance concerns. The enforcement action also included an additional licence condition under section 111 of the Health and Social Care Act. The Trust has worked closely with Monitor to fulfil the requirements of the enforcement undertakings and has to date been successful at removing one of the undertakings in relation to interim support in view of the work the Board undertook to recruit to key substantive positions. Although the financial challenges remain, Monitor has recognised the increased financial rigour now in place in the Trust and the trajectory of improvement in key areas.

The Audit Committee reviews compliance with the Trust's Provider Licence at each of its meeting and the Board has agreed to track compliance against the enforcement undertakings as part of the review of its financial and operational performance as it acknowledged that the monthly Board review undertaken was not considered to be adding value.

NHS Staff Survey

Following the disappointing NHS staff survey in 2014, the Trust embarked upon an ambitious staff engagement campaign using the Listening into Action LIA methodology. The LIA action plan was supplemented by divisional plans that have been acted upon and monitored throughout 2015 by the Workforce and Communications Group, Staff Satisfaction Steering Group and Listening into Action Sponsor Group. Recently, the latter two groups have merged due to overlap in remit. The Trust Board agreed that the Staff Friends and Family Test (Staff FFT) would be used to monitor whether the required improvements were being made on an incremental basis in advance of the Annual NHS Staff Survey, with additional questions added that make up the staff engagement score in line with the Annual NHS Staff Survey. This aimed to give the Trust a greater sense of how it was progressing and that the actions put in place were effective. The table below provides an overview of the measurable improvement from 2014/15 to 2015/16

	2014/15 NHS staff survey	2015/16 NHS staff survey
Staff Engagement Score	3.48	3.79

The Trust has agreed to build upon this work even further during 2016.

The Care Quality Commission

The Care Quality Commission (CQC) undertook a focused inspection on 18th May 2015 in response to a number of concerns that were reported to them relating to the theatre recovery area being used as part of the Trust escalation processes and procedures when there was a shortage of inpatient beds. These concerns related to unsuitable facilities and inappropriate staffing and the medical wards 25 and 37 not having suitable staffing arrangements in place. Concerns had previously been raised that staffing numbers were not sufficient to meet people's needs and a requirement to address this had been made at the last inspection in November 2014. The Trust received a requirement notice under Regulation 18 of the Health and Social Care Act in relation to staffing.

The Trust responded to the requirement notice by building upon the existing action plan in this area which saw the Trust embark on a local, national and international recruitment campaign, the impact of which is outlined below.

The CQC carried out its comprehensive inspection in September 2015. Overall, the Trust was rated as 'Requires Improvement' which was in line with the Trust's own self-assessment. The breakdown of ratings under each of the domains is outlined below:

<i>Are services safe?</i>	Requires Improvement
<i>Are services effective?</i>	Good
<i>Are services caring?</i>	Good
<i>Are services responsive?</i>	Requires Improvement
<i>Are services well-led?</i>	Requires Improvement
<i>Overall Trust</i>	Requires Improvement

The Trust received requirements notices under Regulations 11, 12, 13, 15, 16, 17 and 18.

The conclusion is that the Foundation Trust is not fully compliant with the registration requirements of the Care Quality Commission.

Although the report recommended a series of improvements to be made, the CQC acknowledged that the Trust was aware of the need to make improvements and in

many cases the actions to progress these were being implemented. The considerable efforts put in place to address the early issues relating to nurse staffing was recognised with vacancies rates now consistently circa 5% compared nationally to rates of 10%.

The CQC evidenced the journey of transformation the Trust was embarking upon and this was highlighted in the comments made by staff and the visibility of the leadership team. The results of the 2015 NHS staff survey further evidenced the improvements made in terms of staff engagement and overall staff morale. The Trust and its partners took part in a Quality Summit held on the 14th March 2016. This was an opportunity for CQC to present its findings to partners and for the Trust to respond with appropriate actions. As part of that summit, Monitor also secured the support of partners in areas where the Trust required action to be taken on a health economy basis if real improvements were to be made.

The Trust has developed a comprehensive action plan to mitigate and address the issues identified which was submitted to CQC on the 14 April 2016.

Ahead of the comprehensive inspection the Trust implemented a programme of internal care quality inspections (CQI) which were used to inform the organisations where improvements could be made and where best practice could be shared. The feedback from staff to this programme of work was very positive and the Board has agreed therefore to continue with these into 2016. The Board of Directors and Council of Governors will form part of the inspection team going forward albeit their role will be largely of an observational nature, this brings together the previously conducted Board walkabouts and the CQI's into one place.

The Quality and Safety Committee continue to monitor CQC compliance and the outputs of the CQIs. Following submission of the action plan on the 14th April 2016 the Committee will monitor progress accordingly and formally report to the Board.

Governance Reviews

The Board undertook a financial governance review in December 2015; this review enabled the Board to consider the improvements made in financial governance since the licence breach in August 2015; what further improvements needed to be made and also afforded the Board the opportunity to re-visit some external recommendations which were either outstanding or not enacted upon at the time as not felt to be appropriate.

The Trust has undertaken two quality governance framework self-assessments, the last being in May 2015 as presented to the Quality and Safety Committee. This framework has now been superseded by the Monitor Well Led Governance Reviews for which the Trust undertook its self-assessment in August 2015, externally facilitated by MIAA. The results of the self-assessment informed the tender process for the full review Governance Review to be undertaken April – June 2016.

The Board of Directors reviews the validity of its Corporate Governance Statement on an annual basis by reviewing evidence that supports statements ahead of formal approval as well as reviewing the additional information which enables the Board to consider when support of a statement cannot be made.

Internal Audits

MIAA conducted 16 formal internal audits during 2015/16 which all received a rating of “significant assurance” with the exception of:

IM&T: Threat and Vulnerability Management – The Director of Infrastructure and Informatics asked for a series of audit to be undertaken on the IT systems that were outsourced to Cheshire and Merseyside Commissioning Support Unit. The Assurance rating was in line with expectations and has enabled the Trust to target improvement now that services have been insourced.

NHS Pension Scheme

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

Equality, Diversity and Human Rights Legislation

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

Carbon Reduction

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

Key In-Year Risks

The Board Assurance Framework describes the key in-year risks together with mitigating action to address these. An overview of the key in-year risks associated with quality, workforce, finance and partnership/collaborative working is provided below:

- **Workforce** – the Trust’s investment in nursing, delivery of the workforce and organizational development strategy and commitment to not open unplanned escalation beds has all had a significant impact on staff morale as evidenced in the NHS staff survey 2015 described early in the Annual Report. Nursing vacancy rates are also now one of the lowest nationally. The risks in relation to Workforce are all considered to be within acceptable tolerances.
- **Quality** – The Trust has managed to consistently achieve lower hospital mortality rates than the national average. The non-compliance with access targets for RTT and A & E continue to be a cause for concern although both are on track to meet the improvement trajectories agreed. The Trust has separated out its internal and external action plans. The long waits for community paediatrics has been a particular focus of attention for both the Trust and its Commissioner during 2015/16 with external reviews undertaken to identify areas of best practice and to agree actions to improve this.

35 reported cases of avoidable C difficile exceeded the target of 29 in 2015/16 however the implementation of a full and ongoing action plan has led to no avoidable cases being reported since mid-January 2016. End of life Care was rated as “inadequate” in the CQC inspection in September 2015; huge progress has been made in year to address the concerns raised. The Trust will continue this work into 16/17 and with the support of partners address the issues that are the responsibility of the whole health economy. The Trust was issued a series of requirement notices, outlined separately in this report, from CQC and has formally responded to concerns in its action plan submitted on the 14th April 2016. Many of the actions have either now been completed or are progressing well to completion.

- **Finances** – The Trust delivered a deficit out-turn of £15.4M against a revised target of £15.3M; the original target of £13.5M excluding the impact of the junior doctor industrial action. The Trust was found to be in breach of its Provider Licence in August 2015 for financial governance concerns. The Trust has made significant changes to its financial processes and reporting which has been acknowledged by Monitor. The Trust has concluded contract negotiations with its main commissioner and accepted the control total set by Monitor for 2016/17 noting that there are significant health economy challenges in the achievement of this which again is acknowledged by Monitor.
- **Partnership/Collaborative Working** – the Trust has identified a range of opportunities and risks associated with partnership/collaborative working which it is seeking to address through formal governance processes and clinical engagement exercises.

Future Risks

In addition to the above the future risks/threats facing the Trust are outlined in the Operational Plan as follows:

Risk & Effect	Likelihood (1-5)	Impact (1-5)	Score (2-25)	Mitigation
Initiatives to suppress demand or develop community based substitute services fail to deliver a reduction in emergency demand: non-delivery of ED trajectory	4	4	16	Active participation within the Urgent Care Recovery Group and System Resilience Group. The Trust will continue to improve patient pathways in line with the Emergency Care Improvement Programme On-going development of Healthy Wirral programme
Capacity hotspots (e.g. therapies and community paediatrics) and/or growth in non-elective admissions: non-delivery of RTT target	3	4	12	Through the System Resilience Group actively champion robust workforce plans across organisational boundaries The introduction of pathway coordinators will enable early notification of constraints within specialties so robust corrective action can be initiated.
Failure to reduce emergency demand and capacity hotspots and/or growth in non-elective admissions: increased (unplanned) expenditure and/or loss of income	4	4	16	Active participation within the Urgent Care Recovery Group and System Resilience Group. To ensure sufficient step up & down capacity across the economy, with the Trust taking an active lead
Deterioration in Industrial Relations climate: loss of capacity/income; limited	2	4	8	Continue the successful delivery of HR and OD strategy in 16/17 and build

<p>progress in clinician dependent service redesign</p>			<p>further on our improved staff satisfaction results and our continued staff engagement through LIA.</p> <p>A medical engagement strategy will be launched in Quarter 1, 2016</p>
---	--	--	--

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

The Trust has considered the impact of the changes made by the National Audit Office to the Use of Resources assessment for 2015/16. Three sub-criteria will now be used by the Auditors to inform the assessment as follows:

- Informed decision making
- Sustainable resource development
- Working with partners and other third parties

Financial Planning and overview of financial performance

The development of the operational plan and the sustainability and transformation plan has been progressed through the senior management team; the annual plan advisory committee; finance business performance and assurance committee and the Board.

Divisions are held to account for the delivery of operational plans through performance review framework which include monthly operational reviews and quarterly strategic reviews. An enhanced review process was implemented this year for the Division of Surgery in light of under-performance to plan and the impact on the overall financial plan.

The Trust has maintained a FSRR rating of 2 in line with plan and cash continues to be well above plan, this being without the anticipated requirement of distressed funding from the Department of Health. The deficit for 15/16 was £15.4M against the original plan of £13.5M. Key factors affecting the deficit out-turn were associated with the junior doctors strike; the national initiative to reduce beds over the Christmas period and the application of penalties out-with the national guidance, at a late stage.

The Trust has delivered a CIP programme of £11.9M (before the application of mitigation reserve of £1.5M) against the £13M target which was broadly in line with the forecast position since November 15. The Trust has engaged with the services of a Recovery Advisor as required by Monitor during the reporting period, however this arrangement has now ceased due to the appointment to key operational and financial positions and the development of internal expertise.

As part of the Trust's enforcement undertakings the Trust had to retain the services of interim support until such time as the Trust had a sustainable solution. The following appointments have been made since August 2015 which has enabled Monitor to remove this particular undertaking:

- Appointment of substantive Head of PMO
- Appointment of substantive Chief Operating Officer
- Appointment of substantive Director of Finance
- Successful appointment to the post of Director of Nursing and Midwifery following the retirement of Mrs Jill Galvani
- The appointment to the interim Director of Operations

The Lord Carter Review and reference costs

The Trust has undertaken a review of the recommendations following the release of the Lord Carter report on the 5th February 2016. The full extent of the opportunity is due to be articulated in the Trust Procurement Transformation Plan due to be completed by April 2016. The Trust is working in collaboration with Wirral Partners as part of the Vanguard Population Health Management Bid and with the Countess of Chester on the establishment of an Acute Care Alliance, both initiatives are designed to improve efficiency, effectiveness and release savings.

The Trust is working on the development of a strategic estates partnership with a view to exploring how the Trust could manage its estate in an alternative way through the use of VAT efficient funding. The Trust has sought legal advice and is currently exploring the benefits of holding a "soft marketing day" with the private sector to help formulate the specification without providing any commitment at this stage.

The Trust's reference cost return was submitted in July 2015. The outputs of this return show that the Trust has a reference costs index (RCI) of 91 which indicates that the Trust's costs are 9% less in total than the national mean for like services.

The Return on investments

The investment in safer nursing staffing levels made by the Trust over the period 2013/14 – 2015/16 was evaluated by the Board in March 2016, with the following areas highlighted:

- 66% reduction in the number of new colonised cases of CPE through the investment in a purpose built isolation unit
- Zero reported avoidable Grade 4 pressure ulcers through compliance audits; education; review and assessment
- Significant reduction in the numbers of falls through the use of technology as well as cohorting patients who are at risk of falls to provide increased

supervisions. AQUA reported in January 2016 that the Trust had one of the lowest falls prevalence rates in the region.

- Increase in MEWS compliance from 52% in Q3 2014/15 to 82% in Q3 2015/16 through the provision of improved staffing levels and the use of technology
- Improved National Inpatient survey results 2015 by 5% or more as a result of improved staff morale and staff engagement

In November 2015 the Trust entered into a contract with NHSP for the supply of temporary worker. The review undertaken in March 2016 evidenced that the Trust was on track to achieve the year on year savings after the contract costs of £63K as well as improving the fill rates overall and therefore improving the efficiency of the Trust's resources. Nursing vacancy rates now stand at circa 5% well below the national average of 10%. The Trust has been consistent in its compliance with the nursing agency cap of 3%. The Trust has recently been benchmarked as one of the lowest in the North West for agency cap breaches.

The Quality and Safety Committee review at each meeting a high level dashboard with key indicators to track the impact of the Cost Improvement Plans on quality through an evidenced based methodology. The Trust reviewed the process further in 2015/16 and now has in place a quality impact assessment for each work stream in the CIP programme.

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.

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.

Information Governance

The Trust has reported no level 2 incidents during 2015/16.

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 2015/16 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 2015/16. External audit assurance reports on the Quality Report are reviewed by the Audit Committee.

The Board of Directors agreed the priorities for 15/16 as part of the Quality Account Report which sets out ambitions and milestones for further improvement of safety, clinical effectiveness and patient experience. The Quality and Safety Committee utilises a quality dashboard that enables it to measure trends in performance of key indicators that contribute to high level quality and safety metrics and identify improvement work.

The Trust has a dedicated Quality and Safety Team with the relevant skills and experience to identify, direct and measure quality improvement work across the organisation.

The Audit Committee reviewed the effectiveness of Clinical Audit in December 2015. This included how the audit programme was developed in terms of mandated audits; nursing audits; the prioritisation of key areas and how the learning was being disseminated.

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 Co-ordinating Committee.

Priorities for 2016/17 have been discussed with stakeholders and agreement reached.

The key external and publically reported measure on elective waiting time data is in Referral to Treatment performance.

The External Audit testing, as part of the review of the Quality Account, on the “Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period” concluded in a qualified opinion from the External Auditors. The auditors identified 6 accuracy errors from the 25 cases they tested. The errors related to incorrect start and stop dates. In response to these findings the trust is currently undertaking an in-depth review which will be monitored by the Task and Finish Group to be chaired by the Chief Operating Officer. The task and finish group has three sub groups focusing on 1) Demand & Capacity management 2) Booking, access and Validation and 3) Information systems to support RTT delivery. Underpinning these areas of work is a review of all open incomplete pathways, coupled with a training package being compiled for all staff who have an input into RTT process. Full implementation of this work is expected by November 2016 although significant progress will be made sooner.

The External Auditors also tested the mandated indicator for A & E waits which again they qualified. The Auditors founds errors in 3 cases out of a total of 40 reviewed. The errors related to A & E waiting times not being validated to patient records. The Trust again is using the Task and Finish Group to ensure that validation is improved during this financial year.

The External Auditor testing of the local indicator selected by Governors, this being the percentage of admitted patients who had a risk assessment for malnutrition (MUST) found no evidence that the reported indicator was not reasonably stated in all material respects in accordance with relevant calculations.

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 by the Operational Management Team.

Plans made in response to external inquiries 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.

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 on a regular basis.

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 2015/16.

The Trust’s programme of clinical audit work, which is agreed and monitored by the Quality and Safety Committee and the Audit Committee, provides me with assurance on the quality and continuous improvement of clinical practice and patient care.

Financial management and governance is monitored through the Finance Business Performance and Assurance Committee and reviewed by the Audit Committee. This provides me with assurance on the continuous improvements being made to deliver the necessary financial savings.

My review is also informed by External Audit Opinion, periodic assessments of compliance with CQC standards and other external inspections, accreditations and reviews.

Conclusion

The Trust has identified significant internal control issues in relation to its quality and financial processes and systems as raised by the CQC and Monitor. The Trust has worked extensively with both regulators to address the findings from the CQC comprehensive inspection undertaken in September 2015 and the financial governance breach in August 2015. The Trust has developed and implemented at

pace the CQC action plan and reports progress through the Trust's assurance systems. Nurse vacancy rates have been addressed and are now well below national levels, staff attendance, appraisals and morale continues to improve as evidenced by the NHS staff survey in 2015. The Trust is working with partners on those areas of quality assurance that require a whole system approach to be able to enact the transformational change required. The Trust has worked closely with Monitor to address the financial governance concerns and performed broadly in line with its financial plan for 2015/16 despite the challenging NHS financial context. The Trust has concluded contract negotiations with its main commissioner for 2016/17 which should improve financial sustainability and facilitate an improved approach to care pathways for patients. Monitor has acknowledged the progress made by the Trust and supported it in terms of removing specific enforcement undertakings as a result of appointments made to substantive Executive positions as well as the improving performance against improvement trajectories for RTT and A & E.

Despite a challenging year, the Trust is now in a stronger position to mitigate issues before they materialise into risks and concerns and has a strong basis for monitoring financial performance going forward.



David Allison
Chief Executive
25TH May 2016

Quality Report 2015/16

25th May 2016

Joe Roberts, Head of Assurance

Contents

Part 1: Chief Executive's statement

Part 2: Review of Quality Performance - How we have performed

- 2.1 Review of the Priorities for Improvement 2015/16
 - Priority 1: Improve care for patients with dementia
 - Priority 2: Support patients with eating and drinking
 - Priority 3: Reduce harm in relation to newly formed pressure ulcers
 - Priority 4: Reduce the number of missed medication events
 - Priority 5: Reduce emergency admissions within 30 days
 - Priority 6: Reduce the Hospital Standardised Mortality Rate
- 2.2 External Reviews
- 2.3 Listening into Action
- 2.4 Local and National Quality Indicators
 - Local Indicators
 - Advancing Quality
 - Reducing Hospital Acquired Infections
 - National targets
 - Core indicators

Part 3.1: Looking Forward to 2016/17

- 3.1.1 Priorities for improvement in 2016/17
- 3.1.2 Monitoring our Priorities for 2016/17
- 3.1.3 Provision of Feedback

Part 3.2: Statement of Assurance from the Board of Directors

- 3.2.1 Service reviews
- 3.2.2 Participation in National Clinical Audits and Confidential Enquiries
- 3.2.3 Participation in clinical research

- 3.2.4 Commissioning for Quality and Innovation
- 3.2.5 Care Quality Commission registration and reviews
- 3.2.6 Data Quality
- 3.2.7 Information Governance
- 3.2.8 Clinical Coding
- 3.2.9 Duty of Candour

Annex: Statements from Third Parties

Statement from NHS Wirral Clinical Commissioning Group

Statement from Wirral Metropolitan Borough Council

Statement from Wirral Healthwatch

Glossary for Quality Report

Appendix 1: Services provided by the Trust

Appendix 2: National Clinical Audit List

Appendix 3: Statement of Directors' responsibilities in respect of the quality report

Appendix 4: 2015/16 Limited Assurance Report on the Content of Quality Report - Draft

Part 1: Chief Executive's Statement

This has been a successful year for our Trust, in which we have made real progress in so many ways: increasing frontline staff numbers; planning ahead to manage winter pressures; working with our partner organisations to shape the future of local health services; and engaging with our staff to ensure that they share our vision and can make their voices heard.

In last year's edition of this report, I mentioned the £1.1 million investment in increased nurse staffing which the Trust Board had recently approved. Over the past six months, I and my Board colleagues have had the pleasure of welcoming the new intake of nurses to our hospitals, as well as newly-recruited physiotherapists and occupational therapists. Our nursing vacancy rate is considerably lower than the national average, and the impact of the improved staffing levels is being felt by those who use our services. Our nurses also have new professional leadership – in February, my colleague Jill Galvani, Director of Nursing and Midwifery, retired after three very busy and productive years at the Trust and more than thirty years as a nurse. She has been replaced by Gaynor Westray, a home-grown talent who first joined Arrowe Park Hospital as a student nurse in the 1980s.

The NHS operates in an ever more challenging environment, simultaneously having to manage increased demand for its services from a growing and ageing population, and tightening public finances. I am proud that this Trust has been proactive and continues to plan ahead to meet these challenges. For example, we ensured that we were in good shape for the winter, and particularly the very busy period which always follows Christmas and New Year, by participating in the national 'Safer Start' initiative in January. This meant that, compared to the same period last year, we had fewer patients being cared for on wards which specialised in a different aspect of medicine to that for which they had been admitted, far fewer additional beds needed to be opened, and we received significantly fewer complaints. We aim to make these improvements permanent by implementing the 'Safer Bundle' – a set of measures and processes to improve patient flow through the system, based on what we did during 'Safer Start'.

We are not working on our own, but in close partnership with the other organisations in Wirral which aim to meet peoples' health and social needs, such as Wirral Metropolitan Borough Council, Wirral Clinical Commissioning Group, Wirral Community NHS Foundation Trust and Cheshire and Wirral Partnership. The 'Healthy Wirral' initiative aims to make sure that patients are treated in the right way, at the right place and time, by the right organisation. It is also about helping people to lead healthy lives, not just treating them when they become ill. It was a hugely significant moment when, in January 16, the leaders of all the organisations involved signed a memorandum of understanding, committing us all to move forward and work together.

In such a difficult and constantly changing environment, the hard work and commitment of our staff must never be taken for granted. We have made staff engagement a priority for managers at all levels of the organisation. During the year, every single ward and department held a 'mini-huddle' as part of the Listening into Action programme that we have mentioned in previous year's reports. At these meetings, participants were asked to say what made them proud of where they work, and what their frustrations and concerns were. Based on this feedback, each department then identified some 'quick win' actions to be completed straight away, and further actions to be completed within a hundred days. We called this the '100 Day Challenge'.

Furthermore, every ward and department now has a Board Partner – a Director who acts as a channel of communication between that department and the Trust's Board and Executive Team. We also have four Staff Guardians with whom employees can raise any concerns, if for any reason they do not feel confident to take up an issue through the normal line management structure; our approach to this issue has been recognised nationally as good practice.

All this work has made a real impact – in February we received our Trust’s results in CQC’s National Staff Survey. This showed that we had made great strides forward since the very disappointing staff survey report which we received in 2015. Indeed, in several of the survey’s key findings we were in the top 20% of acute trusts nationally, and our response rate of 47% was 6% higher than the national average. Quality Health who administer the survey reported that the improvements were the most significant seen in any Trust in any one year.

The Trust underwent a full-scale planned inspection by the Care Quality Commission in September 2015, although the inspection report was not published until March 2016. Overall, the Trust was rated as ‘requiring improvement’ – in common with the majority of NHS acute hospitals which have been inspected to date, noting that the standard is very high. This broadly reflected the results of our own self-assessment which we completed prior to the inspection; we acknowledge that the Trust has experienced challenging times and is on a journey of improvement, but that the journey is not yet complete.

We were pleased that the report rated our surgical services as ‘good’, and that the care provided by our staff was rated as ‘good’. CQC also highlighted examples of outstanding practice, for example the quality of care for patients who have suffered a stroke, as measured by national audits and data benchmarking, and how the Surgical Assessment Unit measure patients’ fluid balance to ensure that they are well hydrated. We have developed, and are implementing, a comprehensive Trust-wide action plan in response to the inspection report, and resources will be made available to deliver improvement where it is needed.

Overall, the story of the past twelve months at Wirral University Teaching Hospitals has been one of steady and sustained improvement. This Quality Report tells that story in considerable detail. I would like to thank our staff and volunteers for making those improvements happen, and our patients for showing their confidence in us by choosing to be treated here.

I am pleased to confirm that the Board of Directors has reviewed the 2015/16 Quality Account. I confirm that it is a true and fair reflection of our performance and that to the best of our knowledge the information within this document is accurate.



David Allison
Chief Executive

Part 2: Review of Quality Performance

This section of the report tells you how we performed against the six priorities that we set ourselves in 2015/16. In 2015/16, we retained the same six priority topics, as there was still work to be done for each of them before we could reach the standards to which we aspire. However, the detailed targets for these priorities were adjusted and updated.

2.1.1 Patient Experience Priorities

1. Improve care for patients with dementia

The target for 2015/16 is:

- People with dementia receive care from staff appropriately trained in dementia care.
- All patients with dementia will have a “This is Me” booklet.

Executive Lead: Gaynor Westray (Director of Nursing and Midwifery)

During the past year, we have completed a great deal of work to ensure that patients suffering from dementia and their carers get the care and support they need, and to train our staff to provide that support.

During 2015/16 over 2,000 staff have received training on dementia care, which has taken a variety of forms including attendance at our Dementia Conferences, and the more intensive #dementiadoo programme. Working with Wirral Community NHS Trust, we have delivered training for our partners in the community, including staff from several local nursing homes. We have focused on those homes whose residents have a high rate of readmission to the hospital. We have also taken part in the pilot programme for a training package called ‘House of Memories’ which is delivered in partnership with Liverpool Museum. This incorporates an app for tablets and smartphones, which can be used by staff and by carers.

Participation in training has been lower among doctors than among nursing staff but the Dementia Matron has worked with the Consultant who leads on dementia to encourage more medical staff to take part.

The ‘This is Me’ booklet forms part of the Dementia Care Bundle – a package of measures developed in our Trust to ensure consistency and quality of care for people with dementia. Implementation of the care bundle is audited on a monthly basis and is also one of our Service Delivery Improvement Programme (SDIP) targets, for which we are funded by our commissioners. The most recent audit report, in April 2016 and covering the final quarter of the year, showed that for 100% of patients in the sample, a ‘This is Me’ booklet had been given to their carer, or contact had been made with the nursing or residential home where they were staying. However, not all the booklets had been completed, or signed by the carer. This varied from 65% in March to 97% in February.

A range of other initiatives to improve the experience of patients with dementia are underway. We launched our Dementia Strategy at the start of the year. Each ward received a copy of the strategy, and the Sister of each ward signed a pledge to put it into effect in their area. The wards are working to implement the key points of the strategy, such as a dementia friendly environment, personalised care planning, and using the FAIR assessment (Find, Assess, Investigate, Refer).

On Thursday afternoons there is a drop-in session for carers, attended by representatives from Age UK and Wired (a support network for carers in Wirral). A hairdressing salon, a kitchen and a garden have been built for dementia patients at the Arrowe Park site. We have also recruited more befriending volunteers and added more reminiscence boxes filled with keepsakes and mementos to stimulate patients.

Our work to improve dementia care has received external recognition. We won a North West regional leadership award and we were nominated for the 'Personalisation of Care' award at the Patient Experience Network's national awards ceremony, which took place in March.

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

The target for 2015/16 is:

- More than 85% of patients will report receiving appropriate assistance with eating, and more than 90% with drinking in Quarter 4. This will be a patient reported outcome measure captured by our Learning with Patients Survey.
- We will also report the following measures, which are included in our Patient Focused Audit, with a target of 85% compliance in Quarter 4: whether the patient has a drink within reach; whether the patient has a filled water jug or bottled fluids available; MUST nutritional screening completed within 24 hours of admission; MUST screening completed weekly thereafter; review of the patient by a dietician where necessary

Executive Lead: Gaynor Westray

During the year, our performance against the first target has fluctuated. However, in quarter 4, 87% of respondents to the Learning with Patients Questionnaire responded that they received help with eating if they needed it (2% better than our target), and 90% responded that they were helped with drinking if required. Although the target has not strictly been met – the requirement was for more than 90% to respond positively – this does represent a substantial improvement over the past year. By comparison, one year ago in March 2015, only 66% said that they had received assistance with eating, and 77% with drinking.

With regard to the second target, in the first half of the year, only 8 of 31 wards which were audited by the Corporate Nursing Team as part of the Patient Focused Audit met the 85% compliance target for all relevant questions in the audit. Recording of food and fluid balance were the two criteria where performance was lowest.

The Patient Focused Audit is under review, in order that it can cover a wider range of topics and form the basis of a ward accreditation scheme. As part of this, we are changing how we audit nutrition and hydration. A point prevalence (spot check) audit was carried out against some of the indicators during January. This showed that 98% of patients had a filled water jug within reach, 93% of those who had been in hospital for longer than a week had their MUST nutritional score re-calculated, and 93% of those scoring 2 or higher in their MUST assessment had been referred to a dietician. Due to the audit methodology being changed, these results are not directly comparable with those from the first two quarters, although there is some evidence of improvement.

However, the audit did not check whether the patient had been assessed using MUST within 24 hours of admission. In the past, we have audited whether the patient was assessed within 24 hours of arriving on a ward, i.e. patients had to be re-assessed after being transferred from one area of the hospital to another. Going forward, the audit will simply measure whether the patient was assessed within 24 hours of being admitted to the hospital. Although we have been able to extract data from Cerner Millennium for this indicator, we are not yet confident of the quality of the data and are working to find a more accurate way of measuring performance.

We have in place a variety of initiatives which aim to improve the mealtime experience and ensure that patients get help to consume their food and drink when they need it. These have included: flexible visiting hours to encourage family members to attend at meal times; designating a Clinical Support Worker to act as mealtime co-ordinator on each ward; nutrition boards to identify patients who need extra support; and making snack bags available for when patients have to miss a mealtime. These initiatives continue. More recently, a Ward Sister undertook a Trustwide review of the mealtime experience, making recommendations which are now being put into effect. We anticipate that these actions should result in improved performance over the year to come.

2.1.2: Safer Care Priorities:

3. Reduce harm to patients particularly in relation to newly formed pressure ulcers

The target for 2015/16 is:

- Harm free care as measured by the safety thermometer monthly will be above 95% all year
- We will aim for zero tolerance of avoidable new pressure ulcers at grade 3-4 and an 50% reduction in avoidable new grade 2 pressure ulcers compared to the 2014/15 year end position

Executive Lead: Gaynor Westray

We acknowledge that the target for pressure ulcers will not be met this year. In the first three quarters of 2015/16, there have been 11 grade 3 pressure ulcers which were found to have been avoidable when investigated, plus two which remain under investigation, compared to 10 in the whole of 2014/15.

There have been 182 grade 2 pressure ulcers during the same period; to achieve the target of a 50% reduction compared to the previous financial year, we would have needed to record no more than 110 for the year as a whole. However, despite missing the target, we have maintained a downward trend in the number of grade 2 pressure ulcers. By comparison, there were 226 of these in 2014/15, and 466 in 2013/14.

We have a number of actions in place which we expect will show results during 2016/17. We have added resource to the Tissue Viability Service using some of the funding awarded by the NHS Litigation Authority for our successful 'Sign up to Safety' bid (referred to in the 2014/15 Quality Account), by employing two new staff: a Pressure Ulcer Prevention Nurse, and a Pressure Ulcer Prevention Assistant. Their role is to: deliver training and education for staff; to monitor clinical practice (for example by checking that assessments have been completed on admission and discharge and that the right type of mattress is being used); and to visit patients with grade 1 and 2 pressure ulcers to see that they are managed effectively and that their pressure ulcers do not deteriorate to a grade 3 or 4.

We have adopted a new Standard Operating Procedure which should ensure a more consistent and thorough approach to the management of pressure ulcers. The process is set out in a simple flow chart. Patients should have a skin assessment on assessment, transfer and discharge, and this may trigger a wound assessment, depending on what is found. Each Ward Sister receives a daily list of new pressure ulcers on the ward and should review those ulcers with the staff nurse caring for the affected patient. The Ward Sister or deputy should validate each pressure ulcer; if there is any doubt regarding the grading of the ulcer the Tissue Viability Nurse should be consulted for advice. All grade 2 pressure ulcers are investigated using the 'Situation Background Assessment Recommendation' (SBAR) tool, whereas grade 3 and 4 pressure ulcers are subject to a more detailed root cause analysis investigation. Monthly management information is produced at ward and divisional level, to be discussed at local and divisional governance meetings.

A corporate policy on the prevention and management of pressure ulcers has been drafted and has been circulated to interested parties for discussion. When adopted, this should provide our staff with clearer and more detailed guidance than they have had previously. Finally, we are seeking to source funding for the purchase of more profile beds, which make it easier to reposition a patient so that pressure is not continually applied to the same part of the body for long periods.

4. Reduce the number of 'missed medication' events

The target for 2015/16 is:

- We will continue to monitor missed medications and establish the baseline for missed critical medication and then establish a reduction target for Quarter 4
- We have established a baseline appropriate care score for patients sampled. This measures the percentage of patients who received their prescribed medication or who had an appropriate reason for it not being administered, for example the patient was in the operating theatre at the time the medication was due. We will aim to have at least 75% of patients meeting this target. (baseline 59% Nov 2014 – Mar 2015)

Executive Lead: Gaynor Westray

During 2015/16, there have been several work streams to address the issues and move the Trust towards achieving the target of 3.9%. A multidisciplinary missed dose task and finish group was established in quarter 2. Initiatives completed to date are as follows;

- A medicines management housekeeper has been established in the Emergency Department and acute care clinical areas. The primary objective of this role is to ensure patients' own medicines are transferred with the patient which will have an impact on reducing missed doses on admission and a supply will not be required if unavailable on the ward.
- The critical medicines list has been updated to include the names of drugs classified as critical rather than the medicines classification e.g. anti-epileptics. Ward staff are told to bleep their pharmacist or the on call pharmacist for the drugs listed.
- Stock lists have been reviewed on all medical and surgical wards and a 'generic' stock list created to standardise medicine availability across the Trust.
- Critical medicines such as Parkinson's medicines have been added to stock lists where clinically safe and appropriate.
- 'Nursing Millennium Ambassadors' have been launched. These staff members can support other nursing staff to use the system to document missed doses correctly. The role has been established in ~ 50% of inpatient areas and is being extended across the trust. The first Wirral Millennium Ambassadors meeting took place in March 2016 and senior nursing colleagues have been requested to maximise staff engagement with this initiative.
- A 'how to' guide for nursing staff has been developed so they can view on Millennium the reason why a medicine supply request has been declined by a pharmacist.
- Millennium functionality has been improved to provide an additional drop down option for use when signing for missed doses. This option will allow documentation when it is not known whether the dose has been given by staff on the previous shift. This is intended to be used as a last resort when every effort has been made to ascertain whether the dose was given or when a patient has been transferred from a clinical area e.g. critical care, where Millennium prescribing function is not currently used to record prescribing and administration.
- The National Patient Safety Training Suite e-learning package for omitted and delayed medicines in hospitals has been added to the Essential Training Matrix for nursing staff, pharmacists and junior medical staff.

In quarter 3, it was agreed that the quarterly point prevalence would replace the monthly audit. The Pharmacy Team undertook an in-depth review of the number of inappropriately missed medication doses using the data collected in October 2015 and have now completed the quarter 4 spot check. This work will continue during 2016-17 until a sustained improvement has been observed. The purpose of the quarterly review is to provide more detailed analysis of appropriateness of missing a dose, assessed by a clinical staff member, for both critical and regular medicines.

From the quarter 3 and 4 spot check data analysis, using a sample of 5 patients on each ward on both the Clatterbridge and Arrowe park sites, 4.5 and 5.6% of all medication prescribed was inappropriately missed. Work continues to move this figure further towards the target of 3.9%. It is worth noting that this level of omissions needs to be benchmarked with levels in other Trusts to assess targets for 2016/17.

The number of critical medicines inappropriately missed, as a percentage of the total number of critical medicines prescribed was 5.2 and 3.5% respectively. Follow up indicates the correct choice of reason is not always selected in Millennium. The nursing management teams will be addressing this in the coming year.

The number of patients receiving appropriate care (ACS) was 62% (previously 65% in quarter 3), working towards the target of 75%. Further focus on this area will continue in 2016/17.

2.1.2: Clinical Effectiveness Priorities:

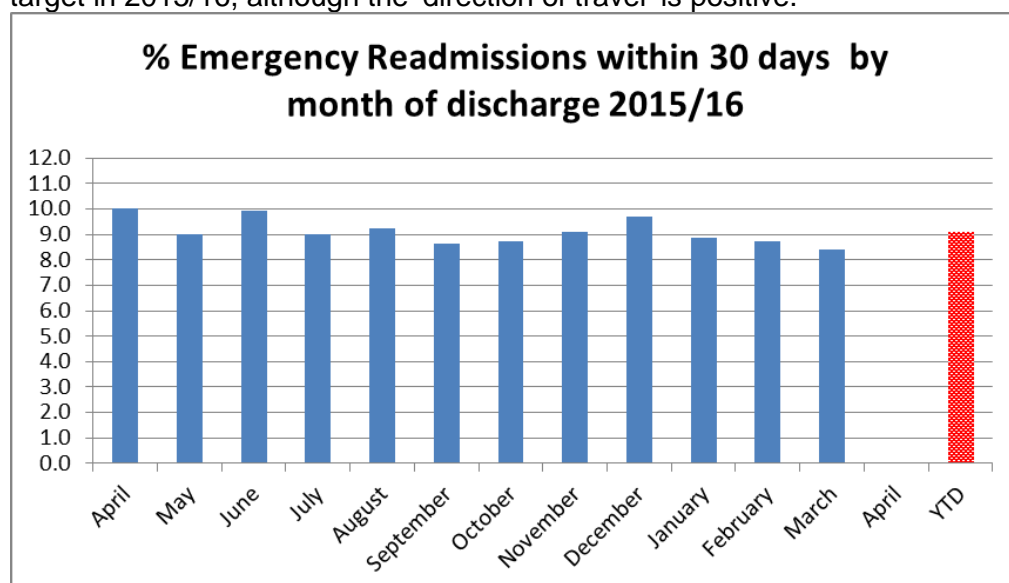
5. Reduce emergency readmissions within 30 days

The target for 2015/16 is:

- We will reduce our readmission rate by 1% during 2015/16 from the 2014/15 baseline (from 9.3% to 8.3%)
- We will reduce our avoidable readmission rate by 30% during 2015/16 from the 2014/15 baseline (from 8% to 5.3%, as measured through our monthly audit)

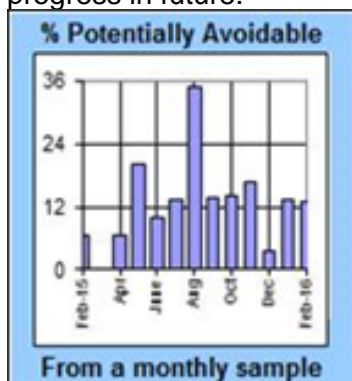
Executive Lead: Dr Evan Moore (Medical Director)

During the first half of the year, performance against the first part of the target was disappointing, although in recent months we have started to see signs of progress in reducing our readmission rate. In October and November the percentage of discharged patients readmitted within 30 days was 8.7%. It rose in December but fell back to 8.9% in January and to 8.3% in March. By contrast, the readmission rate was 10% in April 2015 and had not fallen below 9.0% until September. The percentage of emergency readmissions within 30 days is 9.11% for the year to date, which means that we have not achieved our target in 2015/16, although the 'direction of travel' is positive.



With regard to the second aspect of the target, we undertake a monthly audit of readmissions to assess whether they were avoidable. The results of the audit fluctuated considerably from month to month and so we reviewed the questionnaire which we use. It

was apparent from this review that there had been some delays in treatment but also some instances of poor data quality in the audit. This has been rectified and we are now satisfied that the audit tool is appropriate. The most recent monthly data is from February 2016 and shows that over 12% of readmissions were potentially avoidable. Thus the target will not be met for 2015/16, although we do now have a reliable baseline against which to measure progress in future.



The actions undertaken this year include:

- We undertake a monthly audit of readmissions to assess whether they were avoidable. We have recently reviewed the questionnaire which we use for this audit, after it showed an abnormally high figure of 35% for the percentage of readmissions which were considered avoidable. It was apparent from this review that there had been some delays in treatment but also some instances of poor data quality in the audit. This has been rectified and we are now satisfied that the audit tool is appropriate.
- Early intervention in the last year of life, which involves Community Geriatricians working with nursing homes to identify patients who would benefit from emergency healthcare plans and advanced directives; these ensure that patient's needs and wishes are taken into account.
- Working with local GP's and the Clinical Commissioning Group, we have developed new pathways of care for older patients, so that they can be managed in the community if appropriate, rather than being admitted or readmitted to hospital. These include a redesigned Older Person's Short Stay Unit (OPSSU) with assessment by consultants throughout the day and an Older Person's Rapid Access Clinic (OPRA) so that patients can be referred by primary care and assessed by a consultant to avoid admission.
- During the first working week of January, we took part in Safer Start January. This was a national initiative, run in partnership with the NHS Emergency Care Improvement Programme, to improve the flow of patients through hospitals during what is traditionally one of the busiest times of year for the NHS. The main outputs of this work were a reduction in the number of additional 'escalation' beds in use, fewer patients being treated as outliers (being cared for on wards that specialise in a different type of condition to that which they are being treated for), and more prompt discharges of people who were medically fit to leave. However, we also observed that the readmission rate decreased (improved) during the week after Safer Start, and that this improvement was sustained in the weeks that followed.

6. Reduce the hospital standardised mortality rate (HSMR)

The target for 2015/16 is:

- The HSMR will be lower than expected compared to the national average, with a stretch target to reduce by at least 5 points over the year from the rebased position (2014/15).

Executive Lead: Dr Evan Moore (Medical Director)

The most recent data available is from January 2016 and shows a HSMR of 89.35 (84.31 - 94.61), meaning that we continue to perform better than the national average and are within our expected range, although it will not be clear until later in the summer, after the publication of this report, whether we have achieved our target of a 5-point reduction for the whole year compared to the 2014/15 rebased position. This continues a trend of improvement which has been evident for several years and results from a range of initiatives and projects which aim to improve patient outcomes and learn lessons when things go wrong.

Another positive feature is that there is no statistically significant difference in HSMR depending on day of admission. It is considered to be 'within expected range' for all seven days of the week. In the past, there was a higher risk associated with admissions at weekends.

We monitor mortality on a quarterly basis through Dr Foster (an online benchmarking tool for health care organisations) for any diagnostic group or procedure that has a higher than expected risk of death. We have a standard operating procedure in place to gain assurance when there are alerts for particular conditions or procedures. We also undertake local mortality audits of deaths in each of the clinical divisions. The framework for these mortality reviews, which help us to identify any deaths which might have been avoidable and what lessons should be learned, has recently been reviewed and improved.

Advancing Quality (AQ), which aims to improve the diagnosis and management of conditions such as sepsis, heart failure, pneumonia and acute kidney injury, among others, is one initiative which has contributed to our improving performance. AQ has been in place in our Trust since 2008, but was relaunched in November 2015. Section 2.4.2 of this report talks about Advancing Quality in more detail. Our work on sepsis and acute kidney injury is also the subject of a 'Commissioning for Quality and Innovation' target and we report to our commissioners each quarter on our progress (see section 3.2.4 of this report).

2.2 External reviews

During the year the Trust has had a number of external reviews of its services, examples of which are set out below.

Children and Young People – National Survey

In April 2015, the Trust received its results from CQC's National Patient Survey for Children and Young People. Across the country, 19,000 patients who had been admitted during August 2014, or their parents, were surveyed. The survey covered 137 Trusts in England. Each Trust receives a report which analyses the responses from its own patients and benchmarks them against the national average.

Our results were very positive, and we were rated better than average in ten categories within the survey. The areas where we did particularly well included the following:

- Privacy and confidentiality
- Dignity and respect
- Listening to the patient
- Keeping the patient and their family informed and involved
- Information about what will happen after the patient leaves hospital
- Team work among clinical staff

Our response to this survey forms part of our routine quality monitoring – the CLIPPE (complaints, litigation, incidents and patient experience) report and action plan, and the Friends and Family Test, as well as the implementation of Trust-wide strategies such as the Quality Improvement Strategy and the Nursing and Midwifery Strategy.

Endoscopy

During the year, our Endoscopy Unit retained its Joint Advisory Group (JAG) accreditation following an external assessment. JAG is the quality standard for gastrointestinal endoscopy, with strict criteria relating to clinical requirements, waiting targets, patient experience and staff engagement.

Our Arrowe Park Endoscopy Unit is more than just a diagnostic unit, as it carries out complex therapy for patients too. The unit carries out around 300 procedures a week. In the year 2014/15 it carried out more than 15,000 procedures and based on the activity in the first three quarters of 2015/16, the unit expected the figure to be around 17,000 by year end. Colleagues ensure waiting lists are kept to a minimum with flexible working to meet demand as patients get the results of their endoscopy the very same day (unless a biopsy has been taken) and the majority of patients the unit sees each day are dealt with and sent home the very same day. In a further success for the service, the unit's clinical lead, Dr Bev Oates, was named Clinical Leader of the Year at the 2015 Health Service Journal Awards.

Investors in People

The Trust was re-accredited for another three years by 'Investors in People' in August. The IIP report identified key strengths such as a "very impressive" organisational development strategy and improved internal communication channels such as the monthly CEO Forum meeting and the 'Ask the Chief Executive' section on the intranet. The assessors observed good teamwork among different staff groups, and flexible working arrangements which helped employees maintain a positive work-life balance. Their report also highlighted innovative practice in our Integrated Library Service, and the large number of staff who had completed Institute of Leadership and Management training modules.

The report is consistent with other recent achievements by the Trust in this field. In late 2014 we were rated by City and Guilds as one of the Top 100 employers of apprentices in the UK and we won an award from the Health Service Journal for our work on staff engagement through the Listening into Action programme. We are also rated as one of the Top 10 leaders in using information technology for clinical treatment and information. All this should contribute to a well-trained, motivated workforce which delivers excellent care for patients.

2.3 Staff Engagement - Listening into Action

In 2015/16, we continued to implement Listening into Action (LiA) as a way of working, aiming to achieve a fundamental shift in 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.

Building on the success of Listening into Action, a Trust wide staff satisfaction action plan was developed to address the outcomes of the national staff survey and further embed LiA faster and deeper. This was achieved through the introduction of the 100 Day Challenge. 169 departments took part in this exercise to identify what staff were most proud of, and what needed to be done to improve staff satisfaction for them. Over 1000 improvement actions were identified and are being completed by department managers.

We used LiA methodology to support key challenges such as Winter Planning and Communications and continued LiA work streams for clinical and enabling schemes, monitored the LiA Staff Engagement Group

We also held two further 'Pass it On' events for teams to share what they have achieved. Examples of LiA Team achievements include:

- Dermatology services, standardisation of compression bandaging, psychological support, podcasts to support training

- Surgical Assessment Unit – Standard operating procedures, reduction in waiting times through classification of blood requests as urgent, closer working with radiology, improved use of trolley and triage supported by emergency consultant.
- Improved quality of appraisal to focus on values and behaviours, objectives, improved training
- 5 pathways of care for older people – electronic referral for intermediate care, simplified discharge process, early notification of assessment, named IDT representative
- Improved communications cascade through refreshed Team Brief and audit
- End of Life Care - Improved ward availability of anticipatory care drugs and redistributed clinical guidelines for their use, introduced a butterfly magnet for the last days of life, new & improved patient information, more staff and volunteer training, bid for Z beds to enable loved ones to stay with patient
- Addressing increasing demand for maternity scans - increased some ultrasound clinics to run until 7pm and made the 1st Trimester booking slot compliant with Foetal Anomaly Screening Programme standards.
- Winter planning: Additional 29 bedded winter ward (ward 27) opened, further 29 step down beds in Charlotte House, introduced 'Single Front Door' initiative to triage appropriate patients attending ED to the Walk In Centre (Approximately 11 patients per day now diverted as a result). Introduced weekend discharge team and now regularly discharge 53% more patients over the weekend (previously 60-70 now 100+ patients). Implemented the SAFER Patient Flow Bundle to improve patient flow resulting in 10%-15% improvement in patients discharge before midday. Nurse recruitment - 63 more nurses in March 2016 than in May 2015
- Improving long term outcomes for acute brain injury - Set up a Cheshire and Merseyside Acute Brain Injury Network, established funded beds for the most serious cases requiring long term rehabilitation, audited the shortfall in availability of funded therapies to speed recovery to support business case, identified neuro-psychology clinics. Now no longer on the risk register and patients transferred earlier to a specialist unit.
- Staff Guardians - Since the introduction of the Guardians on 01/05/15 to February 2016, 83 concerns have been raised and responded to. This not only widens our knowledge base and ability to monitor and plan more effectively, but highlights a more open culture. National Staff survey results 2015 have shown a 4% increase in the number of staff who know how to report concerns and 6% increase in the number of staff who would feel secure raising concerns. Staff Guardians presented to NHS Employers event in London November 2015 and feedback was extremely positive recognising our innovative approach and best practice.

This work has contributed to a significant increase in staff satisfaction, as measured by our results in the national staff survey. In the 2015 survey, which was conducted in November, our Staff Engagement Score improved from 3.48 to 3.79, bringing us in line with the national average. Highlights from the survey include the following:

- 14% more staff recommend the Trust to family and friends for care
- 17% more staff recommend the Trust to family and friends as a place to work
- 13% more staff feel that patient care is the Trusts top priority
- More staff feel supported by their managers (3.48-3.76)
- 12% more staff feel communication between senior management and staff is effective
- 7% more staff feel able to contribute towards improvements at work

Our efforts saw the Trust achieve national recognition for staff engagement as winners of the Healthcare People Management Award and the Patient Experience National Network Award, recognising excellent achievements made through Listening into Action and staff engagement culture. We are now aiming to score within the top 20% of Trusts nationally as measured in the national staff survey by 2017.

Performance against specific questions in National Staff Survey

Foundation Trusts are required by Monitor to report their performance against two specific questions in the National Staff Survey 2015:

- The percentage of staff believing that the organisation provides equal opportunities for career progression or promotion – the Trust scored 88% (the average for Acute Trusts was 87%)
- The percentage of staff who have personally experienced bullying, harassment from other staff in the last 12 months – the Trust scored 20% (the average for Acute Trusts was 26%)

2.4 Local and National Quality Indicators

2.4.1 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. Additional information is provided below.

Where there is deterioration in our position (never events, serious incident reporting, VTE risk assessment) work is in progress to improve our performance. For example, there is an action plan in theatres to address surgical never events that is being closely monitored through our governance frameworks.

We have seen a reduction in incident reporting and the rate of patient safety incidents per 100 admissions. This is in part due to our success with reducing the numbers of new pressure ulcers and falls with no or little harm, as well as the impact of introducing web based reporting. We continue to promote an incident reporting culture across the organisation and are working to ensure staff get appropriate feedback and see actions taken as a result of reporting.

Safety measures reported	2013/14	2014/15	2015/16
“Never events” that occurred in the Trust <i>These are a national list of 25 applicable incidents that should never occur (March 2010).</i>	3	5	3
Serious Incidents reported, investigated and remain serious (as of 31/03/2016)	69	114	106
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 31/03/2016)	10,005 0.2%	8,957 0.4%	9,482
National Patient Safety Agency <i>Rate of patient safety incidents (per 100 admissions) and % resulting in severe harm.</i>	11.9 <1%	9.13 <1%	<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 (<i>Dr Foster data</i>) <i>NB: Data for 2015/16 relates to April 2015 – January 2016 as this is the most recent data available.</i>	85 range (80-90)	90 (range 85-96)	89.35 (range 84.31-94.16)

Summary Hospital-Level Mortality Indicator <i>SHMI value and banding (National Information Centre data)</i> <i>NB: Data released in 2015/16 relates to April 2014 – March 2015</i>	101.4 (as expected)	96.74 (as expected)	96.9 (as expected)
% of Deaths with palliative care coding (<i>Dr Foster data</i>)	27.7%	30.3%	28.1%
% of admitted patients risk assessed for VTE	95.5%	94.1%	94%
% of admitted patients who had risk assessment for malnutrition (MUST) <i>Please note: This data refers to compliance at 7 days, and covers quarter 4 of 2015/16 only. Figures for previous years have not been included as the method of calculating performance has changed since the introduction of the Millennium patient information system, so previous statistics are not comparable.</i>	N/A	N/A	84.9%
% Emergency Readmissions within 28 days <i>(Dr Foster data – most recent data available is to the end of January)</i>	9.0%	9.2%	9.2% <i>(ten months' data – April to January)</i>
Average length of stay (days) (<i>Dr Foster data – most recent data available is to the end of January</i>)	4.5	4.5 <i>(against expected figure of 4.7)</i>	5.0% <i>(ten months' data – April to January)</i>
Patient experience measures reported			
Number of complaints received by the Trust	482	456	446
% complaints responded to within agreed timescale	69.6%	83%	80%
% patients who felt they were treated with courtesy and respect <i>(from Learning with Patients survey)</i>	95%	96%	96.5%
Responsiveness to inpatients' personal needs <i>(from National Patient Survey)</i>	67.2%	68.0%	67.9%
Staff respondents who would recommend the Trust to friends or family needing care <i>(from National Staff Survey: CQC)</i>	60%	52%	66%

Table 8 Local and National Quality Indicators

Never Events

The Trust has experienced four never events reported during the financial year 2015/16. These fell into the following categories:

- Wrong site surgery (two incidents)
- Wrong route administration of a medication
- Retained foreign object

Root cause analysis investigations were carried out on three of the never events and the investigations have shown there were lapses in the following of Trust policies and procedures. Action plans were developed and have been implemented to address the learning identified. One of the never events (wrong site surgery) occurred very close to the

end of the financial year and was recorded at the beginning of the new year. A root cause analysis is underway at the time of writing.

Serious Incidents

During the period 1st April 2015 to 31st March 2016 a total of 96 serious incidents were reported on StEIS (the Strategic Executive Information System).

A total of 106 (out of a total of 163 investigations completed within the year) of the serious incidents reported remained at a serious risk rating following investigation (moderate or severe). This is a lower number than the previous year's total of 114 and may be due to a number of reasons including a better safety culture resulting in less serious incidents overall and more robust challenge of the reports and final outcomes resulting in incidents on review being down scored based on actual harm caused. There have been improvements in the communication that takes place in relation to serious incidents and the reporting thresholds with the CCG. In April 2015 NHS England published the revised Serious Incidents Framework which provides much less guidance on what is considered to be a serious incident. In line with this the Risk Team report incidents that clearly meet the reporting thresholds but in other cases the CCG will be contacted and individual cases will be discussed and a joint agreement will then be reached on reporting on StEIS.

Root Cause Analysis investigations identify the key learning points from the incidents to try to prevent recurrence and the 'Lessons Learnt' as a result of the investigation and any opportunities for shared learning. The themes from these investigations included

- Communication
- Documentation
- Training
- Compliance with Review of SOPs in place and policies and procedures

The total number of incidents reported in 2015/16 was 12,009. This represents an increase from in the previous year (11,151 incidents). The 2015/16 figure also includes the safeguarding vulnerable adults and child incidents and referrals. These are now processed on the wider incident reporting system. However, this is a positive trend, demonstrating a positive and open reporting culture.

National Patient Safety Agency (NPSA)

The number of incidents reported to the NPSA via National Reporting and Learning System (NRLS) has increased in 2015/16, with 9,482 incidents reported from 1st April 2015 to the 31st March 2016, which was 525 more than the previous year.

In the 2014/15 report, we highlighted an issue with the management of incidents, which meant that the number of incidents reported was lower than expected that year. When incidents are reported on the web incident system, these incidents are not submitted to NRLS until a web manager's form has been completed and result in a delay in the reporting of clinical incidents to NRLS. There was an action plan in place to address this issue, with work already undertaken which has contributed to ensure timelier and effective reporting. Additionally, a more targeted programme is being developed which will also identify and implement improvements in the reporting of incidents to the NRLS.

Developments in Incident Reporting

Developments to improve the reporting of incidents, the management of RCAs and embedding the lessons learnt from incidents and investigations include:

- RCA training commenced in January 2016 for staff responsible for completing investigations
- New RCA templates have been introduced to ensure consistency and quality of reports.
- The SBAR reports have been replaced with local review reports. This has added an action plan section to the report and the Risk Team have developed a tracking

process for the actions to completion (it was acknowledged that previous SBARs did not have a monitoring facility for actions)

- Communication and information sharing via a dedicated site on the Trust intranet and through the reintroduction of a newsletter.
- Monthly reports to the Operational Management Team detailing current performance against several Quality and Safety key performance indicators
- Participation in Patient Safety Week in March 2016
- Development and introduction of the formal use of the Incident Decision Tree to aid decision making and to ensure staff are treated fairly when they are involved in serious incidents.

Mortality

Our mortality continues to improve (see section 3.1). The SHMI is reducing at a similar rate to HSMR; however, reporting lags six months behind HSMR.

Length of Stay

The most recent data available covers the ten months from April 2015 to January 2016. This shows an average length of stay of 5.0 days, which is increasing. This shows the results of initiatives aimed at reducing the number of short admissions, such as rapid access clinics and the 'single front door', as well as difficulty in arranging discharges and packages of care due to the financial and demographic challenges facing the social care system.

Complaints

The operational pressures at the Trust during 2015 placed increased pressure on complaints management, and resulted in a significant increase in both the number and complexity of complaints. Between April 2015 and November 2015 we had received 15% more complaints compared to the same period in 2014/15. However, there has been a considerable reduction in complaints since December 2015. This will be analysed in detail in the Annual Concerns and Complaints Report; however, this decrease does seem to be an indication of effective winter planning. At the end of March 2016 we had received 3% fewer complaints than for the previous year (446 compared to 461).

By the end of March 2016 the Trust had responded to 80% of complaints within the agreed timescale. To improve how we handle concerns and complaints, we conducted a Listening into Action programme on Complaints during 2015/16. The actions following this are currently being progressed, with an emphasis on resolving concerns before they become complaints, improving the efficiency of how we investigate complaints, and improving how we share learning from complaints. During 2015/16, we also implemented our Complaints Scrutiny Team which is chaired by a Non-Executive Director and comprises external stakeholders, a public governor and senior management within the Trust to review samples of complaints. This has been recognised externally as best practice.

Other Patient Experience Measures

We have shown a modest improvement in the percentage of patients responding to our Learning with Patients Questionnaire that they were treated with courtesy and respect. We have continued to implement our Nursing and Midwifery Strategy ('Modern patient focused nursing and midwifery based on traditional values'). It is based around the '6Cs' of care, compassion, competence, communication, courage and commitment. It is also likely that increased staffing numbers at the front line have contributed to this improvement, as nursing staff have more time to spend with patients.

The results of the national staff survey question about whether staff would recommend the Trust to friends or family members needing care have shown great improvement during the year. This reflects progress in boosting nurse staffing numbers and the Trust's successful efforts to improve staff engagement.

2.4.2 Advancing Quality

Advancing Quality is about ensuring consistent evidence based care in specific focus areas. The table below shows our current position based on the appropriate care score. Appropriate care scores reflect the care given to individual patients. If the score was 100% then everyone received perfect care as defined by the focus area measures. Often we find there is one intervention in the measure set we are struggling to deliver consistently, for example smoking cessation advice to smokers with pneumonia or referring patients with a heart attack to cardiac rehabilitation before they leave hospital.

April 2015 saw the introduction of new Clinical Focus Groups to Advancing Quality: Acute Kidney Injury (AKI); Chronic Obstructive Pulmonary Disease (COPD); Alcohol Related Liver Disease (ARLD); Sepsis; and Hip Fractures. (Stroke retired from Advancing Quality in April 2015, obtaining data from the national stroke database SNAP). A new COPD Case manager was appointed in March 2016 and Advancing Quality welcomed the new AKI Clinical Nurse Specialists and the Substance Misuse Team to better support their focus groups.

A relaunch took place to reinvigorate the Advancing Quality initiative trust wide in November.

New measures were introduced for Pneumonia and Heart Failure for October 2015 discharges. Although performance has maintained throughout the year, we aspire to deliver continuous improvement. Cerner Millennium is continually working with the focus groups leads to better facilitate care, in particular Sepsis and AKI.

AMI (heart attacks) will no longer be included in Advancing Quality from March 2016. As of September 2016, Heart Failure will be discontinued from Advancing Quality. There has been a change in Advancing Quality Case Managers in Pneumonia, Heart Failure and Acute Myocardial Infarction in March 2016.

Please note that the data in the table below for year 9 covers the first nine months of the year only, as the final three months' data will not be published until after this report is published in June 2016.

		Appropriate Care Score (ACS)				
		Heart Attacks	Heart Failure	Hip & Knee	Pneumonia	Stroke
Y1	Oct 08 - Sept 09	89.46%	43.97%	86.09%	47.13%	
Y2	Oct 09- March 10	97.79%	53.89%	91.87%	51.20%	
Y3	April 10 - March 11	98.23%	62.72%	94.16%	55.74%	56.43%
Y4	April 11 - March 12	99.04%	68.41%	93.92%	50.62%	72.43%
Y5	April 12- March13	97.22%	72.57%	85.66%	66.39%	86.38%
Y6	April 13 - Mar 2014	80.12%	59.57%	90.02%	69.63%	92.90%
Y7	April 14 - Dec 14	77.90%	85.90%	95.60%	69.70%	85%
Y8	April 14 - April 15	92%	70.60%	91.10%	74.80%	66.20%
Y9	April 15 - Dec 15	91.70%	N/A	94%	N/A	Withdrawn

New Measures Introduced

		Appropriate Care Score (ACS)				
			Heart Failure		Pneumonia	
Y9	April 15- Sept 15		73.00%		73.50%	
	Oct 15 - Dec 15		63.10%		60.10%	

2.4.3 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 included:

- Adopting an Infection Control Strategy which includes processes to manage multi-drug resistant organisms such as CPE and VRE, which reflects guidance from Public Health England, and is supported by specific funding approved by the Trust Board
- Recruiting to fill vacant posts in the Infection Prevention and Control Team, and implementing IT solutions which allow us to better record details regarding healthcare acquired infections and analyse trends
- Reinstating monthly audits of hand hygiene practice against the World Health Organisation's '5 Moments for Hand Hygiene' and the 'Bare below the elbows' standard – the results are still below our target of 99.9% compliance but have been steadily improving since June 2015
- Learning lessons from post-infection reviews and sharing these with staff, for example the need for thorough documentation, and not to miss screening opportunities
- Monitoring the availability of side rooms on a daily basis; and reporting on a weekly basis to the Senior Management Team about how C.diff is being managed (by prompt isolation of patients and following the 48 hour step-down rule).

Period	MRSA Bacteraemia Cases	Target	Clostridium difficile cases	Target
2010/11	5	6	120	190
2011/12	1	5	68	120
2012/13	2	0	27	50
2013/14	2	0	28	33
2014/15	4	0	28	24
2015/16	2	0	48	29

Table 9 Infection Control Maximum Targets for MRSA and Clostridium difficile cases

Whilst aiming to remain focussed in leading proactive strategies to reduce hospital acquired infection, this has been a challenging year. We have experienced two cases of MRSA, against a target of nil and 48 cases of Clostridium difficile.

It should be noted that these figures for C-Diff, which are those reported internally, are higher than those reported externally to Monitor, which are shown in the 'performance against national targets' section of this report. This is because Monitor only require us to report those cases which are clearly the result of deficient care being provided in the hospital. During the final quarter of the year, there was a 'spike' in the number of cases. This was largely due to an outbreak of Norovirus experienced during February. The 9 cases reported in February were subject to a full Post Infection Review and were found to be unavoidable.

In order to meet the challenge, we will need to take forward a number of actions including:

- Maintaining a full Hydrogen Peroxide Vapour (HPV) ward cleaning programme without interruption
- Introducing readmission screening for CPE, and delivering targeted education and training to staff in the Emergency Department (CPE is Carbapenemase Producing Enterobacteriaceae and was first identified in the Trust during 2013/14; we have experienced 101 new cases during 2015/16 of which 99 were reported as colonised cases, and 2 as clinical infection).
- Reviewing the containment strategy for VRE, to include screening within Orthopaedics
- Managing the risk of flu, by encouraging frontline staff to be vaccinated, and ensuring that staff who are likely to perform aerosol generating procedures are 'fit tested' for respirators

Period	Tolerance for 2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	1	1	0	0	0
C Difficile cases	29	4	5	2	5	3	3	5	3	6	3	9	0

Table 10: Hospital Acquired Infections reported in 2015/16

2.4.4 National Targets

The Trust's performance against the national cancer access targets has been consistently strong with all standards achieved through the year. For Referral to Treatment within 18 weeks, the Trust achieved until December 2015, from which point the growth in demand and waiting lists resulted in the minimum standard not being achieved. The target for a maximum four-hour wait in Accident and Emergency has not been achieved in any quarter of 2015-16. And the number of Clostridium Difficile cases has exceeded the maximum trajectory for the year.

National targets and regulatory requirements	Target	Q1	Q2	Q3	Q4
Referral to treatment time within 18 weeks – incomplete pathways	Min 92%	93.0%	92.1%	91.7%	90.3%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge – <i>Trust's own Emergency Department only</i>	Min 95%	83.5%	91.0%	84.1%	74.7% (83.2% for full year)
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge – <i>Trust's Emergency Department plus Walk-in Centre at Arrowe Park site</i>	Min 95%	87.6%	93.3%	88.0%	80.9%
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	Min 85%	85.0%	85.4%	85.3%	86.1%

National targets and regulatory requirements	Target	Q1	Q2	Q3	Q4
Maximum waiting time of 62 days from NHS Screening referral to treatment	Min 90%	100%	100%	91.5%	100%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer – surgery	Min 94%	94.3%	98.2%	100%	100%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment for cancer – drug treatment	Min 98%	100%	100%	100%	100%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	Min 96%	97.6%	96.2%	97.8%	97.8%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	Min 93%	94.9%	97.4%	94.6%	98.4%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all breast symptom referrals	Min 93%	97.7%	100%	100%	98.8%
Clostridium Difficile cases due to a lapse in care (cumulative)	Max 29 pa	11	22	33	35

Table 11 National targets and regulatory requirements

Referral to treatment time within 18 weeks – incomplete pathways

Ongoing achievement of the Referral to Treatment RTT standard is directly linked to demand & capacity. Both increased demand and reduced capacity in a number of services has meant that the Trust ability to meet the 92% RTT standard was challenging in Quarter 3 and 4.

The specialties that did not achieve and contributed to the Trust's overall failure continue to be General Surgery (with the failing areas in colorectal, upper gastrointestinal surgery, and vascular), Urology, Trauma & Orthopaedics and "Other" which includes numerous specialties but notably Community Paediatrics. The Trust is focussing on current practice for managing elective care against best practice guidance from the NHS Interim Management & Support Group using their elective care guide and developing an action plan for improvement. Reviews will be undertaken at specialty level to ensure full understanding of capacity and demand together with a review of reporting structures to provide assurance that there is proactive management and waiting time tracking at patient level. The Trust is also reviewing and developing its reporting and performance metrics to be able to track the impact of any changes and monitor improvement.

Access for emergency patients

Despite the range of actions being put in place, performance against the Emergency Access Standard remained below the minimum 95% for 2015/16. The Trust is working with external experts and health and social care economy partners to improve patient flow. The Trust has also established internal mechanisms to prioritise key actions to see measurable improvement within the Emergency Department. The Trust has agreed a trajectory of improvement with Commissioners and performance against this will be tracked by the Board. There are two sets of figures given for this performance indicator – the first is for the Trust's Emergency Department only, but the second also includes the Walk-in Centre which is operated by Wirral Community Trust on the Arrowe Park site.

Access to cancer care

The Trust again consistently achieved the Cancer access targets for all quarters and for all metrics across the whole of 2015/16. The continued 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 is to be commended.

Avoidable Cases of C difficile

The Trust now has a robust programme for managing and monitoring C difficile. The HPV programme has continued with the Infection Prevention and Control Team prioritising the wards at greatest risk of C.difficile acquisition.

Ongoing monitoring of side room usage, documentation and the management of patients with diarrhoea continues to ensure all mitigating actions are consistently in place to prevent C.difficile infection against a trajectory of no more than 29 cases by the end of 2016/17. The Trust has not reported an avoidable case of C difficile since the middle of January 2016.

2.4.5 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 earlier financial years. 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 with a clear reduction over time reflecting the ongoing work to reduce mortality described earlier:

	October 2013 – September 2014				October 2014 – September 2015			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
SHMI	1.0	0.967 (as expected)	0.57	1.19	1.0	0.988 (as expected)	0.65	1.17
% Deaths coded for palliative care	25.4%	30.3%	0%	49.4%	26.7%	29.5%	0.2%	53.5%

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 coding for co-morbidities and palliative care was not reflecting the population; this has now been rectified following a review of the clinical coding process, and the difference between our percentage and the national average has reduced somewhat.

The Trust has taken the following actions to improve this percentage, and so the quality of its services: Advancing Quality, and our mortality reviews of the records of patients who have died in the hospital. This work is described in more detail 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.

	April 2014 - March 2015				April 2015 – September 2015			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Groin Hernia Surgery	0.084	0.029	-1.940	0.154	0.088	*	0	0.135
Hip replacement surgery	0.437	0.395	0.330	0.523	0.454	0.399	0.359	0.514
Knee replacement surgery	0.315	0.330	0.204	0.418	0.334	*	0.207	0.412
Varicose Vein Surgery	0.095	*	-0.001	0.154	0.104	*	0.037	0.129

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

Table 12 – PROMS indicator

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. Our response rates have traditionally been low and this has affected the figures that have been reported.

The Trust has taken the following actions to improve this percentage, and so the quality of its services: the introduction last year of the compulsory joint school / pre-operative assessment for all hip and knee arthroplasty patients has ensured we explain the needs for PROM's studies and enrol patients into the PROM's programme. This has produced a considerable increase in the completion rates of both Q1 (pre-operative) and Q2 (post-operative) questionnaires.

We are continuing to monitor the hip outcomes and working with the Health and Social Care Information Centre to look at individual surgeon scores and pre-operative score variation which can skew the outcome.

It must also be noted that the most sensitive of the outcome measures (Oxford Hip & Knee Scores) variation from the national mean is below the minimal clinical important difference (MCID) so although we are a both positive and negative outliers on an individual basis the score is not clinically significant enough to be clinically detectable on an individual basis; however we shall continue to observe our hip scores over the next 12 months.

Readmissions within 28 days

	April 2013 – March 2014				April 2014 – March 2015			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
0 to 15								
16 or over								

*Data not available from Health and Social Care Information Centre – latest data is 2011/12 which has been reported in the 2013/14 Quality Account.

Table 13 – Readmissions within 28 days indicator

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 most recent data available from the Health and Social Care Information Centre is from the year ended 31st March 2012. The next instalment of data is not due until August 2016.

The Trust has taken the following actions to improve this percentage, and so the quality of its services: readmissions has been a priority area in the Quality Account both this year and last year, and has been carried forward to 2016/17. The section of this report which reviews performance against our six priorities provides information about the measures which we have taken and which are still underway.

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 2014 survey showed little change, with our Trust remaining slightly below the national average.

	April 2013 – March 2014				April 2014 – March 2015			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Responsiveness to personal needs (indicator value)	68.7	68	54.4	84.2	68.9	67.9	59.1	86.1

Table 14 – Responsiveness to personal needs of patients

The Trust considers that this data is as described for the following reason – this data is historic; our hospitals experienced considerable operational pressure during the year to which it refers (2014/15), and ensuring consistent levels of nurse staffing was a major challenge.

The Trust has taken actions to improve this score, and so the quality of its services, through an increase in the nursing establishment and recruitment to vacant posts; our vacancy level at the end of 2015/16 was 5.5%, which is approximately half the national average. We are continuing to implement our Nursing and Midwifery Strategy, which is based upon the 6 C's (care, compassion, competence, communication, courage and commitment) and is displayed in summary form on every ward. Matrons undertake regular rounds to check the standard of care on wards within their spheres of responsibility; Corporate Nursing undertake a patient-focused audit; and we have developed a programme of Care Quality Inspections based on the Care Quality Commission's criteria of caring, effective, responsive, safe and well-led.

Recommend the Trust to Family and Friends

	Staff Survey 2014				Staff Survey 2015			
	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	52	20	93	67	66	46	85

Table 14 – Recommending the Trust to family and friends

The Trust considers that this rate is as described for the following reason – the Trust's staff survey results in 2014 had been particularly poor, showing the effect of a difficult year for the Trust and major organisational change. Although our results in the most recent survey (2015) are very slightly below the national average, they represent a significant improvement compared to the year before.

The Trust has taken actions to improve this score, and so the quality of its services, by prioritising staff engagement. As well as the Listening into Action programme, which is described in a specific section of this report, we have taken actions to improve internal communications, such as changing the format of the 'CEO Forum' briefing for managers and

staff, and including a 'Teams and Leaders in the Spotlight' feature in the weekly email newsletter. We have done more to recognise the efforts of staff who do a good job, e.g. recognition for those who achieve 100% attendance, and revamping the annual staff awards ceremony, now known as the PROUD Awards. We have adopted a Staff Charter of rights and responsibilities, and also delivered initiatives to promote health and wellbeing among staff.

VTE assessment – Based on acute trusts

The Trust continues to perform slightly lower than the national average, and there is a slight downward trend in performance.

	Quarter 3 2014/15				Quarter 4 2014/15			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
Compliance (%)	96	93.22	81.19	100	96	94	79	100

Table 16 VTE assessment – based on acute trusts

The Trust considers that this percentage is as described for the following reason – our performance is broadly consistent, has improved slightly, and although falling short of the target, reflects the considerable effort which has been put into raising awareness of how to prevent and manage this disease. Our electronic patient record alerts doctors of the need to assess individual patients in a different way to its predecessor.

The Trust has taken actions to improve this score, and so the quality of its services, by continuing to implement the corporate policy for the prevention and management of VTE disease and delivering a training package to staff, both of which were reviewed and updated during 2014/15 (the period covered by the data above). The Trust's Clinical Audit Team undertake a monthly audit of the measures in place to prevent and manage VTE and feedback is provided to areas which have not met the standard.

C.difficile rates

The Trust has seen an increase in its C-Difficile infection rate, although our performance remains better than the national average:

	April 2013 – March 2014				April 2014 – March 2015			
	National Average	WUTH	Low	High	National Average	WUTH	Low	High
C.difficile (rate per 100,000 bed days)	14.7	11.3	0	37.1	15.1	10.9	0	62.2

Table 17 C.difficile rates

The Trust considers that this rate is as described for the following reason: the data is historic; post infection reviews have identified a number of contributory factors which we have sought to eliminate with the actions mentioned below.

The Trust has taken actions to improve this score, and so the quality of its services, by undertaking post infection reviews, continuing to promote good hand hygiene practice, effective use of isolation, and decontamination through the hydrogen peroxide vapour programme. During the year, we have also increased staffing levels in the Infection Prevention and Control Team.

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 2014 – September 2014				October 2014 – March 2015			
	National Average	WUTH No. Rate	Low	High	National Average	WUTH No. Rate	Low	High
Patient Safety Incidents	4,196	5,292 45.6	35	12,020	4,539	3,917 32.6	443	12,784
	The Trust reported 17 incidents that resulted in severe harm or death				The Trust reported 14 incidents that resulted in severe harm or death			

Table 18 Patient Safety Incidents Reported, based on large acute trusts

The Trust considers that this rate is as described for the following reason – The Trust continues to have higher than average levels of incident reporting. This is associated with low levels of harm and NPSA consider this to be a sign of an open culture. Whilst the national picture is of decreased reporting between the periods, the Trust has increased reporting during 2015/16. We actively encourage our staff to report incidents and the reduction in incident reporting seen with the move to web based reporting lead us to increase the education that might reflect the upturn. However, the majority of incidents reported are low or no harm, allowing us to examine trends and put processes in place to reduce the risk to future patients.

Also, this data is historic, and during 2015/16 we have seen an increase in levels of incident reporting. In 2015/16, the number of incidents reported was 7.7% higher than for 2014/15.

The Trust has taken actions to improve this score, and so the quality of its services, by educating staff about the importance of reporting incidents – during the year we substantially revised the training presentation which is delivered to new staff at their corporate induction, and to existing staff at their mandatory refresher training. We have also introduced a new training programme on serious incident investigation for more senior staff. During the year our new Risk Management Strategy – which was in draft at the time of last year’s edition of this report – was adopted and implemented. We also circulated a staff newsletter about how to report risks and incidents.

Other indicators

The national indicators relating to mental health services are not relevant to the services provided by this Trust and therefore are not included in this report.

Part 3: Priorities for Improvement and Statements of Assurance

Part 3.1: Looking forward to 2016/17; 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 and 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 2016/17 to support making that vision a reality.

3.1.1 Our priorities for improvement in 2015/16 are:

We intend to maintain most of the same priorities which we have been working towards in 2015/16. Over the past twelve months a great deal of work has been done to improve performance in the six selected areas. However, we are not yet consistently achieving the targets which we set, and the work which we are doing will take more time to bear fruit. In the past, we have always retained priorities in the Quality Account until the targets have been achieved, and we are continuing with this approach.

We propose to maintain four of the six priorities (nutrition and hydration; pressure ulcers; medication missed doses; and readmissions). Two priorities – mortality and dementia care – have been discontinued, to make way for new priority topics (implementation of the SAFER bundle for improved patient flow and safe discharge; and end of life care). We have performed strongly compared to the national average for mortality for several years now, and although we did not achieve our two targets for dementia care in full, we have made solid progress.

Therefore, in 2016/17 the priorities are:

Patient Experience

1 Implement the SAFER bundle to improve patient flow and ensure safe discharges

Rationale: the Trust has found it difficult to ensure that patient flow through the hospital is smooth, with the effect that people may remain in hospital even though they are medically fit to be discharged and are keen to return home. This has also resulted in delays for people entering the hospital through the Emergency Department; we have not achieved the four-hour Accident and Emergency target during 2015/16.

We are implementing the SAFER bundle, starting with selected wards which have introduced it as a pilot project. This is a national initiative and includes the following elements:

- S – Senior review. All patients should be reviewed by a senior clinician before midday. A board round takes place before 10am to prioritise which patients to see on the ward round, poorly patients then patients to be discharged and then others.
- A – Assessment. All patients will have a Targeted Date of Discharge (TDD) set and reviewed daily on the board round.
- F – Flow from assessment units. We aim for wards to start 'pulling' assessment patients to their empty beds by 10.00am, so that patients in ED can be transferred to assessment areas as early as possible.
- E – Early discharge. We aim to discharge 33% of patients from base wards before noon. Completing TTHs the day before supports this.

- R – Review. A weekly review of all patients with a length of stay of 7 days or more takes place with staff from the Integrated Discharge Team, social services and community trust.

Target: We will aim for 25% of all medical discharges from base wards to be before noon, against a baseline of 17.7% in January 2016. We will aim to improve compliance within specialty care ('right patient right bed') so that no more than 10% of patients are admitted to the 'wrong' bed, against a baseline of 16% in February 2016.

Lead: *Mrs G Westray, 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: 85% of patients will report receiving appropriate assistance with eating, and 90% with drinking. By quarter 4, where appropriate, patients' nutritional and fluid input will be recorded within their electronic record of care.

Lead: *Mrs G Westray, Director of Nursing and Midwifery*

Safety Priority

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 as we have progress still to make. The key harm is pressure ulcers and therefore we will continue to focus on this and reduce new pressure ulcers further.

Targets: We will aim for zero tolerance of avoidable hospital-acquired pressure ulcers at grades 3 and 4, and a 50% reduction in avoidable hospital-acquired grade 2 pressure ulcers, compared to the 2015/16 year end position.

Lead: *Mrs G Westray, Director of Nursing and Midwifery*

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: Our draft Quality Improvement Strategy aims for fewer than 2% of critical medications to be missed by 2019. In 2016/17 we will aim for no more than 3% of critical medication doses to be missed, and an appropriate care score of 70%.

Lead: *Mrs G Westray, Director of Nursing and Midwifery*

Clinical Effectiveness Priority

1 Improving End of Life Care

Rationale: Across the country, there is evidence of huge variation in the quality of end of life care that people receive, both across services, geographically and between different groups of people. At national level, five new Priorities for Care have now replaced the Liverpool Care Pathway (LCP) as the new basis for caring for someone at the end of their life. The new approach recognises that in many cases, enabling the individual to plan for death should start well before a person reaches the end of their life.

Since 2014, the Care Quality Commission have regulated end of life care as one of the eight core services which they inspect at every planned inspection. In our Trust's inspection, end of life care was rated as 'requires improvement' overall, and 'inadequate' for the well-led standard. The Trust adopted an End of Life Care Strategy during the year, which is now starting to be implemented. A new Clinical Lead at Consultant level is in post, as well as a Nurse Facilitator who is educating nursing staff. It is essential that we implement the strategy make the improvements that are needed. Including this as a priority in the Quality Account will ensure that it is monitored regularly and that our external stakeholders are kept informed of our progress.

Targets: We will re-launch the Palliative and End of Life Care Team to ensure Trust-wide awareness of referral criteria and processes (including how to access services out of hours). We will add 'Care in the Last Days of Life' to corporate induction for all new staff, to 75% of existing nurses and clinical support workers in the Acute and Medical Division, and to 75% of doctors in training Trust-wide. We will roll out the 'Record of Care for Patients in the Last Days of Life'. We will increase the staffing resource allocated to Specialist Palliative Care.

Lead: Mrs G Westray, Director of Nursing and Midwifery

2 Reduce emergency readmissions within 30 days

Rationale: Returning to the hospital for unplanned care is a measure of failure of the healthcare system; not just secondary care. Quality issues that can underpinning 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 among 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: In 2016/17 we will aim to achieve a 1% reduction on overall readmissions compared to 2015/16, with no more than 10% readmissions being potentially avoidable.

Lead: Dr E Moore, Medical Director

3.1.2 Monitoring of our Priorities for 2016/17

We will continue to provide a quarterly report on progress with our priorities to the Board of Directors and internal committees such as the Clinical Governance Group; progress is shared with the governors biannually by means of a presentation. The quarterly reports on progress are available to our local commissioners, Wirral Healthwatch, Wirral Borough Council Overview and Scrutiny Committee via the Families and Wellbeing Policy and Performance 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.

3.1.3 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 3.2 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:

3.2.1 Service reviews

During 2015/16, the Trust provided and/or subcontracted 68 relevant health services (see Appendix 1). The Trust has reviewed the data available to it on the quality of care in all of the relevant health services. The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by the Trust for the year. 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 Board); 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.

3.2.2 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 2015/16, the Trust took part in 33 national clinical audits and five national confidential enquiries covering relevant health services that the Trust provides.

During 2015/16, the Trust participated in 97% (33/34) of national clinical audits and 100% national confidential enquiries that we were eligible to participate in. In 2014/15, we participated in 93% of relevant national audits.

The national clinical audits which the Trust was eligible to participate in during 2015/16, for which data collection was completed during 2015/16 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 from 17 national audits of which 1 has not yet completed the review process. The remainder have been discussed and action plans are either in place or development.

Examples of actions taken in response to our results in national audits include:

- Falls and Fragility Fractures Audit Programme (FFFP) – we are producing clearer guidance on medicines and falls in hospital for junior doctors; improving falls risk assessments; and ensuring that patients who need walking aids have access to the most suitable walking aid from the time of admission.
- Rheumatoid and Inflammatory Arthritis – working with colleagues in primary care so that patients are referred to our service more quickly; initiating treatment more promptly following referral; providing more education to patients about their condition and agreeing targets for their treatment with them.
- Chronic Obstructive Pulmonary Disease – educating patients about their condition; improving referral to pulmonary rehabilitation services.

There were five national confidential enquiries which the Trust was eligible to participate in during 2015/16, all of which we actually participated in (see table 1 below).

National Confidential Enquiries Title	Case Requirement	Cases Audited
NCEPOD – Acute Pancreatitis	100%	4/4
NCEPOD – Care of patients with mental health problems in Acute Trusts	100%	5/5
NCEPOD – Gastrointestinal Haemorrhage	100%	5/6
NCEPOD - Sepsis	100%	3/4
Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRRACE-UK)	100%	26/26

Table 19 - National Confidential Enquiries

The report of two national confidential enquiries were received by the Trust during the year – the first was *Time to Get Control*, which dealt with the subject of gastrointestinal haemorrhage. We undertook a gap analysis, comparing our practice against the recommendations of the report.

As a result, we are revising our clinical pathway for gastrointestinal bleeds. We will also be undertaking an audit to assess how promptly patients with a GI bleed and haemodynamic instability can access an operating theatre. Some actions have already been completed, including making sure that patients have a clearly documented re-bleed plan and that endoscopy equipment and nursing support are comparable in all locations where endoscopy is performed.

The second report received was Just Say Sepsis – we have recently reviewed this report. An action plan has been drafted and will be discussed and approved by the Sepsis Steering Group.

In December 2015, the national report *Surveillance of Maternal deaths in the UK 2011-13 and lessons learnt to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13* was published. At the time of writing the Trust is reviewing its own practice against this report and completing a gap analysis.

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 220 local clinical audits were reviewed by the Trust in 2015/16. The following are examples of action which we have taken, or intend to take, to improve the quality of healthcare provided, resulting from audits which have been completed in the year:

- Establishing a nurse-led clinic for patients of the head and neck service, so that patients can spend time with the Clinical Nurse Specialist to discuss their needs, such as financial support and a better understanding of their treatment options
- Publishing a new clinical pathway for the treatment of patients suffering from delirium, to meet the requirements of NICE guidance
- Improving referrals for cardiac rehabilitation and smoking cessation services
- Developing and implementing a discharge medication checklist for Acute Coronary Syndrome patients and educating nurses and junior doctors on its use

3.2.3 Participation in Clinical Research

In 2015/16, 409 patients receiving NHS services provided or sub-contracted by the Trust were recruited to participate in research approved by a research ethics committee. This 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 National Institute for Health Research (NIHR) is divided into 15 Local Clinical Research Networks (CRN). The Trust is a member of North West Coast (NWC) CRN which is hosted by Royal Liverpool and Broadgreen University Hospital NHS Trust. The NIHR NWC CRN allocates funding to the Trust to support NIHR adopted studies.

Research within the Trust is supported by a small administrative team (2.4 WTE) and 12 Research Nurses (8.3 WTE). The Trust's Research Strategy states that the Trust aims to increase and improve research and development activity within the Trust by embedding research into everyday practice. 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.

The research portfolio continues to be clinically diverse including: cancer, cardiovascular, dermatology, emergency care, dementia, gastroenterology, haematology, paediatric, reproductive health, respiratory, rheumatology and stroke studies.

Since 2012 the Trust has achieved the national key performance indicator for granting NHS permission (R&D approval) to all new studies within the 30 day target; 2 years ago this target was reduced to 15 days and the Trust is still achieving this target.

During 2015/16 the Trust approved 35 studies adopted onto the NIHR portfolio and 16 studies not on the NIHR portfolio.

The Trust is a member of the NIHR Collaboration for Leadership in Applied Health Research & Care (CLAHRC) North West Coast (NWC). The CLAHRC NWC is a joint project run by programme partners: Liverpool Clinical Commissioning Group, The University of Liverpool, Lancaster University and University of Central Lancashire. The Trust is working with the CLAHRC to deliver programmes aimed at tackling health inequalities.

Between April 2015 and March 2016, 58 new articles written by WUTH staff, published in professional journals were identified (as listed on PubMed, Medline and EMBASE). New publications are recorded and disseminated across the organisation in order to share new knowledge. 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.

3.2.4 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 2015/16 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 2015/16 were developed by Wirral Clinical Commissioning Group and NHS England and agreed with the Trust. They reflect areas of desired improvement identified nationally and locally. The table below summarises progress against our CQUIN targets and Service Delivery Improvement Priorities. The final year end position has not yet been agreed with commissioners and the information below is based on what we have reported to them regarding our progress. Further details of the agreed goals for 2015/16 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 2015/16	Current position
<p>1. Acute Kidney Injury For patients with acute kidney injury treated in hospital, their discharge summary should include the following information: stage of AKI; evidence of medicines review having been done; type of blood tests required on discharge; frequency of blood tests required for monitoring after discharge. This will be measured by a local audit, with a target of 90% by quarter 4.</p>	<p><i>On track to achieve</i> The results of the audit have been consistently above our target in the first three quarters, although the results for the questions regarding type and frequency of blood tests have been more variable.</p>
<p>2. Sepsis Patients admitted to the emergency department and who meet the criteria should be screened for sepsis in accordance with the Trust's own sepsis protocol. Patients with severe sepsis, red flag sepsis or septic shock should receive intravenous antibiotics within 24 hours of prescribing. Target of 90% by quarter 4 for sepsis screening.</p>	<p><i>Not achieved</i> The results of our audit show that we have exceeded our target for the first three quarters of the year, but we fell short in quarter 4, achieving only 84.5% for screening and 49.5% for administration of antibiotics.</p>
<p>3. Dementia and Delirium Patients aged over 75 years who are identified as potentially having dementia or delirium following an episode of unplanned or emergency care should be appropriately assessed, and have a written care plan which should be shared with their GP on discharge. Appropriate dementia training should be available to all staff who need it. Carers of people with dementia and delirium should feel adequately supported.</p>	<p><i>On track to achieve</i> At the end of quarter 4, we were achieving our target. Over 2000 staff have been trained, although we are seeking to increase participation by doctors. The response rates to our carers' audit have been quite low but we are working to improve this by spending more time with carers to gather feedback.</p>
<p>4. Avoidable Emergency Admissions The Trust should work with commissioners and with Wirral Community Trust to reduce rates of avoidable admission to urgent care</p>	<p><i>On track to achieve</i> The Trust opened a 'single front door' in December 2015 – a single reception and triage area directing patients either to the All Day Health Centre or the Emergency Department, depending on their needs. In the first three weeks of operation, it directed 15% of patients away from ED.</p>
<p>5. Patients with Mental Health Needs in A&E (improving diagnoses and re-attendance rates) The Trust should improve recording of diagnoses in the Accident and Emergency HES data set, so that the proportion of records with valid codes is at least 85%.</p>	<p><i>On track to achieve</i> Significant progress has been made and we have agreed proposals with Cheshire and Wirral Partnership (our local mental health trust) which are, in some respects, more demanding than the national CQUIN target. In March 2016 we achieved 87.3% compliance.</p>
<p>6. Implementation of the Cultural Barometer The Trust should implement its action plan in response to the 'Cultural Barometer' survey of a sample of staff which was undertaken in early 2015.</p>	<p><i>On track to achieve</i> The action plan is progressing well. Actions taken so far include organising Schwartz Rounds, and providing 360 degree feedback to Directors. A review of governance is being performed by external consultants.</p>
<p>7. Seven Day Working All Trusts providing acute hospital services should implement at least five of the ten clinical standards for seven-day services.</p>	<p><i>On track to achieve</i> The Trust is focusing on these five standards: Multi Disciplinary Team review; shift handover; diagnostics; consultant directed interventions; and transfer to community / primary / social care.</p>

Indicator for 2015/16	Current position
<p>8. Liaison Psychiatry for Acute Trusts All acute hospital Trusts should have a liaison psychiatry service for all ages, appropriate to the size, acuity and specialty of the hospital, in accordance with the national guidance (<i>the Forward View into Action</i>).</p>	<p><i>On track to achieve</i> The Trust has had a liaison psychiatry service for many years. We meet regularly with Cheshire and Wirral Partnership, who provide the service, at Crisis Concordat and Section 136 interface meetings. Estates work is planned, to provide a base for the team in the Emergency Department.</p>
<p>9. Community Opinion and Assessment The Trust should redesign pathways, including criteria and diagnostics for specific conditions, working with other stakeholders in the local health economy.</p>	<p><i>On track to achieve</i> The Trust is working with colleagues from Wirral Community Trust and the Clinical Commissioning Group to design a new model for respiratory services in Wirral. Individuals are leading on the different elements of the project. The resource requirements (premises, personnel etc.) have been identified.</p>
<p>10. Wirral Crisis Concordat Action Plan The Trust should complete the actions which have been allocated in this action plan. These include: reviewing unplanned urgent care pathways to ensure 24/7 access to services and pathways for young people under 16 years of age; establishing multi-agency meetings with Police, Ambulance Service and the local authority; reviewing access to interpreters; reviewing arrangements for information sharing; and improving the information provided to patients and carers.</p>	<p><i>On track to achieve</i> Good progress has been made with the crisis care concordat action plans.</p>
<p>11. Cancer – Oral Formulation of Anti-Cancer Therapy The Trust should improve the quality of data used to measure outcomes, improve prescribing practice and increase the cost efficiency of oral chemotherapy.</p>	<p><i>Achieved</i> We provided a compliance report against NHS England's policy. This demonstrated that there was no waste. This CQUIN target was therefore discontinued.</p>
<p>12. Neonatal Critical Care The Trust should reduce clinical variation and ensure data completeness (target >90%) for specific questions in the NNAP national audit of neonatal care.</p>	<p><i>On track to achieve</i> We have consistently achieved 90% compliance or higher for each of the selected questions in all four quarters of the year.</p>
<p>13. Neonatal Unit Admissions The Trust should reduce separation of mothers and babies and reduce demand for neonatal services by improving how it learns from avoidable term admissions (≥37 weeks), by means of a full clinical review within one month of the baby's admission.</p>	<p><i>On track to achieve</i> All terms have had multidisciplinary review. These are done on a weekly basis and the results are fed back to the divisional perinatal morbidity and mortality meeting each month.</p>
<p>14. Dental Coding The Trust should build on the ground work following the introduction and implementation in 2014/15 of the single operating model for the allocation of codes for dental surgery.</p>	<p><i>On track to achieve</i> The Trust has commissioned a company to undertake audits and has also appointed a trainee auditor.</p>

Indicator for 2015/16	Current position
<p>15. Dental – Clinical Supervision The Trust must prepare for the requirement for Specialists / Consultant job descriptions to be altered to reflect participation in local managed clinical networks or to provide clinical supervision of Primary Care Specialist delivery.</p>	<p><i>On track to achieve</i> Consultants have been nominated to lead on this work and an audit is planned.</p>
<p>16. Public Health - Local The Trust should focus on improving coverage in specified groups that have lower coverage than other groups for specific services. The services selected are digital retinopathy and breast screening.</p>	<p><i>On track to achieve</i> The Trust is reporting full achievement of this target at the end of the financial year.</p>
<p>17. Prior Approval Scheme – using Blueteq This covers the following service areas</p> <ul style="list-style-type: none"> • Multiple Sclerosis • Hepatitis C • Chemo (linked with CDF) 	<p>It has been difficult to make progress with some aspects of this target and we have met with the commissioners to discuss how progress can be accelerated.</p>
<p>18. Chemotherapy Derogation Plan The Trust should ensure that it complies with peer review measures for Chemotherapy and systemic anti-cancer therapy, and also with peer review measures for the Acute Oncology Service. It should also work to deliver e-prescribing of chemotherapy/systemic anti-cancer therapy.</p>	<p><i>On track to achieve</i> Project plans are in place and being delivered for the three aspects of this target.</p>

Table 20: 2015/16 CQUINs

The amount of income in 2015/16 conditional on achieving quality improvement and innovation goals was £5.35million subject to the final year income for 2015/16. For the year 2014/15, the total associated payment was £5,155,436.

NHS England's national CQUIN guidance for 2016/17 includes these five priorities:

- NHS staff health and wellbeing;
- Identification and early treatment of Sepsis;
- Improving the physical health for patients with severe mental illness (PSMI);
- Cancer 62 day waits; and
- Antimicrobial resistance.

At this stage we have not yet agreed local CQUINs with the Clinical Commissioning Group.

3.2.5 Care Quality Commission Registration and Reviews

The Trust is required to be registered with the CQC, and is currently registered without any conditions on its registration. The Care Quality Commission has not taken any enforcement action against the Trust during the year. The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust was inspected twice during the year by the CQC. The first inspection was an unannounced overnight visit during May 2015. The inspectors visited our Medical and Surgical Assessment Units, the Theatre Recovery area, Ward 25 (contingency) and Ward 38 (a respiratory ward).

The report from that inspection concluded that we require improvement and instructed us to ensure safe staffing levels, to ensure the suitability of areas used for escalation at times of high demand, and to ensure that systems to ensure the safety of patients – such as MEWS observations to detect deterioration in their condition – were applied consistently. In

response, we reviewed our Escalation Plan and the Theatre Recovery area is no longer used for escalation. The opening of escalation wards is subject to a risk assessment and must be approved by the Director of Nursing or her deputy. This complements existing initiatives such as the recruitment of additional nurses (including from overseas) and the use of the E-Rostering system to manage staffing levels.

The second inspection was a full-scale inspection of all the Trust's services, of which we were given advance notice. This took place during the second week of September 2015. The Trust achieved an overall rating of 'requires improvement', which broadly reflected our own self-assessment of our performance. We were also scored against five key questions:

Are the Trust's services safe?	Requires improvement
Are the Trust's services responsive ?	Requires improvement
Are the Trust's services caring ?	Good
Are the Trust's services effective ?	Good
Are the Trust's services well-led ?	Requires improvement

CQC also rate each of the Trust's core services, of which there are eight. Surgery was rated as 'good' while the other services were rated as requiring improvement: children and young peoples' services; end of life care; maternity and gynaecology; medical services (including care of the elderly); emergency and urgent care; and critical care.

CQC observed a number of positive features which are noted in their report. Levels of nurse staffing had improved since their unannounced visit earlier in the year. There was substantial evidence of progress being made with staff engagement, which had previously been a major issue for the Trust. Members of staff could articulate the Trust's vision and values; they were proud to work here and their morale was improving. The inspectors commented favourably about the caring and compassionate manner of clinical staff and the report stated that, "we found that staff often went the extra mile to support and comfort bereaved relatives". Some examples of outstanding good practice are highlighted in the stroke service, which has performed very well in national audits and benchmarking initiatives. Also, the report mentions innovative work which was being done in the Surgical Assessment Unit to improve how we monitor patients' fluid balance to ensure they are well hydrated.

The report is very detailed and includes many recommendations covering all services and both our sites, so we do not list them all here. However, there are a number of key themes. We need to improve care for patients at the end of life by implementing the End of Life Care Strategy which we adopted in 2015, and ensuring that there are sufficient staffing resources (in particular, Specialist Palliative Care Consultants). We must ensure that reporting of risks and incidents, and learning from them, is consistent across the organisation. To be more responsive to patients' needs, we must improve patient flow through the hospital; the report mentions that national targets such as the maximum four-hour waiting time in the Emergency Department are not being met; discharges are sometimes delayed; and ambulance assessment times can be longer than they should be. Also, although CQC were happy that we had made good progress in addressing their earlier concerns about staffing levels and the physical environment of our buildings, they recommended that we look again at the level of medical cover on the Clatterbridge site, and pointed out some environmental improvements that are needed.

We have developed an action plan covering all the 'must do' and 'should do' issues highlighted by CQC in their report and have already implemented many actions. Where necessary, additional financial and human resources will be made available to deliver this plan in full. The Trust's Senior Management Team reviewed the progress of the plan in May 2016. The plan includes a total of 82 actions, of which 51 were due to be completed by the start of May (the remainder are longer-term actions which are not due until later in the year, or early in 2017). Of the 51 relevant actions, 43 had been completed in full. Eight actions were still underway. Progress was being made with each of these, which are now expected to be completed by late May, or June at the latest.

In the run up to the planned inspection, we organised our own programme of mock inspections, which were carried out by a cross-section of our own Trust staff, as well as volunteers from Health Watch Wirral and the League of Friends. The inspection teams visited every ward and clinical department in the Trust. These Care Quality Inspections were an effective tool for service improvement and we are continuing them during 2016, with an updated set of questionnaires. These will be a permanent feature of our quality improvement system, not just a means of preparing for external inspections.

3.2.6 Data Quality

The Trust submitted records during 2015/16 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 21 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'. The figures for 2015/16 are based on data covering the ten months to the end of January 2016 as this is the most recent data available at the time of writing; the year end position will not be known until after the final version of this report is published.

NHS Coverage	2012/13	2013/14	2014/15	2015/16
<i>Admitted patient care</i>	99.2	99.6	99.7	99.7
<i>Outpatients</i>	99.5	99.8	99.8	99.9
<i>AandE</i>	98.7	98.8	98.9	99.1
GP Registration				
<i>Admitted patient care</i>	99.9	100	100	100
<i>Outpatients</i>	100	100	100	100
<i>AandE</i>	100	99.9	99.9	99.9

Table 21 - 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 2016/17:

- During their Trust induction, issuing all new starters a "Data Quality – Best Practice Guidelines" booklet, placing Data Quality right at the forefront of colleagues' thinking
- Increasing visibility/awareness of the Data Quality Team and the functions the team carries out
- Further development of the "Data Quality" webpages on the staff facing website, providing a concise reference point for Data Quality related information and guidance
- Continued reinforcement of the patient demographics checking process, with a particular focus on rolling out Summary Care Records access (for checking patient demographics against the National Spine) to high-throughput areas such as A&E and Bed Management
- Production of division specific Data Quality summaries to accompany the monthly Data Quality Reports circulated to divisional managers, focusing on any trends or anomalies that may highlight a data quality issue/process issue within division and require remedial action(s)

3.2.7 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 Group ensures the Trust maintains compliance with relevant Information Governance legislation and good practice.

The Trust Information Governance assessment report overall score for 2015/16 was 76%. This is an improvement of 2% compared to last year's score. Together with the percentage score, Trusts obtain a Textual 'Score', either Satisfactory which means level 2 attainment or above has been achieved on all requirements, or Not Satisfactory where level 2 or above has not been achieved on all requirements. The Trust scored Satisfactory for 2015/16.

Information risks are managed in the same way as all other risks identified in the Trust. They are reviewed by the Information Group, which reports to the Finance, Business Performance and Assurance committee. The Information Group also continues to report to the Audit Committee to increase the level of assurance on Information Governance processes.

Highlights from the work programme for this year will include continued reviews of the Corporate Records Register and Data Flows in and out of the Trust, integrating Privacy Impact Assessments (PIAs) into project planning for new or changed information assets/systems, commencement of Information Asset Management programme for level 3 information assets, increasing visibility and accessibility of the IG team across the Trust and a targeted public and staff Information Governance communications campaign.

3.2.8 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 Merseyside Internal Audit Agency (MIAA). Two audits have been conducted across the year. This was a targeted audit on a known problem with signs and symptoms in the primary diagnosis position. The results of these audits should not be extrapolated beyond the specialities and samples audited. Following these audits individual and team feedback has been given to enhance performance. Overall accuracy for primary diagnosis was 78.9%, secondary diagnosis was 94.2%, primary procedure 93.4% and secondary procedures 94.4%. These external audits were supplemented with additional internal audit.

The Trust was not subject to the Payment by Results clinical coding audit during 2015/16. 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

Towards the end of 2015/16, the Trust commissioned five combined coding and clinical audits from Maxwell Stanley who benchmarked against a peer group to identify areas of poor data collection. Work is on-going to improve data collection in both paper and electronic systems. Clinician involvement with audit work has proved valuable in highlighting the quality of documentation available to the clinical coders. Staff have been appointed into the two vacant Divisional Lead posts and an auditor post has been created. Trained clinical coders are a scarce resource and their recruitment continues to be challenging for the service as a whole.

3.2.9 Duty of Candour

Duty of Candour is outlined in a specific Trust policy and procedure which was adopted in March 2015. It is incorporated into our Root Cause Analysis documentation when we investigate serious incidents. We notify the family (and / or their relatives or carers) within ten days, ideally face-to-face, and follow up with a written notification. When the Root Cause Analysis is complete, the report is shared with them.

We monitor compliance with timescales on a weekly basis at the Quality and Safety Review Team. An exception report is produced monthly for the Clinical Commissioning Group which outlines compliance.

We cover the duty of candour as part of our mandatory risk management training programme at Level 1 (delivered to all staff on induction) and Level 2 (for senior managers and clinicians in job bands 7 and above). There is also an information leaflet for staff in circulation. The key message given to staff is that “saying sorry is not an admission of liability and is the right thing to do”.

Annex: Statements from Third Parties

Statement from Wirral Clinical Commissioning Group

Quality Account 2015/16

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.

We welcome the opportunity to comment on this account and believe it reflects accurately quality performance in 2015/16 and clearly sets out the direction regarding quality for the 2016/17.

Against a challenging backdrop, the Trust has made progress in a number of areas in particular in the area of staffing. It is pleasing to see the investment in increased nurse staffing having a benefit on the quality of care provided to patients, and the staff engagement programme which has led to an improvement in CQC's national staff survey.

We acknowledge the six priority topics in 2015/16, and in the areas of nutrition and hydration; pressure ulcers; medication missed doses and readmissions these standards have not been consistently achieved. We therefore support approach of the continuation of these into 2016/17 to ensure that these are embedded into practice across the organisation.

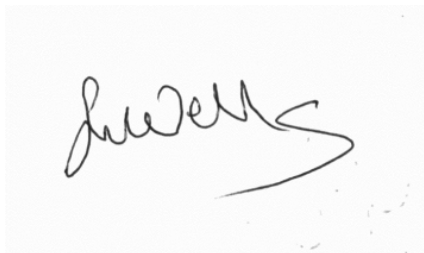
A comprehensive inspection was undertaken by the Care Quality Commission in September 2015. This gave the trust an overall rating of "requiring improvement" with a rating of "good" in the domains of caring and effective. We believe the two new priorities identified for 2016/17 of End of Life and implementation of the SAFER bundle will address some of the areas identified within the CQC action plan and enhance further partnership working.

For the 2015/16 contract, in partnership with the Trust, a set of challenging local CQUINs were developed. The objectives were developed by the CCG and agreed with the Trust, and reflected areas of desired improvement identified nationally and locally. To date, not all of these have been fully achieved. This demonstrates, at least in part, the high standard that have been set in order improve the quality of care for our patients. Both organisations remain resolute to achieving these standards in the forthcoming year.

Patient safety and preventing harm remains of paramount importance to the CCG. While we acknowledge there has been a decrease in Never Events from 5 in 2014/15 to 3 2015/16, these are the most serious events that cause harm to patients and therefore remains a concern for the CCG.

The trust has seen a decrease from last year in Hospital attributed MRSA cases, with 2 cases reported for this period against a target of zero (there is another case awaiting assignment). C. Difficile infection rate is above the challenging allocated trajectory of 29 at 48. The Trust has undertaken a number of actions in order to reduce and contain the spread of infection within the trust including the opening of a cohort ward and a ward cleaning programme.

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 2016/17. 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.

A handwritten signature in black ink, appearing to read 'Sue Wells', is centered within a light gray rectangular box. The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Sue Wells
Acting Chair- Wirral CCG

Statement from Wirral Metropolitan Borough Council

16th May 2016

Commentary on the draft Quality Account, 2015/16

Wirral University Teaching Hospital (WUTH)

The Families and Wellbeing Policy and Performance Committee undertake the health scrutiny function at Wirral Council. The Committee has established a Panel of Members (the Health and Care Performance Panel) to undertake on-going scrutiny of performance issues relating to the health and care sector. Members of the Panel met on 10th May 2016 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 (WUTH) for the opportunity to comment on the Quality Account 2015/16. Panel Members look forward to working in partnership with the Trust during the forthcoming year. Members provide the following comments:

Overview

Members acknowledge that 2015/16 has again been a year of challenges for the Trust, due to increasing pressure on the health and care system and rising demand for the services provided by the Trust. This is set against the difficult financial circumstances in which the Trust, along with many other Foundation Trusts, finds itself. There is, therefore, a challenge to ensure that these factors do not impact adversely on service quality.

The investment in frontline staff which took place during the year, against a difficult financial background, is welcomed as is the improvement in staff morale which is demonstrated by the results of the national staff survey. The successful initiatives relating to staff recruitment, such as the recruitment drives, are welcome as is the relatively low vacancy rate for nursing staff.

The CQC inspection, carried out in September 2015, resulted in an overall rating of 'Requires Improvement'. Although this presents challenges to the Trust, it is also noted that the CQC recognise that the Trust has positive momentum and is on an upward trend. This is a view endorsed by members based on the content of this Quality Account and on other meetings held during the year. Although the targets for all of the 2015/16 priorities were not met, progress has been demonstrated in all six areas.

Review of Quality Performance for 2015-16

Improve care for patients with dementia

Progress regarding a number of initiatives relating to the care for people with dementia is welcome, particularly the work to expand the use of 'This is Me' and the extension to the number of staff who have received training on dementia care. However, it is noted that participation in training has been lower among doctors than among nursing staff.

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

Members welcome the impressive list of initiatives which have been introduced by the Trust to aid the nutrition of patients. This demonstrates a focus on patient-centred care, which is borne out by the improved results in the Learning with Patients survey compared to the previous year.

Reduce harm to patients in relation to newly formed pressure ulcers

It is noted that neither of the targets relating to both grade 2 and grade 3-4 pressure ulcers will be met during 2015/16. The retention of this priority for 2016/17 is, therefore, welcomed.

Looking forward to 2016/17; what are our priorities?

In general, Members welcome the selection of the six priorities for 2016/17; four of them continuing from the previous year. The inclusion of the two new priorities, End of Life care and implementation of the SAFER bundle are appropriate.

Improving End of Life care

End of Life care was rated as 'Requiring Improvement' by the CQC inspection and was highlighted as an issue for greater attention. It is, therefore, appropriate that it is now included as a priority and will be subject to regular monitoring and that stakeholders are kept informed of progress. A wider issue is to ensure that patients, where appropriate, have the choice to end their life in a non-hospital environment.

Implement the SAFER bundle to improve patient flow and ensure safe discharges

There is concern regarding the failure of the Trust to meet the four hour A&E waiting time target on a consistent basis. It is expected that increased emphasis on the SAFER bundle will lead to improved patient flow through the hospital and will hopefully assist with meeting the increased demand at the front door, although further evidence will be required to prove that this is the case. Members will be interested in assessing progress in the future.

Other comments:

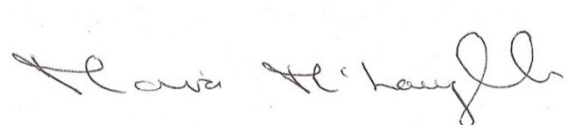
Friends and Family Test

Although the Quality Account report refers to staff responses to the Friends and Family Test, there is no reference to patient responses to the Test. As an indicator of patient experience, it is suggested that patient scores for the Friends and Family Test would be a useful addition to the report in future years.

Never Events

Members note the occurrence of 4 Never Events during 2015/16, which is disappointing.

I hope that these comments are useful



Councillor Moira McLaughlin
Chair, Health and Care Performance Panel and
Chair, Families and Wellbeing Policy & Performance Committee

Commentary by Healthwatch Wirral for Wirral University Teaching Hospital Foundation Trust Quality Account 2015/16

Healthwatch Wirral (HW) would like to thank WUTHFT for the opportunity to comment on the Quality Account for 2015/16. Over the last year WUTHFT have been receptive to HW's input on improving patient experience and have accepted both challenge and recommendations.

HW acknowledges that the Trust works in a challenging environment, having to manage increased demand for its services from a growing and ageing population. It is reassuring that the Trust appears to have been proactive by increasing frontline staff numbers, engaging with staff and planning ahead to manage winter pressures.

HW noted that in the past twelve months a great deal of work has been done to improve performance in the six selected areas. However, it was disappointing to learn that the Trust were not yet consistently achieving the targets set, particularly in Pressure Ulcers and A&E waiting times and that there had been 3 Never Events reported.

It was reassuring that the Trust retains priorities in the Quality Account until the targets have been achieved, and that they are continuing with this approach.

Progress against the CQUIN targets and Service Delivery Improvement Priorities were noted.

HW would like to congratulate the Trust on receiving external recognition for their work to improve Dementia care and the Endoscopy Unit retaining its Joint Advisory Group (JAG) accreditation. We would also commend the Trust for continuing to perform better than the national average in reducing the hospital standard mortality rate.

Priorities for 2016/17

HW noted that two priorities, Mortality and Dementia care, have been discontinued. These are to be replaced by new priority topics which are implementation of the SAFER bundle for improved patient flow and safe discharge and end of life care.

Healthwatch Wirral Recommendations and Concerns

HW have some concerns in the discontinuation of the Dementia priority and would like to be kept informed on how the Trust will continue to report and monitor this priority. Also, what measures will be put in place to monitor how many staff read and act on the content of the 'This is me' booklet, how many booklets are completed and how the Trust intends to improve the take up of Dementia training for doctors.

HW has noted the Trust's lack of consistency in achieving some of the targets set. However, HW would seek assurance on any underlying issues that may be responsible for this such as the consistent delivery of basic nursing care, staff shortages and comprehensive training for staff.

The Trust may benefit from contacting other Trusts to share good practice in achieving their targets.

HW will monitor progress in the targets achievement during 2016/7 through the quarterly updates.

Finally, overall the report was honest, informative, self-critical and a fair reflection of the healthcare services provided. HW appreciates the opportunity to comment on the report as a "critical friend" and looks forward to working with the Trust in the future to support the implementation of the Quality Account and strategic plans.

Karen Prior

Chief Officer-Healthwatch Wirral
May 2016

Glossary for Quality Report

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 organism
DASS	Department of Adult Social Services
DME	Department of Medicine for the Elderly
ECIST	Emergency Care Intensive Support Team
EAU	Emergency Assessment Unit
ERP	Enhanced Recovery Programme
FCE	Finished Consultant Episode
FFT	Friends and Family Test – a question contained within the national inpatient and staff survey
HPV	Hydrogen Peroxide Vaporiser
HES	Hospital Episode Statistics
HSMR	Hospital Standardised Mortality Rate
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 from hospital; not adjusted for palliative care
SSKIN	SSKIN is a five step model for pressure ulcer prevention. Surface: make sure patients have the right support. Skin inspection: early inspection means early detection. Keep patients moving. Incontinence/moisture: patients need to be clean and dry. Nutrition/hydration: help patients have the right diet and plenty of fluids
TARN	Trauma Audit Research Network
VRE	Vancomycin Resistant Enterococci
VTE	Venous Thrombo-Embolicism or blood clot in the vein
WUTH	Wirral University Teaching Hospital

Services Provided by the Trust

CLINICAL SUPPORT DIVISION (11)

Pathology	Radiology
Bed Management	Therapies
Integrated Discharge Team	Theatres and Anaesthetics
Hotel Services	Sterile Services
Cancer Pathway Management	Pain Management
Booking and Outpatients	

ACUTE AND MEDICAL SPECIALTIES DIVISION (15)

Emergency Department	Respiratory
Acute Medicine	Rheumatology
Critical Care	Haematology
Department of Medicine for the Elderly	Endoscopy
Cardiology	Sexual Health
Gastroenterology	Stroke
Diabetes	Rehabilitation
Nephrology	

SURGICAL AND WOMEN'S AND CHILDREN'S DIVISION (17)

Surgical Elective Admissions Lounge	Maxillofacial
Pre-operative Assessment	Dermatology
Surgical Assessment	Park Suite
Surgical Day Case	Trauma and Orthopaedics

Colorectal	Paediatrics
Limb Centre	Obstetrics and Maternity Services
Upper Gastro-intestinal	Gynaecology
Urology	Ophthalmology
Ear, Nose and Throat	

CORPORATE SERVICES (25)

Corporate Governance and Foundation Trust Membership Office	Information Technology
Finance and Procurement	Informatics
Clinical Coding	Information Governance
Programme Management Office	Medical Records
Quality and Safety	Equipment Services
Corporate Nurse Management (including End of Life Care)	Switchboard
Chaplaincy	Strategy and Partnerships
Bereavement Office	Communications
Infection Prevention and Control	Human Resources
Complaints and Patient Experience	Learning and Development
Safeguarding	Occupational Health
Pharmacy	Health and Safety
Estates	

Appendix 2

National Clinical Audits Participation

Name of Audit/Confidential Enquiry	Data collection 2015/16	Participation Yes/No Number Participation %	Report received and reviewed (Y/N)	Actions taken and comments
Bowel Cancer (NBOCAP)	Yes	Yes 205 99%	Yes	Annual report published December 2015 covering data from 1/4/13 – 31/3/14. All members of the Multi-Disciplinary Team will be given log-ins to ensure accuracy of data prior to submission. All other areas compliant.
Elective Surgery (National PROMs Programme)	Yes	Hernia Yes - Apr 15 - Feb 16 – 227 (61%) Varicose Vein Yes Apr 15 – Feb 16 – 89 (64%)	Interim report received and reviewed	Increased monitoring of date of form completion has been introduced to reduce the number out of date prior to submission.
National Emergency Laparotomy Audit	Yes	Yes Dec 13 – Nov 14 166 (92%) Apr 15 - Mar 16 210	Yes	1 st patient Report was published July 2015 covering 1/12/13 – 30/11/14. We were non-compliant with patients over 70 years receiving regular review from Medicine for Care of Older Person (MCOP) Consultant. A meeting has been held with the Surgical and Anaesthetic Leads and a Department of Medicine for the Elderly Consultant. A risk assessment has also been completed and further discussion can take place.
National Prostate Cancer Audit	Yes	Yes 133 (100%)	Yes	No actions were required.
Oesophago-gastric audit (NAOGC)	Yes	Yes 189 (>90%) Apr 12 – Mar 14	Yes	Annual report published December 2015. Data submission has been reviewed and discussed with the NAOGC team as it showed that data submitted for stents was incomplete. Other areas compliant.
National Comparative Audit of Blood Transfusion programme - Use of blood in Haematology	Yes	Yes 100%	No	Report not yet published.
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Still ongoing	No	Data collection ongoing until after end of the financial year. Last report published Dec 2014.

Falls and Fragility Fractures Audit Programme (FFFP)	Yes	Yes 465 95.9%	Yes – First round report 18/11/15.	There are three rounds to the audit. First round of audit is completed. Second round commences Sept 16. Falls action plan is developed and approved. Actions: 1. Falls risk scores removed from Millennium and falls care plan is to reflect accordingly. 2. Audit of 5 patients per ward aged over 65 years: for lying and standing/sitting blood pressure completed for admission over 24 hours (to exclude patients who are immobile). 3. Medicines and Falls in Hospital: Guidance (Fallsafe) to be laminated for all ward pharmacy rooms and to be included in the Junior Doctors teaching programme and induction. 4. Continence meetings arranged with the Community Trust 5. The Dementia Care Bundle which includes a falls assessment is completed on Millennium for every patient with a diagnosis of dementia. Agenda item for Dementia Steering Group to review the Dementia Guidelines. 6. Falls Multidisciplinary Operational Group meeting recommenced. To meet every 6 weeks to monitor interventions and use proven methods to embed changes. 7. To review multifactorial falls risk assessments. All domains of the audit should be included and linked to quality improvement projects ensuring that the In-patient Falls policy translates as to what takes place in the ward setting. 8. There is no workable policy to ensure that all patients who need walking aids have access to the most appropriate walking aid from the time of admission. Regular audits should be undertaken to assess whether the policy is working and whether mobility aids are within the patient's reach if they are needed
Inflammatory Bowel Disease (IBD) programme	Yes	Yes 31 100%	No	Most recent report for 2014 was published in August 2015
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Yes	Yes 304 62.8%	Yes	Organisational and National Reports shared. Actions: 1. Provide ongoing education to Primary and Secondary care. 2. Pulmonary Rehabilitation (PR) to be identified as part of the COPD Healthy Wirral Registries. 3. Work with Healthy Wirral to make the business case to improve resources and increase the number of programmes to include St Caths as a venue. 4) Work with Healthy Wirral to make the business case to improve resources so that appropriate Post Exacerbation patients can be offered

				<p>PR within 4 weeks.</p> <p>5) Suitable patients to be identified from the AQ measures and the COPD bundle on the Cerner system.</p> <p>6) Referrers better at selecting more appropriate patients to refer to PR. Showing a reduction in inappropriate referrals.</p> <p>7) Patients will be better educated at the point of referral which can be measured by a reduction in DNA rates.</p>
National Heart Failure Audit	Yes	Yes 405 88%	No	<p>The report is not due until late May 2016.</p> <p>The last report, based on 2013-14 data, was published in October 2015.</p>
National Lung Cancer Audit (NLCA)	Yes	Yes 304 <i>No % available shown in report</i>	Yes	<p>Report published Dec 2015</p> <p>The audit showed low pathological diagnosis rates (60.5%- target above 75%) and low numbers SCLC having chemotherapy (65.2% vs target 70%). An action plan has been completed. A retrospective audit is to be completed of 20 cases without pathological diagnosis "Real time" reasons now to be set and documented in MDT of diagnosis without pathological confirmation. An audit of all 2013/4 SCLC patients is ongoing.</p>
Renal Replacement Therapy (Renal Registry)	Yes	Yes <i>Number of cases submitted – not available</i>	No	<p>Report still awaited - due later in 2016.</p>
Rheumatoid and Early Inflammatory Arthritis	Yes	Yes 94	Yes	<p>The report has been shared with colleagues and the key actions arising are as follows:</p> <ol style="list-style-type: none"> 1. Patients not being referred within 3 days - Rheumatology consultants to raise awareness in primary care of early inflammatory arthritis and the need to refer to rheumatology service ASAP. 2. Patients not being seen within 3 weeks of referral from GP - Increase number of consultants in line with recommendation of The Royal College of physicians from 2 to 3. 3. Treatment not being initiated within 6 weeks of referral - Increase number of consultants in line with recommendation of The Royal College of physicians from 2 to 3. 4. No education offered to patient within 1 month of diagnosis - Increase number of specialist nurses and clinic capacity so that informal or structured education or self-management activities are offered to patients. 5. No setting of agreed treatment targets with patients - Increase the number of clinical nurse specialists to provide structured education with a specialist nurse allowing more time to be allocated to discuss treatment options and plans. Target to be documented in hospital notes. 6. Disease Activity Score (DAS) not being reduced by 1.2 or more within 3 months; potentially due to difficulty in getting patient in to follow-up clinics,

				improved by increased staffing levels so that patients are seen quicker and treatments implemented quicker - Increase current new to follow-up cap ratio to 1-8 from 1-3.9. Have in place functioning database that can best capture DAS scoring and improvement in rheumatoid arthritis outcomes. 7 Incomplete DAS scoring in clinic - Staff to be re-educated in the performance and importance of documenting DAS scoring in clinical notes.
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes 676 100%	Yes	Report published Dec 2015; Arrowe Park were outliers for mortality therefore a local mortality audit was undertaken and presented in November 2015. Everything that is included in the audit complements the continuous SSNAP audit that produces quarterly reports and the acute organisational audit. SSNAP is discussed at Stroke Executive Group Meetings.
UK Parkinson's Audit – Occupational Therapy	Yes	No	No	The Trust was not able to participate in this audit during 2015/16 because of staffing vacancies which meant that no administrative support could be given.
UK Parkinson's Audit - Physiotherapy	Yes	Yes 100%	No	
National Diabetes Inpatient Audit	Yes	<i>Awaiting confirmation of number of cases submitted</i>	No	Data collection completed Sept 15. Publication due June 16.
National Emergency Use of Oxygen Audit	Yes	Yes 180 institutions participated in the audit nationally. 55208 patients audited nationally, 727 locally (1.3%). 7741 patients on oxygen nationally, 82 locally (1.1%).	Yes	Trust performance was found to be ahead of national averages. However improvement is still required to meet measures set in relation to oxygen prescribing, administration and monitoring.
Elective Surgery (National PROMs Programme)	Yes	Yes <i>Hip</i> 327 85.15% <i>Knee</i> 379 78.95%	No	
National Joint Registry (NJR)	Yes	Yes 1,273 98.5%	No	
National Ophthalmology Audit	Yes	Yes <i>Awaiting confirmation of number of cases submitted</i>	No	

Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes 779 100%	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.
Asthma (paediatric and adult) care in emergency departments	No	No	n/a	No audit 2015-2016. Next audit will be 2016-2017
Consultant Sign-off (Emergency Departments)	No	No	N/A	No audit 2015-2016. Next audit will be 2016-2017
Major Trauma Audit (TARN)	Yes	Yes 307 62%	Yes – reviewed by Trust Trauma Lead but not yet by group.	The TARN audit report will be reviewed at next Trauma Group meeting in April 2016. Trust trauma lead will be providing a written update regarding future actions and shared learning.
Procedural Sedation in Adults (care in emergency departments)	Yes	Yes 30 required 100%	No	Report not due until summer 2016
Severe Sepsis and Septic Shock - care in emergency departments	No	No	N/A	No audit 2015-2016. Next audit will be 2016-2017
Society for Acute Medicine's Benchmarking Audit (SAMBA) - annual since 2012	Yes	Yes 63 100%	Yes	There is a good discharge rate from the Acute Medical Unit. Patients are usually transferred to Medical Short Stay Ward therefore do not stay long on AMU. Most new patients are post-taken by acute physicians (75%)
Vital signs in children (care in emergency departments)	Yes	Yes 30 required 100%	No	Report not due until summer 2016
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	Yes 30 required 100%	No	Report not due until summer 2016
National Comparative Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	Yes	Yes 40 100%	No	Report due July 2016
Paediatric Pneumonia	No	No	No	Data not collected 2015/16
Paediatric Asthma	No	No	No	Data not collected 2015/16
Neonatal Intensive and Special Care (NNAP)	Yes	Yes 100% of admissions to neonatal unit	2015 report (of 2014 data) received and reviewed	
Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	Yes	Yes 0% no maternal deaths	No	No report was published in 2015/16
Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal)	Yes	Yes 100%	Yes	The report has been reviewed; the care process will be amended slightly to meet the recommendations.

deaths)				
Perinatal Mortality Surveillance	Yes	Yes 100%	Yes	Figures reviewed and response sent to MBRRACE.
Diabetes (Paediatric) (NPDA)	Yes	Yes Still underway until July 2016	No	The report for 2014/15 is not expected to be published until June 2016.
Maternal mortality surveillance	Yes	Yes 1 100%	Yes	Our gap analysis is underway at the time of writing.

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 to prepare Quality Accounts for each financial year.

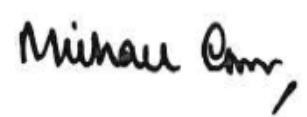
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take actions to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance
- 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 2015 – March 2016
 - Papers relating to Quality reported to the Board over the period April 2015 – June 2016;
 - Feedback from the commissioners dated May 2016
 - Feedback from governors dated March 2016
 - Feedback from local Healthwatch; dated May 2016
 - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2014;
 - The latest national patient surveys (2014/15);
 - The latest national maternity survey (2015);
 - The latest national staff survey (2015);
 - The Head of Internal Audit's annual opinion over the trust's control environment dated May 2016
- 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

Handwritten signature of Michael Carr in black ink.

Chairman
Date: 25th May 2016

Handwritten signature of D. Allen in blue ink.

Chief Executive
Date: 25th May 2016

Appendix 4

Independent Practitioner's Limited Assurance 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 limited assurance engagement in respect of Wirral University Teaching Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in Annex 2 to Chapter 7 of the 'NHS Foundation Trust Annual Reporting Manual 2015/16' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to the limited assurance engagement consist of those national priority indicators as mandated by Monitor:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathway at the end of the reporting period
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge (Wirral University Teaching Hospital patients only)

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the Council of Governors and Practitioner

The Council of Governors are responsible for the content and the preparation of the Quality Report covering the relevant indicators and in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2015/16' issued by Monitor and 'Detailed guidance for external assurance on quality reports 2015/16'.

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
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2015/16'; 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 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 2015/16, 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 1 April 2015 to 25 May 2016;
- Papers relating to quality reported to the Board over the period 1 April 2015 to 25 May 2016;
- Feedback from Commissioners dated May 2016;
- Feedback from Governors dated May 2016;
- Feedback from local Healthwatch organisation dated May 2016;
- Feedback from Overview and Scrutiny Committee dated 16 May 2016;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2014/15;
- The national patient survey dated 2014;

- The national maternity survey dated 2015;
- The national staff survey dated 2015;
- Care Quality Commission Intelligent Monitoring Report dated May 2015; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated March 2016.

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.

The firm applies International Standard on Quality Control 1 and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Ethics for Professional Accountants issued by the International Ethics Standards Board for Accountants, which is founded on the fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. 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 2016, 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, except 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
- analytical procedures
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2015/16' to the categories reported in the Quality Report; and
- reading the documents.

The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement and consequently, the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

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 affect 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 2015/16'.

The scope of our limited 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.

Our audit work on the financial statements of Wirral University Teaching Hospital NHS Foundation Trust, is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Wirral University Teaching Hospital NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Wirral University Teaching Hospital NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Wirral University Teaching Hospital NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Wirral University Teaching Hospital NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Wirral University Teaching Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion

The indicator percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period did not meet the six dimensions of data quality in the following respect:

- Accuracy – Our testing identified errors in data accuracy in six of the 25 cases we tested. These errors included data input for both clock starts and clock stops, as well as completeness of reporting. The errors ranged from 16 to 109 days.

The indicator for the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge did not meet the six dimensions of data quality in the following respects:

- Accuracy – Our testing of 25 cases identified three where the A&E discharge time could not be agreed to the patient records.

Qualified conclusion

Based on the results of our procedures, with the exception of the matters reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the Criteria;
- the Quality Account is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2015/16'; 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 2015/16' and supporting guidance and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2015/16'.

Grant Thornton UK LLP
Chartered Accountants
Manchester

25th May 2016

Independent auditor's report to the Council of Governors of Wirral University Teaching Hospital NHS Foundation Trust

Our opinion on the financial statements is unmodified

In our opinion the financial statements of Wirral University Teaching Hospital NHS Foundation Trust (the 'Trust'):

- give a true and fair view of the state of the financial position of the Trust's affairs as at 31 March 2016 and of the Trust's expenditure and income for the year then ended; and
- have been prepared properly in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the NHS Foundation Trust Annual Reporting Manual and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

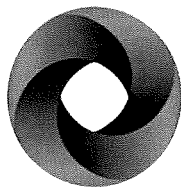
Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors 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 Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

What we have audited

We have audited the financial statements of Wirral University Teaching Hospital NHS Foundation Trust for the year ended 31 March 2016 which comprise the Trust statement of comprehensive income, the Trust statement of financial position, the Trust statement of changes in taxpayers' equity, the Trust statement of cash flows and the related notes.

The financial reporting framework that has been applied in their preparation is applicable law and IFRSs as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the NHS Foundation Trust Annual Reporting Manual (ARM) and the Directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006 issued by Monitor, the Independent Regulator of NHS Foundation Trusts.



Overview of our audit approach

- Overall materiality: £4,605,000, which represents 1.5% of the Trust's prior year gross revenue expenditure;
- Key audit risks were identified as:
 - Occurrence and valuation of income from patient care activities and existence of the associated receivable balances
 - Occurrence of other operating income and existence of the associated receivable balances
 - Valuation of property, plant and equipment
 - Completeness of operating expenditure on goods and services

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that, in our judgement, had the greatest effect on our audit:

Audit risk	How we responded to the risk
<p>Occurrence and valuation of income from patient care activities and existence of the associated receivable balances</p> <p>Over 90% of the Trust's income is from contracts with NHS commissioners of healthcare services.</p> <p>The Trust invoices its commissioners throughout the year for services provided, and at the year-end estimates and accrues for activity not yet invoiced. Invoices for the final quarter of the year are not finalised and agreed until after the year end and after the deadline for the production of the financial statements. This can involve further negotiation of contractual adjustments with commissioners. There is therefore a risk that income from patient activities from commissioners recognised in the financial statements may be misstated.</p> <p>We identified the occurrence of income from patient care activities and existence of the associated receivable balances as a significant risk requiring special audit consideration. We also identified valuation of income from patient care activities as a risk requiring particular audit attention.</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> • evaluating the Trust's accounting policy for recognising income from patient care activities for appropriateness and consistency with the prior year; • gaining an understanding of the Trust's system for accounting for income from patient care activities and evaluating the design of the associated controls; • using a summary of expenditure with the Trust accounted for by other NHS bodies provided by the Department of Health to identify any significant differences in income and receivable balances with contracting bodies; • testing, on a sample basis, amounts recognised as income from patient care activities in the financial statements to signed contracts and invoices; • testing, on a sample basis, contract variations and non-contractual income adjustments made to year-end balances to supporting documentation; and • testing, on a sample basis, receivable balances at the year end to subsequent receipt of payment. <p>The Trust's accounting policy for income from patient care activities, including its recognition, is shown in note 1.4 to the financial statements and related disclosures are included in note 2. The Trust's accounting policy for the associated receivables is shown in note 1.13 to the financial statements and related disclosures are included in note 16.</p>
<p>Occurrence of other operating income and existence of the associated receivable balances</p> <p>9% of the Trust's income is derived from services which are not directly related to core patient activity such as training and income from other bodies.</p> <p>Income is recognised when the service has been performed and at the year-end income is accrued for services that have been performed but for which an invoice has not been issued.</p> <p>We therefore identified occurrence of other operating income, and existence of the associate receivables as a significant risk requiring special audit consideration.</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> • evaluating the Trust's accounting policy for recognising other operating income for appropriateness and consistency with the prior year; • gaining an understanding of the Trust's system for accounting for other operating income and evaluating the design of the associated controls; • testing, on a sample basis, other operating income recognised in the financial statements to signed contracts and invoices; • testing, on a sample basis, other income transactions to supporting documentations; and • testing, on a sample basis, receivable balances at the year end to subsequent receipt of payment. <p>The Trust's accounting policy for other operating income, and its recognition, is shown in note 1.4 to the financial statements and related disclosures are included in note 3. The Trust's accounting policy for the associated receivables is shown in note</p>

Audit risk	How we responded to the risk
	1.13 to the financial statements and related disclosures are included in note 16.
<p>Valuation of property, plant and equipment</p> <p>The valuation of property, plant and equipment requires significant judgement and represents 81% of the total asset value on the Trust's statement of financial position.</p> <p>The Trust's last full external valuation was as at 31 March 2014 and the policy is for an interim valuation every 3 years and full revaluation every 5 years, with significant estimation uncertainty in the intervening years.</p> <p>We therefore identified the valuation of property, plant and equipment as a significant risk requiring special audit consideration.</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> • obtaining management's assessment of the valuation of property, plant and equipment and understanding the valuation process including the design of key controls and significant assumptions used; • reviewing the competence, objectivity and expertise of management's valuer; • reviewing the instructions issued to the valuer and the scope of their work; • challenging and obtaining corroborative evidence of the assumptions made by management in relation to: <ul style="list-style-type: none"> ○ the valuation of property, plant and equipment, in particular the modern equivalent asset basis; ○ the useful lives of property, plant and equipment; and ○ the amount of depreciation charged in the year. <p>The Trust's accounting policy for property, plant and equipment is shown in note 1.8 to the financial statements and related disclosures are included in note 11.</p>
<p>Completeness of operating expenditure on goods and services</p> <p>Expenditure on goods and services represent 31% of the Trust's total expenditure. Management uses judgement to estimate accruals of expenditure for amounts that have not been invoiced at the year end.</p> <p>We therefore identified completeness of expenditure on goods and services as a risk requiring particular audit attention.</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> • gaining an understanding of the systems used to recognise expenditure on goods and services and year-end accruals, and evaluating the design of the associated controls; • review of the year-end reconciliation of the subsidiary interface and general ledger control account, to ensure that all transactions from the subsidiary system are reflected in the financial statements; • testing, on a sample basis, post year-end payments one month after year-end to confirm the completeness of year-end creditors and accruals; and • considering the completeness of reported accruals and provisions by review of Trust committee minutes and reports and events subsequent to the year end. <p>The Trust's accounting policy for expenditure on goods and services is shown in note 1.5 to the financial statements and related disclosures are included in note 4.</p>

Our application of materiality and an overview of the scope of our audit

Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

We determined materiality for the audit of the Trust's financial statements as a whole to be £4,605,000, which is 1.5% of the Trust's prior year gross revenue expenditure. This benchmark is considered the most appropriate because we consider users of the Trust's financial statements to be most interested in how it has expended its revenue and other funding.

We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 60% of financial statement materiality for the audit of the Trust's financial statements.

We also determine a lower level of specific materiality for certain areas such as cash, disclosure of senior manager salaries and allowances in the Remuneration Report and related party transactions.

We determined the threshold at which we would communicate misstatements to the Audit Committee to be £250,000. In addition we have communicated misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit

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 Chief Executive Officer as 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.

We conducted our audit in accordance with ISAs (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of Financial Statements of Public Bodies in the UK (Revised)'. Our responsibilities under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code) and those standards are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

We are independent of the Trust in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based, and in particular included an interim visit to evaluate the Trust's internal control environment including its IT systems and controls over key financial systems.

Overview of the scope of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to

achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016 and to report by exception where we are not satisfied.

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

Other reporting required by regulations

Our opinion on other matters required by the Code is unmodified

In our opinion:

- the part of the Remuneration Report and Staff Report subject to audit have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the NHS Foundation Trust Annual Reporting Manual; and
- the other information published together with the audited financial statements in the annual report is consistent with the Trust's audited financial statements.

Matters on which we are required to report by exception

Under the ISAs (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to report to you if:

- we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the annual report is fair, balanced and understandable; or
- the annual report does not appropriately disclose those matters that were communicated to the Audit Committee which we consider should have been disclosed.

Under the Code of Audit Practice we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust ARM or is misleading or inconsistent with the information of which we are aware from our audit; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of the above matters.

Responsibilities for the financial statements and the audit

What the Chief Executive, as Accounting Officer, is responsible for:

As explained more fully in the Chief Executive's Responsibilities Statement, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Direction issued by Monitor and for being satisfied that they give a true and fair view. The Accounting Officer is also responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

What we are responsible for:

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

We are also required under Section 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the financial statements of Wirral University Teaching Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.



Karen Murray
Director
for and on behalf of Grant Thornton UK LLP
Manchester

27 May 2016

Wirral University Teaching Hospital NHS Foundation Trust

Annual accounts for the year ended 31 March 2016

FOREWORD TO THE ACCOUNTS

Wirral University Teaching Hospital NHS Foundation Trust

These accounts, for the year ended 31 March 2016, have been prepared by Wirral University Teaching Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

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

Signed



David Allison
Chief Executive Officer

Date

25 May 2016

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Statement of Comprehensive Income

	2015/16	2014/15
Note	£000	£000
Operating income from patient care activities	276,347	277,791
Other operating income	30,003	28,534
Total operating income	306,350	306,325
Operating expenses	(317,485)	(306,519)
Operating surplus / (deficit)	(11,135)	(194)
Finance income	130	72
Finance expenses	(437)	(394)
PDC dividends payable	(3,983)	(4,165)
Net finance costs	(4,290)	(4,487)
Surplus / (deficit) for the year	(15,425)	(4,681)
Other comprehensive income		
Will not be reclassified to income and expenditure		
Impairments	2,500	-
Revaluations	1,807	-
Other reserve movements	1,544	(1)
Total comprehensive income / (expense) for the period	(9,574)	(4,682)

The notes on pages 176 to 217 form part of these accounts.

All income and expenditure is derived from continuing operations.

Statement of Financial Position

	Note	31 March 2016 £000	31 March 2015 £000
Non-current assets			
Intangible assets	10	13,190	13,210
Property, plant and equipment	11	163,678	159,046
Trade and other receivables	16	1,613	1,716
Total non-current assets		178,481	173,972
Current assets			
Inventories	15	4,378	4,073
Trade and other receivables	16	15,589	13,234
Cash and cash equivalents	17	3,523	22,938
Total current assets		23,490	40,245
Current liabilities			
Trade and other payables	18	(34,103)	(34,636)
Other liabilities	19	(4,998)	(3,606)
Borrowings	20	(1,050)	(1,377)
Provisions	22	(664)	(640)
Total current liabilities		(40,814)	(40,259)
Total assets less current liabilities		161,157	173,958
Non-current liabilities			
Other liabilities	19	(9,496)	(11,553)
Borrowings	20	(10,322)	(11,372)
Provisions	22	(2,202)	(2,358)
Total non-current liabilities		(22,020)	(25,283)
Total assets employed		139,137	148,675
Financed by			
Public dividend capital		72,453	72,417
Revaluation reserve		51,337	46,337
Income and expenditure reserve		15,347	29,921
Total taxpayers' equity		139,137	148,675

The primary financial statements on pages 173 to 176 and the notes on pages 177 to 218 were approved by the Trust's Board of Directors on 25 May 2016 and signed on its behalf by David Allison, Chief Executive Officer.

Signed

25 May 2016

David Allison
Chief Executive Officer

Statement of Changes in Equity for the year ended 31 March 2016

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2015 - brought forward	72,417	46,337	29,921	148,675
Surplus / (deficit) for the year	-	-	(15,425)	(15,425)
Other transfers between reserves	-	(702)	702	-
Impairments	-	2,500	-	2,500
Revaluations	-	1,807	-	1,807
Transfer to income and expenditure reserve on disposal of assets	-	(33)	33	-
Public dividend capital received	36	-	-	36
Other reserve movements	-	1,428	116	1,544
Taxpayers' equity at 31 March 2016	72,453	51,337	15,347	139,137

Statement of Changes in Equity for the year ended 31 March 2015

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2014 - brought forward	68,885	47,054	33,886	149,825
Surplus / (deficit) for the year	-	-	(4,681)	(4,681)
Other transfers between reserves	-	(536)	536	-
Impairments	-	-	-	-
Revaluations	-	-	-	-
Transfer to income and expenditure reserve on disposal of assets	-	(182)	182	-
Public dividend capital received	3,532	-	-	3,532
Other reserve movements	-	1	(2)	(1)
Taxpayers' equity at 31 March 2015	72,417	46,337	29,921	148,675

Information on reserves

Revaluation reserve

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

Income and expenditure reserve

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

Public dividend capital

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

In 2015/16, the Trust received additional PDC totalling £36k from the Department of Health's *Preventing avoidable harm in maternity care* capital fund.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Statement of Cash Flows

	Note	2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(11,135)	(194)
Non-cash income and expense			
Depreciation and amortisation	4.1	8,118	8,644
Impairments and reversals of impairments	5	68	-
(Gain) / loss on disposal of non-current assets	3 & 4.1	26	(706)
Income recognised in respect of capital donations	3	(86)	(195)
(Increase) / decrease in receivables and other assets		(1,335)	4,649
(Increase) / decrease in inventories		(305)	63
Increase / (decrease) in payables and other liabilities		(1,075)	6,315
Increase / (decrease) in provisions		(169)	(341)
Other movements in operating cash flows		-	(2,483)
Net cash generated from / (used in) operating activities		(5,893)	15,752
Cash flows from investing activities			
Interest received		137	67
Purchase of intangible assets		(2,232)	(5,526)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(5,858)	(6,182)
Sales of property, plant, equipment and investment property		-	3,371
Receipt of cash donations to purchase capital assets		86	-
Net cash generated from / (used in) investing activities		(7,867)	(8,270)
Cash flows from financing activities			
Public dividend capital received		36	3,532
Public dividend capital repaid		-	-
Movement on loans from the Department of Health		(1,015)	6,860
Capital element of finance lease rental payments		(360)	(325)
Interest paid on finance lease liabilities		(39)	(74)
Other interest paid		(356)	(283)
PDC dividend paid		(3,921)	(4,288)
Net cash generated from / (used in) financing activities		(5,655)	5,422
Increase / (decrease) in cash and cash equivalents		(19,415)	12,904
Cash and cash equivalents at 1 April		22,938	10,034
Cash and cash equivalents at 31 March	17.1	3,523	22,938

Note 1. Accounting policies and other information

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *Foundation Trust Annual Reporting Manual (FT ARM)*, which shall be agreed with the Secretary of State. Consequently, the following financial statements and associated notes have been prepared in accordance with the *FT ARM 2015/16* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual (FReM)* to the extent that they are meaningful and appropriate to NHS foundation trusts.

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.

The accounting policies have been applied consistently to all periods presented in these financial statements and in dealing with items considered material in relation to the accounts.

The financial statements are presented in pounds sterling, rounded to the nearest thousand.

Assets and liabilities are classified as current if they are expected to be realised within, or where they have a maturity of less than, twelve months from the Statement of Financial Position date. All other assets and liabilities are classified as non-current.

1.2 Joint operations accounting

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to assets, and obligations for liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenditure.

1.3 Accounting judgements and key sources of estimation uncertainty

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

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

Critical accounting judgements

Listed below are areas where management have made critical judgements in the process of applying the entity's accounting policies.

Going concern

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. The Trust is judged to be a going concern if it is to continue in operation for the foreseeable future. There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows.

In forming a view, the directors have considered the financial factors captured in the Trust's 2016/17 plan, including any projected losses or liquidity risks, alongside any other foreseeable operational and compliance matters. This assessment covers a period of at least 12 months from the date of approval of the financial statements.

In particular, the directors have noted the following indicators of going concern status.

- The Trust's 2016/17 plan has been submitted to the regulator, Monitor / NHS Improvement, and no queries or issues have been brought to the Trust's attention by the regulator subsequent to that submission.
- No major losses of commissioner income are anticipated.
- No deterioration in the overall Financial Sustainability Risk Rating (FSRR) is forecast, with planned improvements in both the Capital Servicing Capacity and I&E Margin ratings.
- Planned operating cash-flows for 2016/17 are positive.
- Regulator approval of a working capital facility for 2016/17 has been secured, supporting liquidity, with no anticipated problems in complying with the terms of the facility.
- The Trust has not identified any risk of an inability to repay borrowings when they fall due. All treasury activity is included in the Trust's planning models and all borrowings are intra-governmental. Ultimately, if required, terms may be renegotiated.
- Key management vacancies have been, and will be, filled, and the Trust's general vacancy rates are low compared with comparator trusts.
- Robust plans are in place to support the Trust's governance risk rating.
- The Trust is actively engaged in local strategic transformation planning with health economy partners, to develop models to deliver sustainable healthcare from 2016/17 onwards.

Based on their detailed assessment, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. The Trust's directors do not foresee any cause for application to the Secretary of State for the dissolution of this NHS foundation trust. For these reasons, they continue to adopt the going concern basis in preparing the accounts.

Segmental reporting

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

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

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

Interests in other entities and joint arrangements

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

The Trust has assessed its existing contracts and collaborative arrangements for 2015/16, and has determined that the only arrangements which would fall within the scope of IFRS 10, IFRS 11 *Joint Arrangements* or IFRS 12 *Disclosure of Interests in Other Entities*, are the Trust's subsidiary charity and its joint operations (Note 14).

Consolidation

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

The Trust has reviewed the value of the Charity's fund balances at 31 March 2016 and does not consider these to be material to the Trust. Consequently, consolidated financial statements, incorporating the accounts of both the Trust and the Charity ('group accounts') have not been prepared for the year ended 31 March 2016.

Finance leases

Finance leases for which the Trust acts as lessee

It has been assumed that the leased asset's economic life is equal to the lease term, and that there is no residual value. Lease term and values are sufficiently low that indexation is judged to be immaterial and has not been applied.

Finance leases for which the Trust acts as lessor

It is assumed that the leased asset's economic life is equal to the lease term, and that there is no residual value.

Estimation uncertainty

The following are key sources of estimation uncertainty at the end of the reporting period that present significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

Asset valuation and lives

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

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

The Trust's reliance on valuation methods and estimates leads to estimation uncertainty. The total value of intangible and tangible fixed assets as 31 March 2016 is £176.9m.

Other sources of estimation uncertainty

The following are other sources of estimation uncertainty that are not currently judged to cause a significant risk of material adjustment to the carrying amount of assets and liabilities within the next financial year.

- Provisions such as those for employer and public liability legal claims.
- 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% unless actuals are known, 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 1.37% in real terms.

- Provision for impaired receivables, including 21.99% (18.90% 2014/15) of accrued Injury Cost Recovery (ICR) income to reflect the average value of claims withdrawn as advised to the Department of Health by the Compensation Recovery Unit (CRU) of the Department for Work and Pensions.
- Employee benefits in respect of annual leave entitlement not taken at the end of the year, for which an accrual is calculated on a sample of Trust employees.
- Income accruals for clinical episodes not yet fully completed as at the end of the reporting period ('partially completed spells'), as the calculation involves an average specialty-specific tariff per episode.
- Inventory balances are measured by counting stock, and attributing values to that inventory. There is an estimation uncertainty related to the timing of the Trust's stock counts, which cannot, operationally, all be undertaken simultaneously at close of play on 31 March.

1.4 Income

Recognition

Income in respect of services provided is recognised when and to the extent that performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of 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.

Revenue government and other grants

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

Partially completed spells

The Trust recognises income for incomplete patient spells. Patients admitted before 31 March but not discharged before midnight 31 March are accounted for on the basis of average length of stay for the admitting speciality minus the patient's length of stay at midnight 31 March.

1.5 Expenditure on 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 expenditure except where it results in the creation of assets such as property, plant and equipment or inventory.

1.6 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 untaken leave forward into the following period.

NHS pension schemes

The schemes

Past and present employees are covered by the provisions of the two NHS pension schemes. Both are unfunded, defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes are designed such that it is not possible for NHS bodies to identify their share of the schemes' underlying assets and liabilities. Therefore, each scheme is accounted for as if it was a defined contribution scheme.

Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Pension costs

The cost to the Trust of participating in the schemes is taken as equal to the contributions payable to the schemes for the accounting period. That is, employer's pension costs of contributions are charged to operating expenditure as and when they become due.

For early retirements other than those due to ill-health, the additional pension liabilities are not funded by the NHS pension schemes. The full liability for the additional costs is charged to the Trust at the time the Trust commits itself to the retirement, regardless of the method of payment.

Accounting valuation

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, HM Treasury's *FReM* requires that 'the period between formal valuations shall be four years, with approximate assessments in intervening years'. An outline of these follows.

A valuation of scheme liability is carried out annually by the scheme actuary (currently, the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the schemes' liabilities as at 31 March 2016 is based on the valuation data as at 31 March 2015, updated to 31 March 2016 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 schemes 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.

Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS pension schemes was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the scheme actuary and appropriate employee and employer representatives as deemed appropriate.

Detailed scheme provisions as at 31 March 2016

The NHS pension schemes provide 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 schemes or the specific conditions that must be met before these benefits can be obtained.

Annual pensions are normally based on 1/80th of the best of the last three years pensionable pay for each year of service for the 1995 section, and 1/60th of reckonable pay per year of membership for the 2008 section of the final salary scheme. 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 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, with reference to the Consumer Price Index (CPI), in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the schemes who are permanently incapable of fulfilling their duties effectively through illness or infirmity. The additional costs of other early retirements are not funded by the schemes.

On death, a pension is normally payable to the surviving spouse. A death gratuity is payable, which amounts to twice the final year's pensionable pay for death in service, or five times annual pension for death after retirement.

Members can purchase additional service in the schemes and contribute to money purchase Additional Voluntary Contributions (AVCs) run by the schemes' approved providers or by other Free Standing Additional Voluntary Contributions (FSAVCs) providers.

National Employment Savings Trust (NEST)

NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. This alternative scheme is provided under the Trust's 'automatic enrolment' duties to the small number of employees who choose this scheme or are excluded from actively contributing to the NHS pension schemes.

NEST Corporation is the Trustee body that has overall responsibility for running NEST. It is a non-departmental public body (NDPB) operating at arm's length from government, and it reports to Parliament through the Secretary of State for Work and Pensions.

NEST levies a contribution charge and an annual management charge which is paid for from employee contributions. There are no separate employer charges levied by NEST and employees do not have to enter into a contract to utilise NEST-qualifying pension schemes. The Trust is legally required to make a minimum contribution for opted-in employees who earn more than the qualifying earnings threshold, and the cost to the Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. That is, employer's pension costs of contributions are charged to operating expenditure as and when they become due.

1.7 Intangible assets

From 2015/16, IFRS 13 *Fair Value* is adopted in full. However, IAS 38 *Intangible Assets* has been adapted and interpreted for the public sector context, which limits the circumstances in which a valuation is prepared under IFRS 13.

Recognition

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

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

provided to, the Trust, the asset is expected to be used for at least one financial year, and where the cost of the asset can be measured reliably and is at least £5,000.

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the related 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 market value in existing use. Where no active market exists, intangible assets are valued at the lower of amortised replacement cost and the value in use where the asset is income-generating. Where there is no value in use, the asset should be valued using amortised replacement cost.

Intangible assets under construction, revaluation gains and losses, and impairments are treated in the same manner as for property, plant and equipment.

As for property, plant and equipment, an intangible asset which is surplus, with no plan to bring it back into use, is valued at fair value under IFRS 13 *Fair Value Measurement*, if it does not meet the requirements of IAS 40 *Investment Property* or IFRS 5 *Non-current Assets Held for Sale and Discontinued Operations*. Intangible assets re-classified as held-for-sale under IFRS 5 are measured at the lower of their carrying amount or fair value less costs to sell.

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 when all of the following conditions are met.

- The project is technically feasible to the point of completion, and will result in an intangible asset for sale or use.
- The Trust intends to complete the asset and sell or use it.
- The Trust has the ability to sell or use the asset.
- There is a demonstrable way for the intangible asset to generate probable future economic or service delivery benefits e.g. there is a market for it or its output, or where it is to be used for internal use, the usefulness of the asset can be shown.
- The Trust has adequate financial, technical and other resources to complete the development and sell or use the asset.
- The Trust can measure reliably the expenditure attributable to the asset during development.

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

Expected useful economic lives at point of first recognition are as follows.

Software	2 to 9 years.
----------	---------------

1.8 Property, plant and equipment

From 2015/16, IFRS 13 *Fair Value* is adopted in full. However, IAS 16 *Property, Plant and Equipment* has been adapted and interpreted for the public sector context, which limits the circumstances in which a valuation is prepared under IFRS 13.

Recognition

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

- The item is held for use in delivering services or for administrative purposes.
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust.
- The item is expected to be used for more than one financial year.
- The cost of the item can be measured reliably.
- The cost meets one of the following three criteria.
 - For single assets, the cost is at least £5,000, including irrecoverable VAT.
 - For grouped assets, where the assets are functionally interdependent, they have broadly simultaneous purchase and disposal dates and are under single managerial control, the collective cost is at least £5,000, and each individual cost exceeds £250, including irrecoverable VAT.
 - The cost forms part of the initial equipping and setting-up, or refurbishment, costs of a building, ward or unit, and each individual asset exceeds £250 including irrecoverable VAT.

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

Measurement

Valuation – carrying amount

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. The carrying amount in the period between initial recognition and revaluation or impairment is this initial cost less any subsequent accumulated depreciation.

All property, plant and equipment assets are revalued subsequently at fair value or current value in existing use. Where management conclude that the carrying amount of assets may be materially different from fair value or current value in existing use, an independent valuation is commissioned. Revaluations of property and land are carried out as mandated by a qualified valuer who is a member of the Royal Institute of Chartered Surveyors and in accordance with the Practice Statements contained within RICS' *Valuation - Professional Standards* (the 'Red Book').

Revaluations are routinely performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of Financial Position date. Debenham Tie Leung Ltd (DTZ) carried out a full revaluation of the Trust's land and buildings as at 31 March 2014. Revaluations are scheduled as follows.

- Interim revaluations every 3 years.
- Full revaluations every 5 years, as recommended by Monitor.

Between revaluation exercises, the carrying amount of an asset is the value at the date of previous revaluation less any subsequent accumulated depreciation, and less any subsequent accumulated impairment losses.

Valuation is determined as follows.

- Specialised buildings – current value in existing use, which is equivalent to depreciated replacement cost (DRC), modern equivalent asset (MEA) approach.
- Land and non-specialised buildings – market value for existing use, which is defined in the RICS Red Book as existing use value (EUUV).
- Other assets (e.g. medical equipment) – depreciated historic cost (DHC), as this is not considered to be materially different from either fair value or current value in existing use, for short-life low-value assets.

Prior to 31 March 2009, the depreciated replacement cost of specialised buildings was based on an exact replacement of the asset in its present location, whereas HM Treasury now require that an alternative site valuation basis should be adopted, provided that the location requirements of the service are met.

The accounting entries for revaluation gains and losses are detailed below. Where an individual asset is revalued, then all the assets within its class must be revalued at the same time.

An item of property, plant and equipment which is surplus, with no plan to bring it back into use, is valued at fair value under IFRS 13 *Fair Value Measurement*, if it does not meet the requirements of IAS 40 *Investment Property* or IFRS 5 *Non-current Assets Held for Sale and Discontinued Operations*. Property, plant and equipment re-classified as held-for-sale under IFRS 5 is measured at the lower of its carrying amount or fair value less costs to sell.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred will flow to the Trust, and the cost of the item can be determined reliably. That is, only subsequent expenditure which enhances an asset beyond its original specification can be capitalised.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part which has been replaced is de-recognised.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance intended to restore an asset to its original specification, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

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

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

Property is depreciated over the following useful lives.

- Buildings excluding dwellings 2 to 80 years.
- Dwellings 2 to 80 years.

Equipment is depreciated over the following useful lives.

- Plant and machinery 2 to 17 years.
- Vehicles 2 to 9 years.
- Furniture and fittings 2 to 12 years.
- Information technology equipment 2 to 7 years.

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 expenditure, 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 expenditure.

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

Impairments

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

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

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

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

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

Assets under construction

Assets under construction are measured at the cost of construction less any impairment loss. The cost of construction includes professional fees, but not borrowing costs. Assets are reclassified to the appropriate category when they are brought into use, and depreciation commences. For an asset that is newly-constructed, a formal revaluation should only be necessary if there is an indication that the initial cost is significantly different from the potential revalued amount. Otherwise, the asset is only revalued on the next occasion when all assets of that class are revalued.

De-recognition

An asset intended for disposal is reclassified under IFRS 5 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.:
 - i. management are committed to a plan to sell the asset;
 - ii. an active programme has begun to find a buyer and complete the sale;
 - iii. the asset is being actively marketed at a reasonable price;
 - iv. the sale is expected to be completed within 12 months of the date of classification as held-for-sale; and
 - v. the actions needed to complete the plan indicate that it is unlikely that the plan will be dropped or that significant changes will be made to it.

Following reclassification, the asset is measured at the lower of its carrying amount or fair value less costs to sell. Depreciation ceases to be charged. The asset is then fully de-recognised when all material sale contract conditions have been met.

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

1.9 Donated and grant-funded assets

Donated and grant-funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor. When such a condition is imposed, 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.

1.10 Private Finance Initiative (PFI) transactions including service concessions

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

The annual contract payments ('unitary fee') are apportioned between the repayment of the liability, a finance cost and charges for services. The service charge is recognised in operating expenditure and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

The Trust has identified one 'service concession' asset. An accommodation block, built and operated by Frontis Homes Limited (Your Housing Group) on the Trust's Arrowe Park site, is an infrastructure asset used in the delivery of public services. The Trust controls the residual interest in the asset and the services to be provided. No unitary fee is payable. As outlined in Note 19, a deferred income balance has been created which is released each year as income to offset the straight line depreciation charge incurred over the asset's useful economic life.

1.11 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 and the weighted average cost method.

1.12 Cash and cash equivalents

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

Cash, bank and overdraft balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Trust's bank account belonging to patients (see *Third party assets*, below).

1.13 Financial instruments

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent that, 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 cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

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

Classification and measurement

The only category of financial assets held by the Trust is 'loans and receivables'.

The only category of financial liabilities held by the Trust is 'other financial liabilities'.

Loans and receivables

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

The Trust's loans and receivables comprise cash and cash equivalents, and parts of the Trust's trade receivables, accrued income and other receivables balances.

Loans and receivables are recognised initially at fair value, net of transaction 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. For short term receivables, amortised cost usually equates to invoice value.

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

Other financial liabilities

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. For short term payables, amortised cost equates to invoice value.

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 non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs.

Loans from the Department of Health are included in other financial liabilities. However, they are always measured at historic cost less repayments, with any unpaid interest accrued separately, as directed by HM Treasury's *FReM*,

Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets 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, impacting on the estimated future cash flows of the asset (e.g. the Trust may not be able to collect amounts due).

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. For financial assets other than receivables, the loss is recognised in the Statement of Comprehensive Income, and the carrying amount of the asset is reduced directly.

Impairments of receivables

At each period end the Trust individually reviews receivables for recoverability. Following this review, an impairment is recognised in the Statement of Comprehensive Income for those receivables where there is reasonable uncertainty of obtaining settlement. The carrying amount of each impaired asset is usually reduced through an allowance account called 'provision for impaired receivables', although occasionally, debts may be directly and permanently written-off.

1.14 Leases

Finance leases – Trust as lessee

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

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

The annual rental is split between the repayment of the liability and a finance cost, which is calculated by applying the implicit interest rate to the outstanding liability, so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

In summary, the various charges apply as follows.

- The finance charge is allocated across the lease term on a straight line basis.
- Depreciation is charged on the asset as per the Trust's property, plant and equipment policy.
- Any lease rental expenditure that would otherwise have been charged to expenditure under an operating lease is fully de-recognised.

Finance leases – Trust as lessor

Where substantially all risks and rewards of ownership of a Trust-owned asset are transferred to a lessee, the lease is classified as a finance lease. The leased asset is de-recognised from property, plant and equipment, and a 'finance lease debtor' balance is recognised within other receivables, which is calculated as the aggregate of future minimum lease payments receivable and the unguaranteed residual value accruing to the Trust, discounted at the interest rate implicit in the lease.

The interest rate implicit in the lease is the discount rate that, at the inception of the lease, causes the aggregate present value of both the minimum lease payments and the unguaranteed residual value to be equal to the sum of the fair value of the leased asset and any initial direct costs of the lessor.

The annual rental inflows are split between repayment of the Trust's receivable, and finance income in the Statement of Comprehensive Income. Finance income is calculated by applying the implicit interest rate to the outstanding receivable, so as to achieve a constant rate of finance over the life of the lease.

Operating leases

Operating leases are any leases which are not classified as finance leases. Operating lease rentals are charged to operating expenditure 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 expenditure over the life of the lease.

In applying IFRIC 4 *Determining whether an Arrangement Contains a Lease*, collectively significant rental arrangements that do not have the legal status of a lease but convey the right to use an asset for payment are accounted for under the Trust's lease policy, where fulfilment of the arrangement is dependent on the use of specific assets.

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.

1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount, for which it is probable that there will be a future outflow of cash or other resources, and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates in real terms of -1.55% for short-term provisions, -1.00% for medium term provisions, and -0.80% for long term provisions (-1.50%, -1.05% and 2.20% 2014/15). For post-employment benefits including early retirement provisions and injury benefit provisions the HM Treasury's pension discount rate of 1.37% in real terms (1.30% 2014/15) is used.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the 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 Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in Note 22.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk-pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority 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 expenditure when the Trust is notified.

1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in Note 23 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 23, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of predecessor NHS trust(s), with the addition of subsequent investment by the Department of Health in the Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32 *Financial Instruments: Presentation*.

A charge, reflecting the forecast cost of capital utilised by the Trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

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 Service (GBS) and National Loan Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (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 occur as a result of the audit of the annual accounts.

1.18 Value added tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply, and input tax on purchases is not recoverable. 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.

1.19 Corporation tax

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

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts (Note 17.2) in accordance with the requirements of HM Treasury's *FReM*.

1.21 Foreign exchange

The functional and presentational currencies of the foundation trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the financial transaction. Exchange gains or losses are recognised in income or expenditure in the period in which they arise.

1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is 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 foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The note on losses and special payments (Note 27) is compiled directly from the Trust's losses and special payments register, which reports on an accruals basis with the exception of provisions for future losses.

1.23 Accounting standards and amendments issued but not yet adopted in the FT ARM

Where a new standard or interpretation has been issued, but has not yet been implemented, IAS 8 *Accounting Policies, Changes in Accounting Estimates and Errors* requires disclosure in the accounts of this fact, and the known or reasonably-estimated impact that application will have in the period of initial application. The expected financial year in which the change is expected to become effective is disclosed after the standards' names; in each case below, the amendments or new standards are not yet adopted by the European Union (EU).

IFRS 11 Joint Arrangements: [amendment to existing standard] (2016/17) – this amendment addresses the accounting treatment required for the acquisition of an interest in a joint operation, in which the activity constitutes a business. This is therefore not expected to impact on the accounts of the Trust.

IAS 16 Property, Plant and Equipment and IAS 38 Intangible Assets: [amendments to existing standards] (2016/17) – these amendments address the amortisation of service concession arrangements and are not expected to significantly impact on the accounts of the Trust.

IAS 16 Property, Plant and Equipment and IAS 41 Agriculture: [amendments to existing standards] (2016/17) – these amendments address agricultural assets and so will have no impact on the accounts of the Trust.

IAS 27 Separate Financial Statements: [amendment to existing standard] (2016/17) – this amendment addresses accounting options for investments in subsidiaries, joint ventures and associates, and therefore is not expected to impact on the accounts of the Trust.

IFRS 10 Consolidated Financial Statements and IAS 28 Investments in Associates and Joint Ventures: [amendments to existing standards] (2016/17) – these amendments address associates and joint venture accounting, and so they are not expected to impact on the accounts of the Trust.

IAS 1 Presentation of Financial Statements: [amendment to existing standard] (2016/17) – this amendment addresses the level of disclosure appropriate for reporting bodies, and specific presentational matters. This may have some minor effect on the future presentation of financial statements.

IFRS 9 Financial Instruments: [new standard] (2018/19) - this new standard is likely to have a non-material impact on the Trust's accounts. It is intended to eventually replace IAS 39 *Financial Instruments: Recognition and Measurement*, which currently sets out the requirements for the recognition and measurement of financial instruments.

IFRS 15 Revenue from Contracts with Customers: [new standard] (2017/18) – this new standard may have some impact on disclosures, and specific interpretations for the public sector are currently being considered. There may be some impact on the timing of recognition of income from complex spells of care, penalties and sanctions, and readmissions.

Annual Improvements 2012-14 cycle (2016/17)

The IASB's Annual Improvements process is intended to enhance the quality of existing standards by clarifying or rectifying relatively minor issues. A number of standards have been subject to improvement however none of the changes are likely to have significant impact on the Trust.

IASB – The International Accounting Standards Board - the independent, accounting standard-setting body of the IFRS Foundation.

IFRS - International Financial Reporting Standard.

IFRIC - International Financial Reporting Interpretations Committee.

IAS - International Accounting Standard.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by nature)

	2015/16 £000	2014/15 £000
Acute services		
Elective income	49,997	52,054
Non elective income	79,846	79,705
Outpatient income	36,550	35,964
A & E income	10,757	10,592
Other NHS clinical income ¹	97,578	97,864
Additional income		
Private patient income	560	742
Other clinical income ²	1,059	870
Total income from activities	276,347	277,791

¹ Other NHS clinical income includes income received in respect of rehabilitation and renal services, diagnostic services, community and elderly care services.

² Other clinical income relates largely to ICR income, described in Note 2.2, below.

Note 2.2 Income from patient care activities (by source)

	2015/16 £000	2014/15 £000
CCGs and NHS England	268,786	268,269
Other NHS foundation trusts	363	792
NHS trusts	1,127	1,072
NHS other	55	3,425
Local authorities	427	2,545
Other non-NHS		
Private patients	560	738
Overseas patients (chargeable to patient)	20	4
Injury cost recovery (ICR) scheme (was RTA income)	1,025	870
Other	3,984	76
Total income from activities	276,347	277,791

ICR income represents the recovery of costs from insurers, in cases where personal injury compensation is paid, such as after a road traffic accident (RTA). The scheme is administered by the Compensation Recovery Unit (CRU) of the Department for Work and Pensions. The Trust's ICR debt is subject to a provision for impaired receivables at 21.99% (18.90% 2014/15). This percentage is updated by the CRU, and reflects expected rates of collection across the NHS.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 2.3 Overseas visitors

(relating to patients charged directly by Wirral University Teaching Hospital NHS Foundation Trust)

	2015/16	2014/15
	£000	£000
Income recognised this year	20	4
Cash payments received in-year	2	-
Amounts added to provision for impairment of receivables	34	-
Amounts written off in-year	-	-

Note 3 Other operating income

	2015/16	2014/15
	£000	£000
Research and development	535	516
Education and training	9,518	9,234
Income from the receipt of donated assets	86	195
Non-patient care services to other bodies	11,259	7,064
Profit on disposal of non-current assets	-	768
Reversal of impairments	244	-
Rental revenue from operating leases	471	744
Rental revenue from finance leases	-	109
Other income ¹	7,891	9,904
Total other operating income	30,003	28,534

¹ Other income of £7.9m (£9.9m 2014/15) includes car parking income, catering income, pharmacy income, staff accommodation rental income and other miscellaneous income recharged to other NHS bodies.

Note 3.1 Income from activities arising from commissioner requested services

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

	2015/16	2014/15
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	253,700	254,013
Income from services not designated as commissioner requested services	52,650	52,312
Total operating income per Statement of Comprehensive Income	306,350	306,325

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 4.1 Operating expenses

	2015/16	2014/15
	£000	£000
Services from NHS foundation trusts	575	2,263
Services from NHS trusts	2	1,269
Services from CCGs and NHS England	-	975
Services from other NHS bodies	-	83
Purchase of healthcare from non NHS bodies	385	288
Employee expenses - executive directors	1,002	1,034
Remuneration of non-executive directors	140	130
Employee expenses - staff	212,589	207,982
Supplies and services - clinical	32,274	33,172
Supplies and services - general	5,301	5,621
Establishment	1,855	2,776
Research and development	64	-
Transport	1,000	491
Premises	13,705	10,401
Increase / (decrease) in provision for impairment of receivables	160	260
Increase / (decrease) in other provisions	-	(21)
Change in provisions discount rate(s)	-	(14)
Inventories written down	5	6
Drug costs	1,717	173
Inventories consumed	20,187	19,864
Rentals under operating leases	1,325	385
Depreciation on property, plant and equipment	5,866	6,986
Amortisation on intangible assets	2,252	1,658
Impairments	312	-
Audit fees payable to the external auditor		
Audit services - statutory audit	46	62
Other auditor remuneration (external auditor only) - see Note 4.2	7	20
Clinical negligence ¹	11,312	7,300
Loss on disposal of non-current assets	26	62
Legal fees	143	72
Consultancy costs	1,673	1,058
Internal audit and local counter-fraud service	82	79
Training, courses and conferences	834	644
Patient travel	9	14
Car parking & security	-	170
Redundancy	4	-
Hospitality	2	-
Insurance	407	419
Other services, e.g. external payroll	68	-
Losses, ex gratia & special payments ²	200	-
Other expenses	1,954	837
Total	317,485	306,519

¹ Clinical negligence costs relate to the Trust's annual contribution to the NHS Litigation Authority under its risk-pooling scheme.

² Losses, ex gratia & special payments includes the value of industrial injury claims notified but not yet settled.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 4.2 Other auditor remuneration

	2015/16 £000	2014/15 £000
Other auditor remuneration paid to the external auditor		
1. Audit of the accounts of any associate of the Trust	-	-
2. Audit-related assurance services	7	20
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	7	20

Note 4.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2014/15: £1m).

Note 5 Impairment of assets

	2015/16 £000	2014/15 £000
Net impairments charged to operating deficit by cause		
Unforeseen obsolescence	12	-
Changes in market price	(236)	-
Other impairments	292	-
Total net impairments charged to operating deficit	68	-
Impairments charged / (credited) to the revaluation reserve	(2,500)	-
Total net impairments	(2,432)	-

The impairment of the main hospital block at Arrowe Park Hospital (£1.7m) is included in impairments charged to the revaluation reserve. This was a result of the full desktop revaluation of the Trust's estate as at 31 March 2016.

Other impairments (£292k) relates to exploratory costs incurred in the planning and developmental phases of capital schemes which were not progressed.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 6 Employee benefits

	Permanent	Other	2015/16 Total	2014/15 Total
	£000	£000	£000	£000
Salaries and wages	169,546	214	169,760	172,070
Social security costs	12,885	-	12,885	12,850
Employer's contributions to the NHS Pension Scheme	18,381	-	18,381	17,915
Employer's contributions to the National Employment Savings Scheme (NEST)	11	-	11	-
Agency / contract staff	-	12,849	12,849	6,181
Total staff costs	200,823	13,063	213,886	209,016
Capitalised (non-revenue) costs within total staff costs	200	95	295	-

Note 6.1 Retirements due to ill-health

During 2015/16 there were 3 early retirements from the Trust agreed on the grounds of ill-health (4 in 2014/15). The estimated additional pension liabilities of these ill-health retirements is £203k (£222k in 2014/15). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 6.2 Directors' remuneration

The aggregate amounts payable to directors were as follows.

	2015/16 £000	2014/15 £000
Salaries	799	1,050
Taxable benefits	4	4
Employer's contributions to the NHS Pension Scheme	101	124
Total	904	1,178

Further details of directors' remuneration can be found in the remuneration section of the Annual Report.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 7 Operating leases

Note 7.1 Lease income under operating leases where the Trust is the lessor

	2015/16 £000	2014/15 £000
Operating lease revenue		
Minimum lease receipts	471	744
Total	471	744
	31 March 2016 £000	31 March 2015 £000
Analysis of future minimum lease receipts by due date		
Not later than one year	480	578
Later than one year and not later than five years	893	1,918
Later than five years	1,014	1,926
Total	2,387	4,422

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

	From	To
Ronald McDonald House	December 2009	December 2034
Frontis Homes Limited - underlying land related to staff accommodation blocks	June 2006	June 2046
Postgraduate Medical Centre - underlying land	May 1971	April 2070

Note 7.2 Lease expenditure and commitments under operating leases where the Trust is the lessee

	2015/16 £000	2014/15 £000
Operating lease expense		
Minimum lease payments	1,325	385
Total	1,325	385
	31 March 2016 £000	31 March 2015 £000
Analysis of future minimum lease payments by due date		
Not later than one year	1,143	353
Later than one year and not later than five years	3,724	446
Later than five years	6,763	1,440
Total	11,630	2,239

The Trust holds a long-term lease for the use of car parking land at the Arrowe Park Hospital site, and also leases complex medical equipment used in the delivery of healthcare for periods not exceeding 10 years.

Where applicable, break clauses in the Trust's lease contracts have been taken into account in the calculation of future minimum lease payments.

The Trust is also committed to a 15 year contract with the Carbon and Energy Fund, for the provision of a maintained energy service, including the installation of infrastructure assets at the Trust's main hospital sites. A 'lease' of the infrastructure assets is deemed to be embedded in the main service contract, through IFRIC 4 *Determining whether an Arrangement Contains a Lease*. Therefore, figures for these assets are included in the tables above.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 8 Finance income

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

	2015/16	2014/15
	£000	£000
Interest on bank accounts	68	72
Other	62	-
Total	130	72

Note 9.1 Finance expenditure

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

	2015/16	2014/15
	£000	£000
Interest expense		
Loans from the Department of Health	363	283
Finance leases	37	74
Interest on late payment of commercial debt (see Note 9.2)	-	-
Total interest expense	400	357
Other finance costs - unwinding of discount	37	37
Total	437	394

Note 9.2 The Late Payment of Commercial Debts (Interest) Act 1998

No payments have been made or costs accrued under this legislation in either 2015/16 or 2014/15.

Note 9.3 Better Payment Practice Code (BPPC)

The Better Payment Practice Code gives NHS organisations a target of paying 95% of invoices within agreed payment terms or in 30 days where there are no terms agreed.

Performance for the financial year against this target is contained in the table below.

	2015/16		2014/15	
	Number	£000	Number	£000
Non-NHS				
Trade invoices paid in the period	93,286	121,266	85,833	98,932
Trade invoices paid within target	77,939	101,086	73,525	80,554
Percentage of trade invoices paid within target	83.5%	83.4%	85.7%	81.4%
NHS				
Trade invoices paid in the period	2,484	34,552	2,501	31,245
Trade invoices paid within target	1,870	31,768	1,943	23,432
Percentage of trade invoices paid within target	75.3%	91.9%	77.7%	75.0%

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 10 Intangible assets - 2015/16

	Software licences £000	Other £000	Intangible assets under construction £000	Total £000
Gross cost at 1 April 2015 - brought forward	15,913	-	2,893	18,806
Additions	2,170	30	32	2,232
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	1,722	-	(1,722)	-
Revaluations	-	-	-	-
Disposals / derecognition	-	-	-	-
Gross cost at 31 March 2016	19,805	30	1,203	21,038
Amortisation at 1 April 2015 - brought forward	5,596	-	-	5,596
Provided during the year	2,252	-	-	2,252
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	-	-	-	-
Revaluations	-	-	-	-
Disposals / derecognition	-	-	-	-
Amortisation at 31 March 2016	7,848	-	-	7,848
Net book value at 31 March 2016	11,957	30	1,203	13,190
Net book value at 1 April 2015	10,317	-	2,893	13,210

Note 10.1 Intangible assets - 2014/15

	Software licences £000	Other £000	Intangible assets under construction £000	Total £000
Gross cost at 1 April 2014 - brought forward	13,064	-	216	13,280
Additions	931	-	4,595	5,526
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	1,918	-	(1,918)	-
Revaluations	-	-	-	-
Disposals / derecognition	-	-	-	-
Gross cost at 31 March 2015	15,913	-	2,893	18,806
Amortisation at 1 April 2014 - brought forward	3,938	-	-	3,938
Provided during the year	1,658	-	-	1,658
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Reclassifications	-	-	-	-
Revaluations	-	-	-	-
Disposals / derecognition	-	-	-	-
Amortisation at 31 March 2015	5,596	-	-	5,596
Net book value at 31 March 2015	10,317	-	2,893	13,210
Net book value at 1 April 2014	9,126	-	216	9,342

The balance held as an intangible asset under construction relates to costs incurred in respect of the implementation of the Wirral Millennium project for the replacement of the Trust's Patient Care Information System. The closing balance in assets under construction relates to Phase 2d of this project.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 11.1 Property, plant and equipment - 2015/16

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Gross cost at 1 April 2015 - brought forward	1,927	131,204	12,536	281	36,724	101	7,953	3,723	194,449
Additions	-	3,544	-	11	969	6	1,893	183	6,606
Impairments	-	(1,981)	-	(292)	-	-	-	-	(2,273)
Reversals of impairments	2	4,479	-	-	-	-	-	-	4,481
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluations	-	(5,226)	814	-	-	-	-	-	(4,412)
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(349)	-	-	(56)	-	-	-	(405)
Gross cost at 31 March 2016	1,929	131,671	13,350	-	37,637	107	9,846	3,906	198,446
Accumulated depreciation at 1 April 2015 - brought forward	-	2,677	492	-	23,931	91	5,691	2,521	35,403
Provided during the year	-	2,796	492	-	1,819	2	599	158	5,866
Impairments	-	8	-	-	12	-	-	-	20
Reversals of impairments	-	(244)	-	-	-	-	-	-	(244)
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluations	-	(5,235)	(984)	-	-	-	-	-	(6,219)
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(2)	-	-	(56)	-	-	-	(58)
Accumulated depreciation at 31 March 2016	-	-	-	-	25,706	93	6,290	2,679	34,768
Net book value at 31 March 2016	1,929	131,671	13,350	-	11,931	14	3,556	1,227	163,678
Net book value at 1 April 2015	1,927	128,527	12,044	281	12,793	10	2,262	1,202	159,046

Note 11.2 Property, plant and equipment - 2014/15

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Gross cost at 1 April 2014 - brought forward	2,012	126,857	12,536	1,014	38,093	101	10,040	3,686	194,339
Additions	-	3,628	-	-	1,475	-	831	104	6,038
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	733	-	(733)	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	(85)	(14)	-	-	(2,844)	-	(2,918)	(67)	(5,928)
Gross cost at 31 March 2015	1,927	131,204	12,536	281	36,724	101	7,953	3,723	194,449
Accumulated depreciation at 1 April 2014 - brought forward	-	(15)	-	-	23,863	87	7,943	2,249	34,127
Provided during the year	-	2,706	492	-	2,783	4	666	335	6,986
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	(14)	-	-	(2,715)	-	(2,918)	(63)	(5,710)
Accumulated depreciation at 31 March 2015	-	2,677	492	-	23,931	91	5,691	2,521	35,403
Net book value at 31 March 2015	1,927	128,527	12,044	281	12,793	10	2,262	1,202	159,046
Net book value at 1 April 2014	2,012	126,872	12,536	1,014	14,230	14	2,097	1,437	160,212

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

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 11.3 Property, plant and equipment financing - 2015/16

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2016									
Owned	1,929	130,204	-	-	10,981	14	3,545	1,174	147,847
Finance leased	-	-	-	-	100	-	-	-	100
On-SoFP PFI contracts and other service concession arrangements	-	-	13,350	-	-	-	-	-	13,350
Government granted	-	-	-	-	-	-	-	-	-
Donated	-	1,467	-	-	850	-	11	53	2,381
NBV total at 31 March 2016	1,929	131,671	13,350	-	11,931	14	3,556	1,227	163,678

Note 11.4 Property, plant and equipment financing - 2014/15

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2015									
Owned	1,927	127,087	-	281	11,778	10	2,259	1,141	144,483
Finance leased	-	-	-	-	136	-	-	-	136
On-SoFP PFI contracts and other service concession arrangements	-	-	12,044	-	-	-	-	-	12,044
Government granted	-	-	-	-	-	-	-	-	-
Donated	-	1,440	-	-	879	-	3	61	2,383
NBV total at 31 March 2015	1,927	128,527	12,044	281	12,793	10	2,262	1,202	159,046

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 12 Donations of property, plant and equipment

In 2015/16, the Trust received cash donations to fund donated assets, which have have been recognised as additions (£0.1m). Donated assets in 2014/15 totalled £0.2m.

Note 13 Revaluations of property, plant and equipment

The value and remaining useful lives of land and building assets are estimated by the Trust's valuers DTZ Debenham Tie Leung Ltd (DTZ) / Cushman & Wakefield. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

A full desktop asset valuation was undertaken during 2015/16 as at the valuation date of 31 March 2016 and was applied on 31 March 2016.

Assets revalued have been written down to their recoverable amount within the Statement of Financial Position, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for that asset and, thereafter, to expenditure - impairment of property plant and equipment. Increases in value have been credited to the revaluation reserve unless circumstances arose whereby a reversal of an impairment was necessary. In these circumstances this has been credited to income - reversal of impairments property plant and equipment. As a result of the 31 March 2016 revaluation, the revaluation reserve has increased by £1.8m, and was further credited by £2.5m, due to impairment reversals (Note 5).

The useful economic lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. In 2015/16, the lives of equipment assets were reviewed and extended, to better reflect the observed operational lives of similar assets in recent years. The lives of assets are disclosed within the accounting policies (Note 1).

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 14 Disclosure of interests in other entities

The Trust has determined that, in addition to its subsidiary charity, it has interests in two joint operations. Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to assets, and obligations for liabilities relating to the arrangement. The Trust therefore includes within its financial statements its share of the assets, liabilities, income and expenses relating to its joint operations.

The Trust does not attribute levels of risk significantly above 'business as usual' with these arrangements, as its joint operator is a partner NHS body, working together with the Trust within the same healthcare operating environment. In practical terms, this translates to a longstanding related party relationship based on contracts and transactions, collaborative working, shared objectives and common policies. In addition, the 'going concern' risk and credit risk associated with other NHS bodies is very low.

The Trust's joint operations are detailed below.

MicroPath (MP)

The Trust works collaboratively with Countess of Chester Hospital NHS Foundation Trust to provide microbiology laboratory services to both trusts. MicroPath was established in 2012, and the intention of the arrangement is to reduce running costs through joint use of a modern site and laboratory facilities, to provide resilience in each trust's microbiology service, and to enable both trusts to respond to future market opportunities.

The majority of MicroPath activity is carried out in the main combined laboratory in Bromborough, which is jointly and equally owned by the two trusts. The carrying value of the Trust's half of this asset in its Statement of Financial Position is £1.3m. Additionally, there are small satellite laboratories at each hospital site for urgent out-of-hours specimens.

The Trust retains the rights to assets contributed at the start of the arrangement. The Trust is responsible for the administration of MicroPath payroll costs, and wholly recharges these costs to Countess of Chester Hospital NHS Foundation Trust.

As the financial 'host' partner, Countess of Chester Hospital NHS Foundation Trust retains the obligation to pay other suppliers' invoices, and offsets all direct and recharged costs against the income generated by MicroPath for tests performed for both the trusts and new customers, using a tariff of prices. In 2015/16, the Trust's net expenditure on MicroPath services was £2.5m.

HR and Wellbeing Business Services (HRWBS)

This arrangement was created in 2011 and is jointly operated by the Trust and Countess of Chester Hospital NHS Foundation Trust (the 'host' operator). This collaboration was designed to create savings through scale efficiencies, and provide resilience to each of the operators' HR functions, including payroll and recruitment.

Activities are carried out at the Countess of Chester Health Park, and end-user services can be accessed via intranet portal. In 2015/16, HRWBS has additionally sold services to Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Clinical Commissioning Group, and Wirral Community NHS Trust.

Assets purchased are owned by the purchasing trust, with the further possibility of joint procurement of future assets. As the 'host' operator, Countess of Chester Hospital NHS Foundation Trust is responsible for HRWBS staff, and administering the payment of staff and suppliers in the first instance. Each trust is ultimately responsible for its share of HRWBS's costs, and the net charge to the Trust for 2015/16 is £0.5m.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 15 Inventories

	31 March 2016 £000	31 March 2015 £000
Drugs	1,343	1,344
Consumables	3,009	2,709
Energy	26	20
Total inventories	<u>4,378</u>	<u>4,073</u>

Inventories recognised in expenses for the year were £48,164k (2014/15 £49,280k). Write-down of inventories recognised as expenses for the year was £5k (2014/15 £6k).

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 16.1 Trade and other receivables

	31 March 2016 £000	31 March 2015 £000
Current		
Trade receivables due from NHS bodies	2,747	6,856
Receivables due from NHS charities	336	105
Other receivables due from related parties	588	-
Capital receivables	932	34
Provision for impaired receivables	(609)	(623)
Deposits and advances	141	-
Prepayments (non-PFI)	3,621	1,872
Accrued income	3,616	1,306
Interest receivable	4	10
PDC dividend receivable	-	8
VAT receivable	767	442
Other receivables	3,446	3,224
Total current trade and other receivables	15,589	13,234
Non-current		
Provision for impaired receivables	(277)	(378)
Finance lease receivables	630	630
Other receivables	1,260	1,464
Total non-current trade and other receivables	1,613	1,716

The majority of the Trust's debt relates to the Trust's provision of healthcare.

Other receivables balances relate mainly to recharge arrangements, whereby the Trust recoups costs from third parties for goods or services delivered.

The carrying amounts of trade and other receivables approximates to fair value.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 16.2 Provision for impairment of receivables

	2015/16	2014/15
	£000	£000
At 1 April	1,001	764
Increase in provision	241	260
Amounts utilised	(275)	(23)
Unused amounts reversed	(81)	-
At 31 March	886	1,001

Trade receivables that are less than 3 months past due, and not referred to a debt agency, will not usually be assessed as impaired, unless there is strong and specific evidence that recovery is unlikely.

Note 16.3 Analysis of impaired receivables

	31 March	31 March
	2016	2015
	£000	£000
Ageing of impaired receivables		
0 - 30 days	26	-
30 - 60 days	23	178
60 - 90 days	18	122
90 - 180 days	71	143
Over 180 days	298	203
Total	436	646

This note addresses the disclosure requirements of IFRS 7 *Financial Instruments: Disclosures*. The above table does not include the provision of £450k (2014/15: £355k) against NHS Injury Compensation Recovery (ICR) scheme debts, since they are not deemed to be financial instruments.

	31 March	31 March
	2016	2015
	£000	£000
Ageing of non-impaired receivables past their due date		
0 - 30 days	-	862
30 - 60 days	92	807
60 - 90 days	146	668
90 - 180 days	295	943
Over 180 days	172	1,039
Total	705	4,319

The above table does not include non-instrument debtors, including the amounts pertaining to the NHS ICR scheme debtor. Further information on the credit quality of the Trust's receivables is included in Note 25.

The Trust's current payment policy is that all invoices are due for payment after 28 days.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 17.1 Cash and cash equivalents movements

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

	2015/16	2014/15
	£000	£000
At 1 April	22,938	10,034
Net change in year	(19,415)	12,904
At 31 March	<u>3,523</u>	<u>22,938</u>
Analysis of cash balances		
Cash at commercial banks and in hand	177	90
Cash with the Government Banking Service (GBS)	3,346	22,848
Total cash and cash equivalents as in SoFP	<u>3,523</u>	<u>22,938</u>
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in Statement of Cash Flows	<u>3,523</u>	<u>22,938</u>

Note 17.2 Third party assets held by the Trust

Wirral University Teaching Hospital NHS Foundation Trust has identified two types of assets of which it has physical possession, but which it does not own. Both types of asset are outlined below, and have been excluded from the Trust's Statement of Financial Position.

The Trust holds money on behalf of some inpatients as a service during their hospital stay. The Trust also holds unused consignment inventories in the normal course of business. These inventories typically comprise surgical equipment, which is held on Trust premises whilst still owned by suppliers, and the Trust is only obliged to pay for these assets when they are used or expire.

Total balances for third party assets held by the Trust are disclosed below.

	31 March	31 March
	2016	2015
	£000	£000
Monies held on the behalf of patients	4	6
Consignment inventories	2,502	2,767
Total third party assets	<u>2,506</u>	<u>2,773</u>

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 18.1 Trade and other payables

	31 March 2016 £000	31 March 2015 £000
Current		
Receipts in advance	932	900
NHS trade payables	980	4,172
Amounts due to other related parties	313	-
Other trade payables	1,578	10,715
Capital payables	2,703	1,023
Social security costs	1,919	1,836
Other taxes payable	1,846	1,896
Other payables	8,494	3,030
Accruals	15,283	11,064
PDC dividend payable	54	-
Total current trade and other payables	<u>34,103</u>	<u>34,636</u>

Other payables includes NHS Pension Scheme contributions to be paid over, and other arrangements whereby the Trust collects funds to be paid over to third parties.

The carrying amounts of trade and other payables approximates to fair value.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 19 Other liabilities

	31 March 2016 £000	31 March 2015 £000
Current		
Deferred grants income	1,406	-
Deferred rent of land income	14	-
Other deferred income	3,578	3,606
Total other current liabilities	<u>4,998</u>	<u>3,606</u>
Non-current		
Other deferred income	9,496	11,553
Total other non-current liabilities	<u>9,496</u>	<u>11,553</u>

The non-current deferred income balance above is wholly attributable to the staff accommodation blocks which are owned and operated by Frontis Homes Limited, and which are accounted for as 'on-Statement of Financial Position' in accordance with IFRIC 12. The deferred income balance is released to the Statement of Comprehensive Income over the period of the arrangement, and therefore there is an additional balance in current deferred income which represents next year's income release.

Note 20 Borrowings

	31 March 2016 £000	31 March 2015 £000
Current		
Drawdown in committed facility	-	-
Loans from the Department of Health	1,015	1,015
Obligations under finance leases	35	362
Total current borrowings	<u>1,050</u>	<u>1,377</u>
Non-current		
Loans from the Department of Health	10,269	11,284
Obligations under finance leases	53	88
Total non-current borrowings	<u>10,322</u>	<u>11,372</u>

Note 25 contains further details relating to the Trust's loans.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 21 Finance leases

Future lease receipts due under finance leases where the Trust is the lessor

	31 March 2016 £000	31 March 2015 £000
Gross lease receivables	630	630
Analysis of gross minimum lease receipts by due date		
Not later than one year	-	-
Later than one year and not later than five years	2	2
Later than five years	628	628
Net lease receivables	630	630

Obligations under finance leases where the Trust is the lessee

	31 March 2016 £000	31 March 2015 £000
Gross lease liabilities	76	450
Analysis of gross minimum lease payments by due date		
Not later than one year	29	362
Later than one year and not later than five years	47	88
Later than five years	-	-
Finance charges allocated to future periods	12	-
Net lease liabilities	88	450
Analysis of net minimum lease payments by due date		
Not later than one year	35	362
Later than one year and not later than five years	53	88
Later than five years	-	-
Net lease liabilities	88	450

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 22.1 Provisions for liabilities and charges

	Pensions - other staff	Other legal claims	Total
	£000	£000	£000
At 1 April 2015	2,631	367	2,998
Change in the discount rate	-	-	-
Arising during the year	66	241	307
Utilised during the year	(263)	(113)	(376)
Reversed unused	-	(100)	(100)
Unwinding of discount	37	-	37
At 31 March 2016	2,471	395	2,866
Expected timing of cash flows			
Not later than one year	269	395	664
Later than one year and not later than five years	1,144	-	1,144
Later than five years	1,058	-	1,058
Total	2,471	395	2,866

Other legal claims totalling £0.4m (£0.4m 2014/15) are made up of employer's liability and public liability claims for which there is also a corresponding contingent liability of £0.2m declared in Note 23. Pensions - other staff (£2.5m) relates to the cost of permanent injury retirements.

The amount provided for employer's / public liability claims is based on actuarial assessments received from the National Health Service Litigation Authority (NHSLA) as to their value and anticipated payment date.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 22.2 Clinical negligence liabilities

At 31 March 2016, £168,346k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Wirral University Teaching Hospital NHS Foundation Trust (31 March 2015: £93,115k).

Note 23 Contingent assets and liabilities

A contingent liability of £188k exists in 2015/16 for potential third party claims in respect of employer's liability and public liability claims (2014/15 £171k). A provision for the expected value of probable cases is shown in Note 22.1.

Note 24 Contractual capital commitments

	31 March 2016 £000	31 March 2015 £000
Property, plant and equipment	-	35
Intangible assets	375	5,724
Total	<u>375</u>	<u>5,759</u>

Contractual capital commitments relate to committed expenditure with Cerner Limited on the Wirral Millennium project. This supplier is engaged in replacing the Trust's Patient Care Information System.

There are no other capital contracts which commenced in 2015/16, and which are due for completion in a future year.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 25 Financial instruments

Note 25.1 Financial risk management

Liquidity risk

The Trust's net operating costs are incurred in delivering healthcare under annual contracts with Clinical Commissioning Groups (CCGs), which are ultimately funded from resources voted annually by Parliament. The Trust receives this CCG income through the Payment by Results (PBR) mechanism, which bases the income received each year to the activity delivered in that year by reference to the National Tariff. Monthly payments are received from CCGs based on annual service contracts, and this national framework reduces the Trust's exposure to liquidity risk.

In addition, the Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form. Liquidity is monitored by the Board on a monthly basis through monthly reports on movements, variances and trends in Monitor's Financial Sustainability Risk Rating (FSRR).

The Trust may borrow from commercial organisations to support liquidity, but currently has no commercial borrowings. The Trust holds two loans with the Department of Health which have funded capital developments. A total facility of £14m is in place, which comprises a 25 year loan (£6.5m at 4.32% fixed interest rate, drawn down in 2009/10), and a 10 year loan (£7.5m at 1.96% fixed interest rate, drawn down in 2014/15). Repayments on the loans have commenced, and are paid according to a set schedule over the period of the loans; there is therefore no risk that a number of significant borrowings could become repayable at one time, and cause unplanned cash pressures.

The loan repayment schedule is contained within the maturity of financial liabilities table in Note 26.3.

Interest rate risk

All of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest other than the Trust's bank accounts which earn interest at a floating rate. The Trust is not exposed to significant interest rate risk.

Credit risk

The Trust minimises its exposure to credit risk arising from deposits with banks and financial institutions through implementing its Treasury Management Instructions. Cash required for day to day operational purposes is held within the Trust's Government Banking Services (GBS) account. GBS balances are swept into the Bank of England overnight, with the specific aim of reducing credit risk exposure for bodies within government.

The main source of income for the Trust is from CCGs in respect of healthcare services provided under agreements. The credit risk associated with such customers is minimal. The Trust regularly reviews debtor balances, and has a comprehensive system in place for pursuing past-due debt. Non-NHS customers typically have a higher default rate, but represent a small proportion of income. Therefore, the Trust is not exposed to significant credit risk from its customers.

The carrying amount of financial assets represents the Trust's maximum level of credit exposure. Therefore, the maximum exposure to credit risk at the Statement of Financial Position date was £10.3m (£8.9m 2014/15), being the total of the carrying amount of financial assets excluding cash (Note 26.1).

There are no amounts held as collateral against these balances.

An analysis of aged and impaired receivables is disclosed in Note 16.3.

The movement in the provision for impaired receivables during the year is disclosed in Note 16.2. From the total balance of assets which require a provision for their impairment, £0.4m (£0.6m 2014/15) are impaired financial assets.

Terms have been renegotiated for financial assets totalling £34k (£25k 2014/15), which would otherwise be deemed past due or impaired.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Currency risk

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

Note 26.1 Financial assets

	Loans and receivables £000	Total £000
Assets as per SoFP as at 31 March 2016		
Trade and other receivables excluding non financial assets	10,283	10,283
Cash and cash equivalents at bank and in hand	3,523	3,523
Total at 31 March 2016	13,806	13,806

	Loans and receivables £000	Total £000
Assets as per SoFP as at 31 March 2015		
Trade and other receivables excluding non financial assets	8,884	8,884
Cash and cash equivalents at bank and in hand	22,938	22,938
Total at 31 March 2015	31,822	31,822

Note 26.2 Financial liabilities

	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2016		
Borrowings excluding finance lease and PFI liabilities	11,284	11,284
Obligations under finance leases	88	88
Trade and other payables excluding non financial liabilities	27,928	27,928
Provisions under contract	-	-
Total at 31 March 2016	39,300	39,300

	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2015		
Borrowings excluding finance lease and PFI liabilities	12,299	12,299
Obligations under finance leases	450	450
Trade and other payables excluding non financial liabilities	19,289	19,289
Provisions under contract	-	-
Total at 31 March 2015	32,038	32,038

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 26.3 Maturity of financial liabilities

	31 March 2016 £000	31 March 2015 £000
In one year or less	28,978	27,356
In more than one year but not more than two years	1,048	959
In more than two years but not more than five years	3,066	3,723
In more than five years	6,208	-
Total	39,300	32,038

Note 26.4 Fair values of financial instruments at 31 March 2016

The Trust has two loans with the Department of Health. The carrying value of this borrowings liability is considered to approximate to fair value, the interest rate not being significantly different from market rate. All other financial assets and liabilities have carrying values which are not significantly different from their fair values.

Note 27 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise.

The Trust made the following losses and special payments, on an accruals basis, during the financial year.

	2015/16		2014/15	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	11	3	1	1
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	22	3	48	37
Stores losses and damage to property	1	5	2	6
Total losses	34	11	51	44
Special payments				
Extra-contractual payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Compensation payments	-	-	-	-
Special severance payments	1	20	-	-
Ex gratia payments	68	212	23	11
Total special payments	69	232	23	11
Total losses and special payments	103	243	74	55

Note 28 Events after the reporting date

There are no events after the reporting period which require disclosure.

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Note 29 Related party transactions

Wirral University Teaching Hospital NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. Monitor (the regulator of NHS foundation trusts) does not prepare group accounts; instead, Monitor prepares NHS Foundation Trust Consolidated Accounts, for further consolidation into the Whole of Government Accounts. Monitor has powers to control NHS foundation trusts, but its results are not incorporated within the consolidated accounts, and it cannot be considered to be the parent undertaking for foundation trusts. Although there are a number of consolidation steps between the Trust's accounts and Whole of Government Accounts, the Trust's ultimate parent is HM Government.

Whole of Government Accounts bodies

All bodies within the scope of the Whole of Government Accounts (WGA) are considered to be related parties as they fall under the common control of HM Government and Parliament. The Trust's related parties therefore include other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies, non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Trust has had a number of transactions with WGA bodies. When the total transactions with a given counterparty are collectively significant, they are listed below.

Significant balances and transactions held against WGA related parties

Related party	2015/16		2015/16	
	Income £000	Expenditure £000	Receivables £000	Payables £000
Countess of Chester Hospital NHS Foundation Trust	3,556	5,484	806	791
Health Education England	9,572	-	7	227
HM Revenue & Customs	-	12,885	767	3,765
NHS Blood and Transplant	3	1,752	-	85
NHS England (including sub-entities)	25,635	819	508	1,157
NHS Litigation Authority	352	11,620	-	251
NHS Pension Scheme	-	18,391	-	2,600
NHS Professionals	-	1,179	13	846
NHS West Cheshire CCG	16,578	-	283	61
NHS Wirral CCG	225,059	1	1,797	2,367
The Clatterbridge Cancer Centre NHS Foundation Trust	5,007	466	1,354	1,011
Betsi Cadwaladr University Local Health Board	3,340	167	196	73
Wirral Community NHS Trust	1,673	703	249	102
Wirral Metropolitan Borough Council	1,145	243	340	55

Related party	2014/15		2014/15	
	Income £000	Expenditure £000	Receivables £000	Payables £000
Countess of Chester Hospital NHS Foundation Trust	2,922	5,000	1,030	522
Health Education England	9,483	-	62	-
HM Revenue & Customs	-	12,850	442	3,732
NHS Blood and Transplant	-	-	-	-
NHS England (including sub-entities)	25,945	1,058	999	275
NHS Litigation Authority	-	7,581	-	3
NHS Pension Scheme	-	17,915	-	2,410
NHS Professionals	-	-	-	-
NHS West Cheshire CCG	16,054	-	99	314
NHS Wirral CCG	223,670	3	1,735	1,528
The Clatterbridge Cancer Centre NHS Foundation Trust	4,958	435	1,849	1,086
Betsi Cadwaladr University Local Health Board	3,183	-	-	-
Wirral Community NHS Trust	1,642	1,330	1,273	939
Wirral Metropolitan Borough Council	2,542	-	-	-

Wirral University Teaching Hospital NHS Foundation Trust - Annual Accounts 2015/16

Public dividend capital (PDC) transactions with the Department of Health

The Trust made PDC dividend payments to the Department of Health totalling £3.9m (£4.3m 2014/15), received additional PDC of £0.04m (£3.5m 2014/15), and is reporting a year-end creditor totalling £0.1m (£0.0m 2014/15) for PDC dividend payable.

Provision for impairment of receivables - related parties

Four related party debts have been written off by the Trust in 2015/16 totalling £1k (nil 2014/15). The Trust has included a balance of £101k within its provision for impairment of receivables against related parties. Of this, £86k relates to aged debts with Wirral Metropolitan Borough Council, and £15k relates to aged debts with non-NHS commissioners.

Charitable related parties

Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund (registered charity number 1050469) is a subsidiary of the Trust and therefore a related party. The Trust is the Charity's corporate trustee, which means that the Trust's Board of Directors is charged with the governance of the Charity. The Charity's sole activity is the funding of charitable capital and revenue items for the benefit of patients.

The Charity's reserves balance as at 31 March 2016 was £1,634k (£1,553k 2014/15) with net incoming resources of £81k (£470k 2014/15). During the year the Charity incurred expenditure of £343k (£380k 2014/15) in respect of goods and services for which the Trust was the beneficiary.

Other related parties

Aside from the Trust's Charity, the Trust has no subsidiaries or associates.

Key management personnel

During the financial year under review, no member of either the Board or senior management team, and no other party closely related to these individuals, has undertaken any material transactions with Wirral University Teaching Hospital NHS Foundation Trust.

Key management personnel are identified as those directors who are members of the Trust's senior management team, and the non-executive directors of the Trust. Details of their remuneration and other benefits can be found in Note 6.2 and the remuneration section of the Annual Report.

