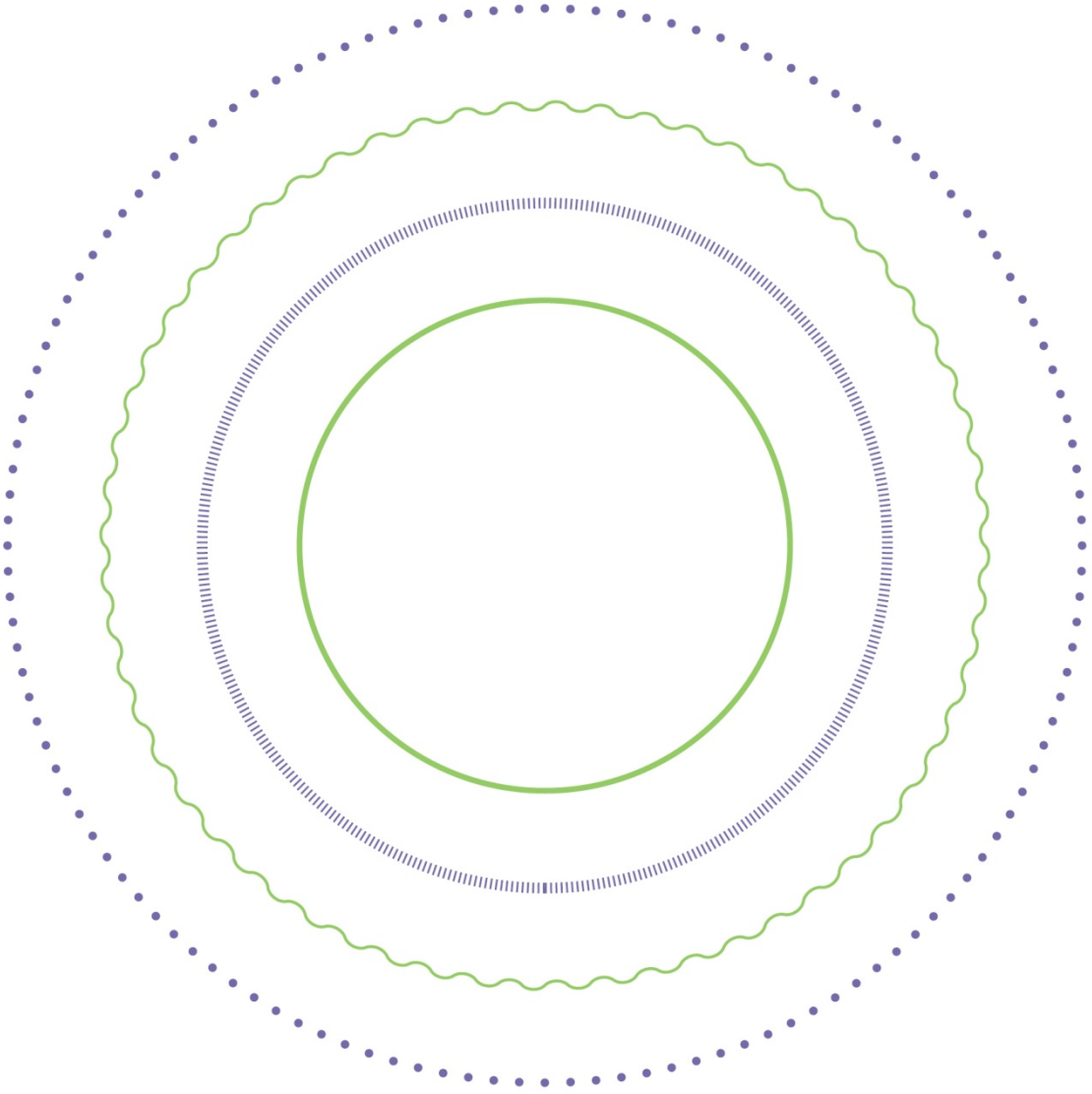
Wrightington, Wigan and Leigh
NHS Foundation Trust

Annual Report and Accounts
1 April 2011 – 31 March 2012



your hospitals, your health, our priority

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

Wrightington, Wigan and Leigh NHS Foundation Trust

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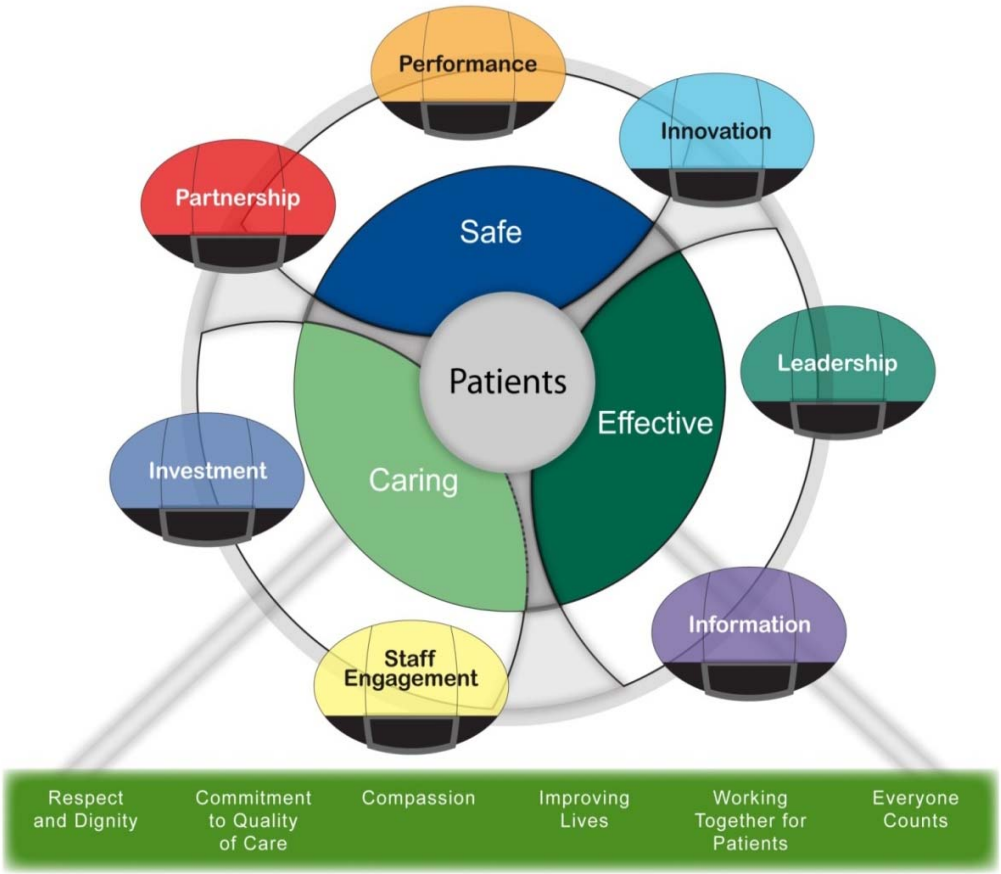
Contents

Review of the Year

Welcome to our annual review. We very much hope that you will enjoy reading about the successes and challenges of our three hospitals during another highly eventful year. This annual publication always contains many facts, figures and diagrams but this does not mask the fact that what really happens in hospitals are millions of highly important interactions between individual people, whether patients, carers or staff. Patients and carers are often at their most vulnerable in hospital and the very human, caring nature of staff and volunteers makes more difference than all of the complex drugs, equipment and procedures. It is one of the greatest strengths of the NHS that staff and volunteers have a true sense of vocation and derive real pleasure and satisfaction from being able to make a difference to patients.

2011/12 was the first year of austerity for the NHS and our biggest challenge has been to continue to improve the quality of services at the same time as reducing our costs. We expect this to be the economic environment for some years to come, so to explain our overall approach, this year we have introduced the 'WWL Wheel' (see below). The wheel is a simple visual representation of what we are trying to achieve. It places patients right at the heart and surrounds them with a commitment to quality, defined as "safe, effective and caring". The wheel sits firmly on a foundation of the NHS Values and has seven 'pods', representing the Trust's seven strategic priorities. Over time we expect everyone to become fully familiar with the Wheel and you will see the way that it has influenced the structure of the Annual Report.

The WWL Wheel



There have been many highlights of the year, here are just a few:

Safe

- In the whole year we had just three MRSA bloodstream infections
- The number of cases of Clostridium Difficile fell again to 47 compared with 62 in the previous year
- We only had six hospital acquired pressure ulcers

Effective

- Our Hospital Standardised Mortality Ratio (HSMR) fell again to 87.1 (for the period 1 April 2011 to 29 February 2012)
- We achieved a surplus of £2.9m (subject to audit) to invest in new buildings and equipment for next year
- We successfully achieved all of the targets for waiting times

Caring

- We reduced the number of cancelled outpatient appointments to 5.11% compared with 6.08% last year
- Our national patient survey showed that 91.2% of patients would recommend the hospital to family and friends
- Our local patient survey showed that 95.5% of patients would recommend the hospital to family and friends

It is also important to note that we conducted a year-long review into whether to close one or more of our hospitals in order to cope with the economic downturn. We are very pleased to report that this exhaustive analysis concluded that our best strategy is to retain and invest in all of our hospital sites. We have appointed development partners and the first investments will take effect during 2012.

Our main challenge was and will continue to be economic. Our turnover is £247m, but last year we had to achieve savings of £14m and expect a similar annual target for the foreseeable future. This means shrinking the size of the hospital and this year saw the closure of two wards as well as the first year of a staff pay freeze.

These are difficult times for everybody and we would like to conclude this review by expressing our heartfelt thanks to three very important groups. Firstly, we thank our GPs and other colleagues in commissioning who have worked in close partnership to protect the viability of your NHS Hospitals during times of austerity. Secondly, we thank our unpaid Board of Governors who generously contribute their time in overseeing our Board and our strategy. Finally, we thank our staff and volunteers who continue to provide that most excellent human quality of care despite these demanding times.

Les Higgins
Chairman

Andrew Foster
Chief Executive

Trust Profile

Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) is the leading provider of acute hospital services to the people of the Wigan Borough and surrounding area. The Trust provides district general hospital services for the local population of over 300,000 and specialist orthopaedic services to a much wider regional, national and international catchment area.

The Trust's strategy puts patients at the centre of all we do. Our commitment to quality surrounds our patients to ensure we deliver services which are safe, effective and caring. The Trust continues to demonstrate considerable success in improving quality. We have again reduced incidences of MRSA Bacteraemia, Clostridium Difficile, incidences of pressures sores and also continue our focus on improving our mortality rate (Hospital Standardised Mortality Ratio). The Quality Accounts section of this annual report provides much more detail on the ongoing quality improvements we are achieving.

WWL employs approximately 4,275 staff and operates from three hospital sites, as well as the Thomas Linacre Centre (TLC), a state-of-the-art outpatient centre in Wigan town centre. In addition, the Trust has administration offices located at Buckingham Row in central Wigan.

WWL's three hospital sites are:

Royal Albert Edward Infirmary (RAEI)
The RAEI is the Trust's main district general hospital site that is located in central Wigan. This is the largest of the Trust's sites with over 738 beds and provides the main operating base for high quality emergency and associated secondary care.

Wrightington Hospital
Wrightington Hospital is a leading orthopaedic centre of excellence and attracts patients locally, regionally, nationally and internationally. Hip replacement surgery was pioneered at Wrightington Hospital in the early 1960's by Professor Sir John Charnley. The site continues to operate as one of the country's leading treatment centres for joint replacement.

Leigh Infirmary
Leigh Infirmary offers a range of outpatient, diagnostic and limited inpatient services. It is mainly devoted to planned patient care and is protected from the pressures of emergency work.

The Trust has rationalised services by concentrating all acute and emergency services at the main RAEI site in Wigan, with Leigh Infirmary and Wrightington Hospital developing primarily as specialist diagnostic and treatment centres. Our service and site strategy has defined a £80 million investment programme across the three hospital sites over the next 10 years.

The Care Quality Commission (CQC) is the health and social care regulator for England. It carried out inspections in the Trust in the summer of 2011 and their report, published in July 2011, stated:

> "We found that Wrightington, Wigan and Leigh NHS Foundation Trust was meeting all the essential standards of quality and safety we reviewed."

Mission Statement

The Trust has a mission statement which is simple, but direct:

“To provide the best quality healthcare for all our patients”

To provide the best care for patients, WWL must strive to attract and support the best staff. The Trust is dedicated to improving the working lives of staff and recognises that it cannot provide the best possible patient care unless it provides a working environment in which staff can thrive.

Quality Governance Reporting

During 2011/12 the Trust has had arrangements in place to govern service quality. These arrangements include having regard to Monitor’s quality governance framework, which has been built into the business planning process for Divisions. The Board Assurance Framework for 2011/12 included monitoring of key quality indicators, including reducing mortality figures, achieving positive patient experience scores in real-time patient experience surveys and maintaining CQC registration without conditions.

The Trust has a quality strategy, and later in this report information is provided from Divisions and Departments on initiatives undertaken to bring about quality improvements during the year.

Within the annual accounts section of this report there is an Annual Governance Statement (AGS) from page 2 of this report. This statement sets out the steps that have been put in place to assure the Board that the governance arrangements for maintaining a sound system of internal control are in place. Section 4.2 of the AGS outlines the processes in place for the quality governance arrangements. In addition, the Trust’s Quality Accounts for 2011/12 is a separate section of this report that goes into much more detail on how the Trust has performed against a wide range of quality indicators aimed at improving the experience of patients who use our services.

Part 2 of the Quality Accounts provides details of the Trust’s performance against key healthcare targets, the monitoring arrangements for improving quality using Divisional quality dashboards and the Trust’s performance against Commissioning for Quality and Innovation (CQUIN) and the CQC.targets. Our partnership arrangements with key stakeholders are also described in section 2.1.2. Part 3 of the Quality Accounts reports in detail on a wide range of initiatives that the Trust has engaged with to improve patient care. The Advancing Quality Programme, Safety Express/Harm Free Care and Energising for Excellence are all initiatives designed to improve the care we provide to patients. More details on each of these programmes is provided in Part 3 of the Quality Accounts.

Trust Board

The Trust Board comprises a Chairman, seven Non-Executive Directors and six Executive Directors. During the period of this report, the Trust Board comprised:

Non-Executive Directors:

Les Higgins
Chairman

Louise Barnes
Vice Chair/ Senior Independent Director

Robert Armstrong
Non-Executive Director

Stephen Ball
Non-Executive Director (Resigned 31/01/12)

Geoff Bean
Non-Executive Director

Robert Collinson
Non-Executive Director

Neil Turner
Non-Executive Director

Christine Parker Stubbs
Non-Executive Director (Appointed 12/03/12)

Executive Directors:

Andrew Foster
Chief Executive

Silas Nicholls
Director of Strategy and Planning

Umesh Prabhu
Medical Director

Gill Harris
Deputy Chief Executive Director of Nursing and Performance

Keith Griffiths
Director of Finance and Informatics (resigned 22/07/11)

Jon Lenney
Director of Human Resources

Rob Forster
Director of Finance and Informatics (Acting 24/07/11. Appointed 10/11/11)

Board of Directors Report

The Board of Directors operates according to the highest corporate governance standards. It is a unitary Board with collective responsibility for all aspects of the performance of the Trust including strategic development, approving policy and monitoring performance. This includes ensuring the delivery of effective financial stewardship, high standards of clinical and corporate governance and promoting effective relations with the local community. The Board is responsible for ensuring that the Trust is, at all times, compliant with its Terms of Authorisation.

The Trust Board has seven independent Non-Executive Directors including the Chairman. During the year there were changes to the Board of Directors. Mr Stephen Ball resigned as a Non-Executive Director on 31/01/12 and Mrs Christine Parker Stubbs joined the Trust as a Non-Executive Director on 12/03/12. The Executive Director of Finance and Informatics, Mr Keith Griffiths left the Trust on 22/07/11 to take up a new post with Huddersfield and Calderdale NHS Foundation Trust. We were pleased to appoint Mr Rob Forster as the new Director of Finance and Informatics. The Board members are as follows:

Non-Executive Directors:

Leslie Higgins (Reappointed 1/11/11)
Chairman

Experience:

Les Higgins has lived in Wigan for over 30 years and has mainly worked in Local Government in Liverpool and Warrington.

Les is a highly experienced senior manager with a total of 32 years within the public sector. As a specialist in social housing, in particular repairs, maintenance and estate regeneration, Les has extensive experience in community consultation and the development of contracts for the delivery of public services. Prior to retirement he worked for the Chief Executive at Warrington Borough Council. He continues his links with local government as Clerk to Winwick Parish Council.

Les chairs the Trust Board, the Council of Governors, Charitable Trust Board and Remunerations Committee.

He is also involved in the development of local strategic policies through his membership of the Wigan Borough Partnership Board, the Wigan Health and Wellbeing Board and the Quality, Innovation, Productivity and Prevention (QIPP) Board.

The Chairman has no other significant commitments.

Qualifications:

Diploma in Public Administration.

Louise Barnes (Reappointed 1/12/11)
Deputy Chair/Senior Independent Director

Experience:
After graduating from higher education as a mature student, Louise worked for a national company developing and implementing the Telemarketing function. She went on to work with a local business, facilitating the development of a five year business plan, strategic marketing plan and the buy-out of a rival company. Following this she worked as a freelance Public Relations and Marketing consultant for several large North West businesses, also advising on internal and external communication strategies.

Louise joined the Trust as a Non-Executive Director in 2003.

Louise chairs the Governance and Risk Committee within the Trust.

Qualifications:
HND in Business and Finance.
BA (*Hons*) Business Administration First Class Degree.

Stephen Ball
Non-Executive Director (Resigned 31/01/12)

Experience:
Stephen has spent 27 years in the banking and finance industry at a senior level and more recently Managing Director of a leading edge property company specialising in urban regeneration.

A qualified banker with strong commercial and financial experience at director level, Stephen has worked in a variety of customer-centric and complex businesses across a range of national and international markets. Currently, Stephen runs his own consultancy and is involved with a number of finance projects linked to the property sector and environmentally responsible businesses engaged in renewable energy and recycling.

Qualifications:
Associate of the Chartered Institute of Bankers.
National Diploma in Marketing.

Geoff Bean
Audit Chair (Reappointed 1/08/11)

Experience:
Geoff is a qualified accountant and has broad financial experience at Finance Director level. He has worked for over 35 years in a variety of international businesses.

After 13 years in the automotive industry, he worked in the paper industry in the USA, and in businesses using plastics and coated materials in environmental, sports equipment, consumer and safety products. He has also

worked in businesses which supplied medical equipment and other medical products to the NHS. This was part of the connection which drew Geoff to his role at the Trust along with a strong belief in the NHS.

In addition to his financial roles he has held responsibility for procurement, sales, customer service and IT.

Geoff Chairs the Trust's Audit Committee.

Qualifications:
BSc, MSc, FCMA (Fellow of the Chartered Institute of Management Accountants).

Robert Collinson
Non-Executive Director (Reappointed 1/08/11)

Experience:
Robert has been qualified as a solicitor since 1988 and he has had broad experience in commercial legal practice. His professional work has included giving practical legal advice on many aspects of the law of direct relevance to the work of an NHS Foundation Trust.

He is currently a senior law lecturer in higher education and is also an external examiner for the Solicitors' Regulation Authority. Robert has previous experience of working in a governance role and has served as a Non-Executive Board Member of a housing association since 2005.

Qualifications:
LLB First Class Honours - Lancaster University (1984).
BCL (Masters degree in Law) Balliol College - University of Oxford (1985).
Solicitors Final Examinations, passed with honours - The College of Law (1986).
Qualified as a solicitor 1988.

Robert Armstrong
Non-Executive Director (Reappointed 1/03/12)

Experience:
Robert has lived in Wigan for 18 years since moving from Carlisle.
He joined the Post Office in 1973 as a telecommunications engineer then moved into management and senior management positions in BT.

His experience covers; business development, customer service and business improvement. He specifically led projects in the creation of joint ventures in Europe and the USA, always championing the "customer led" approach. His final position in BT saw him lead business improvement projects using LEAN methodologies. Robert lives in Wigan with his family.

Robert chairs the Finance and Investment committee and Shared Services Board.

Robert is a school governor at Britannia Bridge School, in Ince.

Qualifications:
BSc – Open University, HNC Business and Finance, Telecommunications Certificates – City & Guilds.

Neil Turner
Non-Executive Director (Appointed 30.3.11)

Experience:
Neil brings a vast amount of knowledge to the Trust, having had extensive experience of working within public services at local government level.

Neil was also Member of Parliament for Wigan for over 10 years and has campaigned at national level for improvements in health services and health funding within the Wigan constituency.

Christine Parker Stubbs
Non-Executive Director (Appointed 12/03/12)

Experience:
Christine is an IT graduate with a broad range of experience delivering and managing IT in commercial environments. Following university Christine worked as a consultant for Oracle, delivering bespoke IT solutions into North West based blue chip companies. Since then Christine has worked predominantly in the automotive sector latterly as a Divisional IT Director at RAC Motoring Services where she was responsible for the Business Solutions division. Christine's experience also includes the delivery of large scale business change and transformation projects.

Christine lives in the Wigan area with her young family.

Qualifications:
BSc (Hons) Computing and Information Technology (University of Surrey)

Details of Non-Executive Appointments:

Name	Date of Appointment	Appointment Ends
Mr Robert Armstrong	1/03/08 Reappointed 1/03/12	28/02/12 28/02/15
Mr Geoff Bean	1/08/07 Reappointed 1/08/11	31/07/11 31/07/14
Mr Robert Collinson	1/08/07 Reappointed 1/08/11	31/07/11 31/07/14
Mrs Janine Louise Barnes (Senior Independent Director)	First appt. 1/12/03 Reappointed 1/12/07 Reappointed 1/12/11	30/11/11 30/11/14
Mr Les Higgins (Chair)	Reappointed 1/12/06 Appointed Acting Chair 30/06/07 Appointed Chair 1/11/07 Reappointed 1/11/11	31/10/11 31/10/14
Mr Stephen Ball	1/07/09	31/06/12 Resigned 31/01/12
Mr Neil Turner	30/03/11	29/03/14
Mrs Christine Parker Stubbs	12/03/12	11/03/15

Executive Directors:

Andrew Foster
Chief Executive

Experience:

Andrew was appointed as Chief Executive in January 2007 after a short secondment as Human Resources Director at Blackpool, Fylde and Wyre NHS Trust. Before that he spent five years as the NHS Director of Human Resources (Workforce Director General) at the Department of Health with principal responsibility for implementing the workforce expansion and HR systems modernisation set out in the NHS Plan. This notably included the creation of the first ever NHS HR Strategy (the HR in the NHS Plan), the negotiation and implementation of the new Consultant Contract and Agenda for Change, three year pay deals and EU Working Time Directive compliance.

Previously, he spent two years as part time Policy Director (HR) at the NHS Confederation. Andrew was also the Chairman of Wrightington, Wigan and Leigh NHS Trust from 1996 to 2001 and before that Chairman of West Lancashire NHS Trust and Non-Executive Director at Wrightington Hospital NHS Trust.

Qualifications:

BA (Hons) in Philosophy, Politics and Economics from Keble College, Oxford, 1976.

Gill Harris
Deputy Chief Executive / Director of Nursing and Performance

Experience:

Gill Harris was appointed Deputy Chief Executive/Director of Nursing and Performance, DIPC (Director of Infection Prevention and Control) in 2010 following her appointment as Director of Nursing and Patient Services from April 2007.

Gill's nursing career began as a Specialist Nurse at Addenbrookes NHS Trust, moving on to the Head of Nursing position at University Hospitals of North Staffordshire NHS Trust before moving into general management. Her career at WWL initially commenced as General Manager for the Division of Surgery in June 2004, and also included appointments as Deputy Director of Operations and Director of Nursing and Patient Services.

As part of her role at WWL, Gill is responsible for Governance, Patient Relations and the Operational Management. She also provides clear leadership to the Trust's Nursing and Midwifery workforce whilst contributing significantly to the Trust's agenda for quality, safety and improvement of our patients' experience of services.

Gill also currently undertakes various other roles for the Region including the North West Director of Nursing Lead for Energising for Excellence which clearly demonstrates her commitment to patient care, quality and safety.

Qualifications:

Registered General Nurse, MA (Strategic Healthcare).

Keith Griffiths
Director of Finance and Informatics (Resigned 22/07/11)

Experience:

Keith joined the Trust as Director of Finance and Informatics in August 2005, having previously worked as Director of Finance at the East Cheshire NHS Trust in Macclesfield.

Prior to this, from 1996, Keith had worked as Finance Director at the Walton Centre for Neurology and Neurosurgery NHS Trust in Liverpool.

Qualifications:

Chartered Institute of Public Finance and Accountancy (CIPFA), BSc (Hons).

Dr Umesh Prabhu
Medical Director

Experience:

Dr Umesh Prabhu joined the Trust in early 2010 from the Pennine Acute Hospitals NHS Trust where he held the position of Consultant Paediatrician based at Fairfield General Hospital.

After his graduation in India, Dr Prabhu came to the UK in 1982. He then trained in Paediatrics at Oxford, Edinburgh and Leeds and in 1992 was appointed as a Consultant Paediatrician to the Bury NHS Trust. After six years as lead clinician in Paediatrics, Dr Prabhu was appointed as Medical Director. As Medical Director he conducted an audit of all medico-legal cases and complaints.

In his role as Consultant Paediatrician at Fairfield General Hospital, Dr Prabhu developed and implemented guidelines for the Neonatal Unit and Paediatric Department. His broad experience includes a period as a Non-Executive member of the National Patient Safety Agency (NPSA), National Clinical Assessment Service (NCAS) adviser on secondary care and Clinical Director for NHS Professionals. Dr Prabhu was also a member of Patient and Public Involvement Forum of Rochdale PCT.

Dr Prabhu has always been keen on patient safety, quality of care and patient involvement and engagement. He has lectured on many topics including patient safety, medical errors, clinical risk management, clinical governance, medical leadership, patient and public involvement and performance management of doctors.

With a strong belief that protecting patients and supporting doctors and nurses are two sides of the same coin, Dr Prabhu's passion for the NHS is obvious. His commitment to improving services centred on patients and their experience will greatly assist WWL in its clinical development strategy.

Qualifications:

MBBS, DCH, FRCPCH.

Silas Nicholls
Director of Strategy and Planning

Experience:

Silas joined the Trust in October 2010 as Director of Strategy and Planning arriving from his previous role as Director of Operations and Performance at the Clatterbridge Centre for Oncology NHS Foundation Trust.

Silas started his career in the NHS as a graduate management trainee and has held a wide range of general management posts within the Health Service. These have included commissioning posts in health authorities, management of community services and working as a Divisional Manager in a number of large hospital trusts in the North West.

In addition to this Silas has worked outside of the Health Service, most notably as Head of NHS Strategy and Policy for 3M Health Care Ltd.

Qualifications:

Silas holds a Law Degree as well as a Master's Degree in Business Administration.

Jon Lenney
Director of Human Resources and Organisational Development

Experience:

Jon Lenney was appointed Director of Human Resources and Organisational Development at WWL in October 2010. Jon has a strong commitment to staff engagement and to workforce and leadership development.

He has worked in the NHS since 1986 in a variety of different settings within the Human Resources and Organisational Development fields and comes to the Trust with 16 years experience as an Executive Director.

From March 2007 he worked for North West Ambulance Service NHS Trust as Director of Organisational Development and led on the Trust's application to become an NHS Foundation Trust. Prior to this, Jon was Director of Human Resources at University Hospital of Morecambe Bay NHS Trust between 1998 and 2007.

Qualifications:

Jon has a MA in Health Service Management (University of Manchester - 2000) and BA (Hons) in Public Administration (Sheffield City Polytechnic - 1986) and is a FCIPD (Fellow of the Chartered Institute of Personnel and Development.)

Rob Forster
Director of Finance and Informatics (from 24/07/11)

Experience:

Rob was appointed as Director of Finance and Informatics in July 2011, after joining the Trust as Deputy Director of Finance in April 2009.

After qualifying in Law, Rob then went on to become a chartered accountant with PricewaterhouseCoopers, spending most of his professional and commercial accounting career at General Motors where he worked across Europe, including in Italy and Switzerland

Qualifications:

LLB (Hons) in Law
ACA in Finance
MBA in Business

Trust Board Attendance:

Non-Executive Directors:	Attendance 2011/12
Mr Les Higgins, Chairman	12/12
Ms Louise Barnes, Vice Chairman/Senior Independent Director	11/12
Mr Geoff Bean, Chair of Audit	12/12
Mr Robert Armstrong	11/12
Mr Robert Collinson	11/12
Mr Stephen Ball	7/9
Mr Neil Turner	9/12
Mrs Christine Parker Stubbs	1/1
Executive Directors:	**Attendance 2011/12**
Mr Andrew Foster, Chief Executive	12/12
Mrs Gill Harris, Director of Nursing and Performance	11/12
Mr Keith Griffiths, Director of Finance and Informatics	3/3
Dr Umesh Prabhu, Medical Director	9/12
Mr Jon Lenney, Director of Human Resources and OD	11/12
Mr Silas Nicholls, Director of Strategy and Planning	12/12
Mr Rob Forster, Director of Finance and Informatics	10/10

Charitable Trust Board Attendance:

Board Member	Attendance 2011/12
Mr Les Higgins, Chairman	2/4
Ms Louise Barnes, Vice Chairman/Senior Independent Director	4/4
Mr Geoff Bean, Chair of Audit	3/4
Mr Robert Armstrong	3/4
Mr Robert Collinson	4/4
Mr Stephen Ball	1/3
Mr Neil Turner	2/4
Mrs Christine Parker Stubbs	0/0
Mr Andrew Foster, Chief Executive	3/4
Mrs Gill Harris, Director of Nursing and Performance	2/4
Mr Keith Griffiths, Director of Finance and Informatics	1/2
Dr Umesh Prabhu, Medical Director	2/4
Mr Jon Lenney, Director of Human Resources and OD	4/4
Mr Silas Nicholls, Director of Strategy and Planning	3/4
Mr Rob Forster, Director of Finance and Informatics	3/4

Sub-Committees of the Board

During 2011/12 the Board has the following sub-committees:

Committee	Members	Attendance 2011/12
Remuneration	LH (Chair)	1/1
	GB	1/1
	RA	1/1
	RC	0/1
	LB	1/1
	SB	0/1
	NT	0/1
Governance and Risk	LB	6/6
	UP	4/6
	GH	5/6
	AF	3/6
	RC	3/6
	LH	4/6
	SB	4/5
	JL	3/6
Finance and Investment	AF	12/12
	JL	9/12
	KG	2/3
	LB	10/12
	GH	5/12
	SN	11/12
	UP	7/12
	GB	10/12
	RA	12/12
	RF	12/12
Audit	GB	6/7
	RA	5/7
	RC	7/7
	SB	1/6
	NT	5/7

Key:

AF	Andrew Foster	LH	Les Higgins
GH	Gill Harris	LB	Louise Barnes
KG	Keith Griffiths	GB	Geoff Bean
UP	Umesh Prabhu	RA	Robert Armstrong
SN	Silas Nicholls	RC	Robert Collinson
JL	Jon Lenney	SB	Stephen Ball
RF	Rob Forster	NT	Neil Turner
		CPS	Christine Parker Stubbs

Disclosure to Auditors

For each individual Director, so far as he or she is aware, there is no relevant audit information of which the auditors are unaware. Each Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information. All Directors have taken the necessary steps as required of a Director to exercise reasonable care, skill and diligence.

Balance of Board Membership

The Board of Directors collectively considers that it is appropriately composed with a balanced spread of expertise to fulfil its function and terms of authorisation with the Chairman and Non-Executive Directors meeting the independence criteria laid down in the NHS Foundation Trust Code of Governance.

Performance Evaluation and Decision Making

There is a schedule of matters reserved for the Board of Directors that details the roles and responsibilities of the Board, Council of Governors and Sub-Committees of the Board.

The performance of the Executive Directors is evaluated by the Chief Executive, and that of the Chief Executive and Non-Executive Directors by the Chairman, on an annual basis. A Non-Executive Director appointment may be terminated on performance grounds or for contravention of the qualification criteria set out in the Constitution, with the approval of three quarters of the members of the Council of Governors present and voting at the meeting, or by mutual consent for other reasons.

The Trust's Executive Team provides organisational leadership and takes appropriate action to ensure that the Trust delivers its strategic and operational objectives. It maintains arrangements for effective governance throughout the organisation, monitors performance in the delivery of planned results and ensures that corrective action is taken when necessary. During 2011/12 progress against the external governance review action plan conducted by PricewaterhouseCoopers in 2010/11 has been monitored. The areas for improvement have been addressed and embedded in the Trust moving forward.

Remuneration Committee

The Remuneration Committee met in June 2011 to approve the annual performance reviews of Executive Directors. The terms of reference were reviewed to ensure these remained in line with best practice. The committee also agreed a new Executive Director remuneration policy. During 2011 an independent external consultancy was commissioned to support the process to appoint a new Executive Director of Finance and Informatics.

Statement of Accounts Preparation

The Directors can confirm that the accounts have been prepared under directions issued by Monitor, the independent Regulator for Foundation Trusts as required by Paragraph 24 and 25 of Schedule 7 to the National Health Service Act, in accordance with the NHS

Annual Reporting Manual 2012 and Monitor Code of Governance provision F1.1. During the 2011/12 reporting period the Trust did not make any political or charitable donations.

Review of System of Effectiveness of Internal Controls

The Board has in place processes to conduct an annual review of the effectiveness of the Trust's system of internal controls. All sub-committees of the Board conduct an annual review of effectiveness including Finance and Investment, Governance and Risk and Audit Committee. In addition the Audit committee received annual effectiveness reports from the HR, Patient Engagement, Clinical Audit, Information Governance and Corporate Communications Committees. The annual governance statement giving more details on the internal controls is reported separately within the Annual Accounts.

Director Register of Interests

Members of the public can gain access to the Register of Director's Interests by writing to Helen Hand, Trust Board Secretary, Wrightington, Wigan and Leigh NHS Foundation Trust, The Elms, Royal Albert Edward Infirmary, Wigan Lane, Wigan, WN1 2NN. Telephone 01942 822027 or email helen.hand@wwl.nhs.uk.

The Audit Committee

The objective of the Audit Committee is to provide a source of assurance for the Trust Board regarding the effectiveness of the Trust's Financial, Quality and Governance processes. As part of its work plan, the Committee reviewed the various regulatory reports which the Trust Board has to provide, including reports to Monitor and the Care Quality Commission (CQC). The Committee reviewed the Reports and Accounts of the Trust and the Charitable Funds before recommending them to the respective Boards.

In its meetings the Audit Committee has again requested presentations from each of the Trust's clinical Divisions on the continuing development of their Quality Accounts and how the Divisions are using these as part of their own management and monitoring of quality standards. These presentations assured the Committee that progress is continuing and that actions are in place to address areas requiring improvement. Presentations have also been received on the Trust's progress towards meeting the requirements laid out in the Information Governance Toolkit. Considerable progress has been made in the past year and, although achievement of the full requirements has not been possible to date, the Committee is assured that action plans are in place to do so in 2012/13.

The Internal Audit work plan which was developed in conjunction with Trust Executives and Internal Audit specialists has been completed. At each meeting, the Committee received and reviewed individual reports which identified the level of assurance which could be given for specific processes, along with recommended corrective actions. Status reports which monitor progress against the action plans are used to ensure timely completion and, if necessary, the responsible manager is called to the Committee to explain performance against the action plans. Some of the topics covered by the Internal Audit reports included: several areas of financial control procedures; Human Resources personal files; CQC registration (which included the multiple requirements relating to patient safety and care); business planning and investments in information management and technology.

The performance of the Trust and decisions being made by management relating to clinical quality and business depend upon the quality of data held and used throughout the Trust. The Trust has a Data Quality Committee (DQC) which aims to verify and improve the quality of these huge amounts of data. To do this it uses audits carried out by the Data Quality Department which assess the processes for data collection and the accuracy of data used in reporting. Managers and clinicians are responsible for ensuring data quality improvements. The Audit Committee received a presentation from the DQC on the level of data assurance and also received two Internal Audit reports on data quality specifically relating to the clinical areas of mortality rates and A&E clinical indicators.

The Audit Committee has received progress reports from the Trust's Counter Fraud Specialist (CFS) on the performance against planned actions to deter, prevent, and detect fraud in the Trust. The CFS worked with several other NHS and legal agencies to identify and investigate possible fraud. In the year, £16,771.69 has been recovered from persons committing fraud or unintentional overcharging. The Trust continued to improve its counter fraud performance and has achieved a creditable Level 3 on the national fraud assessment indicators.

During the reporting period Deloitte, the Trust's external auditors, were remunerated for services which were non-audit related. This was for ongoing Board development support which took place in the year. Selection of Deloitte for this was made by an open market tender process, which was carried out by Board members and approved by the Board. The process was approved by the Council of Governors to ensure objectivity and independence had been safeguarded.

Remuneration and Pension Entitlements of Senior Managers

The following tables provide details of the remuneration and pension benefits for senior managers for the year ended 31 March 2012.

These tables are subject to External Audit review.

1. Salaries and Allowances

Name & Title	Year ended 31-Mar-12 Salary	Year ended 31-Mar-12 Other Remuneration	Year ended 31-Mar-12 Benefits in Kind	Year ended 31-Mar-11 Salary	Year ended 31-Mar-11 Other Remuneration	Year ended 31-Mar-11 Benefits in Kind
	Bands of £5,000	Bands of £5,000		Bands of £5,000	Bands of £5,000	
Directors:-	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
L Higgins - Chairman	45 - 50			45-50		
A Foster - Chief Executive	165 - 170			165-170		
G Harris - Director of Nursing and Performance & Deputy CEO	140 -145			130-135		
K Griffiths - Director of Finance & Informatics (in post until 24th July 2011)	35 - 40			125-130		
R Forster - Acting Director of Finance and Informatics(in post 24/07/11 to 09/11/11)	25 - 30					
R Forster - Director of Finance and Informatics(in post 10/11/11 - ongoing)	40 - 45					
J Lenney - Director of HR & Organisational Development	105 - 110			45-50		1.0
M Cloney - Acting Director of HR (in post 28/06/10 to 17/10/10)				20-25		
S Nicholls - Director of Strategy & Planning	100 - 105			45-50		
U Prabhu - Medical Director	40 - 45	100 - 105		40-45	65-70	
C J Chandler - Medical Director (in post 01/04/10 to 05/04/10)				0-5	0-5	
W Livingstone - Director of HR & Deputy CEO (in post 01/04/10 to 17/10/10)				75-80		
J L Barnes - Non Executive Director	15 - 20			15-20		
G Bean - Non Executive Director	15 - 20			15-20		
R Armstrong - Non Executive Director	10 - 15			10-15		
R Collinson - Non Executive Director	10 - 15			10-15		
S Ball - Non Executive Director (in post until 31/01/12)	10 - 15			10-15		
N Turner - Non Executive Director	10 - 15			0-5		
C Parker Stubbs - Non Executive Director (in post 12/03/12 - ongoing)	0 - 5					
P McCann - Non Executive Director (in post 01/04/10 to 17/09/10)				05-10		

All of the above Directors were in post for the 12 month period to 31 March 2012 except where indicated.

2. Hutton Review of Fair Pay

Band of Highest Paid Director Remuneration (£'000s)	165 - 170	165-170
Median total remuneration of the Trust	£24,544	£24,028
Ratio of median remuneration to that of the highest paid Director	6.80	6.95

The Hutton Review of Fair Pay requires reporting bodies to disclose the relationship between the highest paid Director of the Trust and the median remuneration of the organisation's workforce. In this context the median is defined as the total remuneration of staff members lying 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 in WWL in the financial year 2011/12 was £165k to £170k (2010/11 £165k to £170k). This was 6.80 times the median remuneration of the workforce, (2010/11 6.95) which was £24,544 (2010/11 £24,028).

In 2011/12, eight employees received remuneration in excess of the highest paid director (2010/11 14 employees). Their remuneration in 2011/12 ranged from £165k to £210k (2010/11 £165k to £220k).

Total remuneration includes salary, non-consolidated performance related pay if applicable, benefits in kind, as well severance payments.

Factors which have had an impact on the median remuneration of the workforce during 2011/12 were:

1. A mutually agreed severance scheme (MASS) which resulted in 72 leavers in 2011/12.

2. The overall headcount reduction of 146 Whole Time Equivalents (WTE) during 2011 (including 47 MAS leavers in 2011/12).

3. The TUPE transfer of unscheduled care services from Bridgewater Community Healthcare NHS Trust on 1 October 2011 resulted in a headcount increase of 87 staff.

4. As part of the Trust's redesign of pathology services 123 pathology staff were TUPE transferred to Salford Royal NHS Foundation Trust on 1 December 2011.

5. The national pay freeze introduced in 2011/12 for public sector employees affected all staff on Agenda for Change terms and conditions except those earning £21,000 or less.

6. Staff employed via temporary staffing agencies are excluded on the grounds that comparable median remuneration data is not available to provide a meaningful comparison.

3. Remuneration Sub-Committee

Directors' salaries (excluding Non-Executive Directors) are determined by the Trust's Remuneration Committee, the membership consisting of the Chairman and all the Non-Executive Directors. The policy of the Committee is to motivate and reward Executive Directors fairly, individually and collectively to recruit and retain high quality people, ensuring a clear link between pay increases and the achievement of individual key tasks and overall corporate performance. The purpose of the Committee is to consider the remuneration and terms of service, including any performance related elements and the provision of other benefits, for executive members of the Trust Board. The Committee will review an individual director's performance against agreed measurement factors for key tasks approved by the Trust Board. In addition they advise the Chairman on any termination arrangements for the Chief Executive, and advise the Chief Executive on any termination arrangements, other than the contractual 12 week period of notice, for executive board members.

The benefits in kind shown are in relation to non-cash benefits as a contribution towards the leased vehicle scheme as part of the executives' remuneration.

During the period there were no performance related bonus payments, no compensation payments made to former senior managers or any amounts payable to third parties for the services of a senior manager.

Independence of Non-Executive Directors is established in accordance with the Monitor NHS Foundation Trust Code of Governance (2010), provision A.3.1.

4. Pension Benefits

	Pension Benefits						
	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000	Cash Equivalent transfer value at 31 March 2012	Cash Equivalent transfer value at 31 March 2011	Real increase in Cash Equivalent transfer value
Executive Directors	£000	£000	£000	£000	£000	£000	£000
A Foster - Chief Executive	0 - 2.5	5 - 7.5	20 - 25	30 - 35	433	364	40
G Harris - Director of Nursing and Performance & Deputy CEO	2.5 - 5	7.5 - 10	50 - 55	160 - 165	966	810	92
K Griffiths - Director of Finance & Informatics	0 - 2.5	2.5 - 5	40 - 45	130 - 135	727	562	33
R Forster - Director of Finance and Informatics	0 - 2.5	0	0 - 5	0	45	22	11
J Lenney - Director of HR & Organisational Development	2.5 - 5	10 - 12.5	30 - 35	100 - 105	569	432	87
S Nicholls - Director of Strategy & Planning	0 - 2.5	0 - 2.5	5 - 10	25 - 30	123	96	16
U Prabhu - Medical Director	0 - 2.5	2.5 - 5	60 - 65	185 - 190	1,338	1,230	49

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

Cash Equivalent Transfer Values

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

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

Real Increase in CETV

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

Signed…..……. Date…… 30/05/12 ……

Andrew Foster – Chief Executive

Council of Governors

Role and Responsibilities

The Council of Governors (CoG) is responsible for representing the interests of patients, public and staff members and local partner organisations in the governance of the Trust and has specific responsibility for the appointment of the Chairman, Non-Executive Directors and the Trust's Auditors.

The Council of Governors also approve the appointment of the Chief Executive and the remuneration and terms of office of the Chairman and Non-Executive Directors. The CoG receives the Trust's Annual Report and Accounts and comments on the forward plans for the Trust. The Council of Governors supports the Trust in an advisory capacity, communicating the views and comments of the wider membership community to the Board of Directors. In addition, the Council of Governors advises on the longer-term strategic direction of the Trust.

Terms of Office and Attendance

The Council consists of the Chairman of the Trust and 29 elected or appointed Governors. The Trust received authorisation as a Foundation Trust on 1 December 2008. Details of our Governors' terms of office and attendance at meetings are given below:

Public Governors	Public Constituency	Term of Office	Attendance at Governors Meetings 2011/12
Bill Greenwood OBE	Wigan	2012	7 /10
Pauline F Gregory	Wigan	2012	9/10
Jim Walls	Wigan	2011	4/5
Catherine Martindale	Wigan	2013	9/10
Ann Heaton	Wigan	2013	3/5
Anne D Vernengo	Leigh	2012	5/10
Bob Horrocks	Leigh	2014	4/5
Janet Atherton	Leigh	2013	3/10
David Oultram	Leigh	2011	4/5
Gordon Jackson (re-elected)	Leigh	2013	8/10
Kate Fussell	Makerfield	2012	8/10
Margaret Hughes	Makerfield	2012	9/10
Fred Lever	Makerfield	2011	5/5
Glenys A Shepherd	Makerfield	2014	4/5
Rachel Webster	Makerfield	2013	8/10
Vincent France	Eng & Wales	2012	7/10
Anthony Gallagher	Eng & Wales	2011	1/5
Tom Frost (Lead Governor)	Eng & Wales	2012	8/10
Trevor Barton	Eng & Wales	2011	0/5
Sarah Hassan Umal	Eng & Wales	2014	0/5
Bill Baker	Eng & Wales	2014	5/5

Staff Governors	Staff Constituency	Term of Office	Attendance at Governor Meetings 2011/12
George Ghaly	Medical and Dental	2012	2/10
Janet M Irvine	Nursing and Midwifery	2012	6/10
Tony Ashton	Nursing and Midwifery	2011	2/5
Christine Swann	All Other Staff	2012	7/10
George Conway	All Other Staff	2014	2/5
Susan Shalders	Nursing and midwifery	2014	3/5
Nominated Governors	**Constituency**		**Attendance**
NHS Ashton Leigh and Wigan - Dr Andy Sutton	Partnership Organisation	2013	5/10
NHS Ashton Leigh and Wigan - Dr Kate Arden	Partnership Organisation	2012	1/10
Wigan Council – Cllr Keith Cunliffe	Partnership Organisation	2012	5/10
LINK Wigan – Mrs Ann Heaton	Partnership Organisation	2012	2/3
LINK Wigan – Dr Gary Young	Partnership Organisation	2014	3/6
Wrightington Wigan and Leigh Staff Side Committee – Jean Heyes	Partnership Organisation	2012	4/10
Age Concern Wigan – Jim Maloney	Partnership Organisation	2012	5/10
University of Central Lancashire - Ruth Cowburn	Partnership Organisation	2012	4/10
University of Central Lancashire – Ann Foley	Partnership Organisation	2015	2/10
5 Boroughs Partnership NHS Trust – Ray Walker	Partnership Organisation	2012	1/2
5 Boroughs Partnership NHS Trust – Donna Sandiford	Partnership Organisation	2014	4/8

Governor Elections

Between June and September 2011 the Electoral Reform Services conducted the Governor election process on behalf of the Trust. The election results were posted on the Trust's web site on 8 September 2011.

Governor Register of Interests

Members of the public can gain access to the register of Governors' interests by writing, telephoning or emailing the Trust Board Secretary, Trust HQ, The Elms, Royal Albert

Edward Infirmary, Wigan Lane, Wigan, WN1 1AH. Helen.hand@wwl.nhs.uk Tel: 01942 822027

Working with the Board of Directors

Members of the Board of Directors meet quarterly with the Council of Governors. The Chief Executive is invited to all meetings of the Council of Governors. All formal Council of Governor meetings are open to the public. Governors also attend informal seminars between Board meetings. The schedule of matters details the level of decision making for the Board, Council of Governors and their respective sub-committees.

Council of Governor Sub-Committees

Nomination and Remuneration Sub-Committee

The Council of Governors' Nomination and Remuneration Committee has met on four occasions during the reporting period. The Committee oversaw the process for the appointment of a new Non-Executive Director. Open advertising and support from an external consultant was used during the recruitment process. Governors, Executive and Non-Executive Directors were engaged during part of the process. The final recommendation for appointment was made to the Council of Governors for approval. In addition during 2011/12, the Committee oversaw the process for the re-appointment of two Non-Executive Directors, the Senior Independent Director and Chairman, for recommendation to, and approval by, the Council of Governors.

The Nomination and Remuneration Sub-committee membership is as follows:

Member	Constituency	Attendance
Les Higgins	Chairman	4/4
Rachel Webster	Elected: Makerfield Public	3/4
Jean Heyes	Appointed: Staff Side	1/4
Keith Cunliffe	Appointed: Local Authority	3/4
Tom Frost (Lead Governor)	Elected: England and Wales Public	4/4
Vincent France	Elected: England and Wales public	1/4
Pauline Gregory	Elected: Wigan Public	4/4
Ruth Cowburn	Appointed: University of Central Lancashire (UCLAN)	2/3
Gordon Jackson	Elected: Leigh Public	3/4

Membership

The Trust has a robust plan to continue to develop and increase its membership which is drawn from both public and staff. The current membership figures are as follows:

Total Public Members **6,339**

This table gives a breakdown of membership by public constituency:

	Wigan	Leigh	Makerfield	Out of Borough
Total Males	852	605	644	433
Total Females	1,270	977	924	621
Not Given	3	1	5	4
Total Membership	2,125	1,583	1,573	1,058

This table gives a breakdown of membership by staff constituency:

	Medical and Dental	Nursing and Midwifery	All Other Staff	Total Figures
Total Males	209	61	461	731
Total Females	78	1,102	2,278	3,458
Not Given	0	0	0	0
Total Membership	287	1,163	2,739	4,189

The Membership Development Strategy set annual recruitment target is to increase the public membership by 200 members a year up to 2013 whilst maintaining the staff membership. Greater concentration has been placed on developing the engagement with the existing membership.

The Trust has a Membership Development Officer who supports the Council of Governors in recruiting and maintaining the membership. A membership recruitment plan was in place for 2011/12 and Governors have been actively involved in recruiting new members. Members wishing to contact Governors and/or Directors of the Trust can do so by contacting the Membership Office on freephone 0800 0731477.

Membership is open to anyone aged 16 years and over. Public membership is open to anyone in England and Wales although the majority of members are drawn from within the boundary of the Wigan Borough. Staff automatically become members if they have been 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 have been continuously employed by the Trust for at least twelve months unless they chose to opt out. The public and staff membership classes are shown in the tables above.

Membership profiling was conducted independently by the Electoral Reform Service on behalf of the Trust. This report has shown the Trust to have a representative membership. Further information about membership engagement can be found in the Patient and Public Engagement section of this report.

Compliance with the Code of Governance Provisions

The Board of Directors and Council of Governors of the Trust are committed to the principles of good corporate governance. The Audit Committee reviewed the Trust's performance against this Code and can confirm that the Trust has achieved full compliance with the revised Monitor Code of Governance 2010.

Corporate Objectives 2011/12

Our mission is to provide the best quality health care for all our patients.

Our vision is to be in the top 10% for everything we do.

Our strategy is to be safe, effective and caring.

The Trust strategy is supported by seven strategic aims:

- **Performance**
- **Innovation**
- **Leadership**
- **Information**
- **Staff Engagement**
- **Investment**
- **Partnership**

Annual Corporate Objectives

• **Performance**	To score zero points on the Monitor Compliance Framework in each month and achieve an average Financial Risk Rating of 4
• **Innovation**	To support value for money through investment in new projects identified as having at least a 2:1 payback and measured by finance and/or quality
• **Leadership**	To identify the community of leaders within the organisation and to draw up a Leadership Development Programme for approval by the Board by 30 November 2011
• **Information**	To be on track to implement a system of paper light, integrated patient information and administration by 1 April 2013
• **Staff engagement**	To continually improve the ratings in staff surveys
• **Investment**	To agree a new service and site strategy in April 2011 and within this to set a corporate objective for progress by April 2012
• **Partnership**	To establish effective demand management in the health economy

Forward Strategy

The Clinical Services Strategy is a key element which drives the future shape and scope of the Borough's secondary care health services. The Trust has a challenging service transformation agenda to support its service and site investment strategy and is committed to developing clinical pathways to deliver the quality outcomes aspired to.

The Trust Board has an ongoing commitment to put quality on a par with finance and performance, with safety being the highest priority of all. These values are incorporated within the Trust's revised mission, vision and strategy for 2012/13:

- **Our Mission** – to provide the best quality healthcare to all of our patients
- **Our Vision** – to be in the top 10% for everything we do
- **Our Strategy** – to be safe, effective and caring

Service quality is the most important factor influencing patients' choice when selecting a care provider and is therefore critical to our future success as a Trust. A number of Senior Clinicians and members of the Executive Team have attended a variety of quality events and the Trust is affiliated to the North West's Advancing Quality Alliance (AQuA). This will help us to achieve the culture and climate to have open conversations about quality and to make the improvements to which we aspire.

The Trust has reviewed its objectives and re-emphasised its commitment to the quality and safety agenda. Aligned with this are key objectives to improve quality and safety and support the adoption of a '**Zero Tolerance to Harm Culture'.** In 2012/13, a new quality governance framework will be taken forward with the establishment of a Quality Executive led by the Chief Executive. Quality Champions will be appointed to drive forward the key quality enablers to reduce harm. These are described in more detail in the Quality Accounts section of this report. In addition a Quality Faculty will be established with membership drawn from the Quality and Safety matrons, Quality Champions and staff trained in Leading Improvement in Patient Safety (LIPS) programme. There will also be a Quality and Safety Committee, acting as a sub-committee of the Board and taking the lead role for scrutinising quality and safety outcomes.

Strategic Aims

Safe

- Reduce HSMR across all specialities to a maximum of 83 by 31 March 2013
- Reduce instances of harm, as measured by the Incident Reporting Systems, by 50% by 31 March 2013

Effective

- Clear alignment with the Audit Programme
- Introduction of evidence-based pathways (Map of Medicine)
- Continue to provide evidence of cash releasing savings as a consequence of quality initiatives

Caring

- Achieve at least 90% scores on the real time patient survey questions on pain control and worries and fears
- Implement a system of real time monthly staff opinion testing by April 2013 and continually improve all staff survey scores

Key Risks 2011/12 and 2012/13

The key organisational risks for the year were identified from the corporate strategic objectives for 2011/12, forming part of the Board Assurance Framework and included failure to:

- Achieve a Financial Risk Rating of four including the Cost Improvement Programme for 2011/12 and maintaining compliance with the Monitor Compliance Framework
- Successfully manage the transfer of community services from NHS Ashton, Leigh and Bridgewater Community Healthcare NHS Trust to WWL
- Achieve a Hospital Standardised Mortality Ratio (HSMR) of no more than 90
- Achieve the revised A&E standards

The key future risks for 2012/13 include failure to:

- Meet all of our performance and financial targets in full every month
- Fully invest £300,000 this year in innovative projects that will save money and or improve quality
- Design and deliver a leadership training programme for middle and senior leaders by the end of this year
- Implement a new electronic patient information system this year for A&E, referral letters and out-patient case notes
- Introduce a short monthly staff opinion survey this year and use this to improve staff satisfaction
- Keep to the timetable and budget for this year's big projects: the Education Centre; electrical upgrades at Wigan and Wrightington; Oncology Unit; Pathology Laboratory; second MR scanner and conversion of the Hanover block
- Achieve close working with other health and social care organisations to provide better services at home and in community clinics in order to reduce use of hospital services
- Keep our death rates well below the average of other hospitals
- Reduce the number of patients who tell us that they are not satisfied with their pain control and with their ability to talk about their concerns
- Ensure that the Care Quality Commission is completely happy with our services
- Maintain and improve the very good relationships we have with partner organisations, especially Wigan GPs and NHS Greater Manchester

External Factors

Looking ahead, the Trust continues to face the challenge of reduced activity because of demand management schemes from Commissioners, as services are put out to external tender. In addition, the commissioning intentions of the Greater Manchester Cluster could see a reduction in the number of general surgical services being delivered from District General Hospitals in favour of regional specialist centres. In spite of this, the Trust has seen a rise in activity in some specialties, including orthopaedic services, and is continuing to strengthen its relationship with local Clinical Commissioning Groups (CCGs).

The Trust continues to collaborate with neighbouring healthcare providers, including Salford Royal NHS Foundation Trust, and is building relationships with other Trusts in the Greater Manchester area and beyond.

Service Transformation

This year has seen the Service Transformation team working with the wider organisation to support the development of a clear Service and Site strategy for WWL. This is focused on improving the patient experience, improving access to single sex accommodation, developing more accessible and patient centred services and eliminating delays in pathways of care. The strategy outlines plans to provide new and modernised hospital facilities and describes how patient services will be provided by WWL in the future.

Whilst the building work outlined in the strategy will occur over a period of ten years, the work to develop and transform clinical services has already commenced with the initiation of five ‘flagship’ projects, each led by an Executive Director. These projects have been focusing on improving the quality of service for patients and enabled the organisation to function more efficiently. They have also supported the achievement of financial savings which in turn will be re-invested to enable WWL to improve infrastructure as outlined in the Service and Site Investment Strategy.

Bed Reconfiguration

This project ensured that the clinical services re-design work being undertaken within the Divisions was incorporated into a Trust-wide approach to the management of beds. Examples of the work undertaken within the Divisions include the implementation of the enhanced recovery programme, reducing length of stay for patients within both the Surgical and Musculo-skeletal Divisions and the expansion of ambulatory services within the Division of Medicine.

Human Resource Productivity

In conjunction with employees, the team has reviewed the way staff work and implemented new ways of working which will enable staff to function more efficiently. A number of projects have been delivered under this theme, including new shift patterns for ward teams and electronic-rostering for clinical teams.

Medical Workforce Productivity

This project has focused on working with consultants and the clinical services to ensure that consultants are able to have the maximum amount of clinical time available to work within their specialties and improve patient care.

Infrastructure and Business Process

Encompassing a number of projects, this work stream includes the implementation of The Productive Operating Theatre (TPOT) which worked with operating theatre teams to review the way they work, and improve the use of theatre time. Other projects include ensuring that the Trust's purchase of equipment and stores are obtained for the best possible price and, using Information Technology, enable clinicians to spend the maximum amount of clinical time with patients.

Royal Alliance Project

A review of pathology services has resulted in the development of a partnership with Salford Royal NHS Foundation Trust to provide these services jointly across both Trusts. This project is an example of a substantial change which will take a number of years to fully implement but will result in a significantly improved service with improved financial efficiency.

Other projects

These include the Transforming Community Services transfer into WWL to support early discharge and help prevent admissions, together with a significant number of smaller Divisional projects.

Facts and Figures

For the period 1 April 2011 until 31 March 2012:

Number of Referrals	From GPs	70,294
	From Other sources	69,519
	Total	**139,813**
Inpatients	Elective/planned activity	8,324
	Day cases	38,584
	Non-elective admissions	36,541
	Total	**83,449**
Outpatient Attendances	New appointments	100,555
	Follow-up appointments	272,459
	Procedures	46,291
	Total	**419,305**
Accident and Emergency Attendances	New patients	85,368
	Unplanned re-attendance	5,608
	Total	**90,976**
Walk-in Centre Attendances	Leigh	58,048
	Skelmersdale	23,278
	Total	**172,783**
Number of beds as at 31 March 2012	RAEI	552
	Wrightington	113
	Leigh	73
	Total	**738**

Number of Employees as at 31 March 2012 – 4,275

On average a member of the public attends Accident and Emergency every 5.77 minutes.

Financial Performance Report

Financial performance is reported for the year ended 31 March 2012. During the year the Trust delivered an income and expenditure trading surplus of £2.9m, which whilst is lower than the original plan of £4.0m is a significant achievement, in this a testing economic environment, and after incurring exceptional reorganisation costs.

The Trust's cash balance at 31 March 2012 was £18.2m, being £4.6m ahead of plan, which is to be utilised in supporting the Trust's trading and capital expenditure investments going forward.

The following tables summarise key financial performance indicators.

Financial Risk Rating (FRR)

As a Foundation Trust we have to manage financial performance within Monitor's Compliance Framework which is a risk based assessment with specified ratios and a table of performance grades ranging from a level 5 to a level 1. Level 5 is the highest rating representing the least risk, with level 1 being the lowest rating representing the highest risk of breaching its Foundation Trust Terms of Authorisation.

For the year ended 31 March 2012 the Trust achieved a Financial Risk rating of 3.6 in line with the plan, resulting in a planned FRR of 4. This is the third successive financial year that the Trust has achieved a FRR of 4 which is assisting with our strategic direction. The FRR calculation prescribed excludes £1.2m of exceptional re-organisational costs as a non trading expense but includes the accounting policy adjustment for recognising incomplete patient spells in 2011/12.

The table below shows the performance measures that make up the FRR:

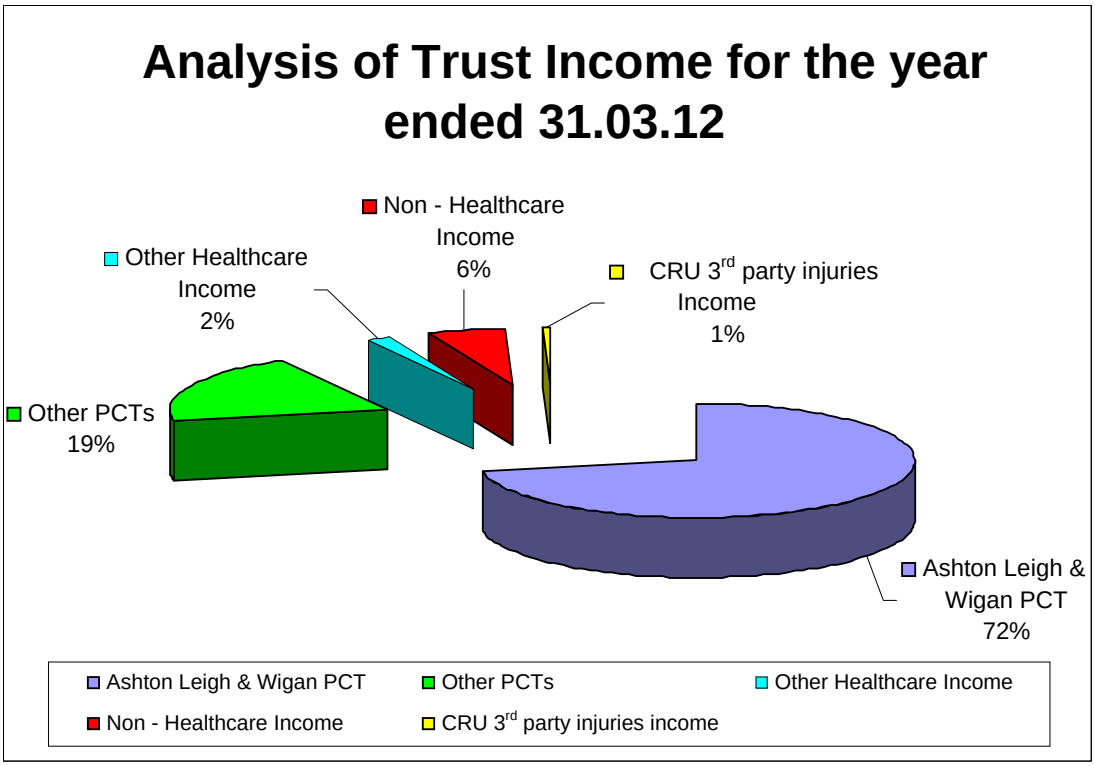
Metric	Criteria	% Achieved	Risk rating	% Weighting
EBITDA margin	Underlying Performance	**6.7%**	**3**	**25%**
EBITDA, % achieved	Achievement of Plan	**97.0%**	**4**	**10%**
ROA	Financial Efficiency	**5.3%**	**4**	**20%**
I&E surplus margin	Financial Efficiency	**1.7%**	**3**	**20%**
Liquid ratio	Liquidity	**32.2**	**4**	**25%**
Weighted Average			**3.6**	
Overall Financial Risk Rating			**4.0**	

Income

Total income received by the Trust in the year ended 31 March 2012 was £246.6 million, with £231.8m (94%) coming from the delivery of clinical services. The majority of the Trust's clinical income, being £177.6m (72%), comes from NHS Ashton, Leigh and Wigan.

Non-clinical income for the period is £14.8m with the majority of this income received to fund Education and Training; services provided to other organisations; and commercial activities such as the provision of catering services.

A breakdown of total income by source is shown in the graph below:



Clinical Income by Point of Delivery

Income from activities	Year ended 31-Mar-12 £'000		Year ended 31-Mar-11 £'000
Elective income	59,558		59,570
Non-elective income	59,637		60,395
Outpatient income	45,884		43,366
A&E income	7,763		7,943
Other NHS clinical income	45,338		41,000
Private patient income	2,334		2,396
Commmunity Service income from PCT *	1,910		0
Other non-protected clinical income	9,385		2,478
	231,809		**217,148**

*Represents related income from NHS Ashton, Leigh and Wigan PCT for the period 1 April 2011 to 31 September 2011, prior to the transfer of part of the community services from Bridgewater Community Healthcare NHS Trust on 1 October 2011.

Private Patient Cap

Section 44 of the NHS Act 2006 requires that the proportion of private patient income to the total patient related income of the NHS Foundation Trust should not exceed its proportion whilst the body was an NHS Trust in 2002/03.

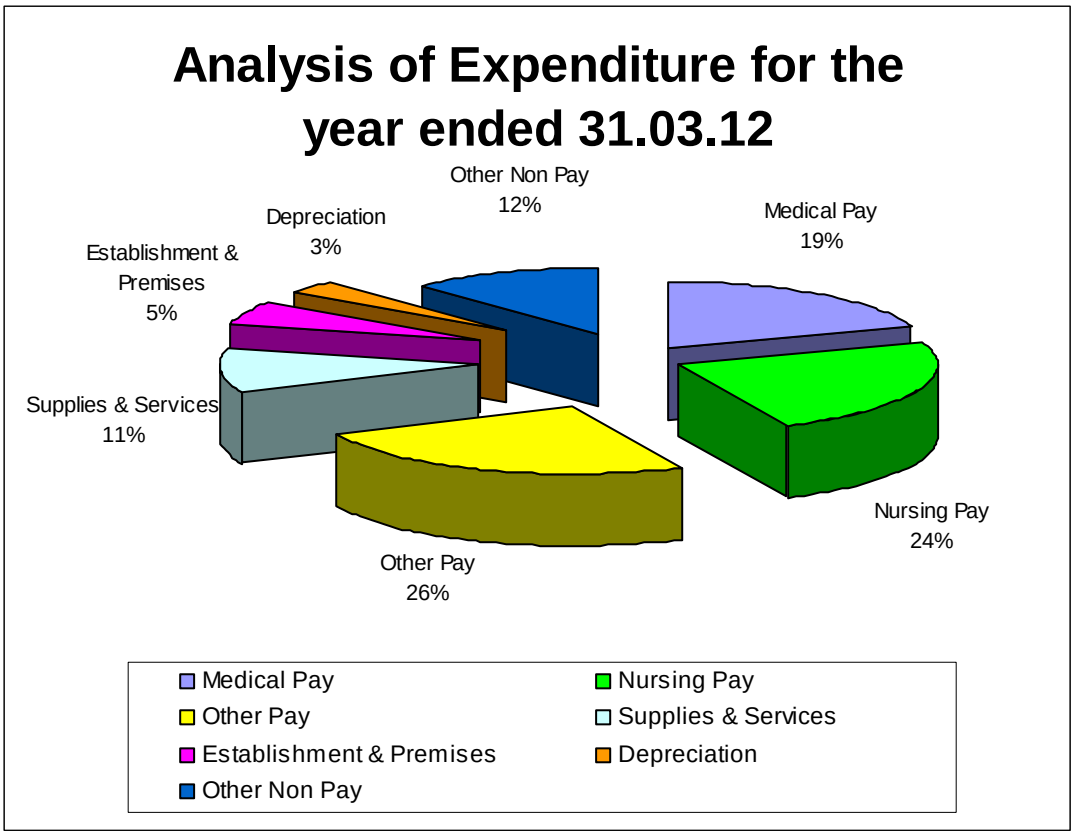
The Trust's performance for the year was as follows:

	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000	Base Year 2002/03 £'000
Private patient income	2,334	2,396	2,891
Total patient related income	231,809	217,148	140,399
Proportion (as a percentage)	**1.0%**	**1.1%**	**2.1%**

This restriction is set to change in 2012/13

Expenditure

Operating expenses totalled £238.9 million for the year and, as in previous years, staff costs account for the largest use of resources, 69% of total expenditure. An analysis of operating expenses by type is shown in the graph below:



Prudential Borrowing Code

As an NHS Foundation Trust, the Trust has greater freedoms to borrow money to contribute towards the financing of capital investment.

However, there are Monitor conditions and performance limits on the amount that can be borrowed. The conditions that the Trust must satisfy are to demonstrate that the levels of borrowing are affordable as set out in the Prudential Borrowing Code (PBC) published by Monitor.

The PBC sets out five financial ratios with individual criteria to be met in order for the Trust to undertake any borrowing. The maximum cumulative borrowing that the Trust may have, or Prudential Borrowing Limit (PBL), is set by Monitor with reference to the Trust's Financial Risk Rating.

For the year ended 31 March 2012 Monitor set the Trust a cumulative long term borrowing limit of £45.8.m and an approved working capital facility of £16.0m. The Trust has not utilised the working capital facility in the year, but there are a number of small finance leases that are measured against the PBL, the performance of which is set out below:

	Approved PBL ratios		Actual ratios
Maximum debt to capital ratio	< 25%		0.01%
Minimum dividend cover	> 1x		3
Minimum interest cover	> 3x		912
Minimum debt service cover	> 2x		1,092
Maximum debt service to revenue	< 2.5%		0.01%

Financial and Operating Risk

In the financial year 2011/12 the Trust is reporting a surplus of £2.9m which, although below planned expectations, reflects a successful financial year for the organisation given the reduction in Payment by Results (PBR) tariffs, national expenditure pressures such as increasing clinical negligence premiums and challenges to acute providers from primary care to reduce secondary care activity in line with the Quality, Innovation, Productivity and Prevention (QIPP) agenda.

The Trust and the host commissioner settled their contract in quarter 3 which greatly assisted both parties with their financial planning and control. The agreement negated the financial risk associated with contract conditions and commissioning for Quality and Innovation (CQUIN) payment framework, but maintained operational focus in both areas. The overall financial evaluation of the Trust is captured in Monitor's Financial Risk Rating for which the Trust is reporting an FRR of 4.

The Trust's ongoing strategy is to ensure a sustainable long term financial position that is robust and flexible enough to cope with economic pressures, whilst generating surpluses that will be used to develop and modernise the infrastructure of the organisation. Above all is to provide the best quality of care for patients in a safe and secure environment for both patients and staff. The Trust has and will continue to adopt a collaborative approach with commissioners and other NHS Trusts to benefit from financial economies of scale and

best practice ways of working. Through collaboration, innovation and openness to new ways of working, the Trust remains confident it can deliver required revenue surpluses for the next three years and overall Financial Risk Rating performance in line with the Monitor planning regime.

Cash balances remain buoyant at £18.2m and capital reinvestment remained significant in year at £12.9 million with further investment plans maintained at appropriate and affordable levels.

Capital Investment Programme

The Trust's full year capital investment programme was £12.9m. Details of the most significant investments are set out below:

	Year ended 31-Mar-12 £'000
Individual schemes more than £100,000	
Leigh - Relocation of IT Department from Bryan House (building work)	1,739
Leigh - Relocation of IT Department from Bryan House (equipment)	1,640
Trust wide - IM&T Health Information System (HIS)	1,569
RAEI - Purchase of the Mesnes Terrace Car Park for staff usage	1,390
RAEI - Redevelopment of the Medical Education Centre (MEC)	1,281
Leigh - Conversion of Hanover Building (UIU / Gastro / Decontam)	879
Trust wide - Major Maintenance / Statutory upgrades	567
RAEI - Anaesthetic Machines & Monitors for Theatres/Recovery	361
RAEI - Phase V Project Management	353
Wrightington - Anaesthetic Machines & Monitors for Theatres/Recovery	309
Trust wide - Fire, Health & Safety and Disability Discrimination	205
Trust wide - IM&T Data Warehouse	157
Trust wide - Energy & carbon efficiencies	152
Trust wide - IM&T Service Line Reporting (SLR)	142
Trust wide - Corporate Information Asset Register (Information Governance)	121
RAEI - Essential Services Pathology Laboratory / Cancer Care Centre	118
Trust wide - Unified Communication (Phase 4 Digital Telecoms)	117
Wrightington - Enabling works for new Theatre 9	116
RAEI - Purchase of four new Bronchoscopes	108
Other schemes (under £100k)	1,626
	12,950

A description of the main capital investments are as follows:

- The IT department had to vacate their current base at Bryan House by December 2011, so the decision was made to relocate to the former instrument sterilisation building at Leigh Infirmary. The Trust invested in converting the existing building into a modern Data Centre to provide robust, future-proof IT and telecommunications infrastructure capable of supporting current and anticipated business demand.

- To service the physical IT relocation (above), the Trust also invested in new IT equipment and infrastructure for the Data Centre following best practices in virtualization, business continuity and disaster recovery.

- The Trust continued into the second year of development of the Health Information System (HIS). The Health Information System (HIS) will allow the Trust to manage Emergency Care, Patient Administration and the prescription of drugs in one system.

- As part of the enabling works for the Service and Site strategy the Trust took the decision to purchase Mesnes Terrace car park from Wigan Council for staff usage. The car park was then refurbished with improved lighting and the installation of CCTV and re-opened in March 2012. This project improved both access for patients and visitors to RAEI and increased the overall number of parking spaces available.

- Work has begun on the redevelopment of the present Medical Education Centre and Trust Library Service to form a Multi-Disciplinary Education Centre for the local health community. The development encompasses an Education Centre which will not only support the educational requirements of medical students and doctors but will provide a fully integrated facility supporting the educational requirements of the local health economy. The aim is to provide a modern, flexible and high quality facility, fit for the purpose of providing first class educational premises to meet the needs and expectations of all stakeholders and users in line with current statutory requirements.

- Building work has begun to convert the Hanover Block at Leigh Infirmary to house a new Urological Investigation Unit, an expanded Gastroenterology Department, as well as a state-of-the-art Scope Decontamination Facility. This will allow the Trust to achieve statutory compliance, offer highest availability of service and an improved environment for patients.

In 2012/13 the Trust has established a capital investment programme of £17.7million, based on service and site strategy requirements and operational priorities in continually improving facilities and services provided by the Trust.

The Trust is not planning to utilise any of its authorised borrowing capability to achieve its 2012/13 capital programme.

Better Payments Practice Code (BPPC)

The BPPC requires the Trust to aim to pay 95% of all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's performance against the BPPC in the year was as follows:

	Number		£'000
Non-NHS			
Total Non-NHS trade invoices paid in the period	71,260		110,189
Total Non-NHS trade invoices paid within target	64,556		104,630
Percentage of Non-NHS trade invoices paid within target	**90.6%**		**95.0%**
NHS			
Total NHS trade invoices paid in the period	2,558		23,437
Total NHS trade invoices paid within target	2,482		23,214
Percentage of NHS trade invoices paid within target	**97.0%**		**99.0%**

Accounting Policies

The accounting policies in 2011/12 are in accordance with International Financial Reporting Standards (IFRS), with the annual accounts prepared in accordance with accounting standards and Monitor Annual Reporting Manual.

The Trust's main accounting policies, including those for pensions and other retirement benefits, used to prepare the accounts are set out in the Trust's annual accounts in appendix * of this annual report.

Details of senior employees' remuneration can be found in the remuneration report as set out on pages 22 through to 25.

The accounting policies are in line with IFRS and Monitor guidance.

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

Balance Sheet Events

In the opinion of the Directors there are no Post Balance Sheet events.

Going Concern

After making enquiries, 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.

Signed…… Date…… 30/05/12 ……

Andrew Foster – Chief Executive

Divisional Achievements

Clinical Support Services

The Division is aiming for a year end break-even income and expenditure position and has fully achieved its in-year and recurrent cost improvement targets. It has all diagnostic waiting times under the breach targets and has achieved all HR metrics, including induction attendance, appraisals within the last 12 months and mandatory training compliance and currently has a sickness absence level of 3.4% (current Trust target is 4%).

The roll out of order communications in Pathology to the Trust has occurred throughout 2011/12 and is now almost complete. This system, which allows referring clinicians to order pathology tests via ward or outpatient computers rather than completing paper request forms, has already been rolled out to many GP practices. It will ensure all appropriate patient information accompanies requests, thereby preventing misidentification and transcriptional errors encountered with hand-completed forms. During September 2011, the Trust approved a business case which will lead to a joint Pathology service with Salford Royal NHS Foundation Trust (SRFT) with the aim of achieving 20% cost savings and a 20% increase in quality. The main laboratory will be based on the SRFT site; however, a new Essential Services Laboratory will be built at RAEI to provide urgent test results for casualty and inpatients.

Throughout the first half of the year, Pharmacy implemented several internal re-organisations. From December 2011, the service has provided a full seven day service, including bank holidays, and extended working hours between Monday and Friday. This has facilitated the processing of discharge prescriptions and enables earlier patient discharge.

During 2011/12, Radiology has continued to see increases in demand for cross-sectional imaging, in particular, CT examinations (12% increase). These have been absorbed by the department whilst at the same time making improvements to the number of same day inpatient requests being completed. We have also introduced same day/next day appointments for cancer referrals. The Breast screening unit is currently in the process of expanding the service and introducing new equipment which produces digitised images. This fulfils the requirements of the expansion of the national screening programme from the 50 – 70 year age range to 47 – 73 year olds and should increase the number of women screened by 30%.

A comprehensive Outpatient re-design project was carried out at Thomas Linacre Centre (TLC) and Leigh which resulted in improvements in most outpatient processes. This includes patient flow, the environment, communication systems with patients, outcome recording and staff training. Various patient surveys were undertaken and a staff video diary produced. It also incorporated a full staffing review. Work is now ongoing at Wrightington Outpatients to improve patient flow.

A patient appointment text reminder service has now been implemented and is being rolled out across specialties; a system has also been introduced to send copies of outpatient letters to patients when requested. The opening hours of the outpatient appointment centre have been extended into the early evening (Monday – Friday) and

Saturday mornings. The centre has introduced a GP helpline and is looking to expand appointments to other services, beginning with Phlebotomy. The Appointment Centre received positive feedback to a patient satisfaction survey undertaken by volunteers.

Division of Medicine

The Division of Medicine has continued to develop a number of initiatives from last year.

Divisional Governance Structures

The Division has continued to develop its governance structures following a review in 2010. There is now a monthly quality meeting that is well attended by clinicians and management. The set agenda covers all aspects of quality and safety. The role of the clinical governance co-ordinator has been developed and embedded into the Divisional management structure and is supported at consultant level. The Division has met its obligations in responding to complaints and incidents in a timely manner and identified key learning points to improve quality and safety.

Complex Discharge Team

A review of discharge processes throughout the Division has led to the development of a smaller but more focused team, that supports patients with complex discharge needs through liaison with external agencies, including health and social care partners. The improved information analysis supports communication and co-ordinated responses to pressures within the health economy unscheduled care system.

Acute Physicians

A key achievement is the recruitment of a number of consultants in acute medicine. There is now extended consultant cover to medical assessment areas, with twice daily consultant review, which is reducing length of stay and improving patient flow.

Ambulatory Care

The General Practitioner (GP) assessment area and ambulatory care clinic provide an alternative to the A&E pathway and support early review of patients who may previously have been admitted for overnight observation. In this consultant-led unit, all patients receive an early senior review which supports early diagnosis and appropriate treatment.

Cardiology

The new coronary care unit was opened this year, which provides up to date facilities and an improved environment for the local population. The support of the local community was invaluable as the unit was supported by the Heartbeat Appeal.

Achievement of 18 Week Target

The Division of Medicine achieved the 18 week Referral to Treatment (RTT) target for admitted and non-admitted pathways. The year-end position is as below:

Admitted	97.20%	(target 90%)
Non-Admitted	98.94%	(target 95%)

Accident and Emergency (A&E) Performance

Patient flow has been one of the Division's challenges as many factors, both internally and externally, influence this. The Division of Medicine has worked in partnership with the whole health economy to improve patient flow and achieve the A&E four hour target for the year (96.9%; target 98% Internal, 95% national).

Elderly Care

The Elderly Care Consultant Team has successfully integrated within the community-led Hospital at Home service. This service enables patients to receive elements of their care within their own home, delivered by the Multi-Disciplinary Community Team. This service is clinically led by the elderly care consultants who provide in-reach and domiciliary support to the service with one full time consultant providing seven day support.

The Elderly Care Team have also commenced a pilot of comprehensive geriatric assessments for frail elderly patients. This includes extended care planning into the community and supports safe discharge thus reducing readmissions.

Musculoskeletal Division

WWL offers comprehensive trauma, orthopaedic and rheumatology services covering:

- Hip replacement
- Pelvic reconstruction
- Shoulder replacement
- Joint arthroscopy
- Treatment of fractures
- Tendon and nerve surgery
- Knee replacement
- Ankle replacement
- Joint replacement in hand, wrist and elbow
- Joint resurfacing
- Treatment of foot problems
- Inflammatory arthritis

2011/12 has been a successful year for the Musculoskeletal Division. Referrals continue to increase and elective activity has grown for Trauma and Orthopaedics by 8.55 ending the year with a total elective activity of 11,839 cases (including the Rheumatology Service). The Pelvic Service, which was launched in 2009, has continued to develop and they have worked jointly with the lower limb teams in treating pelvic discontinuity. The Trust has appointed five new consultants in the year, to cope with the increase in referrals and an increase in elective admissions. In total, the Division has performed 14,000 operations across the two sites.

In April 2011, "Wrightington @" (a hand and wrist clinic) was launched at Wilmslow health centre and the Trust will shortly be launching an additional elbow clinic at the centre.

In August, Rheumatology services were redesigned to implement an ambulatory care model and services were moved from the acute sector to primary care, although The Trust has retained responsibility for those services.

In October, the Division launched a programme of early supported discharge to help achieve a reduction in the length of stay for primary joint replacements. In October, 22.5% of patients had a length of stay of two to three days.

The Division remains committed to ensuring that 80% of primary joint replacement patients have a low length of stay whilst maintaining high quality of care and excellent patient experience.

The Trust has implemented a service line reporting (SLR) tool, and the Musculoskeletal Division and SLR Team have led the way on validating the tool and understanding its use in clinical decision making. The work the team did with SLR was submitted and won a Health Service Journal award in October 2011 and subsequently won a Recognising Excellence Award in November 2011.

Surgical Division

During 2011/12, the Surgical Division has seen a range of successes, which include:

Nursing

- Since the launch of the Enhanced Recovery Programme (ERP) there has been a substantial reduction in the patient's length of stay
- Recent patient satisfaction surveys demonstrate excellent results with 100% patients stating they considered they were fully informed about their treatment and involved in decision making
- The programme is supported by two dedicated ERP nurses with Colorectal ERP well embedded and has now spread into Gynaecology. Breast Surgery and Urology are the next specialities to be adopted
- There has been the successful integration of 14 endocrinology beds on Langtree Ward
- Recognising Excellence Awards – a very successful year with awards in six out of seven categories including:

    - Effective – Surgical Assessment Unit and the Enhanced Recovery Programme
    - Innovative – 23 hour breast surgery pathway
    - Caring – The 3 Step Wound Plan
    - Chairman's Employee of the Year winner – Leonora Anson (Sister on the Cancer Care Suite)
    - Foundation Trust Award Winner – The 3 Step Wound Plan

Women and Children's Services

- The Maternity Service at WWL has developed a business case to appraise the Trust of the resource requirements to achieve NHS Litigation Authority Clinical Negligence Scheme for Trusts (CNST) Level 2 compliance, with the assessment booked for January 2013
- The service responded to the Commissioning for Quality and Innovation Payment Framework (CQUIN) set for breast feeding by setting up an Infant Feeding Team. The Public Health Midwifery Team successfully achieved third prize in the British Journal of Midwifery Team of the Year category

Theatres, Anaesthetics and Critical Care

- The successful cessation of all waiting list initiative payments for all medical staff
- The successful development of weekend trauma cover arrangements
- Waiting time targets in most areas have been achieved

Surgical Specialities

- The Diabetic Screening Programme has been successfully re-located to a main town centre location
- Re-configuration of services to aid the Friday closure of Leigh theatres and overnight stays
- Achievement of 18 weeks without the need for premium rate spend
- Cancer Peer Review – excellent feedback received for Urology tumour site
- Identified and secured the presence of patient representative to be involved in Divisional Quality Improvement Group
- Paediatric Out Patient Reconfiguration – now designed and signed off
- GP Education Events – arranged for a number of tumour sites
- Urology Patient Awareness Event – took place and well received at JJB Stadium during 2011
- Commencement of Laparoscopic Cholecystectomy Day Case pathway.

Cancer

- A significant pathway redesign across all tumour sites to support the 62 day pathway and achieve 17 days from GP referral to transfer for tertiary services.

Surgery – General Information

- Surgical Team Brief – Third Place award winners at Recognising Excellence Awards 2011- Supporting Staff and Colleagues Category
- Successful relocation of the Senior Management Team on to one floor within the Old Nurses Home to aid improved communication and management systems

Estates and Facilities Division

The Division continues to provide and manage a wide range of non-clinical support services to all Trust sites and via Service Level Agreements to both NHS Ashton, Leigh and Wigan and 5 Boroughs Partnership NHS Foundation Trust.

In addition, the Division has played a key role in supporting the Trust's Service and Site Strategy review. This strategy has moved to the next stage in the process with a number of major projects being planned and delivered, and the appointment of a P21+ partner to procure major developments at all sites.

Capital Programme and Major Works

Significant projects which have commenced/completed include:

- Leigh Hanover block conversion to create Gastro/Urology Investigation/scope decontamination centre
- RAEI design work for clinical offices
- RAEI new Pathology Essential Services Laboratory (ESL) and Cancer Care Unit
- RAEI Education Centre
- Purchase of Mesnes Terrace car park
- Relocation of Ophthalmology Out Patients Department (OPD) to Boston House in partnership with Foundation for Life
- Relocation of Paediatric OPD into refurbished accommodation at the Thomas Linacre Centre (TLC)
- Leigh OPD upgrade works
- Wrightington Temporary Theatre 9
- Relocation of IT Department from Bryan House to Leigh Infirmary
- Health and Safety/fire upgrade works across all sites
- Investment in Carbon Trust Energy schemes

Estates Operational and Security Services

The Estates Operational Team provides a breakdown and planned maintenance service across the Trust.

During the course of this year the operational estates management structure has been reviewed to provide a more functional arrangement. This will not only support the modernisation of working practices but will also ensure the right level of focus into key areas such as the "front of house" care environment and technical compliance. The team continues to support the deep clean and Patient Environment Action Team (PEAT) programmes which have delivered demonstrable improvements in the patient environment.

Medical equipment management has seen the team settle into the new workshop facility and continues to enhance the new medical devices database and the service delivery to all clinical departments within the Trust.

The Security team provides security and car park management across all sites. This year has seen the development of a new car parking strategy to support the RAEI site. A key

part of this has been the purchase of the Mesnes Terrace multi storey car park from Wigan Council for use by Trust staff and the re-allocation of spaces at RAEI and Freckleton Street for patients, visitors and disabled parking. This strategy will ensure significant improvements in this area of the patient experience.

Facilities Services

The Facilities teams continue to support the Clinical Divisions in the provision of essential non-clinical support services. This year has seen further improvements in both the quality of service and efficiency of delivery. Notable successes and achievements have been:

- Trust's Kitchens received the maximum score of 5 stars for Food Safety from the Food Standards Agency
- Catering Team were involved in the rapid spread initiative to improve nutrition and screening for patients which received a 'highly commended' at the HSJ awards
- Portering team have expanded their help desk at RAEI to include x-ray. This has resulted in less waiting time for patients and increased throughput in x-ray
- New porters' rota has been implemented at RAEI to utilise resources more efficiently
- New rota has been implemented in catering at Wrightington which utilises resources more efficiently
- Domestic services have striven to improve the National Cleaning Standard scores and achieved the target of 95% - within the existing budget
- PEAT – maintained performance of good across all Trust sites with Catering scoring excellent

Regulatory Ratings Report

The tables below show the Trust's ratings for the Monitor compliance framework over the last two financial years:

	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial Risk Rating	4	3	3	4	4
Governance Risk Rating	Green	Green	Green	Green	Green
Mandatory Services Rating	Green	Green	Green	Green	Green

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial Risk Rating	4	3	3	3	4
Governance Risk Rating	Green	Amber/ Green	Green	Green	Amber/ Green
Mandatory Services Rating	Green	Green	Green	Green	Green

Governance Risk Rating

During 2011/12 the Trust improved its governance rating from amber green at Q1 to be rated green for governance in Q2, Q3. However 18 weeks, was not achieved at quarter 4, with an aggregate performance of 86.46%. The areas of non-achievement are Trauma and Orthopaedics, General Surgery, Vascular and Urology. This was due, in part, to the Trust being commissioned to undertake additional activity to deal with the legacy breaches. The Trust also maintained unconditional registration with the Care Quality Commission Mandatory Services Rating.

The Trust has continued to provide all mandatory services under the terms of its authorisation throughout 2011/12, as expected.

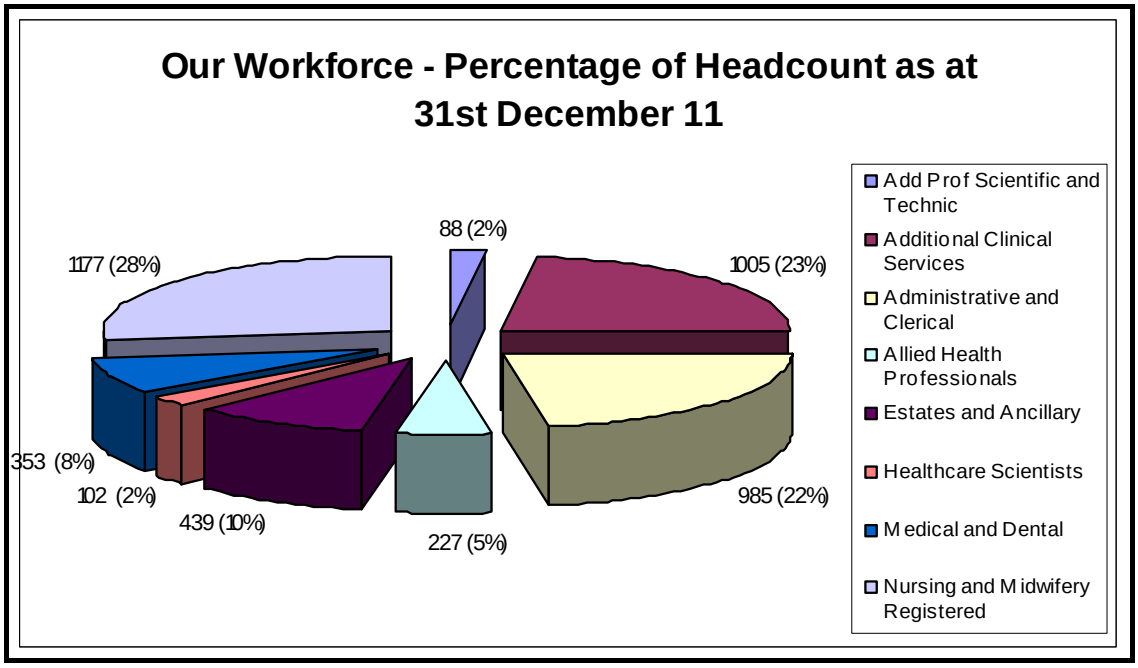
Workforce and Staff Engagement

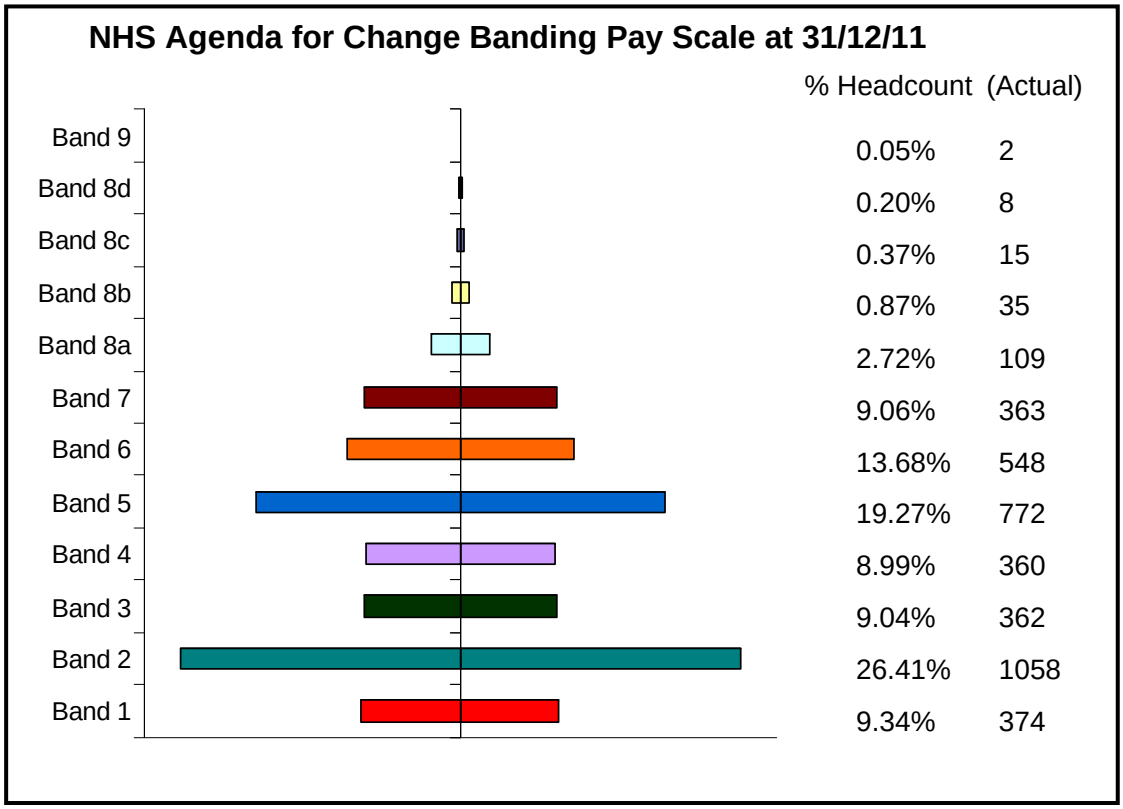
Human Resources (HR) and Organisational Development (OD) Strategy

In November 2011, we launched our new HR and OD Strategy (Supporting Staff and Caring for Patients) in order to support our mission to provide the best quality health care for all of our patients and our vision to achieve the top 10% performance in everything that we do. Our workforce is critical to achieving this mission and vision. We need to ensure that we have the right numbers of skilled and well-motivated staff to provide a safe, effective and caring service to our patients both today and in the future. Our strategy is based on the seven core elements of the WWL Wheel – Performance, Innovation, Leadership, Information, Staff Engagement, investment and Partnership. It aims to ensure that employees are supported at every level with the right working conditions and development opportunities and the highest quality leadership.

Workforce Profile

The composition of the Trust's workforce is shown below (Table 2 excludes medical staff).





Performance

Our workforce indicators continue to demonstrate that the Trust is in good health. Labour turnover remains within target although 2011/12 turnover has increased slightly since 2010/11 due to a voluntary severance scheme. Turnover remains stable currently at 7.48% which is 0.59 % lower than the 2010/11 reported figure of 7.67%. Sickness absence for the 12 month period up to February 2012 is currently 4.50%, which represents a small improvement on the similar period last year, but is above our Trust target of 4%. Staff are required to complete a range of Compulsory Training topics with 87.9% completing training specific to their roles in topics such as risk management, fire safety and infection control.

Supporting staff to maintain their competence and learn new skills remains a priority. This is supported by through the annual personal development review (PDR) process. The PDR process and documentation has been revised and updated for 2012 to align with WWL Wheel which is the outline strategy for the Trust. Information is collected each quarter and reported to the Trust Board. At 31 December 2011 71% of staff were reported as having had a PDR during the previous 12 months.

Employees are made aware of Trust performance through monthly team briefings which are also available on the Trust Intranet in podcast and presentation format. This, together with regular briefings and focus groups ensures that Trust employees have a common awareness of financial and economic factors affecting the Trust performance.

Innovation

Supported Employment and Business Cadet Programmes
We have facilitated 3 supported employment programmes and piloted one Business Cadet programme to enable people who may not be in a position to currently obtain paid work gain valuable work experience.

Recognising Excellence and Encouraging Staff-led Improvements
We have introduced new categories for our staff awards scheme to support and promote our core quality objectives to be 'safe, effective and caring', and we are improving the staff suggestion scheme and encourage staff to submit suggestions for improvement via the intranet.

Reviewing and Standardising Hours to meet Service Needs
The Trust has reviewed nursing attendance patterns in line with service needs and has introduced revised shift patterns in line with expected activity which 'went live' in March 2012.

Leadership

The Trust Board approved a new Leadership Development Strategy in December 2011 which is based on three main themes; the acceptance of personal accountability and responsibility; effective leadership practice distributed among a community of leaders; and the maintenance of high standards. The strategy is designed to build the Trusts leadership capacity and capability and proposes to develop managers and leaders through a variety of methods to increase personal effectiveness; lead others successfully and the develop the right levels of governance, service improvement and business skills. It will be delivered through a series of targeted development programmes which will commence in 2012/13.

Information

Policies and Procedures
HR Policies are ratified through the Partnership Council. All revised policies are formatted to the standard trust template to ensure compliance with NHSLA standards and are available on the policy pages of the Trust Intranet. The Policy Development Group continues to meet and develop priorities for the forthcoming months to ensure compliance with legal changes and best practice. Policies are regularly reviewed and updated in line with NHSLA requirements with most policies reviewed every two years.

The Trust has recently been re-accredited with the Two Ticks symbol as recognition to the Trust's commitment to equality and diversity in which confirms that Trust Policies and Procedures are compliant. The Recruitment and Selection Policy gives specific guidance to ensure that applications made by disabled persons are progressed to a guaranteed interview where the applicant meets the essential criteria for the role.

The Trust Equality and Diversity, Attendance Management Policy and Capability Policies all have specific references regarding continuing employment as a result of accident, illness or injury and guidance regarding reasonable adjustments where required.

All Trust Policies and Procedures have are Equality Impact assessed and a copy is retained with the policy.

Staff Engagement

NHS Staff Survey

The Trust continues to take part in the NHS annual staff opinion survey, which provides important feedback on our staff experiences and attitudes. For the fourth year running the staff survey report has been structured around the four pledges made to staff in the NHS Constitution.

Overall there has been a reduction in our performance in the 2011 survey in comparison with the 2010 survey results. This may be a reflection of a number of challenging workforce changes having been introduced in 2011/12 (including changes to nursing shift patterns, bed reconfigurations, rationalisation of pathology services and harmonisation of on-call payments). Despite these factors, the survey results are nevertheless disappointing and will provide the focus for concerted efforts to improve in 2012/13.

The number of above average results has decreased from 47% in 2010 to 21% in 2011. The number of below average results has also increased significantly from 28.9% in 2010 to 55.3% in 2011. However, 2 of the 8 results which were above average were in the best 20% of Acute Trusts.

Top Four Ranking Scores

- % of staff having equality and diversity training in the last 12 months
- % of staff experiencing harassment, bullying or abuse from staff in the last 12 months
- % of staff saying that hand washing materials are always available
- % of staff working extra hours

Bottom Four Ranking Scores

- % of staff experiencing physical violence from patients, relatives or the public in last 12 months
- % of staff suffering work related injury in the last 12 months
- % of staff reporting good communication between management and staff

Priorities and Targets

Increasing the percentage of staff reporting good communication between senior management and staff will continue to be a key priority.

To improve our lowest ranking scores the Trust intends to continue with the actions identified from the 2010 survey which includes:

- Implementation of briefing sessions, podcasts and articles on key organisational change. All General Managers are responsible for ensuring all key messages are cascaded and understood

- Continue Divisional Senior Management ward/department visits to meet staff whilst they work to discuss how they feel we can improve service delivery, their working lives and make cost savings
- Seek the involvement and contribution of front line staff in developing options for change and embed the WWL key strategic themes
- Promote benefits to staff from the feedback received from Staff Involvement Delivers Walkabouts and Staff Survey
- Continue to promote team working within divisions/departments/wards through communication aligned to the WWL Strategic Themes
- Ensuring the redesigned Personal Development Review documentation is fully embedded into the appraisal process
- Develop clear action plans following incident reporting

Survey results are publicised across the Trust and Divisional action plans are developed to address areas of concern at a Trust Wide and Divisional level. Progress against action plans is monitored at quarterly Divisional performance reviews and through the Partnership Forum.

Engagement Activity

Effective communication and engagement with managers, staff and other stakeholders remains a high priority which we have supported through a number of initiatives, such as national staff opinion survey, 'Staff Involvement Delivers' (SID) Champions and walkabouts, communication events and focus groups.

SID engages staff through a series of "conversations" with Executive Directors and an annual walkabout event conducted over a two week period where a paired staff side representative and a member of the executive team visit staff in wards/department across all sites. This ongoing initiative has been extremely successful over the past few years providing staff with a vehicle for both raising concerns and highlighting good experiences about working for the Trust.

SID focus groups were introduced in 2011 along with a number of other formal communications events (e.g. 'Start of the Year and 'Mid-Year Review' conferences) to ensure that staff were fully briefed on changes which may affect them during the year and were given the opportunity to comment on significant changes.

Health and Wellbeing

The Trust has further developed a range of initiatives to improve the health and well-being of our staff and to support Department of Health recommendations outlined in the 'Boorman Report'. The Cycle to Work Scheme remains popular with staff and staff also have access to Health Trainers, Occupational Health Services, smoking cessation and staff counselling services. The Trust has continued to be Smoke Free across all sites since October 2010. A Health and Wellbeing steering group meets on a regular basis to drive forward health and wellbeing initiatives across the divisions. A revised staff handbook was issued during 2011 which includes details of local services available to staff. A dedicated health and wellbeing web page has been developed to draw together into a single focal point information on health and wellbeing work including the Trust's action plan which and details of the steps being taken within the Trust to attain the Greater Manchester Good Work: Good Health Charter.

Investment

The Trust has introduced electronic systems to support and speed up pre-employment checks (including an e-Criminal Records Bureau system). We have also introduced an e-rostering system for junior doctors in training. The Trust is looking to introduce a similar system for all doctors during 2012/13.

The Trust was successful in its bid to Skills for Health to support 153 staff in roles such a health care support workers, laboratory assistants and catering and domestic assistants to develop their skills using the new QCF apprenticeship training pathway.

The Trust invested in an add-on software package to the existing occupational health IT system to speed up the process of assessments and enhance the ability to intervene early in the clinical management of ill health in staff. The software also encompassed an additional Health Screening program to promote the health and wellbeing of staff and complement the Trust's Health and Wellbeing strategy.

Partnership

The Trust is committed to work in partnership with trade unions and staff side representatives though the SID programme and other initiatives. We are also committed to developing effective partnerships with other health care provider organisations across the wider health economy.

A revised Partnership Framework was introduced during 2011/12 to improve mechanisms for formal consultation and negotiation with trade unions, including the creation of a new Partnership Council. Working in partnership has facilitated delivery of a wide range of organisational change programmes to consolidate and improve services to patients. Examples include:

- Integration of Unscheduled Care Services, as part of the Transfer of Community Services (TCS) initiative
- Integration of pathology services with Salford Royal Hospitals NHSFT
- Reconfiguration and consolidation of pharmacy services RAEI
- Changes of working practice, shift changes and organisational re-design

Alongside our Partnership Council, our Doctors' Local Negotiating Committee continues to provide a forum for consultation and negotiation on issues affecting medical staff. The introduction of SID champions and the Health and Wellbeing Working Group has further strengthened partnership working. Staff are also encouraged to apply to become staff governors.

The Trust has continued to work in collaboration with other Trusts for the provision of Decontamination, Pathology and Occupational Health services to the benefit of all stakeholders. The integration of unscheduled care from Community Services required collaboration and team work which will ultimately enable a more seamless patient pathway and reduction of length of stay.

Ready and Waiting

The Trust has a responsibility under the Civil Contingencies Act 2004 to ensure that local arrangements are in place for civil protection should an emergency or major incident occur. As such, the Trust has well rehearsed plans in place and continues to engage with staff and local and regional agencies to enhance preparedness and ensure resilience for the present and for the future.

Prevent, Prepare, Respond, Recover

The Trust works towards preventing emergencies from occurring through a robust risk management process. This identifies those high level risks which the Trust will aim to mitigate the likelihood or impact of. The Trust also continues to work closely with partner agencies in Wigan and the wider Greater Manchester footprint to identify local risks and to agree joint plans to provide a co-ordinated multi-agency response, for example, Wigan Multi-Agency Flood Plan. The Trust is actively represented on a variety of local and regional resilience forums including Wigan Resilience Forum, Greater Manchester Acute Group (Trust Emergency Planning Leads) and Greater Manchester NHS Emergency Planning Leads meeting.

The Trust has a Major Incident Plan, which provides a generic management framework to respond and recovery from an emergency or major incident. The Plan is under constant review through local and regional tests and exercises. The Plan was not fully activated during 2011-2012, but the Trust has been placed on stand-by on several occasions including during the riots in Manchester in July 2011 and for the receipt of contaminated casualties from a local chemical fire in May. The Trust is constantly striving to improve its response and recovery arrangements and actively encourages staff to participate in the debrief process to identify good practice and lessons learnt following exercises and major incident stand-by situations.

During 2011/12, the Trust participated in local and regional multi-agency emergency planning exercises including Exercise Chin Chin (a mass casualty scenario) and a Burns Exercise looking at local and regional burns facilities. The Trust has also run a series of Project Argus sessions, open to all staff, which is a terrorist attack based scenario which reflects on the Major Incident Plan, security, lockdown, and evacuation. In September, Exercise Apple was run at the IM&T and Finance Mid-Year Away Day. This was a desktop exercise based on a mass casualty incident and not only highlighted how the Trust would respond as an organisation in the event of a major incident or emergency, but also raised awareness around the roles and responsibilities of other teams and how they inter-linked in the response phase to an incident.

During October and November 2011, an Organisational Planning Group was established to plan and prepare for the industrial action taken by some public sector workers on 30 November. The Trust developed a comprehensive Operational Plan to ensure the safety of patients and staff, and to continue to provide as near to a normal range of services as possible. The de-brief process has enabled us to learn from this day of action and better prepare us for such action in the future.

The Trust also has several risk-specific plans in place including influenza pandemic planning, cold weather, flooding, and CBRN (chemical, biological, radiological and nuclear), all of which are regularly reviewed. Staff awareness and engagement is maintained through training, exercises, communication cascades and via the intranet. There has also been Executive Director attendance on the Emergency Planning Strategic Leadership Programme facilitated by NHS North.

The Trust has a full suite of business continuity plans, enabling individual departments and Divisions to respond more effectively to both local incidents and together in response to larger scale major incidents. These plans were reviewed in advance of the industrial action to identify critical services and the resources required to maintain those services. Plans are also regularly reviewed through testing and activation – for example, a building fire resulting in evacuation, telecommunications outages. The implementation of business continuity plans ensures minimum disruption to staff and patients and a timely return to ‘business as usual’ in the event of such an incident.

Patient Relations/Patient Advice and Liaison Service (PALS)

Introduction

The Trust welcomes the views of people who have experience of its services, even if they are critical, because they provide an opportunity to learn and improve for the benefit of others who may use the services in the future. We would like the opportunity to put things right at the time a concern is identified to ensure that the experiences of our patients, carers and staff are starting out in a positive way.

During the last year the Patient Relations/PALS Department has maintained a close relationship with the Divisions, working together to improve the services provided for our patients, relatives and carers who visit this Trust.

This year has seen the start of a way of working that identifies any complex or serious complaints and escalates these to an Executive Team. Weekly meetings are undertaken to ensure that these are reviewed at the highest level.

A new development in the last year was the introduction of the Careline. This gives patients, relatives and carers, another different way of contacting the Trust in which they can express their worries or fears, as well as being able to convey any concerns. In keeping with the Trust's tag line 'your hospital, your health, our priority', this service is available during the extended hours of 9:00 am to 9:00 pm.

Patient Relations/PALS Department have also been monitoring the stories posted through Patient Opinion. Patient Opinion is a different way for Trusts to get feedback from patients, visitors, relatives and carers. It was founded in 2005 and is a national independent feedback platform for health services. Patient Opinion is non-profit making and is about sharing experiences and opinions regarding health services within the UK.

Patient Opinion information and leaflets have been distributed around the Trust and by the end of the financial year every ward and department will have been asked to promote this service to patients, relatives and carers in their area or ward. This is an anonymous way of providing feedback to the Trust and has provided valuable intelligence and given us the opportunity to make positive changes. All feedback is on the Patient Opinion website and is available for anyone to read and is www.patientopinion.org.uk .

Recognising that we need to learn from complaints is an important part of the complaint process and something that the Patient Relations/PALS team are passionate about. Following the recent purchase of a Customer Care Board Game members of the Patient Relations/PALS team will be conducting training sessions around the handling of complaints with a customer focussed theme.

Information and Performance

From the 1 April 2011 to 31 March 2012 the Trust received 473 formal complaints.

Complaints by Division

The Divisions received formal complaints as follows:

- Medicine 162
- Surgery 149
- Clinical Support 57
- Musculoskeletal 88
- Estates and Facilities 16
- Corporate Services 1

Complaints by Severity:

- High – 83
- Moderate – 296
- Low – 85
- Very Low – 9

Formal Complaints which were upheld or well founded

The Trust welcomes all complaints and believes that all complaints reflect dissatisfaction to a greater or lesser extent. For this reason all complaints are held to be well founded as this provides us with the opportunity to put things right.

Concerns and request for advice/information

The Patient Relations/PALS Department dealt with over 1000 concerns, requests for assistance or information dealt with on an informal basis.

The Ombudsman

From the 1 April 2011 to 31 March 2012 there have been 13 requests from the Ombudsman. 6 of these have been returned as not being investigated; three returned for further Local Resolution; one under consideration; one where a partial investigation is being undertaken and two files have been requested with no action notifications received.

Improvement Arising from Complaints

The following are a sample of the improvements made following complaints investigations:

- Birth After Thoughts leaflet – This is distributed to new mothers. If there are any outstanding questions or concerns following birth this service is available to give new mums an opportunity to discuss these with either a midwife or consultant.

- Change of policy in respect of MRSA swabbing at the pre-operative assessment, ensuring that patient dignity is preserved and maintained.

- Training provided to ensure greater understanding of complex behaviour in vulnerable adults. This includes a DVD to enable staff to be visually aware of some of the challenging behaviour they may come across and how to handle this.

- A change in the appointment system for Phlebotomy appointments to enable a more efficient service.

- A new deep vein thrombosis (DVT) pathway for pregnant women.

Monitoring Arrangements

The Patient Relations Department/PALS continue to meet with the Divisions to discuss complaints received, responded to, and the progress made with outstanding complaints, reviewing the identified learning points and how these can be implemented.

The Evidence Audit Tool has been implemented. Evidence is requested from the Divisions to ensure that lessons learned as a result of complaints made to the Trust are embedded.

Statistical information is reported on a monthly basis to the Trust Board and identifies the number of complaints received broken down by Division, subject and performance against the Trust's twenty five days standard.

Benchmarking

The Trust will be undertaking a Benchmarking exercise following the release of the national statistics later this year and will be reported within the next annual report.

Information Governance

Information Governance Toolkit Version Nine 2011/12

The Information Governance Toolkit submission is required by the 31 March each year and is a measurement of the Trust's performance to ensure that personal data is dealt with securely and confidentially.

The Trust achieved 82% compliance with the Information Governance (IG) Toolkit assessment for 2011/12. This is the highest score the Trust has achieved in the nine years of the IG Toolkit being in existence. There are forty five requirements in total which are scored at four Levels of compliance ranging from Level 0 to Level 3.

All 45 requirements are mandated to achieve at least a Level 2 or above. The Trust obtained a non-satisfactory status as all forty five IG Toolkit requirements do not meet the minimum Level 2 status. Two requirements out of forty five remain below Level 2.

Information Risk Programme

The objective of the on-going Information Risk programme is to ensure that the Trust has established a robust control environment to identify, record, manage and mitigate risks for information assets and systems.

Regular risk assessment of Trust information systems will be carried out by Information Asset Owners in line with IS27001. These assessments will be accessible on the Trust risk register together with all other risks identified within the Trust.

An Information Asset Register is being maintained with information about our key systems and who is responsible for them (Information Asset Owners and Information Asset Administrators). The register holds policies, procedures and assessments about systems which can be checked to ensure information systems and assets are being managed correctly especially when they hold and process personal information. Information Asset Owners and Administrators have been identified for the Trust's key systems and have been trained and made aware of their role.

Freedom of Information

The Trust has received one hundred and thirty one Freedom of Information requests from 1 April 2011 – 31 March 2012.

Further information about Freedom of Information and how to request information about the Trust can be found on the Trust website - www.wwl.nhs.uk.

Incident Reporting

The Information Governance Department has recorded twenty eight Information Governance incidents between 1 April 2011 and 31 March 2012. None of these were classified as Serious Untoward Incidents.

Patient and Public Engagement (PPE)

Improvements in Patient/Carer Experience

The Trust has continually achieved excellent scores for cleanliness throughout the hospital. This places the Trust in the top 20% of all Trusts in this area of assessment in the National Survey Programme for 2011 including the Inpatient Survey, Outpatient Survey, Paediatric Inpatient and Outpatient Surveys.

The Patient and Public Engagement (PPE) Team continues to obtain feedback from inpatients using the Real Time Patient Experience Survey. The surveys are undertaken by hospital volunteers and Governors. The results are presented to the Trust Board every month to monitor performance against the corporate objective to achieve over 85% of patients surveyed reporting a positive patient experience.

Patients, visitors and carers continue to use the comment cards to give feedback to the Trust on their experience when attending the hospital. The Trust has received very positive comments and has also addressed issues raised, to improve patient services.

The Trust has continued to engage with the membership panel by inviting the members to "An Evening with the Medical Director on Safety", and a "21st Century Cancer Event" showcasing our cancer services. We also held a young person's event engaging with local schools and colleges about careers in the NHS and Health Promotion.

21st Century Cancer Event

Young Person's Event

The Engagement Department worked with patients on projects such as the Service and Site Investment Strategy, Text Messaging Service, (to improve did not attend rates (DNA) and the Extending Working Hours project. Patients also attended a focus group meeting on the redesign of Phlebotomy Services at Leigh Infirmary.

The Governors have met with the Trust Board to discuss key issues and challenges facing the Trust. Governors have been involved in the design and content of the Membership Newsletter and the organisation of the Membership Events. Governors are involved in many Trust committees, for example, Service and Site Investment, Discharge Improvement and Equality and Diversity.

Consultation with local Groups and Partnerships

The Trust continues to work in partnership with the local PCT Commissioners. We held three "Visioning" events with NHS Ashton, Leigh and Wigan on the redesign of unscheduled care services. Patients who were users of the urgent care system were invited to patient panels. Patient input was an integral part in the redesign of the urgent care pathway.

We have worked with the Wigan Borough Local Involvement Networks on discharge improvements, text messaging service and the equality delivery system.

The Patient and Public Engagement Committee monitors progress against the National Survey Programme. Its remit is to ensure that patient and public engagement is integral to the work of the Trust. The Committee is chaired by the Lead Governor and also has representation from The Local Involvement Network (LINKs), Overview and Scrutiny Committee and a carer.

Voluntary Services

The current database of the number of hospital volunteers stands at 446.

Ten induction sessions for new volunteers were held during the period April 2011 to December 2011, resulting in 117 new volunteers completing applications.

Volunteers Annual Training

Sixty nine percent of volunteers attended the seven sessions held through the year. Volunteers find the sessions very informative and have said that they are ‘very interesting, helps me in my volunteer role’. The lecturers are very supportive as they know the volunteer role is important and have commented that ‘it is great as they help me when visiting different sites, they point out various concerns bringing, them to my attention’.

Volunteers Long Service Awards

The Volunteers long service awards, hosted by the Trust Chairman, Les Higgins, took place on 2 June 2011. Forty three Volunteers received certificates and badges.

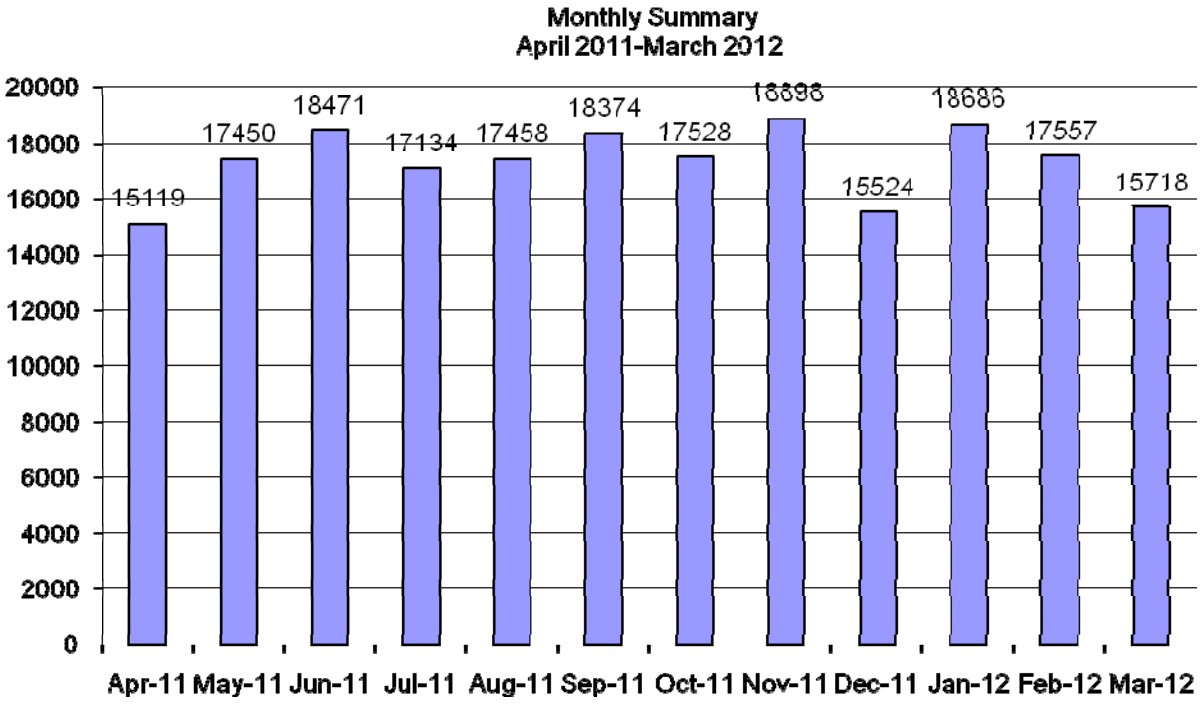
- 30 volunteers received five year badges
- 10 volunteers received 10 year badges
- two volunteers received 15 year badges
- one volunteer received a 20 year badge

Pauline Carr received her 20 years long service badge after first volunteering for the Wigan League of Hospital Friends and now, along with other volunteers has formed the new Hospital Volunteer Fundraisers.

Volunteers Long Service Awards held at Wrightington

Pauline Carr receiving her long service badge from Les Higgins, Chairman

Help Desk Statistics



For the period April 2011 to March 2012 a total of 210,635 enquires were dealt with by the six help desks within the Trust.

From April 2011 to March 2012 the hours covered by volunteers calculated at the minimum rate provided a benefit to the Trust of £209,930.24.

WWL Volunteers Involvement with the Trust

Volunteers continue to support the Engagement department in Membership events, including the Young Person's and the 21st Century Cancer Care events that were both held at the DW Stadium. They also support the department, along with some of the Governors, in carrying out the real time surveys on the wards each month.

Volunteers also play a part in the Nutrition Delivery Group, supporting ward staff at meal times.

Women's Royal Voluntary Service

Voluntary Services work in partnership with WRVS on all three sites, RAEI, TLC and Leigh, in recruiting new volunteers and offering training programmes. The newly refurbished WRVS café area in the main entrance at RAEI became operational in April 2011 and staged an active recruitment programme for new volunteers to cover the extended opening times.

Main Entrance to RAEI and WRVS Café

Fundraising

The Trust benefits from a number of fund raising groups, two Leagues of Hospital Friends, Wrightington and Wigan, and a relatively new group called Hospital Volunteer Fund Raisers.

During 2011/12 the Wrightington League of Hospital Friends' tea bar profit has increased because of extended opening times resulting in £29,000 raised for 2011. The total donations made for the year were £35,550, which included £10,000 for Theatres, £8,200 for Ward 7, and £4,500 for the Therapy Department, all at Wrightington Hospital.

The newly formed Hospital Volunteer Fund Raisers, through their five tombola sessions held at Thomas Linacre and Wigan Infirmary, have raised £914.00 which was paid directly into the Nurse Directorate fund for patients' comforts.

Sustainability and Environmental Management

The Trust has continued to invest considerable resources towards ensuring the reduction of environmental impact within the current and future built environment.

Within the Site and Service developments, the designs for the new buildings and refurbishments will aim to satisfy the BREEAM assessment tool (Building Research Establishment Environmental Assessment) as well as HTM 07-07 Sustainable Health and Social Care buildings.

Within our existing estate, the Trust has continued to reduce its environmental impact through reducing energy related CO_2 emissions year on year. Significant capital investment (£200,000 p.a.) towards energy efficiency and sustainability over the past five years has helped the Trust achieve such reductions, as well as the continued support of our staff across all Trust sites.

Participation in the focus group setting up a local Environmental Management System (EMS) across the Wigan Borough, together with NHS Ashton, Leigh and Wigan and Bridgewater Community Health NHS Trust in conjunction with Groundwork, has proved a valuable asset and will aid the development of the Trust's own EMS within the coming financial year 2012/13.

Also within 2012/13, we aim to reduce our CO_2 impact due to waste disposal and the introduction of a recyclables waste stream within the Trust sites is a key aspect of this. The introduction to the Trust of a Waste Minimisation Officer this year has provided a key strength to the E&F team within Environmental Management. A target to reduce waste disposal costs by 10% compared with 2011/12 has been set for the forthcoming year.

Further to this, the Division has targeted a 5% reduction in gas consumption and 3% reduction in electricity consumption for the forthcoming year against 2011/12 levels.

Equality and Diversity (E&D)

Our Approach to E&D

The Trust is committed actively to recognise and promote equality and diversity within the community. We believe that people who use our services, their carers and our staff, should be treated with respect and dignity.

We are committed to challenging discrimination in all its forms and ensuring that equality lies at the heart of everything we do. We want to be a fair and equitable organisation, one where everyone accepts differences between individuals and values the benefits that diversity brings.

We believe that the E&D agenda is a vital and integral part of working that underpins all aspects of our vision and values. It will be through the effective implementation of this agenda that the Trust will achieve its vision and values.

Legislative Framework

The General Public Sector Equality Duty under the Equality Act 2010 came into force in April 2011 and it requires public bodies to eliminate discrimination, advance equality of opportunity and foster good relations between different groups. In addition to the general equality duty, specific duties came into force in 2011 and under the specific duties public bodies are required to:

- Publish information to demonstrate compliance with the general equality duty. This includes information relating to persons who share a relevant protected characteristic who are its employees or other persons affected by its policy and practice (by January 2012)
- Prepare and publish one or more equality objectives (by April 2012)

The Trust has produced an employment monitoring report and a service monitoring report. This information enables us to identify key trends and support future decisions in relation to both employment and service development. This information also has enabled us to meet our requirement to publish information from January 2012 to comply with the general equality duty.

Equality Delivery System (EDS)

The EDS provides guidance to the NHS on how to achieve better equality outcomes for all. It has been designed as a tool to help all staff and NHS Organisations understand how equality and diversity can drive improvement and strengthen accountability of services to the patients and the public. It will help ensure that everyone – patients, public and staff have a voice in how organisations are performing and where they should improve. The EDS is about making a positive difference to healthy lives and working lives.

At the heart of the EDS is a set of 18 outcomes, grouped into four goals. These outcomes focus on the issues of most concern to patients, carers, communities, NHS Staff and Boards. It is against these outcomes that performance is analysed, graded and action determined.

The Trust has undertaken a self assessment against the EDS framework and will seek feedback from stakeholder groups on the assessment. This assessment will inform the Trust’s equality objectives which were published in April 2012.

Glossary of Terms

Acute
Having or experiencing a rapid onset of short but severe pain or illness.

Acute care
Necessary treatment, usually in hospital, for only a short period of time in which a patient is treated for a brief but severe episode of illness, injury or recovery from surgery.

Agenda for Change
Agenda for Change is the single pay system in operation in the NHS. It applies to all directly employed NHS staff with the exception of doctors, dentists and some very senior managers.

Bacteraemia
Bacteraemia is the presence of bacteria (such as MRSA) in the blood. The blood is normally a sterile environment, so the detection of bacteria in the blood (most commonly with blood cultures) is always abnormal.

Cardiology
The medical study of the structure, function, and disorders of the heart.

Clostridium difficile (C diff)
A bacterium that is recognised as the major cause of antibiotic associated colitis and diarrhoea. Mostly affects elderly patients with other underlying diseases.

Colonisation
The presence of a bacterium (such as MRSA) simply sitting on the surface of the skin but causing no adverse effect to the patient.

Council of Governors
There are three types of Governors: public, staff and partner. The main role of the Governors is to represent the communities the Trust serves and our stakeholders and to champion the Trust and its services. The Council of Governors do not “run” the Trust or get involved in operational issues as that is the job of the Trust Board. However, it has a key role in advising the Board and ultimately holding the Board to account for the decisions it makes.

CQUIN
The Commissioning for Quality and Innovation Payment Framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

Elective surgery
Surgery which need not be performed on an emergency basis.

Freedom of Information (FOI)

The Freedom of Information Act deals with access to official information and gives individuals or organisations the right to request information from any public authority.

Gastroenterology

The study of disorders affecting the stomach, intestines and associated organs.

Hospital at Home

The provision of a hospital service in a person's own home. The service provides time-limited intensive support and treatment that would traditionally be provided in an acute hospital. The Hospital at Home service provides a proactive approach, including social work support, for people who may be deteriorating in the community setting with the primary aim of preventing hospital admission. It also helps to facilitate early discharge from acute settings.

Hospital Standardised Mortality Ratio (HSMR)

This is an important measure that can help support efforts to improve patient safety and quality of care in hospitals. The HSMR compares the actual number of deaths in a hospital with the average patient experience, after adjusting for several factors that may affect in-hospital mortality rates, such as the age, sex, diagnoses and admission status of patients. The ratio provides a starting point to assess mortality rates and identify areas for improvement, which may help to reduce hospital deaths from adverse events.

IM&T

Information Management and Technology.

Information Governance

Information Governance is a framework for handling information in a confidential and secure manner to appropriate ethical and quality standards.

Information Technology (IT)

The development, installation and implementation of computer systems and applications.

John Charnley Wing

A private patient wing at Wrightington Hospital named after Professor Sir John Charnley in recognition of his pioneering hip replacement work.

League of Friends

A voluntary organisation which supports the work of the hospitals in the Trust. The League of Friends is able to provide much needed equipment and comforts for the benefit of patients and staff through the income raised by the work of volunteers.

LEAN

Lean can be described as a process for identifying the least wasteful way to provide maximum value to our patients. It is a management philosophy, using a set of tools which can be applied across all activities of an organisation.

Lean thinking seeks to streamline the patient journey and make it safer, helping staff to eliminate waste of all kinds and to treat more patients with existing resources. It was

originally developed by manufacturing companies such as Toyota, but it is now being successfully applied in service organisations including hospitals across the world.

Monitor

Monitor is the independent regulator of NHS Foundation Trusts. The organisation was established in January 2004 to authorise and regulate NHS Foundation Trusts. It is independent of central government and directly accountable to Parliament.

There are three main strands to Monitor's work:

- Determining whether NHS Trusts are ready to become NHS Foundation Trusts
- Ensuring that NHS Foundation Trusts comply with the conditions they signed up to and that they are well-led and financially robust
- Supporting NHS Foundation Trust development

Methicillin-resistant Staphylococcus aureus (MRSA)

Staphylococcus aureus (SA) is a common type of bacteria that live harmlessly, as a colonisation, in the nose or on the skin of around 25-30% of people. It is important to remember that MRSA rarely causes problems for fit and healthy people. Many people carry MRSA without knowing it and never experience any ill effects. (These people are said to be colonised with MRSA rather than being infected with it).
In most cases, MRSA only poses a threat when it has the opportunity to get inside the body and cause an infection; this is called a bacteraemia.

Musculoskeletal (MSK)

The system of muscles, tendons, ligaments, bones, joints and associated tissues that move the body and maintain its form.

Neurology

The study of the nervous system and disorders affecting it.

NHS Foundation Trusts

NHS Foundation Trusts are a key part of the reform programme in the NHS. They are autonomous organisations, free from central Government control. They decide how to improve their services and can retain any surpluses they generate or borrow money to support these investments. They establish strong connections with their local communities; local people can become members and governors. These freedoms mean NHS Foundation Trusts can better shape their healthcare services around local needs and priorities. NHS Foundation Trusts remain providers of healthcare according to core NHS principles: free care, based on need and not ability to pay.

Orthopaedics

The diagnosis and treatment, including surgery, of diseases and disorders of the Musculo-skeletal system, including bones, joints, tendons, ligaments, muscles and nerves.

P21+

The Procure 21+ National Framework is a framework agreement with six Principal Supply Chain Partners (PSCPs) selected via an Official Journal of the European Union (OJEU) Tender process for capital investment construction schemes across England up to 2016.

An NHS Client or joint-venture may select a Supply Chain for a project they wish to undertake without having to go through an OJEU procurement themselves.

Pathology

The study and diagnosis of disease through examination of organs, tissues, bodily fluids and whole bodies. The term also includes the study of disease processes.

PbR

Payment by Results (PbR) was introduced to improve efficiency, increase value for money, facilitate choice, enable service innovation and improvements in quality, and reduce waiting times. PbR uses a national tariff of fixed prices that reflect national average prices for hospital procedures

Performance Development Reviews (PDR)

The purpose of a PDR is to review periodically the work, development needs and career aspirations of members of staff in relation to the requirements of their department and the Trust's plans and to take appropriate steps to realise their potential. It facilitates communication, clarity of tasks and responsibilities, recognition of achievements, motivation, training and development to the mutual benefit of employer and employees.

Primary Care

The medical care a patient receives upon first contact with the health care system, such as a GP or Dentist, before referral elsewhere within the system.

QCF

Qualifications and Credit Framework.

QIPP

The quality, innovation, productivity and prevention (QIPP) challenge is our opportunity to prepare the NHS to defend and promote high quality care in a tighter economic climate.

Radiology

The medical speciality that uses radioactive substances in diagnosis and treatment of disease especially the use of X-rays.

Rheumatology

Rheumatology is the diagnosis and therapy of rheumatic diseases such as clinical problems involving joints, soft tissues and allied conditions of connective tissues.

Root Cause Analysis

A process for identifying the basic or causal factor(s) that underlie variation in performance.

Secondary Care

The term secondary care is a service provided by medical specialists who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists.

Summary Hospital-level Mortality Indicator (SHMI)

SHMI is a hospital-level indicator which reports mortality at trust level across the NHS in England using standard and transparent methodology. This indicator is being produced and published quarterly by the Health and Social Care Information Centre.

Staff Side

Staff Side comprises representatives of all recognised Trade Unions within the Trust. They meet on a regular basis to discuss issues and to update on any concerns and points of interest throughout the Trust.

Urology

The branch of medicine concerned with the study of the anatomy, physiology, and pathology of the urinary tract, with the care of the urinary tract of men and women, and with the care of the male genital tract.

WRVS

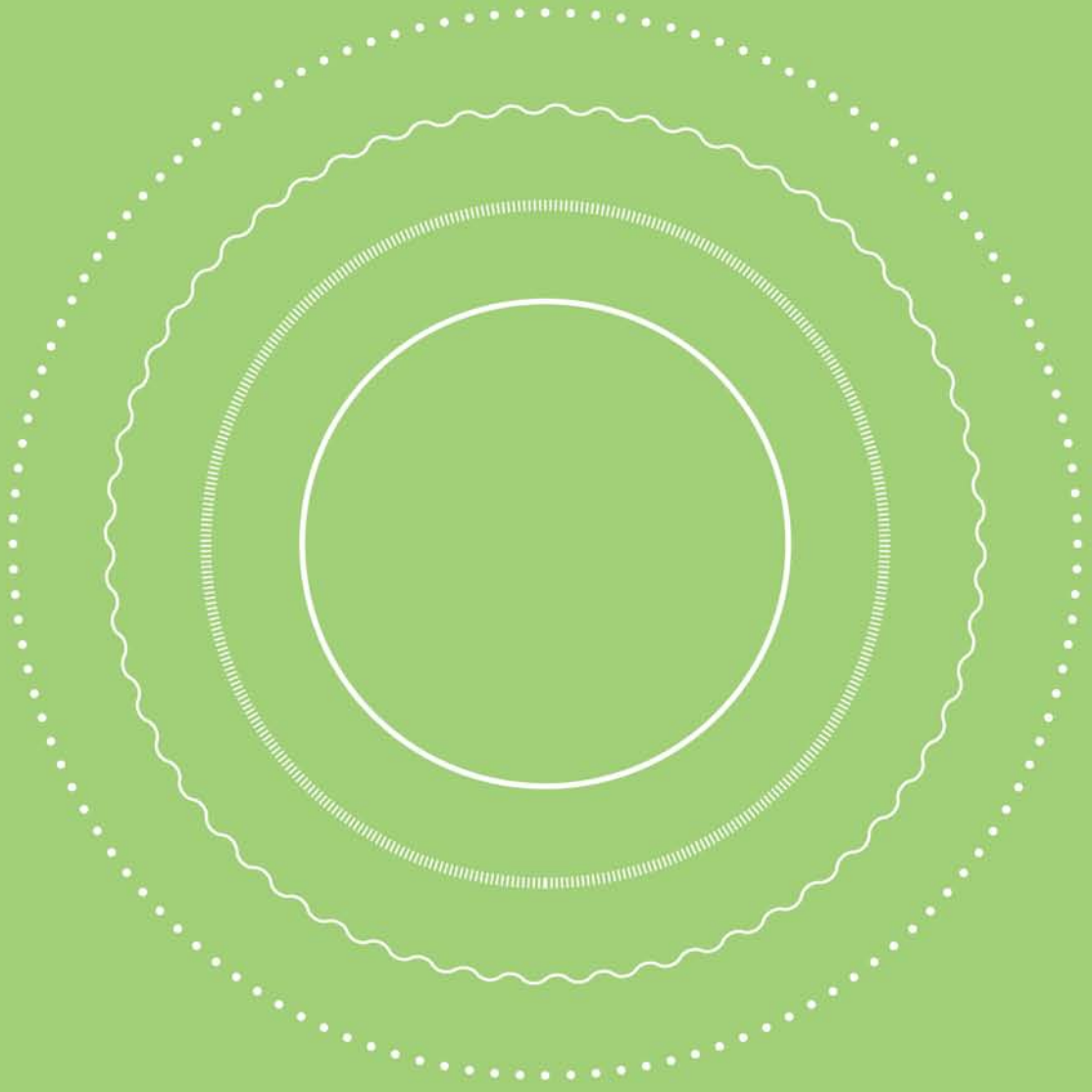
Formerly the Women's Royal Voluntary Service, known until 1966 as the Women's Voluntary Service; is a voluntary organisation concerned with helping people in need throughout the UK.

WWL Wheel

The Strategic framework for the Trust is represented by the WWL wheel, there are 7 strategic aims that are underpinned by the 6 core values contained in the NHS Constitution. Patients are at the centre of the wheel as they are at the heart of everything we do.

Wrightington, Wigan and Leigh
NHS Foundation Trust

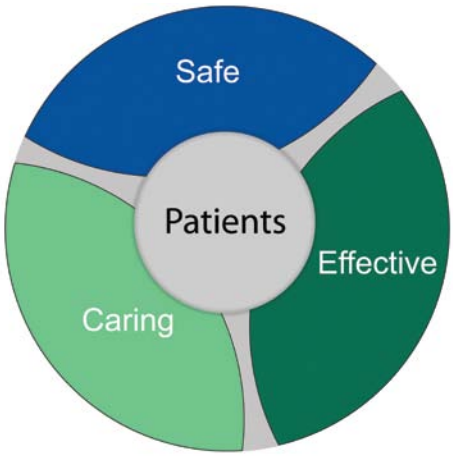
Quality Accounts 2011/12



your hospitals, your health, our priority

Wrightington, Wigan and Leigh NHS Foundation Trust

Quality Accounts
1 April 2011 – 31 March 2012



Our strategy for quality surrounds our patients:

Safe – Protecting our patients against harm

Effective – Treating our patients efficiently with good clinical outcomes

Caring – Compassionately caring for our patients and meeting their personal needs

Part 1

1.1 Statement on Quality

Welcome to our fourth Quality Account. This is a tremendously important document for us, as quality is the overarching focus for our Trust. This report sets out our progress on the never ending task of improving quality. It remains our vision to be in the top 10% for everything we do.

During this year, we wanted to strengthen awareness and understanding of our quality strategy amongst our staff. We have developed the WWL Wheel (see page 11) as a simple visual representation of our objectives and values relative to the pursuit of quality. The wheel sits on a platform of the values as described in the NHS Constitution and has Patients at the very centre. Surrounding the Patients is what quality means to us in three words – Safe, Effective and Caring. Finally, around the wheel are seven 'pods', each containing a strategic theme. You will see the way we use the wheel in this document and elsewhere, to frame and describe our plans and achievements.

As the science of healthcare improvement has developed, it has enabled us to be more precise in the measurement of quality. This means that we can do much more than make pleasant sounding aspirational statements about our commitment to quality. We can demonstrate with facts and figures just how well we are doing on our journey of improvement.

2011/12 was another year of great progress. On infection control we had just three reported cases of MRSA bacteraemia infection and one of these was a contaminated sample rather than an infected patient. So in five years we have reached a point where we have all but eliminated MRSA bacteraemia bloodstream infections. The other much publicised infection is Clostridium Difficile and in 2011/12 we have had just 47 cases compared to 62 the previous years. We have also started to record and report cases of MSSA and E Coli bacteraemia.

Another key quality measure is Hospital Standardised Mortality Ratio (HSMR) and we have seen a five year improvement trend. The HSMR figure for 2011/12 is 87.1 and we are very proud of this further reduction. As the whole NHS improves these figures are rebased annually and we will probably see an increase of about six points later in the year. Nonetheless this firmly places us as distinctly better than average.

This report contains many more facts and figures and I encourage you to study the range of quality initiatives and measures that are in place to improve quality and reduce avoidable harm. Here are just three highlights:

- We have introduced the concept of harm free wards which constantly record and publicly report the five most common harms. Our objective is to achieve zero harm
- We have joined NHS Quest – a membership organisation which shares experience and learning in order to achieve cutting edge levels of quality
- We have an ultra-low rate of hospital acquired pressure sores with just seven cases in the whole year

Of course, there are also areas where we have not done as well as we hoped to. Our annual Picker Survey Results have improved compared to the previous year but still have a long way to go with 10% of patients not being satisfied with their care. We have also seen great improvements in our stroke care but still we are only average in the quality of this service. These are just two areas which will be the subject of much effort to raise performance next year.

Like the rest of the NHS, we face a huge challenge next year in maintaining and, ideally, improving quality, despite an environment of growing demand and shrinking resources. The good news is that almost all quality improvements have the effect of reducing costs. Every harm avoided is a cost saved. Every patient who gets the right treatment first time and without delay represents the most efficient use of health care. It is by being in the top 10% for everything we do that we will meet our biggest challenges.

In 2012/13 we will set up a new Quality Executive to bring strengthened rigour and capacity to our work programme. The Quality Executive will be supported by a Quality Faculty of over 50 individuals who will have special identity badges to mark them out as champions of quality and leaders on quality initiatives. I would like to thank this group who have already contributed so much to the Trust and who will be the backbone of our continuing drive for improvement.

In making this statement I can confirm that, to the best of my knowledge, the information contained in this Quality Account is accurate.

Andrew Foster
Chief Executive

Part 2

2.0 Priorities for the Five Domains of the NHS Outcomes Framework 2011/12

Domain			Priority	Reference Section
Domain 1	Preventing people from dying prematurely	Effectiveness	Halving the harm Hospital Standardised Mortality Ratio (HSMR) / Summary Hospital Mortality Indicator (SHMI)	3.1.8 3.1
Domain 2	Enhancing quality of life for people with long-term conditions		• AQuA care pathways	3.13
Domain 3	Helping people to recover from episodes of ill health or following injury		• Stroke and Transient Ischaemic Attack (TIA) pathway • Advancing Quality Initiative • Outreach	3.21 3.13 3.7
Domain 4	Ensuring that people have a positive experience of care	Patient Experience	• Patient Experience Taskforce (projects) • Delivering Same Sex Accommodation	3.6 3.6
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	Safety	• Infection Control – Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium Difficile, Methicillin-sensitive Staphylococcus aureus (MSSA) etc) • Fractured neck of femur • Falls prevention • Safety Express • Venous Thromboembolism (VTE)	3.1 3.11 3.22 3.18 3.18 3.18

Progress against these priorities was measured, monitored and reported on a monthly basis. This was carried out by a combination of the Quality Improvement Committee and via the Trust Board's performance report. Section 3 of this report gives details of the Trust's performance against these measures.

The NHS Outcomes Framework 2012/13 can be found in Appendix B

2.1 Priorities for Improvement in 2012/13

The Trust defined 11 quality enablers to be engaged and successfully delivered:

Domain	Quality Enabler	Outcome
Caring	Nutrition and Hydration	That all meals and drinks are suitable to the patient and the patient receives appropriate help and support with meals and drinks.
Caring	Patient Experience	That each patient has an individual, bespoke and unique experience where communication, engagement, privacy, dignity, holistic care are treated as important as outcome.
Effectiveness	Senior Review	That every patient receives a senior review every day.
Effectiveness	Intelligence (Dr Foster, Complaints, Incidents, HM Coroner's Inquests, Deaths' Audit, audit and effectiveness)	That every episode of care is coded accurately. That patients records are clear and complete.
Effectiveness	Modified Early Warnings Score (MEWS) escalation	That deterioration of a patient is escalated and responded to with appropriate levels of input in a timely manner.
Effectiveness	Admission	That patients are admitted to unscheduled care with a full history to allow excellent care to commence on the ward.
Effectiveness	Discharge	That patients are discharged with care bundles designed to avoid re-admission.
Safe	Infection Control	That all hospital interactions with a patient are in line with or exceed all Infection Control (IC) policy and procedure requirements (including relatives).
Safe	Medication	That all prescriptions are reviewed, all side effects noted and acted upon; that all administrations are completed in a timely manner and all records are kept up-to-date.
Safe	Falls Prevention	That risk assessments are undertaken thoroughly and reviewed when changes occur and that all actions from risk assessments are implemented and adhered to.
Safe	Mortality – Fractured Neck of Femur (NOF)	Work to ensure patients arrive early on the correct ward, with early accurate pre-operative assessments are priorities for the year ahead.

A paper was presented to the Trust Board in September 2011 outlining how quality could be better geared towards achieving the 'top 10%' aim. The central component of the 'top 10% hospital' aim is the reduction of HSMR – its importance in its place on the Board Assurance Framework and Quality Strategy. The proposal was aligned to the AQUA RMP2 (Reducing Mortality Programme – Phase 2), in recognising that measurement, clinical care bundles and preferred place of death focus areas. The enablers agreed and listed below all correlated to one of the three RMP2 focus areas.

The paper proposed an overarching Quality Executive chaired by the Chief Executive with the Nursing and Medical Directors as joint Deputy-Chairs and the Divisional Chairs and other key leads as members. The Head of Governance and Assurance will act as programme manager for the Quality Executive. The Quality Executive will replace the Quality Improvement Committee and the SMR Task Force.

Each Division will have a corresponding 'Quality Executive' – these forums will replace Divisional QIC forums, chaired by the Divisional Chairperson, whilst each will need to be localised they will need to have named and identified champion/lead covering the enabling subjects as shown in the improvement table opposite.

A perfect episode of care – which, as a 'top 10% Hospital', the organisation would need to be achieving for the vast majority of patients, would require nine of the eleven described enablers to be engaged and successfully delivered.

2.1.1 Quality Strategic Aims

The quality of clinical care is **the** business of NHS organisations. This is a self evident truth emerging from recent failings illustrated in the Francis Report. It is reinforced within the key themes of the White Paper 'Equity and Excellence Liberating the NHS' which include, improving health outcomes to among the best in the world and giving more information and choice to patients about their care;

'there will be no decision about me without me'

To attract patients to WWL, the services, treatment and care that is offered to our patients must not purely meet national requirements of being provided within agreed timescales and finances: it must be patient-centred, recognised as being a quality service that ensures consistent delivery of evidence-based standards and, most importantly is viewed as delivering safe and effective outcomes.

The Government have also renewed the pledge to eliminate mixed sex accommodation and further reduce Healthcare Acquired Infections (HCAIs). This is to support reductions in harm and enhance the patient experience.

The Trust Board has made a commitment to put quality on a par with finance and performance, with safety being the highest priority of all. A number of quality measures are reported to the Trust Board monthly within the performance framework. The Trust is also committed to establishing a fair and open culture to promote learning from incidents.

The Trust has a challenging "service transformation agenda" to support its service and site investment strategy. We are committed to developing clinical pathways to deliver the quality outcomes we aspire to.

We have had considerable success in reducing the incidence of infection, pressure ulcers and reducing our Hospital Standardised Mortality Ratio (HSMR).

A number of senior Clinicians and Executive Directors have attended a variety of quality events and the Trust is affiliated to the North West's Advancing Quality Alliance (AQuA). This will help the Trust in achieving the culture and climate to enable positive open conversations about quality.

The Trust in reviewing its objectives has re-emphasised its commitment to the quality and safety agenda. Aligned with this are key objectives to improve quality and safety and support the adoption of a **'Zero Tolerance to Harm Culture'.**

From April 2012 a new Quality Executive will be established and led by the Chief Executive that will take forward the Trust's ongoing commitment to improving quality through its over-arching strategy of 'Safe, Effective and Caring'.

The Trust is continually reminded of the importance of the patient journey and starts each Trust Board meeting with a patient story which is an actual reflection of the patient experience.

2.1.2 Partnership Working

The Trust is committed to working in partnership with trade unions, stakeholders and the wider health economy.

A revised partnership framework was introduced during 2011/12 to include a partnership council. The Local Negotiating Committee (LNC) continues to provide representation for medical staff. The introduction of Service Improvement Delivers (SID) champions and the Health and Wellbeing Working Group has further strengthened partnership working. Staff are also encouraged to apply to become Staff Governors.

The Trust has continued to work in collaboration with other Trusts for the provision of Decontamination and Pathology Services to the benefit of all stakeholders. The integration of unscheduled care from Community Services required collaboration and teamwork which will ultimately enable a more seamless patient pathway and reduction of length of stay.

Partner Organisation	Yes/No	Consulted on Quality during 2011/12
Local Involvement Network (LINk)	Yes	During 2011/12, the Local Involvement Network Governor has attended Joint Trust Board and Council of Governor meetings. This provides an opportunity to show how well the Trust is performing on a wide range of quality measures and provides an opportunity for the LINk Governor to act as a conduit bringing information to the Trust and from the Trust to the LINk community. The Head of Engagement has continued to work in partnership with the LINk throughout the year on a variety of engagement projects, the most significant of which have been the discharge from hospital and hearing services.
Governors	Yes	The Council of Governors hold meetings in public and also have private seminar meetings to undertake discussion on special interest areas or for training sessions. Monitoring the quality of our services is a constant feature on every agenda. Governors sit on key quality committees including the Risk and Environmental Committee, Quality Improvement Committee, Engagement Committee and Equality and Diversity Committee. Each of these forums provides opportunities for Governors to challenge the Trust on quality indicators and to provide advice and support to further enhance our quality performance. The Governors agreed the locally determined indicator for 2011/12 at a meeting on 23/03/11 and held a seminar in June 2011 to receive the outcome of the External Auditor's review of the quality accounts for 2010/11.
Wigan Borough Council	Yes	The Trust Chief Executive and Executive Directors have attended meetings of the Wigan Borough Adult Health and Wellbeing Scrutiny Committee to provide performance updates, including information on the quality of Trust services. The Cabinet Member for Health and Social Care continues to serve as an appointed stakeholder Governor.
Primary Care Trust	Yes	We have continued to meet with the PCT formally, in the regular Clinical Quality Review Meetings hosted and chaired by the PCT. This forum gives the PCT opportunity to challenge and act as a critical friend to the Trust, in its delivery of key measures associated with the quality agenda. The Trust collaborates directly with the PCT on Serious Untoward Incidents (SUIs) as and when these occur.

2.2 Our Business Strategy

During the year the Trust consulted with staff over a new framework for the business strategy and new corporate objectives. The aim of this new framework is to explain in very simple terms, our core purpose as defined in our mission, vision and strategy for the future. The framework also aims to clarify the underpinning values that will guide our actions in delivering this strategy and providing services to our patients.

The intention is that all staff should be able to recognise and support the strategy and values in their own areas of work. They should also immediately understand the contribution that they make personally in achieving these. The key elements of the new framework are summarised below.

2.2.1 What We are Here for and What Matters To Us

Our strategic framework aims to describe our mission, vision and strategy in a way which will make sense to everyone, as follows:

- Our **mission** To provide the best quality health care for all our patients
- Our **vision** To be in the top 10% for everything we do
- Our **strategy** To be safe, effective and caring

The above phrases describe the essence of what we aim to do for our patients, staff and the communities we serve. But our strategic framework also needs to describe clearly for our staff how we will work together to achieve these aims. This element of the framework is captured in our statement of values that we have agreed and match those detailed in the NHS Constitution.

2.2.2 Supporting Strategic Themes

We have identified seven core themes to describe the actions and plans that we need to implement in order to achieve our vision:

- Sustaining high performance
- Promoting innovation
- Developing leaders and teams
- Providing rapid, accurate information
- Engaging with staff
- Investing in improvement
- Working in partnership

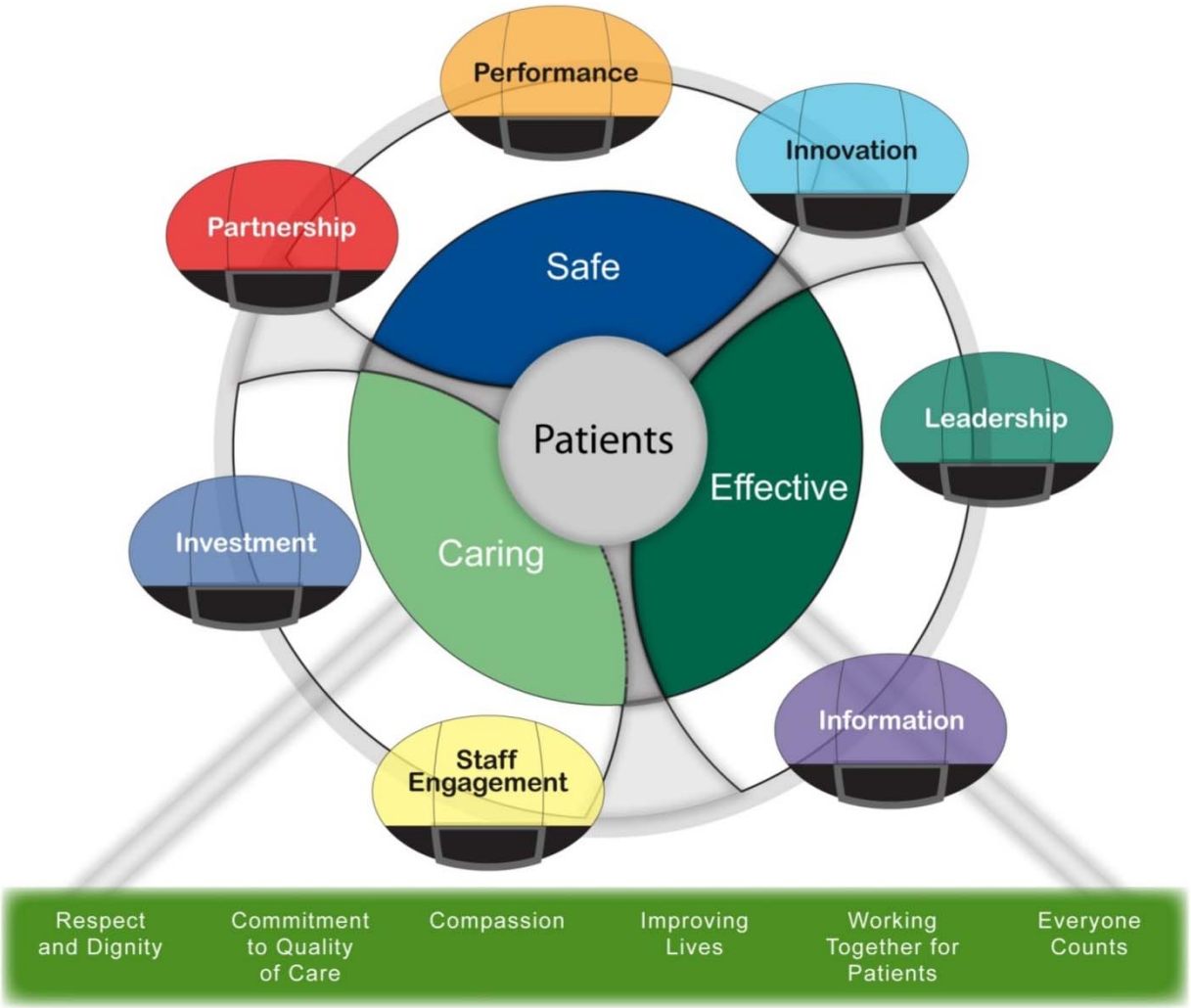
These themes have been identified as we believe they will continue to apply over the long term. On this basis, they will provide an important reference point around which we can build our annual corporate objectives, our Divisional and team objectives, as well as our personal objectives and development plans.

2.2.3 The WWL Wheel

The WWL Wheel (shown below) has been developed as a visual aid to demonstrate how all the elements contained within the Trust's strategic framework link together:

- Patients are at the centre of the wheel as they are at the centre of everything we do
- Meeting patient needs in terms of outcomes and patient experience is also emphasised by the description of our strategy for quality in the inner segments of the wheel – 'safe, effective and caring'
- The seven pods around the wheel represent our long-term strategic themes
- Our values make up the strong base that supports the wheel

The WWL Wheel acts as a regular reminder to everyone of our core purpose and priorities.



2.3 Statement of Assurance from the Board

The Statement of Assurance from the Board is included as Appendix C.

2.4 Review of Services

During 2011/12 WWL provided and/or sub-contracted 43 NHS services as defined in the Trust's Terms of Authorisation as a Foundation Trust.

The Trust has reviewed all the data available to them on quality of care in all 43 of these NHS services.

The income generated by the NHS services reviewed in 2011/12 is £218,179,214 of the total income generated from the provision of NHS services by WWL for 2011/12.

The quality aspirations and objectives outlined for 2011/12 reached into all care services provided by the Trust and so will have had impact on quality of all services. Various activities enable assurance that quality improvement is being achieved including:

- Ward-to-Board reports
- Energise for Excellence in Care (E4E) - a quality framework for nurses, midwives and health visitors which aims to support the delivery of safe and effective care, creating positive patient and staff experiences that build-in momentum and sustainability.
- Monthly performance reports
- Clinical audit
- External independent audits (for example Care Quality Commission (CQC) inspections, Pathology Networks, Local Supervisory Authority review for Midwifery)

2.5 Participation in Clinical Audits

During the period 1 April 2011 to 31 March 2012, there were 43 National Clinical Audits and four National Confidential Enquiries covering NHS services that Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) provides.

During 2011/12 WWL participated in 72% National Clinical Audits and four (100%) National Confidential Enquiries of the National Clinical Audits and National Confidential Enquires which it was eligible to participate in.

The national clinical audits and national confidential enquiries that WWL was eligible to participate in during 2011/12 are reported at Appendix A.

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The national clinical audits and national confidential enquiries that WWL participated in, and for which data collection was completed during 2011/12, are listed in Appendix A, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of nine national clinical audits were reviewed by the provider in 2011/12 and WWL intends to take the actions reported at Appendix A to improve the quality of healthcare provided.

The reports of 215 local clinical audits were reviewed by the provider in 2011/12 and WWL intends to take the actions reported at Appendix A to improve the quality of healthcare provided.

Appendix A is a list of the National and local Clinical Audits and National Confidential Enquiries in which WWL took part in. Also listed is the number of cases submitted to each National audit or enquiry as a percentage of the actual submissions.

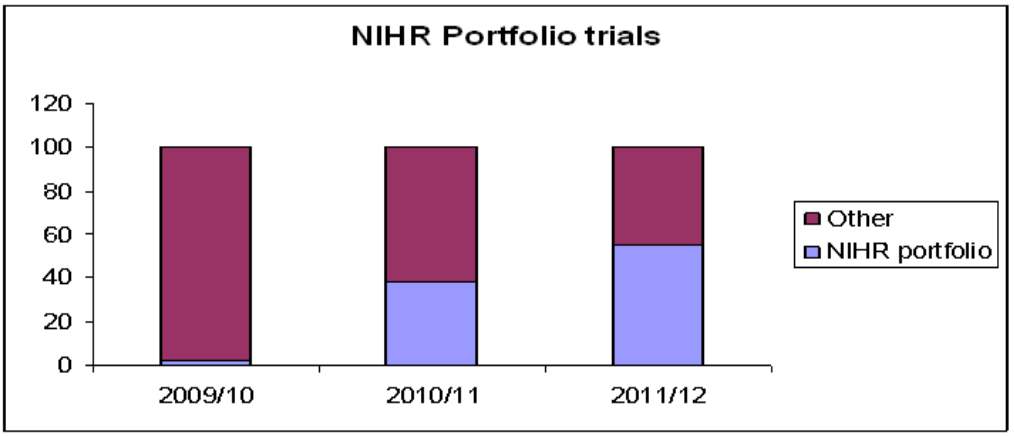
2.6 Research

Within the last four years, research and development has undergone a national programme of complete restructure. The national programme for research is led by the United Kingdom Clinical Research Network (UKCRN). This was formed from 25 local research networks in England. This enabled 100% of the total population in England to be covered thereby providing all of the population the opportunity to engage in clinical research at point of need, should they wish to do so.

The Trust has developed a strong working relationship with the Comprehensive Local Research Network (CLRN) and works very closely with them to ensure that patients and staff have access to quality research projects, which will ultimately have a positive impact on the treatment provided.
This partnership enables the Trust to put into place a strong infrastructure and allows us to support the Department of Health vision for doubling research participation within a five year period.

The Research and Development Department have been active in promoting studies and trials which are managed by the National Institute for Health Research (NIHR) Portfolio.

2011/12 has evidenced an increase from 2% of all trials carried out in WWL in 2008/09, to 55% of WWL research being registered with the NIHR Portfolio in 2011/12.

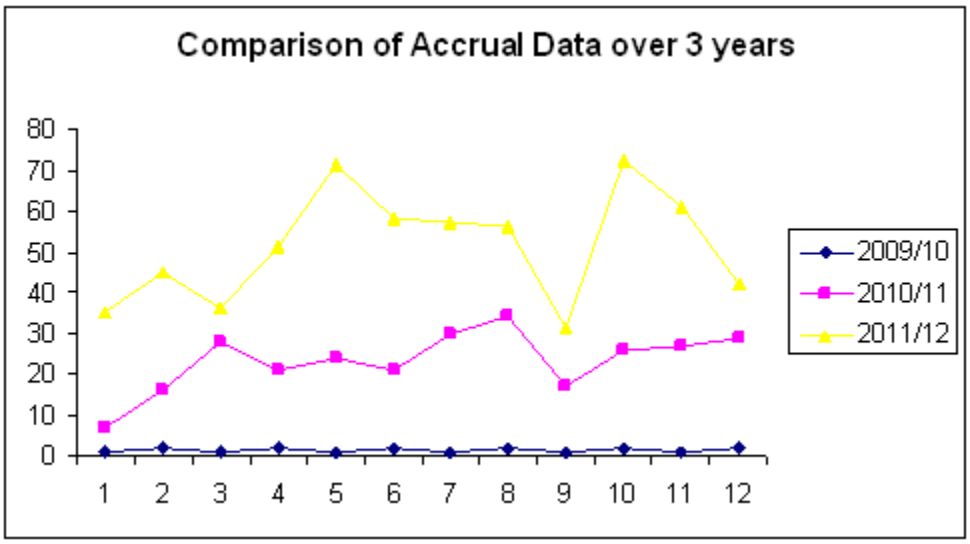


Following NIHR changes to the funding structure in the provision of Flexibility and Sustainability Funding (FSF), which formed a significant part of the funding in 2009/10, the Research and Development department collaborated with the Clinical Research Networks in building research capacity. This enabled the Trust to support the developing research infrastructure within the organisation which in turn will provide assurance to the various clinical areas of activity that the Trust is committed to supporting a quality research portfolio.

Participation in Research

The number of patients receiving NHS services in 2011/12, provided or sub-contracted by WWL that agreed to participate in research approved by a research ethics committee was 615, an average of 51 patients per month.

The graph below shows the comparison for accrual data over three years, 2009/10, 2010/11 and 2011/12. This represents a significant increase in recruitment year-on-year and to a level substantially above the projected number required by the UKCRN.



Flexibility and Sustainability Funding

There is no requirement for a formal report to go to the NIHR in 2011 because there was no FSF provision made to WWL for the year 2011/12. However it is necessary to maintain a close relationship with the CLRN who provide support to Trusts in funding research positions with the FSF they receive. The Research and Development Department monitor recruitment to clinical trials and ensure that the monies received are used specifically to fund staff.

Research and Development Department

Our participation in clinical research shows the Trust's commitment to improving the quality of care. It also supports our contribution to wider health improvements. Actively taking part in research allows staff to be informed of the latest treatment possibilities which can lead to better patient outcomes.

In accordance with section 3.10 of the Research Governance Framework for Health and Social Care, the Research and Development Department holds a record of all research projects and their current status.

The Trust has conducted 121 portfolio trials. Sixty-seven of these remain active and an additional seven are in active follow up. Seventeen trials are in the set up process. Areas of activity are:

- Cancer
- Paediatrics
- Musculoskeletal
- Rheumatology
- Stroke
- Gastroenterology
- Physiotherapy
- Cardiology

Good clinical practice training is provided for all staff who participate in research. This assists the progress of quality research throughout the Trust. The training is offered to all staff including consultants, medical staff, nurses and administrative staff.

Innovation

Encouraging staff to develop new innovative ideas is supported by the Trust in the following ways:

- The provision of an up to date Intellectual Property Policy
- The development of an internal Innovation Fund and Steering Group, which meets monthly, to which interested parties are invited to submit requests for funding. The creation of an innovation micro web-site on the Trust's Intranet
- Continuing a close working relationship with Innovation Hubs to protect and aid in further development of innovative ideas
- Open Space activity at Professional Development Days to involve and encourage staff to bring their ideas forward for improving healthcare on the ward. This has proved very successful with a number of projects in varying stages of development

2.7 Commissioning for Quality and Innovation (CQUIN)

As part of the CQUIN scheme for 2012/13 the GM Cluster added a number of indicators focussed on Quality and Safety building on the requirements for safety thermometer and care of patients with dementia. Earlier this year the Director of Nursing, Quality and Performance at the SHA wrote to Trusts outlining the requirements and for Providers to demonstrate 95% of harm free care for all patients all of the time with subsequent agreement that this will be monitored as part of the monthly safety thermometer survey.

Other key areas included in the GM cluster measures are smoking prevalence and brief intervention building on our progress from last year and alcohol disorder identification and brief intervention which is a growing area of concern for treatment for these patients.

In terms of local indicators a number of measures remain from 2011/12 regarding smoking, admissions for ambulatory care conditions, unscheduled care discharges, fractured neck of femur repairs within 24 hours. There are new areas WWL have proposed are around Personal Development Review (PDR), Induction and Mandatory Training, to fit with Trust objectives; however there are three new measures to improve the reduction of length of stay from 20.5 days to 15 days, 50% of patients to be discharged home and for patients to be admitted to an orthopaedic ward within four hours.

A proportion of WWL's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between WWL and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. WWL monetary total of income in 2011/12 for CQUIN is £2,095,000m and monetary total for the associated payment in 2010/11was £2m. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at: www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

Safe & Caring - CQUIN Quality Scheme - 2011/12

	Areas of Quality Improvement	Indicator	Weighting	Financial Value	Baseline	Q1		Q2		Q3		Q4	
						Actual %	Target	Actual %	Target	Actual %	Target	Actual %	Target
National	N1 - VTE	N1 Percentage of adults who have had a VTE risk assessment on admission.	0.15	£300,000		67.54%	90%	88.15%	90%	92.52%	90%	95.99%	90%
National	N2 - Improving Patient Experience	N2 Improve responsiveness to personal needs of patients.	0.15	£300,000		2011/12 data will be published May 2012	TBC	2011/12 data will be published May 2012	TBC	2011/12 data will be published May 2012	TBC	64.1	72.5
Local	L1 - Unscheduled Care: Admissions	L1 Reduce the number of admissions associated with 19 ambulatory care conditions	0.06	£120,000		13.1%	<11.7%	11.4%	<11%	12.4%	<11%	12.4%	<11%
Local	L2 Unscheduled Care - improving discharge rates	L2a Completion of notes in a contemporaneous order	0.06	£120,000		ALW Audit	95%	ALW Audit	95%	ALW Audit	95%	ALW Audit	100%
Local		L2b Reduce the number of late discharges	0.1	£200,000		16.97%	45%	20.14%	40%	21.05%	35%	19.42%	30%
Local		L2c Increase the proportion of patients discharged at weekends	0.1	£200,000		193.46%	75%	218.38%	80%	209.33%	85%	278.15%	90%
Local		L2d Increase the number of discharge summaries issued within 24hrs of discharge	0.06	£120,000		22.41%	80%	25.53%	80%	27.47%	80%	28.44%	80%
Local	L3 Prevention of Pressure Ulcers	L3a Assessment with Waterlow tool	0.04	£80,000		100%	95%	100%	96%	100%	97%	100%	99%
Local		L3b Patients with an action plan	0.05	£100,000		95%	95%	98.83%	96%	99.44%	97%	100%	99%
Local		L3c Patients with Grade 2-4 ulcers	0.05	£100,000		1.2%	<10%	0.7%	<8%	0.5%	<6%	2.1%	<4%
Local		L3d Patients with a deterioration of a pressure ulcer	0.04	£80,000		100%	95%	100%	96%	100%	97%	100%	99%
Local	L4 Breastfeeding	Increase the number of mothers continuing to breastfeed	0.04	£80,000		75.1%	70%	75.2%	72%	72.6%	75%	71.0%	75%
Local	L5 Increase the number of discharge prescriptions reaching Pharmacy in a timely manner	L5a 60% in the Pharmacy department by 1pm	0.03	£60,000		53.00%	45%	50.26%	50%	50.79%	55%	49.06%	60%
Local		L5b 97% in the Pharmacy department by 5pm	0.03	£60,000		97.24%	75%	96.55%	80%	96.92%	90%	96.70%	97%
Local	L6 Dementia	L6a Reduce the initiation of Low Dose Anti Psychotic medication in an inpatient setting	0.03	£60,000		9.34%	N\A	9.52%	30%	6.83%	45%	18.14%	60%
Local		L6b Increase recognition of people with dementia.	0.075	£150,000		4.85%	N/A	4.66%	TBC	5.69%	TBC	6.36%	TBC
Local		L6c Reduce LOS of people with dementia.	0.075	£150,000		8.1	8.1	7.4	7.6	6.86	7.2	6.8	6.7
Local	L7 Fractured Neck of Femur	Increase number of completed repairs within 24 hours	0.04	£80,000		69.3%	60%	59.2%	65%	72.8%	65%	70.4%	70%
Local	L8 Delivering and Monitoring brief interventions to reduce tobacco use	L8a Percentage of patients attending pre op assessment with smoking status recorded	0.01	£20,000		100.0%	30%	100.0%	50%	100.0%	75%	100.0%	90%
Local		Percentage of smokers attending pre op assessment receiving a brief intervention.	0.05	£100,000		100.0%	30%	88.6%	50%	97.4%	75%	97.3%	90%
Local		Monitoring prevalence of patients undergoing any elective procedure who are smokers receiving brief intervention.	0.06	£120,000		100.0%	30%	96.1%	50%	84.0%	80%	89.9%	95%
Local	L8 Delivering and Monitoring brief interventions to reduce tobacco use	Monitoring prevalence in wigan resident women who are smokers at time of delivery and have been given brief intervention.	0.06	£120,000		0.0%	30%	86.3%	50%	90.9%	80%	86.3%	95%
Local	L9 To safeguard children through increased assessment and referral to integrated targeted services	Number of CAFs completed where appropriate	0.05	£100,000		Removed from 2011/12 Scheme							
Regional	R1 TARN	Improved trauma care for patients in the NWest	0.04	£80,000		95.4% & √√√	97% TBC	92.0% & √√√√	97% TBC	97.8% & √√√√	97% TBC	Due to be published late May 2013	N\A
Regional	R2 AMI	To promote clinical effectiveness through AQ	0.01	£20,000		100.00%	95.00%	100.30%	95.00%	AQ Composite Quality Reports Released - 29/05/2012		AQ Composite Quality Reports Released - 28/08/2012	
Regional	R3 Heart Failure	To promote clinical effectiveness through AQ	0.01	£20,000		97.89%	84.10%	100.00%	84.10%				
Regional	R4 Hip & Knee	To promote clinical effectiveness through AQ	0.01	£20,000		93.51%	95.00%	94.75%	95.00%				
Regional	R5 Pneumonia	To promote clinical effectiveness through AQ	0.01	£20,000		93.47%	83.38%	77.17%	83.38%				
Regional	R6 Stroke	To promote clinical effectiveness through AQ	0.01	£20,000		77.41%	TBC	75.97%	TBC				

Awaiting published data for Regional Indicators.
The Cquin Return deadline is the 12th working day, following month end. Therefore L1 & L6 percentages may change due to retrospective coding and refreshed data warehouse weekend

2.8 Statement from the CQC

WWL is required to register with the Care Quality Commission (CQC) and its current registration status is fully compliant. The CQC has not taken enforcement action against WWL during 2011/12.

The CQC is the independent health and social care regulator for England. All providers of health and social care services must be registered with the CQC and show they are meeting essential standards of quality and safety. The Trust is registered and has been awarded unconditional registration which means we are licensed to provide our services under the new system for regulating standards in the NHS.

In July 2011 the Trust was visited by the CQC as concerns were identified in relation to:

- Safety, availability and suitability of equipment
- Staffing
- Assessing and monitoring the quality of service provision

The review was also carried out as the CQC wanted to check whether we had made improvements in relation to:

- Care and welfare of people who use our services
- Complaints

The CQC carried out the review by visiting and inspecting wards, examining records, observing practice and talking to patients. A number of managers were also interviewed.

On Thursday 22 March 2112 the CQC visited the Trust and completed an audit of consent forms related to the termination of pregnancy.

All forms were found to be compliant with the requirements of the audit.

The CQC found that the Trust was compliant and meeting all the essential standards of quality and safety they reviewed.

The full CQC report can be found at:

http://www.cqc.org.uk/sites/default/files/media/reports/RRF_Wrightington_Wigan_and_Leigh_NHS_Foundation_Trust_RRF02_Royal_Albert_Edward_Infirmary_201107.pdf

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

The CQC made no compliance or enforcement actions against the Trust and gave just two improvement actions relating to:

- Outcome 13: Staffing – Further analysis and evidence need to confirm that staffing is effective at all times
- Outcome 21: Records – Design of record keeping audits should look at the level of potential risk associated with the different aspects of record keeping.

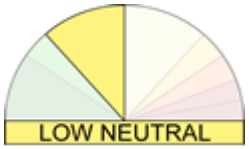
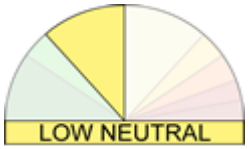
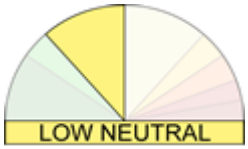
An action plan has been developed to monitor progress relating to the improvement action. This action plan has been monitored by Quality Executive Committee. Each of these improvement actions have now been addressed.

Latest CQC Risk Estimates

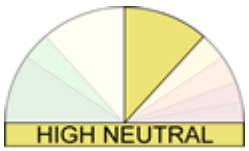
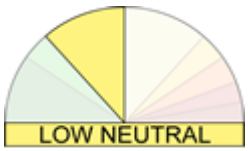
The Care Quality Commission's Quality and Risk Profiles (QRPs) bring together information about a care provider and provide an estimate of risk of non-compliance against each of the 16 essential standards of quality and safety.

They are primarily intended as a tool to support the day-to-day work of CQC's inspectors. The tables below list the two most recent risk estimates for each of the 16 standards.

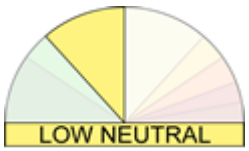
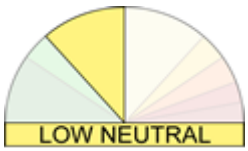
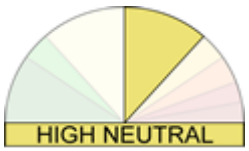
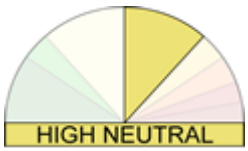
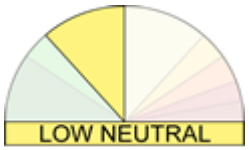
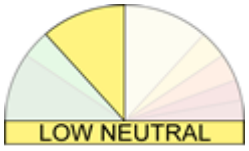
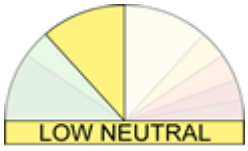
Section 1 - Involvement and information

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 1 (R17) Respecting and involving people who use services			Total number of data items: 85 Number of qualitative data items: 9 Number of quantitative data items: 76
Outcome 2 (R18) Consent to care and treatment			Total number of data items: 4 Number of qualitative data items: 1 Number of quantitative data items: 3

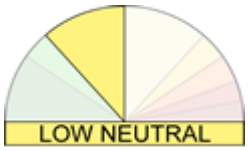
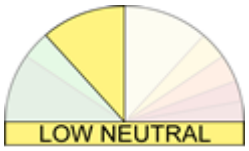
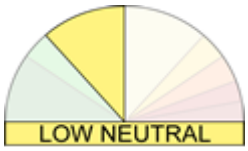
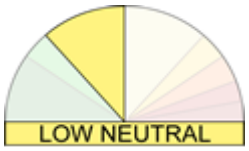
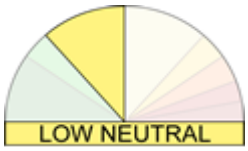
Section 2 - Personalised care

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 4 (R9) Care and welfare of people who use services			Total number of data items: 158 Number of qualitative data items: 29 Number of quantitative data items: 129
Outcome 5 (R14) Meeting nutritional needs			Total number of data items: 21 Number of qualitative data items: 3 Number of quantitative data items: 18
Outcome 6 (R24) Cooperating with other providers			Total number of data items: 14 Number of qualitative data items: 1 Number of quantitative data items: 13

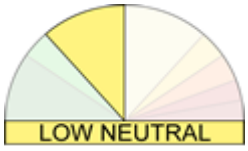
Section 3 - Safeguarding and safety

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 7 (R11) Safeguarding people who use services from abuse			Total number of data items: 1 Number of qualitative data items: 0 Number of quantitative data items: 1
Outcome 8 (R12) Cleanliness and infection control			Total number of data items: 78 Number of qualitative data items: 5 Number of quantitative data items: 73
Outcome 9 (R13) Management of medicines			Total number of data items: 10 Number of qualitative data items: 1 Number of quantitative data items: 9
Outcome 10 (R15) Safety and suitability of premises			Total number of data items: 53 Number of qualitative data items: 3 Number of quantitative data items: 50
Outcome 11 (R16) Safety, availability and suitability of equipment			Total number of data items: 8 Number of qualitative data items: 0 Number of quantitative data items: 8

Section 4 - Suitability of staffing

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 12 (R21) Requirements relating to workers			Total number of data items: 4 Number of qualitative data items: 0 Number of quantitative data items: 4
Outcome 13 (R22) Staffing			Total number of data items: 7 Number of qualitative data items: 0 Number of quantitative data items: 7
Outcome 14 (R23) Supporting staff			Total number of data items: 44 Number of qualitative data items: 0 Number of quantitative data items: 44

Section 5 - Quality and management

Outcome	Previous Risk Estimate	Latest Risk Estimate	Latest Data Summary
Outcome 16 (R10) Assessing and monitoring the quality of service provision			Total number of data items: 30 Number of qualitative data items: 3 Number of quantitative data items: 27
Outcome 17 (R19) Complaints			Total number of data items: 8 Number of qualitative data items: 1 Number of quantitative data items: 7
Outcome 21 (R20) Records			Total number of data items: 70 Number of qualitative data items: 0 Number of quantitative data items: 70

2.9 Data Quality

All Trust staff have a responsibility to record accurate data which is reflected in the Data Quality Policy. Key staff in the organisation have designated roles to ensure procedures and guidelines are in place to accurately capture information in real time. The Trust's Data Quality Committee has responsibilities to ensure procedures and guidelines are being followed, that data is accurate and validated by the Divisions and audits are carried out as approved by the Audit Committee.

Planned improvements for data quality validation were implemented in 2011/12 including:

- A review of existing documentation to support data capture has been completed for all aspects of IT systems and training to ensure all mandatory data items required for reporting purposes are captured and recorded accurately
- Data Quality audits are regularly undertaken to asses compliance with training and procedural guidelines
- The Data Quality Committee meets monthly to validate data capture, address any data quality issues and action any recommendations from data quality audits.

WWL will be taking the following actions to improve data quality:

- Implementation of refresher training for data entry into core Trust IT Systems via face-to-face and E-Learning training
- Continuation of Data Quality Audits
- Validation of data achieved with the Data Quality Department working closely with the data quality leads within the Divisions

Capturing patient level information is key to ensuring the Trust continues to improve patient care and provides a service to support the needs of the local population and surrounding areas. Patient demographic data, including ethnicity and registered GP are validated with the patient at every face-to-face interaction. This ensures quality data and aligns patient records to reduce the clinical risks of duplicate records and delayed correspondence with the patient and/or their GP.

The Trust submitted records during 2011/12 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records in the published data that contain valid NHS number is:

- 99.6% for admitted patient care
- 100% for outpatient care
- 98.8% for accident and emergency care
  of which included the patient's valid General Medical Practice Code was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 100% for accident and emergency care

The patient NHS number is the key identifier for patient records. The Trust in accordance with National Patient Safety Agency Guidelines, clearly displays this on all patient documentation, correspondence, patient wristbands and in core Trust IT systems.

2.10 Information Governance Toolkit Attainment Levels

WWL Information Governance Assessment Report overall score from 1 April 2011 to 31 March 2012 is 82%**.** The Trust failed to achieve the minimum Level 2 requirement for 2 requirements out of the 45 requirements which grades the assessment as non-satisfactory. All requirements must achieve at least a Level 2 standard to achieve a satisfactory status.

- IG Toolkit requirement 324 relates to psuedonymisation and a project team has been set up to review the data flows captured by the data flow mapping exercise (Requirement 308) to see if they are eligible for Pseudonymisation. The technical solution has been developed and these reports have been built into the data warehouse environment and testing will commence during Quarter 1 of 2012/13.

- IG Toolkit requirement 402 was not achieved due to the lack of documented evidence for the capture of information at ward level. Actions in place to address this are that the Data Quality Policy has been updated and will be approved by the Data Quality Committee. The Transfer policy is to be reviewed by senior managers and will include reference and responsibilities for data capture. The Discharge policy has been updated and IT Training manuals have been amended to include the collecting information from patients key point.

The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit are one measure to provide assurance of the quality of data systems, standards and processes within the Trust.

2.11 Clinical Coding Error Rate

WWL was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rate reported in the latest published audit for that period for diagnoses and treatment coding were 2.2 % which is better than the national average of 9.1%.

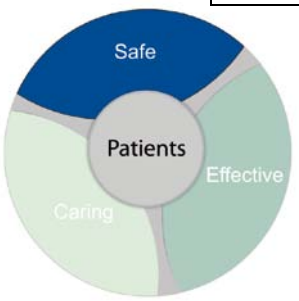
The audit reviewed 200 inpatient episodes, 100 random sample and 100 ophthalmology cases, results should not be extrapolated further than the actual sample audited; and which services were reviewed within the sample, which was the specialty selected for review by NHS Ashton Leigh and Wigan Primary Care Trust. The findings showed the following results:

Ophthalmology Episodes	Number Audited	% Incorrect
Primary Diagnosis	100	1%
Secondary Diagnosis	341	2.6%

Ophthalmology Episodes	Number Audited	% Incorrect
Primary Procedure	95	1.1%
Secondary Procedure	264	0.4%

Random Sample Episodes	Number Audited	% Incorrect
Primary Diagnosis	100	5.0%
Secondary Diagnosis	286	2.8%

Random Sample Episodes	Number Audited	% Incorrect
Primary Procedure	58	1.7%
Secondary Procedure	59	1.7%



Three recommendations were reported as part of this audit as whilst the findings show a good standard of coding the levels were not 100% accurate, this is often due to the complex nature of translating clinical information into clinical codes using the national rules and guidelines.

Measures put in place to maintain and improve the accuracy are:

- Maintain the refresher training of clinical coders to ensure they comply with the current rules and guidelines
- Continue to work with Clinicians to improve the completeness of clinical information required to support clinical coding translation
- Ensure that coding is allocated to the correct inpatient spell

There was also some positive feedback in the report commending the work of the clinical coding team and clinical colleagues:

> *'The Trust has an excellent track record of clinical validation. This has helped reduce coding inaccuracy because clinicians now regularly engage with coders and this was bedecked in the files and in the improvement in coding accuracy.'*
>
> *(Payment by Results Data Assurance Framework Audit 2011/12)*

2.12 Compliance Framework

Monitor uses a limited set of national measures to assess the quality of governance at NHS foundation trusts. Monitor uses performance against these indicators as a component of the service performance score used to calculate governance risk ratings. The following table sets out the indicators, thresholds, and weightings for these measures.

Compliance - Monitor Compliance Framework Performance Page 4

Area	Indicator	Weighting	Thresholds	Q4 10/11	Q1 Threshold	Q1 Actual	Q2 Threshold	Q2 Actual	Q3 Threshold	Q3 Actual	Q4 Threshold	Q4 Actual	YTD Performance
Safety	Clostridium difficile (cumulative monitoring)	1.0	58 Full Year	7	16	16	14	12	14	14	14	5	47
	MRSA (cumulative monitoring)	1.0	6 Full Year	1	1	1	2	0	1	1	2	1	3
Quality	31 day wait for second or subsequent treatment: surgery	1.0 for either part	94%	97.98%	94%	98.48%	94%	95.83%	94%	100.00%	94%	100.00%	98.35%
	31 day wait for second or subsequent treatment: anti cancer drug treatments		98%	100.00%	98%	100.00%	98%	100.00%	98%	100.00%	98%	100.00%	100.00%
	31 day wait for second or subsequent treatment: radiotherapy (from Jan 2011)		94%	100.00%	94%	100.00%	94%	No patients	94%	No patients	94%	No patients	100.00%
	62 day wait for first treatment from urgent GP referral to treatment	1.0 for either part	85%	84.62%	85%	90.55%	85%	85.85%	85%	88.52%	85%	92.68%	89.36%
	62 day wait for first treatment from urgent GP referral to treatment : Sourced from CWT *				85%	90.55%	85%	85.85%	85%	91.13%	85%	94.06%	90.34%
	62 day wait for first treatment from consultant screening service referral		90%	100.00%	90%	98.04%	90%	95.40%	90%	100.00%	90%	100.00%	98.23%
Patient Experience	Referral to treatment waiting times: admitted (95th Percentile)	1.0	23 weeks	21.96	23 weeks	24.16	23 weeks	20.75	23 weeks	22.20	23 weeks	25.47	23.53
	Referral to treatment waiting times: non admitted (95th Percentile)	1.0	18.3 weeks	15.46	18.3 weeks	15.21	18.3 weeks	15.13	18.3 weeks	14.46	18.3 weeks	15.58	15.07
	Shadow monitoring 12/13 - Maximum time of 18 weeks from point of referral to treatment in aggregate - admitted	*1.0*	*90%*								*90%*	*86.46%*	
	Shadow monitoring 12/13 - Maximum time of 18 weeks from point of referral to treatment in aggregate - non-admitted	*1.0*	*95%*								*95%*	*97.06%*	
	Shadow monitoring 12/13 - Maximum time of 18 weeks from point of referral to treatment in aggregate - incomplete pathway	*1.0*	*92%*								*92%*	*93.57%*	
	Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	0.5	N\A	Achieved	N\A	Achieved	N\A	Achieved	N\A	Achieved	N\A	Achieved	Achieved
Quality	31 day wait for diagnosis to first treatment - all cancers	0.5	96%	98.52%	96%	97.67%	96%	100.00%	96%	99.47%	96%	99.19%	99.08%
	Two week wait from referral to date first seen: all cancers	0.5 for either part	93%	99.37%	93%	99.13%	93%	99.28%	93%	99.18%	93%	98.53%	99.03%
	Two week wait from referral to date first seen: symptomatic breast patients		93%	96.67%	93%	96.38%	93%	98.20%	93%	98.36%	93%	96.36%	97.14%
	Total time in A&E: 4 hour waits	1.0	95%	97.4%	95.0%	98.8%	95.0%	96.9%	95.0%	95.2%	95.0%	96.5%	96.9%
	Stroke indicator	0.5	TBC	N\A	TBC	N\A	TBC	N\A	TBC	N\A	TBC	N\A	N\A
	Overall governance risk rating			1.0		1.0		0	n/a	0.0		1.0	1.0

Monitor risk rating criteria:
Green: Score of 0 - 0.9
Amber/Green: Score of 1 - 1.9
Amber/Red: Score of 2 - 3.9
Red: Score of 4 or above

* Please note :

Monitor Reported performance – 89.36%

CWT Performance – 90.34%

Trust performance against the 62 day operational standards is routinely submitted to the Cancer Wait Times system and reported to Monitor via Trust board submissions. In September Monitor wrote to all Foundation Trust's within GMCCN to clarify their regulatory position in regards to the 62 day cancer waiting standard performance. A key change to this position was the adoption of Trusts now being monitored against their 62 day position including breach re-allocations between organisations from 1st October 2011.

This requested change led to a two tier position with performance measured via Cancer Wait Times (CWT) and separately to Monitor after breaches had been re-allocated. The reported end of year performance for Monitor therefore combines the two methodologies for calculating cancer performance, with Quarter 1 and 2 data matching that reporting on CWT and Quarter 3 and 4 being different from the CWT performance.

Part 3: Review of Quality Performance 2011/12

3.1 Trust Quality Account (as at Month 12)

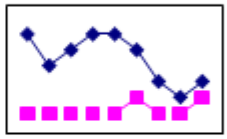
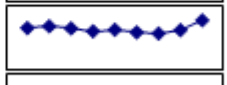
Key:

- Performing on or above target
- Performing below trajectory; robust recovery plan required
- Failed target or significant risk of failure

- ↑ Improving position
- ↓ Worsening position
- ↔ Steady position

Please note Trend shows the last nine months data view.

Safe

Indicator	2011/12 Status	Trend	2010/11 Status
Infection Control: C.Diff - Target 58 cases.	47 ↓		62 ↓
Infection Control: MRSA - Target: Monitor 6 cases, DOH 2 cases.	3 ↓		2 ↑
HSMR (Target <=90)	87.1 ↓		94.8 ↓
Temporary Staffing (Target £12,877,210)	£15,198,786 ↓		£14,346,247 ↓
Never Events (Target = 0)	0 ↔		0 ↔

Key Messages

Clostridium Difficile (C Diff)

47 C. Diff cases where identified in 2011/12. Well below the Department of Health target of 58 C Diff cases. The Trust has continued to show year on year improvement against its Trust C Diff target.

Each episode of C Diff is subject to detailed root-cause analysis and an action plan is prepared and implemented, based on the findings.

Source: Narrative – Local

Source: Figures – National

MRSA

Three MRSA Bacteraemia cases were recorded in 2011/12. This was just over the Trust's reduction target of two episodes set by the Strategic Health Authority, but under the financial penalty target set by Monitor of six episodes. Each episode of MRSA bacteraemia is subject to detailed root-cause analysis and an action plan is prepared and implemented, based on the findings.

Source: Narrative – Local

Source: Figures – National

HSMR

This financial year has seen good progress in our mortality data. The Data for the financial year to date (this is incomplete because of the time lag in reporting HSMR but includes data to February 2012) shows our mortality rate at 87.1. As an organisation we have a target for HSMR to be below 90, and sought one below 83 (within the best 10% in the country). This is the first year we have achieved a value below 90, and is therefore a milestone in our progress. We still have some way to go if we are go get below 83.

Each year the Dr Foster data is "re-based" – a correction for improvement in mortality throughout the country. This re-basing will happen again during the summer. The estimate for our HSMR after rebasing is 95.

HR - Temporary Staffing:

The overall temporary spend figure for 2011/12 is £15,199k against the target of £12,877k. This is an increase on the 2010/11 temporary spend figure which was £14,345k. The 2012/13 planned temporary spend trajectory is £9,249k which represents a 28% reduction on the 2011/12 trajectory and a 39% reduction on 2011/12 actual spend. Twenty percent of the 2012/13 trajectory (£1,889k) is expected to be basic rate spend (such as Bank NHSP/Internal Bank), 15% of the 2012/13 trajectory (£1,335) is expected to be Intermediate rate spend (such as Overtime) and 65% of the trajectory (£6,025k) is expected to be premium rate spend (such as agency).

During March 2012 a nurse recruitment day was held to recruit to vacancies supported by £2.1m of investment agreed by the Trust. It is anticipated that the reduction in temporary spend will reduce from quarter two of 2012/13.

Never Events

There have been no Never Events between April 2011 and March 2012. This reflects a progressively improving patient safety awareness and culture.

A specific Never Events Policy is currently under development. The Trust reportable incidents list is being revised. The 'Never Events' list available on the intranet will be updated to reflect the recent National Patient Safety Agency (NPSA) changes. These changes will be completed by the beginning of May 2012.

Key Messages

Effective

Indicator	2011/12 Status	Trend	2010/11 Status
Total time in A&E : Less than 4 hours (Target 95%)	96.86% ↑		98.40% ↓
Referral To Treatment: 95th Percentile: Admitted (Target 23 wks)	23.53 ↓		20.95 ↓
Cancer Waits: 62 day - GP Referral (Target 85%)	89.36%* 90.34** ↑		84.62% ↑
Financial Risk Rating - Cumulative (Year end Target 4)	4 ↔		4 ↑

Key Messages

A&E

A&E have achieved the key performance target of 95% patients treated and discharged within four hours for all quarters throughout 2011/12 and the final year end position was 96.9%.

A&E four hour performance in the first quarter of 2011/12 was maintained at above 98% and met the WWL internal performance indicator. Following the bed reduction and increased attendances in July 2011 performance dipped in August but was maintained above the national threshold of 95%. Significantly high numbers of A&E attendances in October were a contributory factor to failing the monthly performance indicator and a number of measures were taken to assist in improving performance back to expected levels. This included additional management support and a review of internal escalation processes. Over the winter period of November – March the system managed to achieve despite increased pressures that were replicated across Greater Manchester.

There was a period of very poor performance at the end of December that was the cause of a failure to meet the monthly performance indicator however the impact was mitigated by high performance earlier in the year. An internal review was undertaken and an action plan completed which included support from the health economy on managing public health messages and access to community health and social care support which improved performance ahead of the rest of Greater Manchester. This has been a challenging year and the department remains dependant on the whole trust to ensure inpatient capacity is available to ensure patient flow and achieve the required quality indicators.

Referral to Treatment (RTT) 95th Percentile Admitted

The Trust achieved the referral to treatment time (RTT) 18 week standard as follows:

		Quarter 1	Quarter 2	Quarter 3	Quarter 4
RTT 18 week	Admitted	90.84	92.14	90.85	86.46
	Non-admitted	97.37	97.46	97.73	97.06
	Incomplete	94.26	94.17	93.38	93.57
RTT 95th percentile	Admitted	24.16	20.75	22.2	25.47
	Non-admitted	15.21	15.13	14.46	15.58
	Incomplete	18.84	19.02	19.69	19.61

The Trust struggled with 18 week performance during quarter four due to the strategy of ensuring that patients who had been waiting longest were dealt with effectively. Due to the tertiary nature of the organisation, the orthopaedic service is currently undergoing a service and pathway redesign to ensure a reduction in patients waits therefore improving the patient experience of our services.

Cancer 62 Days - GP Referral to First Treatment

Whilst WWL have not achieved these measures in all months of 2011/12, we have achieved above the 85% required performance for all reportable full quarters in 2011/12 and this has also been continued with the revised local measures from October 2011.

* Monitor Reported performance – 89.36%
** CWT Performance – 90.34%

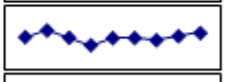
Trust performance against the 62 day operational standards is routinely submitted to the Cancer Wait Times system and reported to Monitor via Trust board submissions. In September Monitor wrote to all Foundation Trust's within GMCCN to clarify their regulatory position in regards to the 62 day cancer waiting standard performance. A key change to this position was the adoption of Trusts now being monitored against their 62 day position including breach re-allocations between organisations from 1st October 2011.

This requested change led to a two tier position with performance measured via Cancer Wait Times (CWT) and separately to Monitor after breaches had been re-allocated. The reported end of year performance for Monitor therefore combines the two methodologies for calculating cancer performance, with Quarter 1 and 2 data matching that reporting on CWT and Quarter 3 and 4 being different from the CWT performance.

Financial Risk Rating (FRR)

At the end of the 2011/12 financial year the Trust is reporting a surplus of £2.9m versus a planned surplus of £4.0m and an FRR rating of four against a planned FRR of four.

Caring

Indicator	2011/12 Status	Trend	2010/11 Status
Hospital Outpatient Cancellations (Target 5%)	5.56% ↓		7.78% ↑
Cancelled Operations (Target <=0.8%)	1.29% ↑		0.77% ↑
Feedback Scores - Real Time Patient Survey (Target >=85%)	89.60% ↑		89.14% ↓
Complaints 'Attitude of Staff (Target = 0)	46 ↔		52 ↓

Key Messages

Hospital Outpatient Cancellations

Increase compared to last month. The Trust continues to maintain progress with the reduction of hospital initiated cancellations and in 2011/12 cancelled 58% fewer appointments than in 2009/10 (72,665 in 2009/10 versus 30,499 in 2011/12). The Trust continues to measure performance monthly against a target of <5% with particular emphasis on preventing avoidable short notice cancellations through improved forward planning.

Cancelled Operations

During 2011/12 there has been an increase in the number of cancelled operations reported. From Quarter two the methodology of collecting cancelled operations data has changed to a fully electronic mechanism based on clinical coding. This is following reported differences between the manual process and detailed analysis relating to accuracy. The main causes of cancellation are No Beds, running out of Theatre time, Emergency cases taking priority and equipment failure.

Real Time Patient Survey

During March 2012 we have scored an average of 90.50% (89.84% in February) of a positive patient experience in the Real Time Survey this score has shown an increase of 0.66% from February's data. Please see section 3.6 for further details.

Complaints - Attitude of Staff

Patient Relations have raised concerns and noted the number of complaints received in relation to attitude of Staff.

In 2012/13 all Trusts will be required to report on new measures, which take account of a wide variety of factors such as diagnostic groups in order to make comparison between Trusts more refined. WWL has already included a number of these measures within this year's report.

Indicator summary	Location of latest available published data	Reference Section
Summary Hospital – Level Mortality Indicator: • SHMI value and banding • Percentage of admitted patients whose treatment included palliative care; and • Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (context indicator)	http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/summary-hospital--level-mortality-indicator-shmi	3.9
Ambulance response items	http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/ambulance	N/R
Ambulance trust clinical outcomes: • Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction who received the appropriate care bundle • Suspected stroke patients assessed face to face who received an appropriate care bundle	http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AmbulanceQualityIndicators/index.htm	N/R
Patient reported outcome scores for (i) groin hernia surgery, ii) varicose vein surgery, iii) hip replacement surgery, and iv) knee replacement surgery	http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/patient-reported-outcome-measures-proms	3.21
Emergency readmissions to hospital within 28 days of discharge	http://www.ic.nhs.uk/pubs/hesemergency0910	3.15

Responsiveness to inpatients' Personal needs	http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_126972 (follow the link to "Download a tool to assist with the Commissioning for Quality and Innovation (CQUIN) framework")	3.6 3.18
Percentage of staff who would recommend the provider to friends or family needing care	http://www.nhsstaffsurveys.com/	3.18
Percentage of admitted patients risk assessed for Venous Thromboembolism	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_131539	3.18
Rate of C.Difficile	http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ClostridiumDifficile/EpidemiologicalData/MandatorySurveillance/cdiffMandatoryReportingScheme/	3.11
Rate of patient safety incidents and percentage resulting in severe harm or death	http://www.nrls.npsa.nhs.uk/resources/?entryid45=132789	3.18

3.1.1 Musculoskeletal Division (MSK) – Quality Dashboard Extract

Domains	Measures	Goal	Published 2010/11 Measure	Latest 2011/12 Measure	National Avg. Figure
Patient Safety	Staff e-compulsory training	90%	82.0%	86.6%	N/A
	Staff Personal Development Reviews	85%	76.5%	82%	N/A
	Staff Induction	90%	86.8%	84.2%	N/A
	MRSA bacteraemia	Nil	Nil	Nil	
	MRSA Screening at Pre-Operative assessment	100%	100.0%	100.0%	100%
	Primary hip replacement – average length of stay	5.7	5.96	6.41	6.3
	Primary knee replacement – average length of stay	6.0	6.61	6.11	6.2
	Revision hip replacement – average length of stay	11.0	12.44	8	9.7
	Revision knee replacement – average length of stay	9.4	7.6	7	9.4
Clinical Effectiveness	Reduced HSMR for Fractured Neck of Femur (hip)	<100	81.6	106.3	As at Feb.
	Reduced length of stay for Fractured Neck (hip)	19	16.5	15	10.6
	Antibiotic received within one hour of incision time	100%	100.0%	97%	N/A
	Adherence to thromboprohylaxis policy	100%	75.6%	99.%	N/A
	Antibiotic discontinues within 24 hours of surgery end time	95%	97.3%	96.2%	N/A
	Recommended venous thromboembolism prophylaxis ordered	95%	82.8%	99%	N/A
	Appropriate Venous Thromboembolism (VTE) prophylaxis received within 24 hours prior to or after surgery end time	95%	82.8%	97%	N/A
Patient Experience	Complaints resolution within 25 days	100%	79.2%	67%	N/A
	Day Case Rates	58%	75.5%	70%	59.7%
	Reduced Outpatient Hospital cancellations (Trauma and Orthopaedic)	0%	13.8%	8.3%	N/A
	Reduced Outpatient Hospital cancellations (Rheumatology)	0%	2.1%	2.9%	N/A
	18 week pathway for non-admitted Trauma and Orthopaedic	95%	94.49%	95.06%	95%
	18 week pathway for non-admitted Rhuematology	95%	100%	97.98%	95%
	18 week pathway for admitted Trauma and Orthopaedic	90%	75.31	81.06%	90%
	18 week pathway for admitted Rheumatology	90%	99.32	100%	90%
	Same day admission rate	80%		95%	92.4%

Musculoskeletal Division Achievements

The Division has retained its excellent track record against zero MRSA bacteraemia and has also achieved a significant reduction in C Difficile rates for a second year.

In October 2011, the Division launched an enhanced recovery programme for primary hip and knee replacement to achieve a reduction in length of stay.

Ward-to-Board audits have been above the 90% target all year, as has antibiotic policy compliance. Venous Thromboembolism (VTE) compliance was variable early in the year, but has been above target since July 2011.

The rate of admission on day of surgery is very high and is the highest within the Specialist Orthopaedic Alliance.

Service redesign in Rheumatology has enabled consistent achievement of the 18 weeks standard for both admitted and non-admitted pathways.

Areas for improvement

The Division has struggled to achieve three human resource performance indicators, namely e-mandatory training, personal development plans and sickness absence rates. Work is on-going with ward and department managers to improve performance.

The area requiring the greatest improvement is achievement of 18 weeks for elective orthopaedics for both admitted and non-admitted pathways.

3.1.2 Medicine Division Quality Accounts – Quality Dashboard Extract

Domains	Measures	Goal	Published 2010/11 Measure	Latest 2011/12 Measure	National Target
Patient Safety	Staff e-compulsory training	90%	83.6%	84.5%	N/A
	Staff Personal Development Reviews	85%	79.6%	66%	N/A
	Staff Induction	90%	97.5%	93%	N/A
	Ward-to-Board Audits	90%	95.23%	95.04%	N/A
	Falls review by Quality and Safety Matron within three days	100%	100%	100%	N/A
	Aseptic Non-Touch Technique (ANTT) Training	100%	Yes	Yes	N/A
	HSMR – Coronary Heart Disease	90	89.4	47	100
	HSMR – Fractured Neck of Femur (Hip)	90	76.7	106.3	100
Clinical Effectiveness	Stroke patients to receive a CT scan within 24 hours	90%	100%	85.48%	100
	Increase in number of eligible patient to Theatre within 24 hours	100%	100%	100%	100
	Patients Treated and Discharged within four hours	98%	98%	96.76%	95
	Reduction in Elective (planned) Length of Stay	One day	6.5	7.58	N/A
	Reduction in non-Elective Length of Stay	One day	4.94	4.5	N/A
	Implementation of care bundle for Acute MI (Heart Attack)	90%	90%	100%	90%
Patient Experience	Privacy and Dignity	90.0%	95.29%	95.38%	N/A
	Hospital Cancellations	0	7.9	6.7%	N/A
	Compliance with Access Time Targets	3 weeks	3.39	3.95 (to Feb)	N/A
	Picker Institute Surveys Action Plan Complete	Yes	Yes	Yes	Yes

Medicine Division Achievements

The Division has continued to meet the national four hour target for the Accident and Emergency (A&E) Department despite challenges throughout the Greater Manchester region. This has been supported by developments within the complex discharge team to improve utilisation of inpatients beds, increased discharges and maintaining patient flow through the unscheduled care system.

A key achievement is the recruitment of a number of consultants in acute medicine. There is now extended consultant cover to medical assessment areas with twice daily consultant review which is reducing length of stay and improving patient flow. This supports the use of the GP Assessment Area and Ambulatory Care Clinic providing an alternative to the A&E pathway and early review of patients who may previously been admitted for overnight observation.

The new Coronary Care Unit was opened this year. It provides up to date facilities and an improved environment for the local population. The local community was invaluable as the unit was supported by the Heartbeat Appeal. The new unit is supporting the second Cardiac Catheter Laboratory and continuing the high level of cardiac services provided as part of the Greater Manchester and Cheshire Cardiac Network.

There has been improvement in a number of areas including:

- The continued development of governance structures following a review in 2010. There is now a monthly quality meeting that is well attended by clinicians and management. The role of the Clinical Governance Coordinator has been developed and embedded into the Divisional management structure and is supported at consultant level
- The achievement of the Venous Thromboembolism (VTE) risk assessment for over 90% of admitted patients. There is now an embedded process for ensuring the review is captured and the data is validated to ensure appropriate quality care
- The Division of Medicine consistently achieved the 18 weeks waiting time standard for admitted and non-admitted pathways
- Infection Control: The Division remains well within the trajectory for MRSA bacteraemia and Clostridium Difficile infection rates
- Falls: The number of serious falls has significantly reduced and local actions, including risk assessments, are in place to ensure compliance with the agreed standards of practice

Areas for improvement

The Division aims to ensure the correct levels of nursing staff within ward areas to provide safe and effective care. This will support further improvement in HR performance metrics, such as, sickness rates, mandatory training and personal development reviews.

A review of medical staffing will identify what resources are required to ensure daily senior medical review and the needs of services in line with local and national agendas.

There will be further development of financial controls and budget accountability to improve the financial performance of the Division in future years.

3.1.3 Clinical Support Services – Quality Dashboard Extract

Domains	Measures	Goal	Published 2010/11 Measure	Latest 2011/12 Measure	National Target
Patient Safety	Staff e-compulsory training	90%	90.70%	92.9%	N/A
	Staff Personal Development Reviews	85%	96.30%	93.6%	N/A
	Staff Induction	90%	100%	98.3%	N/A
	Sickness Absence	<3.7%	3.77%	3.43%	N/A
	Antimicrobial Policy Compliance – Medicine	90%	89%	100%	N/A
	Antimicrobial Policy Compliance – Surgery	90%	94%	94%	N/A
	Antimicrobial Policy Compliance – MSK	90%	94%	97%	N/A
	% Patients assessed by Physio <72 hrs	90%	Not Measured	92%	90%
	% Patients assessed by OT <72 hrs	90%	Not Measured	92%	90%
	% #NOF patients assessed by Physio <24 hrs	100%	Not Measured	100%	N/A
Clinical Effectiveness	Pathology and Radiology – ECC TRT - % <1 hour	90%	95%	91%	N/A
	Pathology - C.difficile TRT <36 hrs	99%	100%	100%	N/A
	Pathology - Negative MRSA TRT <36 hrs	99%	99%	99%	N/A
	Pathology - Positive MRSA TRT <48 hrs	100%	100%	100%	N/A
	HCO - Case Note Availability Outpatients	99%	99.46%	99.9%	N/A
	IP Discharges completed <60 mins (RAEI)	>60%	32%	41%	N/A
	% OP prescriptions completed <20 mins (RAEI)	>90%	86%	84%	N/A
	IP Discharges completed <60 mins (WTN)	>60%	97%	98%	N/A
	% OP prescriptions completed <20 mins (WTN)	>90%	100%	98%	N/A
Patient Experience	Outpatient Hospital Cancellations		5.9%	5.3%	N/A
	Patient Surveys		Completed		
	Out Patients – Patient Journey through Clinic		n/a		
	Patient Complaints		3		
	Outpatients – Video Diaries		Completed		
	Outpatients – Spot checks on 18/52 forms		n/a		
	Outpatients – Up to Date Waiting Times in Clinic		n/a		
	Initiative Clinics		565		
	Delays in clinic >30 mins		28.4%		

N/A – national targets not available – targets are locally agreed.

Clinical Support Division Achievements

The Division have maintained their excellent record against the HR Quality Account metrics with 98.3% staff having had induction, 93.6% of staff with appraisals in the last 12 months, over 90% compliance with mandatory training and a sickness absence level of 3.43% (against a target of 3.7%).

There have been improvements across the Divisions since last year regarding antimicrobial policy compliance. Medicine has improved from 89% to 100%, Surgery has maintained compliance at 94% and MSK have improved from 94% to 97%. These improvements are probably due to the work undertaken to increase awareness across the Trust over the last 12 months of the need to comply with the policy.

Physiotherapy and Occupational Therapy assessment of patients in less that 72 hours and assessment of patients with a fractured neck of femur (broken hip) in less than 24 hours are all being maintained at or above the level required.

Turnaround times for diagnostic tests on the Emergency Floor have been maintained above 90% within less than one hour. The Radiology performance has improved throughout the year, however recent issues with analyser IT links have reduced the Pathology times slightly, although none of the other Pathology turnaround times within the Quality Accounts have been affected and remain at 100% compliance. The availability of case-notes in Outpatients has improved slightly from 99.5% to 99.9%.

Inpatient and Outpatient prescription turnaround times have performed well at Wrightington, however due to sickness absence issues and three major staffing re-configurations in Pharmacy during 2011/12, including provision of a seven-day Pharmacy service at Wigan, turnaround times have deteriorated significantly at RAEI. Work is now underway to improve these measures.

A major redesign project has been taking place over the last 18 months in the Thomas Linacre Centre (TLC) and Leigh Infirmary Outpatient Departments in order to improve the patient experience. Work has now also begun in Wrightington Outpatients. The Divisional patient experience quality account has focussed on this work and is using both the national Picker survey and local patient satisfaction survey results to measure outcomes. The Picker 2011 outpatient survey showed that there had been significant improvements in some areas and that the Trust was not significantly worse than the average compared to other trusts on any of the questions.

Ongoing work on reducing hospital outpatient cancellations has now resulted in an average of 5 to 6% cancellations (reduced from 16% in April 2009) of which 30% of them are beneficial to the patient, for example appointment being brought forward.

Areas for Improvement

Work is ongoing to improve prescription turnaround times in Pharmacy at RAEI. Additionally, Radiology are implementing procedures which will improve the availability of imaging reports on inpatients scanned on the same day as requested.

As a consequence of the imminent re-configuration of Pathology services between WWL and Salford Royal NHS FT, in addition to the associated cost savings, the project is also looking at ways where quality can also be improved.

The major review of case-notes storage and destruction has continued throughout 2011/12 in order to reduce the number of case-notes being stored across the sites and to improve the access to those required for patients.

3.1.4 Surgery Division - Quality Dashboard Extract

Domains	Measures	Goal	Published 2010/11 Measure	Latest 2011/12 Measure	National Target
Safety	Staff e-compulsory training	90%	82%	85.7%	N/A
	Staff Personal Development Reviews	85%	55.9%	59%	N/A
	Staff Induction	90%	96.9%	96.45%	N/A
	MRSA screening	100%	100%	100%	N/A
	Ward-to-Board reports	90%	94.7%	93.75	N/A
	Hand washing audit	86%	91.86%	95.2%	N/A
	Never events	0	0	0	0
	Central Alerting System (CAS) / National Patient Safety Agency (NPSA) Alerts	100%	100%	100%	N/A
Clinical Effectiveness	Mortality rates	0.20%	0.39%	0.27%	N/A
	Day Case Surgery rates	80%	79.69	81.2%	N/A
	Breast 2 week referrals	93%	100%	99.2%	N/A
	31 day Cancer target	94%	100%	100%	N/A
	Reduced length of stay – for elective patients	2 days	2.02	2.0	N/A
Patient Experience	Hospital Re-admission within 28 days	Zero	3%	5.54%	N/A
	Reduced Outpatient waiting times	3 weeks	3.49	3.11	N/A
	Reduction in hospital medical theatre cancellations	20	32	12	N/A
	Outpatient appointment cancellations	Zero	7.8%	6.34%	N/A
	Percentage of same day admissions (Inpatient Electives)	85%	76.7%	96.5%	N/A

Surgery Division Achievements

The Division has implemented a number of quality initiatives across individual sub specialties and the division as a whole. With regard to elective surgical admissions these are now staggered across the day to avoid patient delays for assessment and elongated waits for surgery. We have also started a revised Laparoscopic Cholecystectomy Day Case pathway.

The Maternity service responded to the CQUIN set for breast feeding by setting up an Infant Feeding Team. The Public Health Midwifery Team successfully achieved third prize in the British Journal of Midwifery (BJM) Team of the Year category.

There has been a substantial reduction in the patients' length of stay since the launch of the Enhanced Recovery Programme within the Division. Recent patient satisfaction surveys demonstrate excellent results with 100% patients considered they were fully informed about their treatment and involved in decision making.

The Enhanced Recovery Programme (ERP) is supported by two dedicated ERP nurses and the colorectal ERP is well embedded. The programme will now be expanded to include Gynaecology and Urology.

The Surgical Division has achieved the National Stage of Treatment standard whereby patients have received first definitive treatment within 18 weeks of referral.

Hospital readmission rates within 28 days reduced to 3% though work is ongoing to reduce this even further and it is the intention of the Division to monitor these rates through clinical revalidation teams.

Ward-to-board reports relating to quality of care provided on wards and hand washing audits across the Division have achieved their targets.

Areas for improvement

The elective surgical admissions lounge is undergoing pathway redesign and needs to be relocated within the main body of the hospital to significantly improve the patient pathways.

The Maternity Service is currently working to the new Clinical Negligence Scheme for Trusts (CNST) measurement with the aim of being assessed against Level 2 in January 2013.

Significant pathway redesign across all cancer tumour sites to support the 62 day pathway and achieve 17 days from GP referral to transfer for tertiary services work is ongoing.

Staff compulsory training and completion of Personal Development Reviews (PDR) is a priority for the division. An opportunity has arisen from the Divisional restructure to implement a more robust approach to the monitoring of compulsory training and PDR in a proactive manner; this will be incorporated once the Divisional team is in place.

Outpatient cancellations continue to fall. However, this data does include patients whose appointments have been expedited. Cancellations are authorised at Divisional Director of Performance level and monitored through the control tower. Where there is no option other than to cancel appointments additional capacity is agreed to accommodate patients.

3.1.5 Estate and Facilities - Quality Dashboard Extract

Domains	Measures	Goal	Latest 2010/11 Measure	Latest 2011/12 Measure	National Average Figure
Safety	Staff e-compulsory training	90%	94.9%	95%	N/A
	Staff Induction	90%	93.8%	94%	N/A
	Fire Authority Enforcement Notices	0%	0%	0%	N/A
	Monthly Review of Divisional Risks	100%	100%	100%	N/A
	Construction, Design and Management (CDM) Regulations – Zero Accidents on Construction Sites	0%	0%	0%	N/A
	Medical Devices – Full Compliance with the CQC C4b standard	100%	100%	100%	N/A
Clinical Effectiveness	Staff Personal Development Reviews	85%	91.18%	73.2%	N/A
	Staff Turnover	<10%	8.89%	8.38%	N/A
	Sickness Absence	5.50%	5.72%	5.31%	N/A
	Adherence to Asbestos Legislation	90%	100%	97%	N/A
	Adherence to Legonella L8 legislation	90%	100%	90%	N/A
	Energy/Carbon Reduction KWh	-	2.5%	5.50%	N/A
	Waste Reduction (Tonnage of Disposal)	10%	1.89%	1.71%	N/A
Patient Experience	Complaints Resolution within 25 days	100%	100%	50%	N/A
	Patient Environment Action Team (PEAT) – Catering	Good	Excellent	Excellent	N/A
	Patient Environment Action Team (PEAT) – Environment	Good	Good	Excellent	N/A
	In-House Facilities Survey (Very Good – Excellent)	80%	97%	90.5%	N/A
	Picker Institute Surveys Action Plan Complete	Yes	Yes	Yes	N/A
	National Cleaning Standards (aggregated)	90%	94.3%	94.12%	92%

Achievements

The Division has continued with its performance within the financial year 2011/12, particularly around the HR Metrics requirements.

- Maintain high level of e-compulsory training requirements
- Maintain staff induction compliance
- Maintain zero accidents on construction sites
- Staff turnover reduced
- Sickness absence reduced

Continued efforts around energy initiatives and improvement in the carbon reduction have been made throughout a number of areas across the Trust. These have given a further reduction of 5.5%.

The Facilities team have maintained improvements in key areas which been reflected in the recent survey results which have been improved upon 2010/11 scores.

The National Cleaning Standard scores have maintained scores of 94%, however the last three months have seen this rise to 95% across all sites.

Areas for improvement

The Divisional key areas of focus for improvement in 2012/13 are to:

- Continue to maintain and improve levels of sickness absence
- Reduce energy consumption and associated carbon emissions – 5% for gas and 3% for electricity against 2011/12
- Minimise waste to the lowest level possible with clear focus on clinical waste/targets of 10% cost reduction
- Achieve PEAT environmental full score of excellent
- Maintain National Cleaning Standard score of 95%

3.2 Stakeholder Engagement

The Trust's Quality Accounts were discussed with the Council of Governors (CoG). The Governors are the key link between the Trust, its staff and the local community.

The Trust continues to work in partnership with the local PCT Commissioners. We held three "Vision" events with NHS Ashton, Leigh and Wigan on the redesign of unscheduled care. Patient Groups with Long Term Conditions, Wigan Borough Local Involvement Networks and the Trust's Council of Governors who were users of the urgent care system were invited to attend patient panels. Patient input was an integral part in the redesign of the urgent care pathway.

Some of the key feedback from the vision events was that the current urgent care services design was:

- Confusing
- Difficult to access
- Fragmented
- Services unresponsive to their needs
- Inefficient
- Duplicating

Instead, patients wanted an urgent care system that is:

- One NHS in Wigan and not lots of different services that patients had to navigate their way through
- All layers of services removed - plus reduce duplication
- Improved communication between teams
- Improved access to primary care
- Improved support to self care
- Improved services to address the needs of elderly and frail elderly patients in the community
- More care closer to home
- If they are acutely ill, that there is sufficient capacity in hospital to meet their needs

3.3 National and Local Measures

The Trust has measured its performance against national and local performance indicators. An audit of data quality has been undertaken by the external auditor on the following performance measures:

- MRSA – reference section 3.10
- Cancer 62 day – reference section 3.14
- Re-admission rates – reference section 3.15

Re-admission rates were the locally determined indicator chosen by the Council of Governors.

3.4 Transforming Community Services (TCS)

From the 1 October 2011 seven services transferred to WWL from Bridgewater Community Healthcare NHS Trust as part of the Transforming Community Services agreement. The services that transferred are:

- GP triage in A&E
- Access to Community Services
- Physician Advisor
- Intermediate Care Coordinators
- Hospital at Home
- Community Matrons
- Advanced Nurse Practitioners

Since transfer, the teams have focused on integrating into WWL and facilitating pathways into community care from inpatient areas as well as A&E to support reduced admissions, reduced length of stay and improved quality of care. There has also been an increased focus on reducing re-admissions and facilitating access to their services through the introduction of a single point of access.

Following the Divisional restructure, from the 1 April 2012, the above services will be integrated into the Division of Medicine and therefore their quality account indicators will form part of that report.

The focus will continue to be on reducing admissions and facilitating discharge through provision of care closer to home, case management and integration of the team with the wider health economy - their quality indicators will monitor the achievement of these outcomes.

3.5 Complaints

During the last year the Patient Relations/PALS Department has maintained a close relationship with the Divisions. They are working together to improve the services provided for patients, relatives and carers who visit this Trust.

The Patient Relations/PALS Department are dedicated to making improvements wherever possible for our patients, relatives and carers and along with the Divisions are striving to build on the system that has been established and embedded over the last twelve months.

A new development in the last year was the introduction of a dedicated telephone Careline. This new facility provides patients, relatives and carers, another different way of contacting the Trust in which they can express their worries or fears, as well as being able to convey any concerns. In keeping with the Trust's tag line 'your hospital, your health, our priority', this service is available during the extended hours of 9:00 am to 9:00 pm.

This year has seen the start of a way of working that identifies any complex or serious complaints and escalates these to the Executive Team. Weekly meetings are undertaken to ensure that these are reviewed at the highest level.

The following shows the distribution of complaints within a specific service area:

- Inpatient
- Outpatient
- A&E
- Maternity

It is imperative that complaints are used positively as it is through complaints that we learn and reflect on how we work and how we can improve. The Patient Relations/PALS Department have been completing audits in respect of complaints learning and monitoring the actions proposed to ensure that we have the evidence to reassure that we are learning and embedding improvements. The following is a sample of learning following complaints:

- Birth After Thoughts leaflet – This is distributed to new mothers. If there are any outstanding questions or concerns following birth this service is available to give new mothers an opportunity to discuss these with either a midwife or consultant
- Change of policy in respect of MRSA swabbing at the pre-operative assessment, ensuring that patient dignity is preserved and maintained
- Training provided to ensure greater understanding of complex behaviour in vulnerable adults. This includes a DVD to enable staff to be visually aware of some of the challenging behaviour they may come across and how to handle this
- A change in the appointment system for Phlebotomy (blood taking) appointments to enable a more efficient service
- A new Deep Vein Thrombosis (DVT) pathway for pregnant women

3.6 Patient Feedback/Surveys/Patient Experience

The real time patient experience surveys provide opportunities for patients to give feedback to independent Governors and volunteers collecting data current to their time in hospital. The questionnaire is based on core elements of what patients believe are important to them. These are privacy and dignity, cleanliness, involvement in decisions of care, communication and pain control, choice of food and if patients would recommend the hospital to family and friends. On average 150 surveys are completed per month.

The results are presented to the Trust Board every month to monitor progress against our corporate objective of achieving over 85% of patients reporting a positive patient experience. Patients are reporting a positive experience in dignity and respect, cleanliness of the wards, involvement in decisions about their care, being communicated to in a way that they can understand and choice of food.

The Picker National Inpatient Survey 2011 reported that 56.5% of patients would definitely recommend our hospital to family and friends. We have undertaken a lot of work improving our patient experience and patients who completed the real time survey reported on average that 95.5% would definitely recommend our hospital to family and friends.

The Picker National Outpatient Survey 2011 reported that 66.3% of patients would definitely recommend our hospital to family and friends. The Picker survey results are based on the patients experience recollection of their experience which may have been up to six months after their stay.

Patients have also told us that they could not find a member of staff to talk to about any worries and fears and that their pain control could be improved. Areas that we need to improve have been continually monitored through the Chief Executive's Patient Experience Task Force.

In addition we have conducted regular Delivering Same Sex Accommodation survey's. In March 97.5% of our patients told us that when they were first admitted to a bed on a ward that they did not share a sleeping area with patients of the opposite sex.

Eliminating Mixed Sex Accommodation

In March 2012 the Trust re-published its declaration of compliance with the national policy for the elimination of mixed sex accommodation:

> "Wrightington, Wigan and Leigh NHS Foundation Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interests, or reflects their personal choice.
>
> We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be adjacent to their bed area.
>
> Sharing with members of the opposite sex will only happen when clinically necessary (for example when patients need specialist equipment such as in critical care areas) or when patients actively choose to share (for example in the children's ward where children may find it preferable to share with children of a similar age rather than those of the same gender).
>
> If our care should fall short of the required standard, we will report it. We will also undertake patient surveys and environmental audits to make sure we do not misclassify any of our reports. We will publish the results of those surveys and audits in our report to commissioners and in our members' newsletter."

During 2011/12 the Trust reported a total of four breaches of the standards which were not clinically justifiable (two each in August 2011 and February 2012 respectively) in all cases the breaches related to a delay in transferring a patient from a critical care area due to clinical pressures on the general wards.

The requirement to deliver high standards of same sex accommodation is further helping to inform the design of new wards as the Trust develops its site strategy. The development will include the increased provision of single rooms with en suite facilities.

How we have made a difference

The Pain Team are providing extra training and awareness sessions for staff on pain control and results have improved since the extra training and awareness was introduced. Intentional Rounding has also been introduced on the wards and we are showing improvements in these areas.

Intentional Rounding is a process whereby nurses visit each patient at hourly intervals in order to address specific needs. These needs include hydration, position, concerns, continence and pain management. These visits are then documented using an Hourly Rounding Tool, and also transcribed into the nursing notes. Intentional Rounding is intended to reduce patient anxiety and enable the nurse to become more visible to the patient.

The Estates and Facilities Department have made restructured ward arrangements to create improved same sex accommodation. This has improved the patients' experience.

We have improved on communication between doctors and patients. Presentations on effective communication were delivered at the intentional rounds to bring to the attention of all doctors how important communication is to our patients and colleagues. Communication has been one of the key priorities for improvement of the Chief Executive's Patient Experience Task Force.

2011/12 Patient Real-time Patient Survey Summary

Real-time Patient Survey	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Dignity and Respect	98.1%	98.3%	94.4%	97.6%	100.0%	97.0%	96.1%	96.1%	97.2%	99.3%	97.4%	97.2%
Pain Control	78.8%	82.3%	77.5%	83.4%	83.8%	75.8%	76.6%	79.6%	77.9%	82.8%	87.2%	87.4%
Involved in Decisions	88.8%	94.3%	90.1%	87.0%	90.6%	90.9%	89.0%	93.2%	87.6%	89.4%	88.0%	93.7%
Communication:Worries & Fears	73.8%	74.9%	76.1%	71.6%	74.4%	75.8%	66.2%	75.7%	74.5%	68.9%	70.1%	72.7%
Catering	84.4%	82.3%	84.5%	87.0%	88.9%	84.1%	87.7%	82.5%	86.2%	88.1%	88.0%	88.8%
Cleanliness	99.4%	100.0%	100.0%	100.0%	100.0%	98.5%	99.4%	100.0%	99.3%	98.7%	98.3%	97.9%
Communication:Questions Answered	93.1%	94.3%	95.1%	94.7%	93.2%	97.0%	94.2%	95.1%	95.2%	94.0%	94.0%	92.3%
Recommend this hospital	95.6%	97.7%	97.2%	95.9%	97.4%	97.0%	94.2%	93.2%	97.9%	90.7%	95.7%	93.7%
Average	88.99%	90.51%	89.36%	89.65%	91.04%	89.51%	87.93%	89.43%	89.48%	88.99%	89.84%	90.46%
Benchmark	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Highlights

The Catering Department has worked very hard making improvements to there choice of food for patients by introducing an ordering service, a snack trolley and choice of food menus. Our patients also have access to food 24 hours a day seven days a week. They have maintained positive scores throughout two-thirds of the year.

We have ended the year showing improvements in pain control during February and March. We have been working with the pain control nurses providing extra training and awareness for staff on pain training. Intentional Rounding has been introduced on the wards, which includes pain management. The Trust Board will be monitoring the pain control over the next twelve months as one of their objectives.

We have maintained and improved our position in the 'involved in decisions about your care' area. Presentations on effective communication were delivered at the intentional rounds to bring to the attention of all doctors how important communication is to our patients and colleagues. Staff also attends the IMPACT Training Course which includes effective communication. Communication has been one of the key priorities for improvement of the Chief Executive's Patient Experience Task Force.

Even though we have maintained a positive experience score in Dignity and Respect it was quite surprising to see that our average score over the year had reduced by 8.32% compared to last years score. All staff are being made aware of this drop in score in order to make sure we improve our dignity and respect for our patients to a higher level. The Patient and Public Engagement Department are currently in the process of developing a Dignity Charter with the feedback that they received from patients the public and staff on Dignity Day.

Again, even though we have maintained a positive experience score in "questions answered in a way that could be understood", our score has slightly reduced by 0.85%. Again all staff are being made aware of this drop in score in order to improve they way we communicate to our patients.

Our patients continue to report a very high positive 99.29% patient experience in the ward cleanliness. We have reduced our score slightly by 0.11% on the previous year's average. The recent Patient Environmental Action Team report showed excellent scores for all three sites.

We have undertaken a lot of work improving our patient experience over the past 12 months. Patients who completed the real time survey reported on average that 95.5% would definitely recommend our hospital to family and friends, this showing we are providing patients with a positive patient experience. This score has reduced by 1.3% compared to last year's score.

Lowlights

Worries and fears have made no improvements over the last twelve months; in fact the score has decreased by 0.4%. The worries and fears area has also been introduced into the intentional rounding under personal wishes in an aim to improve this area. We have also raised awareness with staff on the wards around this area of concern.

The Trust Board will be continually monitoring the pain control and worries and fears question over the next 12 months and the corporate objective is to achieve 90% of a positive patient experience in all areas of the Real Time Survey.

3.7 Care of Deteriorating Patients

Acute illness can lead to physiological deterioration, which may progress to organ failure and ultimately cardio-respiratory arrest. Abnormal physiological observations are evident in the hours preceding many cardio-respiratory arrest episodes The outcome from in-hospital cardio-respiratory arrest is very poor, especially if the initial rhythm is non-VT/VF, with as few as 6.2% surviving to hospital discharge.

With early recognition and appropriate treatment such abnormal physiology is potentially reversible, often with simple measures to support airway, breathing and circulation.

Unfortunately, physiological monitoring and recording of observations are often incomplete and abnormal results not recognised or treated appropriately. Knowledge levels of the basic principles of care for the at-risk patient are surprisingly low.

There is a considerable body of evidence to suggest that care of the critically ill patient is sub-optimal at ward level (although this is improving), and that hospital mortality is increased in this group. The highest Intensive Therapy Unit (ITU) mortality is seen in patients received from general wards, and more than 25% of ITU mortality occurring post discharge.

It is acknowledged that there are organisational reasons for this, as we attempt to cope with the increasing expectations of an older, sicker population undergoing increasingly more complex interventions and a reduction in the number of acute beds available. It is estimated that there would need to be a threefold increase in the number of critical care beds to achieve adequate provision for those with developing critical illness.

In 2005 The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) ‘An Acute Problem’ was published. Two further papers were published in 2007 by the National Patient Safety Agency: Safer Care for the Acutely Ill Patient: learning from serious incidents and recognising the early signs of deterioration. All three papers highlight similar themes and demonstrate consistent failings such as failure to measure basic observations, lack of recognition of the importance of worsening vital signs and delay in response to deteriorating patient.

In response to the demonstrated need for education and support for frontline staff, multi-professional courses have been developed to raise knowledge levels and provide a common approach to the management of the acutely ill and deteriorating patient. In September 2004 we introduced the Greater Manchester Acutely Ill Management Course (GM AIM) to assist in addressing these issues.

The GM AIM course is delivered as a one day multi-professional course, using a series of small group, scenario based workshops to maximise interaction and promote an ethos of teamwork.

The aims of the GM AIM course are to:

- optimise the outcome for patients at risk of developing critical illness
- enhance the knowledge base, confidence and performance of ward staff in dealing with unfamiliar/stressful situations
- encourage teamwork and communication
- promote a multi professional approach
- maximise the efficiency of use of critical care services
- address clinical governance and clinical risk factors

The course is aimed at all members of the Multi-Disciplinary Team – doctors, nurses and Allied Health Professions (AHPs).

In 2006 a Critical Care Outreach service was instigated to further support the teams in managing the deteriorating patient and for patients about who staff were concerned. This team goes to all areas on the RAEI site and assists, manages and advises. The referral protocol utilises the Modified Early Warning Score (MEWS) which is a tool used to alert the ward staff that the patient is deteriorating.
A score is attributed to results that fall outside of normal parameters. If a score greater than three is recorded, the Outreach Team can be called to support ward-based medical and nursing staff to implement timely, appropriate care with the aim of preventing further deterioration in the patient. The Team was further extended in 2009 with the inclusion of Night Nurse Practitioners to improve the quality of care and create continuity.

As part of improving patient care and raising awareness the Surviving Sepsis course was introduced in 2008: this is also aimed at the Multi-Disciplinary Team. It is a half day course aimed at the management of septic patients and compliments the GM AIM course.

By April 1 2012 the Team will be available 24/7 providing a strong educational focus so that we are able to achieve fully, the goals of an Outreach service which are:

- to share critical care skills and expertise
- identify early patients with acute illness and avert admissions to Critical Care units
- to facilitate timely admissions to Critical Care and discharge back to wards
- to promote continuity and quality of care
- facilitate the monitoring of at risk patients via the widespread use of the MEWS
- critical care education for ward clinicians including critical care skills course, GM AIM , Sepsis and observation competencies
- to ensure thorough audit and evaluation of Outreach Services

These initiatives, designed to improve quality, have been supported fully by the Trust Board to assist in improving the experience our patients receive thereby helping to meet the Trust's commitment to the quality and safety agenda.

3.8 Action plans to improve as a result of complaints referred to Ombudsman - Health Service Ombudsman Requests

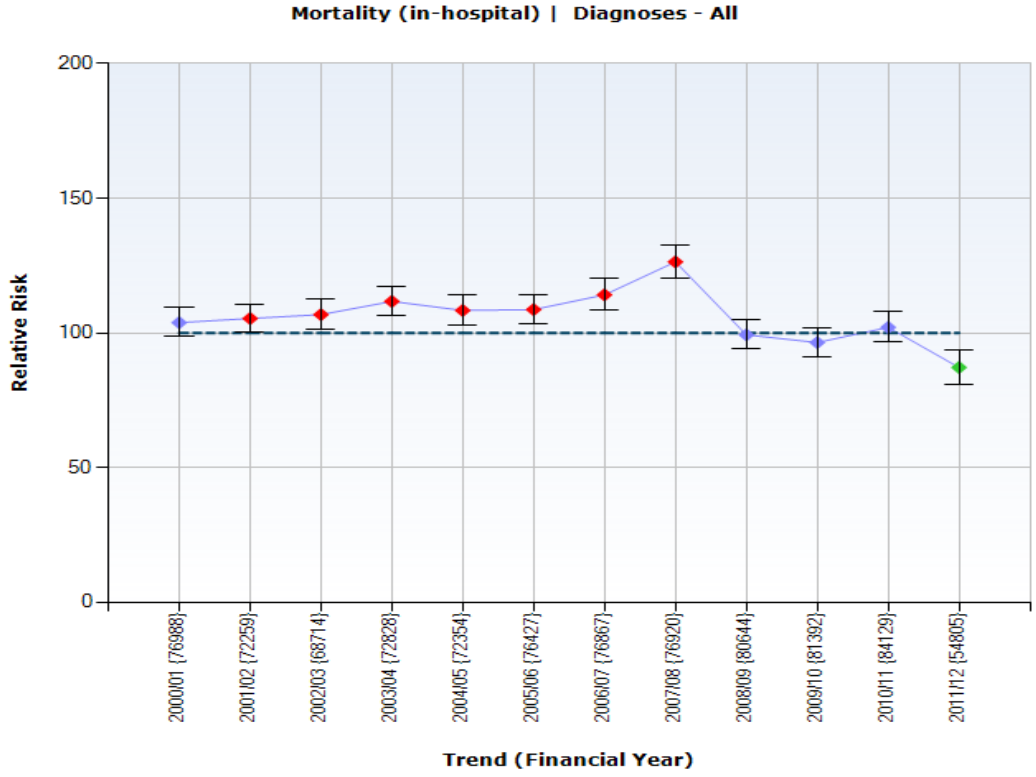
The role of the Parliamentary and Health Service Ombudsman is to provide a service to the public by undertaking independent investigations into complaints that government departments, a range of other public bodies in the UK, and the NHS in England, have not acted properly or fairly or have provided a poor service.

Their aim is to provide an independent high quality complaint handling service that rights individual wrongs, drive improvement in public services and informs public policy.

In respect of investigation requests from the Ombudsman and the Trust, from 1 April 2011 to 31 March 2012 there have been 13 requests.

3.9 Hospital Standardised Mortality Ratio (HSMR)

Our goal for HSMR has been set at 83 which would reflect an excellent performance, being inside the best performing 10% of Trusts within the country. We have made significant improvement since 2007/8 in HSMR, and we continue to see steady improvement. It has not yet reached our target, and will remain a major focus of our organisation. Hospital data are assessed to account for the number of admissions and the severity of illness that a patient has. If there are an expected number of deaths in a hospital, that hospitals HSMR will be 100.



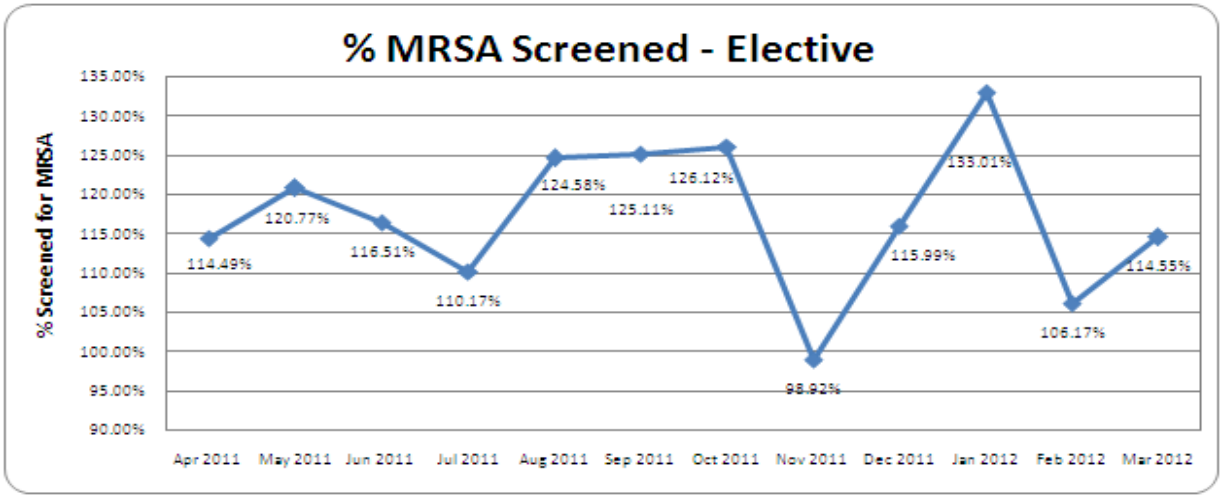
Performance on all cause mortality for the financial year to date gives a combined mortality rate of 87.1. This is an important improvement, and represents a rate significantly lower than average (data is correct at the 1 April 2012, including discharges up to and including February 2012).

This year a new Summary Hospital-level Mortality Indicator (SHMI) has been published on NHS Choices, and represents an alternative view of mortality. It takes different data to HSMR, but attempts to do a similar job of measuring whether a hospital has an appropriate number of deaths. Only two points have so far been published. Our most recent rolling one year SHMI score is 1.06 (the expected score for SHMI is 1.00, where for HSMR it is 100). This is significantly different from Dr Foster published HSMR data. SHMI is still early in its development and we need to establish a fuller understanding of the differences between both measures.

Specific work on reducing mortality continues. Information and understanding of problems comes from auditing deaths, arrests, readmissions, and drug chart reviews. Data also is highlighted from clinical incidents and governance pathways. These have brought to light areas where improvement can be achieved and plans for this are well advanced. Reducing death from sepsis is a particular area of development at the present time. Areas of improvement during the last year have included early consultant review, use of ward round checklists, thromboprophylaxis, and hydration/nutrition.

3.10 MRSA

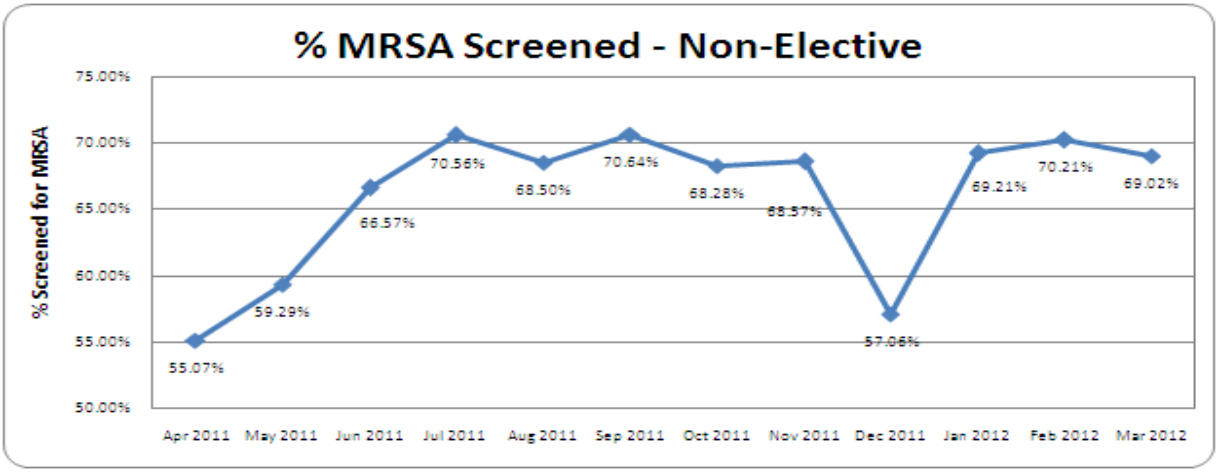
MRSA - Elective screening



The Trust has continued to work in line with the Department of Health's MRSA Elective Screening Guidelines and has used the Assurance Framework to monitor its compliance.

All patients undergoing elective procedures have continued to be screened for MRSA. Those that have been identified as positive have received either a decolonisation programme and negative screening swab, or have had a controlled admission and treatment programme. The Trust continues to have a reserve pool of patients whose elective MRSA Screening Status is known, in order to maximise operational throughput.

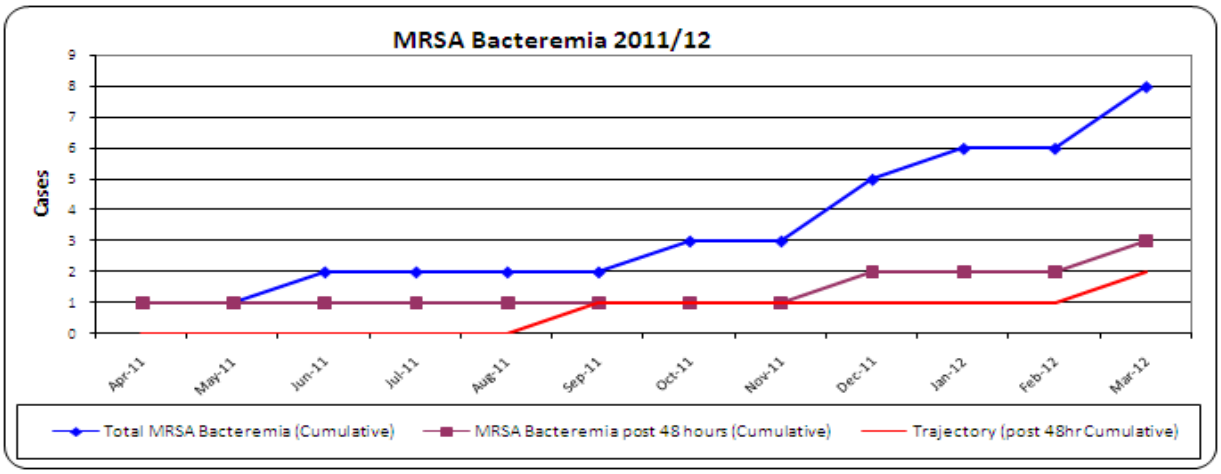
MRSA – Non-Elective (Emergency Screening)



The Trust implemented the MRSA Emergency Screening in December 2010, but the 100% target has proved to be difficult to attain. The Department of Health's Emergency Screening guidelines advise that all emergency patients should be screened on admission. As a consequence of the Trust only attaining 50% of its target, an Infection Control secondee has been appointed to work with the Divisions to enhance compliance. As a result of this new secondment post, compliance has risen from average monthly percentages of 40% to just under 70%.

All emergency patients identified as positive on their emergency MRSA screening were isolated and treated in line with the Trust's MRSA Policy.

MRSA – Bacteraemia

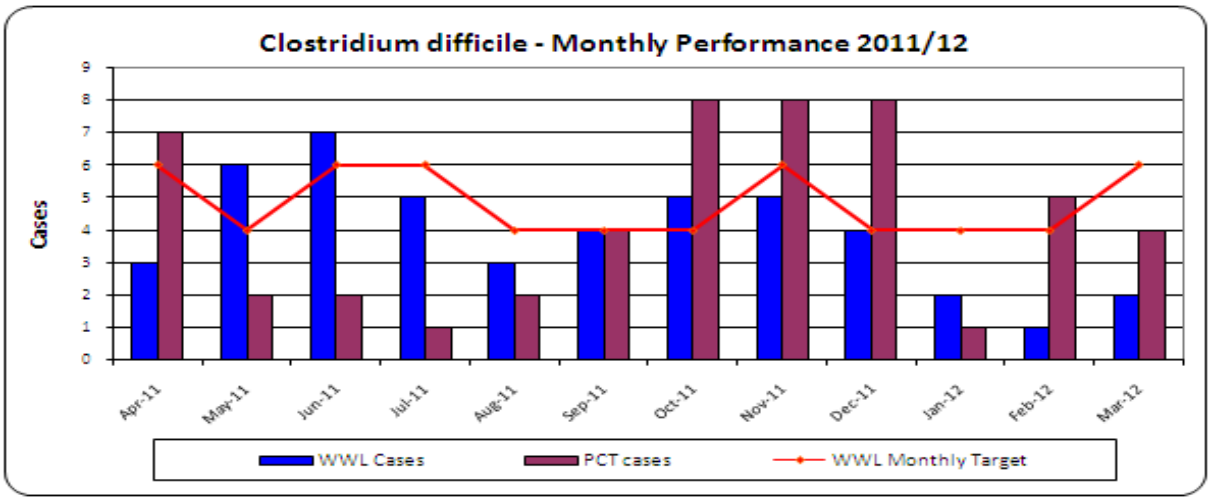


The Trust has continued to implement the Department of Health Guidelines on MRSA Bacteraemia and has reported all instances of MRSA Bacteraemia identified within blood cultures for inpatients.

The Trust's MRSA Bacteraemia target for 2011/12 was set by the Department of Health as two. In view of this small allocated MRSA Trust target and the difficulty to attain it, Monitor allocated a performance target of six MRSA Bacteraemia cases, before financial penalties would be implemented. The total Trust MRSA Bacteraemia cases at end of year were three cases. This compares with two hospital-acquired cases recorded in 2010/11.

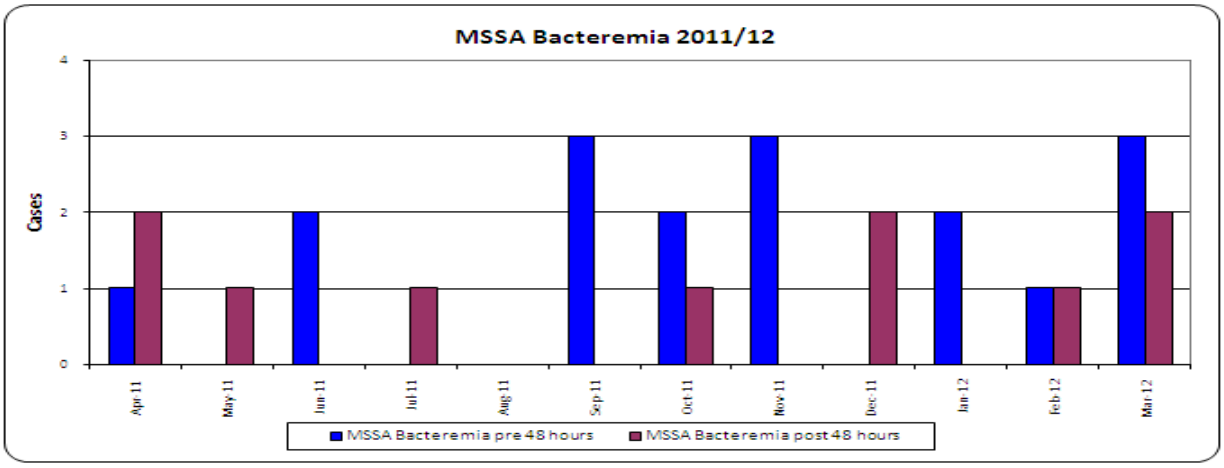
Each individual episode of MRSA Bacteraemia was subjected to a full Executive root cause analysis in order to identify opportunities for improvement.

3.11 Clostridium-Difficile



The Department of Health Guidelines on Clostridium difficile continues to be implemented within the Trust. To date the Trust has performed well against its target with only 47 cases for 2011/12. The Trust has continued to show a reduction in the number of reported cases, which are at an all time low. Each individual case of Clostridium difficile toxin undergoes Executive root cause analysis in order to identify opportunities for improvement. There has been no instance of cross infection and Trust antibiotic prescribing has been inline with the Department of Health guidance within 2011/12. Root Cause Analysis indicated an issue with timely isolation of patients with symptoms, which has been addressed. Other actions taken have been the replacement of patient bedside chairs and collaborative working with NHS Ashton, Leigh and Wigan regarding community antibiotic prescribing.

3.12 MSSA – Bacteraemia



Staphylococcus aureus is a bacterium that commonly colonises human skin and mucosa (for example inside the nose) without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or a medical procedure. The term MSSA refers to Methicillin antibiotic sensitive Staphylococcus aureus.

The Trust has continued to collect the MSSA Bacteraemia in line with Department of Health Guideline, but no target has been issued to date. However, the Trust is mirroring its approach to MRSA Bacteraemia with monitoring and full root cause analysis being performed on each episode for lessons learned.

At present the root cause analysis has identified that majority of the Borough MSSA cases are community acquired and the Trust is working collaboratively with NHS Ashton, Leigh and Wigan. The volume of MSSA bacteraemia recorded indicates the Trust is within the top performing quartile within the Greater Manchester region.

3.13 Advancing Quality Alliance (AQUA)

AQUA is a membership health improvement organisation whose mission is:

> 'To stimulate innovation, spread best practice and support local improvement in health and in the quality and productivity of health services.'

AQUA provides a range of learning opportunities, many of which have been accessed by the Trust's staff as well as access to collaborative working through programmes such as Advancing Quality, Management of Long Term Conditions, Reducing Mortality and Shared Decision Making.

Advancing Quality Programme

Advancing Quality (AQ) is one of AQUA's flagship programmes which the Trust has participated in since its inception in North West hospitals in October 2008.

The AQ programme aims to improve standards of care in specific clinical areas by focussing on adherence to key evidence based clinical interventions, patient experience and patient reported outcomes.

The programme is now operating in five clinical treatment areas relevant to WWL:

- Heart Attack (Acute Myocardial Infarction) (AMI)
- Heart Failure
- Pneumonia
- Hip and knee replacement surgery
- Stroke (new measure set for 2010/11)

For each of the above clinical areas there is an agreed set of measures for all patients; the extent to which patients receive care against the relevant set of measures is calculated to give a composite quality score. If all patients, for example, with an acute myocardial infarction receive the correct care against all of the measures, then a composite quality score of 100% would be achieved. Steady improvement has been achieved within the Trust.

2010/11 Performance

Year three of the AQ Programme relates to the 2010/11 financial year and specifically to those patients discharged between 1 April 2010 and 31 March 2011. Results are published annually and in retrospect therefore official publication of 2011/12 results is not expected until early in 2013. Results for the 2010/11 year were released to the public in February 2012 and are summarised below:

Heart Attack

The Trust achieved a Composite Quality Score (CQS) of 98.97%. This score represents a slight improvement on the previous year when a CQS of 98.78% was achieved. The area for improvement within this measure set continues to be the need to get it right for every patient every time.

Heart Failure

The Trust achieved a CQS of 84.67% representing a marginal (1.11%) improvement on the CQS for the previous year (83.56%). The main area of concern continues to relate to discharge instructions (64.62% compliance) despite the specialist heart failure nurse making changes to her work pattern in order to address this issue. It continues to be a problem that patients with heart failure are often admitted to non-cardiac wards or may only be briefly admitted meaning that the specialist team are often not made aware of them prior to discharge. It is anticipated that the development of the new cardio-respiratory unit on Ince and Winstanley wards will at least partially assist in addressing this issue.

Community Acquired Pneumonia

The Trust achieved a CQS of 82.16% which demonstrates an improvement (4.58%) on previous performance (77.58%). Scope for improvement lies predominantly within the following measures:

- initial antibiotic selection
- blood cultures performed prior to antibiotics
- initial antibiotic within six hours of arrival

It is notable that the measures largely occur in the emergency care setting and some staff from that setting have attended learning events in an attempt to promote their engagement. Further awareness training is planned for emergency care staff.

Hip and Knee Surgery

The Trust achieved a CQS of 92.98% which represents an improvement (4.1%) on the previous year (88.88%).

Greatest scope for further improvement is within two measures:

- Prophylactic antibiotics within one hour prior to surgery
- Timely Venous Thromboembolism (VTE) prophylaxis

The clinical team has an action plan in place which is aimed at achieving 100% compliance across all measures.

Staff have changed their practice in order to ensure accurate recording of surgical start and finish times as well as the initial dose of antibiotics.

All consultants now adhere to the agreed protocol for the prevention of venous thrombo-embolism and therefore an improvement in this measure should be seen.
Advancing Quality results for hip and knee are presented at clinical audit on a regular basis.

A monthly report is now made available to the management team detailing the individual consultant activity. This report is also sent to the individual consultants so that they can review their own outcomes and in turn review their activity, making them aware of their results and the actions that need to be communicated within their teams, to further improve their outcomes.

Stroke

The AQ measure set for stroke went live in October 2010 and as such there has not yet been any public reporting of results.

The stroke team have identified a number of difficulties with regard to AQ processes and undertook a risk assessment in July 2011 resulting in the application of a number of control measures:

- A weekly meeting takes place where all stroke patients' pathways are examined to ensure all care measures are applied and documented and subsequently recorded correctly
- A daily review takes place to ensure that clinical interventions have been completed in the correct time frame
- The stroke team meet and greet patients seven days a week, track and support quick access to the stroke ward and commence investigation and treatment in the emergency department
- An education programme has been developed to ensure that all members of the Emergency Care Team (nursing and medical) are aware of the correct stroke pathway and care measures required
- Detailed investigation is carried out on all cases where the stroke pathway is not adhered to

3.14 Cancer Services

The Trust is measured against eight National Key performance indicators around patients with suspected and diagnosed cancer. In addition during this financial year the local Cancer Network, following a review of cancer performance across the network, has introduced in October 2011 a revised calculation of the three 62 day standard measures and also measurement of the time taken to refer patients to treatment centres to improve performance of all Trusts. These measures have since been adopted by Monitor and are used as the primary measure of performance for these indicators from the 1 October 2011.

These measures relate to the time taken from a patient being identified as a suspected cancer and receiving their first treatment for this within 62 days and covers patients referred via their General Practitioner with suspected cancer, from a national screening programme and those patients upgraded by a Consultant.

All data referenced below is the final month and quarter positions as uploaded to the National Reporting portal (Open Exeter) and reported as part of the Trust Board Report. For the local Monitor measures these are verified against the GMCCN network reports to Trust Boards from October 2011.

Fourteen Day Cancer Standards

WWL has consistently achieved the required standard in each quarter for both the 14 day Cancer standards, which require that patients with either suspected cancer or have breast symptoms are seen within 14 days of referral by their GP.

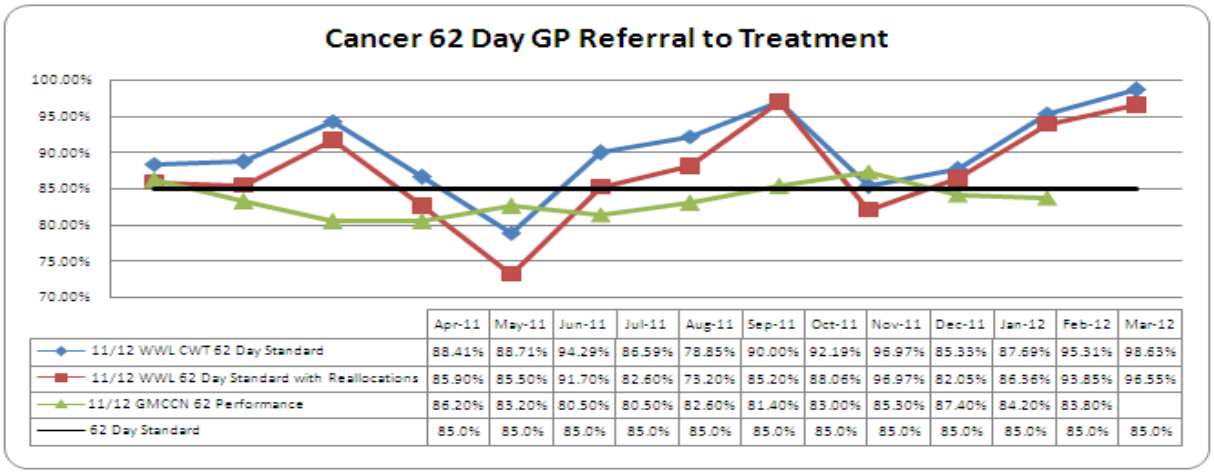
Thirty-one Day Cancer Standards
Thirty-one Day – First Definitive Treatment

All patients with a diagnosed cancer must have first treatment at the provider within 31 days of the patient agreeing to undergo this treatment. WWL has achieved this target for patients diagnosed with cancer throughout the year.

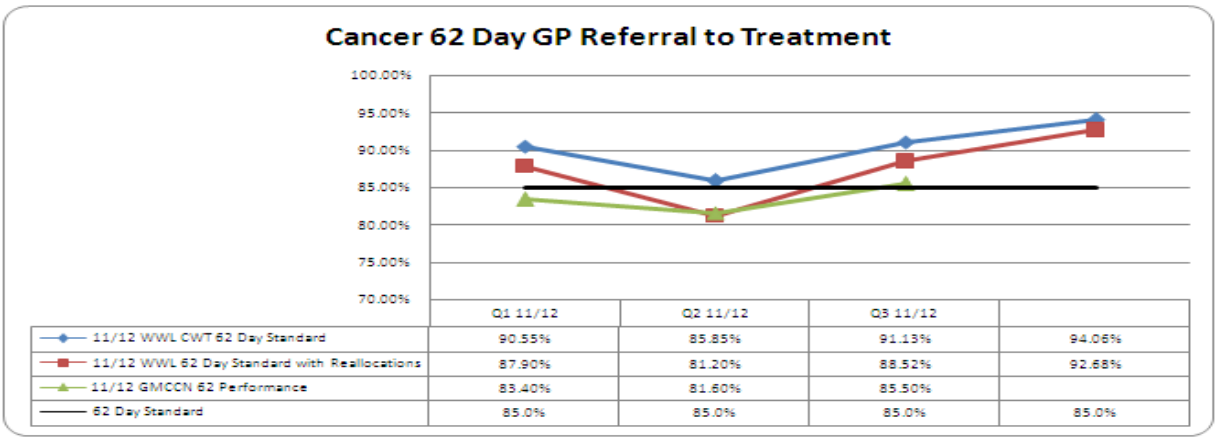
Thirty-one Day Subsequent Treatment
Surgery
Anti-Cancer Drug Regimen

All patients who have been diagnosed with cancer may have a number of treatments planned following their first treatment. Reporting data shows the organisations compliance with achieving these within 31 days of the patient being ready for the next treatment in their plan.

Sixty-two Day Cancer Waiting Time Standard



	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
11/12 WWL CWT 62 Day Standard	88.41%	88.71%	94.29%	86.59%	78.85%	90.00%	92.19%	96.97%	85.33%	87.69%	95.31%	98.63%
11/12 WWL 62 Day Standard with Reallocations	85.90%	85.50%	91.70%	82.60%	73.20%	85.20%	88.06%	96.97%	82.05%	86.36%	93.85%	96.55%
11/12 GMCCN 62 Performance	86.20%	83.20%	80.50%	80.50%	82.60%	81.40%	83.00%	85.30%	87.40%	84.20%	83.80%	
62 Day Standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



	Q1 11/12	Q2 11/12	Q3 11/12	
11/12 WWL CWT 62 Day Standard	90.55%	85.85%	91.13%	94.06%
11/12 WWL 62 Day Standard with Reallocations	87.90%	81.20%	88.52%	92.68%
11/12 GMCCN 62 Performance	83.40%	81.60%	85.50%	
62 Day Standard	85.0%	85.0%	85.0%	85.0%

The graph shows the Trust's performance against the 62 day standard where patients have been referred by their General Practitioner with suspected cancer. The national target is for 85% of these patients to be treated within 62 days and benchmarking data is also shown for the Trust's performance when compared to the Greater Manchester and Cheshire Cancer Networks overall performance.

Whilst WWL have not achieved these measures in all months of 2011/12, we have achieved above the 85% required performance for all reportable full quarters in 2011/12 and this has also been continued with the revised local network measures from October 2011.

Sixty-two Day- Screening

Patients who are screened as part of the National Cancer Screening Programmes who have a positive finding are referred from the programme into WWL for their treatment which marks the start of their 62 day pathway.

During the summer months pressures within one of the National Cancer Screening Programmes resulted in delays in referral to WWL and resulting delays in the patient's timely treatment. If the Monitor re-allocation of breaches were applied to this period WWL would have only failed in one month and would have achieved the overall quarter.

Sixty-two – Consultant Upgrade

Patients who are diagnosed with cancer can present via many other routes than from their GP and where this occurs and our Consultants suspect that the patient may have cancer they upgrade the patient onto a 62 day pathway.

There is currently no national level of performance that must be met for this, however, locally there is a target of 90%. Many of these patients can be very complex to treat within a timely manner, however, through review of all our services and changes to streamline patient pathways we have seen a steady improvement in our performance against this measure and will continue to work in ensuring that these patients are treated within 62 days.

3.15 Hospital Re-admissions

The Trust is committed to reducing re-admission of patients to hospital over the next 12 months. We have actively engaged with the NHS Quest collaborative in an attempt to use our collective knowledge and ideas to achieve this. Representatives from the Trust have now attended the first two sessions in London and Manchester and regularly interact with the other member trusts through Internet-enabled web-ex sessions.

Our focus rests on specific patient groups identified through work so far. Firstly, there are the frail and elderly patients from residential and nursing care. The focus of the work involves closer collaboration with the community teams and the re-structuring of three of the Trust's geriatricians' job plans to involve weekly community-based clinics with a view to developing robust advanced care planning procedures across the Borough. This is attempting to treat increasing numbers of these patients in the community, thereby preventing repeated readmission to the acute hospital site.

We have also chosen to focus on the patients with non-specific chest pain (19 years and over non-interventional acquired chest pain). These patients form a daily part of the medical take and have the highest readmission rate over the last 12 months. The Trust's discharge team are actively auditing this cohort of patients, using questionnaires developed in conjunction with the NHS Quest collaborative. The aim of this work is to gather data from these patients to establish why they are returning to hospital early after discharge: we can then begin to address any common themes or issues that arise from this work and develop more appropriate discharge pathways/care bundles to prevent readmission. We are also in the process of developing patient information leaflets (beginning with "chest pain"), recognising that many readmissions result from a lack of patient information being provided on the initial presentation/episode.

Almost 50% of patient re-admissions occur within 7 to 10 days of discharge. An early review clinic is beginning to further address this issue. So far this clinic has seen almost 2/3 of patients within 14 days of discharge, with the remainder being seen at a later date for agreed clinical reasons (for example needing a repeat chest x-ray at four weeks post-discharge which cannot be done sooner as would not be clinically relevant). We are in the process of obtaining patient satisfaction data from the people seen so far in this clinic and hope to find that having these acute follow up appointments planned has prevented re-attendance through the Emergency services.

In summary, the process of reducing re-admissions is still very much in the early stages but we expect that, through continued hard work that, we can achieve our goal of reducing re-admissions even further over the next 12 months.

3.16 Maternity

Service Summary

The Service has continued to move forward with standard and innovative practices. The reconfiguration of Maternity Services across Greater Manchester (Making it Better) has been closely monitored for any potential adverse impact on the Trust's capacity.

The contribution to the National Birth Place research study was well received and the results of this have now prompted the initiation of a Home Birth Team provision for the Borough.

The Commissioned Public Health Midwifery Team have been shortlisted for two prestigious National awards, Team of the Year for the Royal College of Midwives and British Journal of Midwifery.

Improvements for Next Year

The three key improvements that will be worked on over the next year are:

- CQUINN
  Maintenance and improvements of the current target around supporting mothers who choose to breastfeed.

  Smoking cessation – the implementation of carbon monoxide monitoring in pregnancy.

  Children's Centre use – to provide the Local Authority with contact details for pregnant women who wish to take up the Children's Centre offer.

- National Confidential Enquiry into Maternal and Child Health Publication
  The tri-ennial review of maternal deaths was published in March 2011: the Trust has completed a robust review of the recommendations and has taken forward those that were relevant. The Greater Manchester (GM) maternity network will review the actions in all maternity providers in the coming year to ensure equity of provision across GM and also in line with the GM Service Specification which will come into effect from April 2012.

- Improving Normal Birth Rate
  The reduction of the number of induced labours will continue throughout the coming year with a clinical audit of this planned.

  The maintenance of Consultant cover on labour ward is seen as an imperative for ensuring the Caesarean Section rate remains below the national average.

  The team are enthusiastic about the service and site investment programme with the provision of the Midwife Led Unit being part of the initial phase. This will then allow for the Trust to become fully compliant with the Department of Health 'Maternity Matters' document.

Review of Current Services

- Safety
  Key achievements over the last year were the successful recruitment of Consultant Obstetricians to allow for the required 60 hour labour ward presence of a Consultant as recommended in Safer Births. The Consultant workforce has worked collaboratively to ensure the minimum standard of 40 hours has not been jeopardised.
  The Supervisor of Midwives resource has been maintained with the Supervision of Midwife ratio being 1:15.

The service is currently working towards the CNST level 2 assessment which is scheduled for January 2013.

- Effectiveness
  The Maternity dashboard has continued to be a valuable tool to monitor the effectiveness of the service.

  Work with Dr Foster and clinical coding have also supported improvement in the reporting of clinical risks in the Dr Foster report thus the reputation of the service being shown correctly.

- Experience
  The service has continued to ensure the strong involvement of service users. The Maternity Services Liaison Committee, lay user group, has grown in membership over the year and continues to ensure the views of women and their families are articulated to the service.

  The Maternity service continues to review the feedback from the small number of complaints they receive very seriously and actively manages any identified learning from these throughout the service.

This multi-disciplinary approach continues to identify further improvements and a number across the services have been initiated throughout the year.

3.17 Central Line Infection (previously known as Matching Michigan)

Bloodstream infections associated with central venous catheter insertion are a major cause of morbidity. Approximately three in 1000 patients admitted acquire a blood stream infection. One third of these are catheter related.

Central venous catheters are life saving devices which enable the safe administration of medicine and fluids, obtain blood samples for testing and cardiovascular measurements. The use of central venous line insertion guidelines, together with a method for monitoring usage of these guidelines, has been shown to reduce significantly the incidence of Catheter-Related. Bloodstream Infection (CRBSIs) in intensive care units.

In December 2009, The Trust enrolled on the Matching Michigan programme the focus of which is:

- Quality improvement project based on a model developed in the United States which over 18 months, saved around 1,500 patient lives (2006)
- Intensive Care Units in Michigan
- Introduced data definitions, technical interventions - changes in clinical practice - and non-technical interventions - linked to leadership, teamwork and culture change
- When these interventions are applied together these have been shown to reduce Central Venous Catheter Bloodstream Infections (CVC BSIs)

Following the principles of the programme, review of the clinical practices within the Intensive Care/High Dependency Unit, before, during and after the insertion of a central venous catheter has been undertaken; implementation of a best practice checklist; daily reviews of line necessity and prompt removal have all contributed in the units achievement of a rate of zero from the onset in December 2009 and for the subsequent years 2010 and 2011 for CRBSI's.

Dec 2010 to Feb 2012 Clinical Data Illustrated:

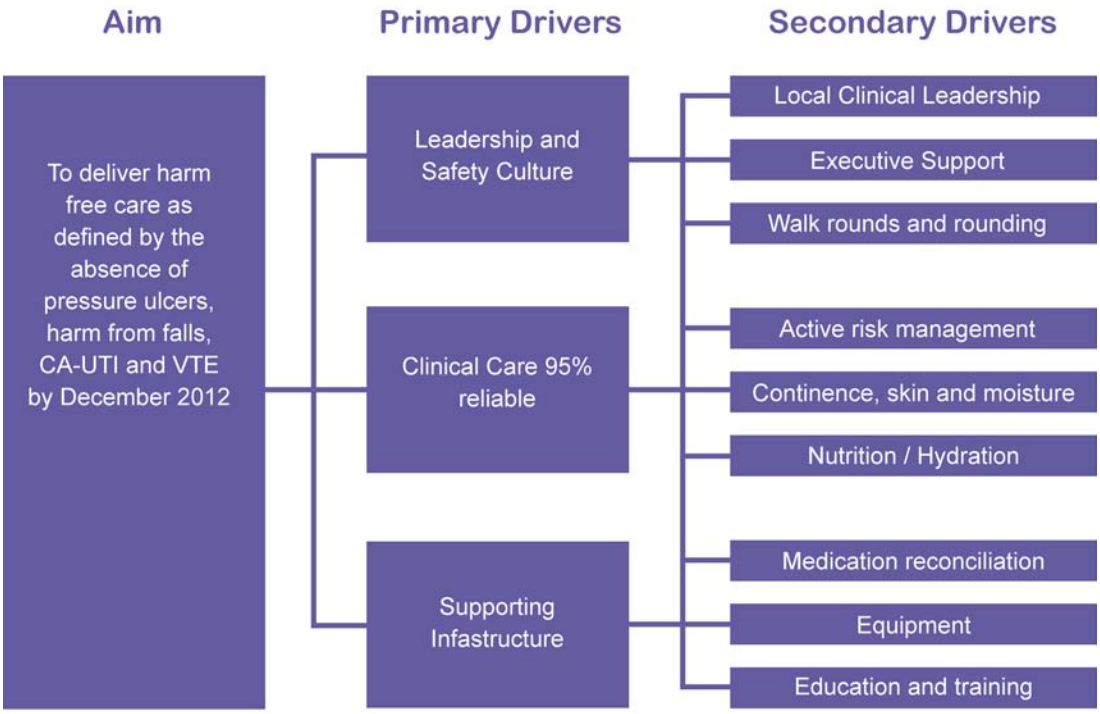
Month	Central Lines	Vascaths	Complications
December 2010	18	11	0
January 2011	23	6	0
February 2011	20	2	0
March 2011	19	5	0
April 2011	19	6	0
May 2011	15	5	0
June 2011	6	3	0
July 2011	2	3	0
August 2011	9	3	0
September 2011	9	7	0
October 2011	13	2	0
November 2011	11	3	0
December 2011	8	0	0
January 2012	6	0	0
February 2012	10	3	0

3.18 Safety Express/ Harm Free Care including Pressure Ulcers/Sores and Falls

In January 2011 the Trust signed up to the national QIPP safe care work stream “Safety Express”; a ‘call to action’ for NHS staff who want the NHS to be safer and more reliable with improved outcomes at significantly lower cost.

The shared aim of the Trusts who joined Safety Express is to reduce harm from pressure ulcers, falls, urinary tract infection (UTI) in patients with a urinary catheter and venous thromboembolism (VTE). In particular to increase the percentage of patients who complete an episode of care without experiencing any of these four harms.

The driver diagram for the programme is depicted below:



The approach used in Safety Express was a collaborative model whereby separate organisations would work together across traditional boundaries and share and learn together. Teams tested changes in the various areas of the driver diagram and shared learning from the results of those tests.

At WWL a Harm Free Ward initiative was launched in May 2011. An initial cohort of five wards was recruited from different specialties within the Trust. The ward leaders, or other members of the ward team, met fortnightly to refine their ideas; they left each meeting with a plan for testing changes aimed at reducing harm over the coming fortnight then fed back their results at the next meeting. This led to cross germination of ideas between wards on different hospital sites. Learning was also shared at local and national networking events.

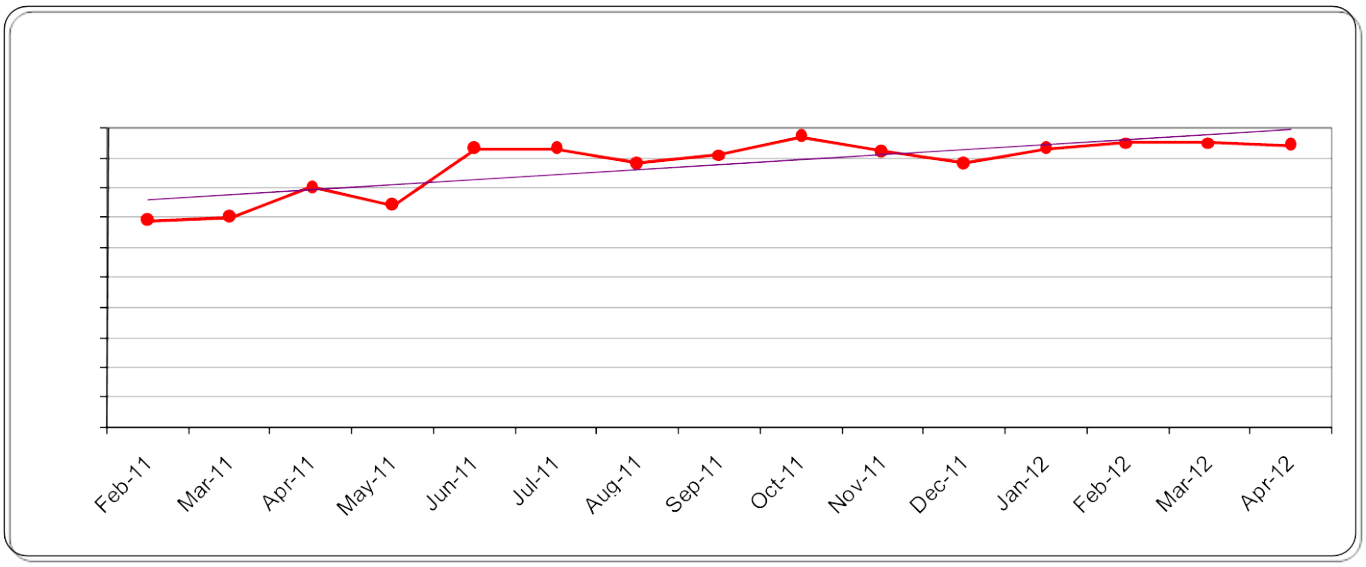
Tests of change included:

- More frequent changes of water jugs and more frequent hot drinks rounds to encourage increased fluid intake by patients.
- The use of intentional rounding
- The introduction of a hot breakfast in MAU
- Out of hours food availability
- A star system to visually identify patients at risk

Measurement of Harm

Within the programme harm to patients is measured in two ways:

The NHS Safety Thermometer is a tool which the Trust uses to proactively measure the rate of harm from the 4 harms referenced above; it is essentially a prevalence survey which is carried out on or around a given day every month. The tool looks at the whole patient pathway and as such, captures harm which occurred before the patient was admitted to hospital (in the case of pressure ulcers, UTI & VTE) as well as harm acquired in hospital. The Trust has implemented the Safety Thermometer since its introduction in 2010 initially using it to measure harm on pilot wards only. Since December 2011 the thermometer has been used to measure harm across all adult in-patient areas in the Trust. The chart below illustrates the % of patients receiving harm free care as measured by the NHS Safety Thermometer.

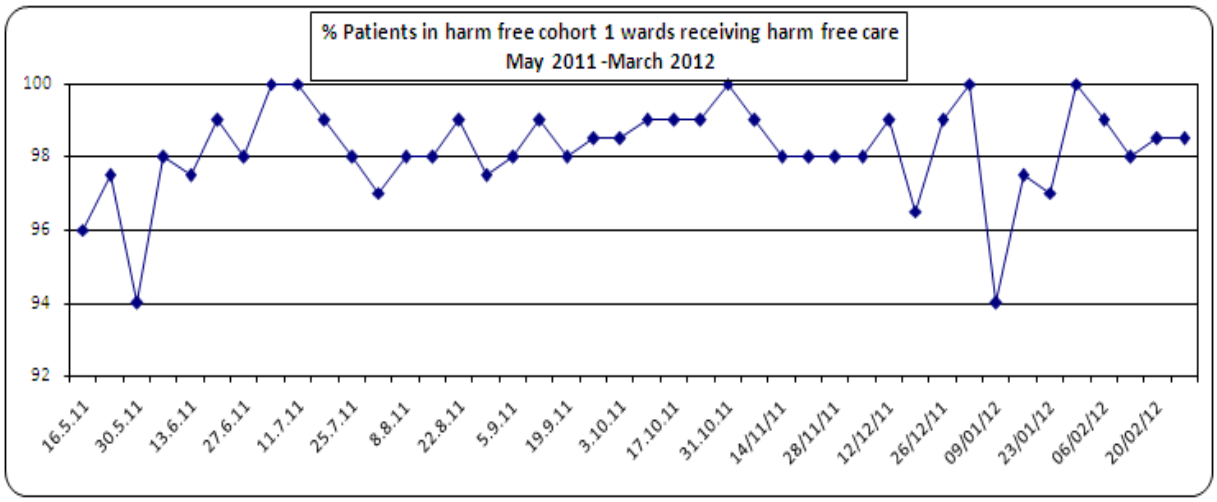


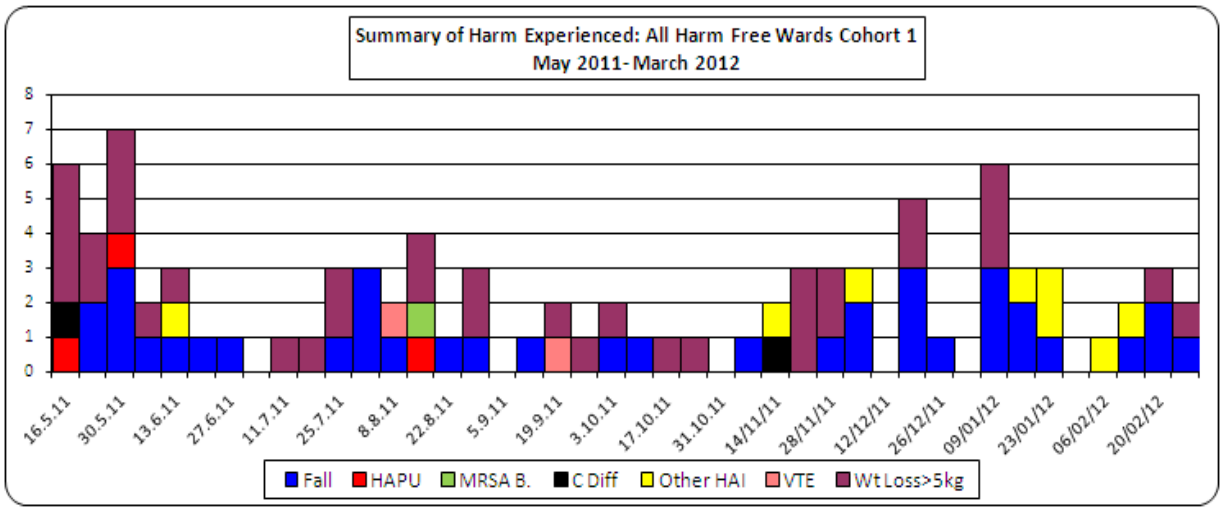
There has been variation in the results arising from Safety Thermometer surveys largely related to changes in the sample population over time; it is therefore difficult at this stage to make inferences from the data. It has been found however that pressure ulcers present on admission are a prevalent cause of harm.

Internal data set: At the commencement of the Harm Free Ward initiative the team also introduced an in-house audit, designed to capture harm which was experienced by patients whilst in our care. Data is taken about all patients on the day of their discharge, transfer or death rather than just the snapshot of patients on a given day as is captured by the safety thermometer. The Harm Free Ward data set was also extended to include additional harms including all hospital acquired infections and weight loss[1].

[1] The weight loss measure should be treated with caution as there are many reasons why a patient may lose weight some of which may be intentional/ therapeutic. The decision to include weight loss>5kg as harm is arbitrary and more detailed analysis of cases where weight loss is reported is required.

Results: The initial cohort of harm free wards have been successful in consistently achieving > 95% harm free care as measured by the in house data collection system. The most prevalent harms are falls (regardless of whether any physical harm actually occurred) and weight loss > 5kg





Next Steps

A second cohort of harm free wards was recruited in December 2011 and a roll out plan is in place to extend the initiative to the whole Trust during the first half of 2012.

The North West Transparency Pilot

In addition to the Safety Express work on harm free care, the Trust is one of eight in the North West that has participated in a transparency pilot led by NHS North as part of the Energise for Excellence Call to Action.

The aim of the pilot is to build public trust and confidence in the nursing profession by:

- engendering a culture of openness by publishing the incidence of harms
- review care and learn lessons when harm occurs thus improving patient outcomes
- identifying areas where nurses can improve the experience of patients and staff.

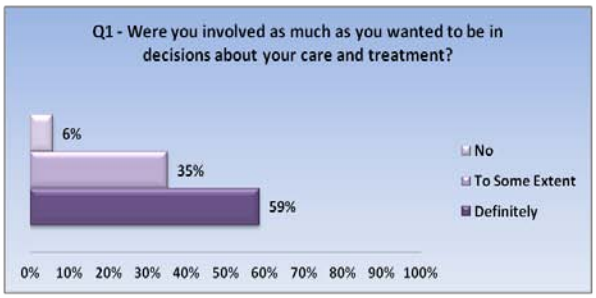
The transparency process involves reviewing the care of each patient that suffers harm from a fall or pressure ulcer in our care and carrying out a satisfaction survey of 10 patients and 10 members of the nursing team in that ward. The results are then collated and analysed prior to publication on the Trust's website.

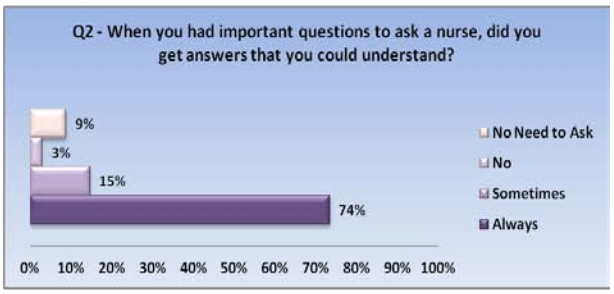
The Trust is very proud to be able to report such low rates of harm and this represents the commitment of our staff to improving safety in our hospitals. The survey results detailed over represent the views of only a very small number of patients and staff and should therefore be treated with caution. The Trust is continuing to work to eliminate avoidable harm and to improve the experience of patients and staff. The mechanisms through which we are doing this are detailed within other sections of this report.

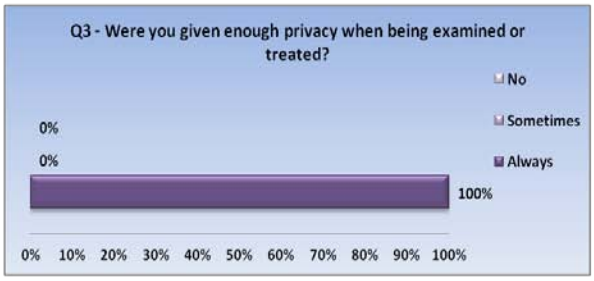
The Trusts results for January and February 2012 are detailed overleaf:

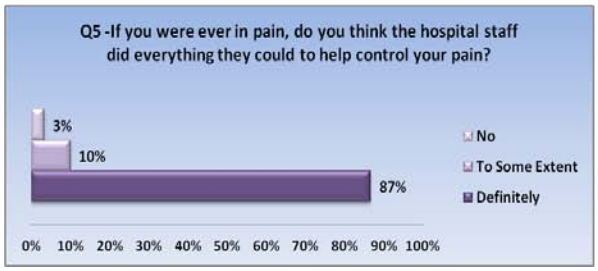
In January we cared for 6,913 patients	3 patients suffered harm from a fall in our care	1 patients suffered a Pressure Ulcer in our care

What our patients said:

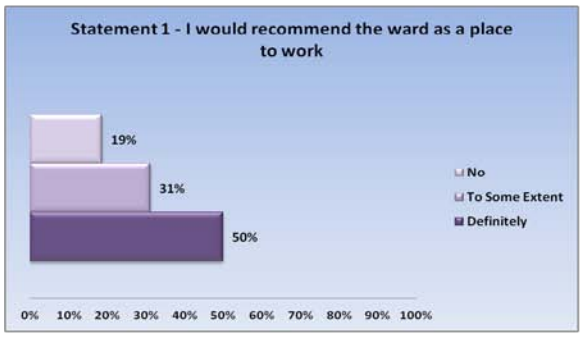


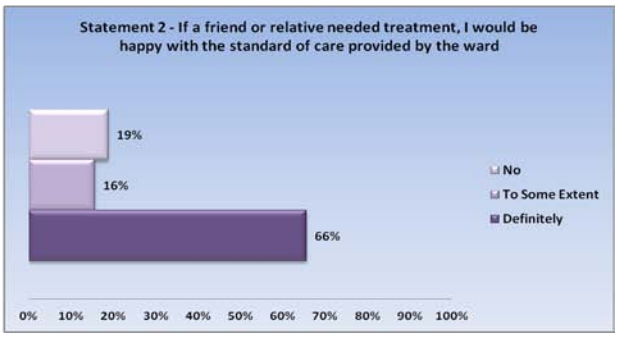


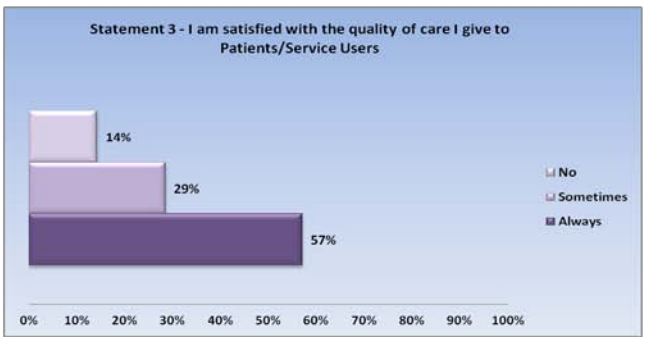




What our Nurses said about the care they provided:

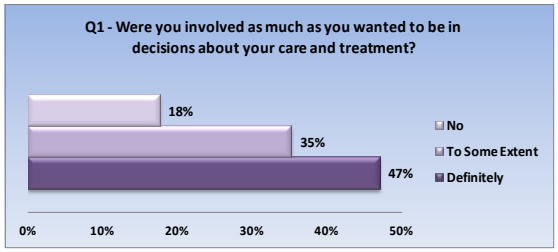


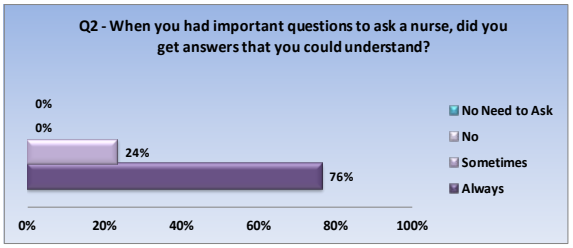


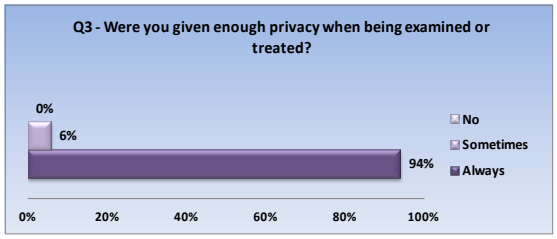


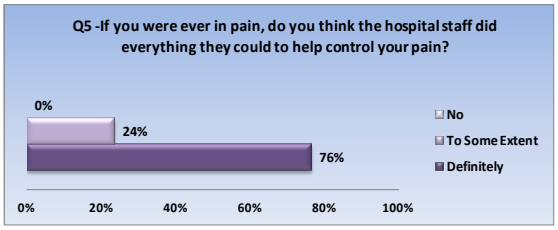
In February we cared for 6,528 patients	2 patients suffered harm from a fall in our care	No patients suffered a pressure ulcer in our care

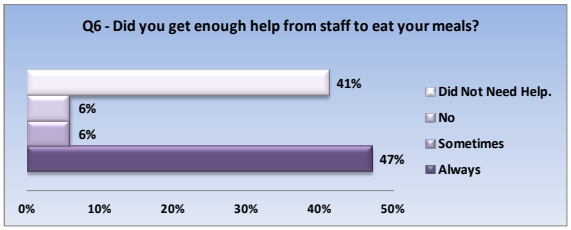
What our patients said:



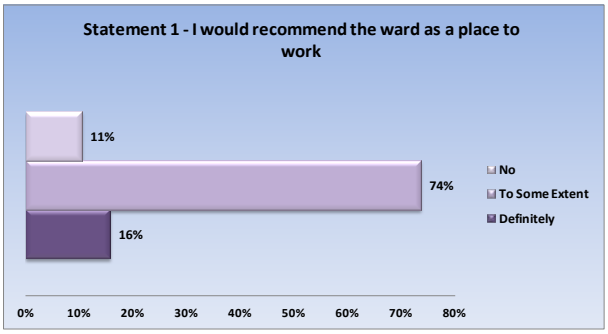


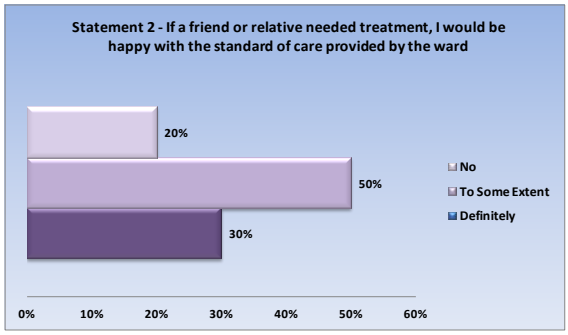


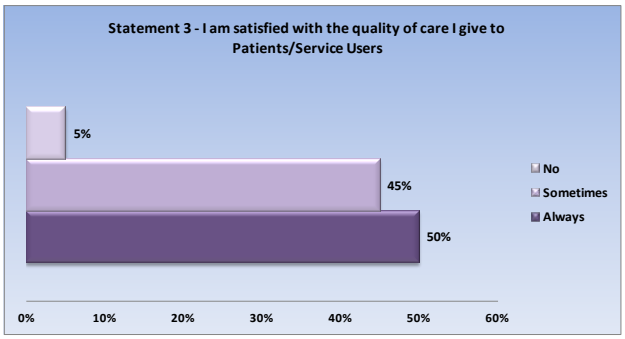




What our Nurses said about the care they provided:







3.19 Accident and Emergency/Medical Assessment Unit (MAU)

As at 28 February 2012 the Trust A&E performance stood at 96.9%, against the national threshold of 95%. With the introduction of the A&E Quality Indicators in April 2011 the quality of the department is also monitored on a number of new standards.

These include:

- Ambulatory Care proportion of patients admitted
- Unplanned re-attenders
- Patients leaving without being seen
- Total time spent in A&E for both admitted and non-admitted patients
- Time to initial assessment
- Time to Treatment in A&E
- Patient experience

There have been a number of developments within the Trust to support high quality care within the A&E department:

- Implementation of the 'Pit Stop', ensuring patients are seen rapidly for their first assessment, and supporting the standard of 'time to initial assessment'
- Improved streaming of patient into other services such as ambulatory clinic
- Working in partnership with the health economy to support options in primary care rather than patients attending the A&E Department
- The transfer of community demand management services has enabled services to be provided 'closer to home'

These patient pathways will be further improved during 2012/13.

MAU/Ambulatory Care

Following the development of the Medical Assessment Unit

- The Ambulatory Unit has supported rapid assessment and treatment for ambulant medical patients, reducing the need for patient admission, facilitating supported follow up for this cohort of patients
- Introduction of a seven day acute physician input has facilitated reducing steps and delays in patient assessment and treatment, subsequently reducing admissions and a reduction in length of stay
- Enabled treatment plans and diagnostics to be undertaken within an out-patient setting reducing the need for admission and facilitating earlier discharge

Future planned developments include:

- The development of a comprehensive ambulatory care pathway unit, further improving the patient pathway and communication. Treatment and follow up within the most appropriate care setting without the need for admission
- Rapid multi-disciplinary assessment and care planning, supporting safe supported discharge into primary care

3.20 Governance Rating

During 2011/12 the Trust improved its governance rating from amber green at Q1 to be rated green for governance in Q2 and Q3. However 18 weeks, was not achieved at quarter four, with an aggregate performance of 86.46%. The areas of non-achievement are Trauma and Orthopaedics, General Surgery, Vascular and Urology. This was due, in part, to the Trust being commissioned to undertake additional activity to deal with the legacy 18 week breaches. The Trust also maintained unconditional registration with the Care Quality Commission.

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial Risk Rating	4	3	3	3	4
Governance Risk Rating	Green	Amber/Green	Green	Green	Amber/Green
Mandatory Services Rating	Green	Green	Green	Green	Green

3.21 Stroke and Transient Ischemic Attack (TIA)

In April 2011 the Trust launched its new community stroke team. This multi-disciplinary service provides a model of care for the 'early' supported discharge of stroke patients. It joins together the care being delivered in the hospital setting with ongoing rehabilitation delivered in the community. The community stroke team attend the hospital on a daily basis to identify those patients suitable for the service and provides rehabilitation, either in the patients own home, or in an intermediate care setting (depending on the needs of the patient). Since the introduction of the community stroke team the length of stay for stroke patients within the hospital has reduced, with feedback from the initial patient survey indicating high levels of satisfaction with the service being delivered.

The Trust's acute stroke unit is based at RAEI with access to a specialist team of Consultants and specialist nurses and therapists. On-site access to diagnostics ensures timely diagnosis and intervention which minimises any potential delays in treatment. A stroke bleep is carried seven days a week by the Stroke Team to ensure a timely review when a patient presents with a suspected stroke. The Trust's aim is to receive all stroke patients admitted, either from accident and emergency, or from Salford Royal NHS Foundation Trust (SRFT) following thrombolysis (clot removing/busting) directly onto the ward to reduce delays.

The service for Transient Ischemic Attack (TIA - a 'mini stroke') continues to be one of the few five-day clinics in operation across the North West region with patients identified as being at high risk seen within 24 hours of their referral being received. All TIA patients attending the clinic will be seen by the stroke specialist nurse and consultant and will have a brain scan and vascular imaging performed, reported and actioned on the same day.

The stroke service takes part in the North West's Advancing Quality programme and also the Stroke Improvement National Audit Programme (SINAP) – the continuous national stroke audit which looks in detail at the first 72 hours of care. The service has developed close links with both national and local voluntary organisations for stroke, to improve care and support for patients and carers following a stroke or TIA.

The services aim is to provide stroke patients with the best evidence-based care available. This is monitored through our involvement in audit of best practice and reports performance to the Division, Trust Board and NHS Ashton, Leigh and Wigan. Trust reports on standards of care within stroke are also available on notice boards in the ward areas for the public to view.

3.22 Fractured Neck of Femur (NoF)

Fractured Neck of Femur (broken hip) is a common well-defined injury, which occurs mostly in older people and is associated with significant morbidity and mortality: their care presents a challenge to any health care system.

One of the most important aspects of care for patients with Fractured NoF is early surgery. Patients will benefit from early mobilisation rather than staying in bed as this leads to better patient outcomes. When this is done effectively, patients can be discharged earlier.

Bluebook Times Last 12 months	Local	SHA	National
Average Time to ward (hrs)	36.34	9.96	9.17
Average Time to Theatre (hrs)	26.34	35.92	34.58
Average length of stay (days)	19.64	20.91	19.70

Bluebook Indicators Last 12 months	Local count	Local %	SHA %	National %
Pressure Ulcers	7	2.09	3.84	3.63
Preoperative Assessment	173	51.64	58.04	69.94
Bone Protection Medication	317	94.63	68.99	73.64
Specialist Falls Assessment	323	96.42	86.68	86.63

Source: National Hip Fracture Database

The Trust's performance relating to average time arriving on the ward is due to the pathways being utilised where admissions are filtered via a clinical decisions ward. The Trust bed reconfiguration priority for 2012/13 is to increase the orthopaedic assessment and treatment areas that will provide early access to the right ward and early pre-operative assessment.

The Trust has better than average performance for patients arriving in theatre. Whilst this is the case the Trust is aiming to further improve this key measure with the pre-operative assessment work and bed reconfiguration, with the aim of reducing this to below 24 hours.

The Trust is performing very well in fall assessment and bone protection medication provided to our patients.

We are pleased that we are successful in getting patients to theatre quickly. We are also pleased that we achieve a short length of stay. This indicates early mobilisation, a fact reinforced by the low rate of pressure ulcers. Care of patients must look to prevent further problems, and we are proud that we are well ahead in assessment of falls and strengthening bones. Patients can go home earlier, and more safely.

Mortality rates for NoF had fallen below the expected level for a hospital of our size. However, for this financial year the have risen, and are now 106.7 (data is correct at the 1 April 2012, including discharges up to and including February 2012). Work to ensure patients arrive early on the correct ward, with early accurate pre-operative assessments are a priority for the year ahead.

3.23 Recognising Excellence Awards

The Trust holds an annual awards ceremony at which it recognises and celebrates individual staff and team achievements from the previous year. This year's ceremony took place at the DW Stadium, Wigan on the evening of the 4 November 2011. It was a special night of celebration and entertainment with over 350 attendees. The awards ceremony provided an opportunity for staff to showcase areas of good practice and awards were won for the following categories:

Award Category	Winners
Safe A clear demonstration of commitment to implement improvements that have resulted in the reduction of harm or an improvement in the quality and safety of service delivery.	**Diane Lee and Diane Lawrenson** Matron Ward Safety Status Checklist
Effective An award that recognises improved service delivery to ensure we meet or exceed performance standards and deliver excellent outcomes for patients and/or service to colleagues.	**Wrightington Outpatients** Foot and Ankle Nurse-led Clinic
Caring An award that recognises work that has strong evidence of keeping patients at the heart of everything we do by delivering services that enhance the patient experience and make a positive impact on the reputation of the Trust.	**Langtree Ward** The Three-Step Wound Plan
Innovation/BIG Idea The introduction of an initiative or new way of working that has delivered **B**etter care and **I**mproved efficiency through **G**etting involved to deliver measurable transformational change.	**Finance Team** Working together to improve the efficiency of pathways of care
Supporting Staff and Colleagues An award for an individual or team who have listened to and engaged with staff and taken specific action to make Wrightington, Wigan and Leigh NHS Foundation Trust a better place to work.	**Renee Steward** Supporting Adult Learners
Employee of the Year To recognise from all the winners of Employee of the Month the person who has made the most outstanding personal contribution to the delivery of quality services to patients, and/or colleagues.	**Leonora Anson** Sister on the Cancer Care Suite
Foundation Trust Award This is an overall award chosen from individual winners of the top five categories above that recognises the most outstanding positive impact on the delivery of high quality healthcare in the Trust.	**Langtree Ward** The Three-Step Wound Plan

Pictured to the right are members of Langtree Ward with Andrew Foster, Chief Executive. Langtree Ward won the Caring and Foundation Trust Award categories for their Three-Step Wound Plan entry. This initiative delivers immediate treatment to patients with painful non-healing leg ulcers that enables rapid healing without the need for surgery and often leads to a reduced length of stay in hospital.

The award ceremony is a highlight of the year for staff that celebrates heroes from across the organisation for the excellence they have achieved in their daily work. The awards recognise the commitment and dedication of staff to ensure all our patients receive the best possible care every day. Planning is already underway for the 2012 awards.

3.24 Awards Success

Individuals and teams from the Trust continue to enter numbers of projects and initiatives in regional and national awards. The table below lists the considerable success achieved over the last year:

Awards Name	Organisers	Entry Summary
Respiratory Best Practice Awards	NHS North West	The Hospital at Home Team came third in the Supported discharge category
BJM Clinical Practice Awards	British Journal of Midwifery	Achieved third in the Team of the Year for our Integrated Health Service Team
2011 Health and Social Care Adult Learners Week Awards	NHS North West	A first and second place in the Skills for Life Awards for our Adult Learners Week initiatives
2011 Health and Social Care Adult Learners Week Awards	NHS North West	Highly commended in the Supported Learners award for our Adult Learners Week initiatives
North West Mentoring Scheme Annual Conference	NHS North West	Radhika Rangaraju was recognised as the leading model mentee
HSJ Efficiency Awards	Health Service Journal	First for our Service Line Management (SLM) Pathfinder Project in the Efficiency in Financial Services category
Advisory Committee on Clinical Excellence Awards (ACCEA)	Department of Health	Nirmal Kumar was awarded a prestigious ACCEA Silver Award
Healthcare Quality Improvement Partnership	Healthcare Quality Improvement Partnership (HQIP)	Patient and Public Involvement in Clinical Audit - Poster Presentation was highly commended
Safety Express Coalition	NHS Safety Express	Highly commended in the quality improvement category
Safety Express Coalition	NHS Safety Express	Gill Harris was highly commended in the Senior Leader category
North West Public Health Awards 2011	Cheshire and Merseyside Public Health Network	The Alcohol Team were highly commended for their project success in reducing alcohol related presentations and admissions at the Royal Albert Edward Infirmary
HSJ Awards 2011	Health Service Journal	The Rapid Spread - Nutritional Care and Pressure Ulcer Prevention programme was highly commended in the patient safety category
RCM Annual Midwifery Awards 2012	Royal College of Midwives	The Midwifery Team were shortlisted for the Team of the Year
Excellence in Public Procurement Awards 2012/13	Government Opportunities	The Procurement Team were shortlisted for our Excellence in Supply Awards in the Best Supplier Engagement category.

3.25 Energise for Excellence (E4E)

The Trust is fully engaged with the Energise for Excellence (E4E) agenda and there are a number of areas of good practice in quality improvement that have been recognised nationally. WWL has truly embraced E4E which is a 'call to action' for all nurses to re-energise the compassion and caring elements of the profession. It is about energising all the resources available to ensure the best possible standards of care, particularly when we are facing challenging times. The resources include staffing tools, harm free initiatives, safety thermometer, LEAN methodologies and many more as summarised in the diagram below:

3.26 NHS Quest

During 2011 the Trust became a founder member of NHS Quest – a network of 13 NHS acute providers who wish to focus continuously on improving quality and safety.

Emphasis is on 3 key areas:

- The development of senior leadership teams through an Executive Development Programme for Improvement.
- Building capability by enabling senior leaders to support a culture of continuous improvement in their own organisations.
- A shared strategy and approach to measurement for improvement via a Quest strategic dashboard containing high level system measures for mortality, length of stay, readmissions, infections, harm and satisfaction.

In terms of work streams NHS Quest members have agreed to focus collectively on three work streams:

- Harm Free Care (commenced March 2011)
- Reducing Re-admissions (commenced December 2011)
- Reducing Mortality (commenced March 2012)

Details of the Trust's progress in these work streams can be found in relevant sections of this document.

3.27 Statements from NHS Ashton, Leigh and Wigan, Wigan Council OSC and the Wigan Local Involvement Network

3.27.1 NHS Ashton, Wigan and Leigh

We are pleased to be invited to give feedback on the 2011/12 Quality Accounts.

There are many areas of care in which the Trust performs very well, and in which we as the lead commissioners have confidence that good care is being provided. We are pleased to see that Serious Hospital Acquired Infections such as Clostridium Difficile and MRSA are down on previous years and are below the targets set. Equally it is positive that serious falls and pressure ulcers acquired in hospital have continued to be reduced in the year.

We welcome the fact that in the period the overall HSMR (Hospital Standardised Mortality Rate) has dropped. However Weekend Mortality, or the death rate on Saturdays and Sundays compared to weekdays, was featured in the national press when Dr Foster published its summary hospital performance statistics for 2010-11 in the autumn of 2011. We are pleased to see that the latest figures for 2011-12 show that weekend mortality in the Trust is now below 100.

It is a welcome sign that the Trust wishes to not only implement best practice from elsewhere but to also actively engage in defining best practice via its work with various research projects. In addition we welcome the commitment and involvement in Clinical Audit. For example the Trust has participated in the Trauma Audit and Research Network. This did show a low level of consultant cover for serious chest trauma - only 21% of cases of serious chest injuries were attended by a Consultant, 50% of patients were attended by a Foundation grade doctor. Although deaths from serious trauma are not higher at WWL NHS FT than would be expected, senior medical attention is obviously desirable when these very severe injuries are brought into the Accident & Emergency Department to reduce the risk of future disability. This is particularly important if the Trust is to become a Trauma Unit. We would note the recent appointment of additional Accident and Emergency consultant staff.

It is to the Trust's credit that within the Accounts there is recognition of specific poor outcomes with action plans detailing the Trust's response to these. For instance identification of issues requiring staff training, sourcing examples of best practice from elsewhere and a consideration of evidence of effectiveness, as implemented in the care of the deteriorating patient. The action plan being put in place to improve stroke care and compliance with the care pathway is a further example.

The Trust misses the opportunity to describe how it has used the CQUIN mechanism (these are additional payments made by the Commissioner to improve quality). A positive example would be work done on Venous thromboembolism (blood clots). The driver for this was a CQUIN set at national level for the last 2 years, which has taken the Trust's performance from only 45% in early 2010 to over 90% by end of 11/12; an impressive success. Again in a spirit of transparency we would hope it would be clearer that the Trust has struggled to achieve targets for the last 2 years in reducing admissions for a list of 19 conditions for which admission is not always necessary and for getting Discharge Summaries completed and available to GPs quickly. We are pleased that the Trust has undertaken actions in both of these areas, but further work is needed if the Trust is to achieve the CQUIN targets in these areas.

We commend the list of proposed indicators to be used in 12/13 to monitor quality of care, and will give the Trust benchmarking data against which to make comparisons.

The Real-time Patient Surveys are an excellent example of how the Trust is soliciting feedback enabling prompt action to be taken if required. Participation in the Harm Free Care and Energising for Excellence is to be commended.

Although not cited as partners in this report, we hope that WWL NHS FT will engage with the new Clinical Commissioning Groups (CCG), in particular Wigan Borough CCG which will become the lead commissioner for most WWL provided services. We would also encourage the Trust to continue to work closely with local providers, in particular Bridgewater Community NHS Trust to help ensure patients pass seamlessly between services.

16 May 2012

3.27.2 Wigan Council Overview and Scrutiny Committee

Copies of the draft quality accounts were issued to the Wigan Council Adult Health and Wellbeing Scrutiny Committee who circulated it to their members. No feedback was received.

3.27.3 Wigan Local Involvement Network(LINk)

Health and Care Together, Wigan Borough Local Involvement Network would like to make the following comment re: WWL's Quality Accounts for 2011/2012

'Whilst recognizing improvements in 2011/2012 results there are, on the dashboards, a significant number of failures to meet goals. The amount of red coding is plain to see. It is re-assuring that in the following fields, improvement has taken place: Clostridium Difficile infection rates, MSRA infection rates and the Hospital Standardised Mortality Ratio. Health and Care Together send congratulations to the staff who have achieved both hospital and external awards.'

Thank you giving us an opportunity to comment on your Quality Accounts for 2011/2012.

Appendix A

National Clinical Audits and National Confidential Enquiries

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible to participate Y/N	Participated	Number eligible	Actual submissions
Peri-operative care	Yes	Yes	11	100%
Surgery in Children	Yes	Yes	0	100%
Cardiac Arrest procedures	Yes	Yes	7	100%
Bariatric Study	Yes	Yes	0	NA
National Audits	**Eligible**	**Participated**		
Peri-natal mortality - (MBRRACE-UK)	Yes	Programme discontinued	NA	NA
Neonatal Intensive and special care (NNAP)	Yes	Yes	306	100%
Paediatric Pneumonia - British Thoracic Society (BTS)	Yes	No	NA	NA
Paediatric asthma (BTS)	Yes	No	NA	NA
Pain Management (College of emergency medicine)	Yes	Yes	50	100%
Childhood epilepsy - Royal College of Paediatrics and Child Health (RCPCH)	Yes	Yes	22	100%
Diabetes (RCPH National Paediatric Diabetes)	Yes	Yes	130	100%
Emergency use of oxygen (BTS)	Yes	No	NA	NA
Adult community acquired pneumonia (BTS)	Yes	No	NA	NA
Non-invasive ventilation (NIV) adults (BTS)	Yes	No	NA	NA
Pleural procedures (BTS)	Yes	No	NA	NA
Cardiac Arrest (National Cardiac Arrest)	Yes	No	NA	NA
Severe sepsis & septic shock (College of emergency medicine)	Yes	Yes	30	100%
Adult Critical Care audit (ICNARC CMPD)	Yes	Yes	283	222 (78%) submitted – remainder due for submission end April 12 (100% by due date)
Potential donor audit (NHS Blood & Transplant)	Yes	Yes	ICU 82 A & E 176	100%
Seizure management (National Audit of Seizure management)	Yes	No	NA	NA
Diabetes (National Adult)	Yes	Yes	4371	100%
Heavy Menstrual Bleeding (RCOG)	Yes	Yes	Not known Awaiting report	Not known
Chronic Pain	Yes	Yes	170	100%
Ulcerative colitis & Crohn's disease (National IBD)	Yes	Yes	39	97.5%
Parkinson's disease	Yes	No	NA	NA
Adult Asthma (BTS)	Yes	Yes	20	90%
Bronchiectasis (BTS)	Yes	No	NA	NA
Hip, Knee and ankle replacements (NJR)	Yes	Yes	1994 (100%) Data entered and submitted by NJR registry clerk	
Elective Surgery (PROMs)	Yes	Yes	Data entered and submitted by Nursing staff	
Coronary angioplasty (NICOR)	Yes	Yes	PCI – 413 Diagnostic Angiogram – 905 Pressure Wires - 70 (Due to switch of servers from CCAD to NICOR – submission	

			dates have been modified to 15 June Trust is fully compliant to date	
Peripheral vascular surgery (VSGBI)	Yes	Yes	36 (JM) (100%) 30 (SR) (100%) Data completed and submitted by surgeons	
Carotid interventions	Yes	Yes	Submitted via NW Vascular Audit group	
Acute Myocardial Infarction & Other ACS (MINAP)	Yes	Yes	400 to date – Data collected by Cardiology Nurse and validated by Information Department	
Heart Failure Audit	Yes	Yes	550 (100%) to date Data entered by Specialist Cardiology Nurse	
Acute Stroke (SINAP)	Yes	Yes	Data collected by Regional co-ordinator	
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Yes	No	NA	
Lung Cancer (LUCADA) Audit participation independently carried out by Cancer Services Team	Yes	Yes	Data collected by Cancer Services Team	
Bowel Cancer (NBOCAP) Audit participation independently carried out by Cancer Services Team	Yes	Yes	Data collected by Cancer Services Team	
Head & Neck (DAHNO) Audit participation independently carried out by Cancer Services Team	Yes	Yes	Data Collected by Cancer Services Team	
PCI Oesophago-gastric cancer (National O-G Cancer Audit) Audit participation independently carried out by Cancer Services Team	Yes	Yes	Data Collected by Cancer Services Team	
Hip fracture (NHFD) Audit participation independently carried out by Trauma Nurses	Yes	Yes	296 100% to date – Data collected by Trauma Nurses	
Severe Trauma (TARN) Audit participation independently carried out by TARN co-ordinator	Yes	Yes	178 to date – data collected by TARN co-ordinator	
Bedside transfusion (National Comparative Audit of Blood Transfusion	Yes	Yes	32	100%
Medical use of blood (National Comparative Audit of Blood Transfusion	Yes	No	NA	NA
National Audit of Dementia	Yes	Yes	40	100%
Risk factors (National Health Promotion in Hospitals Audit)	Yes	No	NA	NA
Care of dying in hospital (NCDAH)	Yes	Yes	30	100%

* These figures represent the information provided to the Clinical Audit Department by the relevant audit leads/departments. Data collection for some of the audits extends beyond the date of this report meaning that the figures contained within the report may not correspond with the actual figures published in the final audit reports.

The reports of 9 National Clinical Audits were reviewed by the provider in the period 1 April 2011 to 31 March 2012, and WWL intends to take/has taken the following actions to improve the quality of healthcare provided.

National Reports/Actions

Audit	Trust Actions	Status
Cardiac Arrhythmia	1. Atrial Fibrillation management including Rate, Rhythm and Embolic complications Trust has implemented the Guidelines for this including setting up specialist Arrhythmia clinics. 2. Malignant Ventricular Arrhythmia management and NICE recommendations have been reviewed. 3) The management system is in place locally with the exception of cases where there is some subgroup of concurrent ventricular arrhythmia and left ventricular function abnormality where facilities have prevented full local implementation of the guideline.	Actions complete Partially implemented Underway
Blood Transfusion – Bedside Transfusion	1) Report/Results presented at Divisional Senior Nurse Meetings and the Hospital Transfusion Committee. The Trust's comparison against regional and national hospitals was of equal or higher percentage compliance against the audit standards. Re-audit locally to be done in 2012.	Actions complete – awaiting re-audit
Emergency Oxygen	1) The Trust is in the process of changing the Oxygen alert Card. 2) Include in formulary the use of Indacaterol	In progress In progress
Adult Asthma	1) Follow up rates need to be improved. Asthma specialist nurse now checks lists weekly to ensure appropriate follow up. 2) Teaching sessions for pharmacy staff and junior doctors has taken place and will continue with each new intake.	Ongoing Complete and ongoing
Upper GI Cancer	1) Increase number of SCA cancer slots available. 2) Dedicated bleeding list to increase outpatient endoscopy capacity – planned department expansion 3) Inappropriate referrals – Consultant to meet with GPs to discuss 4)Improvement needed in TNM staging	Complete Underway Underway Now showing improvement
Lung Cancer	1) To ensure all relevant fields are completed for each patient – lung cancer pro-forma to be reviewed and used for data collection. Key person to be identified to quality assess this prior to submission. Mapping and allocation of responsibility along patient pathway 2) Review of specialist nurse service and allocate extra nursing support alongside lung cancer clinics 3) Reviews undertaken with relevant teams	Underway Underway Completed
Colorectal Surgery	Blood cross-matching policy to be changed and implemented	Completed
IBD Audit	Report under review	Underway
NAP 4	Standard difficult airway trolley made available in A & E, ICU and at Leigh infirmary	Completed

The reports of 215 local clinical audits were reviewed by the provider in the period 1 April 2011 to 31 March 2012. Where recommendations indicated, WWL intends to take the following actions to improve the quality of healthcare provided.

Local Reports/Actions

Audit	Recommended actions	Status
Audit of Re-admissions rate following total hip replacement	Some re-admissions being wrongly coded. Improve clinical coding system	Actions complete
Critical Incidents	Epidural and Spinal Equipment– Non-leur lock equipment to be ordered but a lead is needed for each site. Actions complete	Actions complete
Pathology Incidents 2010	Last Offices policy revised and published on internet	Actions complete
Are Antibiotics Being Administered As Prescribed Re-Audit?	Data should be sent to Medical Director highlighting the two wards which have seen no improvement so this can flagged this to ward managers.	Actions complete
A shortened prophylactic antibiotic regime for pelvi-acetabular surgery - results from an audit	A formal prophylactic antibiotic policy can be drawn up to replace the old policy.	Actions complete
MRCP Audit	To consider using this predictive model in conjunction with clinical judgement to rule out patients who do not need a MRCP. Re-audit in 1 year	Actions complete
Audit on Enhanced Recovery After Surgery (ERAS) Dept. of Colorectal Surgery	Adding a session of ERAS management in the induction of junior doctors as a part of education. Compile a flow chart for the management of post-op nausea and vomiting which covers the first 3 points. This will also address whether to take patients out who develop an ileus. Provide a permanent poster in Swinley ward for ERAS. Actions complete	Actions complete
Serum Magnesium testing	To develop a Trust Protocol for these patients	Actions complete
ICU Record Keeping Kontron PIS at RAEI	A trainee induction should be given to explain how to use the Kontron system	Actions complete
Re-audit of Thrombo-prophylaxis in Orthopaedic Patients - CG92	Verbal / written information on: 1. Signs and symptoms of DVT/PE 2. Importance of using VTE prophylaxis. Actions completed	Actions complete
Safeguarding Supervision/Peer Review Audit	Upload supervision policy onto intranet	Actions complete
Northwest Regional Urology audit - The management of Stones:- PCNL	A list of guidelines agreed at the Northwest Urology audit meeting will be implemented within the Trust	Actions complete
Northwest Regional Urology audit - Ureteroscopy	A list of guidelines agreed at the Northwest Urology audit meeting will be implemented within the Trust	Actions complete
Ulysses - improving the bereavement service	Single system introduced. Potential to improve service further	Actions complete
Newborn BCG Immunisation Re-audit	Train midwives to immunise	Actions complete
Length of stay: Mastectomy and wide local excision cases	Implement the 23 hours breast discharge pathway. Re-audit after implementation of this pathway	Actions complete

Audit	Recommended actions	Status
Nurse screening for Sepsis on SAU	Intervention to be rolled out on Langtree Ward	Actions complete
Critical Incidents in Anaesthetics	Epidural and spinal equipment – non-leur lock equipment to be ordered. Lead is needed for each site	Actions complete
Child protection audit	Pro-forma needs to be updated	Actions complete
Open food challenge audit on Rainbow Ward	Set up a database to enable access to data	Actions complete
CQUIN for Hip and Knee patients	Formulate sheet for use at induction of new doctors. AQ report to be brought back to audit meetings – Add to Agendas	Actions complete
Hand Hygiene Audit – Theatres Royal Albert Edward Infirmary September 2011	Infection control nurses invited to observe and advise practice within the directorate, particularly in ICU, Theatres and the Chronic Pain Unit	Actions complete
Emergency Caesarean Section audit	Reminders to be cascaded to colleagues as not all sections are being entered into database. Euro king to be used following staff training	Actions complete
Supra-district audit of the postnatal management of antenatal hydronephrosis (ANH) using North West Regional Guideline	Further effort needed in communication with GPs, Communication with families, early postnatal ultrasound scanning. Action: Change criteria within guideline	Actions complete
Success of sedation for children having MR scan	Make changes to sedation guideline, should be chloral hydrate	Actions complete
EPR discharge audit – Gynaecology department	Audit lead agreed to emphasise the use of EPR discharge letters at doctor induction, in particular 'primary diagnosis'	Actions complete
See and treat colposcopy audit	Make changes to Compuscope system	Actions complete
Audit of induction of labour in women with a stillbirth in pregnancy	Review and update guidelines (review doses at different gestations)	Actions complete
Initial assessment of patients with chronic open-angle glaucoma (COAG), suspected COAG or ocular hypertension (OHT)	Remove 'target IOP' 'risk of conversion' and 'risk of progression' from the departmental guidance as this is individual to each patient	Actions complete
Severe sepsis audit – College of Emergency Medicine	Mews scoring to be reviewed and audited; sepsis poster for pit stop; Mews by hand, not electronically	Actions complete
Cardiac Arrest Audit	Make staff aware of alternative emergency calls. Send out global e mail to remind staff	Actions complete
Management of Positive Chlamydia swab results	Investigate reasons for missed results	Actions complete
DNA Audit – Diabetic retinopathy screening service	Patients requested more out of hours clinics – to be discussed in all DRSS MDT meetings	Actions complete

The following are audits where actions have been indicated and the audit department informed that actions are in progress	
Title	**Actions recommended**
Audit on newborn examination – discharge NHSLA	Several areas for improvement – Pro-forma needs to be updated
Audit of NHSLA documentation in Child Health	EPR needs to include safeguarding tick box
Audit of blood usage in elective bowel resections	1. Change the hospital's maximum blood ordering schedule to state that only rectal surgeries will require a cross match. All other elective bowel resections need a group and save. 2. Increase the use of pre-operative iron supplementation.
Group B streptococcal disease	EPR microbiology positive results to be highlighted. Agreed management plan for positive HVS/MSU results. Use of patient information leaflets. When admitted to labour suite, EPR and notes to be checked for full microbiology history.
Audit of compliance to safeguarding children pro-forma	Suggested adjusting pro-forma to include notes at the front. More training for clinicians in use of pro-forma
Audit of x-ray reporting	Delays being experienced. 5 week pilot study to be undertaken
Management of Alcohol intoxication in A & E at Royal Albert Edward Infirmary	Increase the awareness of history taking. Topic to be built into A & E induction
Therapeutic Hypothermia	Proposed that a pilot project be set up in two level 2 sites across GM network prior to transfer to NICU cooling centre for ongoing care
BIPP audit	Indication to stop using BIPP in revision otology surgery
Laparoscopy audit	Laminated sheets to be formulated to highlight risks and complications

Audit Actions are monitored at monthly audit meetings as well as at Directorate Quality Improvement meetings. Actions are signed off as complete (on the audit database) when feedback is relayed back to the audit department by those responsible for implementing the actions.

Appendix B

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
1b Life expectancy at 75 i males ii females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
Cancer
1.4 i One-and ii five-year survival from colorectal cancer
iii One-and iv five-year survival from breast cancer
v One-and vi five-year survival from lung cancer
vii under 75 mortality rate from cancer*

Reducing premature death in people with serious mental illness
1.5 *Excess under 75 mortality rate in adults with serious mental illness**

Reducing deaths in babies and young children
1.6.i Infant mortality* ii Neonatal mortality and stillbirths

Reducing premature death in people with learning disabilities
1.7 *An indicator needs to be developed*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions**

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions*

Reducing time spent in hospital by people with long-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness **

Enhancing quality of life for people with dementia
2.6 *An indicator needs to be developed*

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital

Improvement areas

Improving outcomes from planned procedures
3.1 **Patient Reported Outcomes Measures** (PROMs) for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia
iv Varicose veins

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 *An indicator needs to be developed.*

Improving recovery from stroke
3.4 *An indicator to be derived based on the proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months*

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility / walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 Proportion of older people (65 and over) who were i still at home 91 days after discharge into rehabilitation*** ii offered rehabilitation following discharge from acute or community hospital ***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services ii GP Out of Hours services iii NHS Dental Services
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 *An indicator to be derived from the survey of bereaved carers*

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator to be derived from a Children's Patient Experience Questionnaire*

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b safety incidents involving severe harm or death

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

One framework
defining how the NHS will be accountable for outcomes
Five domains
articulating the responsibilities of the NHS
Twelve overarching indicators
covering the broad aims of each domain
Twenty-seven improvement areas
looking in more detail at key areas within each domain
Sixty indicators in total
measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2012/13
at a glance

**Shared responsibility with the public health system and Public Health England and local authorities - subject to final publication of the Public Health Outcomes Framework.*

*** A complementary indicator is included in the Adult Social Care Outcomes Framework*

****Indicator replicated in the Adult Social Care Outcomes Framework*

Indicators in italics are placeholders, pending development or identification of a suitable indicator.

Appendix C

Statement of Assurance from the Board

The Directors of Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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 can confirm that they have taken steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12:
- The content of the Quality Report is consistent with internal and external sources of information including:
    - Board minutes and papers for the Period April 2011 to June 2012
    - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
    - Feedback from NHS Ashton, Leigh and Wigan dated 16 May 2012
    - Feedback from Council of Governors on16 May 2012
    - Feedback from Local Involvement Networks (LINks) dated 24 April 2012
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 22 September 2011
    - The 2011 national patient survey
    - The 2011 national staff survey
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 23 May 2012
    - CQC quality and risk profiles dated April 2012
- 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 Account 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), as well as the standards to support data quality for the preparation of the Quality Report

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

30/05/12 Date ……  …… Chairman

30/05/12 Date ……  …… Chief Executive

Appendix D

External Auditors Limited Assurance Report

2011/12 LIMITED ASSURANCE REPORT ON THE CONTENT OF THE QUALITY REPORT AND MANDATED PERFORMANCE INDICATORS

Independent Auditors Report to the Board of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust to perform an independent assurance engagement in respect of Wrightington, Wigan and Leigh NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Board of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust as a body, to assist the Board of Governors in reporting Wrightington, Wigan and Leigh 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 2012, to enable the Board of Governors to demonstrate that is has discharged its 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 Board of Governors as a body and Wrightington, Wigan and Leigh NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- MRSA; and
- Cancer 62 day waits.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in *NHS Foundation Trust Annual Reporting Manual*; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six

dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with those documents listed below:

- Board minutes for the period April 2011 to June 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to June 2012;
- Feedback from the Commissioners dated 16 May 2012;
- Feedback from Council of Governors dated 16 May 2012;
- Feedback from LINks dated 24 April 2012;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 22 September 2011;
- The 2011 national patient survey;
- The 2011 national staff survey;
- Care Quality Commission (CQC) quality and risk profiles dated April 2012; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 23 May 2012;

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Wrightington, Wigan and Leigh NHS Foundation Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

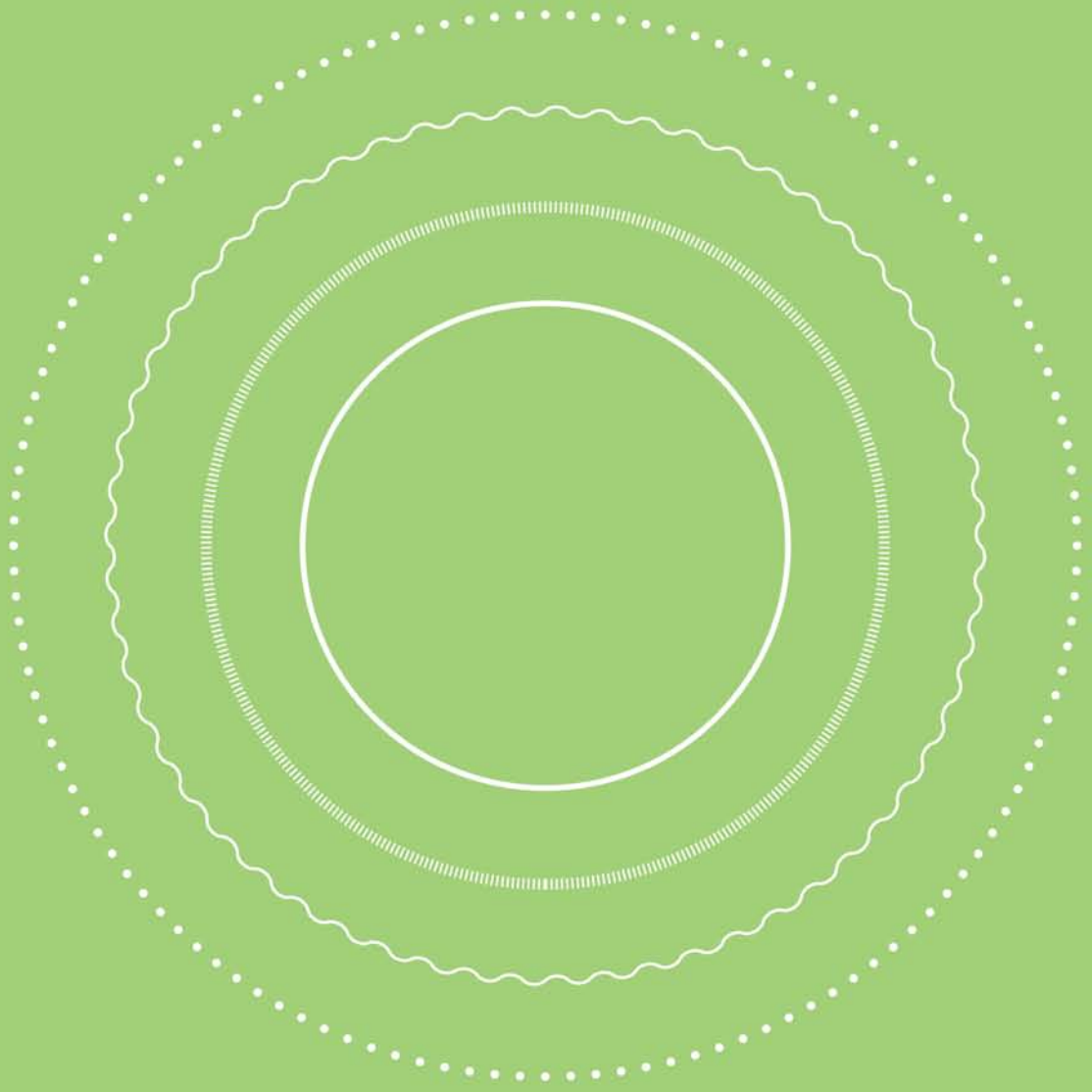
- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in *Foundation Trust Annual Reporting Manual;* and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

Deloitte LLP

Deloitte LLP
Chartered Accountants
Newcastle Office
30 May 2012

Wrightington, Wigan and Leigh
NHS Foundation Trust

Annual Accounts
1 April 2011 – 31 March 2012



your hospitals, your health, our priority

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

Wrightington, Wigan and Leigh NHS Foundation Trust
Accounts for the year ended 31 March 2012

WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

Contents

WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

Statement of the Chief Executive's responsibilities as the Accounting Officer of Wrightington, Wigan and Leigh NHS Foundation Trust

For the year ended 31 March 2012

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Wrightington, Wigan and Leigh 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 Wrightington, Wigan and Leigh NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him 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*.

Signed:  Andrew Foster, Chief Executive

Dated: 30th May 2012

ANNUAL GOVERNANCE STATEMENT 1.4.2011 – 31.3.2012

Organisation Name: Wrightington, Wigan and Leigh NHS Foundation Trust

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1. SCOPE OF RESPONSIBILITY

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

2. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Wrightington, Wigan and Leigh 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 Wrightington, Wigan and Leigh NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

3. CAPACITY TO HANDLE RISK

3.1 Leadership

As Accounting Officer, I have overall accountability and responsibility for leading risk management arrangements on behalf of the Board.

The Director of Nursing and Performance (who is also the Director of Infection Prevention and Control and Deputy CEO) provides leadership at Board level for the implementation of integrated governance and risk management. The Director of Finance is designated as the accountable and responsible officer for managing financial risk in the Trust. The Medical Director provides professional medical leadership for governance and patient safety within the Trust. The Trust's Risk Management Strategy clearly defines the responsibilities of individual Executive Directors specifically and the Risk Management Strategy applies to all employees and requires an active lead from managers at all levels to ensure risk management is a fundamental part of the total approach to quality, corporate and clinical governance, performance management and assurance.

Employees, contractors and agency staff are required to report all adverse incidents and concerns. The Trust supports a learning culture, ensuring that an objective investigation or review is carried out to learn from things when they go wrong, only assigning blame to individuals, where it is clear that Trust policies and procedures have deliberately or negligently not been appropriately followed.

From April 2012 the Governance and Risk Committee and Quality Improvement Committee have been replaced by the Quality and Safety Committee and Quality Executive Committee. These changes were made to further strengthen the quality governance arrangements in the Trust. The role of the Quality and Safety Committee is to act as a scrutiny and strategy committee. It will take reports and minutes from the Quality Executive Committee. The role of the Quality Executive Committee is to act as an executive and planning committee. It will be led by the Chief Executive and will provide assurance to the Quality and Safety Committee that high standards of care are provided by the Foundation Trust and in particular that adequate and appropriate governance structures, processes and controls are in place throughout the Trust. Further information on the changes in the committee structure are reported in section 6.

3.2 Training

To ensure that the Trust's approach to risk management is successfully implemented and maintained, staff at all levels are appropriately trained in incident reporting and carrying out risk assessments. All staff are required to regularly update their knowledge and skills and maintain their personal awareness of their responsibilities for risk management via an ongoing risk management training programme. This has been developed to include, Incident Reporting, Health and Safety, Risk Management, Patient Safety, Fire Safety, Basic Life Support, Infection Control and Prevention, Safeguarding Children and Vulnerable Adults, Information Governance, Conflict Resolution and Equality and Diversity. This training is mandatory for all staff and is identified via a training needs analysis that is reviewed on an annual basis and subject to scrutiny by the Trust's Risk and Environmental Management Committee. More advanced training is available for selected managers and clinical staff through a taught programme on the principles of risk management. The Trust is also an accredited centre with the Chartered Institute of Environmental Health and delivers a regular programme of Health and Safety awareness training. This is a nationally recognised accredited programme. All new starters to the Trust mandatorily attend a Trust induction programme that covers all the areas of risk management outlined above.

Compliance with risk management training is reported to the Board on a monthly basis and monthly reports informing managers of staff who require update training are sent to all Divisional and Departmental Managers.

To further encourage a positive and wider learning culture, the Trust's in-house newsletter, Focus, features regular contributions on the learning arising from the analysis of claims, incidents and complaints. The newsletter also features regular articles highlighting key risk management areas and promoting the update training that staff are required to complete.

The Trust also delivers additional risk management training to the Board (Executive and Non-Executive Directors) and to all senior managers. This year the Trust met its 90% target for this training. The target is 90% to recognise natural absence through for example, long term sickness and staff turnover.

4. THE RISK AND CONTROL FRAMEWORK

4.1 Key Elements of the Risk Management Strategy

The Risk Management Strategy is endorsed by the Trust Board. It covers the principles of risk management and is subject to review every two years, (next due in August 2012) to ensure it remains appropriate and current. Staff accountable and responsible for risk management are

clearly identified as well as the system for identifying, managing, evaluating and controlling individual risk. Risks are identified from risk assessments and analysis of data from other intelligence sources, including concerns, near misses, incidents, serious untoward incidents, formal and informal complaints and litigation

The key organisational risks for the year were identified from the Corporate Strategic Objectives for 2011/12 that formed part of the Board Assurance Framework that were:

- Failure to achieve an average Financial Risk Rating of 4
- Failure to score zero points on the Monitor Compliance Framework each month
- Failure to support value for money through investment in new projects in line with innovation criteria
- Failure to establish effective demand management systems in the health economy
- Failure to successfully manage the transfer of community services
- Failure to achieve HSMR of no more than 90
- Failure to achieve a good patient experience (Real Time Patient Experience surveys score 85% positive experience)
- Failure to maintain CQC registration without conditions

The key risks for 2012-13 included on the Board Assurance Framework are:

- Failure to meet all of our performance and financial targets in full every month
- Failure to fully invest £300,000 this year in innovative projects that will save money and or improve quality
- Failure to design and deliver a leadership training programme for middle and senior leaders by the end of this year
- Failure to implement a new electronic patient information system this year for A&E, referral letters and out-patient case notes.
- Failure to introduce a short monthly staff opinion survey this year and use this to improve staff satisfaction
- Failure to keep to the timetable and budget for this year's big investment projects, the Education Centre, electrical upgrades at Wigan and Wrightington, Oncology Unit, Pathology Laboratory, second MR scanner and conversion of the Hanover block
- Failure to achieve close working with other health and social care organisations to provide better services at home and in community clinics in order to reduce use of hospital services
- Failure to keep our death rates well below the average of other hospitals
- Failure to reduce the number of patients who tell us that they are not satisfied with their pain control and with their ability to talk about their concerns
- Failure to ensure that the Care Quality Commission is completely happy with our services
- Failure to maintain and improve the very good relationships we have with partner organisations, especially Wigan GPs and NHS Greater Manchester

Each of the key risks are included on the Board Assurance Framework and the risk scores are discussed monthly by monitoring committees, the Executive Meeting Point (a weekly meeting of the Executive Directors) and reported in the monthly performance reports to the Board.

The Risk Management Strategy is cross referenced to a series of related risk management documents i.e. the Health and Safety Policy, Divisional Risk Management Strategies, Risk Assessment Policy, Risk Assessment Guidance and the Incident Reporting and Investigation Policy.

The Risk Management Strategy is available to all staff via the document library on the Trust's Intranet.

4.2 Elements of the Assurance Framework

The Board Assurance Framework has been in place during 2011/12. The Assurance Framework:

- Covers all of the Trust's main activities
- Identifies the corporate objectives/targets that the Trust is striving to achieve
- Identifies the risks to the achievement of these objectives and targets
- Identifies the system of internal control in place to manage the risks
- Identifies and examines the review and assurance mechanisms which relate to the effectiveness of the system of internal control
- Records the actions taken by the Board to address control and assurance gaps
- Monitors the Trust's compliance with the CQC Essential Standards of Quality and Safety during 2011/12

The Governance and Risk Committee and Risk Management and Environmental Committee consider high/significant risks and, if appropriate, recommend their inclusion on the Corporate Risk Register and/or Board Assurance Framework. The Board considers high/significant risks and approves their inclusion on the Board Assurance Framework and/or Corporate Risk Register.

Risk prioritisation and action planning is informed by the corporate objectives which have been derived from internal and external sources of risk identified from national requirements and guidance, complaints, claims, incident reports and audit findings. This also includes any other sources of risk derived from ward, departmental and divisional risk assessments, which feed up to Divisional and Corporate level management.

Action plans are developed for unresolved risks and the rating of risks is established using a 5x5 matrix which was derived from the Aus/NZ 4360 Risk Management Process.

Lead Executive Directors and Lead Managers are identified to deal with the gaps in control and assurance and are responsible for developing action plans to address the gaps. The Board Assurance Framework serves to assure the Board of Directors that the organisation is addressing its risks systematically. The action plan ensuing from each risk assessment also serves as a work plan for the Lead Manager to ensure mitigation against risks and closure of any gaps in control or assurance.

The Board Assurance Framework is monitored and reviewed on a monthly basis by the Trust Board and bi-monthly by the Governance & Risk Committee which has conducted an in depth analysis to enable the Trust to work towards:

- Achieving a good patient experience
- Establish effective demand management systems in the health economy

In addition, Meeting Point reviews and discusses the BAF on a monthly basis and each risk has an identified committee which owns the risk and subjects it to regular scrutiny and monthly review of risk scores. This provides evidence to support the Annual Governance Statement.

The Audit Committee is a sub-committee of the Board of Directors and provides independent assurance on aspects of governance, risk management and internal control. The Audit

Committee has an annual work plan that ensures effective monitoring of risk management takes place including review of Divisional quality account dashboards.

The Trust received a significant assurance opinion from internal audit on its Board Assurance Framework process for 2011/12.

4.3 Quality Governance Arrangements

For the last five years the Trust has committed to place quality on a par with finance and performance, with safety as the highest priority. During 2011 the Trust agreed a revised mission statement, vision and strategy defined under the headings of safe, effective and caring. It also agreed a set of strategic priorities and values and these are communicated regularly to all staff via the visual device of the WWL Wheel. Further details of the WWL wheel are reported within the Annual Report and Quality Accounts.

During 2011/12 the Trust had arrangements in place to govern service quality via its Quality Strategy. The Trust had regard to Monitor's quality governance framework in the development of Divisional business plans for 2012/13 with Divisions being asked to confirm their plans were safe for patients. In addition each Division has a quality dashboard that is monitored at Divisional Quality Improvement meetings and at the corporate Quality Improvement Committee. The Audit Committee work plan includes presentations on the quality dashboards from each Division.

Looking to 2012/13 the quality governance framework has again been refreshed and a new Quality Executive Committee was established from April 2012. Quality Champions have been identified to lead on 11 quality enablers to achieve a safe, effective and caring patient experience. A Quality Faculty will be established in 2012/13 with membership drawn from the Quality Champions, Quality and Safety Matrons and other staff trained in leading on patient safety. Performance is reviewed on a monthly basis by the Trust Board.

Quality of performance information is assessed at Divisional and Corporate levels through the Quality Improvement Committees. Performance information data is reviewed by the Data Quality Committee.

All papers submitted to the Trust Board are required to declare how they relate to CQC, NHSLA and the Board Assurance Framework (BAF). Maintaining CQC registration without conditions has been a corporate objective for 2011/12 and has been rolled forward to 2012/13. This is monitored on a monthly basis via the BAF.

4.4 How Risk Management is embedded in the activity of the Trust

This section of the statement describes ways in which equality impact assessments are integrated into core trust business and how incident reporting is openly encouraged and handled across the Trust.

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

In line with Equality Legislation, all public organisations are required to publish information to demonstrate compliance with the General Public Sector Equality Duty under the Equality Act 2010 (which came into force in April 2011). All public bodies are required to eliminate discrimination, advance equality of opportunity and foster good relations between different groups. Equality Objectives must be published by April 2012.

Progress is monitored by the Trust's Equality and Diversity Steering Group and Human Resources Committee on a quarterly basis and reflected within the Trust's Equality and Diversity Annual Employment and Service Monitoring Reports.

All new and existing policies and services are Equality Impact Assessed**.** Equality Impact Assessments are an integral part of strategy and policy development. All Trust policies include an Equality Impact Assessment which is scrutinised by the relevant and ratifying committees before publication.

The Trust's Equality and Diversity Service and Employment Leads link in with all Divisional Managers and their teams to ensure all managers are aware of their duty to ensure equality impact assessments are undertaken and embedded in all that they do. Any factors which are identified during assessment are raised as an agenda item at Divisional Service Improvement Team meetings.

Risk management is embedded in the activity of the organisation through induction training, regular risk management training and ad hoc training when need is identified. An untoward incident reporting system, (Datix web), was launched across the organisation in April 2010 on which concerns, near misses and incidents are reported by staff and stored on a database for analysis. Root cause analysis is undertaken and identified changes in practice are implemented as a result.

Risk management is embedded within the Trust through key committees, identified in the corporate governance structure, and consists of clinical and non clinical committees which report to the Governance and Risk Committee (G&R) and the Risk and Environmental Management Committee (REMC) and the Quality Improvement Committee (QIC).

The Risk and Environmental Management Committee receives and discusses all key Divisional risks and where appropriate escalates issues to the Governance and Risk Committee. The Trust has processes in place to assess itself against the CQC Quality Risk Profiles that will continue to be reported to the Quality Executive Committee in 2012/13.

The Governance and Risk Committee reported to the Audit Committee and also directly to the Board. Changes to governance structures in 2012/13 are described in sections 3 and 6.1 of this statement.

4.5 How Public Stakeholders are involved in Managing Risks

Public stakeholders, including NHS Ashton, Leigh and Wigan, Wigan Clinical Commissioning Group, Wigan Council Adult Health and Wellbeing Scrutiny Committee, Wigan Local Safeguarding Children & Adults Board and Wigan Local Involvement Networks (LINk) are consulted on service developments and changes. There is lay representation on a wide range of key committees in the Trust, including representation from the Foundation Trust Council of Governor members on the Quality Improvement Committee, Engagement Committee, Patient Experience Task Force, Clinical Audit Committee and Patient Environment Action Team (PEAT) visits.

The Trust recognises that risk management is a two way process between healthcare providers across the health economy. Issues raised through the Trust's risk management processes that impact on partner organisations e.g. NHS Ashton, Leigh & Wigan would be discussed in the appropriate forum, so that action can be agreed.

An established communications framework is in place in the form of a Major Incident plan and cross community emergency planning and business continuity arrangements are in place.

4.6 Information Governance, Data Security - Identifying and Maintaining Risk

The Information Governance Committee monitors the information governance work programme which is chaired by the Medical Director, who is the Caldicott Guardian. The Director of Finance is the nominated Board lead for information risk and the Senior Information Risk

Owner (SIRO) for the Trust and attends the Information Governance Committee. The nominated Information Asset Owners for information systems / assets have overall responsibility for identifying information risks. The Information Asset Administrators undertake operational activities to ensure risks are mitigated.

The Trust achieved 82% compliance with the Information Governance Toolkit Version 9 for 2011/12 submitted on the 31 March 2012. This is the best overall percentage score the Trust has ever achieved. However, the Trust achieved a non-satisfactory status as a result of not all 45 Information Governance Toolkit requirements meeting the minimum level 2 status which is stipulated for all requirements this year. Two requirements out of 45 remain below level 2:

- IG Toolkit requirement 324 relates to psuedonymisation and a project team has been set up to review the data flows captured by the data flow mapping exercise (Requirement 308) to see if they are eligible for pseudonymisation. The technical solution has been developed and these reports have been built into the data warehouse environment and testing will commence during Quarter 1 of 2012/13.

- IG Toolkit requirement 402 was not achieved due to the lack of documented evidence for the capture of information at ward level. Actions in place to address this are that the Data Quality Policy has been updated and will be approved by the Data Quality Committee. The Transfer policy is to be reviewed by senior managers and will include reference and responsibilities for data capture. The Discharge policy has been updated and IT Training manuals have been amended to include the collecting information from patients key point

For the year ending 2011/12, the Trust had 28 reported information governance and / or security related incidents recorded. These were classified as per the Information Governance (IG) incident reporting scoring criteria from 0-2. Only incidents classified as a severity rating of 3-5 need to be reported as a serious untoward incident (SUI) and reported to Monitor and the Information Commissioners Office (ICO). The Trust did not have any IG SUI's in this financial year.

Table 1 provides a summary of the information incidents classified with a risk score of 0-2.

1st April 2011 – 31st March 2012

Category	Nature of Incident	Total
1	Loss of inadequately protected electronic devices or paper documents from secured NHS premises	1
2	Loss of inadequately protected electronic devices or paper documents from outside secured NHS premises	0
3	Insecure disposal or inadequately protected electronic equipment, devices or paper documents	0
4	Unauthorised disclosure	24
5	Other	3
	TOTAL	28

4.7 Compliance

The Care Quality Commission (CQC) visited the Trust on Monday 27 June 2011, their visit and subsequent report explained that whilst the Trust was compliant with the following key CQC outcomes: '4: care and welfare of people who use services', '11: Safety, availability and suitability of equipment', '13: Staffing', '16: Assessing and monitoring the quality of service provision', '17 Complaints', '21: Records', the CQC issued some improvement notice recommendations for Outcomes 13 and 21. An action plan was put in place to address these

improvements. Progress against the action plan was monitored by the Risk and Environmental Management Committee (REMC).

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

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

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

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

5. REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

The Trust has robust arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include ensuring the financial plan is affordable, ensuring delivery of cost improvement requirements and service transformation, compliance with the terms of authorisation and the co-ordination of individual objectives with corporate objectives as approved by the Board of Directors.

Performances against objectives are monitored and actions identified through a number of channels:

- Approval of annual budgets by the Board of Directors
- Monthly reporting to the Board on key performance indicators, covering quality and safety, finance, activity and human resources targets
- The Divisions play an active part in the ongoing review of financial performance including service transformation requirements
- Quarterly reporting to Monitor and compliance with terms of authorisation
- Service transformation is covered at a dedicated monthly Service Transformation Management Board to ensure clinical engagement and full visibility
- The Trust also participates in initiatives to ensure value for money for example:
    - Value for money is an important component of the internal and external audit plans that provides assurance to the Trust regarding processes that are in place to ensure effective use of resources
    - Ongoing benchmarking and tenders of operations occur throughout the year to ensure competitiveness of service
    - In year cost pressures are rigorously reviewed and challenged, and alternatives for avoiding cost pressures are always considered

- The Trust subscribes to a national benchmarking organisation (Dr Foster) that provides comparative information analysis on patient activity and clinical indicators. This is used for the risk management process and to identify where improvements can be made

- The Trust utilises a WWL productivity tool that allows it to review performance against national indicators to drive efficiency

- Service Line Reporting / Service Line Management Board meet monthly led by the Clinical Director to review service line profitability

- CQUIN are negotiated and signed off by Clinical, Operational and Finance Executive directors and operational leads are assigned for each scheme

- The Trust has a standard assessment process for future business plans to ensure value for money and to ensure that full appraisal processes are employed when considering the effect on the organisation. Procedures are in place to ensure all strategic decisions are considered at Board level

6. ANNUAL QUALITY REPORT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 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.

6.1 Governance & leadership

The mission of the Trust is to provide the best quality health care for all patients that we serve. Our vision is to be in the top 10% for all that we do. The Trust has reviewed its objectives and re-emphasised its commitment to the Quality and Safety Agenda. We are committed to improving quality and safety by adopting a 'Zero Tolerance to Harm Culture'. These values are incorporated within the Trust Mission, Vision and Strategy. During 2011/12 the WWL Wheel was launched. This is a simple visual representation of what we are trying to achieve. It places patients right at the heart and surrounds them with a commitment to quality, defined as "safe, effective and caring". The wheel sits firmly on a foundation of the NHS Values and has seven 'pods', representing the Trust's seven strategic priorities. In 2012/13 the new Quality Executive Committee will replace the Quality Improvement Committee and will oversee the delivery of the 11 key quality enablers detailed within the Trust Quality Account. The new Quality and Safety Committee is a sub-committee of the Trust Board that will provide scrutiny to the delivery of our strategic quality aims.

6.2 Policies

In January 2011 the Trust Board approved its quality strategy which was launched across the Trust in February 2011. This document sets out a quality strategy based around key themes of "safe, effective and caring." Following a further review the new Quality Executive Committee has been established from April 2012.

The Trust recognises that all the decisions, whether clinical, managerial or financial; need to be based on information which is of the highest quality. The Trust had a data quality policy that draws together all strands of data quality into an over-arching and reinforcing policy. This aims to support efficient delivery of patient care by making sure administrative and clinical processes are never compromised through lack of data, thus minimising clinical risk. A Data Quality

Committee has been established to monitor data quality standards, which is attended by a Non- Executive Director representative.

6.3 Systems and processes

Clinical quality improvements are monitored at the Clinical Advisory Board and through the Quality Improvement Committee. Escalation arrangements include referral to Governance and Risk Committee and from there to Trust Board. The Clinical Audit committee have an annual clinical audit cycle. Clinical Audit performance is also monitored by the Audit Committee.

Complaints and Serious Untoward Incidents are monitored weekly, with all serious complaints being red rag rated and discussed weekly by the Director of Nursing and Medical Director. Monthly monitoring was conducted on all serious complaints and SUIs at the Quality Improvement Committee. A quarterly report is received by the Trust Board. This information is also reported within the quarterly Monitor returns, signed off by the Board. Moving forward in 2012/13 the new Quality Executive committee will continue monthly monitoring.

Each Division has produced a quality account, reporting on progress against the three domains of patient safety, clinical effectiveness and patient experience. The new Quality and Safety Committee will meet monthly, chaired by the Senior Independent Director and will have the responsibility of scrutinising quality and safety on behalf of the Trust Board.

6.4 People and Skills

Senior Clinicians and members of the Executive have attended a variety of quality events and the Trust is affiliated to the North West Advancing Quality Alliance (AQuA). The Trust is also a member of NHS Quest, a membership organisation of Trust's with excellent quality performance to share good practice and drive standards ever higher through a series of collaborative programmes.

In 2012/13 a new Quality Faculty has been established which includes Quality and Safety Matrons, IHI attendees, Leading Improvement in Patient Safety (LIPS) trained staff and the champions for the 11 quality enabler areas. Each Division will have someone responsible to check on compliance and report this back to the Quality Executive.

The Trust holds an annual award ceremony, entitled "Recognising Excellence Awards", at which it recognises and celebrates individual staff and team achievements during the year. In 2011/12 the awards were aligned to the WWL wheel covering the categories of safe, effective, caring, innovation and supporting staff and colleagues. There were also awards for employee of the year and the overall Foundation Trust Award chosen from the winner of the top five categories, recognising the most outstanding positive impact on the delivery of high quality healthcare in the Trust.

6.5 Data Use and reporting

All Trust staff have responsibility to record accurate data which is reflected in the Data Quality Policy. Key staff in the organisation have designated roles to ensure procedures and guidelines are in place to accurately capture information in real time. The Trust's Data Quality Committee has responsibility to ensure procedures and guidelines are being followed, that data is accurate and validated by the Divisions and audits are carried out as approved by the Audit Committee and through the Data Quality Audit Team. As part of its work plan the Audit Committee receives presentations on the quality account dashboards from each Division.

6.6 Financial Position/Risks

The Trust delivered a trading surplus of £2.9m in year, including the transfer of agreed elements of community services from Bridgewater Community Healthcare NHS Trust in October 2011. This fell short of plan by £1.1m driven by a shortfall in achieving expenditure reduction plans.

Based on the trading surplus of £2.9m (subject to final audit) the Trust achieved a Monitor Financial Risk Rating (FRR) of 4, (excluding re-organisational exceptional expenditure), but including the accounting policy adjustment for recognising incomplete patient spells in 2011/12, which is in line with the planned FRR of 4 as submitted to Monitor in the Trust's three year plan.

In considering significant risks the Trust reached a full and final settlement with NHS Ashton Leigh and Wigan PCT in respect of 2011/12. Looking forward to 2012/13, the income contract was signed on 14 March 2012 on what is believed to be an equitable basis for all parties.

The key outstanding risks remain in delivering the required Service Transformation Programme, minimising increasingly stringent contract condition challenges and maximising increased Commissioning for Quality and Innovation (CQUIN) payment framework income available, whilst maintaining safety and improving quality in line with the Trust's corporate objectives and vision.

7. 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 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, the Audit Committee, Governance and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. My review has been informed by:

- The Board Assurance Framework itself provides me with evidence of the effectiveness of controls that manages the risks to the organisation

- The Board of Directors, Audit Committee, Governance and Risk Committee and the Risk and Environmental Management Committee advise me on the implications of the results of my review of the effectiveness of the system of internal control. These committees also advise outside agencies and myself on serious untoward events

- All the relevant committees within the corporate governance structure have a clear timetable of meetings and a clear reporting structure to allow issues to be raised

- A plan to address weaknesses and ensure continuous improvement of the system is in place

- During the quarter four reporting period a serious untoward incident was StEISd relating to discovery of delays in follow up appointments for patients with wet AMD who had not been seen within NICE recommended periods for treatment. An action plan was put in place to address this gap and the back log of patients has been removed

- The Trust Board also monitors and reviews the effectiveness of the Board Assurance Framework on a monthly basis

- The Governance and Risk Committee managed and reviewed the Board Assurance Framework, which is agreed in conjunction with Executive Directors. Responsibility for reviewing risks was devolved to the Finance and Investment committee, REMC, Service and Site Investment committee, HR committee, IT Strategy committee, Management Board, HSMR Task Force, Patient Experience Task Force and Trust Board prior to final score by the Executive Meeting Point. The minutes of the Governance & Risk Committee are presented to the Board of Directors

- The Risk and Environmental Management Committee produces a Risk Management Report which is presented to the Governance and Risk Committee and the Audit Committee followed by the Board of Directors to provide assurance on control

- The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non clinical) that supports the achievement of the organisation's objectives. The Audit Committee reviews the Board Assurance Framework on an exceptional basis

- The Audit Committee reviews the Trust's performance against Monitor's Foundation Trust Code of Governance (2010). The Trust was deemed compliant with all provisions set out at Schedule A of the Code, reported in detail within the Trust's Annual Report

- Internal Audit reviews the Board Assurance Framework and the effectiveness of the system of internal control as part of the internal audit work to assist in the review of effectiveness. Internal Audit provided an overall significant assurance opinion on the Assurance Framework.

- During the year Internal Audit conducted various audits in line with the agreed audit plan. For the period 11/12 most reports obtained a significant assurance opinion. There were six reports that provided overall limited assurance opinion. The Trust has taken the recommended actions to increase assurance. These are being monitored by the Audit Committee

- The Head of Internal Audit Opinion for 2011/12 is that significant assurance can be given that there is a generally sound system of internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.

- The Trust invested in a joint decontamination unit (K61) which is responsible for the decontamination of the vast majority of equipment. This service has met a series of challenges during the year and an action plan to address areas for improvement has been implemented and monitored via the Governance and Risk committee

- My review also takes account of comments made by external auditors and other external review bodies in their reports, for example, in March 2012 the Trust received an unannounced visit from the CQC in relation to carrying out unannounced inspections in abortion clinics across England to check they are abiding by the law. WWL's Termination of Pregnancy clinic at Leigh received an unannounced visit by the CQC when 20 sets of notes were selected at random and all were found to be satisfactory

8. CONCLUSION

With the exception of the internal control issues relating to the decontamination unit and the delays in the AMD service that I have outlined in this statement, my review confirms that Wrightington, Wigan and Leigh NHS Foundation Trust has generally sound systems of internal control that supports the achievement of its policies, aims and objectives and that where a gap in control has been identified, that those control issues have been or are being addressed.

Signed: 

Andrew Foster
Chief Executive

Date: 30/05/12

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

We have audited the financial statements of Wrightington, Wigan and Leigh NHS Foundation Trust for the year ended 31 March 2012 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes 1 to 29. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Wrightington, Wigan and Leigh NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards 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 Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us 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 Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate
We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Paul Thomson (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Leeds, UK
30 May 2012

Foreword to the accounts
For the year ended 31 March 2012

These accounts for the year ended 31 March 2012 have been prepared by Wrightington, Wigan and Leigh NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Services Act 2006.

Signed:  Andrew Foster, Chief Executive

Dated: 30th May 2012

WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

Statement of Comprehensive Income
For the year ended 31 March 2012

	Note	Year ended 31-Mar-12 £'000	As Restated Year ended 31-Mar-11 £'000
Operating Income from continuing operations	**2**	246,600	230,939
Operating Expenses from continuing operations	**3**	(238,969)	(222,132)
OPERATING SURPLUS		**7,631**	**8,807**
FINANCE COSTS			
Finance income	**6**	224	201
Finance expense - financial liabilities	**7**	(17)	(11)
Finance expense - unwinding of discount on provisions	**18**	(26)	(21)
PDC Dividends payable		(4,908)	(4,814)
NET FINANCE COSTS		**(4,727)**	**(4,645)**
Surplus from continuing operations		**2,904**	**4,162**
SURPLUS FOR THE PERIOD		**2,904**	**4,162**
Other comprehensive income			
Other reserves movements		0	1
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE PERIOD		**2,904**	**4,163**
Prior period adjustments		0	358
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**2,904**	**4,521**

All income and expenditure is derived from continuing operations.

Notes 1 to 29 form part of these accounts.
Note 29 explains the alignment project restatement of prior year accounts for the year ended 31 March 2011

WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

Statement of Financial Position
As at 31 March 2012

	Note	31-Mar-12 £'000	As Restated 31-Mar-11 £'000	As Restated 01-Apr-10 £'000
Non-current assets				
Intangible assets	**8**	5,530	4,797	4,104
Property, plant and equipment	**9**	148,682	144,390	140,235
Trade and other receivables	**12**	226	267	163
Total non-current assets		**154,438**	**149,454**	**144,502**
Current assets				
Inventories	**11**	3,408	3,298	3,769
Trade and other receivables	**12**	8,254	7,899	8,574
Non-current assets for sale and assets in disposal groups	**10**	195	307	648
Cash and cash equivalents		18,161	17,260	16,716
Total current assets		**30,018**	**28,764**	**29,707**
Current liabilities				
Trade and other payables	**13**	(20,167)	(18,281)	(17,875)
Borrowings	**14**	(8)	(15)	(15)
Provisions	**18**	(1,600)	(286)	(800)
Other liabilities	**13**	(233)	(165)	(160)
Total current liabilities		**(22,008)**	**(18,747)**	**(18,850)**
Total assets less current liabilities		**162,448**	**159,471**	**155,359**
Non-current liabilities				
Borrowings	**14**	(15)	(22)	(35)
Provisions	**18**	(919)	(839)	(877)
Total non-current liabilities		**(934)**	**(861)**	**(912)**
Total assets employed		**161,514**	**158,610**	**154,447**
Financed by (taxpayers' equity)				
Public dividend capital		94,083	94,083	94,083
Revaluation reserve		34,920	35,553	36,246
Income and expenditure reserve		32,511	28,974	24,118
Total taxpayers' equity		**161,514**	**158,610**	**154,447**

In circumstances where a prior period adjustment is actioned IFRS suggests a third Statement of Financial Position column to show the pre and post adjustment. Note 29 identifies the prior period adjustments and notes 1 to 29 have been restated where the prior period adjustment has been in effect.

The financial statements on pages (17 to 59) were approved by the board on 30 May 2012 and signed on its behalf by:

Signed: ..... Andrew Foster, Chief Executive

Dated: 30th May 2012

WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2012

	Public Dividend Capital £'000	Revaluation Reserve £'000	Donated Asset Reserve £'000	Income & Expenditure Reserve £'000	TOTAL £'000
Taxpayers' Equity at 1 April 2011 - as restated	94,083	35,553	0	28,974	**158,610**
Prior period adjustment	0	0	0	0	**0**
Taxpayers' Equity at 1 April 2011 - as restated	**94,083**	**35,553**	**0**	**28,974**	**158,610**
Surplus for the year	0	0	0	2,904	**2,904**
Asset disposals	0	(217)	0	217	**0**
Other reserves movements	0	(416)	0	416	**0**
Taxpayers' Equity at 31 March 2012	**94,083**	**34,920**	**0**	**32,511**	**161,514**

Taxpayers' Equity at 1 April 2010 - as previously stated	94,083	36,419	1,627	21,960	**154,089**
Prior period adjustment	0	(173)	(1,627)	2,158	**358**
Taxpayers' Equity at 1 April 2010 - as restated	**94,083**	**36,246**	**0**	**24,118**	**154,447**
Surplus/(Deficit) for the year as restated	0	0	0	4,162	**4,162**
Asset disposals	0	(242)	0	242	**0**
Other reserves movements	0	(451)	0	452	**1**
Taxpayers' Equity at 31 March 2011 - as restated	**94,083**	**35,553**	**0**	**28,974**	**158,610**

Note 29 explains the alignment project restatement of prior year accounts for the year ended 31 March 2011

WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

Statement of Cash Flows
For the year ended 31 March 2012

	Year ended 31-Mar-12 £'000	As Restated Year ended 31-Mar-11 £'000
Cash flows from operating activities		
Operating surplus from continuing operations	7,631	8,807
Operating surplus	**7,631**	**8,807**
Non-cash income and expense		
Depreciation and amortisation	7,957	7,317
Impairments	0	59
Decrease/(Increase) in Trade and Other Receivables	(314)	573
Decrease/(Increase) in Other Assets	41	(97)
Decrease/(Increase) in Inventories	(110)	471
(Decrease)/Increase in Trade and Other Payables	1,886	(544)
(Decrease)/Increase in Other Liabilities	68	6
(Decrease)/Increase in Provisions	1,394	(509)
Other movements in operating cash flows	(229)	(261)
NET CASH GENERATED FROM OPERATIONS	**18,324**	**15,822**
Cash flows from investing activities		
Interest received	228	203
Purchase of Intangible Assets	(2,396)	(1,656)
Purchase of Property, Plant and Equipment	(10,555)	(9,454)
Sales of Property, Plant and Equipment	365	484
Net cash used in investing activities	**(12,358)**	**(10,423)**
Cash flows from financing activities		
Capital element of finance lease rental payments	(14)	(13)
Interest element of finance lease	(17)	(11)
PDC Dividend paid	(5,034)	(4,831)
Net cash used in financing activities	**(5,065)**	**(4,855)**
Increase/(Decrease) in cash and cash equivalents	**901**	**544**
Cash and Cash equivalents at 1 April	**17,260**	**16,716**
Cash and Cash equivalents at 31 March	**18,161**	**17,260**

Note 29 explains the alignment project restatement of prior year accounts for the year ended 31 March 2011.

Notes to the Statement of Cash Flows
For the year ended 31 March 2012

Cash Flow Note 1: Cash and cash equivalents

	31-Mar-12 £'000	31-Mar-11 £'000
Brought forward at 1 April	**17,260**	**16,716**
Net change in year	901	544
Carried forward at 31 March	**18,161**	**17,260**
Broken down into:		
Cash at commercial banks and in hand	32	30
Cash with the Government Banking Service	18,129	17,230
Cash and cash equivalents as in SoFP	**18,161**	**17,260**

Cash Flow Note 2: Reconciliation of net cash flow to movement in net funds

	31-Mar-12 £'000	31-Mar-11 £'000
Increase/(Decrease) in cash and cash equivalents in the year	901	544
Cash outflow from debt repaid and finance lease capital repayments	(14)	(13)
Change in net funds resulting from cash flows	**887**	**531**
Non-cash changes in debt (new finance leases / HP contracts)	14	13
Change in net funds	**901**	**544**
Net funds brought forward at 1 April	**17,260**	**16,716**
Net funds carried forward at 31 March	**18,161**	**17,260**

Notes to the accounts
For the year ended 31 March 2012

Note 1: Accounting Policies

Basis of preparation

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 HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2011/12 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.

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 have been prepared in accordance with International Financial Reporting Standards (IFRSs) and International Financial Reporting Interpretation Committee (IFRIC) interpretations as endorsed by the European Union, and those parts of the Companies Act 2006 applicable to companies reporting under IFRSs.

The financial statements are presented in Pounds Sterling, rounded to the nearest thousand. They are prepared on the historical cost basis modified for the revaluation of certain financial instruments.

Accounting judgments and key sources of estimation and uncertainty accounting policy

In the application of the Trust's accounting policies management is required to make judgments estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources.

The estimates and associated assumptions are based on historical experience and other factors 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.

The following are the areas that critical judgments have been made in the process of applying accounting policies at the end of the reporting period that have a risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

- Going Concern
- Asset valuation and lives
- Impairments of receivables
- Provisions
- Accruals

The critical judgements are addressed in the accounting policies that follow.

Going concern

After making enquiries, the directors have a reasonable expectation that the Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing these financial statements.

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.

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, including partially completed spells, 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.

Partially Completed Spells

The Trust recognises income for incomplete patient spells. Patients' admitted before 31st March but not discharged at midnight 31st March are accounted for as the average length of stay for the admitting speciality minus the patient's length of stay at midnight 31st March.

Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

The cost of annual leave entitlement earned but not taken by employees at the end of the period is

recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions

The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

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

Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Current / non-current classification
Assets and liabilities are classified as current if they are expected to be realised within twelve months from the Statement of Financial Position date, the primary purpose of the asset and liability is to be traded, or for loans and receivables 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.

Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- It is expected to be used for more than one financial year; and
- The cost of the item can be measured reliably.

Property, plant and equipment assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- Individually have a cost of at least £5,000; or
- Collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are and its under single managerial control; or
- Form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

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
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.

Valuations of property and land are carried out as mandated by a qualified valuer DTZ Debenham Tie Leung who are members of the Royal Institute of Chartered Surveyors and in accordance with the appropriate sections of the Practice Statement ("PS") and United Kingdom Practice Statements contained within the RICS Valuation Standards, 6th Edition. The valuations are carried out as follows:

- Interim every 3 years
- Full valuation every 5 years

A full valuation was conducted during the year ending 31st March 2010. In addition to the valuation programme reviews, where management conclude that the book value no longer reflects fair value a separate independent valuation will be commissioned.

All assets are measured subsequently at fair value:

- Specialised buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and any subsequent accumulated impairment losses. Revaluations are 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.
- Fair values are determined by using a (depreciated replacement cost) Modern Equivalent Asset approach.
- Land and non specialised buildings – market value for existing use.

The carrying value of existing assets (fixtures and fittings) at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

Subsequent Expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by a qualified valuer recognised in accordance with RICS. Leaseholds are depreciated over the primary lease term.
Useful economic life of property, plant and equipment is depreciated over the following:

- Buildings excluding dwellings 3 to 79 years
- Dwellings 33 to 60 years

Equipment is depreciated on current cost evenly over the estimated life of the asset as follows:

- Engineering plant and equipment 5 to 15 years
- Vehicles 5 to 7 years
- Furniture 1 to 10 years
- Office and IT equipment up to 5 years
- Soft furnishings up to 7 years
- Medical and other equipment 5 to 15 years
- Mainframe-type IT installations up to 5 years

Where the useful economic life of an asset is reduced from that initially estimated due to the revaluation of an asset for sale, depreciation is charged to bring the value of the asset to its value at the point of sale.

Revaluation gains and losses
At each reporting period end, the trust checks whether there is any indication that any of its PPE 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.

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

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

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

Impairments
In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:

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

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that give rise to the loss is 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 in the course of construction
Assets in the course of construction are measured at cost of construction as at the 31 March 2012. Assets are reclassified to the appropriate category when they are brought into use.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales; and
- The sale must be highly probable, i.e.:
    1. Management are committed to a plan to sell the asset;
    2. An active programme has begun to find a buyer and complete the sale;
    3. The asset is being actively marketed at a reasonable price;
    4. The sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
    5. The actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

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

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

Intangible Assets

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

Impairments
Assets that are subject to amortisation are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. Any impairment loss is recognised in the Statement of Comprehensive Income to reduce the carrying amount to the recoverable amount.

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- The Foundation Trust intends to complete the asset and sell or use it;
- The Foundation Trust has the ability to sell or use the asset;
- How the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- Adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset; and
- The Foundation Trust can measure reliably the expenses attributable to the asset during development.

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

Measurement
Intangible assets are recognised initially at cost, comprising of all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.
Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

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

Development expenditure	up to 5 years
Software	up to 5 years

Government Grants
Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services.

Where a grant is used to fund revenue or capital expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. The exception to this is where specific grant conditions apply regarding the recognition of income.

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.

Trade receivables
Trade receivables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method, less provision for impairment. A provision for impairment of trade receivables is estimated when there is objective evidence that the Foundation Trust will not be able to collect all amounts due.

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 say, from date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Bank overdrafts are shown as borrowings in current liabilities; however, they would be included in cash and cash equivalents for the purpose of cash flow statement.

Trade payables
Trade payables are recognised initially at fair value and subsequently measured at amortised at amortised cost using the effective interest method.

Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

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

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.

Notes to the accounts
For the year ended 31 March 2012

Classification and Measurement
Financial assets are categorised as loans and receivables or available for sale financial assets.

Financial liabilities are classified as 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 current assets.

The trust's loans and receivables comprise; cash and cash equivalents, NHS debtors, accrued income and other debtors.

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.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Foundation Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains and losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'finance costs' in the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

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

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

Impairments of receivables
A provision for the impairment of receivables has been made for specific amounts where there is reasonable uncertainty of obtaining settlement from organisations at 31st March 2012.

Leases

The trust as lessee

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

The asset and liability are recognised at the 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 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.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

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

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

Provisions
The NHS Foundation 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 rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% in real terms. (2010/11 2.9%)

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 18 but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS Foundation 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 expenses when the liability arises.

Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 21 where an inflow of economic benefits is probable. Contingent liabilities are not recognised, but are disclosed in note 21, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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

A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) net cash balances held with the Government Banking Service (GBS), 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 to net assets occur as a result of the audit of the annual accounts.

Value Added Tax
Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Corporation Tax
The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988).

None of the Trust's activities in the period are subject to a corporation tax liability.

Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in note 23 in accordance with the requirements of HM Treasury's FReM.

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 NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, note 24 is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

Segmental Analysis
In line with IFRS 8 on Operating Segments, the Board of Directors, as Chief Decision Maker, have assessed that the Trust continues to report its Annual Accounts on the basis that it operates in the healthcare segment only. The accompanying financial statements have consequently been prepared under one single operating segment.

Joint Operations Accounting
Joint operations are activities that are carried out, which are carried out with one or more other parties, but which are not performed through a separate entity. The Trust has a joint operation with Salford Royal NHS Foundation Trust for decontamination and sterilisation services, for which the Trust includes within its financial statements, its share of the financial activities, income, expenditure, assets and liabilities.

Note 2.1: OPERATING INCOME (by classification)

	Year end 31-Mar-12 £'000	Inter-NHS Foundation Trusts £'000	Restated Year end 31-Mar-11 £'000	Inter-NHS Foundation Trusts £'000
Income from Activities				
Elective income	59,558	0	59,570	0
Non elective income	59,637	25	60,395	0
Outpatient income	45,884	0	43,366	0
A & E income	7,763	0	7,943	0
Other NHS clinical income	45,338	0	41,000	0
Private patient income	2,334	0	2,396	0
Community Service income from PCT	1,910			
Other non-protected clinical income	9,385	760	2,478	373
Total income from activities	**231,809**	**785**	**217,148**	**373**
Other operating income				
Research and development	322	132	86	54
Education and training	6,390	49	5,990	5
Charitable and other contributions to expenditure	302	0	320	0
Non-patient care services to other bodies	4,190	3,182	3,865	1,521
Other *	3,532	141	3,483	290
Gain on disposal of assets held for sale	55	0	47	0
Total other operating income	**14,791**	**3,504**	**13,791**	**1,870**
TOTAL OPERATING INCOME	**246,600**	**4,289**	**230,939**	**2,243**

* Significant items within the category of 'other' in other operating income include staff and patient car parking income of £1,139k, catering income of £565k, pharmacy income of £524k, staff accommodation rentals of £254k, and other income of £783k.
Note 29 explains the alignment project restatement of prior year accounts 31 March 2011.

Note 2.2: Private patient income

	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000	Base Year 2002/03 £'000
Private patient income	2,334	2,396	2,891
Total patient related income	231,809	217,148	140,399
Proportion (as percentage)	**1.0%**	**1.1%**	**2.1%**

Section 44 of the NHS Act 2006 requires that the proportion of private patient income to the total patient related income of the NHS Foundation Trust should not exceed its proportion whilst the body was an NHS Trust in 2002/03.

Note 2.3: OPERATING INCOME (by type)

	Year end 31-Mar-12 £'000	As Restated Year end 31-Mar-11 £'000
Income from Activities		
NHS Foundation Trusts	785	373
Primary Care Trusts	226,400	211,998
Local Authorities	68	276
NHS Other	211	57
Non NHS: Private patients	2,334	2,396
Non-NHS: Overseas patients (non-reciprocal)	8	10
NHS injury scheme (was RTA) *	1,232	1,349
Non NHS: Other	771	689
Total income from activities	**231,809**	**217,148**
Other operating income		
Research and development	322	86
Education and training	6,390	5,990
Charitable and other contributions to expenditure	302	320
Non-patient care services to other bodies	4,190	3,865
Other	3,532	3,483
Gain on disposal of assets held for sale	55	47
Total other operating income	**14,791**	**13,791**
TOTAL OPERATING INCOME	**246,600**	**230,939**

* NHS injury scheme income is subject to a provision for doubtful debts of 9.6% (2010/11: 9.6%) to reflect expected rates of collection.

A change in accounting policy to recognise income from partially complete patient spells benefits income in 2011/12 by £0.7m (which is 0.03% of total income).
Note 29 explains the alignment project restatement of prior year accounts 31 March 2011.

Note 2.4: Income from activities - mandatory and non-mandatory services

	Year end 31-Mar-12 £'000	Year end 31-Mar-11 £'000
Income from activities		
Mandatory services	229,806	215,110
Non-mandatory services	2,003	2,038
Total income from activities	**231,809**	**217,148**

Notes to the accounts
For the year ended 31 March 2012

Note 3.1: OPERATING EXPENSES (by type)

	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000
Services from NHS Foundation Trusts	2,254	1,423
Services from NHS Trusts	386	608
Services from PCTS	14	35
Services from other NHS Bodies	25	19
Purchase of healthcare from non NHS bodies	2,575	1,424
Employee Expenses - Executive directors	975	930
Employee Expenses - Non-executive directors	142	137
* Employee Expenses - Staff	162,219	153,567
Drug costs	14,524	13,368
Supplies and services - clinical (excluding drug costs)	22,990	21,516
Supplies and services - general	3,153	3,124
Establishment	2,720	2,312
Research and development	3	0
Transport	1,074	1,039
Premises	9,272	9,311
Increase in bad debt provision	942	285
Depreciation on property, plant and equipment	6,419	5,854
Amortisation on intangible assets	1,538	1,463
Impairments of property, plant and equipment	0	59
Audit fees:		
audit services - statutory audit	74	68
audit services - regulatory reporting	44	0
Clinical negligence	4,710	3,777
Loss on disposal of other property, plant and equipment	17	1
Legal fees	372	133
Consultancy costs	513	420
Training, courses and conferences	396	407
Patient travel	23	23
Redundancy	100	18
Hospitality	1	0
Insurance	349	345
Losses, ex gratia & special payments	262	143
Other*	883	323
TOTAL	**238,969**	**222,132**

* Employee costs in 2011/12 include £1.2m of exceptional costs outside of normal trading paid by the Trust in year to support fundamental restructure and reorganisation (which is 0.05% of total expenditure)

*'Other' in operating expenditure includes various balances that are not of a significant value and include such expenditure as childcare vouchers, as well as other expenditure for Transforming Community Services (TCS).

Note 3.2.1: Arrangements containing an operating lease

	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000
Minimum lease payments	871	903
TOTAL	**871**	**903**

Note 3.2.2: Arrangements containing an operating lease

	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000
Hire of plant and machinery	302	340
Other operating lease rentals	569	563
TOTAL	**871**	**903**

Note 3.2.3: Arrangements containing an operating lease

	Land & Buildings		Other Leases	
	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000
Future minimum lease payments due:				
- not later than one year;	556	526	860	646
- later than one year and not later than five years;	1,966	1,937	1,826	1,643
- later than five years.	3,117	3,117	0	0
TOTAL	**5,639**	**5,580**	**2,686**	**2,289**

The Trust leases various premises under non-cancellable operating leases, with lease terms between 5 and 15 years. The leases are at market rates. The Trust also leases various equipment under non-cancellable operating leases, with lease terms between 3 and 5 years.

Operating lease expenditure charged to the Income Statement during the year is disclosed in note 3.2.1.

Notes to the accounts
For the year ended 31 March 2012

Note 4.1: Directors aggregate remuneration

	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000
Executive Directors	774	742
Employer's contribution to pension	107	104
	881	**846**
Non Executive Directors *	130	125
TOTAL	**1,011**	**971**
The total number of directors accruing benefits under the NHS Pension Scheme	**8**	**9**

* Non Executive Directors are not members of the NHS pension scheme.

Note 4.2: Employee Expenses

	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000
Salaries and wages	130,459	123,742
Social security costs	9,773	9,412
Pension Costs - Employers contributions to NHS Pensions	14,234	13,835
Agency/contract staff	11,020	8,646
TOTAL	**165,486**	**155,635**

Staff costs capitalised in the year amounted to £2,192k (31 March 2011: £1,119k).

Note 4.3: Average number of employees - whole time equivalent (WTE) basis

	31-Mar-12 Number	31-Mar-11 Number
Medical and dental	426	415
Administration and estates	783	753
Healthcare assistants and other support staff	511	496
Nursing, midwifery and health visiting staff	1,527	1,463
Scientific, therapeutic and technical staff	494	472
Bank and agency staff	235	139
Other	121	125
TOTAL	**4,097**	**3,863**

Note 4.4: Exit packages

Exit package cost band	Number of Compulsory redundancies	Numbers of other departures agreed	Total number of exit packages by cost band
<£10,000	1	28	29
£10,001 - £25,000	0	34	34
£25,001 - 50,000	0	10	10
£50,001 - £100,000	1	0	1
Total number of exit packages by type	**2**	**72**	**74**

During 2011/12 the Trust's exit packages are in line with Agenda for Change contractual terms and conditions or Treasury approved Mutually Agree Severence Scheme

Note 4.5: Early retirements due to ill health

During the year ended 31 March 2012 there were 9 (31 March 2011: 15) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £165k (March 2011: £826k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 5: Better Payments Practice Code (BPPC)

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is the later.

The Trusts performance against the BPPC in the year was as follows:

	Year ended 31-Mar-12		Year ended 31-Mar-11	
	Number	£'000	Number	£'000
Non-NHS				
Trade invoices paid in the period	71,260	110,189	73,902	102,150
Trade invoices paid within target	64,556	104,630	69,075	97,552
Percentage of trade invoices paid within target	**90.6%**	**95.0%**	**93.5%**	**95.5%**
NHS				
Trade invoices paid in the period	2,558	23,437	2,536	24,954
Trade invoices paid within target	2,482	23,214	2,392	24,589
Percentage of trade invoices paid within target	**97.0%**	**99.0%**	**94.3%**	**98.5%**

Note 6: Finance income

	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000
Bank interest receivable	224	177
Other interest receivable	0	24
TOTAL	**224**	**201**

Note 7: Finance costs - interest expense

	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000
Finance leases	**17**	**11**

Note 8.1: Intangible assets 2011/12

	Software licences (purchased) £'000	Information Technology (internally generated) £'000	Intangible Assets Under Construction £'000	TOTAL £'000
Gross cost at 1 April 2011 as previously stated	**8,827**	**566**	**1,385**	**10,778**
Prior period adjustments				**0**
Gross cost at 1 April 2011	**8,827**	**566**	**1,385**	**10,778**
Reclassifications	460	210	(795)	**(125)**
Additions - purchased	330	(3)	2,069	**2,396**
Gross cost at 31 March 2012	**9,617**	**773**	**2,659**	**13,049**
Amortisation at 1 April 2011 as previously stated	**5,856**	**125**	**0**	**5,981**
Prior period adjustments	0	0	0	**0**
Amortisation at 1 April 2011	**5,856**	**125**	**0**	**5,981**
Provided during the year	1,417	121	0	**1,538**
Reclassifications	0	0	0	**0**
Amortisation at 31 March 2012	**7,273**	**246**	**0**	**7,519**
Net book value				
NBV - Purchased at 1 April 2011	2,971	441	1,385	**4,797**
NBV - Finance Lease at 1 April 2011	0	0	0	**0**
NBV - Donated at 1 April 2011	0	0	0	**0**
NBV total at 1 April 2011	**2,971**	**441**	**1,385**	**4,797**
Net book value				
NBV - Purchased at 31 March 2012	2,344	527	2,659	**5,530**
NBV - Finance Lease at 31 March 2012	0	0	0	**0**
NBV - Donated at 31 March 2012	0	0	0	**0**
NBV total at 31 March 2012	**2,344**	**527**	**2,659**	**5,530**

The reclassification of £125k is a transfer from property, plant and equipment to intangible assets following a detailed review of asset categorisation on capitalisation.

Note 8.2: Intangible assets 2010/11

	Software licences (purchased) £'000	Information Technology (internally generated) £'000	Intangible Assets Under Construction £'000	TOTAL £'000
Gross cost at 1 April 2010	**8,308**	**148**	**143**	**8,599**
Reclassifications	374	303	(143)	**534**
Additions - purchased	145	115	1,385	**1,645**
Gross cost at 31 March 2011	**8,827**	**566**	**1,385**	**10,778**
Amortisation at 1 April 2010	**4,478**	**17**	**0**	**4,495**
Provided during the year	1,378	85	0	**1,463**
Reclassifications	0	23	0	**23**
Amortisation at 31 March 2011	**5,856**	**125**	**0**	**5,981**
Net book value				
NBV - Purchased at 1 April 2010	3,830	131	143	**4,104**
NBV - Finance Lease at 1 April 2010	0	0	0	**0**
NBV - Donated at 1 April 2010	0	0	0	**0**
NBV total at 1 April 2010	**3,830**	**131**	**143**	**4,104**
Net book value				
NBV - Purchased at 31 March 2011	2,971	441	1,385	**4,797**
NBV - Finance Lease at 31 March 2011	0	0	0	**0**
NBV - Donated at 31 March 2011	0	0	0	**0**
NBV total at 31 March 2011	**2,971**	**441**	**1,385**	**4,797**

Note 8.3 NBV of Intangible assets in the revaluation reserve

	31-Mar-12	31-Mar-11
Carrying Value at 1 April	2	4
Movement in year	(2)	(2)
Carrying Value at 31 March	**0**	**2**

Notes to the accounts
For the year ended 31 March 2012

Note 9.1: Property, plant and equipment 2011/12

	Land £'000	Buildings £'000	Dwellings £'000	Assets Under Construction £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000	TOTAL £'000
Cost or valuation at 1 April 2011 as previously stated	**15,025**	**107,463**	**3,106**	**4,021**	**41,186**	**182**	**9,352**	**506**	**180,841**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Cost or valuation at 1 April 2011	**15,025**	**107,463**	**3,106**	**4,021**	**41,186**	**182**	**9,352**	**506**	**180,841**
Additions - purchased	0	4,206	0	4,697	707	20	910	15	**10,555**
Additions - donated	0	0	0	64	178	0	0	0	**242**
Reclassifications	0	1,646	0	(3,673)	1,493	25	880	(246)	**125**
Reclassed as held for sale	(57)	(74)	(75)	0	0	0	0	0	**(206)**
Disposals	0	0	0	0	(1,046)	0	0	(8)	**(1,054)**
Cost or valuation at 31 March 2012	**14,968**	**113,241**	**3,031**	**5,109**	**42,518**	**227**	**11,142**	**267**	**190,503**
Accumulated depreciation at 1 April 2011 as previously stated	**0**	**3,565**	**123**	**0**	**27,390**	**152**	**4,997**	**224**	**36,451**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Accumulated depreciation at 1 April 2011	**0**	**3,565**	**123**	**0**	**27,390**	**152**	**4,997**	**224**	**36,451**
Provided during the year	0	2,063	61	0	2,813	9	1,461	12	**6,419**
Impairments recognised in operating expenses	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	20	0	0	2	0	0	(22)	**0**
Reclassed as held for sale	0	(7)	(4)	0	0	0	0	0	**(11)**
Disposals	0	0	0	0	(1,030)	0	0	(8)	**(1,038)**
Accumulated depreciation at 31 March 2012	**0**	**5,641**	**180**	**0**	**29,175**	**161**	**6,458**	**206**	**41,821**
Net book value									
NBV - Owned at 1 April 2011	15,025	102,812	2,983	4,021	12,790	30	4,350	282	**142,293**
NBV - Finance lease at 1 April 2011	0	0	0	0	37	0	0	0	**37**
NBV - Government Granted at 31 March 2011	0	0	0	0	300	0	0	0	**300**
NBV - Donated at 1 April 2011	0	1,086	0	0	669	0	5	0	**1,760**
NBV total at 1 April 2011	**15,025**	**103,898**	**2,983**	**4,021**	**13,796**	**30**	**4,355**	**282**	**144,390**
Net book value									
NBV - Owned at 31 March 2012	14,968	106,541	2,851	5,099	12,310	66	4,682	61	**146,578**
NBV - Finance lease at 31 March 2012	0	0	0	0	26	0	0	0	**26**
NBV - Government Granted at 31 March 2012	0	0	0	0	225	0	0	0	**225**
NBV - Donated at 31 March 2012	0	1,059	0	10	782	0	2	0	**1,853**
NBV total at 31 March 2012	**14,968**	**107,600**	**2,851**	**5,109**	**13,343**	**66**	**4,684**	**61**	**148,682**

The reclassification of £125k is a transfer from intangible assets to property, plant and equipment following a detailed review of asset categorisation on capitalisation.

Note 9.2: Property, plant and equipment 2010/11

	Land £'000	Buildings £'000	Dwellings £'000	Assets Under Construction £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000	TOTAL £'000
Cost or valuation at 1 April 2010 as previously stated	**15,050**	**102,748**	**3,181**	**4,986**	**36,956**	**182**	**7,294**	**471**	**170,868**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Cost or valuation at 1 April 2010	**15,050**	**102,748**	**3,181**	**4,986**	**36,956**	**182**	**7,294**	**471**	**170,868**
Additions - purchased	0	3,865	0	2,992	3,425	0	104	29	**10,415**
Additions - donated	0	0	0	0	261	0	0	0	**261**
Impairments charged to revaluation reserve	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	850	0	(3,957)	613	0	1,954	6	**(534)**
Reclassed as held for sale	(25)	0	(75)	0	0	0	0	0	**(100)**
Disposals	0	0	0	0	(69)	0	0	0	**(69)**
Cost or valuation at 31 March 2011	**15,025**	**107,463**	**3,106**	**4,021**	**41,186**	**182**	**9,352**	**506**	**180,841**
Accumulated depreciation at 1 April 2010 as previously stated	**0**	**1,757**	**63**	**0**	**24,831**	**145**	**3,626**	**211**	**30,633**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Accumulated depreciation at 1 April 2010	**0**	**1,757**	**63**	**0**	**24,831**	**145**	**3,626**	**211**	**30,633**
Provided during the year	0	1,808	63	0	2,569	7	1,394	13	**5,854**
Impairments recognised in operating expenses	0	0	0	0	59	0	0	0	**59**
Reclassifications	0	0	0	0	0	0	(23)	0	**(23)**
Reclassed as held for sale	0	0	(3)	0	0	0	0	0	**(3)**
Disposals	0	0	0	0	(69)	0	0	0	**(69)**
Accumulated depreciation at 31 March 2011	**0**	**3,565**	**123**	**0**	**27,390**	**152**	**4,997**	**224**	**36,451**
Net book value									
NBV - Owned at 1 April 2010	15,050	99,880	3,118	4,986	11,568	37	3,660	260	**138,559**
NBV - Finance lease at 1 April 2010	0	0	0	0	49	0	0	0	**49**
NBV - Donated at 1 April 2010	0	1,111	0	0	508	0	8	0	**1,627**
NBV total at 1 April 2010	**15,050**	**100,991**	**3,118**	**4,986**	**12,125**	**37**	**3,668**	**260**	**140,235**
Net book value									
NBV - Owned at 31 March 2011	15,025	102,812	2,983	4,021	12,790	30	4,350	282	**142,293**
NBV - Finance lease at 31 March 2011	0	0	0	0	37	0	0	0	**37**
NBV - Government Granted at 31 March 2011	0	0	0	0	300	0	0	0	**300**
NBV - Donated at 31 March 2011	0	1,086	0	0	669	0	5	0	**1,760**
NBV total at 31 March 2011	**15,025**	**103,898**	**2,983**	**4,021**	**13,796**	**30**	**4,355**	**282**	**144,390**

The reclassification of £534k is a transfer from property, plant and equipment to intangible assets following a detailed review of asset categorisation on capitalisation.

Note 9.3: Analysis of property, plant and equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets Under Construction £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000	TOTAL £'000
Net book value									
NBV - Protected assets at 31 March 2012	0	59,322	0	0	0	0	0	0	**59,322**
NBV - Unprotected assets at 31 March 2012	14,968	48,278	2,851	5,109	13,343	66	4,684	61	**89,360**
Total at 31 March 2012	**14,968**	**107,600**	**2,851**	**5,109**	**13,343**	**66**	**4,684**	**61**	**148,682**
Net book value									
NBV - Protected assets at 31 March 2011	0	59,905	0	0	0	0	0	0	**59,905**
NBV - Unprotected assets at 31 March 2011	15,025	43,993	2,983	4,021	13,796	30	4,355	282	**84,485**
Total at 31 March 2011	**15,025**	**103,898**	**2,983**	**4,021**	**13,796**	**30**	**4,355**	**282**	**144,390**

Note 9.4: Assets held at open market value

	31-Mar-12 £'000	31-Mar-11 £'000
Freehold	**4,244**	**4,570**

Note 9.5: The net book value of land, buildings and dwellings at the balance sheet date comprised:

	31-Mar-12 £'000	31-Mar-11 £'000
Freehold	**125,419**	**121,906**

Note 9.6: Net book value of assets held under finance leases

	31-Mar-12 £'000	31-Mar-11 £'000
Plant & Machinery	26	37

Note 9.7: Depreciation charged to the income statement in respect of assets held under finance leases and hire purchase contracts

	31-Mar-12 £'000	31-Mar-11 £'000
Plant & Machinery	11	12

Note 9.8 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2012

	Land	Buildings £'000	Dwellings £'000	Assets Under Construction £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000	TOTAL £'000
Net book value									
As at 1 April 2010	15,050	66,566	3,118	0	5,682	9	0	2	**90,427**
Movement in the year	(25)	(1,185)	(135)	0	(1,452)	(3)	0	(1)	**(2,801)**
As at 31 March 2011	**15,025**	**65,381**	**2,983**	**0**	**4,230**	**6**	**0**	**1**	**87,626**
Net book value									
As at 1 April 2011	15,025	65,381	2,983	0	4,230	6	0	1	**87,626**
Movement in the year	(57)	(1,185)	(132)	0	(1,283)	(1)	0	0	**(2,658)**
As at 31 March 2012	**14,968**	**64,196**	**2,851**	**0**	**2,947**	**5**	**0**	**1**	**84,968**

Note 10: Non-current assets held for sale and assets in disposal groups

	Property, Plant & Equipment £'000
NBV of non-current assets for sale and assets in disposal groups at 31 March 2011	**307**
Plus assets classified as available for sale in the year	195
Less assets sold in year	(307)
NBV of non-current assets for sale and assets in disposal groups at 31 March 2012	**195**

Note 11.1: Inventories

	31-Mar-12 £'000	31-Mar-11 £'000
Materials & consumables	**3,408**	**3,298**

Note 11.2: Inventories recognised in expenses

	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000
Inventories recognised in expenses	25,221	25,724
Write-down of inventories recognised as an expense	8	73
TOTAL	**25,229**	**25,797**

Note 12.1: Trade and other receivables

	31-Mar-12 £'000	As Restated 31-Mar-11 £'000
Current		
NHS Receivables	4,802	4,361
Other receivables with related parties	179	237
Provision for impaired receivables	(1,093)	(329)
Prepayments	1,209	778
Accrued income	8	40
Interest receivable	3	6
PDC receivable	162	36
VAT receivable	63	357
Other receivables	2,921	2,413
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**8,254**	**7,899**
Non-Current		
Other receivables	226	267
TOTAL NON-CURRENT TRADE AND OTHER RECEIVABLES	**226**	**267**

All non-current receivables are due after one year.

The carrying amounts of trade and other receivables approximates to the fair value.
Note 29 explains the alignment project restatement of prior year accounts 31 March 2011.

Note 12.2.1: Provision for impairment of receivables

	31-Mar-12 £'000	As Restated 31-Mar-11 £'000
Brought forward at 1 April	**(329)**	**(314)**
Increase in provision	(1,017)	(412)
Amounts utilised	178	270
Unused amounts reversed	75	127
Carried forward at 31 March	**(1,093)**	**(329)**

Included in the above table is a provision of £177k against the NHS Injury Scheme, which is externally managed by the Compensation Recovery Unit and therefore has not been aged and is excluded from the analysis in note 12.2.2 below.
Note 29 explains the alignment project restatement of prior year accounts 31 March 2011.

Note 12.2.2: Analysis of impaired receivables

	31-Mar-12 £'000	As Restated 31-Mar-11 £'000
Ageing of impaired receivables		
0 to 30 days	603	0
31 to 60 days	43	8
61 to 90 days	29	0
91 to 180 days	9	2
181 to 360 days	409	319
Total	**1,093**	**329**
Ageing of non-impaired receivables past their due date		
0 to 30 days	2069	2691
31 to 60 days	0	122
61 to 90 days	142	524
91 to 180 days	329	142
181 to 360 days	63	147
Total	**2,603**	**3,626**

Trade receivables that are less than 6 months past due and not with a debt agency are not considered impaired.

Trust receivables from related parties are not considered impaired and therefore are included in non-impaired receivables past their due date.
Note 29 explains the alignment project restatement of prior year accounts 31 March 2011.

Note 13.1: Trade and other payables

	31-Mar-12 £'000	As Restated 31-Mar-11 £'000
Current		
Receipts in advance	469	445
NHS payables	1,999	1,196
NHS payables - Capital	0	341
Amounts due to other related parties	1,789	2,091
Trade payables - capital	1,053	2,938
Other trade payables	3,401	865
Taxes payable	2,931	3,080
Other payables	27	29
Accruals	8,498	7,296
TOTAL CURRENT TRADE AND OTHER PAYABLES	**20,167**	**18,281**

Note 29 explains the alignment project restatement of prior year accounts 31 March 2011.

Note 13.2: Other liabilities

	31-Mar-12 £'000	As Restated 31-Mar-11 £'000
Current		
Deferred Income	233	165
TOTAL OTHER CURRENT LIABILITIES	**233**	**165**

Note 29 explains the alignment project restatement of prior year accounts 31 March 2011.

Note 14: Borrowings

	31-Mar-12 £'000	31-Mar-11 £'000
Current		
Obligations under finance leases	8	15
TOTAL CURRENT BORROWINGS	**8**	**15**
Non-current		
Obligations under finance leases	15	22
TOTAL OTHER NON-CURRENT BORROWINGS	**15**	**22**

Note 15: Finance lease obligations

	Minimum Lease Payments		Present Value of Minimum Lease Payments	
	31-Mar-12 £'000	31-Mar-11 £'000	31-Mar-12 £'000	31-Mar-11 £'000
Gross liabilities due:				
- not later than one year;	11	20	11	20
- later than one year and not later than five years;	18	28	18	28
- later than five years.	0	0	0	0
Gross lease liabilities	**29**	**48**	**29**	**48**
Finance charges allocated to future periods	(6)	(11)	(6)	(11)
Net lease liabilities	**23**	**37**	**23**	**37**
of which liabilities are due:				
- not later than one year;	8	15	8	15
- later than one year and not later than five years;	15	22	15	22
- later than five years.	0	0	0	0
	23	**37**	**23**	**37**

Note 16: Prudential borrowing limit

The NHS Foundation Trust is required to comply with and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and can therefore impact upon the long term borrowing limit; and

- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The Trusts performance against the Prudential Borrowing Limit (PBL) in the year was:

	31-Mar-12 £'000	31-Mar-11 £'000
Total long term borrowing limit set by Monitor	45,800	41,600
Working capital facility agreed by Monitor	16,000	16,000
TOTAL PRUDENTIAL BORROWING LIMIT	**61,800**	**57,600**
Long term borrowing at 1 April	**37**	**50**
Net actual (repayment)/borrowing in year - long term	(14)	(13)
Long term borrowing at 31 March	**23**	**37**
Working capital borrowing at 1 April	**0**	**0**
Net actual borrowing/(repayment) in year - working capital	0	0
Working capital borrowing at 31 March	**0**	**0**

Financial ratio performance for the year ended 31 March 2012:

	Approved PBL ratios	Actual ratios
Maximum debt to capital ratio *	< 25%	0.01%
Minimum dividend cover	> 1x	3
Minimum interest cover	> 3x	912
Minimum debt service cover	> 2x	1,092
Maximum debt service to revenue	< 2.5%	0.01%

* The percentage approved depends on the Financial Risk Rating (FRR) achieved in the year. The percentage used above is that relating to a Foundation Trust with an FRR of 4.

Note 17: Financial Risk Rating (FRR)

Metric	Criteria	Actual	Rating	Weighting
EBITDA margin	Underlying Performance	6.7%	3	25%
EBITDA, % achieved	Achievement of Plan	97.0%	4	10%
Return on investment	Financial Efficiency	5.3%	4	20%
I&E surplus margin	Financial Efficiency	1.7%	3	20%
Liquid ratio (days)	Liquidity days	32.2	4	25%
Weighted Average			**3.6**	**100%**
Overall Financial Risk Rating			**4.0**	

Financial Risk Rating boundaries:

	Weighting	5	4	3	2	1
EBITDA margin	25%	11%	9%	5%	1%	< 1%
EBITDA, % achieved	10%	100%	85%	70%	50%	< 50%
Return on investment	20%	6%	5%	3%	-2%	< -2%
I&E surplus margin	20%	3%	2%	1%	-2%	< -2%
Liquid ratio (days)	25%	60	25	15	10	< 10
	100%					

The Financial Risk Rating (FRR) is a key component of Monitors Compliance Framework which provides details of financial metrics that reports the level of financial risk faced by the Trust.

The Compliance Framework identifies a range of risks from 1 (highest risk) to 5 (lowest risk).

The FRR calculation prescribed excludes £1.2m of exceptional reorganisational costs as a non trading expense but includes the accounting policy adjustment for recognising incomplete patient spells in 2011/12.

The Trust achieved an FRR of 4 in the year.

Note 18: Provisions for liabilities and charges

	Other Legal Claims 31-Mar-12 £'000	Other 31-Mar-12 £'000	TOTAL 31-Mar-12 £'000	Prior Year 31-Mar-11 £'000
Opening	**1,125**	**0**	**1,125**	**1,677**
Change in the discount rate	9	0	**9**	**(64)**
Arising during the year	446	1,323	**1,769**	**420**
Utilised during the year	(256)	0	**(256)**	**(250)**
Reversed unused	(154)	0	**(154)**	**(679)**
Unwinding of discount	26	0	**26**	**21**
Closing	**1,196**	**1,323**	**2,519**	**1,125**
Expected timing of cash flows:				
- not later than one year;	277	1,323	**1,600**	286
- later than one year and not later than five years;	240	0	**240**	214
- later than five years.	679	0	**679**	625
TOTAL	**1,196**	**1,323**	**2,519**	**1,125**

Legal provisions include £213k for employers and public liability claims (for which there is also a corresponding contingent liability of £115k declared in note 21), and £983k for the capitalised cost of permanent injury retirees.

The amount provided for employers / public claims are based on actuarial assessments received from the National Health Service Litigation Authority (NHSLA) as to their value and anticipated payment date.

£42,385,478 is included in the provisions of the NHSLA at 31 March 2012 in respect of clinical negligence liabilities of the Trust (31 March 2011: £43,375,297).

Other provisions include £176k for the recognition in respect to the Carbon Reduction Commitment scheme and £1,147k for the Pathology service restructure jointly agreed with Salford Royal NHS Foundation Trust.

Note 19: Capital commitments

At 31 March 2012 the Trust had capital commitments as follows:

	31-Mar-12 £'000	31-Mar-11 £'000
Contracted for but not provided in the financial statements	**3,384**	**1,774**

Note 20: Events after the reporting period

The Trust does not have any material events after the reporting period.

Note 21: Contingencies

	31-Mar-12 £'000	31-Mar-11 £'000
Contingent liabilities	**115**	**123**

The contingent liability relates to employers and public liability claims.

Note 22: Private finance transactions

The Trust does not have any PFI transactions.

Note 23: Third party assets

Third party assets held by the NHS Foundation Trust	31-Mar-12 £'000	31-Mar-11 £'000
Brought forward at 1 April	2	5
Gross inflows	33	29
Gross Outflows	(30)	(32)
Carried forward at 31 March	**5**	**2**

The Trust held £5,497 cash at 31 March 2012 (31 March 2011: £2,039) which relates to monies held by the NHS Foundation Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Note 24: Losses and special payments

During the year ended 31 March 2012 there were 168 cases of losses and special payments (31 March 2011: 233 cases) totalling £196,304 (31 March 2011: £180,498). No individual cases were greater than £100k.

Note 25.1: Related party transactions

Wrightington, Wigan and Leigh NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff have undertaken any material transactions with Wrightington, Wigan and Leigh NHS Foundation Trust.

Members of the Trust Board, Governors of the Trust and senior staff hold positions with the following bodies which during 2011/12 the Trust has had a significant number of material transactions and or hold debtor and creditor balances with them at 31 March 2012:

NHS Ashton, Leigh and Wigan
5 Boroughs Partnership NHS Foundation Trust
Wigan Metropolitian Borough Council
Depuy International Limited
Johnson & Johnson Medical Ltd
Osteotec Ltd

The Department of Health, and the Collaborative Procurement Hub and other entities are regarded as related parties. During the year Wrightington, Wigan and Leigh NHS Foundation Trust has had a significant number of material transactions with them which have provided balances at year end. All transactions are carried out at arm's length. Listed below are balances which are regarded as related parties:

	Receivables £'000	Payables £'000	Income £'000	Expenditure £'000
Department of Health	**0**	**0**	**0**	**9**
5 Boroughs Foundation Trust	290	59	1,243	0
Salford Royal Foundation Trust	423	610	2,507	0
All other FTs	466	364	539	2,300
Ashton Leigh & Wigan PCT	1,159	10	178,027	41
Bridgewater Trust	448	53	559	0
North West Strategic Health Authority	19	1	6,303	9
Bolton PCT	323	0	4,399	0
Bury PCT	36	30	1,055	0
Central and Eastern Cheshire PCT	102	0	891	0
Central Lancashire PCT	422	1	13,382	18
Cumbria PCT	62	1	2,610	1
Halton and St Helens PCT	40	0	6,131	0
East Lancashire Teaching PCT	123	0	1,666	0
Heywood And Middleton PCT	144	0	1,023	0
Manchester PCT	0	22	767	0
North Lancashire PCT	0	166	2,001	1
Salford PCT	0	107	785	0
Sefton PCT	25	0	1,621	0
Stockport PCT	0	131	4,076	0
Warrington PCT	33	0	1,232	0
Blackpool PCT	0	16	686	0
Liverpool PCT	0	89	403	0
NHS Litigation Authority	5	146	0	4,779
National Blood Authority	2	53	24	1,521
All other NHS / WGAs	680	685	4,600	417
Total NHS Bodies	**4,802**	**2,544**	**236,530**	**9,087**
Wigan Borough Council	81	1	290	1,182
Bolton Borough Council	20	0	125	65
HM Revenue and Customs	63	2,931	17	0
NHSPA	0	1,719	0	0
All other WGAs	71	0	331	169
Total WGA	**235**	**4,651**	**763**	**1,416**
Total Inter NHS/WGA	**5,037**	**7,195**	**237,293**	**10,512**
Depuy International Limited	81	38	82	3,381
Osteotec LTD	0	0	0	100
Johnson & Johnson Medical Limited	0	21	0	515
Edge Hill University	12	10	12	96
Total Other Related Parties	**93**	**69**	**94**	**4,092**
Charitable funds	**0**	**0**	**134**	**0**
Total Related Parties	**5,130**	**7,264**	**237,521**	**14,604**

Note 25.2: Related party transactions with key management personnel

Key management personnel are identified as Executive Directors, Deputy Directors / Associates and Non-Executive Directors of the Trust.

	Year ended 31-Mar-12 £'000	Year ended 31-Mar-11 £'000
Short-term employee benefits (gross pay and employers NIC)	1,839	1,702
Post employment benefits (employers costs for NHS pension scheme)*	212	197
Total remuneration paid to key management personnel	**2,051**	**1,899**

* Non Executive Directors are not members of the NHS pension scheme.

Note 26.1: Financial Instruments

International Financial Reporting Standard 7 and International Accounting Standard 32 require disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. An NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations, with its functional currency being Sterling.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

Liquidity risk

The Trust's net operating costs are incurred under contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its Prudential Borrowing Limit.

Interest rate risk

The Trust is not exposed to significant interest rate risk. Notes 26.2.2 and 26.3.2 disclose the interest rate profiles of the Trust's financial assets and liabilities.

Note 26.2.1: Financial assets by category

	Loans and receivables £'000	Available for sale £'000	TOTAL £'000
As per Statement of Financial Position at 31 March 2012			
Trade and other receivables (excluding non-financial assets)	4,802	0	**4,802**
NHS Trade and other receivables (excluding non-financial assets)	2,468	0	**2,468**
Non current assets held for sale and assets held in disposal group (excluding non-financial assets)	0	195	**195**
Cash and cash equivalents	18,161	0	**18,161**
Total financial assets at 31 March 2012	**25,431**	**195**	**25,626**

	Loans and receivables £'000	Available for sale £'000	TOTAL £'000
As per restated Statement of Financial Position at 31 March 2011			
Trade and other receivables (excluding non-financial assets)	4,361	0	**4,361**
NHS Trade and other receivables (excluding non-financial assets)	3,027	0	**3,027**
Non NHS Non current assets held for sale and assets held in disposal group (excluding non-financial assets)	0	307	**307**
Cash and cash equivalents	17,260	0	**17,260**
Total financial assets as restated at 31 March 2011	**24,648**	**307**	**24,955**

Note 29 explains the alignment project restatement of prior year accounts 31 March 2011.

Note 26.2.2: Fair value of financial assets

	31-Mar-12		31-Mar-11	
	Book Value £'000	Fair Value £'000	Book Value £'000	Fair Value £'000
Non current trade and other receivables (excluding non-financial assets)	226	226	267	267
Other	25,205	25,205	24,688	24,688
Total	**25,431**	**25,431**	**24,955**	**24,955**

Cash and cash equivalents earn interest at a floating rate, all other financial assets are not interest bearing.

Note 26.3.1: Financial liabilities by category

	Other financial liabilities £'000	Liabilities at fair value through income statement £'000	TOTAL £'000
As per Statement of Financial Position at 31 March 2012			
Obligations under finance leases	23	0	**23**
NHS Trade and other payables (excluding non-financial liabilities)	3,710	0	**3,710**
Non NHS Trade and other payables (excluding non-financial liabilities)	15,989		**15,989**
Other financial liabilities		0	**0**
Provisions under contract	2,519	0	**2,519**
Total financial liabilities at 31 March 2012	**22,241**	**0**	**22,241**

	Other financial liabilities £'000	Liabilities at fair value through income statement £'000	TOTAL £'000
As per Statement of Financial Position as restated at 31 March 2011			
Obligations under finance leases	37	0	**37**
NHS Trade and other payables (excluding non-financial liabilities)	1,537	0	**1,537**
Non NHS Trade and other payables (excluding non-financial liabilities)	16,299		
Other financial liabilities	0	0	**0**
Provisions under contract	1,125	0	**1,125**
Total financial liabilities as restated at 31 March 2011	**18,998**	**0**	**2,699**

Note 29 explains the alignment project restatement of prior year accounts 31 March 2011.

Note 26.3.2: Fair value of financial liabilities

	31-Mar-12		31-Mar-11	
	Book Value £'000	Fair Value £'000	Book Value £'000	Fair Value £'000
Non current trade and other payables (excluding non-financial liabilities)	15	15	22	22
Provisions under contract	2,519	2,519	1,125	1,125
Other	19,707	19,707	17,851	17,851
Total	**22,241**	**22,241**	**18,998**	**18,998**

None of the Trust's financial liabilities are interest bearing.

Note 27: Accounting standards and amendments issued but not yet adopted in the ARM

Change published	Published by IASB	Financial year for which the change first applies
IFRS 7 Financial Instruments: Disclosures - amendment Transfer of financial assets	October 2010	Effective date of 2012/13 but not yet adopted by the EU.
IFRS 9 Financial Instruments Financial Assets Financial Liabilities	November 2009 October 2010	Uncertain. Not likely to be adopted by the EU until the IASB has finished the rest of its financial instruments project.
IFRS 10 Consolidated Financial Statements	May 2011	Effective date of 2013/14 but not yet adopted by the EU.
IFRS 11 Joint Arrangements	May 2011	Effective date of 2013/14 but not yet adopted by the EU.
IFRS 12 Disclosure of Interests in Other Entities	May 2011	Effective date of 2013/14 but not yet adopted by the EU.
IFRS 13 Fair Value Measurement	May 2011	Effective date of 2013/14 but not yet adopted by the EU.
IAS 12 Income Taxes amendment	December 2010	Effective date of 2012/13 but not yet adopted by the EU.
IAS 1 Presentation of financial statements, on other comprehensive income (OCI)	June 2011	Effective date of 2013/14 but not yet adopted by the EU.
IAS 27 Separate Financial Statements	May 2011	Effective date of 2013/14 but not yet adopted by the EU.
IAS 28 Associates and Joint Ventures	May 2011	Effective date of 2013/14 but not yet adopted by the EU.

Note 28: Transforming Community Services (TCS) Transactions

2011/12	1 April 2011 to 30 September 2011		1 October 2011 to 31 March 2012	Full Year
	Wrightington Wigan and Leigh NHS Foundation Trust **£'000**	**Bridgewater Community Healthcare NHS Trust** **£'000**	**Combined Results** **£'000**	**Total** **£'000**
Statement of Comprehensive Income				
Income from activities	107,053	1,910	122,846	231,809
Other income	10,138		4,653	14,791
Operating expenses	(114,559)	(1,910)	(122,500)	(238,969)
Finance costs	(2,473)		(2,254)	(4,727)
Total Comprehensive income for the period	**159**	**0**	**2,745**	**2,904**

On 1st October 2011 the NHS Foundation Trust acquired part of the Community services that support the effective delivery of acute care from Bridgewater Community NHS Trust. The transactions did not include any transfer of assets or liabilities, nor any cash transfers.

This transaction represents the transfer of services between public sector bodies which are under common control and therefore is a 'machinery of Government change'. This transaction meets the definition of a 'Group Reconstruction' under IFRS 3 'Business Combinations' and therefore falls outside the scope of that standard.

Consequently, in accordance with the FT ARM the principles of merger accounting have been applied to this transaction, as set out in Financial Reporting Standard 6 'acquisitions and mergers' issued by the United Kingdom Accounting Standards Board. There was no requirement to provide prior year adjustment for 2010/11 as a consequence of a dispensation in line with the Monitor ARM

Note 29.1: Prior Period Adjustments (PPA)

Changes in Accounting Policy brought in by the Department of Health (DoH) Alignment Project in the financial year ending 31 March 2012 have led to the financial accounts for year ending 31 March 2011 being restated. These restatements include reclassifing balances as part of the agreement of balance exercise and a change in accounting approach for donated and government grant assets.

Note 29.2: Prior Period Adjustment - SOFP

As a consequence of the national DoH policy changes donated asset reserves and government grant reserves are abolished with balances posted to the Trust's Income and Expenditure reserve. Donated asset reserve included revaluation values that were transferred to Revaluation reserve upon change in policy. This meant that £1,760k was transferred from donated asset reserves, £173k from revaluation reserve and increased the income and expenditure reserve on 31 March 2011 by £1,933k.

Trust government grant does not include any exception rule and therefore as per the DoH change in Accounting Policy needs to be posted to income and expenditure reserve. This reduced current liabilities by £70k and non current liabilities by £209k, the transfer to Income and expenditure gave an increase to reserves of £279k as at 31 March 2011. Also due to reclassification as part of the change in Accounting Policy the tax payable is now included within Trade and other payables. Reclassifications are further explained in Note 29.5.

	As Restated 31-Mar-11 £'000	As Audited 31-Mar-11 £'000	As Restated 01-Apr-10 £'000	As Audited 01-Apr-10 £'000
Total non-current assets	**149,454**	**149,454**	**144,502**	**144,502**
Total current assets	**28,764**	**28,764**	**29,707**	**29,707**
Trade and other payables	(18,281)	(15,201)	(17,875)	(14,814)
Borrowings	(15)	(15)	(15)	(15)
Other financial liabilities				
Provisions	(286)	(286)	(800)	(800)
Tax payable	0	(3,080)	0	(3,061)
Other liabilities	(165)	(235)	(160)	(240)
Total current liabilities	**(18,747)**	**(18,817)**	**(18,850)**	**(18,930)**
Total assets less current liabilities	**10,017**	**9,947**	**10,857**	**10,777**
Non-current liabilities				
Borrowings	(22)	(22)	(35)	(35)
Provisions	(839)	(839)	(877)	(877)
Other liabilities	0	(209)	0	(278)
Total non-current liabilities	**(861)**	**(1,070)**	**(912)**	**(1,190)**
Total Assets Employed	**158,610**	**158,331**	**154,447**	**154,089**
Financed by (taxpayers' equity)				
Public dividend capital	94,083	94,083	94,083	94,083
Revaluation reserve	35,553	35,726	36,246	36,419
Donated asset reserve	0	1,760	0	1,627
Income and expenditure reserve	28,974	26,762	24,118	21,960
Total taxpayers' equity	**158,610**	**158,331**	**154,447**	**154,089**

Note 29.3: Prior Period Adjustment - SOCI

New Capital purchased via donated assets in the financial year ending 31 March 2011 is now treated as gifted to income in the financial year. Reserve releases for depreciation would be no longer be included in the accounts. Therefore income from donated assets of £261k is taken fully in the financial year ending 31 March 2011 and not spread out evenly over the life of the asset. The release from reserves for the element of donated asset £128k for the financial year 31 March 2011 is no longer included in comprehensive income or income for continuing operations. The final movement in the financial year was to transfer £80k that had been taken in financial year ending 31 March 2011 as government grant income release to income and expenditure reserve, this was to treat the government grant as if it had all been taken in the financial year it was received.

	As Restated 31-Mar-11 £'000	As Audited 31-Mar-11 £'000
Operating Income from continuing operations*	230,939	230,886
Operating Expenses from continuing operations *	(222,132)	(222,132)
OPERATING SURPLUS	**8,807**	**8,754**
NET FINANCE COSTS	**(4,645)**	**(4,645)**
SURPLUS FOR THE PERIOD	**4,162**	**4,109**
Other comprehensive income		
Receipt of donated assets	0	261
Other reserves movements	1	(128)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR	**4,163**	**4,242**

Note 29.4: Prior Period Adjustment - Other Operating Income

	As Restated 31-Mar-11 £'000	As Audited 31-Mar-11 £'000
Total income from activities	**217,148**	**217,148**
Other operating income		
Research and development	86	86
Education and training	5,990	5,990
Charitable and other contributions to expenditure	320	59
Transfer from donated asset reserve in respect of	0	128
Non-patient care services to other bodies	3,865	3,865
Other	3,483	3,563
Gain on disposal of assets held for sale	47	47
Total other operating income	**13,791**	**13,738**
TOTAL OPERATING INCOME	**230,939**	**230,886**

Note 29.5: Prior Period Adjustment - Reclassifications

DoH led Alignment Project included reorganisation of balances that has led to reclassification of values in the notes to support the SOFP. This included NHS organisations being classified as related parties as opposed to NHS, and also saw VAT receivable being specifically split out from other receivables. Also interest receivable was split out from accrued income. On the current liabilities NHS capital liabilities were pulled from capital creditors, NHS Pensions have been reclassified as related party and not NHS, and several former NHS organisations have been reclassified into other related parties.

	As Restated 31-Mar-11 £'000	As Audited 31-Mar-11 £'000
NHS Receivables	4,361	4,389
Other receivables with related parties	237	209
Provision for impaired receivables	(329)	(329)
Prepayments	778	778
Accrued income	40	46
Interest receivable	6	0
PDC receivable	36	36
VAT receivable	357	0
Other receivables	2,413	2,770
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**7,899**	**7,899**

	As Restated 31-Mar-11 £'000	As Audited 31-Mar-11 £'000
Current Liabilities		
Receipts in advance	445	445
NHS payables	1,196	2,925
NHS payables - Capital	341	0
Amounts due to other related parties	2,091	362
Trade payables - capital	2,938	3,279
Other trade payables	865	865
Taxes payable	3,080	3,080
Other payables	29	29
Accruals	7,296	7,296
TOTAL CURRENT TRADE AND OTHER PAYABLES	**18,281**	**18,281**

Note 29.6: Prior Period Adjustment - Cash Flow

Changes in the Accounting Policy as discussed in Note 29.1 have brought about a restatement of the operating surplus. This combined with changes to donated assets and government grants has meant that the cashflow has been restated to reflect these effects.

	As Restated 31-Mar-11 £'000	As Audited 31-Mar-11 £'000
Cash flows from operating activities		
Operating surplus from continuing operations	8,807	8,754
Operating surplus	**8,807**	**8,754**
Non-cash income and expense		
Depreciation and amortisation	7,317	7,317
Impairments	59	59
Transfer from donated asset reserve	0	(128)
Decrease/(Increase) in Trade and Other Receivables	573	573
Decrease/(Increase) in Other Assets	(97)	(97)
Decrease/(Increase) in Inventories	471	471
(Decrease)/Increase in Trade and Other Payables	(544)	(544)
(Decrease)/Increase in Other Liabilities	6	(74)
(Decrease)/Increase in Provisions	(509)	(509)
Other movements in operating cash flows	(261)	0
NET CASH GENERATED FROM OPERATIONS	**15,822**	**15,822**
Net cash used in investing activities	**(10,423)**	**(10,423)**
Net cash used in financing activities	**(4,855)**	**(4,855)**
Increase/(Decrease) in cash and cash equivalents	**544**	**544**
Cash and Cash equivalents at 1 April	**16,716**	**16,716**
Cash and Cash equivalents at 31 March	**17,260**	**17,260**

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