Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

Annual Report and Accounts

1 December 2008- 31 March 2009

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

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Review of the Year

This is an unusual annual report as it only covers the four month period from 1st December 2008, when we became a Foundation Trust to 31st March 2009, the usual end of the financial year. My review therefore principally covers the events of this short period but many of them are the culmination of a full year programme.

The first highlight to mention is quite simply becoming a Foundation Trust on 1st December 2008.The occasion was marked by displaying banners at entrances to each of our sites with the summary message "Together we did it". The "Together" message refers to the combined effort of staff, our members and local service partners who contributed to the achievement.

Being an NHS Foundation Trust has led to the ownership of the Trust transferring from central Government to the local community. This means that our staff, our patients and our public now have much more influence on the strategies and priorities of our hospitals. The Trust has further gained financial freedom that allows the investment of any surpluses in the future development of services and facilities.

A highlight of the first hundred days of achieving Foundation status was a 'Back to the Floor' exercise for each of the Executive Directors. The roles undertaken were:

Catering Assistant - Bill Livingstone
Complaints Clerk - Chris Chandler
Healthcare Assistant - Gill Harris
Clinic Clerk - Keith Griffiths
Porter - Andrew Foster
Healthcare Assistant - Tony Chambers

This was an eye opener for all concerned and I know that staff enjoyed the experience too.

In March we held a two-day event at Leigh Sports Village to plan our clinical service strategy for the next ten years and this was a huge success. Around 70 senior clinicians and managers took part and debated service strategy as a whole and in more detail, the future of eight sub-groups of services. Attendees were also invited to agree some "audacious goals" and did so with enthusiasm. For example we pledged to eliminate the practice of cancelling outpatient appointments by 1st January 2010 and to move progressively to all clinical services being available 7 days a week from 8am to 9pm by 2020.

This was the year in which quality and safety took centre stage and there have been some very impressive results. MRSA bacteraemia fell to an average of just one per month compared to over three per month two years ago. Even more impressively the numbers of Clostridium Difficile cases was down to around six per month compared to over 30 per month two years ago. In a year when the Trust made improving mortality ratios its top priority, the Trust's ratio improved from 125.7 for 2007/08 to 92.1 for 2008/09. This 27% reduction means that there have been 214 lives saved this year compared to last. These are truly superb results and I am very grateful to the very large numbers of staff who have contributed personally.

Apart from infection control we have two other headline, government objectives which we have comfortably achieved. The first is the standard for patients waiting no more than 18 weeks from GP referral to treatment which was achieved eight months early in April 2008 and has been sustained every month since. The second is the requirement to achieve a financial surplus and again, our accounts show a bottom line of plus £1.1m.

The Trust set itself no less than 56 corporate objectives this year and I am pleased to report that we have completed or nearly completed 51 of them. But of course, this means that five were unsuccessful. Some failures were marginal: we had 13 cases of MRSA compared to a target of 12; our A&E performance was 97.3% compared to a target of 98%. The rest were financial: our year end surplus of £1.1M did not reach the target of £2m, our temporary staffing costs were about £650,000 a month compared to a target of £500,000 and we had hoped to achieve a surplus of £2m for the Wrightington site but the final figure was £1M.

In a large and complex service such as our Hospitals there are always pressures and not everything goes as well as we would wish. The Trust's performance on waiting in A&E may be not far from the target but I am conscious that this means that a lot of patients have had to wait far too long. Also we are seeing a rising number of complaints. This may be because we positively encourage people to let us know when things go wrong. Whatever the cause I would like to apologise to all patients for those occasions when we have not met the standards we would like to achieve.

Last but by no means least I would like to pay tribute to our 4,300 staff who provide such a professional and caring service. The annual inpatient survey shows that 91% of patients think that our services are either good or excellent and other smaller surveys back this up. I was delighted when we came 39th in a national competition for the Top 100 NHS Employers and this confirms the Trust's aspiration to be a good employer and to help every employee make the most of his or her skills. I will close this annual review by saying a big thank you to all of our staff, of whom I am very proud.

Andrew Foster
Chief Executive

Andrew Foster, Chief Executive and Chris Chandler, Medical Director congratulating staff on the Trust achieving Foundation Status.

Trust Profile

Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) was authorised as a foundation trust on 1 December 2009.

Achieving foundation status was a major milestone for WWL as this puts the Trust much more in control of its own destiny with much more accountability to the local community it serves rather than to Whitehall. All foundation trusts continue to provide NHS services to NHS patients, based on need and not ability to pay. Foundation status means that the Trust:

- is not directed by central Government and so has greater freedom to decide its own strategy and the way services are run.
- is able to retain any surpluses and borrow to invest in new and improved services for patients and service users.
- is accountable to its local communities through members and Governors, to commissioners through contracts, to Parliament and to Monitor as their regulator.

As a Foundation Trust, WWL can be more responsive to the needs and wishes of its local community. Anyone who lives in the area, works for the Trust, or has been a patient or service user can become a member of the Trust. Trust members elect the Board of Governors who, as members' representatives, have influence on how the Trust services and facilities are developed.

WWL is a major acute and secondary care service provider that delivers quality healthcare primarily to a local population of over 300,000 in Wigan, Leigh and the surrounding area. The Trust provides district general hospital services for the local population and specialist orthopaedic services to a much wider regional and national catchment area.

WWL employs over 4,300 staff and operates from three hospital sites. The Trust has a total of approximately 800 inpatient beds as well as the Thomas Linacre Centre (TLC), a state-of-the-art outpatient centre in Wigan town centre. In addition, the Trust has a number of offices located at Bryan House and Buckingham Row in central Wigan.

WWL's three hospital sites are:

- **Royal Albert Edward Infirmary (RAEI)**
  The RAEI is a redeveloped modern District General Hospital situated close to Wigan town centre. This is the largest of the Trust's sites with over 500 beds and provides the main operating base for high quality emergency and associated secondary care.
- **Wrightington Hospital**
  One of Europe's foremost orthopaedic centres of excellence that attracts patients locally, regionally and internationally. Wrightington Hospital is the place where hip replacement surgery was pioneered in the early 1960's by Professor Sir John Charnley. This site has a major research and development centre and continues to be a leading quality treatment centre for joint surgery.

- **Leigh Infirmary**
  Leigh Infirmary; based in the south east of the Borough, offers a range of outpatient, diagnostic and limited inpatient services that complement the emergency site in Wigan. Leigh Infirmary is devoted to elective care, protected from the pressures of emergency work.

WWL has provided consistently high clinical standards through achievement of national performance standards. The Trust continues to invest in and develop services and facilities. WWL has rationalised services by concentrating all acute and emergency services at the RAEI site in Wigan with Leigh Infirmary and Wrightington Hospital developed primarily as specialist diagnostic and treatment centres.

WWL is a progressive Trust, forward thinking and innovative in its approach and is committed to designing services around the needs of patients with a strategy based on quality. Over £200 million is invested each year on a diverse range of general hospital and specialist healthcare services. The Trust performed extremely well in the 2008/09 Healthcare Commission's Annual Health Check ratings achieving an overall "Good" assessment for both Effective Use of Resources and Quality of Services.

Mission Statement

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

"To create the right conditions for our staff to put our patients' needs at the heart of everything we do"

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 our staff and recognises that it cannot provide the best possible patient care, unless it provides a working environment in which staff can thrive.

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 of:

Les Higgins
Chairman

Louise Barnes
Vice Chairman/ Senior Independent Director

Robert Armstrong
Non-Executive Director

Geoff Bean
Audit Chair
Non-Executive Director

Robert Collinson
Non-Executive Director

Pamela McCann
Non-Executive Director

Vacant Position
Non-Executive Director

Andrew Foster
Chief Executive

Keith Griffiths
Director of Finance and Informatics

Chris Chandler
Medical Director

Tony Chambers
Director of Operations

Bill Livingstone
Director of Human Resources

Gill Harris
Director of Nursing and Patient Services

The Council of Governors is responsible for the appointment of the Trust's Non-Executive Directors. Non-Executives are appointed on a varying fixed-term basis as determined by the constitution.

The Chief Executive, Director of Finance, Medical Director and Director of Nursing are ex-officio members of the Trust Board, by virture of their posts with the Trust. The other Trust Board Executive Directors are appointed by a committe comprising of the Chairman, Chief Executive and the Non-Executive Directors.

Each Director must state that as far as they are aware, there is no relevant audit information of which the NHS body's auditors are unaware. They have taken all the steps that they ought to have taken as a Director to in order to make themselves aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

Board of Directors

The Board of Directors has overall responsibility for 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 we serve. Profiles for members of the Board of Directors are available in the appendices.

Sub Committees of the Board

The Board has the following sub committees:

Committee	Members	Attendance
Remuneration	Les Higgins	1/1
	Pamela McCann	1/1
	Geoff Bean	1/1
	Robert Armstrong	1/1
	Robert Collinson	1/1
	Louise Barnes	1/1
	Andrew Foster	1/1
Charitable Funds	Les Higgins	2/2
	Andrew Foster	2/2
	Keith Griffiths	1/2
	Chris Chandler	1/2
	Gill Harris	1/2
	Pamela McCann	2/2
	Geoff Bean	1/2
	Louise Barnes	2/2
	Robert Collinson	2/2
	Robert Armstrong	2/2
Governance and Risk	Louise Barnes	2/2
	Andrew Foster	2/2
	Chris Chandler	1/2
	Gill Harris	1/2
	Robert Collinson	2/2
	Les Higgins	2/2
Finance	Andrew Foster	3/3
	Tony Chambers	3/3
	Keith Griffiths	3/3
	Bill Livingstone	2/3
	Louise Barnes	2/3
	Geoff Bean	3/3
	Les Higgins	3/3
Audit	Geoff Bean	2/3
	Keith Griffiths	2/3
	Gill Harris	2/3
	Robert Armstrong	2/3
	Robert Collinson	3/3
	Pamela McCann	3/3

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.

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. Non-Executive Directors appointments 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 or by mutual consent for other reasons.

The Board are committed to working with the Council of Governors through formal meetings and informal seminars.

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.

Members of the public can access the Register of Directors' Interests by contacting:

Helen Hand, Trust Board Secretary

Royal Albert Edward Infirmary
Trust HQ, The Elms, Wigan Lane
Wigan WN1 2NN

E helen.hand@wwl.nhs.uk

T 01942 822027

The Audit Committee

Aims

The aim of the Audit Committee is to provide one of the key means by which the Trust Board ensures effective internal control arrangements are in place.

As defined within the 'Audit Committee Handbook (2005)', the Committee has responsibilities for the review of governance, risk management and internal control covering both clinical and non-clinical areas. In discharging these duties the Committee is required to review:-

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information.
- Risks regarding disclosure statements (Statement on Internal Control and Standards for Better Health) which are supported by the Head of Audit Opinion and other opinions provided.
- The underlying assurances as detailed in the Corporate Assurance Framework.
- The adequacy of relevant policies.
- The policies and procedures related to fraud and corruption.

The conduct of this remit is achieved firstly, through the Committee being appropriately constituted, and secondly, by the Committee being effective in ensuring internal accountability and the delivery of audit and assurance services.

Constitution

The terms of reference were reviewed during the course of the year.

The Committee is a non-executive committee of the Board consisting of at least three Non-Executive Directors, including at least one with 'recent relevant financial experience'. The Committee currently has four members. A quorum of two members is required.

The Board Secretary is in attendance. The Director of Finance and IT and the Director of Nursing and Patient Services are invited to attend and the Committee may request the attendance of the Chief Executive and any other officer of the Trust to answer any points which may arise.

In addition, the Internal and External Auditors attend along with the Local Counter Fraud Specialist. The Committee approves and monitors their annual plans and uses their independent reports as part of the process of ensuring the effectiveness of the internal control system.

Meetings are required at least five times a year. Seven meetings were held within the last financial year of which three were held in the period since Foundation Trust licensing. The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan. All meetings were quorate.

Minutes of the meetings are considered at the Board of Directors' meetings. The Committee Chair brings significant matters to the attention of the Board.

In discharging its duties, the Committee meets its responsibilities through utilising the work of Internal Audit, External Audit and other assurance functions, along with assurances from Trust officers (where required). It directs and receives reports from the auditors and fraud specialists, as well as minutes and reports from other sub committees.

Remuneration and Pension Entitlements of Senior Managers

The following tables provide details of the remuneration and pension benefits for senior managers for the four month period ended 31 March 2009.

Salaries and Allowances

		01/12/08-31/03/09			01/04/08-30/11/08		
		Salary Bands of £5k £'000s	Other Rem'tion Bands £5k £'000s	Benefits in kind £'000s	Salary Bands of £5k £'000s	Other Rem'tion Bands of £5k £'000s	Benefits in kind £'000s
Executive Directors							
L Higgins	Chairman	10-15			10-15		
A Foster	Chief Executive	65-70			90-95		
K Griffiths	Director of Finance & Informatics	45-50			70-75		
C J Chandler	Medical Director	5-10	60-65		10-15	90-95	
W Livingstone	Director of HR/Deputy Chief Executive (01/12/08 to present)	50-55			70-75		
P Kay	Associate Medical Director (In post 01/04/08 - 30/11/08)				5-10	95-100	
G Harris	Director of Nursing & Patient Services	45-50			65-70		
T Chambers	Director of Operations	45-50		2	65-70		4
Non-Executive Directors							
J L Barnes		5-10			0-5		
A Mandall	(In post 01/04/08 - 30/11/08)	0			0-5		
G Bean		5-10			0-5		
R Collinson		0-5			0-5		
P McCann		0-5			0-5		
R Armstrong		0-5			0-5		

Remuneration Sub Committee

Directors' salaries (excluding Non-Executive Directors) are determined by the Trust's Remuneration Sub Committee, the membership consisting of the Chairman and all the Non-Executive Directors. The policy of the Sub 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 Sub 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 Sub Committee will review individual Director's performance against agreed measurement factors for key tasks approved by the Trust Board. In addition to advise the Chairman on any termination arrangements for the Chief Executive, and to advise the Chief Executive on any termination arrangements for Executive Board members.

Performance related salaries are awarded by the Remuneration Sub Committee to Directors according to the Hay Job Evaluation Scheme. 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.

Andrew Foster
Chief Executive

Pension Benefits

		Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31/03/09 (bands of £2,500)	Lump sum at age 60 related to accrued pension at 31/03/09 (bands of £2,500)	Cash Equivalent ransfer value at 31/03/09	Cash Equivalent ransfer value at 30/11/08	Real increase in Cash Equivalent transfer value
Executive Directors		£000	£000	£000	£000	£000	£000	£000
A Foster	Chief Executive	0-2.5	2.5-5	12.5-15	10-12.5	263	228	20
K Griffiths	Director of Finance and Informatics	0-2.35	2.5-5	30-32.5	95-97.5	505	457	25
C J Chandler	Medical Director	0	0	60-62.5	185-187.5	1,433	1,367	22
W Livingstone	Director of Human Resources	2.5-5	7.5-10	40-42.5	122.5-125	971	855	66
G Harris	Director of Nursing and Patient Services	2.5-5	7.5-10	37.5-40	112.5-115	647	565	48
T Chambers	Director of Operations	0-2.5	2.5-5	25-27.5	80-82.5	410	371	21

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

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.

Council of Governors

Role and Responsibilities

The Council of Governors 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 and 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 Council receives the Trust's annual report and accounts and comments on the forward plans for 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 the 1st December 2008. Details of our Governors terms of office and attendance at meetings are given below:

Governor	Public Constituency	Term	Attendance at Governor Meetings
Public Governors			
Bill Greenwood	Wigan	2012	1/3
Pauline F Gregory	Wigan	2012	3/3
Jim Walls	Wigan	2011	3/3
Denis Partington	Wigan	2010	2/3
Anne D Vernengo	Leigh	2012	3/3
Maureen Hilton	Leigh	2012	3/3
David Oultram	Leigh	2011	3/3
Gordon Jackson	Leigh	2010	3/3
Kate Fussell	Makerfield	2012	3/3
Margaret Hughes	Makerfield	2012	3/3
Fred Lever	Makerfield	2011	2/3
Geoffrey Roberts	Makerfield	2010	1/3
Vincent France	Worsley	2012	3/3
Anthony Gallagher	Worsley	2011	2/3
Tom Frost	England and Wales	2012	2/3
Trevor Barton	Englandand Wales	2011	1/3
Staff Governors	**Staff Constituency**		
George Ghaly	Medical and Dental	2012	3/3
Janet M Irvine	Nursing and Midwifery	2012	2/3
Tony Ashton	Nursing and Midwifery	2011	3/3
Christine Swann	All other staff	2012	3/3

Nominated Governor	Constituency	Term	Attendance at Governor Meetings
Ashton, Leigh and Wigan PCT Dr Peter Marwick	Partnership Organisation	2012	3/3
Ashton, Leigh and Wigan PCT Dr Kate Arden	Partnership Organisation	2012	3/3
Wigan Council Cllr Keith Cunliffe	Partnership Organisation	2012	3/3
LINKs Wigan Appointment awaited	Partnership Organisation	2012	
WWL Staff Side Committee Jean Heyes	Partnership Organisation	2012	2/3
Wigan and Leigh Council for Voluntary Services Dr Gary Young	Partnership Organisation	2012	2/3
Age Concern, Wigan Mr Jim Maloney	Partnership Organisation	2012	3/3
University of Central Lancashire Ms Ruth Cowburn	Partnership Organisation	2012	3/3
5 Borough Partnership NHS Trust Mr Ray Walker	Partnership Organisation	2012	0/3

Members of the public can gain access to the Register of Governors' interest by contacting:

Helen Hand, Trust Board Secretary

Royal Albert Edward Infirmary
Trust HQ
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Wigan Lane
Wigan WN1 2NN

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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.

Nomination and Remunerations Committee

Non-Executive Director Appointment and Remuneration

The Council of Governors' Nomination and Remuneration Committee has met on one occasion during the reporting period to agree the appointment and remuneration of the Chairman and Non-Executive Directors.

The Chairman and Non-Executive Directors and Senior Independent Director are appointed by the Council of Governors acting on the recommendation of the Nomination and Remuneration Committee, which is a committee of the Council of Governors. Membership of the Committee is as follows:

Member	Constituency	Attendance
Mr L Higgins	Chairman	1/1
Ms M Hughes	Elected: Makerfield Public	1/1
Mrs J Heyes	Appointed: Staff Side	1/1
Cllr (Mr) K Cunliffe	Appointed: Local Authority	1/1
Mr D Oultram	Elected Leigh public	1/1
Mr V France	Elected Worsley public	1/1
Dr G Young	Appointed: CVS	1/1
Mr G Jackson	Elected: Leigh Public	1/1

Approval of the Committee's recommendation for the re-appointment of the existing Chairman and Non-Executive Directors for a three year period was given by the Council of Governors in January 2009.

Appointment to a vacant Non-Executive Director position on the Trust Board is being taken forward using the support of the Appointments Commission. Members of the nominations committee will sit on the interview panel in accordance with the Trust's Constitution.

Membership

The Trust has a robust plan to develop and increase its membership. The current membership figures are as follows:

Total Public Members	5,538

This table gives a breakdown of membership by public constituency:

	Wigan	Leigh	Makerfield	Worsley	England and Wales
Total Males	729	526	603	138	270
Total Females	973	798	878	244	362
Not Given	005	003	006	0	3
Total Membership	**1,707**	**1,327**	**1,487**	**382**	**635**

This table gives a breakdown of membership by staff constituency:

	Medical and Dental	Nursing and Midwifery	All Other Staff	Total Figures
Total Males	209	59	439	707
Total Females	71	1071	2249	3391
Not Given	0	0	0	0
Total Membership	**280**	**1,130**	**2,688**	**4,098**

The Trust has set a target to increase its public membership by 500 members a year for the next three years whilst maintaining its staff membership.

The Trust has a Membership Development Officer who supports the Council of Governors in recruiting and maintaining the membership. 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.

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 as detailed in Monitor's Code of Governance 2006. For the four month period covered by this report the Trust anticipates achieving compliance with most of the Code provisions.

Work is continuing within the Trust towards compliance with the remaining Code provisions; however as at 31st March 2009, the Trust was still reviewing the schedule of matters reserved for decision by the Board (A1.1), the process for evaluating Board, Chair and Governor performance (D2) and to approve the criteria for reappointing the auditors (F3.5). In addition the Trust would wish to report that the current Executive Directors have permanent contracts of employment and are not on time limited contracts (code C.2.1).

Objectives 2008/09

Corporate Objectives

1 Operating Framework – National Headline Objectives

- Deliver action plan on patient and staff survey results ✓
- Maximum one MRSA bacteraemia per month ✗
- Maximum 15 new Clostridium Difficile per month ✓
- 90% of admitted and 95% of non-admitted pathways within 18 weeks by 01/12/08 ✓

2 The Healthcare Commission – Annual Health Check Ratings

- Achieve 'good' for 07-08 use of resource rating ✓
- Achieve 'excellent' for 08-09 use of resource rating !
- Maintain 'fair' for 07-08 quality of service rating ✓
- Achieve 'good' for 08-09 quality of service rating ✓

3 Trust Strategic Aims

- Maintain 74% (activity) local market share for District General Hospital services NA
- Increase North West share for elective orthopaedics from 7.7% to 7.9% NA
- Identify plan for Christopher Home by October 2008 ✓

Trust Objectives

Achieve Foundation Trust Status

- Oversee Foundation Trust process and assure readiness for Monitor assessment ✓
- Achieve Strategic Health Authority support and Secretary of State approval ✓
- Hold elections for and establish a Council of Governors ✓
- Deliver successful outcome to Monitor's due diligence and financial scrutiny processes ✓
- Prepare final version of the Independent Business Plan and Long Term Financial Model for Monitor assessment ✓

Service and Operational Objectives

- Hospital at Home service operational within three months of Primary Care Trust decision and remove services from Whelley Hospital ✓
- Complete four LEAN value stream improvement projects ✓
- Sustained weekly delivery of 98% Accident & Emergency target ✗

- Theatre productivity: cut late starts by 50%, increase reallocation rates by 20% and maintain cancellation rates at less than 2% 
- Half day reduction in medical Length of Stay and half day reduction in non-elective surgical Length of Stay 
- Achieve and sustain 70% target for day case admission rates 

Quality and Safety Objectives

- Deliver Ward-to-Board monitoring and intranet clock dashboard 
- Draw up a sustainability and green issues strategy 
- Achieve Health and Safety compliance and culture in all areas 
- Achieve Hospital Standardised Mortality Ratio (HSMR) of 100 
- Central line and surgical site infection 
- Achieve zero monthly rate of ventilator acquired pneumonia 
- Deploy rapid response teams with adherence to Medical Early Warning System (MEWS), Finance and IT Objectives 

Finance and FT Objectives

- Introduce service line reporting in all Divisions by May 2009 
- Achieve IT programme on order communications and telecommunications and agree medium/long term strategy for Patient Administration System 
- Achieve surplus of £2m 
- Achieve Cost Improvement Programme of £8.4m 
- Oversee capital programme; hit year-end capital and cash targets 

Workforce Objectives

- Achieve full 24/7 Hospital by Day working 
- Action the 07-08 Staff Involvement Days outcomes and hold an 08-09 event 
- Achieve productivity levels in the top 25% of comparable Trusts 
- Reduce sickness absence to 4.3% and a top 25% performance 
- Cut temporary labour costs to maximum £500k per month 
- Training attendance targets:
  - Induction 75% 
  - Mandatory 90% (of those available) 
  - Performance Development Reviews 85% 

Corporate and Commercial Objectives

- Establish a marketing function and strategy ✓
- Set up information based marketing for orthopaedics !
- Establish improved management process of John Charnley Wing and income of at least £2.6m for 2008-09 !
- Draw up a membership development strategy and programme by August 2008 ✓
- Deliver a Governors' communications and events plan by October 2008 ✓

Site Strategy

Wigan	• Deliver the Phase V SOC by April 2009	!
	• Ensure interim capacity for Pathoogy by October 2008	✓
Leigh	• Agree phased site strategy with PCT by July 2008	✓
	• 30% of all elective work (exc MSK) by December 2008	✓
Whelley	• Achieve technical closure of the site by April 2009	✓
Wrightington	• Use LEAN to improve all aspects of pathways	✓
	• Achieve surplus of £2m for the site	✗
	• Achieve annual savings of £600k on Prosthetics	✓

Key

Not completed ✗

Completed ✓

Nearly completed !

Rainbow Ward Staff

Objectives 2009/10

Care Quality Commission Ratings

1 Use of Resources

- Achieve 'excellent' for 2009-10

2 Quality

- Achieve 'excellent' for 2009-10

Trust Strategic Objectives

3 Marketing

- Achieve 74% market share for District General Hospital Services

4 Marketing

- Achieve an increased Northwest market share for elective Orthopaedic Services from 7.7% to 8.2%

5 Clinical Quality

- Achieve HSMR of no more than 92 and average overall Trust scores of at least 95 for Ward-to-Board reports

6 Patient Experience

- Achieve approval scores of at least 85% in quick feedback patient surveys

7 Operations

- Achieve utilisation of all theatres at over 90% and average length of stay below 3 days elective and 4.5 days non-elective

8 Finance

- Achieve trading surplus of £xm [figure to be notified]

9 Workforce

- Deliver the drive organisational development programme; train over 300 staff per year on impact; produce and implement a succession plan for all posts at band 7 and above; achieve a top 20% performance for a minimum of 11 categories within the NHS annual staff survey

10 Site Strategy

- Complete evacuation of Christopher Home, agree plan for content, layout and timetable for Leigh Phase II and for Wrightington Phase I.

Clinical Services Strategy

The Clinical Services Strategy is the key element which will drive the future shape and scope of the Borough's secondary care health services. It will shape the Trust's hospitals and other buildings required to deliver high quality services and determine which areas will grow or decrease in response to local need and potential competition.

The Trust started a process to determine the long term strategy in the Autumn of 2008 with workshops in the clinical Divisions. There has since been ongoing engagement leading up to a two day workshop in March 2009 to start to bring together the various ideas and themes emerging. The overall message can be encapsulated as:

**The Right Services,
in the Right Place,
at the Right Time,
Every Time**

The Trust's FT application detailed the service strategy in terms of activity volumes over the next 5 years and is largely a story of maintaining the status quo. The Trust plans to maintain market share of ambulatory and elective services and envisages only a small increase in emergency activity. The significant exception to this rule is in Orthopaedics where the Trust intends to build on the strength of services at Wrightington Hospital and expand the volume of patients we see from outside the Wigan Borough.

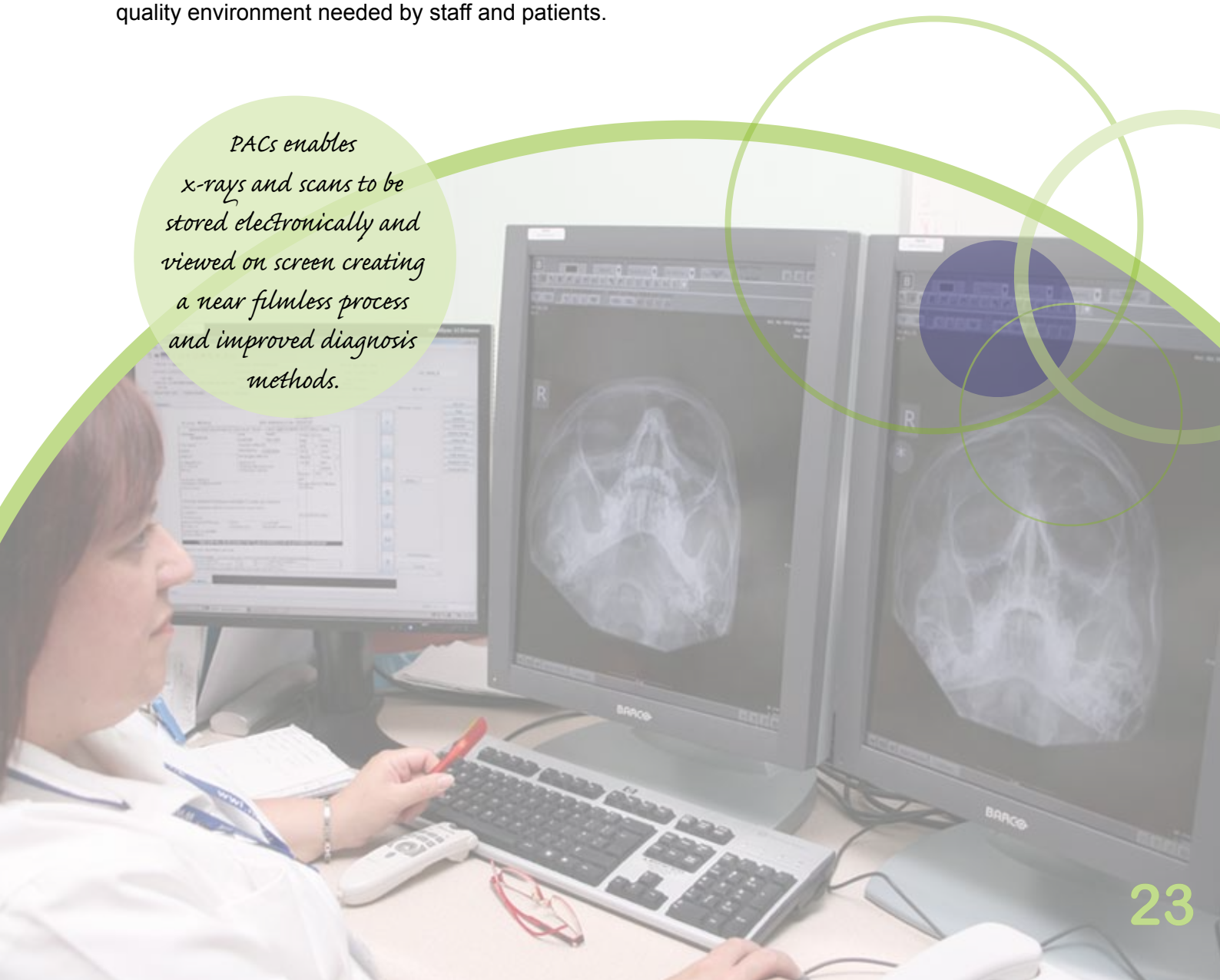
As described above, the Trust has recognised the need to look beyond the next few years and has started a process which will result in a

vision of what services will look like in the year 2020. This is branded as the Trust's 20:20 vision and has involved a series of workshops and focus groups with doctors, nurses and other professionals from across the organisation, plus "trade shows" to ensure we are aware of the perspectives of our patients and other key stakeholders. The Trust aims to be able to share this detail by the autumn of 2009.

However, key themes already emerging are:

- **The separation of Emergency and Planned Care**
- **The segmentation of complex and more straightforward care**
- **The development of "Hub and Spoke" models of care**
- **The need to work closely with our commissioners to reflect the clinical service aspirations they have for the people of the Borough**
- **The need for 'Quality' to remain at the top of our agenda**

The on-going work will feed into the development of a business case for the modernisation of the Trust's facilities to fully reflect the way services will need to be delivered in the future and the high quality environment needed by staff and patients.



PACs enables x-rays and scans to be stored electronically and viewed on screen creating a near filmless process and improved diagnosis methods.

Business Improvement Group

The Trust faces significant challenges over the coming years in improving access, quality of care and patient experience whilst simultaneously making substantial efficiency/productivity gains. To this end the Business Improvement Group (BIG) was set up early in 2008 as a key enabler to facilitate and lead change across the organisation to achieve these aims.

A five year work plan for BIG was agreed at the start of 2008/09 as part of the Trust's long term financial model (LTFM) and application to become a Foundation Trust. BIG has had excellent success in 2008/09 in realising the highest cost improvement programmes this Trust has delivered in recent years. The BIG achieved, at the end of this financial year, efficiency savings of £8.1m (£4.8m was achieved as an NHS Trust and £3.3m as an FT), which consisted of both cost improvement and income generation schemes.

Going forward the Trust faces even greater challenges and therefore from 09/10 and beyond, a Service Transformation Strategy has been formulated and agreed by the Trust Board to act as a key enabler for service change. As part of this strategy, a Service Transformation Team has been introduced to lead and facilitate organisation improvement across the Trust.

Benefits will be monitored using a holistic system of measurement to ensure these projects are supporting all corporate objectives. These measurements will be structured in the following categories:

Delivery/access: e.g. • Reduced waiting times • Reduced cancellations and Did Not Attend (DNA) • Improved convenience of location	**Quality and Safety:** e.g. • Reduced mortality rates • Reduced infection rates • Improved clinical outcomes
Financial: e.g. • Efficient use of staff time • Reductions in non-pay costs • Increased income generation	**Stakeholder experience:** e.g. • Reduced complaints • Increased compliments

The Service Transformation Team will work within the existing BIG structure (created in 2008) which consists of nine thematic areas, each led by a lead clinician and an operational manager who are accountable to the Executive Monitoring Committee.

Lean Healthcare at WWL

In common with many other Hospital Trusts looking for ways of improving services while reducing costs, WWL has been exploring the use of “Lean” concepts and methods in its service transformation projects. Using this approach, significant improvements have been made in discharge planning, ensuring that patients are able to leave hospital at the right time, with appropriate arrangements in place for their further accommodation and care. This project brought together colleagues from many parts of the Trust, together with partners from the wider health economy. The process and outcomes, which include reductions in delayed discharges and lengths of stay, attracted great interest when they were presented at a conference in Cambridge in March 2009.

A “Lean” approach to managing Outpatient bookings is being piloted in four clinical specialisms, and is expected to eliminate a large proportion of appointment cancellations. In the Pathology laboratory, turn-around times for tests have been reduced by bringing samples in sooner, improving processes and smoothing the flow of work through the Department. Several other projects are under way, including the prevention of re-admissions and the improvement of the Trust’s recruitment processes. Over the next year it is intended to involve an increasing number of staff in Lean initiatives and to provide training and accreditation in improvement techniques.

Turnaround time for pathology tests have been significatly reduced

Facts and Figures

For the period 1 December 2008 until 31 March 2009

Outpatient Attendances:

New	34,226
Follow up	94,631
Total	**128,857**

A&E Attendances:

New	26,822
Unplanned re-attendance	1,371
Total	**28,193**

Leigh Walk-In Centre	18,551

On average a member of the public attends A & E every 6 minutes

Ready and waiting

Following the agreement by the Trust of the suite of plans in 2008 for major incidents, business continuity and pandemic flu, further efforts have been made to deepen the knowledge of staff and develop resilience in three main ways, and the following snapshots are representative of the work carried out over the period

December 2008 to March 2009: Training and exercises for staff

- Over 70 senior staff trained on the Trust business continuity and pandemic flu plans.
- All new starters attending Corporate Induction trained on the suite of Trust resilience plans and given six tasks to achieve on their return to work to secure their knowledge of the plans.
- 21 senior managers engaged in the one-day North West-wide Mass Casualty Exercise Maximus with more than 50 other NHS organisations on 20 January, led by the Health Protection Agency. Possibly the largest exercise of its kind.
- Four staff were taught to become trainers by North West Ambulance Service in best practice decontamination techniques to combat the deliberate release of poisonous substances, in February.
- Over 20 senior staff were tested by the Cabinet Office Emergency Planning College national exercise team in the response to pandemic flu in a half-day exercise on 30 March funded by the Department of Health.

Collaboration with other agencies towards a safer Wigan and Greater Manchester

- Successful scrutiny by the lead commissioners for emergency planning in Greater Manchester, NHS Bolton, of the Trust pandemic flu plan as compliant with Health Care Commission Standard C24 for emergency preparedness.
- Over 20 staff from blue-light agencies across Wigan trained in the likely response to a conventional major incident and pandemic flu in a half-day multi-agency seminar on 11 March
- Participation by the Trust in the work to secure staffing for the national resilience mortuary in the event of a major disaster in Greater Manchester
- Election of the Trust as the agency chairing the Greater Manchester NHS Acute Trusts Emergency Planning Managers Group for the next two years.

- Participation by the Trust in the Accelerated Discharge Project commissioned by Greater Manchester Resilience Forum to facilitate new ways of ensuring the rapid discharge of non-urgent patients in the event of a major disaster.
- Testing of Logistics organisations' preparedness for pandemic flu in a half-day pandemic flu exercise facilitated by the Trust on 13 March at the NHS Supply Chain Runcorn Distribution Centre.
- The development via a template and open door sessions of "bite size" local Business Continuity Plans led by Wards and Departments across the Trust.
- Invitation by the North West and North Wales Regional Transfusion Committee to present in April the Trust's 2008 work on exercising the Emergency Blood Management Plan.

Ready to deal with a major incident.

1 Quality Narrative

Our first ever Quality Account is no less than a turning point in the Trust's history. This was the year in which we decided that "Our Business Strategy is Quality" and therefore our annual quality report is just as important as our annual financial report.

We are determined that our focus on quality is far from mere rhetoric. Indeed one of our principal methodologies is the use of evidence-based interventions and metrics to be able to demonstrate hard-nosed, factual improvements. We have carefully studied the work of the Institute for Healthcare Improvement (IHI), in particular its "100,000 Lives Campaign" and we have formed part of the Practice Partner Network with the NHS Institute to learn how to use techniques such as care bundles, the Global Trigger Tool, 4-box analysis and reliability theory to extend and save lives.

So what are the results? Our first priority was to tackle infection control and the two headline national problems of MRSA and Clostridium Difficile. We had 13 MRSA bacteraemias in 2008/09 compared to 19 the previous year. MRSA bacteraemia is often confused with MRSA colonisation which is simply the presence of bacteria on the skin that causes no effect to the patient. Our figures could have been better with more rigorous aseptic techniques as 6 of the positive tests were the result of contaminated samples. A tighter policy on this resulted in just one bacteraemia in the last two months of the year, giving us confidence that next year's figures will be even better. Our progress on Clostridium Difficile can fairly be described as outstanding with 77 cases in 2008/09 compared to 373 the previous year, a drop of 80%. Demonstrating the financial value of quality we estimate that these much smaller numbers of infections have released the equivalent of an entire 28-bedded ward with savings of approximately £1.25m.

In mid 2008 we moved to a top priority of reducing avoidable mortality. Sadly we came from a poor base with Dr Foster reporting HSMR for 2007/08 as 125.7. We introduced at least six initiatives (described within this report) to reduce mortality and we saw our figures begin to reduce and then tumble. Our HSMR for 2008/09 has just been reported with a 27% improvement at 92.1. Sceptics may suggest that this is just about better coding but in addition to HSMR we have also studied actual death rates. These provide corroboration with a fall of 214 deaths year-on-year equating to a 16% reduction.

We are very proud of these results but recognise that we are merely at the start of a journey. Infection and mortality are just some elements of overall harm and harm itself is just one component of quality.

While the annual Health Care Commission healthcheck rated the Trust with an overall "Good" assessment for both Effective Use of Resources and Quality of Services, the Trust's maternity unit was amongst the top rated in the country; achieving the "Best Performing" category

A major outstanding challenge for us is the achievement of the 98% 4-hour Accident and Emergency target. We recognise that

achieving this target represents a safe and effective pathway which supports and demonstrates a good patient experience. Currently our performance adversely affects our overall ambitions in this regard.

We were delighted to have been invited to join a small select group of Foundation Trusts working with Monitor to develop the first Quality Accounts and this has helped us to develop our own new quality framework with much broader aims. Our focus on reducing harm continues but alongside this we are developing programmes to improve effectiveness and the patient experience. Of critical importance is that this is not an imposed top-down programme but the aggregate of a host of bottom-up, individual programmes designed by staff in each department, clinical and non-clinical.

I would like to pay enormous tribute to the growing number of individuals who have not merely “seen the light” but have taken responsibility for leading parts of this programme. I suspect that they will have gained as great a sense of satisfaction and personal fulfilment on this work as in anything else they have done in their working lives.

In conclusion I want to emphasise the commitment from the entire Trust to a strategy based on quality and safety that will deliver an improved patient experience. This is endorsed not only by the Trust Board but at every level in the organisation. The improvements delivered over the last year are indicative of the broadest levels of engagement and active participation throughout the Trust. There is recognition of both the financial value as well as important positive impact quality improvements have on our patients’ experience. We will continue to evolve our quality plans in response to benchmarking and direct feedback from stakeholders to ensure we deliver an ever improving service.

Andrew Foster
Chief Executive

2 Review of 2008/09

2.1 2008/09 Quality Objectives

The Trust Board agreed a comprehensive set of Corporate Objectives for the year, several of which are quality objectives. The key ones were:

- **Reduce the Trust's Hospital Standardised Mortality Ratio (HSMR)**
- **Further reduce the Trust's MRSA and Clostridium Difficile infection rates**
- **Continuous Improvement in quality**

Corporate Objectives Extract

The Operating Framework - national headline objectives
• Deliver action plan on patient and staff survey results ✓
• Maximum one MRSA bacteraemia per month ✗
• Maximum 15 new Clostridium Difficile per month ✓
• 90% of admitted and 95% of non-admitted pathways within 18 weeks by 01/12/08 ✓
The Healthcare Commission - annual health check ratings
Achieve 'excellent' for 08-09 use of resource rating !
Achieve 'good' for 08-09 quality of service rating ✓
Trust Objectives
Sustained weekly delivery of 98% A&E target ✗
Half day reduction in medical LOS by January 2009 and half day reduction in non-elective surgical LOS by October 2008 ✓
Achieve and sustain 70% target for day case rates by April 2009 ✓
Deliver Ward-to-Board monitoring and intranet clock dashboard ✓
Achieve Health and Safety compliance and culture in all areas ✓
Achieve Hospital Standardised Mortality Ratio (HSMR) of 100 ✓
Action the 07-08 Staff Involvement Days outcomes and hold an 08-09 event ✓
Reduce sickness absence to 4.3% and a top 25% performance !

2.2 2008/09 Quality Objectives

2.2.1 Reduce the Trust's Hospital Standardised Mortality Ratio (HSMR)

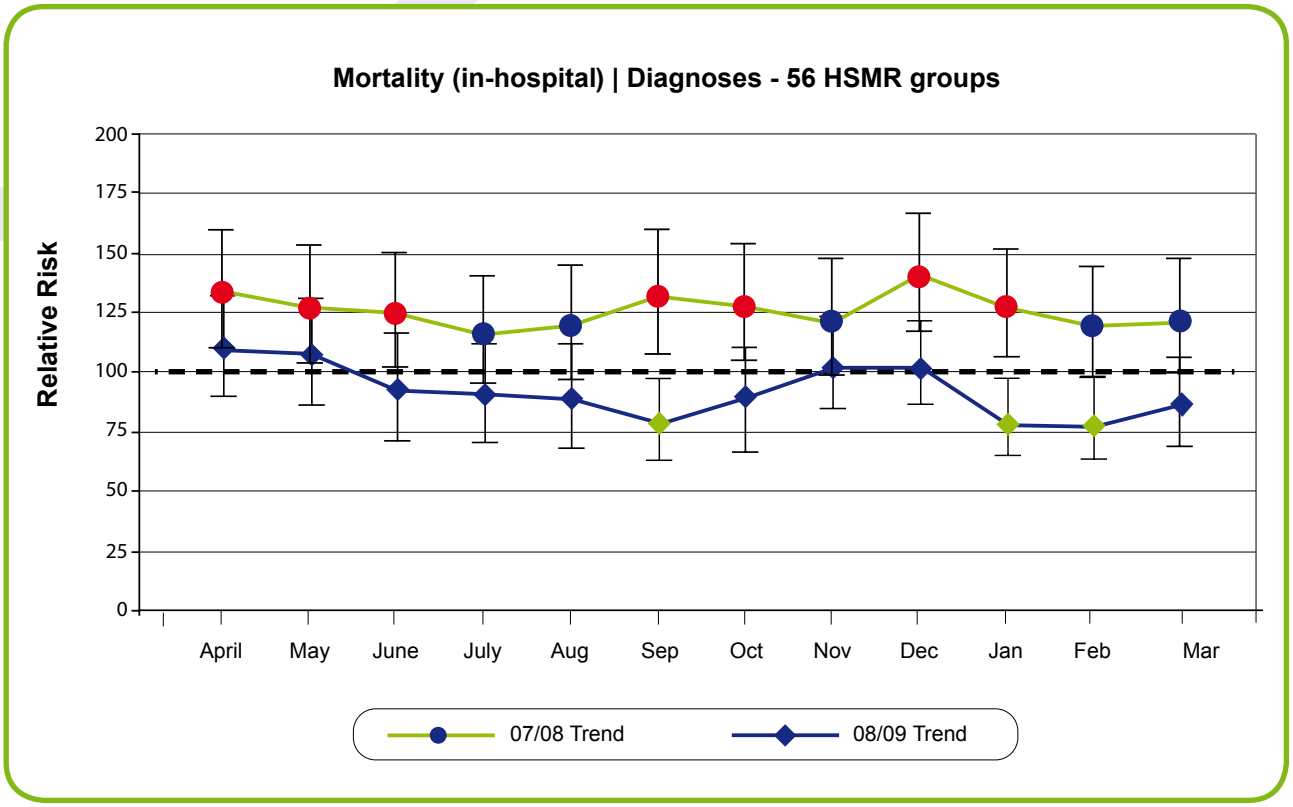
Early in 2007 the Trust realised its Hospital Standardised Mortality Ratio (HSMR) was high when compared with other Trusts in England and Wales. The Trust initially concentrated on tackling two clinical areas with the highest HSMR; acute MI and fractured neck of femur.

A Mortality Task Force was established early in 2008 chaired by the Chief Executive. Other members of the task force included the Medical Director, Director of Nursing and Patient Services, Head of Quality and Safety and Deputy Medical Director. The Task force also included representation from Dr Foster who produce the HSMR national statistics from data provided by each Trust.

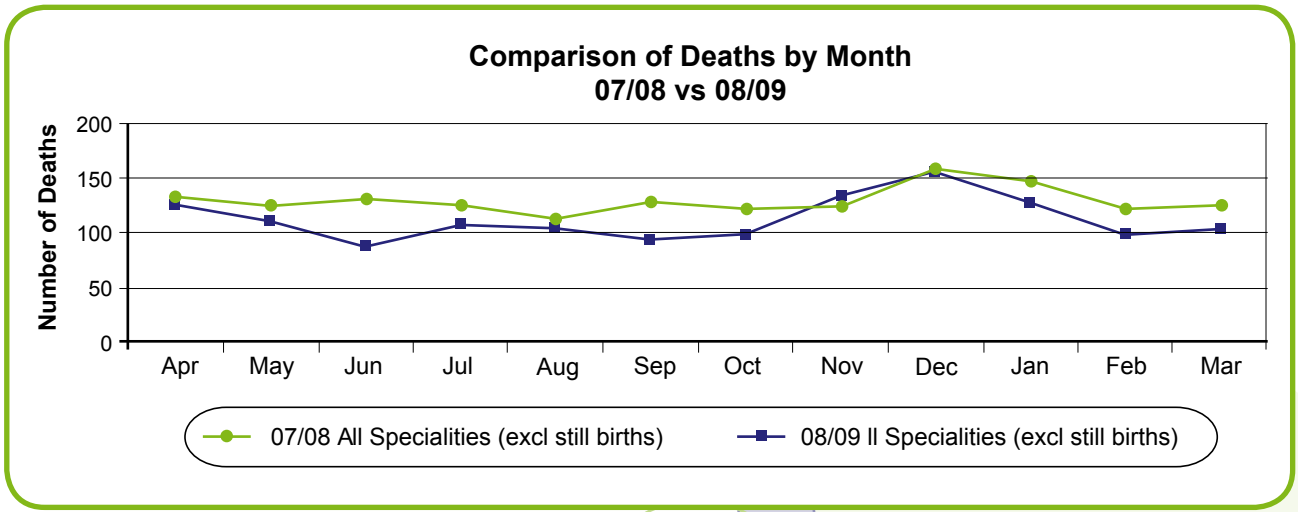
In parallel the Trust investigated best practice from a number of national and international sources including the Institute for Healthcare Improvement (IHI). From the information collected and with additional input from Dr Foster, the Trust prepared a comprehensive programme of action aimed at reducing its HSMR. The Trust increased the priority and focus on reducing HSMR naming it as its top priority early in 2008 and introduced a number of additional initiatives including:

- Campaign to reduce Health Care Associated Infections (HCAIs); Especially MRSA and Clostridium Difficile.
- Monitoring and publication of Ward-to-Board reports including Modified Early Warning Scores (MEWS) – a score based on level of consciousness, blood pressure, heart rate, respiratory rate and body temperature.
- A policy to ensure that patients would be nursed in the right specialty bed – "right patient , right bed".
- An analysis of clinical coding to identify areas for improvement that may have impact on the HSMR.
- Weekly analysis of deaths; especially unexpected deaths or unusual patterns, with feedback to clinical teams in cases of potentially avoidable death.
- Weekly deaths plotted on Statistical Process Control chart and published as part of a regular quality newsletter.
- Advancing Quality. The Trust is part of this programme which is being piloted across the North West, to improve patient care, save lives and reduce cost. This programme is focused on the application of care bundles for patients presenting with myocardial infarction, community acquired pneumonia, heart failure, hip and knee replacement and coronary artery bypass grafts (the latter is not applicable to WWL).

The Trust's annual HSMR for 2007/08 was 125.7 and the latest figures from Dr Foster show this has reduced to 92.1 for 2008/09 (a 27% improvement). The Trust's monthly HSMR peaked at 140.1 in Dec 07 and the impact of the combined initiatives delivered a steady reduction in the monthly HSMR to a low of 78.9 in Sep 08 (a massive 44% reduction in 9 months). The monthly HSMR for Sep 08, Jan 09 and Feb 09 were all reported by Dr Foster as being significantly lower than other Trusts nationally. The Trust is very proud to have made such a significant achievement in such a short period.



The chart below shows that unadjusted death rates were lower in every month but one compared to the previous year. This corroborates the HSMR chart by showing a reduction of 214 (16%) deaths, year on year:



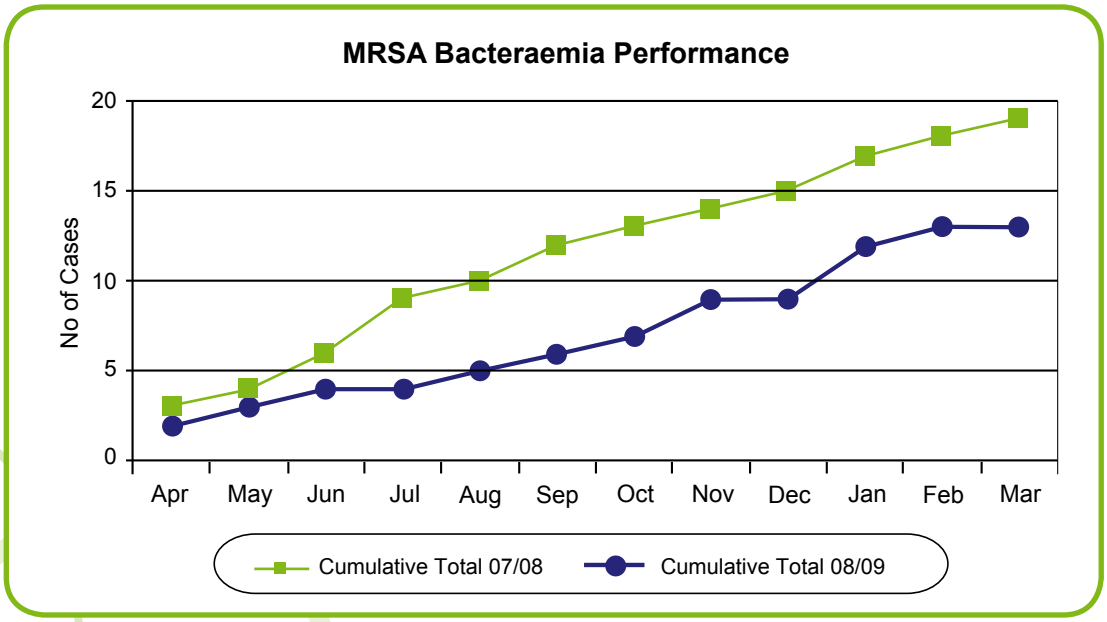
2.2.2 Further reduce the Trust's MRSA and Clostridium Difficile infection rates

MRSA

In 2008, the Trust introduced a number of initiatives to further reduce and prevent infections with the aim of reducing MRSA and C Difficile rates across the organisation.

- **Cohort ward on the Royal Albert Edward Infirmary site**
- **Campaign "bare below the elbow" and improved hand washing**
- **New dress code**
- **Deep clean - keep clean programme**
- **Further enhanced cleaning methods**
- **Route cause analysis of all reported MRSA and C Difficile incidents**
- **Investment in new side wards**

The Trust's MRSA bacteraemia rate was 13 for 2008/09. The Trust exceeded its Department of Health target of 12 by one case. Six of the cases were contaminants where staff accidentally mishandled the sample. As a result of this, the Trust is strengthening its training programme to further support staff. The MRSA infection rate per ten thousand bed days in 2008/09 was 0.63.

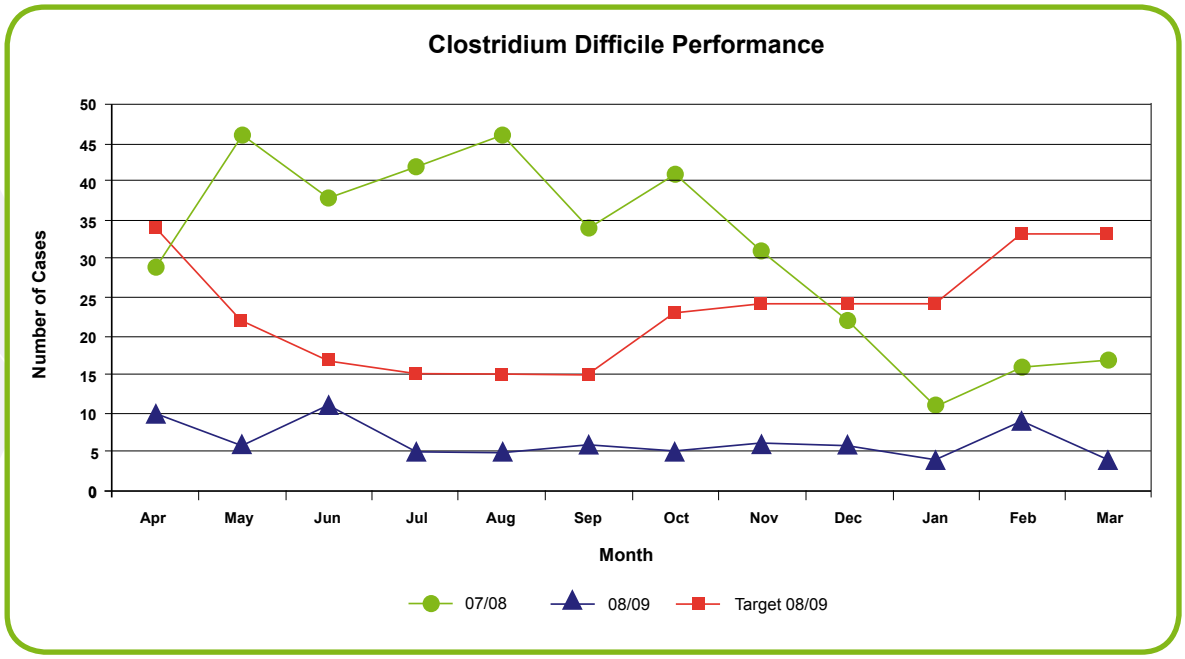


Bacteraemia
Bacteraemia is the presence of bacteria (such as MRSA) in the blood. The blood is normally a sterile environment, so the detection of bacteria in the blood (most commonly with blood cultures) is always abnormal.

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

Clostridium Difficile

The number of Clostridium Difficile cases in the Trust during 2008/09 was 77. The reduction from 273 in 2007/08 represents a reduction of 80% in a year. The Clostridium Difficile infection rate per ten thousand bed days in 2008/09 was 3.74.



This significant and sustained progress means the Trust now has one of the lowest Clostridium Difficile infection rates in the North West of England.

2.2.3 Continuous Improvement in Quality

Quality is a vital thread to improve Safety Effectiveness and Experience. In 2008 the Trust reviewed its priorities for improving Quality.

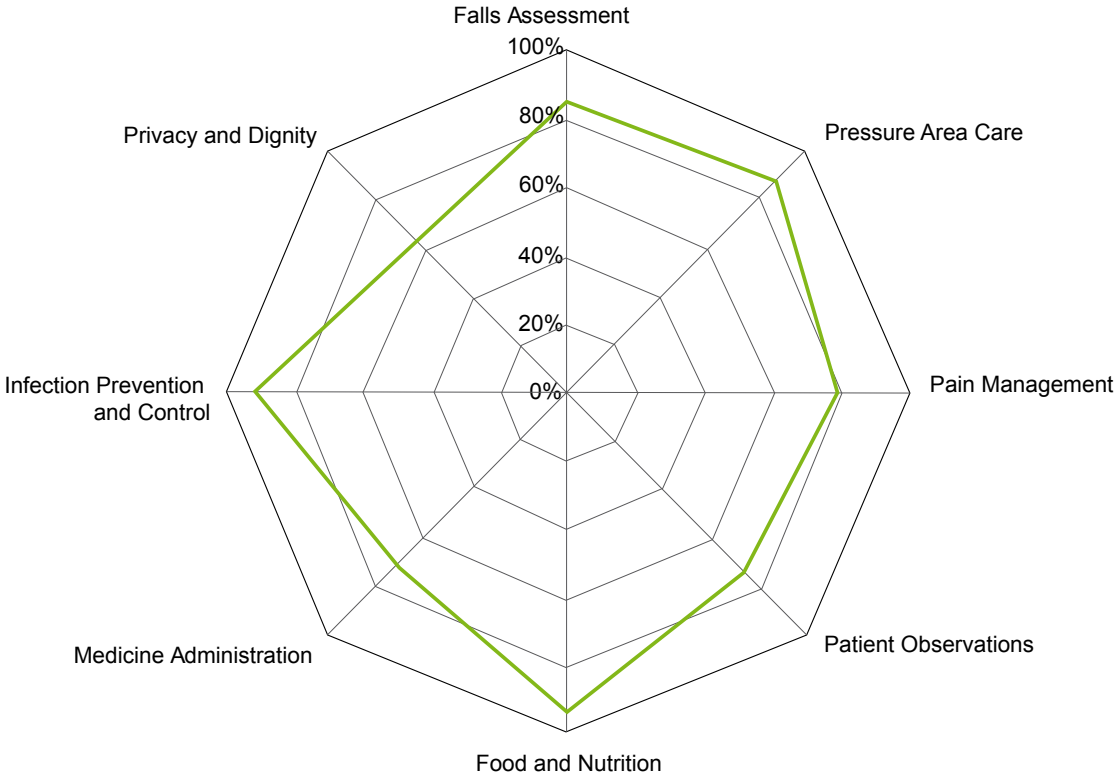
The Trust's primary goals are:-

- **Safety of patients, staff and visitors**
- **Effective treatment with good outcomes**
- **A good experience for patients and staff**

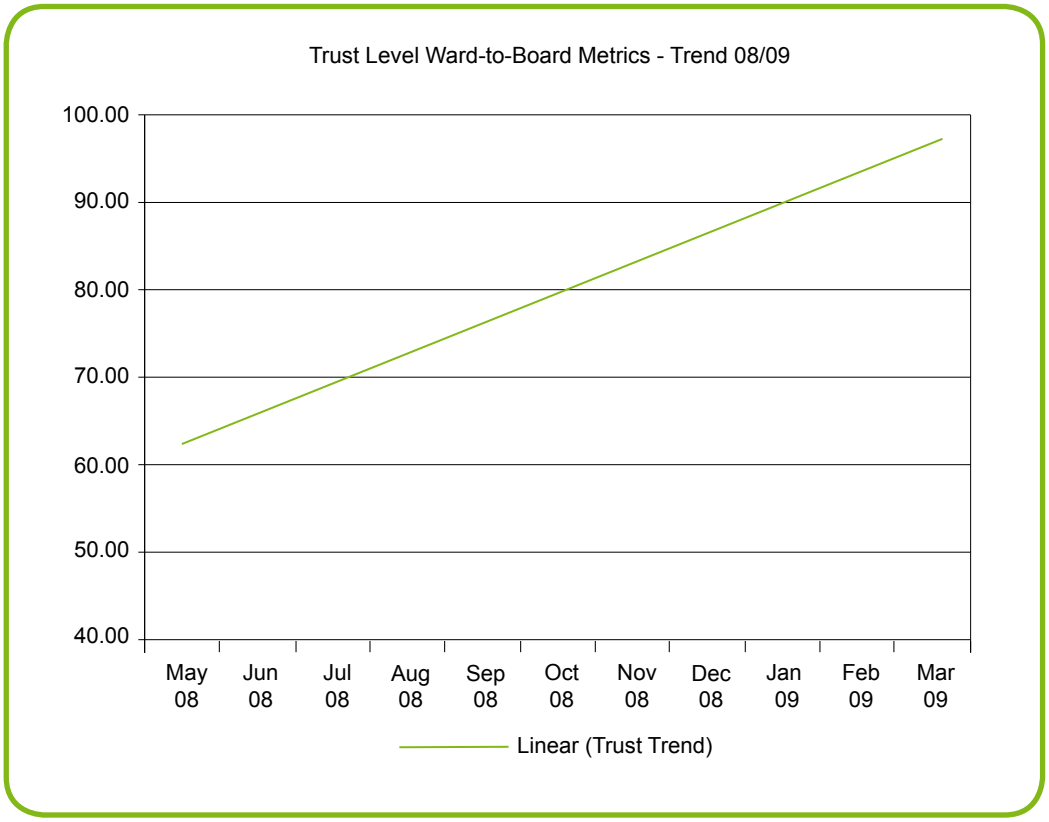
The Trust has developed monthly Ward-to-Board reports which outline its commitment to improving quality. The reports cover eight key quality improvement metrics and are used to engage and empower staff with "*what really matters to our patients".* The reports include the following areas:-

- **Falls assessment**
- **Pressure area care**
- **Privacy and Dignity**
- **Pain management**
- **Patient observations**
- **Food and nutrition**
- **Medicine prescribing and administration**
- **Infection prevention and control**

Trust Level Ward-to-Board Metrics – Percentage Compliance March 09

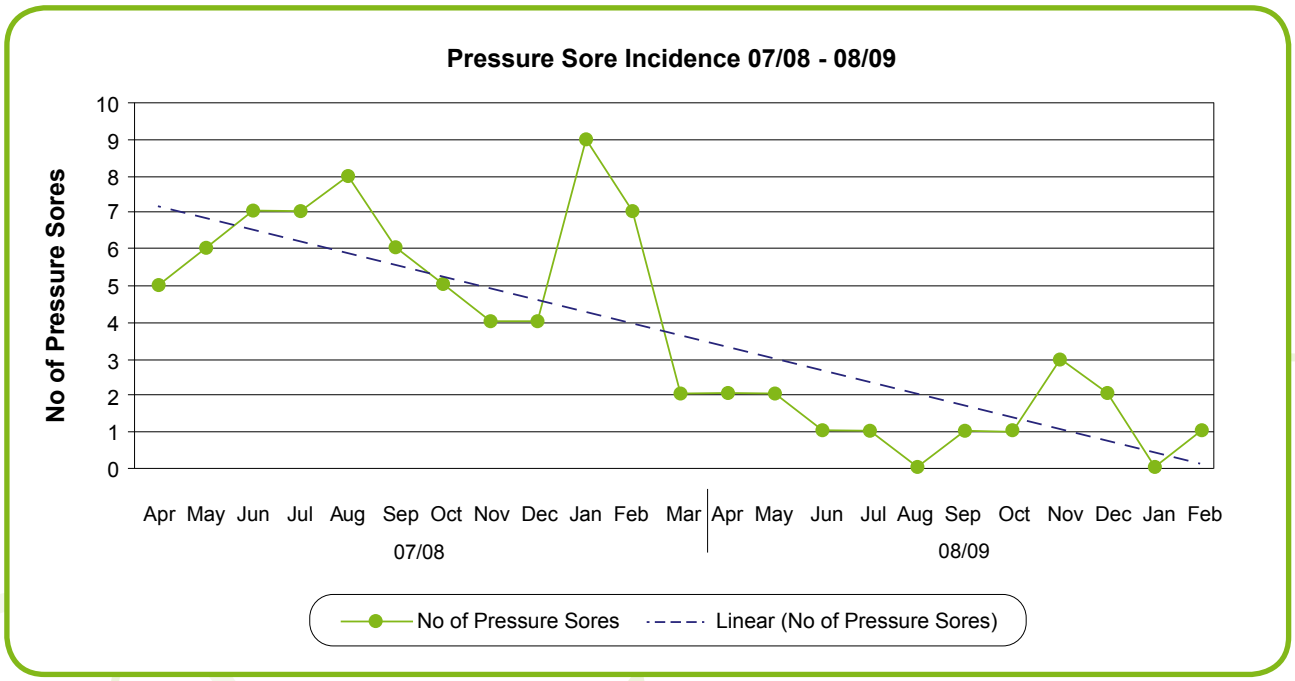


The Ward-to-Board report demonstrates performance and continuous improvement of the above eight key quality improvement metrics with the Trust's goal of achieving 80% compliance.



Pressure Sore Incidence 07/08 - 08/09

A key quality objective was to reduce the incidence of Hospital Acquired Pressure Ulcers. The Trust has implemented reviews of every Hospital Acquired Pressure ulcer, and this has resulted in a significant reduction in incidence.



2.3 Externally Raised Challenges

The Trust declared compliance against 23 of the 24 core Standards for Better Health in the Healthcare Commission's annual health check declaration for 2008/09.

The Trust's non-compliance was against core standard C4c in relation to decontamination facilities at four of the Trust's 19 operating theatres. Although theatres 1-4 located in Wrightington Hospital do not meet current standards, the Trust's infection rate for operations performed in these theatres is exemplary with no post operative wound infections or incident related to the decontamination of reusable medical devices.

In 2003 a process was initiated to provide new, shared decontamination services as part of a Department of Health led Mersey Joint Venture (JV). Unfortunately the JV was very slow to reach conclusion with protracted negotiations with successive private sector partners. This led to successive delays and finally the JV's preferred bidder withdrew from negotiations in December 2008 and the JV was formally disbanded in January 2009.

As a consequence of this unforeseen outcome the Trust is now in the process of evaluating other available options and early in 2009/10 will take a decision on the strategic direction for the provision of decontamination services.

2.4 Quality Metrics

	2007/08 Actual	2008/09 Target	2008/09 Actual
MRSA Actual cases Rates per 10,000 bed days	19	12	13 0.63
Clostridium Difficile Actual cases Rates per 10,000 bed days	373	279	77 3.74
Mortality Rates HSMR	125.7	100	92.7

3 Plans for 2009/10

The Trust has made considerable progress through a number of programmes to improve quality during 2008/9. This is very much the beginning of the journey, but the Trust has both the road map and the compass to allow it to reach its goal of achieving excellence in everything it does. Following a Clinical Services Strategy Workshop in March 2009 involving Commissioners, Board members, Governors and clinicians (Doctors, Nurses and Allied Health professionals), the Trust aims to achieve excellence in everything it does and its aspirations for quality improvement were identified as:

1 **Halve the harm**

2 **Double quality**

3 **Achieve zero tolerance for "never events"**

4 **Achieving 98% Accident and Emergency 4-hour target**

5 **Abolish outpatient cancellations**

6 **Full implementation of National Standards**

3.1 2009/10 Quality Objectives

- **Further reduce the Trust's HSMR**
- **Continue to reduce MRSA and C.Difficile Rates**
- **Further enhance Ward-to-Board reports with 85% compliance**
- **Delivery of the Advancing Quality Initiative**
- **Implement three by three quality matrices**

3.2 2009/10 Priorities

3.2.1 Further Reduce the Trust's HSMR

Mortality is a widely accepted indicator of quality of care that is used nationally to benchmark organisations. Historically the Trust has not performed well against this indicator. A dramatic improvement was achieved in 2008/09 and it is important the Trust continues with the initiatives implemented. The Trust has set an ambitious target to reduce its HSMR down to 85 in 2009/10.

3.2.2 Continue to Reduce MRSA and C.Difficile Rates

Healthcare acquired infection is an important concern for Commissioners and patients. In the last two years the Trust has delivered significant improvements which it is vital to sustain.

In line with its halving the harm aspiration, the Trust aims to continue to reduce MRSA rates to no more than six in 2009/10 and C.Difficile to no more than 40 hospital-acquired cases

3.2.3 Further Develop Ward-to-Board Reports

The Trust believes that timely reporting of Ward-to-Board metrics has been a major contributor to the success achieved in improving quality and safety. The Trust proposes to further develop Ward-to-Board Reports to include patient feedback and comments in real time using technology which will enable staff to receive timely feedback to improve services and recognise their contribution to the patients' experience.

3.2.4 Delivery of the Advancing Quality Initiative

The Trust has been actively engaged with the Advancing Quality (AQ) Initiative and it has developed electronic pathways within the electronic patient record system that facilitate real time-data collection on the AQ care bundles. The real-time approach ensures the defined interventions are embedded in operational processes. This approach to data collection allows easier data uploads for centralised reporting which will commence during 2009/10. These reports will be a powerful indicator of safety and effectiveness in relation to the pathways covered by the initiative.

The Trust will incorporate the Advancing Quality indicators and evidence based clinical pathways into the EPR, whilst continuing to implement these within a paper record in the interim. Monitoring of compliance against mandatory quality data sets will be embedded within the annual clinical audit cycle and will be supplemented by the "Divisional Vital Signs". These will form part of the exception reporting to the Quality Board and Trust Board to stimulate improvement.

3.2.5 Implement Three by Three Quality Matrices

All Departments within the Trust are developing a three by three matrix that will be used to assess quality. The matrices will have the three areas of safety, clinical effectiveness and patient experience on one axis with inputs, process and outcomes on the second. These will be developed "bottom up" within the Trust and cascade upwards to allow a Trust-level matrix to be reported.

Example of 3 x 3 Format Metrics the Trust will Use for Assessing Quality

	Safety	Clinical Effectiveness	Patient Experience
Inputs	• Policies fully understood • Staff appropriately qualified and monitoring in place • 'Implementation of Maternity Matters' • Appraisal • National Patient Safety Agency • Safety First • NHS Litigation Authority • Safer Handovers	• Systems in place to collate and audit data • National Service Frameworks • National Audit programmes • Health Inequalities	• Embedded within matron development programme • System in place for monitoring • Patient Engagement Group – chaired by Governor
Process	• Infection control policies • Ward-to-Board reports • Board 'Safety walkabouts' • Safe Surgery Initiative • Safeguarding	• Advancing Quality Initiative pathways • Clinical Audit – National Institute for Clinical Excellence compliance, National Audit compliance • Accessible Guidelines • Institute for Healthcare Improvement Care Bundles • Dr Foster • Smoking cessation counselling	• Ward-to-Board metrics on privacy and dignity • Access to information • Empathy pilots • 'Real time' patient survey feedback • One Stop clinics • Video diaries
Outcomes	• Rate of Adverse Incidents • Global Trigger Tool • Reduction in Serious Untoward Incidents • Reduction in: - Falls - Pressure ulcers - MRSA - CDiff - Surgical site infection - Ventilator Acquired Pneumonia - Central line infection	• Mortality Rates • Life expectancy • Patient Related Outcome Measures	• Patient Satisfaction rates • Number of complaints • Positive Comment cards • Reduced waiting times

3.2.6 Patient Experience

The Trust will incorporate patient experience metrics within the Board report; these will be defined from the pilot Harding & Yorke proposal on “empathy measures”. This will be supported by the roll out and analysis of the comment card system across the Trust with feedback being posted on the clinical areas. The development of real-time patient survey systems will be implemented to support immediate intervention at ward and departmental level. The Trust will respond to all direct patient feedback including issues identified via the complaints process and implement remedial action where required.

The Trust will further seek solutions and learn from organisations which have successfully embedded patient experience within their performance culture.

3.2.7 Monitor Compliance Framework

The Trust has developed a Monitor compliance Framework which is reported to the Trust Board on a monthly basis.

	Targets-Weighted 1.0 (National Requirements)	Threshold (12)	Weighting	Monitoring Period	Q1	Q2	Q3	Q4
1	Clostridium difficile year on year reduction (to fit the trajectory for the year as agreed with PCT-assumed a 15% reduction (if no level agreed in a contract)	0	1.0	Quarterly	27	16	17	17
2	MRSA - maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level (assumed target is 50% of 2003/04 if no level agreed in a contract)	0	1.0	Quarterly	4	2	3	4
3	Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	To be confirmed	1.0	To be achieved from end December 2008 and monitored quarterly thereafter	Under Development			Jan - 100% Feb - 100% Mar - 100%
4	Maximum waiting time of 62 days from all referrals to treatment extended to cover all cancer treatments. (Includes shared breaches)	To be confirmed	1.0	To be achieved from end December 2008 and monitored quarterly thereafter	Under Development			Jan - 90% Feb - 95% Mar - 100%
5	18-Week Maximum Wait by 2008 Admitted patients: maximum time of 18 weeks from point of referral to treatment	90%	1.0	To be achieved from end December 2008 and monitored quarterly thereafter	April - 94% May - 96% June - 95%	Jul - 94% Aug - 95% Sept - 92%	Oct - 93% Nov - 91% Dec - 92%	Jan - 91% Feb - 93% Mar - 93%
6	18-Week Maximum Wait by 2008 Non-Admitted patients: maximum time of 18 weeks from point of referral to treatment	95%	1.0	To be achieved from end December 2008 and monitored quarterly thereafter	April - 90% May - 95% June - 97%	Jul - 91% Aug - 99% Sept - 95%	Oct - 96% Nov - 95% Dec - 96%	Jan - 95% Feb - 96% Mar - 95%
Targets - weighted 0.5								
7	Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98%	0.5	Quarterly	98.7%	97.8%	96.9%	95.9%
8	Maximum waiting time of 31 days from diagnosis to treatment for all cancers	98%	0.5	Quarterly	100%	100%	100%	Jan - 100% Feb - 100% Mar - 100%
9	Maximum waiting time of 62 days from urgent referral to treatment for all cancers	95%	0.5	Quarterly	96.3%	97.7%	99%	Jan - 90% Feb - 91% Mar 82.4%
10	People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	68%	0.5	Monthly	Apr - 100%, May - 75%, Jun - 75%	Jul - 25%, Aug - 100%, Sept - 100%	Oct - 83%, Nov - 89%, Dec - 83%	Jan - 100% Feb - 88% Mar - 71%
11	Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	98%	0.5	Quarterly	100%	100%	100%	Jan - 98.3% Feb - 99.4% Mar - 99.7%
National Core Standards								
12	Each national core standard	-	0.4	Ad hoc				

Financial Performance Report

Financial performance is reported for the four month period as a Foundation Trust from 1st December 2008 to 31st March 2009. In this trading period the Trust delivered an income and expenditure surplus of £403k, and together with the eight months as an NHS Trust, an overall full year performance of £1,110k, offset by (£13,709k) impairment for the reduction in land and building values.

The Trusts cash balance at 31st March 2009 was £17.7m, being £4.7m ahead of plan and is to be utilised in supporting the Trusts trading and capital expenditure investments going forward.

Summary of Income and Expenditure – 1st December 2008 to 31st March 2009

	£'000
Total income	71,866
Total expenditure	(69,488)
Operating surplus/(deficit)	2,378
Interest and Dividends	(1,975)
Retained surplus/(deficit) for the financial period	403

The following tables summaries the key financial performance indicators

Financial Risk Rating (FRR)

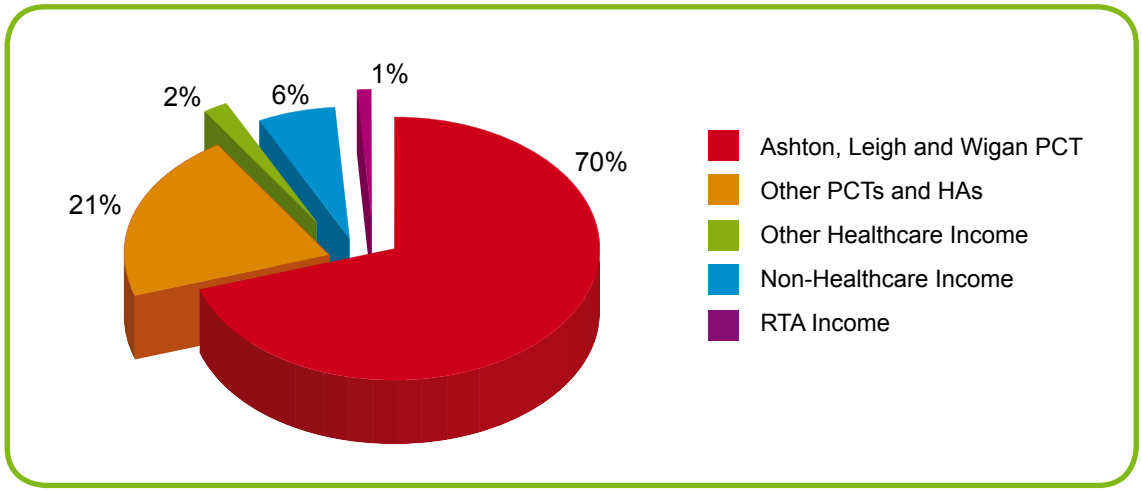
As a Foundation Trust we have to manage financial performance within Monitor's compliance framework which is a risk based assessment with specified ratios and a table of performance grades ranging from level 5 to level 1. Level 5 is the highest rating with least risk, with level one being the lowest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

The Trust achieved a Financial Risk Rating of 3.4 against a plan of 3.5 resulting in a FRR of 3 against a plan of 4.

Metric	Criteria	% Achieved	Risk rating	% Weighting
EBITDA margin	Underlying Performance	7.1%	3	25%
EBITDA, % achieved	Achievement of Plan	86.3%	4	10%
ROA	Financial Efficiency	4.5%	3	20%
I&E surplus margin	Financial Efficiency	0.6%	2	20%
Liquid ratio	Liquidity	50.4	5	25%
Weighted Average			3.4	
Overall Financial Risk Rating			3.0	

Income

Total income received in the period as an NHS Foundation Trust was £71.9 million. A breakdown of total income by source is shown in the graph below



Total income for the period is £71.9m with 94% or £67.6m coming from the delivery of clinical services. The majority of the Trust's clinical income comes from Ashton, Leigh and Wigan PCT, 70% or £47.3m coming via this route. Non clinical income for the period is £4.3m with the majority of this income received to fund Education & Training; services provided to other organisations and commercial activities such as the provision of catering services.

Clinical Income by point of delivery

	£'000
Elective income	17,538
Non-elective income	18,327
Outpatient income	12,782
A&E income	2,310
Other NHS clinical income	15,324
PBR (clawback)/relief	0
Private patient income	969
Other non-protected clinical income	67,565

Private Patient Cap

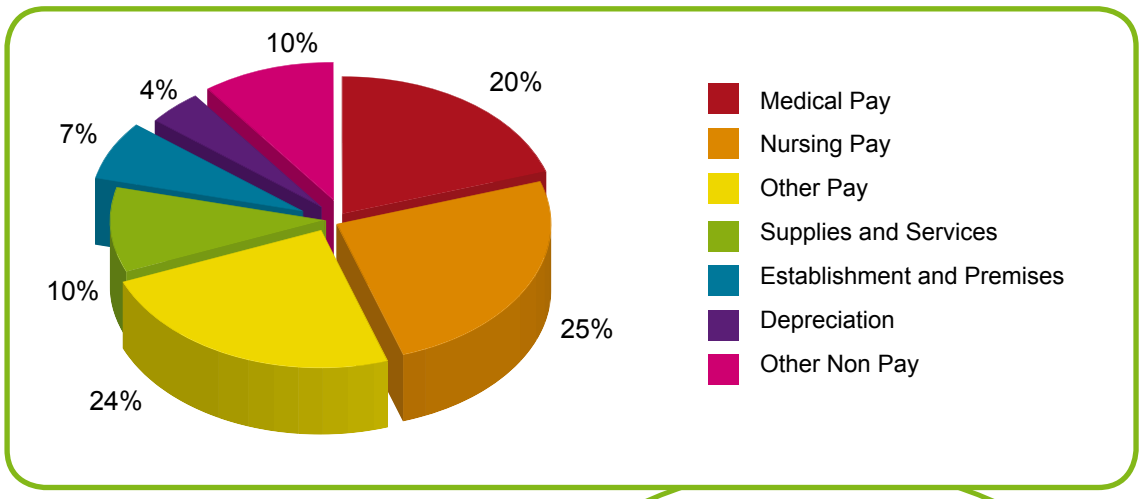
Section 44 of the NHS Act 2006 requires that the proportion of private patient income to the total patient related income of the NHS Foundation Trust should not exceed its proportion whilst the body was an NHS Trust in 2002/03.

The Trusts performance for the period was as follows:

	4 months ended 31/03/09 £'000	Base Year 2002/03 £'000
Private patient income	969	2,891
Total patient related income	67,565	140,399
Proportion (as a percentage)	1.4%	2.1%

Expenditure

Operating expenses totalled £69.5 million for the period, 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

There are however 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 are setout in the Prudential Borrowing Code (PBC), published by Monitor.

The PBC sets out five minimum financial ratios that have to be met in order for the Trust to undertake any borrowing. The maximum cumulative borrowing or Prudential Borrowing Limit (PBL) that the Trust may make is set by Monitor with reference to the Trust's annual financial risk rating.

The Trust's authorised Prudential Borrowing Limit is aligned to its planned financial risk rating of 4, which provides a PBL equivalent to 25% of total Trust assets, resulting in a maximum cumulative borrowing limit of £44.7m.

During the four month period to 31st March 2009 the Trust did not have any borrowing.

In addition to the PBC the Trust also has an approved short term overdraft facility of £16m that also was not utilised either.

The Trusts performance against the Prudential Borrowing code is set out below:

	Approved PBL ratios	Actual ratios
Maximum debt to capital ratio	<15%	Nil
Minimum dividend cover	>1x	3
Minimum interest cover	>3x	N/A
Minimum debt service cover	>2x	N/A
Maximum debt service to revenue	<3%	Nil

Until such time as the Trust draws down a loan only the minimum dividend cover ratio is relevant.

Financial and Operating Risk

2008/9 was a challenging year for the Trust, not only due to the non-recurrent energies expended in achieving foundation Trust status, closing Whelley hospital, implementing the hospital at home service and making significant strides on the road to improving the quality of care we offer our patients e.g. infection controls and HSMR reductions. All these initiatives affected the financial base of the Trust but equally have helped move the Trust to a more affordable platform for the future. This journey will be continuing in 2009/10 where the Trust faces a sizeable CIP programme and an increasingly challenging commissioner. Despite this current position and the prospect of future national restrictions in public sector spending, the Trust is confident it can deliver revenue surpluses for the next three years. It recognises that this will require increases in productivity and efficiency. Cash balances remain favourable throughout this period and appropriate levels of capital expenditure maintained

Capital Investment Programme

The Trust full year capital investment programme was £12.2m with £3.million achieved as an NHS Trust with £8.6m carried forward as a Foundation Trust.

Details of the most significant investment are set out below;

	£'000
Capital expenditure during the period:	
Individual schemes more than £50,000	
Replacement Equipment	1,574
Convert Physio Accommodation	987
Telecoms upgrade all sites	948
Leigh Boiler House	856
Lift Enabling Works	693
Second CT Scanner	644
Document Management (Digitisation Project)	294
Relocation of Occupational Health	267
Data Warehouse	257
Mass Data Storage	235
Carbon Trust/Energy	186
Maternity System	179
RAEI Kitchen Canopies	167
Digital Dictaphones	160
Health Safety and Fire Essential Legionella upgrade work	134
Wrightington Decontammination	116
Service Line Reporting & Patient Level Costing System	101
Diabetic Retinothapy	90
Waste Segregation (Trust wide)	61
MRSA Lab Extension	58
Service Desk	51
Desk top replacements	50
Other schemes (under £50k)	476
	8,584

Details of the most significant investment are set out below:

- The procurement of medical equipment comprises of a significant number of technology leading equipment to ensure the Trust continues its high quality of patient care.
- The conversion of the Physiotherapy ward resulted in the delivery of a twelve bed acute ward comprising of single room accommodation with en-suite facilities. This ward delivers privacy and dignity as well as infection control in line with best procedure guidelines.
- Complete renovation and replacement of the coal fired steam rising boiler plant was delivered on time and to schedule resulting in Leigh Infirmary now being able to deliver highly efficient low pressure long term heating and hot water whilst reducing CO2 emissions (66% reduction) and eliminating the Legionella risk.
- Completion of works to enable the facilitation of the new CT Scanner on schedule that will ensure RAEI have increased capacity to deal with more cases in an efficient manner.
- The Trust has an ongoing investment programme for Information Technology to provide efficient and innovative IT solutions to support improvement to services. In year commenced replacement of the entire telecommunications infrastructure of the Trust with a resilient and modern feature rich platform which is due to go live at the end of June. Future developments include a contact centre facility and integration of the telephony system with the IT systems to allow seamless and effective communications, as well as schemes for document management and data capture systems.
- Relocation of Occupational Health was essential due to the shut down of Whelley in order to preserve an essential service. This was completed to schedule and on time.

In 2009/10 the Trust has established a capital investment programme of £10.4 million based on strategic and operational priorities in continually improving facilities and services provided by the Trust. This programme also sees the start of the major investment for replacing the remaining old Victorian buildings on the Royal Albert and Edward Infirmary (RAEI) site, which is expected to take several years until completion.

The Trust is not planning to utilise any of its authorised borrowing capability to achieve its 2009/10 capital programme.

Better Payments Practice Code

The Better Payment Practice Code 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 following table summaries performance for the four months to 31st March 2009:

	Number	£'000
Total Non-NHS trade invoices paid in the period	23,793	31,158
Total Non-NHS trade invoices paid within target	22,470	30,027
Percentage of Non-NHS trade invoices paid within target	94%	96%
Total NHS trade invoices paid in the period	949	7,874
Total NHS trade invoices paid within target	928	7,805
Percentage of NHS trade invoices paid within target	98%	99%

Accounting policies

The Trust's main accounting policies used to prepare the accounts are set out in the Trusts annual accounts in the appendix of this annual report. The accounting policies are in line with UK GAAP and Monitor 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.

Leigh Infirmary Site

Patient Relations

WWL welcomes the views of people who have experience of the Trust's services, even if they are critical, because this provides an opportunity to learn and improve for the benefit of others who may use the Trust's services in the future.

The Patient Relations Department provides confidential on the spot advice, information and support to patients, relatives and carers aiming to resolve any concerns they may have about the care received. The Patient Relations Department receives and investigates formal complaints and provides advice and support for both the complainant and any staff involved. All complainants who make a formal complaint receive a letter of response from the Chief Executive. In many cases complainants are additionally offered a meeting to give them the opportunity of meeting Trust staff to receive face-to-face answers to their concerns and resolve any misunderstandings.

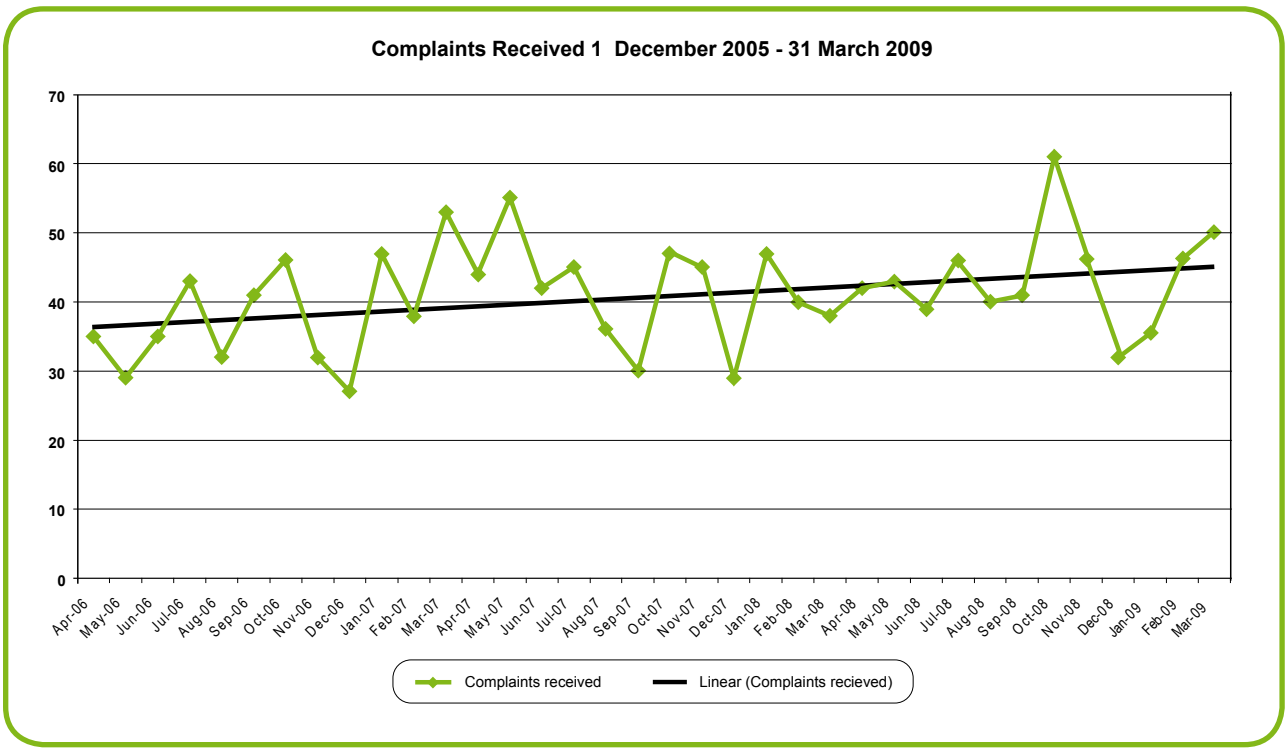
In seeking to respond to complaints and user feedback in a fair and open manner the Trust has been guided by the Ombudsman's 'Principles for Remedy' as follows:

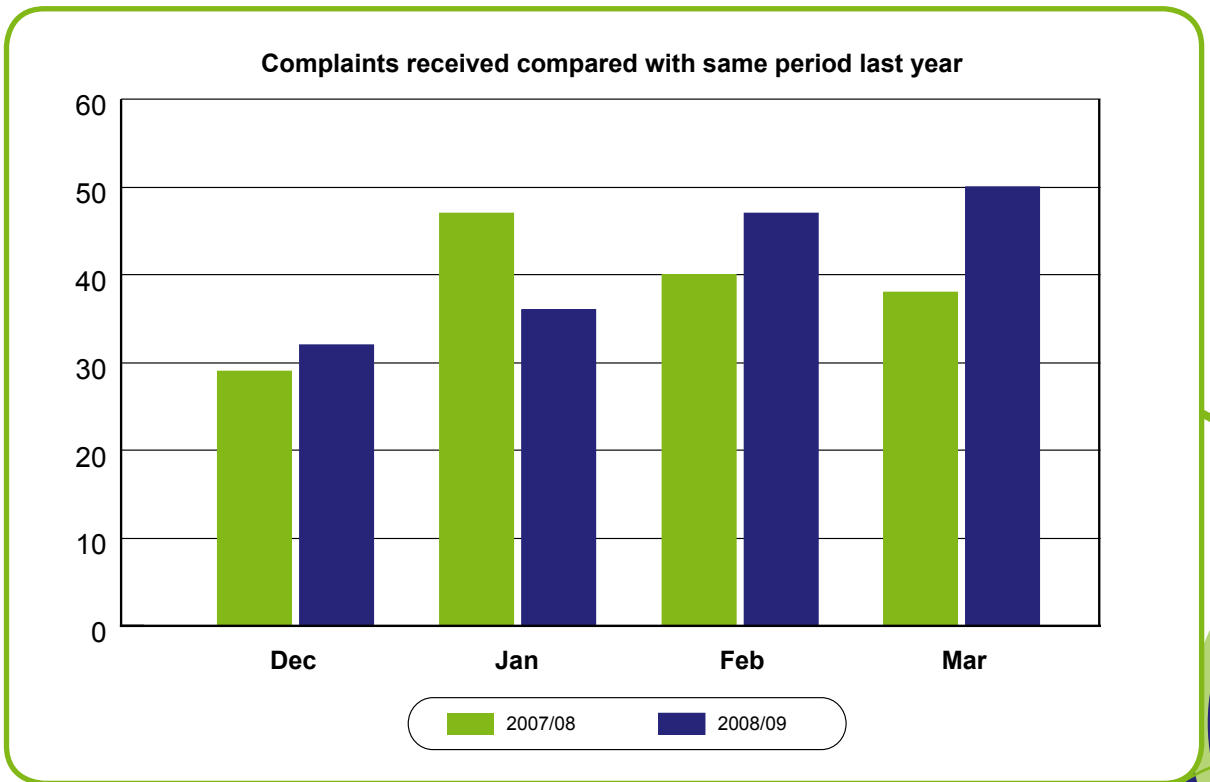
- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

Patient Relations received 165 formal complaints and 212 informal complaints

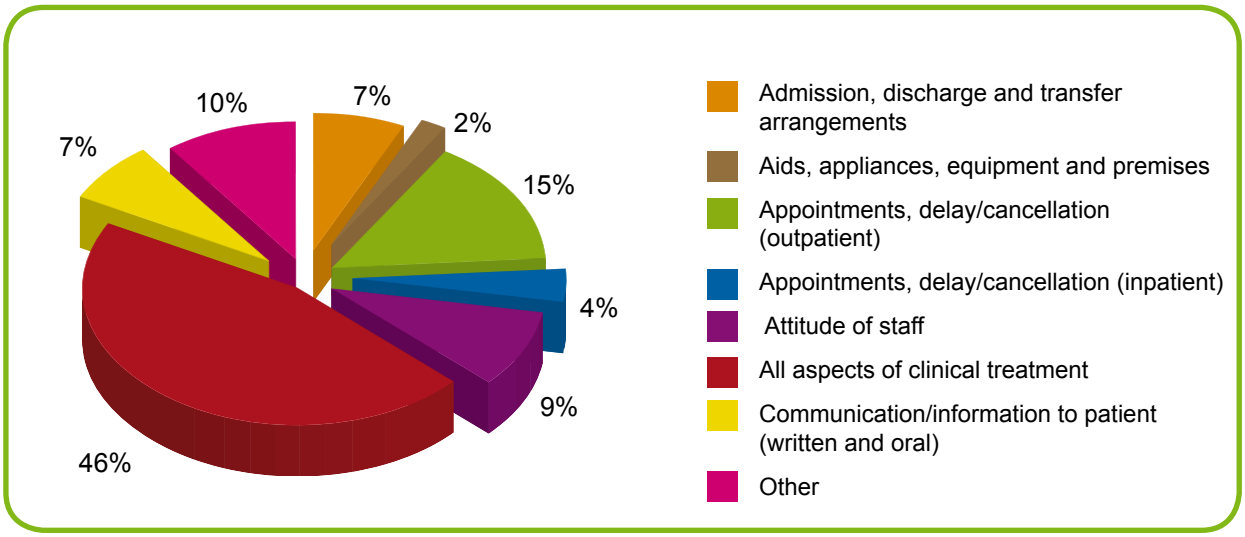
Statistical Information and Performance

From 1 December 2008 - 31 March 2009 the Trust received 165 formal complaints. The Patient Relations Department also dealt with 212 informal complaints and enquiries. This continues to show an upward trend in the number of complaints received as the chart below showing complaints received over the previous three years demonstrates.

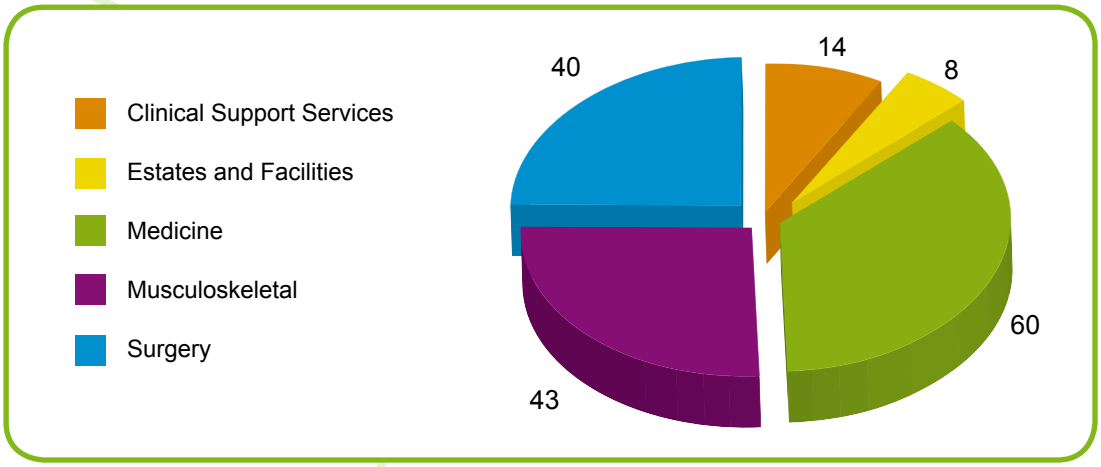




The chart below shows the breakdown of complaints recieved by subject



The chart below shows the number of actual complaints by Division



The highest number of complaints relate to all aspects of clinical treatment within which communication and a perceived lack of information were central themes. Many of the complaints broadly categorised as “all aspects of treatment” also include elements of poor information, misunderstanding or attitude.

The Patient Relations Department aims to acknowledge all complaints within two working days and provide all complainants with a response to their complaint within 25 working days. At the time of writing, the target for acknowledgements was achieved for 100% of complaints and the response target for the period 1 December 2008 to 28 February 2009 was achieved for 90% of complaints received. Year end figures are not yet available. The reasons for not meeting the standard were related to the complexity of some of the complaints. These achievements represent a performance above the national average. The Patient Relations Department continues to strive to improve the response times in collaboration with the clinical Divisions.

The Patient Relations Department also dealt with 212 concerns or requests for assistance on an informal basis and in most cases prompt action was able to resolve these concerns without them being escalated to a formal complaint.

The Healthcare Commission

Most complaints are resolved at the Local Resolution stage with a response from the Trust. Those complainants who were dissatisfied with the response, up to 31 March 2009 could ask the Healthcare Commission to look at their complaint.

At the time of writing, none of the complaints received between 1 December 2008 and 31 March 2009 have been referred to the Healthcare Commission. During this period however the Trust received notification of one complaint which was received by the Healthcare Commission relating to a complaint from the previous year. This has been passed to the Parliamentary and Health Service Ombudsman, due to changes in the Complaints Procedure from 1 April 2009. The Trust also received reports in relation to four cases from previous periods. One complaint was not upheld and three were upheld or partially upheld with recommendations on which the Trust has taken action. These related to:

- Improvements to pre-operative assessments
- Ensuring improvements to post-operative reviews
- Customer care training for staff
- Awareness training for medical staff in relation to improving communications with relatives when a decision is taken that resuscitation would not be appropriate.
- Improved arrangements for the reporting of unexpected/serious radiological findings.
- Pain management audits carried out in the Emergency Care Centre to ensure that patients' pain is adequately documented and managed.
- Improvements to junior doctors induction training to include communication

Service Improvements Arising from Complaints

The complaints process does not end with the final response letter. The Trust takes all complaints seriously and the Patient Relations Department feeds back issues arising from complaints to staff through the Divisional Complaints Performance Meetings, Service Improvement Teams, staff meetings and on an individual basis. Action plans for changes in the light of complaints are monitored to ensure that The Trust extracts lessons from complaints and improves its service.

Much of the learning that takes place from complaints is in relation to staff reflecting on their actions and seeing things from the patients' or relatives' perspective. However below are a few examples in addition to those noted above of the learning that has taken place and the changes introduced as a result of complaints received this year to date:

- Training for junior doctors with regard to death certification
- Introduction of written discharge advice for patients at Wrightington Hospital.
- Development of a new computerised Maternity System
- Pilot being undertaken for staggered admission times for planned surgery
- Training sessions for medical and nursing staff in relation to the 'Care of the Dying' care pathway

Monitoring Arrangements

The Patient Relations Department as part of the Quality and Safety Team provides quarterly reports for the Trust's Quality Board, which identify the number of complaints received broken down by Division, subject and performance against the 25-day standard. Themes and lessons learned are also identified. A monthly report is also provided to the Trust Board. More detailed reports are produced for the clinical Divisions.

Training

All staff have a role to play in responding positively to concerns and complaints and in order to raise awareness of the importance of complaints and the role of all staff, the Patient Relations Department continues to participate in training activities, including induction, mandatory training, student nurses, diversity training and ward /departmental training. In addition an e-learning package to support staff who are unable to attend classroom-based training has been launched and well received.

New Complaints Procedure

1 April 2009 sees a new complaints procedure for both health and social care. The aim is to ensure that complaints are dealt with efficiently and are properly investigated; complainants are treated with respect and courtesy and receive where required assistance to enable them to understand the procedure in relation to complaints; complainants receive a timely and appropriate response, are told the outcome of the investigation of their complaint; and action is taken if necessary in the light of the outcome of a complaint. Greater emphasis is placed on involving the complainant to achieve satisfactory outcomes and ensure that where things have gone wrong they are put right and the organisation uses complaints as opportunities for improving the services provided to patients.

Wigan Council Urban Design Award Winner Royal Albert Edward Infirmary main entrance upgrading

Information Governance

Information Governance Toolkit 2008/09

The sixth assessment of the Information Governance Toolkit has been completed. This is made up of 63 requirements which focus around confidentiality and data protection, clinical information and corporate information assurance, information governance management, information security assurance and secondary use assurance. The deadline for the submission was 31 March 2009.

The table below shows the percentage scores for each initiative and the overall score for the Trust for year ending 2008/2009.

Initiative	Results for 2008 / 2009
Clinical Information Assurance	70% (green)
Confidentiality and Data Protection Assurance	66% (amber)
Corporate Information Assurance	41% (amber)
Information Governance Management	73% (green)
Information Security Assurance	61% (amber)
Secondary Use Assurance	75% (green)
Overall Score	**67% amber**

For more information relating to the Information Governance Toolkit, please visit the following page on the NHS Connecting for Health website: https://www.igt.connectingforhealth.nhs.uk

Information Governance Board

The Information Governance Board meets on a quarterly basis, which is chaired by Mr Chris Chandler, Medical Director and Caldicott Guardian. Membership includes all key personnel associated with Information Governance. Key issues regarding the operational activities of Information Governance are monitored and work programme issues are discussed and actioned such as the Information Governance Toolkit, Data Protection issues, Information Sharing, Access to Health Records, Freedom of Information, Data Quality, Information Governance Training, Health Records, Patient and Public Involvement, Risk and Information Security issues. This group continues to be the forum for discussion and approval for Information Governance policies and procedures. Minutes of the Board meeting can be located on the Information Governance pages on the Trust website.

Statement of Compliance (SoC)

From the 1st December 2006 any organisations using NHS Connecting for Health Digital Services and/or connecting to NHS N3 network are required to complete the Statement of Compliance.

As part of the Statement of Compliance Declaration, the Trust must attain a level two for 20 out of the 63 requirements on the Information Governance Toolkit.

The Trust has attained level two for 18 of the Statement of Compliance requirements and has put action plans in place for two requirements, which have been approved by NHS Connecting for Health, in order to attain a level two. These two requirements relate to personal data flow mapping and corporate records assurance.

Information Governance Assurance Programme

Following serious public sector data security breaches, a series of papers were issued to NHS organisations setting out responsibilities for information governance and for providing additional assurances on information governance, for the Trust, to Monitor, the Independent Regulator of NHS Foundation Trusts.

The papers issued by David Nicholson, Chief Executive of the NHS and Matthew Swindells, the Department of Health's interim Chief Information Officer, included guidance on secure transfers of personal data; reporting of data losses as Serious Untoward Incidents (SUIs); implementation of Privacy Impact Assessment's (PIAs) for any new project/ system, incorporating information assurance within an organisation's Statement of Internal Controls and the appointment of a Senior Information Risk Owner to oversee an Information Risk Policy for the Trust.

The Trust has appointed a Senior Information Risk Officer, who is the Director of Finance. This person is required to:

- Be a member of the Trust Board
- Provide written advice to the Accounting Officer (Chief Executive) on the content of it's annual Statement of Internal Control (SIC) in regard to information risk
- Ensure information security threats are followed up and incidents managed
- Own the Information Risk Policy
- Brief the Board on information risk issues
- Undertake and pass information risk training on annual basis

Work is in progress to ensure the Trust strives to work towards and maintain to all the standards and recommendations set out.

Most of the recommendations will become mandatory for all NHS organisations to comply with next year and will be included in the Information Governance Toolkit.

Freedom of Information (FOI)

The Trust has received 169 FOI requests from 1 Jan 2008 to 31 December 2008. So far in the first quarter of the year for 2009, the Trust has received **61** information requests. Compared to last years statistics as highlighted below, the amount of requests received have doubled.

Total Requests received since implementation of the Freedom of Information Act 2000 by year

2005	65
2006	67
2007	51
2008	169

All responses to FOI requests are now published on the Trust website.

New Publication Scheme

The Information Commissioner introduced a new model publication scheme which all NHS organisations had to adopt by 1 January 2009. A dedicated scheme for NHS Trusts has been made available which indicates the information NHS organisations are required to publish and make available for the public which includes a charter/commitment document, the classes of information which must be published, the manner regarding how the information will be made available and the charging policy.

The new scheme is to shift focus, attention and effort to the consistent proactive release of information and provide easy access, using the Trust website as the primary communication tool; therefore there is a large section on the website dedicated to the new Publication Scheme. If anyone has any difficulties accessing the information or would like hard copies of information, contact details are available on the Trust website on the Access to Information page.

Data Protection Requests – Subject Access to Health Records

In the first quarter of this 2009, the Trust has received 573 subject access requests. These are broken down by site as follows:

Leigh	51 requests
RAEI	420 requests
Wrightington	102 requests

Information Governance Risk and Incident Reporting

The Information Governance Risk and Incident Log continues to be updated from reported incidents undertaken by staff.

Please find below a breakdown of incidents reported by nature of incident.

Table to show Personal Data Related Incidents reported from 1 January – 31 March 2009 by type

Category	Nature of Incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	2
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1
IV	Unauthorised disclosure	2
V	Other	3
Total		**8**

Reported Personal Data Related Incidents Scores (January 2009 – 31 March 2009)

Severity Rating	Number of Incidents
0	2
1	5
2	1
3	0
4	0
5	0
Total	**8**

There have been no information related Serious Untoward Incidents (SUI's) to report.

The Department of Health mandated that all incidents need to be included in this report and any Serious Untoward Incidents are to be reported to the SHA and Information Commissioner.

Information Security

The Trust is working towards ensuring that all portable equipment such as laptops and removable media such as memory sticks and CD's can be encrypted. This means that if the data is lost or stolen, nobody will be able to access the information contained on this equipment and / or devices.

Email – NHSmail is, at the moment the only available option of sending and receiving emails containing personal information securely and confidentially however it must be remembered that this can only be sent if the both sender and recipient have an NHS N3 network connection. In the interim, if staff must send personal information in an email as part of their work, this needs to be risk assessed first to ensure the safest method of transportation has been chosen. The information must be saved in an MS office document, password protected and attached to the email.

Data Quality

Ethnic Origin

As of 1st April 2009, the Trust is required to collect ethnic origin data. We are required to collect this data in order to:

- Demonstrate that the Trust is compliant with the Race Relations (Amendment) Act 2000 which places a statutory duty on NHS organisations, such as the Trust, to promote race equality
- Support the allocation of resources and develop policies relating to equality issues
- Highlight any inequalities and investigate why this is happening and remove any unfairness or disadvantage
- Identify those who need the Trust's services – some groups of people are more at risk of specific diseases and some have specific care needs so ethnic group data can help treat patients and support the Trust by alerting staff to groups who may need specific services
- Improve public health by making sure that services are reaching local communities and are delivering services fairly to everyone who needs them
- Ensure that under-represented groups receive services that are relevant to their needs and provided fairly

Therefore, when patients come into hospital as either an inpatient, outpatient or attend Accident and Emergency, the staff will ask them when checking their demographic details, for example, name, address and date of birth, what their ethnic origin is – this may be asked for verbally or to indicate this on a form. The Trust do understand however that there might be occasions when patients will not be able to provide this information, for example, patients who due to their illness are not able to understand or be understood and when a patient is unconscious. The Trust also has to collect ethnic origin for babies born at the hospital and the parent or guardian will be asked to inform on the child's behalf.
The Trust's "Collecting Information about Ethnicity" leaflet is available on the Trust web site.

IG Communication

The Information Governance website and intranet site continue to be updated and populated with the latest information and news to ensure all staff and the public are aware and know who to contact if they have any questions/concerns surrounding Information Governance.

The current Information Governance leaflets available are:

- Protecting Your Data
  How we use your health records
- Access to Health Records
  For living individuals
- Access to Health Records
  For deceased patients records
- Data Protection Act 1998
  Privacy Notice

These are also available as an audio document and as a high contrast web page (black text against yellow background) and larger font on the Trust web site.

WWL Doctors and Clinicians fully embraced the new infection control policy

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 2008 Inpatient Survey.

The PPE Team has developed a new Trust comment card having taken advice from the National Centre of Involvement on the content of the questions. Patients, visitors and carers use the 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 the services our patients receive. We have continued to conduct the video diary projects including patients experience when attending the Emergency Care Unit.

Relatives Comment

"My son was treated excellently by all staff, surgeons and play staff"

The PPE Team has been recognised by the Institute of Innovation and Improvement for its approach to public engagement. Its work has been published in the Experience Base Design Approach Guide and Toolbook, on how to design better healthcare services.

The Trust has continued to engage with the membership panel, in particular on the Department of Health Choice initiative on what the public look for when choosing a hospital. The final report will be available upon request from the Engagement Department.

The Trust has started to work with the Council of Governors. The Governors have met with the Trust Board to discuss key issues and challenges facing the Trust. Governors sit on a range of Trust committees, examples include the Engagement Committee and Releasing Time to Care Project Steering Group.

Consultation with local Groups and Partnerships

The Trust has continued to work with the local PCT and Local Authority, including the Route to Involvement Team across the Borough and the Partnership and Communities Team (PACT) having attended meetings and events to engage with the local community.

A new corporate style of Patient Information Leaflet has been designed with the involvement of the Governors and Lay readers. Leaflets are available in Audio,

large print, Braille, alternative languages (on request) and are accessible via the Trust website.

The PPE Team has worked in partnership with the Cancer Carer User Group for the Borough of Wigan. It conducted a review of cancelled follow up appointments for cancer patients. A copy of the report and recommendations is available from the Engagement Team.

Good links have been established with the interim development group for the Wigan Borough Local Involvement Networks (LINKs) and we look forward to working in partnership with them upon their establishment in April 2009. The Patient and Public Engagement Committee established in February 2009, monitor 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 chaired by a Governor also has representation from the Local Involvement Network (LINKs) and the Overview and Scrutiny Committee.

Putting patients at the heart of everything we do

Voluntary Services

From 1 December 2008 to 31 March 2009 the Voluntary Services received 80 enquiries which resulted in 53 new applicants. Five induction sessions for the new volunteers where carried out.

Volunteers Annual Training

The Annual training programme began in February which included the following lectures:

- Information Governance
- Infection Control
- Health and Safety
- Risk Management
- Fire

Three sessions have been completed; one for each of the following Trust sites; Leigh, Wrightington and Royal Albert Edward Infirmary (RAEI).

Voluntary Services Policy

Voluntary Services policy updated, ratified and in process of implementation which includes new guidelines for all volunteers and voluntary services agencies.

New Roles

- **Pharmacy at RAEI**

  A new team of volunteers cover the whole day, Monday to Friday, on the reception desk.

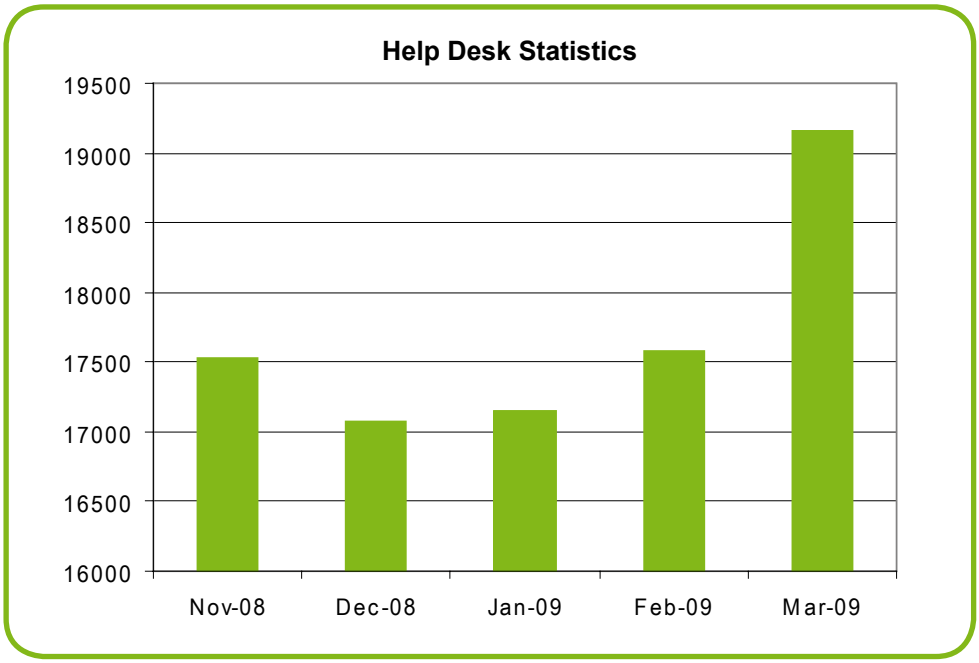
- **Cancer Care Suite at RAEI**

  A new volunteer role was introduced into the Cancer Care suite in March 2009. Specially trained volunteers sit and chat to patients having treatment. The volunteers help with other general duties such as making drinks and running errands for staff.

Help Desk Statisics

A total of 70,862 enquiries have been dealt with by the six volunteer help desks within the Trust:

- Patients Information Desk, Leigh Infirmary
- Helping Hands Desk, Entrance 1 RAEI
- New Lawns Desk, Entrance 2 RAEI
- Christopher Home, Eye Unit, RAEI
- Help Desk, Thomas Linacre Outpatients Centre
- Help Desk, Wrightington Hospital



The number of Help Desk volunteer hours, not including wards or departments, covered during normal sessions equals **10,234 hours**. If this is then valued at the basic NHS hourly rate of pay Band 1 point 1 at £6.42 the saving to the Trust for this period only is £65,702.

sixty-five thousand, seven hundred and two pounds

Voluteers enjoying their annual 'Volunteers Day' celebration at the JJB Stadium

Divisional Achievements

Clinical Support Services

In accordance with National Directives, the Pathology Microbiology Department has been redesigned in order to commence the routine screening for the presence of MRSA in all Elective patients. Following the redesign of the department, the screening programme commenced on the 16th March in order to identify those patients carrying MRSA, both to reduce the risk of infection to themselves and the spread of MRSA to other vulnerable patients within the Hospital.

The Pathology Department has implemented a number of Lean processes throughout the routine specimen processing pathway in order to reduce the need to batch specimens where possible in favour of a continuous flow process. The Biochemistry Laboratory has recently introduced a robotic sample sorting system which simplifies workflow and enables faster throughput, consistent with the principles of Lean working. This has been linked with an extension to existing analysers to future proof for increased activity.

Following Clinical Pathology Accreditation (CPA) re-inspections in all Pathology departments in 2008, the laboratory has been implementing the various recommendations made by CPA and as each department has completed the requirements, an application to be re-instated as fully CPA accredited has been made. Four of the five departments have now been confirmed as fully accredited and work on the final item in the remaining department has begun which has required a major re-design of the Phlebotomy area at the Thomas Linacre Centre (TLC). It is hoped that the laboratory will be fully CPA accredited in early 2009/10.

The Pharmacy department is now open every Sunday afternoon in order to provide a discharge service in order to help the flow of patients through the hospital and speed up the discharge process at weekends.

The Radiology service has continued to balance its demands for service within a sustained access of three weeks, which has supported the Trust to deliver a responsive service to meet the demands associated with outpatient management within 18 weeks, two weeks for cancer patients and management of patients within the 4 hours target in A&E. This

has been achieved against a 7% increase for services, with pressure points in specialist scanning modalities such as CT and MRI in line with the forecasted demands.

Radiology took delivery of a new Dexa scanner in March 2009 which will become operational in April providing a service to both the Trust and GPs, following installation and staff training. During early 2009 Radiology began testing electronic reporting of X-rays directly to GP Surgery computer systems. Once testing is complete, electronic reporting will be offered to all GP practices.

Throughout March the Trust has been developing an Appointment Centre in line with the new telecoms system purchase in order that the Health Care Operations team can implement one central point of contact for patients to organise their appointment bookings.

The Health Records team have continued to populate the Martland Point storage facility with case-notes currently stored in various areas both across the Trust and in external storage facilities.

The TLC outpatient department now has a high quality vasectomy service providing evening clinics and a holistic approach including counselling, minimal invasive procedures and follow up consultations, providing both GP and self referrals, with no waiting time. This service will be marketed in 2009/10.

Realtime imaging means a reduction in both re-testing and waiting times for results.

Musculoskeletal Division

Wrightington Hospital is one of the country's leading orthopaedic centres, treating over 60,000 patients a year and has some of the best orthopaedic surgeons in the country in addition to training surgeons from all over the world. Wrightington Hospital's status as a Centre of Excellence in the treatment of musculoskeletal disease has its origins in the seminal work of Professor Sir John Charnley. Professor Charnley pioneered hip replacement surgery using low-friction arthroplasty and also made innovative advances to counter post-operative infection. The first successful hip-replacement operations were performed at Wrightington in the early 1960s.

Wrightington's reputation for excellence attracts highly talented consultants who specialise in joint surgery, post operative rehabilitation and rheumatology. This multi-disciplinary approach has produced important synergies, particularly in the field of inflammatory arthritis. Few centres can match the collective experience of Wrightington's staff and each year more than 1,800 hip and knee procedures are carried out. Wrightington also has a thriving Upper Limb unit performing over 3,000 procedures annually including 158 upper limb joint replacements. Patients attending the upper limb unit express high levels of satisfaction in both the modern clean environment and the level of care received.

This has been a challenging and eventful year for the Musculoskeletal Division which delivers most of its services on the Wrightington site. The Division has faced dramatic change across all areas and this has been embraced by the staff who have risen to the challenge, enabling us to achieve our 18 week target in December 2008. We will be working hard to sustain this target with the growing number of new patients being referred.

We continue to remain busy as the level of performance has increased dramatically throughout the year and our out of area referrals have increased for both GP and other referrals.

The Wrightington site returned a year end surplus of £1M which will enable us to commit to further development on the hospital which will only benefit our patients, visitors and staff.

In order to improve efficiency and effectiveness we have introduced a number of measures and improved processes to ensure patient procedures go ahead as scheduled. The Division is working hard to further improve the patient experience and is linking with the Health Care Administration team and the Consultant body to change clinic bookings to give specific patient timings and reduce the volume of follow up patients being managed by consultant staff. This will take some time to fully complete but the Division remains committed to improving this aspect of our service. This major service change will also significantly reduce and ultimately eliminate hospital initiated clinic cancellations, other than those in exceptional circumstances.

MRSA free for over 6 years

The Wrightington site continues to be free of hospital acquired MRSA. This is due to robust pre-operative assessment processes for all patients treated at Wrightington. We have further developed the Outpatient and Pre-Operative assessment One Stop Clinic for patients undergoing day case surgery. This enables patients to be seen by the Consultant, booked for theatre and pre operatively checked with a date given all in one episode. This has huge benefits for the patients and enables a seamless pathway of care.

Paralympian Heather Frederiksen with renowned Orthopaedic Consultant, Mr Tim Clough

We are delighted to report that clinical outcome data indicates that some joint replacements undertaken at Wrightington have survived 30 years, this is excellent news when comparing the life span of joints at other specialist centres where 10–15 years is the norm.

The Picker patient survey conducted in 2008 indicates that patients have a high confidence level in both medical and nursing care, they receive pre and post operative information and that 93% would recommend Wrightington to their friends and family. A patient treated in April 2009 for his second hip replacement is currently writing a series of articles for 'Lancashire Life' and recording a patient video diary so he can share his excellent experiences with staff and future patients. The Rheumatology unit also has a very active Arthritis Care group who meeting with the MSK management team quarterly to discuss patient care issues.

The Division remains committed to the overall Trust strategy of putting safety and quality at the top of our agenda. In addition to our team of highly qualified orthopaedic doctors and nurses, this year we have successfully recruited a second trauma co-ordinator and appointed an Orthopaedic geriatrician. These appointments will help drive down the HSMR for Fractured Neck of Femur. We have introduced and implemented consultant surgeon led lists and senior anaesthetic led lists seven days per week and we are pleased to report that this has driven down HSMR from 140 to 101 in March 2009.

Further investment in staffing across all disciplines is planned for 2009 to enhance, modernise and expand our services. One area we are keen to develop is a programme of patient education, beginning in the pre-operative assessment phase and continuing throughout the patient journey.

Key Achievements

- **Increased number of patient referrals**
- **Activity over the 2008/09 plan**
- **Saved £1m on implant costs**
- **Achieved site surplus of £1.1m**
- **Zero MRSA status maintained**
- **Maintained low deep infection rate below 1%**
- **Investment in radiology equipment**
- **Investment in theatre and ward equipment**
- **Decrease in staff sickness rates**
- **Achieved the majority of the Divisional Human Resource targets**
- **High Levels of Patient Satisfaction**
- **Maintained theatre utilisation levels above the Trust target of 90%**
- **Passed Health Technology Assessment and Trading Standards inspections**
- **Upgraded the Private Patient Facility to modernise the environment.**

Division of Medicine

Unscheduled Care

Recognising that a high quality, patient centred service requires consistent development to improve, the Division has continued to focus significant efforts to improve the patient journey from presentation at the Accident and Emergency Department, through treatment and discharge home.

Despite narrowly under-achieving on the Accident and Emergency (A&E) access target (achieving 97.4% against a target of 98% of patients seen, treated and discharged within 4 hours) there have been significant improvements in patient services. The Division is working in partnership with the wider health economy (including the both the providers and commissioners within primary care, as well as social services) to enhance services through the:

- Appointment of a Clinical Director for the Emergency Floor who will commence in post in August 2009, but has already started to work with the team to improve services
- Piloting of a General Practitioner based within A&E at peak periods of demand
- Implementation of an 'ambulatory care' assessment area on the Emergency Floor to enable more mobile, less acutely ill-patients to be treated faster, away from the majors are in A&E
- Increased senior doctor review of patients on the acute assessment ward, supported by improved discharge planning which as resulted in significant improvements in the length of stay for patients on the ward
- Continued work to ensure 'right patient, right ward' for all patients
- Implementation of a daily discharge meeting, in combination with the appointment (supported by the PCT) of discharge assistants, which has had a

The cardiac Catheter laboratory on the Royal Albert Edward Infirmary site

pivotal role in facilitating safe and timely discharges and supported an overall reduction in the average length of stay for the medical wards.

- Significant improvements in infection control most notably in the reduction of C-Difficile.

General and Specialist Medicine

The elective element of services within the Division of Medicine has seen significant developments this year including:

The Cardiac Catheter Laboratory has seen a significant increase in the number of percutaneous coronary interventions (PCI). During this procedure a stent is implanted into the coronary arteries for several reasons – for example to improve circulation to the heart muscle; improve blood flow; relieve angina; prevent a myocardial infarction (heart attack) or to restore blood flow after a myocardial infarction has occurred.

The laboratory is now offering this service five mornings a week and has treated 258 patients with PCI in the year to March 2009. With attendance from two visiting consultants, and now seeing and treating patients from neighbouring hospitals on a 'treat and return' basis, this represents a significant achievement being both a valuable and high quality local service for Wigan and Leigh residents, as well the only District General Hospital in the Greater Manchester area to provide this service. Accreditation by the British Cardiovascular Intervention Society (BCIS) demonstrates recognition of these achievements.

Endoscopy services will also benefit from significant investment in equipment with work progressing rapidly to install new scope washers early in the next financial year, as well as the purchase of new patient trolleys.

Significant work has also been done to improve patient access times and efficiency within the service through multi-disciplinary teams working across both the Division of Medicine and Surgery.

Other successes:

- **Accreditation as a District Stroke Centre within the Greater Manchester Stroke Network which support the roll-out of thrombolysis treatment (at Acute Stroke Centres) for patients with an early diagnosis of stroke, and ensure this Trust continues to provide a high quality service, as confirmed by the recent Sentinel Audit of Stroke which indicates that the Trust has made significant improvements particularly in relation to access to CT scanning.**
- **Significant improvements in the quality of coding which will support improved audit of services as well as ensuring that all appropriate income is identified for the Trust – this has been achieved through effective partnership working between clinicians and senior clinical staff.**
- **An improved pathway for Lung Cancer Patients.**
- **Implementation of a Sleep Apnoea Service with the appointment of a Specialist Respiratory Practitioner enabling patients to be seen locally rather than travelling to other hospitals within Manchester.**
- **Purchase and installation of three new computer assisted exercise systems to assess patients for angina.**

Future developments

- The Division will continue to focus on improve access times for both unscheduled and scheduled care. Within the Emergency Floor this will see patients be re-directed to urgent access services – such as Ophthalmology Clinics, Trauma Clinics and urgent access out-patient clinics to ensure that only those who really need to be seen within A&E attend this area. This will ensure improved access times for all patients.
- A new Coronary Care Unit (opening late 2009), and associated second laboratory, will see an increase in facilities for both insertion of pacemakers, and a further increase in the number of patients treated for PCI locally.
- Neurology services will be enhanced though the appointment of a third visiting consultant for Salford - appointment expected towards the summer.
- Pemberton Ward, opening in June 2009, will see the provision on an entirely single cubicle ward (11 beds) and marks the beginning of a move across the entire Trust to increase the percentage of patients cared for in single rooms.

Surgical Division

During the past four months there has been significant work undertaken by the Division to ensure that service development and expansion has occurred.

There are a number of highlights:

The ordering and delivery of over £200k of medical equipment to support theatres, maternity and the dental services on the RAEI site. This ensures the services are equipped with the latest technology to help ensure safe interventions are made and improve patient outcomes.

There has also been a increase of in-year funding for the assisted conception unit following support from the local commissioners. This has enabled the Trust to treat a significant number of couples during the last quarter, reducing the waiting times for assisted conception.

The Trust has agreed a significant investment in the anaesthetics department with the appointment of substantive consultants to support the work undertaken on all three hospital sites, with the possibility of a further investment, dependant on approval of the business cases.

Full MRSA screening for all elective patients in surgery has commenced. There has also been work undertaken with pre-op assessment that has led to a significant reduction in cancellations due to reasons that could have been picked up during the per-operative period. This has reduced cancellations on the day and the distress that this causes patients.

The Division has continued to deliver the revised key cancer targets for 31 and 62 day patients, as well as maintaining delivery of the 18 week referral to treatment target.

The Division had no MRSA bacteraemia during the quarter, and only one for the year.

The cancer care suite on the RAEI site has begun the delivery of Herceptin for local patients, meaning that there is no longer a need for the patients to travel to Christies for their treatment. Discussions are ongoing to broaden the types of chemotherapy delivered on the cancer care suite so that more patients can benefit from this service.

The Division is delighted that three advanced practitioners have now completed their degrees which has enabled us to expand our critical care outreach service across the RAEI site.

Estates and Facilities Division

Estates and Facilities continue to provide a wide range of non-clinical support services to the new Foundation Trust and via Service Level Agreements to both Ashton, Leigh and Wigan Primary Care Trust and the 5 Boroughs Partnership NHS Trust. Although an extremely busy year, a number of significant developments have commenced and been completed.

Capital Programme

This year has seen a number of significant projects being completed or commenced. The key projects are:

- Creation of more side rooms to improve infection control
- Minor upgrade works and the creation of additional isolation room in Intensive Care Unit
- Environmental improvements in the Maternity ventilation
- Upgrade of Kitchen ventilation systems
- Health & Safety upgrade works
- Major Maintenance upgade works
- Investment in Carbon Trust Energy schemes
- Provision of second CT scanner at RAEI
- Creation of a new ward with all single rooms at RAEI
- Internal improvements to the Oncology Unit at RAEI
- Creation of an MRSA screening laboratory
- Complete modernisation of boiler house at Leigh Infirmary
- Closure of Whelley Hospital and relocation of essential services
- Relocation of Occupational Health Department
- Commence design work on the creation of a new Coronary Care Unit at RAEI
- Commencement of Enabling works to support the LIFT development at Leigh
- Improvements to the theatre water systems at Wrightington

Estates Services

The Estates maintenance team continues to provide a breakdown and planned maintenance service across the Trust. The team continues to play a key role in the successful completion of the Trust's annual Deep Clean programme. Modernisation plans within this area include the role out of a modern Helpdesk facility to improve accessibility and communications.

Facilities Services

The Facilities team continue to support the Clinical Divisions in the provision of portering, transport, catering, domestics, linen, general office, telecommunications services etc. The level of clinical activity continues to challenge the Facilities Team in seeking more innovative ways of supporting the Clinical Divisions.

Notable Successes

This year has seen a number of successes and awards:

- Service Improvement Awards for Catering, Medical Loan Store and the Estates and Domestics teams for the Deep Clean works
- Catering team won the Hospital Caterers Association "Sandra Hayes Memorial Award" for excellence in Hospital Catering.
- Wigan Council Urban Design Award for the RAEI Main Entrance Upgrading.

Environmental Management

The Trust is committed to the sustainability agenda and the Estates and Facilities Division has a key role to play in the development and implementation of an Environmental Management System.

In 2007/8 the Trusts energy based carbon emissions amounted to some 17,400 tonnes.

The Trusts commitment to the "Green agenda" and the reduction in its carbon footprint have resulted in a number of key initiatives:

- Establishment of a Green Committee
- Appointment of an Energy and Environmental Manager
- Working in partnership with ALW PCT on the development of a "whole health economy" Environmental Management System
- Pursuing ISO 14001 accreditation
- Continuation of the Carbon Management Implementation Plan
- Development of local procurement policies with Wigan Council

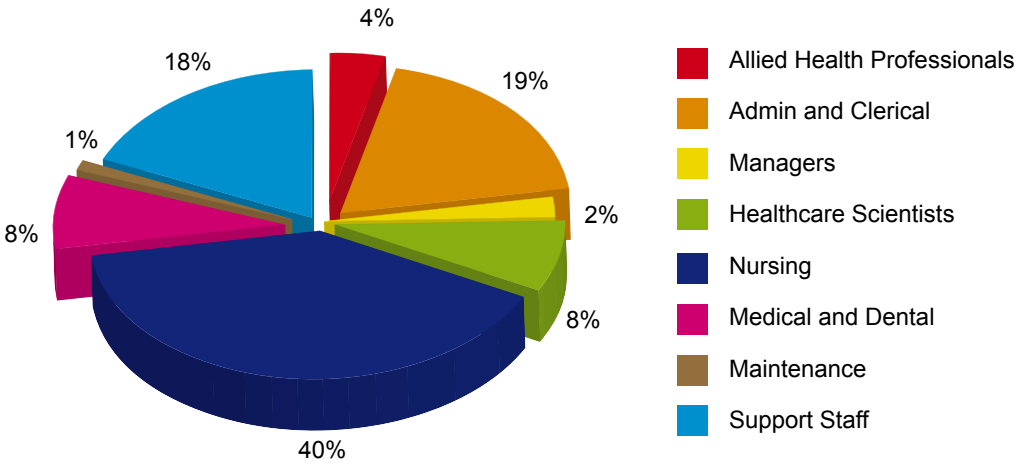
Early indications are that the above initiatives have contributed to a reduction in the energy based carbon emissions for 2008/9 of 3,000 tonnes, excluding the Leigh Boilerhouse conversion which will generate further reductions in 2009/10.

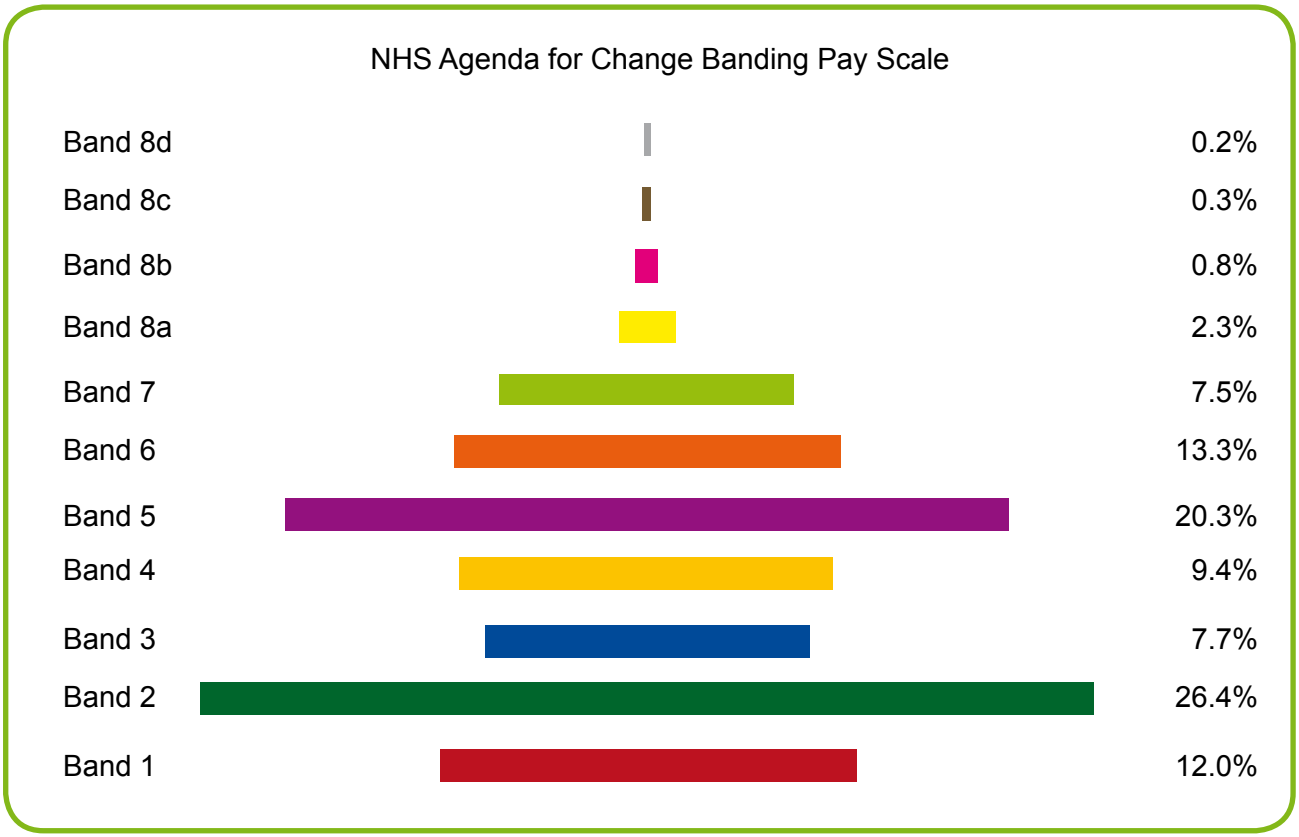
Modernising the boilerhouse on the Leigh site has contributed to reducing the Trust's carbon footprint

Human Resources

Our Workforce

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





HR Performance – Workforce Indicators

The Trust's workforce indicators continue to demonstrate that in workforce terms alone, the Trust is in good health.

The Trust's labour turnover is one of the lowest both nationally and regionally, currently standing at 9.5%. Sickness absence rates for the period 01 March 2008 – 28 February 2009 is 4.67% working towards a target of 4.3 %.

Healthcare 100 – Trust in top 40 nationally

This year, the Trust entered the HSJ Healthcare 100 initiative, a survey based on the opinions of staff which aimed to identify the top 100 healthcare organisations in the UK. The Trust is very pleased to have been recognised in the Healthcare 100 as the 39th best healthcare organisation to work for. This survey has provided the Trust with invaluable data about the levels of engagement with staff and how staff feel about working within the organisation, which will be used to inform developments.

Policy Development

There were 11 Trust HR Policies ratified through the HR Committee at the end of 2008. The Policy Development Group has continued to meet and developed priorities for the forthcoming months which include work on the following:

- Allocation of Finance and Time Off For Training (Study Leave)
- Annual Leave
- Attendance Management
- Capability
- Conduct, Capability, Ill Health and Appeals Procedure (Medical Practitioners) Disciplinary Employee Personal Files, Storage, Retention and Disposal Policy Grievance
- Maternity Paternity and Adoption Leave
- Secondment/Acting Up
- Special Purposes Leave
- Substance Misuse

Healthier Hospitals

The department chairs a number of groups to address how the Trust manages and supports:

- Stress management and prevention
- Smoke free hospitals
- Healthy workplaces
- Corporate citizenship – employment and skills

All these areas of work have now been combined to form "Promoting a Healthy Workplace" Task and Finish Group, to embed current schemes and take forward new initiatives in 2009/10

Training and Development

The Trust commenced the implementation of a Talent Management Strategy, aiming to support talented individuals within the organisation to develop and progress their careers, and to ensure robust succession planning processes are in place across the Trust.

The Trust continues to have a close working relationship with staff side, especially with the Staff Involvement Delivers (SID) Projects, which has seen the introduction of the: "You Said, We Did" campaign on the intranet and in our staff newsletter (Focus), promoting what has been actioned in response to staff feedback from the Staff Attitude Survey and the SID Walkabout events. The SID Walkabout event 2009 has taken place and outcomes from the event have resulted in an action plan to be taken forwards by the SID team.

The Training Department has increased the accessibility of online compulsory training by providing a flexible approach spanning evening and weekend access to training. The eCompulsory online system has recently been upgraded to provide improved ease of usage, functionality and local reporting mechanisms for managers.

We are in the top five of high performing Trusts in relation to the funding we have accessed to support training and development for staff in Bands 1 to 4. Training commissioned has included NVQs in Care, NVQs in Administration, the Certificate in Personnel Practice and the Amspar Medical Terminology qualifications.

Occupational Health Services

The final report on the annual influenza vaccination programme demonstrated an increase in uptake by staff. The final number of staff vaccinated was 1,252 (29.7%) compared to 112 (26.2%) in the previous year.

After 22 years the Occupational Health Department was relocated from its premises at Whelley Hospital to a newly re-furbished ground floor-wing at the Wigan Investment Centre in Wigan. The new accommodation is both spacious and modern.

The Occupational Health Team looks forward to working here and to continue to provide an efficient and professional service to both the Trust and its external clients.

Pay Modernisation

2008 saw the agreement of a new contract for Staff Grade and Associate Specialist doctors, which aims to benefit the service delivery by using doctors' time in ways that best contribute to the quality of patient care by meeting the Trust's priorities whilst meeting the doctors' continuing professional development.

During 2009 the Trust has undertaken diary exercises with medical staff and is in the process of developing an action plan to roll out job planning across the organisation.

Hospital 24

Hospital 24 is a nurse led team responsible for producing seamless care for the management of the acutely ill patient, 7 days a week, 24 hours a day, across all the RAEI areas. The team is a merger of the Hospital at Night, Hospital at Day and Outreach Services. Hospital 24 promotes quality driven care through the use of evidence based practice.

The main Objectives of Hospital 24 are:

- Providing a source of immediate advice for deteriorating patients
- Triage the calls for medical staff in prioritising care delivery.
- Provision of training and education e.g. MEWS, Sepsis, AIM

It enables early intervention for deteriorating patients, therefore reducing risk to them. Hospital 24 expedites rapid treatment and investigations thus enhancing the patient experience.


HUMAN
RESOURCES
TRAINING AN
DEVELOPMEN

Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

Appendices

Appendices

1 Statement of the Chief Executive's Responsibilities

2 Statement on Internal Control

3 Auditor's Report

4 Annual Accounts

5 Directors' Profiles

6 Glossary of Terms

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

Wrightington, Wigan and Leigh NHS Foundation Trust
Annual report and accounts for the 4 month period ended 31 March 2009

Wrightington, Wigan and Leigh NHS Foundation Trust

Accounts for the period ended 31st March 2009

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STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST

The National Health 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 the public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health 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 Financial 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 Financial 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: 3rd June 2009

STATEMENT ON INTERNAL CONTROL
1 December 2008 to 31 March 2009

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 Trust successfully achieved Foundation Trust status on the 1 December 2008. The system of internal control has been in place in Wrightington, Wigan and Leigh NHS Foundation Trust from 1 December 2008 and remained in place up to the year ended 31 March 2009, and up to the date of approval of the annual report and accounts.

2.1 Compliance with the NHS Pension Scheme

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

3. CAPACITY TO HANDLE RISK

3.1 Leadership

As Accounting Officer, I have overall accountability and responsibility for Risk Management within the Trust.

The Director of Nursing and Patient Services 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 Trust Risk Management Strategy clearly defines the responsibilities of individual Executive Directors specifically and generally 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.

3.2 Training

To ensure the successful implementation and maintenance of the Trust's approach to risk management, staff at all levels are appropriately trained in incident reporting and carrying out a risk assessment. An ongoing risk management training programme has been developed which includes Health & Safety, Risk Management, Patient Safety, Fire Safety, Resuscitation, Moving and Handling, Child Protection, Infection Prevention and Conflict Resolution training which is mandatory for appropriate staff.

The learning from incidents and risks takes place at the monthly Quality Board comprising of Executive Directors and senior staff, to ensure concerns identified from incident claims and complaints are investigated, that lessons are learned and is a method of sharing good practice. The Trust fosters an environment where individuals are treated in a fair and just way, and where lessons are learned rather than blame being attributed.

4. THE RISK AND CONTROL FRAMEWORK

4.1 Key elements of the Risk Management Strategy

The Risk Management Strategy is Board approved, covers all risks and is subject to an annual review 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 assessment and from the analysis of untoward incidents. The Risk Management Strategy is cross referenced to a series of related risk management documents for example.

The Risk Management Strategy is available to all staff via the document library on the Trust Intranet.

4.2 How Risk Management is embedded in the activity of the Trust

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 is in place and incidents are entered onto a database for analysis. Root cause analysis is undertaken and identified changes in practice are implemented.

Risk management is embedded within the Trust through key committees, identified in the Corporate Governance Structure, and consists of clinical & non clinical committees which report to the Governance & Risk Committee (G&R) and the Risk Environmental Management Committee (REMEC).

The Governance and Risk Committee links to the Audit Committee and also reports direct to the Board.

The Board Assurance Framework has been in place during 2008/09. The Assurance Framework:

- Covers all of the Trust's main activities;
- Identifies the corporate objectives and targets 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; and
- Covers the core standards on which the Trust has been required to declare its compliance during 2008/09.

The Governance & Risk Committee and Risk Management and Environmental Committee considers significant risks and if appropriate, recommend their inclusion on the 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 funding. 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 adopted from the Australian 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 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 elements of the Board Assurance Framework are monitored and reviewed on an exception basis by the Governance & Risk Committee and the Audit Committee followed by the Board of Directors. This provides evidence to support the Statement of Internal Control.

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 Finance Director and the Deputy Director of Integrated Governance & Safety are also members of the Governance & Risk Committee and provide governance and risk management assurance to the Audit Committee at each of its meetings, thus ensuring an integrated risk management approach.

4.3 Public Stakeholders involved in managing risk

Public stakeholders, which include Ashton, Leigh & Wigan Primary Care Trust, Wigan Council Overview and Scrutiny Committee and the Wigan Local Safeguarding Children's Board are consulted on service developments and changes.

These public stakeholders, Learning Disability Partnership Board and Links are identified within the Board Assurance Framework; this ensures that they are involved in managing the risks, which impact upon them.

Issues raised through the Trust's Risk management processes that impact on partner organisations e.g. Ashton, Leigh and Wigan Primary Care Trust 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 across community emergency planning and business continuity arrangements are in place.

4.4 Information on Governance and identifying and maintaining risk

The Information Governance Committee identifies and manages information risks, which reports to the Governance and Risk Committee. The Medical Director who is also the nominated Board Lead for Information Governance chairs the Information Governance Committee. The Director of Finance and Informatics is the acting Senior Information Risk Officer (SIRO).

There have been no serious untoward incidents involving data loss or confidentiality breaches.

4.5 Compliance with Equality, Diversity and Human Rights Legislation

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

4.6 Disclosure of Standards for Better Health - Core Standards declaration within the SIC

The Trust is compliant with all but one of the Core Standards for Better Health. The exception being core standard C4c - Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that all risks associated with decontamination facilities and processes are well managed.

5. REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

The Trust has robust arrangements in place for objectives and targets on a strategic and annual basis. These arrangements including ensuring the financial plan is affordable, ensuring delivery of Cost Improvement requirements, compliance with the terms of authorisation and co-ordination of individual objectives with corporate objectives as identified in the Integrated Business Plan. In future years, this will be identified in the Annual Plan.

Performance against objectives is 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 resource targets;
- Weekly reporting to the Executive Team on key influences on the Trust's financial position including activity and workforce indicators;

- The Divisions play an active part in the ongoing review of financial performance including Cost Improvement delivery;
- A cycle of quarterly stocktakes which sit at the top of performance management of Divisions by the Executive Team covering performance on key areas;
- Periodic reporting to Monitor and compliance with terms of authorisation;
- 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.
    - 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 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. REVIEW OF EFFECTIVENESS

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors and the Executive Directors within the NHS Foundation Trust who have responsibility for the development and maintenance of the system of internal control framework and 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 and the Governance & Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, I have detailed below some examples of the work undertaken and the role of the Board of Directors, the Audit Committee, Governance and Risk Committee with the Internal Audit and External Audit, and committees in this process.

- The Board Assurance Framework itself provides me with evidence of the effectiveness of controls that manage the risks to the organisation.
- The Board of Directors, Audit Committee and the Governance & Risk Committee have advised me on the implications of the result 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 are in place.
- The Trust's self-assessment declaration of compliance against twenty three of the twenty four core ‘Standards for Better Health' demonstrates continuous improvement against the standards. Supporting evidence is available for all members of the Board of Directors to review as a source of assurance and is an essential part of the Trusts system of internal control.
- The Board of Directors also monitors and reviews the effectiveness of the Board Assurance Framework on a regular basis.
- The Governance and Risk Committee manages and reviews the Board Assurance Framework, which is agreed in conjunction with Executive Directors. The minutes of the Governance & Risk Committee are presented to the Board of Directors. The Risk & Environmental Committee produces an annual Risk Management Report which is presented to the Governance & 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 organisations activities (both clinical and non clinical) that supports the achievement of the organisations objectives. The Audit Committee reviews the Board Assurance Framework on an exception basis.
- 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.
- My review also takes account of comments made by external auditors and other review bodies in their reports, for example, the Trust was subject to the NHS Litigation Authority (NHSLA) assessment on 18 December 2008 resulting in the achievement of NHSLA Risk Management Standards General Level 1 status that provides assurance on controls.

I have to highlight that the delivery of the MRSA bacteraemia target remains a risk. The Trust has made significant and sustainable progress to reduce Healthcare Acquired Infections, which can be demonstrated in our performance regarding Clostridium Difficile, and has one of the lowest rates across the North West. The MRSA target for 2008/09 was 12, a significant reduction from 2007/08; this target was narrowly missed by one additional case. Further action has been taken to review and to strengthen our efforts to continue to reduce MRSA bacteraemia. The Trust complies fully with the Care Quality Commission Healthcare Acquired Infections (HCAI) regulation requirements.

Achieving the A&E 98% target remains high risk and continues to be a clinical challenge for the Trust. Performance for 2008/09 was 97.4% within the context of an underlying growth in A&E attendances and admissions through A&E over the past 5 years.

A detailed action plan has been developed in partnership with the wider health and social care community to address this issue. The two key issues causing breaches are delays in assessment in A&E, which largely relate to difficulties in recruiting clinicians, and a lack of bed capacity on the acute site and a lack of availability of beds on the acute site.

The recruitment challenge is being addressed. A clinical director has been appointed and is due to commence in August. Overseas recruitment is being pursued to close the gap at a middle grade level.

There has been real progress relating to length of stay on the acute site, with over a day being taken off the average during 2008/09. This largely relates to better discharge processes brought about by the joint work across the health and social care community. As Chief Executive I jointly chair the local Provider Partnership Board with membership from acute, primary and social care providers which has overseen the development of the Wigan Borough's 'Hospital at Home' service of which we are still to see the full impact on accelerated discharge and admission avoidance.

The HSE Improvement Notice served on the Trust in June 2008 has been removed following the HSE Inspection in February 2009. The trust received formal notification in March 2009.

Declaration of Non Compliance Standards for Better Health Core standard C4b decontamination, the Trusts 2007/8 statement stated that a compliant service would be provided to all Wrightington Operating Theatres delivered by the Mersey Joint Venture (JV) in 2009/10.

However the Joint Venture's preferred bidder withdrew from negotiations in December 2008 and the JV was formally disbanded in January 2009. As a consequence of this unforeseen outcome the Trust is now in the process of evaluating other available options and early in the new financial year of 2009/10 will take a decision on the strategic direction for the provision of Decontamination Services.

In April 2008 the Trust commissioned a report from an Independent Technical Advisor to review decontamination services within Theatres 1-4 at Wrightington and to make recommendations to further reduce risks to patients and makes progress towards achieving Core Standard C4c, independently of the JV process.

The independent report was considered by the Trust Board in July 2008 and approval was given to implement the recommendations at a cost of £0.75m.

The actions included:

1. Instruments are sent to an accredited laboratory for bio burden testing;
2. New and enhanced nursing protocols introduced to mitigate against the movement between clean and dirty areas;
3. Increased testing of sterilisers/washers disinfectors;
4. Increased testing of steam purity;
5. Installation of a reverse osmosis final rinse on the washer disinfectors; and
6. Installation of additional wash hand basins.

In addition regular reports have been considered by the Trust Board and a Trust Decontamination Services Steering Group has been established under the chairmanship of the Director of Operations to monitor ongoing process. This Group meets fortnightly and reports to the Governance & Risk Committee. WWL is currently reviewing three short listed solution options, all of which will deliver a fully compliant decontamination service but with varying timescales for implementation. The preferred option will be decided early in the new financial year.

The Trust has also entered into an agreement with nearby a NHS Foundation Trust to provide a contingency service in the event of a serious disruption to decontamination services.

The eight North West Trusts which formed the Mersey Joint Venture are now reviewing options to resolve their individual areas of non compliance.

Despite the significant mitigation taken in year to enhance the Wrightington Theatres 1-4 decontamination service the Decontamination Services Steering Group recommends to the Board that the service is currently not compliant with the detail of C4c. The Board has however been assured that there is no evidence whatsoever that any patient has ever been exposed to or suffered from infection as a result of the current decontamination arrangements. Indeed the Board is reassured that there is substantial evidence that the site in question has exemplary low levels of infection.

7. CONCLUSION

There have been no significant internal control issues identified during the year.

Date: 3rd June 2009 **Signed:**  **Andrew Foster, Chief Executive**
(On behalf of the board)

Auditors' Report to the Council of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust

We have audited the financial statements of Wrightington, Wigan and Leigh NHS Foundation Trust for the period ended 31 March 2009 under the National Health Service Act 2006. These comprise the Income and Expenditure Account, the Balance Sheet, the Cash flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies relevant to NHS Foundation Trusts set out therein.

This report is made solely to the Council of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust ('the Trust'), as a body, in accordance with the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to it 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 Trust's Governors as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditors

As described on page 1 the Accounting Officer is responsible for the preparation of the financial statements in accordance with directions issued by Monitor. Our responsibilities, as independent auditors, are established by statute, the Code of Audit Practice issued by Monitor and our profession's ethical guidance.

We report to you our opinion as to whether the financial statements give a true and fair view of the state of affairs of the Trust and its income and expenditure for the period ended 31 March 2009.

We review whether the statement on internal control on pages 2 to 7 reflects compliance with Monitor's guidance issued in the NHS Foundation Trust Financial Reporting Manual. We report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the directors' statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures. Our review was not performed for any purpose connected with any specific transaction and should not be relied upon for any such purpose.

We read the information contained in the Annual Report and consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the statement of accounts.

Wrightington, Wigan and Leigh NHS Foundation Trust

Accounts for the period ended 31st March 2009

Basis of audit opinion

We conducted our audit in accordance with the National Health Service Act 2006 and the Code of Audit Practice issued by Monitor, which requires compliance with relevant auditing standards issued by the Auditing Practices Board.

An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts in England, of the state of the Trust's affairs as at 31 March 2009 and of its income and expenditure for the period then ended; and

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the requirements of the NHS Foundation Trust Financial Reporting Manual.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the NHS Foundation Trust Audit Code of Practice issued by Monitor.

Signature:  Date: 3rd June 2009

Andrew Bostock (Senior Statutory Auditor)
for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 St James Square
Manchester

The maintenance and integrity of the Wrightington, Wigan and Leigh NHS Foundation Trust web site is the responsibility of the Directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

FOREWORD TO THE ACCOUNTS

These accounts for the 4 months ended 31 March 2009 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: 3rd June 2009

Income and Expenditure Account

for the period ended 31st March 2009

	Note	4 months ended 31 March 2009 £'000
Income from activities	3	**67,565**
Other operating income	4	**4,301**
Operating expenses	5-6	**(69,488)**
OPERATING SURPLUS		**2,378**
Loss on disposal of fixed assets	8	**(3)**
SURPLUS BEFORE INTEREST		**2,375**
Interest receivable	9.1	**71**
Interest payable	9.2	**(3)**
SURPLUS FOR THE FINANCIAL PERIOD		**2,443**
Public Dividend Capital dividends payable		**(2,040)**
RETAINED SURPLUS FOR THE FINANCIAL PERIOD		**403**

The notes on pages 15 to 45 form part of these accounts.
All income and expenditure is derived from continuing operations.

Balance Sheet

as at 31st March 2009

	Note	31 March 2009 £'000	Opening balance 01 December 2008 as restated £'000
FIXED ASSETS			
Intangible assets	10	**704**	**486**
Tangible assets	11	**153,468**	**147,616**
TOTAL FIXED ASSETS		**154,172**	**148,102**
CURRENT ASSETS			
Stocks and work-in-progress	12	**3,295**	**3,074**
Debtors	13.1	**6,282**	**10,962**
Cash at bank and in hand		**17,746**	**15,748**
TOTAL CURRENT ASSETS		**27,323**	**29,784**
CREDITORS: amounts falling due within one year	14.1	**(17,840)**	**(14,808)**
NET CURRENT ASSETS		**9,483**	**14,976**
TOTAL ASSETS LESS CURRENT LIABILITIES		**163,655**	**163,078**
CREDITORS: amounts falling due after more than one year	14.1	**(394)**	**(385)**
PROVISIONS FOR LIABILITIES AND CHARGES	15	**(1,778)**	**(1,598)**
TOTAL ASSETS EMPLOYED		**161,483**	**161,095**
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	16.2	**94,083**	**94,083**
Revaluation reserve	16.3	**42,198**	**42,560**
Donated asset reserve	16.3	**1,551**	**1,566**
Income & expenditure reserve	16.3	**23,651**	**22,886**
TOTAL TAXPAYERS' EQUITY		**161,483**	**161,095**

The financial statements on pages (11 to 14) were approved by the board on 3rd June 2009 and signed on its behalf by:

Signed:  Andrew Foster, Chief Executive

Dated: 3rd June 2009

Statement of Total Recognised Gains and Losses

for the period ended 31st March 2009

	4 months ended 31 March 2009 £'000
Surplus for the financial period before dividend payments	**2,443**
Increases in the donated asset reserve due to receipt of donated assets	**31**
Reduction in the donated asset reserve due to depreciation, impairment, and/or disposal of donated assets	**(46)**
TOTAL RECOGNISED GAINS FOR THE FINANCIAL PERIOD	**2,428**
Prior period adjustment	**(465)**
TOTAL GAINS IN THE FINANCIAL PERIOD	**1,963**

The Statement of Total Recognised Gains and Losses shows the net increase/(decrease) in the valuation of the Trust year on year before dividend payments. It represents the surplus/(deficit) on the I&E account (before dividends), plus the movement on reserves within the balance sheet (excluding Public Dividend Capital). A reconciliation of the movements is shown below:

	4 months ended 31 March 2009 £'000
Surplus for the financial period before dividend payments	**2,443**
Movement in the revaluation reserve	**(323)**
Movement in the donated asset reserve	**(519)**
Movement in the I&E reserve (excluding I&E generated surplus)	**362**
	1,963

Cashflow Statement

for the period ended 31st March 2009

	Note	4 months ended 31 March 2009 £'000	£'000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	17.1		**8,806**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE			
Interest received		**110**	
Interest element of finance leases		**(3)**	
Net cash inflow from returns on investments and servicing of finance			**107**
CAPITAL EXPENDITURE			
Payments to acquire tangible fixed assets		**(3,557)**	
Receipts from sale of tangible fixed assets		**0**	
Payments to acquire intangible assets		**(294)**	
Net cash outflow from capital expenditure			**(3,851)**
DIVIDENDS PAID			**(3,062)**
Net cash inflow before financing			**2,000**
FINANCING			
Capital element of finance leases		**(2)**	
Net cash outflow from financing			**(2)**
INCREASE IN CASH			**1,998**

Notes to the Accounts

for the period ended 31st March 2009

1 ACCOUNTING POLICIES

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2008/09 NHS Foundation Trust Financial Reporting Manual issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Part-year accounts information

The Trust was authorised as an NHS Foundation Trust with effect from 1 December 2008. These accounts relate to the period 1 December 2008 to 31 March 2009. Since the body was not an NHS Foundation Trust in the prior period, comparative figures are not included.

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.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS Foundation Trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report 'earning per share' or historical profits and losses.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'discontinued' where they meet all of the following conditions:

(i) the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;

(ii) if a termination, the former activities have ceased permanently;

(iii) the sale or termination has a material effect on the nature and focus of the reporting NHS Foundation Trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the NHS Foundation Trust's continuing operations; and

(iv) the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all these conditions are classified as continuing.

Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

1.3 Income recognition

Income is accounted for by applying the accruals convention. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.4 Expenditure

Expenditure is accounted for applying the accruals convention.

1.5 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are amortised over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred and are amortised over the shorter of the term of the licence and their useful economic lives.

1.6 Tangible fixed assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

(i) individually have a cost of at least £5,000; or

(ii) 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 under single managerial control; or

(iii) form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs, such as installation, directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

All land and buildings are revalued using professional valuations in accordance with FRS 15 every five years. A three yearly interim valuation is also carried out.

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. An interim valuation was undertaken by DVS Manchester in November 2008 with the prospective valuation date of 30 November 2008. The revaluation undertaken at that date was accounted for on 30 November 2008. Prior to this interim valuation the last revaluation took place in 2004 (as at the prospective date of 1 April 2005) in accordance with the requirements of the Department of Health, the value of which was applied on 31 March 2005.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Assets in the course of construction are valued at cost and are valued by the District Valuer as part of the five or three-yearly valuation or when they are brought into use.

Operational equipment is carried at current value. Where assets are of low value, and/or have short useful economic lives, these are carried at depreciated historic cost as a proxy for current value. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land, and assets surplus to requirements.

Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the District Valuer. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset as follows:

Short life engineering plant and equipment	- 5 years
Medium life engineering plant and equipment	- 10 years
Long life engineering plant and equipment	- 15 years
Vehicles	- 7 years
Furniture	- 10 years
Office and IT equipment	- 5 years
Soft furnishings	- 7 years
Short life medical and other equipment	- 5 years
Medium life medical and other equipment	- 10 years
Long life medical and other equipment	- 15 years
Mainframe-type IT installations	- 8 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.

Gains arising from revaluations are taken to the revaluation reserve. Losses arising from revaluation are recognised as impairments and are charged to the revaluation reserve to the extent that a balance exists in relation to the revalued asset.

Losses in excess of that amount are charged to the current year's income and expenditure account, unless it can be demonstrated that the recoverable amount is greater than the revalued amount in which case the impairment is taken to the revaluation reserve. Diminutions in value when newly constructed assets are brought into use are charged in full to the income and expenditure account. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

1.7 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the income and expenditure reserve.

1.8 Lottery funded assets

Fixed assets which are funded through Big Lottery grants (previously the New Opportunities Fund) are capitalised at cost, and are valued and depreciated as described above for purchased assets. The grant receipt is credited to deferred income and released to the income and expenditure account on a straight line basis over the useful economic life of the asset. Gains and losses on revaluations are taken to the revaluation reserve and, each year, an amount equal to the excess depreciation charge in the income and expenditure account is released from the revaluation reserve to the income and expenditure reserve.

1.9 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value.

1.10 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the NHS Foundation Trust's cashbook. These balances exclude monies held in the NHS Foundation Trust's bank account belonging to patients (see 'third party assets' below). Account balances are only set off where formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, 'interest receivable' and 'interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.11 Research & Development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to:
    - its technical feasibility; and
    - its resulting in a product or service which will eventually be brought into use; and
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. The amortisation charge is calculated on the same basis as used for depreciation i.e. on a quarterly basis. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, NHS Foundation Trusts disclose the total amount of research and development expenditure charged in the income and expenditure separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

1.12 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the HM Treasury's discount rate of 2.2% in real terms.

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 20 where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in note 20 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

(i) 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

(ii) 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.

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 15.

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 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.

1.13 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. As a consequence 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 under FRS 17.

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 income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 Accounting valuation

In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Scheme provisions as at 31 March 2008

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk.

1.14 Liquid resources

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cashflow statement. The Trust does not hold any investments with maturity dates exceeding one year from the date of purchase.

1.15 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.

1.16 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).

Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum.

1.17 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 a separate note to the accounts (see note 22) in accordance with the requirements of the HM Treasury Financial Reporting Manual.

1.18 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 a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires.

The interest element of the finance lease payment is charged to the income and expenditure account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the income and expenditure account on a straight-line basis over the term of the lease.

1.19 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the original NHS Trust.

A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of Paymaster General. Average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

1.20 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 the income and expenditure account 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 23 is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.21 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 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 through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as 'loans and receivables'.

Financial liabilities are classified as 'other financial liabilities'.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices, independent appraisals or discounted cash flow analysis.

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 at bank and in hand, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the income and expenditure account.

Other financial liabilities

All 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 balance sheet 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 the income and expenditure account.

Impairment of financial assets

At the balance sheet date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the income and expenditure account and the carrying amount of the asset is reduced directly.

2 Segmental Analysis

We have examined the income and expenditure account for the period ended 31 March 2009 and determined that all activities relate to the provision of healthcare, therefore no segmental analysis has been prepared.

3 Income from activities

3.1 Analysis of income from activities by category

	4 months ended 31 March 2009 £'000	Inter NHS Foundation Trusts £'000
Elective income	17,538	42
Non-elective income	18,327	0
Outpatient income	12,782	14
A&E income	2,310	0
Other NHS clinical income	15,324	0
Private patient income	969	0
Other non-protected clinical income	315	15
	67,565	**71**

All income is derived from the activity of Healthcare.

3.2 Mandatory and non-mandatory services

	4 months ended 31 March 2009 £'000
Mandatory services	66,281
Non-mandatory services	1,284
	67,565

3.3 Private patient income

	4 months ended 31 March 2009 £'000	Base Year 2002/3 £'000
Private patient income	969	2,891
Total patient related income	67,565	140,399
Proportion (as a percentage)	**1.4%**	**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 2002/3.

3.4 Analysis of income from activities by source

	4 months ended 31 March 2009 £'000
NHS Foundation Trusts	71
NHS Trusts	4
Strategic Health Authorities	30
Primary Care Trusts	63,140
Local Authorities	168
Department of Health - other	2,824
Non-NHS: Private Patients	969
Overseas Patients (non-reciprocal)	9
NHS injury scheme (was RTA) *	282
Other	68
	67,565

* NHS injury scheme income is subject to a provision for doubtful debts of 7.8% to reflect expected rates of collection.

4 Other operating income

	4 months ended 31 March 2009 £'000
Research and development	170
Education and training	2,158
Charitable and other contributions to expenditure	19
Transfers from donated asset reserve	46
Non-patient care services to other bodies	1,046
Other income	862
	4,301

Notes to the Accounts

for the period ended 31st March 2009

5 Operating expenses

5.1 Operating expenses comprise:

	4 months ended 31 March 2009 £'000
Services from NHS Foundation Trusts	341
Services from NHS Trusts	300
Services from other NHS bodies	773
Purchase of healthcare from non NHS bodies	407
Executive directors' costs	327
Non-executive directors' costs	43
Staff costs	47,174
Drug costs	4,216
Supplies and services - clinical (excluding drug costs)	6,122
Supplies and services - general	1,071
Establishment	1,068
Transport	315
Premises	3,459
Increase/(decrease) in bad debt provision	17
Depreciation and amortisation	2,836
Audit services - statutory audit	40
Clinical negligence	690
Other	289
	69,488

In the period ended 31 March 2009 Other expenditure consisted of significant items including £44k of consultancy costs, £78k of employers and public liability costs and £167k of miscellaneous items.

The Trusts auditors KPMG LLP have a limitation on their liability of £1,000,000.

5.2 Operating Leases

5.2.1 Operating lease rentals include:

	4 months ended 31 March 2009 £'000
Hire of plant and machinery	72
Other operating lease rentals	186
	258

5.2.2 Annual commitments under non-cancellable operating leases are:

	Land and buildings	Other leases
	4 months ended 31 March 2009 £'000	4 months ended 31 March 2009 £'000
Operating leases which expire:		
Within 1 year	0	72
Between 1 and 5 years	206	116
After 5 years	218	0
	424	**188**

6 Staff costs and numbers

6.1 Staff costs

	4 months ended 31 March 2009 £'000
Salaries and wages	**38,733**
Social security costs	**2,886**
Employer contributions to NHSBSA - Pensions Division	**4,189**
Agency/contract staff	**2,193**
	48,001

Staff costs capitalised amounted to £500k.

6.2 Average number of persons employed

	4 months ended 31 March 2009 £'000
Medical and dental	**316**
Administration and estates	**738**
Healthcare assistants and other support staff	**524**
Nursing, midwifery and health visiting staff	**1,443**
Scientific, therapeutic and technical staff	**432**
Bank and agency staff	**122**
Other	**102**
	3,677

6.3 Retirements due to ill health

During the 4 months ended 31 March 2009 there were 3 (8 months ended 30 November 2008: 11) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £166k (November 2008: £482k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

7 Better Payments Practice code

Measure of compliance:

	4 months ended 31 March 2009 No.	£'000
Total Non-NHS trade invoices paid in the period	23,793	31,158
Total Non-NHS trade invoices paid within target	22,470	30,027
Percentage of Non-NHS trade invoices paid within target	**94%**	**96%**

	4 months ended 31 March 2009 No.	£'000
Total NHS trade invoices paid in the period	949	7,874
Total NHS trade invoices paid within target	928	7,805
Percentage of NHS trade invoices paid within target	**98%**	**99%**

The Better Payment Practice Code 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.

8 Disposal of fixed assets

	4 months ended 31 March 2009 £'000
Loss on disposal of other tangible fixed assets	(3)
	(3)

9.1 Interest receivable

	4 months ended 31 March 2009 £'000
Bank accounts	70
Interest on late debts	1
	71

9.2 Interest payable

	4 months ended 31 March 2009 £'000
Finance leases	**(3)**

10 Intangible fixed assets

	Software Licences £'000	Total £'000
Gross cost at 1 December 2008	**1,696**	**1,696**
Reclassifications	0	**0**
Additions - purchased	294	**294**
Gross cost at 31 March 2009	**1,990**	**1,990**
Amortisation at 1 December 2008	**1,210**	**1,210**
Charged during the period	76	**76**
Amortisation at 31 March 2009	**1,286**	**1,286**
Net book value: Purchased at 1 December 2008	486	**486**
Donated at 1 December 2008	0	**0**
Total at 1 December 2008	**486**	**486**
Purchased at 31 March 2009	704	**704**
Donated at 31 March 2009	0	**0**
Total at 31 March 2009	**704**	**704**

11 Tangible Fixed Assets

11.1 Tangible Fixed Assets

	Total £000	Land £000	Building, excluding dwellings £000	Dwellings £000	AUC and payments on account £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000
Cost or Valuation at 1 December 2008	**175,767**	**22,728**	**100,346**	**1,474**	**3,864**	**35,138**	**169**	**11,844**	**204**
Additions - purchased	**8,584**	0	3,971	0	3,298	906	25	384	0
Additions - donated	**31**	0	8	0	0	23	0	0	0
Reclassifications	**0**	0	2,367	0	(2,605)	(24)	0	262	0
Disposals	**(187)**	0	0	0	0	(153)	(12)	(22)	0
Cost or Valuation at 31 March 2009	**184,195**	**22,728**	**106,692**	**1,474**	**4,557**	**35,890**	**182**	**12,468**	**204**
Depreciation at 1 December 2008	**28,151**	**0**	**0**	**0**	**0**	**23,089**	**147**	**4,712**	**203**
Charged during the period	**2,760**	0	1,204	13	0	864	2	677	0
Disposals	**(184)**	0	0	0	0	(150)	(12)	(22)	0
Depreciation at 31 March 2009	**30,727**	**0**	**1,204**	**13**	**0**	**23,803**	**137**	**5,367**	**203**
Net book value: Purchased at 1 December 2008	**145,546**	22,728	99,130	1,474	3,840	11,232	22	7,119	1
Donated at 1 December 2008	**2,070**	0	1,216	0	24	817	0	13	0
Total at 1 December 2008	**147,616**	**22,728**	**100,346**	**1,474**	**3,864**	**12,049**	**22**	**7,132**	**1**
Purchased at 31 March 2009	**151,917**	22,728	104,277	1,461	4,533	11,783	45	7,089	1
Donated at 31 March 2009	**1,551**	0	1,211	0	24	304	0	12	0
Total at 31 March 2009	**153,468**	**22,728**	**105,488**	**1,461**	**4,557**	**12,087**	**45**	**7,101**	**1**

On 30 November 2008 the DVS Manchester revalued the land and buildings on the basis of Depreciated Replacement Cost (specialised operational property), Existing Use Value (land and non-specialised operational property) and Open Market Value (non-operational property, including surplus land). This valuation is reflected in the brought forward figures in the table above.

11.2 Analysis of tangible fixed assets

Net book value: Protected assets at 31 March 2009	**55,527**	0	55,527	0	0	0	0	0	0
Unprotected assets at 31 March 2009	**97,941**	22,728	49,961	1,461	4,557	12,087	45	7,101	1
Total at 31 March 2009	**153,468**	**22,728**	**105,488**	**1,461**	**4,557**	**12,087**	**45**	**7,101**	**1**

11.3 Assets held at open market value:

	31 March 2009 £'000	Opening balance 01 December 2008 £'000
Land	**5,050**	**5,050**

11.4 The net book value of land, buildings and dwellings at the balance sheet date comprised:

	31 March 2009 £'000	Opening balance 01 December 2008 £'000
Freehold	**129,677**	**124,548**

11.5a The net book value of assets held under finance leases and hire purchase contracts at the balance sheet date comprised:

	31 March 2009 £'000	Opening balance 01 December 2008 £'000
Plant & Machinery	**43**	**0**

11.5b The total amount of depreciation charged to the income & expenditure account in respect of assets held under finance leases and hire purchase contracts:

	31 March 2009 £'000	Opening balance 01 December 2008 £'000
Plant & Machinery	**1**	**0**

12 Stocks and work-in-progress

	31 March 2009 £'000	Opening balance 01 December 2008 £'000
Raw materials and consumables	**3,295**	**3,074**

13 Debtors

13.1 Debtors at the balance sheet date comprised:

	31 March 2009 £'000	Opening balance 01 December 2008 £'000
Amounts falling due within one year:		
NHS debtors	2,572	5,782
Provision for impaired debtors	(242)	(281)
Prepayments	677	2,040
Accrued income	33	111
Other debtors	2,990	3,069
	6,030	**10,721**
Amounts falling due after more than one year:		
Other debtors	252	241
	252	**241**
Total debtors	**6,282**	**10,962**

13.2 Provision for impairment of debtors:

	31 March 2009 £'000	Opening balance 01 December 2008 £'000
Balance brought forward	(281)	(190)
Increase in provision	(25)	(93)
Amounts utilised	3	4
Unused amounts reversed	61	(2)
Balance carried forward	**(242)**	**(281)**

13.3 Analysis of impaired debtors:

	31 March 2009 £'000	Opening balance 01 December 2008 £'000
Ageing of impaired debtors:		
Up to 3 months	3	15
In 3 to 6 months	8	16
Over 6 months	112	152
	123	**184**
Ageing of non-impaired debtors past their due date:		
Up to 3 months	3	2,119
In 3 to 6 months	314	223
Over 6 months	213	(48)
	530	**2,294**

14 Creditors

14.1 Creditors at the balance sheet date comprised:

	31 March 2009 £'000	Opening balance 01 December 2008 as restated £'000
Amounts falling due within one year:		
Payments received on account	617	595
NHS creditors	1,829	3,037
Other taxes and social security costs	2,674	2,756
Obligations under finance lease and HP contracts	6	0
Capital creditors	5,177	194
Other creditors	4,088	4,904
Accruals	3,352	3,151
Deferred income	97	171
	17,840	**14,808**
Amounts falling due after more than one year:		
Obligations under finance lease and HP contracts	36	0
Deferred income	358	385
	394	**385**
Total creditors	**18,234**	**15,193**

Included within other creditors is £1,546k (30 November 2008: £1,548) in respect of outstanding pension contributions.

14.2 Finance lease obligations

	31 March 2009 £'000	Opening balance 01 December 2008 £'000
Within one year	14	0
Between one and five years	52	0
After five years	0	0
Subtotal	**66**	**0**
Finance charges allocated to future periods	(24)	0
Net obligations	**42**	**0**

14.3 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.

- 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 performance against the Prudential Borrowing Limit (PBL) for the 4 months ended 31 March 2009 was:

	Prudential Borrowing Limit £'000	Actual Borrowing £'000
Maximum cumulative long term borrowing	47,900	0
Approved working capital facility	16,000	0
Total	**63,900**	**0**

Financial ratio performance for the 4 months ended 31 March 2009:

	Approved PBL ratios	Actual ratios
Maximum debt to capital ratio	< 15%	Nil
Minimum dividend cover	> 1x	2.5
Minimum interest cover	> 3x	N/A
Minimum debt service cover	> 2x	N/A
Maximum debt service to revenue	< 3%	Nil

Until such time as the Trust draws down a loan only the minimum dividend cover ratio is relevant.

14.4 Financial Risk Ratings

Metric	Criteria	Actual	Year to date Rating	Weight
EBITDA margin	Underlying Performance	7.1%	3	25%
EBITDA, % achieved	Achievement of Plan	86.3%	4	10%
ROA	Financial Efficiency	4.5%	3	20%
I&E surplus margin	Financial Efficiency	0.6%	2	20%
Liquid ratio	Liquidity	50.4	5	25%
Weighted Average			**3.4**	**100%**
Overall Financial Risk Rating			**3.0**	

Risk rating boundaries:

	Weight	5	4	3	2	1
EBITDA margin	25%	11%	9%	5%	1%	< 1%
EBITDA, % achieved	10%	100%	85%	70%	50%	< 50%
ROA	20%	6%	5%	3%	-2%	< -2%
I&E surplus margin	20%	3%	2%	1%	-2%	< -2%
Liquid ratio	25%	35	25	15	10	< 10
	100%					

The Financial Risk Ratings (FRR) are 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 Trust achieved a Financial Risk Rating of 3.4 against a plan of 3.5, resulting in a FRR of 3 against a plan of 4.

15 Provisions for liabilities and charges

	Legal claims £'000	Other £'000	Total £'000
At 1 December 2008	**1,038**	**560**	**1,598**
Arising during the period	183	272	**455**
Utilised during the period	(26)	(107)	**(133)**
Reversed Unused	(105)	(37)	**(142)**
Unwinding of discount	0	0	**0**
At 31 March 2009	**1,090**	**688**	**1,778**

Expected timing of cash flows:			
Within one year	246	688	**934**
Between one and five years	212	0	**212**
After five years	632	0	**632**
	1,090	**688**	**1,778**

Legal provisions include £193k for employers and public liability claims (for which there is also a corresponding contingent liability of £114k declared in note 20), and £897k for the capitalised cost of permanent injury retirees.

The amount provided for employers / public claims is based on actuarial assessments received from the National Health Service Litigation Authority (NHSLA).

Other provisions are £688k, comprising of £75k for the estimated residual pay arrears for the implementation of the NHS consultant contract based on latest estimates, £36k for the estimated cost of the remaining Agenda for Change (AfC) arrears and £577k for the estimated pay arrears arising from the staff grades and associate practitioners contract review.

£27,743,152 is included in the provisions of the NHS Litigation Authority at 31 March 2009 in respect of clinical negligence liabilities of the trust (30 November 2008: £25,998,933).

16 Taxpayers' equity

16.1 Movement in taxpayers' equity

	31 March 2009 £'000
At 1 December 2008, as previously reported	161,560
Prior period adjustments	(465)
At 1 December 2008, as restated	161,095
Surplus for the financial period	2,443
Public dividend capital dividends	(2,040)
Reductions in donated asset reserve	(15)
At 31 March 2009	**161,483**

16.2 Movements in Public Dividend Capital

	31 March 2009 £'000
At 1 December 2008	94,083
New public dividend capital received	0
Public dividend capital repaid in period	0
At 31 March 2009	**94,083**

16.3 Movement on reserves

	Revaluation Reserve £'000	Donated Asset Reserve £'000	Income and Expenditure Reserve £'000	Total £'000
At 1 December 2008, as previously reported	**42,521**	**2,070**	**22,886**	**67,477**
PPA: Transfer of lottery funding to deferred income	39	(504)		**(465)**
At 1 December 2008, as restated	**42,560**	**1,566**	**22,886**	**67,012**
Transfer from income & expenditure account			403	**403**
Transfer of realised profits/(losses) to the income & expenditure reserve	(360)		360	**0**
Receipt of donated assets		31		**31**
Transfers to the income & expenditure account for depreciation, impairment and disposal of donated assets		(46)		**(46)**
Other transfers between reserves	(2)		2	**0**
At 31 March 2009	**42,198**	**1,551**	**23,651**	**67,400**

NHS Foundation Trusts are required to account for Big Lottery grants that finance fixed assets (and grants from its predecessor body, the New Opportunities fund) as government grants under deferred income where the grant has been received by the NHS foundation trust itself.

NHS Trusts accounted for the grants through the donated asset reserve, as such a prior period adjustment is required on transfer to a Foundation Trust.

17 Notes to the cashflow statement

17.1 Reconciliation of operating surplus to net cash inflow from operating activities:

	31 March 2009 £'000
Total operating surplus	2,378
Depreciation & amortisation charge	2,836
Fixed asset impairments	0
Transfer from donated asset reserve	(46)
Increase in stocks	(221)
Decrease in debtors	4,641
Decrease in creditors	(962)
Increase in provisions	180
Net cash inflow from operating activities	**8,806**

17.2 Reconciliation of net cash flow to movement in net funds/(debt):

	31 March 2009 £'000
Increase in cash in the period	1,998
Cash outflow from debt repaid and finance lease capital repayments	2
Change in net funds resulting from cashflows	**2,000**
Non-cash changes in debt (new finance leases / HP contracts)	(44)
Change in net funds	**1,956**
Net funds at 1 December 2008	15,748
Net funds at 31 March 2009	**17,704**

18 Capital commitments

Commitments under capital expenditure contracts at the balance sheet date were £1,430k (30 November 2008: £1,275k).

19 Post balance sheet events

The Trust does not have any material post balance sheet events.

20 Contingencies

	31 March 2009 £'000	Opening balance 01 December 2008 £'000
Contingent liabilities	114	66

The contingent liability relates to employers and public liability claims.

21 Private Finance Transactions

The Trust at 31st March 2009 does not have any PFI transactions off balance sheet.

22 Third party assets

The trust held £4,987 cash at bank and in hand at 31 March 2009 (30 November 2008: £2,434) which relates to monies held by the NHS Foundation Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

23 Losses and Special Payments

There were 267 cases of losses and special payments (30 November 2008: 76 cases) totalling £14,460 (30 November 2008: £95,716) approved during the 4 month period ended 31 March 2009.

24 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 period 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 2008/09 the Trust has had a significant number of material transactions and or hold debtor and creditor balances with them at 31st March 2009:

Ashton, Leigh and Wigan PCT
Five Boroughs NHS Trust
Wigan Metropolitan Borough Council
Depuy International Limited
Johnson & Johnson Medical Limited
West Lancashire District Council

The Department of Health, NHS Supply Chain and the Collaborative Procurement Hub are regarded as related parties. During the period Wrightington, Wigan and Leigh NHS Foundation Trust has had a significant number of material transactions with them and with other entities list below for which are regarded as related parties:

Central Lancashire PCT
Halton and St Helens PCT
Bolton PCT
Bury PCT
Cumbria PCT
Sefton PCT
North Lancashire PCT
Salford PCT
East Lancashire PCT
Heywood, Middleton and Rochdale PCT
North West Strategic Health Authority
NHS Business Services Authority
Salford Royal NHS Foundation Trust

In addition, the Trust has a significant number of material transactions with other Government Departments and other central and local Government bodies.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Trust Board.

25 Financial Instruments

Financial Reporting Standard 29 requires 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 2009 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

Wrightington, Wigan and Leigh NHS Foundation Trust is not exposed to significant interest rate risk. The tables in note 25.1.1 and 25.2.1 show the interest rate profiles of the Trust's financial assets and liabilities.

25.1.1 Financial assets

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed Rate		Non-interest bearing
					Weighted average interest rate	Weighted average period for which fixed	Weighted average term
	£'000	£'000	£'000	£'000	%	(Years)	(Years)
At 31 March 2009							
Sterling	**17,998**	17,736		262			1 year
Gross financial assets	**17,998**	**17,736**	**0**	**262**			
At 30 November 2008							
Sterling	**15,989**	15,716	0	273			1 year
Gross financial assets	**15,989**	**15,716**	**0**	**273**			

Non-interest bearing financial assets include £252k of other debtors due after more than one year.

25.1.2 Financial assets by category

	31 March 2009	Opening balance 01 December 2008
	Loans and Receivables £'000	Loans and Receivables £'000
NHS debtors	2,572	5,782
Provision for irrecoverable debts	(242)	(281)
Accrued income	33	111
Other debtors	2,986	3,095
Cash (at bank and in hand)	17,746	15,748
Total	**23,095**	**24,455**

25.2.1 Financial liabilities

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed Rate		Non-interest bearing
					Weighted average interest rate	Weighted average period for which fixed	Weighted average term
	£'000	£'000	£'000	£'000	%	(Years)	(Years)
At 31 March 2009							
Sterling	**36**	0	0	36			
Gross Financial liabilities	**36**	**0**	**0**	**36**			
At 30 November 2008							
Sterling	**0**	0	0	0			
Gross financial liabilities	**0**	**0**	**0**	**0**			

Non-interest bearing financial liabilities of £36k are obligations under finance leases and HP contracts due after more than one year.

25.2.2 Financial liabilities by category

	31 March 2009	Opening balance 01 December 2008
	Other financial liabilities £'000	Other financial liabilities £'000
NHS creditors	1,829	3,037
Other creditors	4,088	3,353
Accruals	3,352	3,242
Capital creditors	5,177	194
Finance lease obligations	42	0
Provisions under contract	1,778	1,598
Total	**16,266**	**11,424**

25.3 Fair values

Set out below is a comparison, by category, of book values and fair values of the NHS Trust's financial assets and liabilities as at 31 March 2009:

	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000	Book value £000
Financial Assets					
Cash at bank and in hand	0	17,746	0	**17,746**	17,746
Debtors over 1 year	0	252	0	**252**	252
Total at 31 March 2009	**0**	**17,998**	**0**	**17,998**	**17,998**
Cash at bank and in hand	0	15,748	0	**15,748**	15,748
Other financial assets	0	241	0	**241**	241
Total at 30 November 2008	**0**	**15,989**	**0**	**15,989**	**15,989**

	At 'fair value through profit and loss' £000	Other Liabilities £000	Total £000	Book value £000
Financial liabilities				
Creditors over 1 year	0	36	**36**	**36**
Provisions under contract	0	1,778	**1,778**	**1,778**
Total at 31 March 2009	**0**	**1,814**	**1,814**	**1,814**
Provisions under contract	0	1,598	**1,598**	**1,598**
Total at 30 November 2008	**0**	**1,598**	**1,598**	**1,598**

Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 2.2% in real terms.

Directors' Profiles

Andrew Foster

Chief Executive Officer

Andrew was appointed as Chief Executive in January 2007 after a short secondment as HR 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

Honours Degree in Philosophy, Politics and Economics from Keble College, Oxford, 1976.

Bill Livingstone

Deputy Chief Executive and Director of Human Resources

Bill has worked, as the Director of Human Resources at the Trust since 2000 and prior to this was Director of Personnel at Lincoln and Louth NHS Trust for 6 years. Before joining the NHS, Bill worked in both Local Government and Private Industry.

Qualifications

Chartered Fellow of the Institute of Personnel and Development, (CIPD) BA (Psychology).

Chris Chandler

Medical Director

Chris took up the post of Medical Director on 1 April 2004 and has been a Consultant Obstetrician and Gynaecologist in Wigan for the last 20 years. Chris was previously Clinical Director for Obstetrics and Gynaecology and then Chairman of the Surgical Division. His main focus as Medical Director is to ensure that this Trust offers the highest quality services to patients.

Qualifications

Fellow of the Royal College of Obstetricians and Gynaecologists, MBChB.

Keith Griffiths

Director of Finance and Informatics

Keith joined the Trust as Director of Finance and Informatics on 1st 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

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

Gill Harris

Director of Nursing and Patient Services

Gill's career began as a specialist nurse at Addenbrookes NHS Trust, moving onto the Head of Nursing position at University Hospitals of North Staffordshire NHS Trust before moving into general management. Gill originally joined the Trust as General Manager for the Division of Surgery in June 2004 and subsequently became the Trust's Deputy Director of Operations prior to her appointment of Director of Nursing and Patient Services in April 2007.

Qualifications

Registered General Nurse, MA (Strategic Healthcare)

Tony Chambers

Director of Operations

Tony joined the Trust in 2007 from Mid Yorkshire Hospitals NHS Trust where he had been Operations Director since 2005. Prior to this he was Associate Director at the NHS Modernisation Agency, Director on the Greater Manchester CHD Programme, Senior Manager at Salford Hospitals NHS Trust and Operational Manager at Bolton Hospitals NHS Trust

Qualifications

RGN 1988; BA Hons, Coventry University, 1994; DMS, Salford University, 1996; Graduated Greater Manchester Common Purpose Leadership Programme, 2003; Graduated Management Consultancy Skills, Ashridge 2004

Leslie Higgins

Chairman

Les Higgins has lived in Wigan for over 30 years and he joined the Trust as a Non-Exective Director in 2002 and became Chairmain in November 2007. Prior to this he worked in Local Government at Liverpool and Warrington. He 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 and 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 as External Funding Officer helping to bring over £5m in Lottery and other funding to Warrington. He continues his links with local government

as Clerk to Winwick Parish Council and is currently a Trustee of Age Concern Wigan Borough and as the Older Persons' Champion for the Trust works closely with the PCT and Social Services in the development of Older Peoples' Services. Les chairs the Remunerations and Charitable Funds Sub Committees of the Trust Board.

Qualifications
Diploma in Public Administration

Louise Barnes

Vice Chairman and Senior Independent Director

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 5-year business plan, strategic marketing plan and the buy-out of a rival company. Following this she worked as a freelance PR 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 Sub-Committee of the Trust Board and the Patient and Public Engagement Committee.

Qualifications
HND in Business and Finance, graduated top in year, Alex Lawrie prize for best final year performance, Southampton Institute (1996); BA (Hons) Business Administration First Class Degree, Alex Lawrie prize for best final year performance, Southampton Institute (1997).

Geoff Bean

Non-Executive Director

Geoff is a qualified accountant with a Business Administration education. He has broad financial experience at finance director level and has worked for over 35 years in a variety of customer focused international businesses. After 13 years in the automotive industry, he has worked in the paper industry in the USA, and in technical material businesses supplying into environmental, sports equipment, consumer and safety products. Working within businesses which supplied medical equipment and other medical products to the NHS 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 Audit Sub-Committee of the Trust Board

Qualifications
BSc Social Studies (Hons); MSc Business Administration; FCMA (Fellow of the Chartered Institute of Management Accountants).

Robert Collinson

Non-Executive Director

Robert is currently a senior law lecturer in higher education. He has been qualified as a solicitor for nearly twenty years and during that time has gained wide experience of providing practical legal advice on many aspects of the law of direct relevance to the work of an NHS Trust. Robert has already gained experience of governance through his work as a councillor in local government and as Non-Executive Director of a Housing Association.

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.

Pamela McCann

Non-Executive Director

Pamela has over sixteen years experience in urban regeneration and marketing. She has been Director of Marketing for a number of Development Corporations where she has worked with local communities providing housing, tourism, industrial and commercial led regeneration. She gained an in depth insight into the Wigan Borough in the 1990's as Director of Sales and Marketing for Wigan Borough Partnership. Pamela has had extensive experience in working in a governance role having served as a non-executive member on two previous NHS Trust boards, a Greater Manchester tourism agency and an Enterprise Trust. She is currently on the board of a housing association.

Qualifications

BSc Economics (Hons), MSc Marketing

Robert Armstrong

Non-Executive Director

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.

Qualifications

BSc – Open University; HNC Business and Finance; Telecommunications Certificates – City and Guilds.

Glossary

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 recovering from surgery.

Age Related Macular Degeneration (AMD)
A progressive degenerative condition usually of older adults which results in a loss of vision in the centre of the field of vision (the macula) because of damage to the retina.

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.

Angiography
A test in which dye is injected into an artery and X-rays are taken to determine blood flow in an area.

Angioplasty
A non-surgical treatment use to open narrowed coronary arteries to improve the blood flow to the heart.

Anti-coagulation
The use of drugs to stop the blood from clotting.

Assisted Conception
A fertility service.

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.

Business Continuity Planning
Prepared measures that anticipates risk and guards against business disruption in case of unforeseen events; which include local incidents (building fires), regional incidents (earthquakes), or national incidents (pandemic illnesses).

Caesarean Section
A surgical procedure in which incisions are made though a woman's abdomen and uterus to deliver her baby.

Caldicott Guardian
A senior member of staff in the NHS appointed to protect patient information and confidentiality and to enable appropriate information-sharing. The Trust's Caldicott Guardian is the Medical Director.

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

Cardiac Catheter
The insertion of a catheter into a chamber or vessel of the heart. This is carried out for both investigational and interventional purposes.

Chronic Obstructive Pulmonary Disease (COPD)
A non-reversible disease of the lungs in which the airways become narrowed.
COPDs include emphysema, chronic bronchitis, and chronic asthma either alone or in combination.

CJD/Transmissible Spongiform Encephalopathy
Creutzfeldt-Jakob disease (CJD) is a rare, usually fatal, brain disease caused by an unidentified slow virus.

Transmissible Spongiform Encephalopathy
(TSE, also known as prion diseases)
A group of progressive conditions that affect the brain and nervous system. CJD is a prion disease.

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

Clinical Trials
A research study used to find better ways to treat individuals with a specific disease; patients are evaluated after being administered a new treatment or drug.

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

Connecting for Health
Is an agency of the Department of Health which was formed on the 1st April 2005. It has the responsibility of delivering the NHS National programme for Information Technology including electronic patient and staff records, electronic x-rays etc.

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 serve and our stakeholders and to champion the Trust and its services. The Council of Governors does "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.

CT Scan
A computer linked to an x-ray machine which takes a series of detailed pictures of areas inside the body from different angles.

Dermatology
The study of the skin and its diseases.

Diabetes
Type 1 diabetes develops if the body is unable to produce any insulin. This type of diabetes usually appears before the age of 40.

Type 2 diabetes develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance). In most cases this is linked with being overweight.

Diagnostics
The branch of medical science dealing with the classification of disease

Dr Foster
A commercial provider of healthcare information based in the United Kingdom. Dr Foster was launched in 2001 with its core work originally being the publication of guides to healthcare services in the UK and then more recently the provision of information tools.

E-Learning
Training delivered via computer

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

Endoscopy
A procedure that uses a small, flexible tube with a light and a camera lens at the end (endoscope) to examine the inside of a body cavity (eg, colon).

European Working Time Directive
A collection of regulations concerning hours of work, designed to protect the health and safety of workers.

Fractured Neck of Femur
Broken hip

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.

Geriatrics
The branch of internal medicine that focuses on health care of the elderly. It aims to promote health and to prevent and treat diseases and disabilities in older adults.

Haematology
The study and treatment of blood and bone marrow disorders.

Health and Safety Executive
A non-departmental public body in the United Kingdom. It is the body responsible for the encouragement, regulation and enforcement of workplace health, safety and welfare, and for research into occupational risks in England and Wales and Scotland

Healthcare Commission
An independent body established to promote improvements in healthcare through the assessment of performance of those who provide services.

Hospital at Home
The provision of a hospital service in the person's own home. It will 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 new 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.

The Information Commissioner (The ICO)
The ICO is the UK's independent public body set up to promote access to official information and protect personal information by promoting good practice, ruling on eligible complaints, providing information to individuals and organisations, and taking appropriate action when the law is broken. The ICO enforces and oversees the Data Protection Act, the Freedom of Information Act, the Environmental Information Regulations, and the Privacy and Electronic Communications Regulations.

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.

Modified Early Warning Score (MEWS)
A simple guide used by medical staff to quickly determine the risk of death of a patient. It is based on four physiological readings (blood pressure, heart rate, respiratory rate and body temperature) and one observation (level of consciousness).

Monitor
Monitor is the independent regulator of NHS Foundation Trusts. The organisation was established in January 2004 to authorise and regulate NHS Foundation Trusts. They are 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 lives 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.

MRI Scans
A non invasive body imaging procedure that uses powerful magnets and radio waves to construct pictures of the internal structures of the body.

Musculo-Skeletal (MSK)
The system of muscles, tendons, ligaments, bones, joints and associated tissues that move the body and maintain its form.

Myocardiac Infarction
A heart attack.

Neurology
The study of the nervous system and disorders affecting it.

Nephrology
The diagnoses and treatment of disorders of the kidneys.

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.

Obstetrics
The care of women during pregnancy, childbirth, and the recuperative period following delivery.

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

Osteoporosis
Thinning of the bones with reduction in bone mass due to depletion of calcium and bone protein. Unchecked osteoporosis can lead to posture changes, physical abnormality, and decreased mobility.

Patient Administration System
One of the earliest components of a hospital computer system which records the patient's name, home address, date of birth and each contact with the outpatient department or admission and discharge.

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.

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.

Prosthesis
An artificial replacement of a body part.

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.

SBAR (situation, background, assessment, recommendation)
SBAR is a process or guideline for communicating information to a multidisciplinary team with regard to an acutely ill patient.

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.

Staff Side
Staff Side is comprised of 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.

Stress Incontinence
The leakage of urine on laughing, coughing, straining, or even walking. It is common in women whose pelvic floor muscles have been weakened during childbirth.

Thrombosis
The formation, presence, or development of a thrombus, which is a fibrous clot, formed in a blood vessel or in a chamber of the heart.

Tonsillectomy
Surgical removal of tonsils or a tonsil.

Ultrasound
A method of visualising the internal parts of the body, or a fetus within the uterus, using sound waves.

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.

Virtual ward
A virtual ward is a cadre for providing support in the community to people with the most complex medical and social needs.

Walk In Centre
A medical centre designed for dealing with minor illnesses and injuries. This includes: infection and rashes, fractures and lacerations, emergency contraception and advice, stomach upsets, cuts and bruises, or burns and strains. They are predominantly nurse-led first-contact services available to everyone without making an appointment or requiring patients to register.

Ward-to-Board Reporting
This is a rolling audit report which generates results by ward on a monthly basis. It measures aspects of care directly relevant to patients under a number of criteria:

- Pressure sore assessment
- Falls assessment
- Infection control measures
- Observations
- Food and nutrition
- Pain control
- Medications

Wards are scored on each aspect, and results are shared with the ward and Board. Wards are aware of their performance, and where there is weak performance, improvement actions are taken.

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.

Annual Report Production

We are very grateful to all contributors who have had a major involvement in the production of this Annual Report.

The Trust welcomes any comments you may have and asks you to help shape next year's Annual Report by sharing your views and contacting the Marketing and Communications Department via:

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Annual Report Availability

The Annual Report is available in Braille, large print, audio tape, CD and translation into a foreign language. To request one of these versions please telephone 01942 773106.

Additional copies and an abridged podcast version can also be downloaded from the Trust website:

www.wwl.nhs.uk