NHS

Wrightington, Wigan and Leigh

NHS Foundation Trust

Annual report and accounts 2017 - 2018

The WWL Way

Wrightington, Wigan and Leigh NHS Foundation Trust
Annual report and accounts 2017 - 2018

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PERFORMANCE REPORT

It was from here that Professor Sir John Charnley developed the hip replacement in November 1962 and our surgeons of today have continued to enjoy a reputation for excellence.

Performance overview

> The purpose of this overview of performance is to provide information on our organisation, its history and purpose. The Chairman and Chief Executive also present their perspective on our performance during the financial year 2017-18 and describe the key risks to the achievement of our objectives as determined by the board.

Introduction to Wrightington, Wigan and Leigh NHS Foundation Trust

> Who we are

Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) is a medium-sized acute foundation trust in the North West of England, within the Greater Manchester footprint. Initially formed as an NHS Trust following the merger of Wrightington NHS Trust and Wigan and Leigh Health Services NHS Trust, we were established as a foundation trust in December 2008. We are registered with the Care Quality Commission without conditions and hold a provider licence issued by NHS Improvement.

Our purpose is to provide the best possible healthcare for our community, and our vision as an organisation is to make a positive difference to people's lives.

We aim to do this through our newly-introduced strategy, The WWL Way 4wards, which sets out four corporate objectives:

> Patients: Every patient receives the best possible care

> People: Everyone has the opportunity to achieve their purpose

> Performance: We aim to be in the top 10%

> Partnerships: We work together for the best patient outcomes

For over a decade we have committed to delivering high quality services and this continues at the heart of our new strategy. We define quality using three descriptors:

> Safe, meaning it is our job to protect our patients against harm;

> Effective, meaning it is our job to treat patients effectively with good clinical outcomes; and

> Caring, meaning it is our job to care compassionately for patients and to meet their personal needs

We serve a local population of 318,000 and provide specialist services to a much wider regional, national and international catchment area. We provide our clinical services from our five main sites: Royal Albert Edward Infirmary, Wrightington Hospital, Leigh Infirmary, Thomas Linacre Centre and Boston House.

Royal Albert Edward Infirmary is our main district general hospital site and is located in central Wigan. Here you will find our Emergency Department as well as the majority of our in-patient services. There has been a hospital on this site since 1873 and it was named after the then-Prince of Wales, who officially opened it in 1875.

Wrightington Hospital is a specialist centre of orthopaedic excellence and enjoys a world-acclaimed reputation. Situated just over the border in West Lancashire, it was from here that Professor Sir John Charnley developed the hip replacement in November 1962 and our surgeons of today have continued to enjoy a reputation for excellence.

Leigh Infirmary is an outpatient, diagnostic and treatment centre in the south of the borough. **Thomas Linacre Centre** is a dedicated outpatient centre in central Wigan and **Boston House** is a specialist ophthalmology unit; again in central Wigan.

How we operate

We have a divisional management structure to coordinate and deliver high quality clinical care across three divisions, each headed by a divisional triumvirate comprising a Divisional Medical Director, a Divisional Head of Nursing and a Deputy Director of Operations and Performance.

Other services are provided through our corporate services and our estates and facilities teams.

We were delighted to report a year-end surplus of £1.7m, exceeding our control total by £3.5m.

Performance overview from the Chairman and Chief Executive

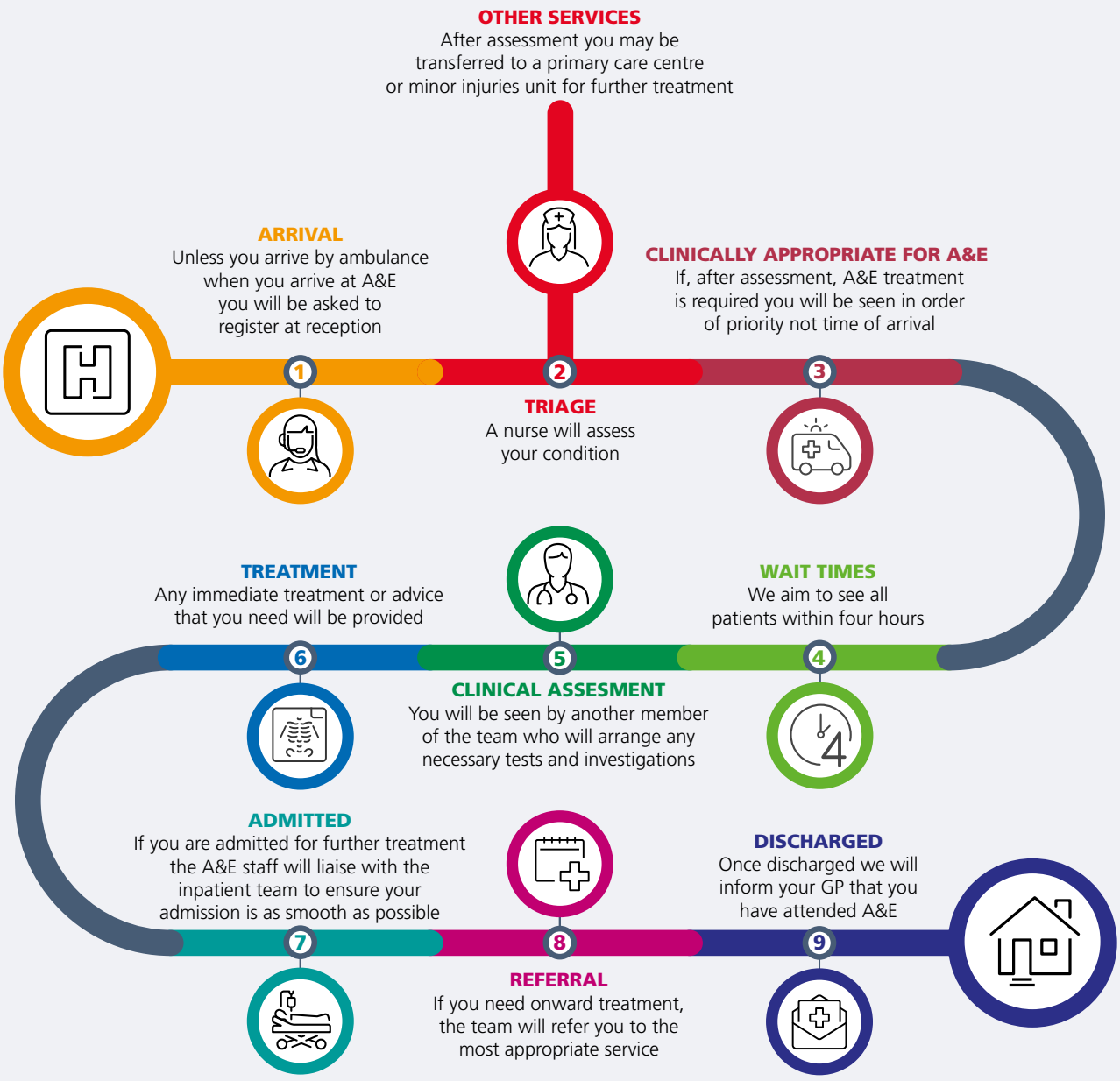
> In all our combined years in the National Health Service, we can honestly say that 2017-18 was the most difficult year we can recall. The scale of challenge across the country cannot be understated, with many NHS organisations struggling to achieve national access targets, to recruit and motivate staff or to balance the books. Set against this national context, we remain extremely proud of our performance and in particular the way that our staff have worked to deliver for our patients.

This report provides us with the opportunity to highlight some of the significant developments to services and improvements to care and outcomes that have occurred over the past year. We believe it provides a fair and balanced review of our performance.

Our financial plan for 2017-18 set a deficit target for the year, however due to robust financial management and strong monitoring of financial performance we were delighted to report a year-end surplus of £1.7m, exceeding our control total by £3.5m. Our cost improvement programme delivered £11.8m of savings during the year, however only £4.3m (36%) are recurrent savings.

As noted earlier, there has been an unprecedented level of demand for unscheduled care across the country. Whilst NHS organisations are familiar with the traditional period of increased demand over the winter period and plan accordingly, there was no respite during 2017-18 and the "winter" pressures continued all year round. Our Emergency Department was not only affected by this increase in demand at the front door, but also by the delays that our wards have encountered in transferring patients to other hospitals and care settings because of the increased demand on all health and social care providers. This had the effect of reducing flow out of the department to our wards.

The patient journey through A&E



These factors meant that, in many cases, patients waited longer in our Emergency Department than we would have wanted. At times of increased demand, our priority is to ensure that high quality care continues to be provided to each and every patient. Our staff work tirelessly to care for our patients and it is only right that this is acknowledged here. Our clinical teams of doctors, nurses and allied health professionals ensure that each patient receives the care they need. But running a hospital requires a wider team and each and every member plays a part: from the housekeepers who respond at a moment's notice to clean cubicles to the porters and transfer teams who transport patients to our wards; from the bed management and patient flow teams working in the background to ensure beds are available to the matrons who ensure sufficient staff are available to provide ongoing care on the wards; from the pharmacy teams who ensure the availability of medication to facilitate swift discharge to the on-call managers who look after the operation whilst the rest of us sleep; from the diagnostic teams in radiology and pathology who hasten the patient journey to the administrative and clerical staff who make the whole system work. There are too many to name individually but we do acknowledge the part that all our staff play.

We continue to work with our partners across the borough to identify and implement changes that improve the patient journey. In October 2017, we introduced a GP-led Primary Care Centre on the Royal Albert Edward Infirmary site. As part of the triage process, patients who self-present at our Emergency Department are assessed to determine whether they are suitable to be seen within the Primary Care Centre. This ensures that lower acuity patients are able to be seen in a more appropriate setting and reduces the waiting time within the Emergency Department. During its hours of operation, up to 40% of eligible patients are streamed to the Primary Care Centre.

In February 2018, we also moved our Minor Injuries Unit and collocated it with the Primary Care Centre. This freed up cubicles within our Emergency Department and allowed us to increase the number of majors patients who are able to be seen at any one time.

In November 2017, we were inspected by the Care Quality Commission and we were judged to be 'Good' across all areas. This is a fantastic achievement with significant improvements noted across numerous areas and means that all of our sites are now either 'Good' or 'Outstanding'. At the same time, we were assessed by NHS Improvement in relation to our use of resources, and we were judged to be 'Good' on this assessment also.

Despite the level of pressure within the organisation, we saw an improvement in some key staff engagement questions within the National Staff Survey. 84% of our staff believe that care of patients or service users is our top priority, and 77% responded that they would be happy with the standard of care provided by us, if a friend or relative needed treatment. Whilst we were pleased that these response rates are both an improvement on the previous year and significantly higher than the national average, we do know that there is still work to be done in order to further increase these scores.

> Key risks to the achievement of our objectives

The board assurance framework is a tool that the board uses to seek assurance around the delivery of corporate objectives. Each corporate objective is allocated to a lead committee which reviews the relevant entries on the board assurance framework at each meeting. If the committee is not scheduled to meet, the entries are reviewed by the executive management team. The complete board assurance framework is reviewed at each meeting of the board and is used to promote discussion and debate as well as informing decision-making by directors. Towards the end of 2017-18 we reviewed the format of our board assurance framework and we introduced our new-style board assurance framework from April 2018.

The key risks that the organisation was exposed to during 2017-18 were related to the following areas:

- delivery of safe, high quality, effective, evidence-based patient care
- having a safe and flexible workforce that meets the needs of the service now and for the future
- improving levels of staff engagement and developing a culture of confidence and optimism where staff can directly influence change
- meeting all national access targets
- achieving two-year budget stability
- making the most of our IT investment to improve quality and efficiency
- improving hospital services through partnerships and standardised hospital care

The risks we have identified for 2018-19 include:

- nurse staffing shortages
- lack of availability of beds within the foundation trust and a lack of appropriate services across the borough
- delivery of recurrent cost improvement plans
- failure to meet the accident and emergency 4-hour wait target; and
- failure to achieve sustainability and transformation funding.

More information on how we manage risk within the foundation trust is available in the annual governance statement which begins on page 64.

> Our performance this year

Our performance during the year 2017-18 is discussed in more detail in the performance analysis section of this report, which begins on page 14 and a summary is provided below:

Access headlines

- 80.97% performance against the Accident and Emergency four-hour wait target (target 95%)
- 96.69% performance against two-week wait from referral to date first seen for all urgent cancer referrals (target 93%)
- 94.80% performance against the 18-week referral-to-treatment pathway (target 92%)
- 99% performance against 6-week diagnostic standard (target 99%)

Quality headlines

- 1 MRSA bacteraemia, against a target of 0
- 25 C. difficile infections against a target of 19, with 6 attributable to lapses in care
- 4 never events against a target of 0
- Hospital Standardised Mortality Rate (HSMR) of 101.9 for the period April 2017 to December 2017 (average is 100)

> Going concern assessment

There is no presumption of going concern status for NHS foundation trusts. It is for the directors to determine each year whether or not it is appropriate to prepare accounts on the going concern basis, taking into account best estimates of future activity and cash flows.

After making enquiries, the directors have a reasonable expectation that Wrightington, Wigan and Leigh NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, we have continued to use the going concern basis in preparing the accounts and further information on this is available on page 25.

ANDREW FOSTER CBE
> Chief Executive and Accounting Officer

22 May 2018

ROBERT ARMSTRONG
> Chairman

22 May 2018

Performance analysis

> At Wrightington, Wigan and Leigh NHS Foundation Trust, we measure performance in a number of ways.

We measure operational and clinical performance through key performance metrics which are included in the performance report, which is presented to the board each month for scrutiny. Copies of our board papers are available to download from our website, and a whole section of this report is dedicated to clinical quality. For more information, please see the quality report which begins on page 73.

There is a clear link between our key performance indicators and the risks facing the organisation. For example, non-achievement of the four-hour wait target is key risk to the organisation and non-achievement of the target can have quality and financial consequences. Similarly, increases in demand affect both our performance against our key performance indicators but can also contribute to our risks, such as a reduced availability of appropriate beds. There are a number of uncertainties in any organisation, and each month the board and its committees hold detailed discussions using contemporary data to identify emerging risks.

> Operational and clinical performance

> Division of Medicine

The Division of Medicine is a large multi-functional division comprising four directorates based over three sites.

The four directorates are:

- > General Medicine
- > Emergency Care which is subdivided into Unscheduled and Scheduled Care
- > Elderly Care and Specialist Rehabilitation
- > Clinical Governance.

> Unscheduled care

Throughout 2017-18, we continued to see an increase in both the number and the acuity of patients admitted through A&E, which has contributed to us being unable to sustain delivery of the 95% 4 hour A&E standard. Although health and social care partners within the locality have focussed on schemes to provide alternatives, this has not had an impact on the rising year-round demand for acute beds.

In October 2017, we implemented the nationally-mandated GP streaming scheme and located the service in a newly refurbished unit inside Christopher Home adjacent to the current Accident and Emergency department. In January 2018 the Emergency Nurse Practitioners and some elements of patients presenting with minor injuries were also streamed to the new unit. The aim is to stream an average of 50 patients per day away from the Emergency Department and into these services. This equates to around 40% of all eligible patients previously attending the Emergency Department. At the start of the year a Paediatric Observation and Assessment Area was also introduced which resulted in a 50% reduction in the number of children breaching the 4-hour standard.

During 2018-19, we will work towards achieving the mandated 90% 4-hour Accident & Emergency standard by the end of Quarter 1. This will be achieved by reviewing bed capacity across the organisation and ensuring a reduction in patients who fall within the 'stranded' patient metric. The focus will involve a reduction in length of stay for patients treated within the Medicine division.

The division enjoys a strong national position in relation to Delayed Transfers of Care, and we currently have the third-lowest number of beds per head of population ratio of general acute trusts in Greater Manchester.

> Scheduled care

Continuing the trend of the last few years, 2017-18 again saw an increase in referrals to many of our scheduled care services, with the largest of these increases being in the gastroenterology and endoscopy services. To keep pace with both the increased demand and national directives with regard to early diagnosis of certain conditions, plans have been put forward to increase the endoscopy department footprint on the Wigan site.

In conjunction with the Healthier Wigan Partnership, an 18-month programme of work is being developed to proactively detect and intervene in those patients who are at risk of requiring acute care related to their respiratory condition. This will predominantly be aimed at patients with Chronic Obstructive Pulmonary Disease (COPD) and will be a holistic intervention looking at an asset and place-based response.

In the cardiology department, a new purpose-built Catheter Lab discharge lounge was opened, which can accommodate 7 patients in chairs. This was made possible by utilising charitable funds, generously donated by patients.

This year, we were successful in a bid to Macmillan Cancer Support, and were awarded £800k of funding to develop the delivery of 7-day palliative care across the Wigan Borough. This project is a pilot and will come into effect from October 2018.

After many months of consultation, the neuro-rehabilitation unit at Leigh closed on 31 March 2018 as it did not have ready access to facilities to treat patients in need of emergency care. Patients that would previously have been cared for here will now be cared for at Trafford General Hospital.

> Clinical governance

Despite the operational challenges of 2017-18, this has been a positive year where the governance team has continued to support the clinical and operational teams in the delivery of safe, effective care. Our emphasis on improvement and learning was reflected this year in the very positive results of the CQC inspection which showed improvements in our rating for the safe domain for both scheduled and unscheduled care, giving the division a 'Good' rating for all domains.

Clinical engagement has been key to driving change and improvement. Each specialty has a consultant designated as governance lead and incidents, complaints, risks and mortality form part of the discussions at specialty and divisional governance meetings, to identify challenges, areas for improvements and changes required in their areas.

> Division of Surgery

The Division of Surgery is another large division and a number of specialties sit within its remit:

- > Anaesthetics
- > Audiology
- > Breast Unit
- > Child Health
- > Circulation Laboratory
- > General and Colorectal Surgery
- > Healthcare Operations
- > Obstetrics and Gynaecology
- > Intensive Care Unit/High Dependency Unit
- > Education Panel
- > Endoscopy
- > Ear, Nose and Throat
- > Theatres
- > Maxillo Facial
- > Urology.

2017-18 was a challenging but productive year for the Division of Surgery and we are pleased to report that we witnessed a number of successes, developments and quality improvements.

Healthier Together through the North West Sector continues to make steady progress and the division is working with partners across Greater Manchester and the North West Sector to develop clinical models to further improve services. The division has also continued to work with partners to identify areas for joint working and managed to implement a joint urology on-call rota with Bolton NHS Foundation Trust.

We continued to improve our services by seeing more patients in a shorter time. The Surgical Assessment Unit (SAU) continued to be successful in caring for acutely ill surgical patients, providing surgical reviews and early management plans. It also actively supported admission avoidance and patient flow by utilising the successful hot clinic and SAU pathways of care. We continued to increase the number of patients who were able to have their surgical procedures as day cases, in order to reduce the number of overnight stays and to help them return home sooner.

All of the teams within the division have focused on developing and improving the services that they offer to patients and we have seen a number of service developments throughout the year, including the Introduction of a Paediatric Observation and Assessment Area to support with increased demand over the winter period and reduce the number of patients have to be transferred for paediatric care. Our Neonatal Unit was successful in receiving the UNICEF Baby Friendly Award and the Maternity Unit was one of a few organisations to pilot the Personalised Maternity Budget.

We have maintained our work with GP partners with the implementation of the colorectal advice and guidance service to support GPs in identifying the best referral routes for their patients. The Healthcare Operations team have also led on the successful implementation of the National Paper Switch off Programme for GP referrals into Secondary Care.

PAWS (Pathology at Wigan and Salford) is part of the division and we have continued to work collaboratively with Salford Royal NHS Foundation Trust to further develop this service to meet the increase in demand. The Assisted Conception Unit based at Wrightington Hospital also continues to develop and widen the availability of services to the local population and surrounding areas.

Clinical governance

The role of the clinical governance team is to ensure that patient safety, experience and effectiveness of services are at the heart of everything we do. This includes, but is not limited to:

- > CQC compliance
- > Risk identification and management
- > Incident reporting and investigation
- > Patient experience
- > Compliance with NICE guidance
- > Audit activity
- > Health and Safety

The team has worked hard to triangulate learning from incidents, complaints, audit and feedback from external regulators such as CQC and Wigan Borough Clinical Commissioning Group, and this is reflected within action plan development and monitoring.

> Division of Specialist Services

The division of Specialist Services comprises the following clinical areas:

- > Trauma and orthopaedics
- > Rheumatology
- > Radiology
- > Outpatients
- > Oncology
- > Dermatology
- > Medical illustrations
- > Private patients and overseas visitors

We continued to increase the number of patients who were able to have their surgical procedures as day cases, in order to reduce the number of overnight stays and to help them return home sooner.

2017-18 was a challenging year in trauma and orthopaedics. We treated more elective and trauma patients across both the Wigan and Wrightington sites than the previous year and achieved the 18-week referral-to-treatment target despite ongoing issues with some of the theatre facilities and the national challenge of nurse recruitment.

In 2017 the orthopaedic service was visited by the Getting It Right First Time (GIRFT) team. GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations. GIRFT reported that Wrightington Hospital was a centre undertaking high volumes of primary joint replacement and revision surgery. In the majority of cases, the highest volumes of procedures equate to better outcomes for patients and recommended that all revision and complex surgery from the region should be referred to Wrightington hospital. The report also highlighted the very low infection and complication rates for orthopaedic patients.

Data from the National Joint Registry also shows that patients who receive their treatment at Wrightington Hospital are less likely to require revision or further surgery and their joint replacements last longer. The National Joint Registry also shows that Wrightington is fifth in the country in terms of the number of operations we undertake annually.

We continue to work collaboratively with Wigan Borough Clinical Commissioning Group to redesign the rheumatology outpatient service, to offer support for both GPs and patients in the local community. New care pathways were agreed with the CCG implemented during 2017-18 and this work will continue into 2018-19.

Demand for diagnostic imaging continues to grow, and we undertake over 300,000 examinations per year. Despite this, we continued to achieve the national six-week standard for diagnostic tests in the year 2017-18.

In terms of cancer and oncology services, activity on our sites has been steadily growing and we remain confident in our ability to gradually increase the numbers of patients we can accept for treatment. In line with the Government initiative of care closer to home, we have already consulted with our staff with a view to increasing our opening hours from 8am to 8pm Monday to Friday and, in the future, to consider treatments on Saturday mornings. This will enable us to deliver more treatments, increasing the opportunity for patients to be cared for in Wigan. This forward-looking initiative requires input from other support services and we continue to work with those parties to facilitate this.

We continue to perform well against all the 14, 31 and 62-day cancer waiting time targets.

This year, we have been above 90% each month for patients treated within 62 days of their GP referral and we are consistently in the top ten trusts nationally for this important measure.

pathways and therefore the patient journey. We are currently trying to bring waiting times for the first appointment to within seven days.

From 1 April 2018 another national target is being introduced, where patients referred from their GP as a suspected cancer will be given either a cancer or cancer-ruled-out diagnosis within 28 days of referral.

The three clinical divisions are supported by our estates and facilities department and our corporate services departments.

> Estates and facilities

The estates and facilities division provides a wide range of non-clinical support services to all our sites, including:

- Catering
- Security
- Hotel Services
- Capital Design
- Medical Electronics
- Operational Estates Maintenance
- Safety Management
- Energy and Waste Management
- Fire Safety
- Grounds Maintenance.

Whilst quality and safety are equally important, we fully recognised the need to provide a cost-effective service and we utilise our estate as efficiently as possible. The recent Carter Review of efficiency identified estates and facilities as a key area of spend for all organisations. We embraced the principles of this review and have continued to work in conjunction with both the Department of Health and the Heath Estates and Facilities Management Association to ensure that overall costs are at, or below, the median benchmark level.

During the past 12 months, we have invested a further £9.1m in capital developments, which has benefited a number of key areas and projects.

The estates and facilities division provides an emergency breakdown repair and planned preventative maintenance service and supported wider estates and facilities activity across our sites. It also provides a technical out of hours emergency on-call service for the built environment and associated engineering services.

The division plays a key part in ensuring that the patient environment is maintained to the highest level. This is audited annually as part of the patient-led assessment of the care environment assessments.

In 2017 we received a score of

99.74%

for condition, appearance and maintenance which placed us second in the whole of England.

Our patient food scores improved to

98.51%,

which places us fourth in England,

and the cleanliness of our clinical areas scored

98.4%;

the third highest in England.

The division also provides medical equipment management services, using an equipment database which now includes more than 20,000 items. The database is a keystone to managing the servicing, maintenance and breakdown repair service that is delivered to all clinical departments.

> Sustainability and environmental management

We have continued to invest considerable resources in order to reduce the impact on our environment. By improving the design of new buildings and refurbishments, we achieved a "very good" score in the Building Research Establishment Environmental Assessment Model.

We continually strive to minimise our environmental impact through reducing energy-related CO_2 emissions year-on-year. As anticipated, we observed greater electric demand on our Leigh site due to the growth of our catering and IT services teams in 2017-18. In April 2017, a new combined heat and power unit at Leigh Infirmary was commissioned, reducing operational costs, providing greater electrical resilience, significant reduction in CO_2 emissions and is performing better than originally anticipated. We have recently completed a business case to install additional equipment, to enable this plant to link with the heat recovery unit; thus further enhancing the efficiency of the Energy Centre on the Leigh site.

We have continued to invest in combined heat and power units, and this is set to be commissioned in April 2018 on the Wrightington site and will closely mirror the set-up at Leigh that has proved so successful this year.

We continue to look to reduce our electrical load due to lighting and in 2017-18 we hope to roll out smart LED lighting, with the first installation expected in the Thomas Linacre Centre as early as May 2018. The potential for this is dramatic and we hope to be a pioneer organisation for such technologies moving forward.

> Waste management

Our objective for 2017-18 was to begin to enhance the safe, compliant and sustainable management of waste and the disposal across all sites, whilst maximising recycling in all areas. Recycling drop-off points and the segregation of cardboard, scrap metals, furniture and electrical waste have further improved our performance, alongside improvements to waste compactors, collection bins, and holding areas for waste materials.

We have recently sought to work with a local waste collection company for our general waste disposal mechanisms. This has dramatically reduced our carbon footprint due to transport of waste, and significantly improved performance of waste material processed for recycling. We continually provide support and advice to all departments regarding waste responsibilities, providing necessary information, equipment and facilities to allow the safe handling, segregation and storage of waste.

Regular waste audits continue and these have led to the impending introduction of a sharps management mechanism that will help dramatically reduce sharps incidents and enable the introduction of the offensive waste stream to our estate, further reducing our cost base for waste processing in 2018-19.

> Emergency preparedness

As a category one responder under the Civil Contingencies Act 2004, we need to be able to plan for, and respond to, a wide range of incidents and emergencies that could impact on health or patient care. These could be anything from extreme weather conditions, contaminated or infected patients, or a major incident resulting in mass casualties or fatalities. NHS organisations are required to plan and prepare for such incidents whilst ensuring that safe services for patients are maintained. NHS England has set out a number of core standards for emergency preparedness, resilience and we are fully compliant with these.

We identify our local high-level risks and put plans and processes in place which aim to reduce the likelihood or impact of these risks materialising. We also work closely with our partner agencies in Wigan and Greater Manchester to identify local risks and to agree joint plans to provide a co-ordinated multi-agency response, for example the Greater Manchester Mass Casualty Plan. We are actively represented on a variety of local and regional emergency planning and response forums including Wigan Borough Resilience Forum and the Greater Manchester Local Resilience Forum.

Our major incident plan provides a generic management framework to respond to and recover from a significant emergency or major incident. During 2017-18 there were several terrorism-related attacks in both London and Manchester, and these resulted in a short-term increase in the international terrorism threat level from severe to critical.

In response to the Manchester Arena bombing incident in May, North West Ambulance Service and acute trusts across Greater Manchester declared a major incident and the Greater Manchester Mass Casualty Plan was activated. Around 14,500 Ariana Grande fans - mainly children and their parents - were leaving the Manchester Arena on the night of 22 May 2017 when a suicide bomb exploded, killing 22 children and adults and leaving over 500 with physical injuries or severe psychological trauma.

Trauma units and centres across GM received a varying number of casualties. The Greater Manchester Mass Casualty Plan had previously been the subject of an exercise, so all receiving hospitals had recently tested their own major incident response to such a large scale, devastating incident. All trusts across GM provided a timely, effective and compassionate incident response and as always, our dedicated staff ensured that our patients and staff were well cared for throughout the hours and days that followed.

As part of the process of continuous learning, we take account of lessons to be learned and good practice from incidents, both local and national, to enhance our own local planning and response. As such, our Major Incident Plan was reviewed following the Manchester Arena attack to reflect issues highlighted in debriefs following the Manchester and London incidents. These changes will be tested through local and regional exercises to ensure that we can continue to provide an effective and efficient response in the event of a major incident or emergency.

All senior managers are required to participate in annual training to rehearse their roles in the event a major incident or emergency. This year, Exercise Fuji was used to test the senior managers' and executives' responses to a potential full site evacuation. These exercises provide facilitated discussions on how they would deal with this type of incident and cover a number of core competencies for on-call senior managers and executives.

Our Business Continuity Plan provides a framework to allow us to respond to large scale localised incidents, for example, significant flooding or utility failure. If such an incident occurs, the implementation of this plan will ensure minimum disruption to staff and patients and a timely return to 'business as usual' in the event of such an incident or emergency.

In May 2017, the whole of the NHS experienced a cyber attack by a virus named WannaCry. The virus sought to encrypt different types of computer data files and to spread itself across networked computers. The attack affected 150 countries and over 200,000 computers within a few hours. Within the NHS, 47 trusts reported infections and 7 A&E departments were forced to close to ambulances.

As soon as the malware was detected, a rapid response took place and a contingency process was implemented which involved containment, eradication and recovery. We established an incident response team that worked relentlessly and which was focussed on maintaining patient safety and keeping critical unscheduled care systems running, whilst working towards returning the organisation to business as usual. No electronic patient data was compromised during this attack and no ransom was paid, despite this being the intention of the virus.

2017 also saw the launch of our Operational Pressures Escalation Levels (OPEL) Plan which is set within the context of the national guidance from NHS England. It has been developed for operational pressures all year round, not just in response to winter pressures, and identifies local triggers and actions that will support the Trust in the continued delivery of safe and effective care throughout the year.

> How we are run

The Board of Directors is responsible for the overall leadership and strategic direction of the organisation. The board is comprised of executive and non-executive directors and further information on the board is available on pages 28 to 31.

The Council of Governors, made up of elected governors from our public and staff membership and appointed governors from our key stakeholders, has a number of statutory functions and two general duties – to represent the interests of members and the general public and to hold the non-executive directors to account for the performance of the board. More information on the Council of Governors is available on pages 54 to 56.

An independent Company Secretary provides corporate governance leadership, advice and support to both the board and the council. We have policies in place to deal with matters such as gifts and hospitality, declarations of interest and anti-bribery matters and we have a Freedom to Speak Up Guardian in place in line with best practice.

The executive directors collectively form the executive management team which provides day-to-day leadership and management of the organisation. Each director has a portfolio of responsibilities and is supported by dedicated support structures.

We employ 4,874 members of staff, all of whom play their part in delivering high quality, safe and effective patient care. We continue to demonstrate considerable success in improving quality, and the quality report section provides much more detail on the quality improvements we are achieving.

> Summary of our operational activity

The table below summarises our activity during 2017-18, and the figures for 2016-17 are provided for comparison:

		2017-18	2016-17
Referrals	GP	84,946	86,680
	Other	85,055	86,253
	Total	**170,001**	**172,933**
In-patient activity	Elective/planned	7,523	7,463
	Day cases	39,705	40,980
	Non-elective	38,403	30,397
	Total	**85,631**	**78,840**
Outpatient activity	New appointments (attendances)	137,267	85,321
	Follow-up appointments (attendances)	349,779	274,328
	Total	**487,046**	**382,379**
Accident and emergency	New attendances	85,582	85,321
	Unplanned re-attendances	3,219	4,155
	Total	**88,801**	**89,477**
Walk-in centre	**Total attendances**	**43,747**	**43,345**

> Social, community and human rights issues

We recognise the need to forge strong links with the communities we serve so that we are responsive to feedback and can develop our services to meet current healthcare needs.

We are committed to meeting our obligations in respect of the human rights of our staff and patients, which is closely aligned both to the NHS constitution and our values. As a public body, it is unlawful for us to act in any way which is incompatible with the European Convention on Human Rights unless required by primary legislation.

We have anti-fraud policies in place and further information is available within the staff report and within the Annual Governance Statement.

All our policies are reviewed on a regular basis and are subject to an equality impact assessment.

> Financial performance

Whilst we have ended the year in a financially positive position, this year has been a very challenging and demanding one. We have worked extremely hard to ensure we have met financial targets which are essential to enable continued investment in staff, facilities and services and to provide value for money and outstanding care for the population we serve.

We ended the year with a trading surplus of £8.6m, which excludes the impact of impairments totalling £6.9m, making the reported position for the year £1.7m.

Capital investment for the year totalled £9.1m and we had a closing cash balance of £12.6m.

Our use of resources score was 1, the best available, and further details of this can be found on page 61.

> Income

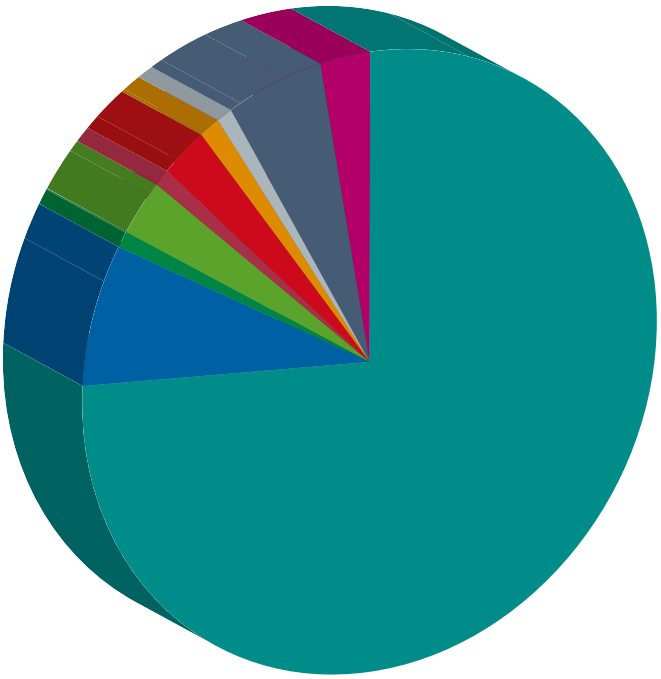
We have generated £310m of income in the year, which is £22.9m more than planned.

Wigan Borough Clinical Commissioning Group remains the largest commissioner of our services, contributing 58.4% of the Trust's overall income.

Section 43(2A) of the National Health Service Act 2006 requires that the income we receive from the provision of goods and services for the purposes of the health service in England must be greater than the income we receive from the provision of goods and services for any other purposes. The charts below demonstrate our compliance with this requirement.

	2017-18 £000	2016-17 £000
Non Principal Income	9,011	13,323
Total Income	310,040	297,493
Non-Principal Income as a % of all income	**2.9%**	**4.5%**

The chart below shows the split of our income by source. As you will see, the majority of income is received from Government bodies, with only 1.8% of income received from bodies outside of the Government.



> Income by Source 2017-18

- Clinical Commissioning Group **86%**
- NHS England **8%**
- Non NHS: other **0%**
- NHS injury scheme (CRU) **1%**
- Non NHS: overseas patients (chargeable to patient) **0%**
- Non NHS: private patients **1%**
- NHS other **0%**
- NHS Trusts **0%**
- NHS Foundation Trusts **3%**
- Local Authorities **1%**

We have worked extremely hard to ensure we have met financial targets which are essential to enable continued investment in staff, facilities and services and to provide value for money and outstanding care for the population we serve.

> Clinical income by point of delivery:

Acute services	2017-18 £000	2016-17 £000
Elective income	63,772	64,063
Non elective income	61,073	54,807
First outpatient income	20,051	28,307
Follow up outpatient income	22,129	20,016
A&E income	11,435	9,792
High cost drugs income from commissioners (excluding pass through costs)	11,103	12,414
Other NHS clinical income*	79,660	61,796
Community services	3,219	4,126
Additional income		
Private patient income	2,760	2,373
Other clinical income**	1,020	1,826
Total income from activities	**276,222**	**259,520**

*Other NHS clinical income includes income in respect of maternity outpatients, diagnostic imaging, breast screening, audiology, chemotherapy, palliative care and community services.

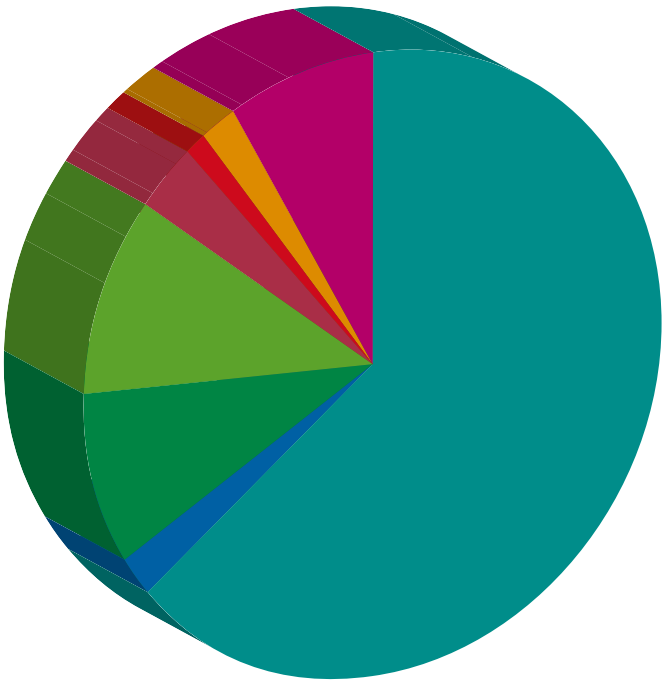
**Other clinical income relates largely to income from the Compensation Recovery Unit (CRU) for third party injury claims.

> Expenditure

Total operating expenditure for the year was £305m (including impairments) an increase of £8.6m or 3% on last year. Pay was the largest expenditure item at £198m which is 65% of total expenditure and, within this figure, the amount spent on registered nursing, midwifery and health visiting staff remains the most significant at £50m.

£24m was spent on drugs which is an increase of £1m when compared to last year. Other notable expenditure items in the year are £31m in respect of clinical supplies, £11m clinical negligence insurance premiums, and £4m energy costs. Depreciation and amortisation of £6.0m is included in the overall expenditure figure, a non-cash item reflecting the reduced value of the Trust's assets.

The following graph depicts the main categories within total reportable expenditure:



> Expenditure by Type (£m)

- Pay **198.2**
- Drugs **24.1**
- Depreciation & Amortisation **6.0**
- Energy **3.5**
- Clinical Negligence **10.6**
- Clinical Supplies **31.1**
- Other **28.0**
- Impairments **6.9**

> Cost improvement plans

The financial benefit derived from cost improvement plans (CIP) is £11.8m in the year.

> Capital investment programme

During the year we completed £9.1m of capital investments which have significantly improved services for both patients and staff. A summary of the capital investments undertaken in the year is provided in the table below:

Capital Investment Scheme	Investment Benefits	£000k
Health Information Scheme (HIS)	The continued introduction of the HIS platform to the Trust providing rapid and seamless access to patient information (software and hardware)	2,795
IT Systems Upgrade	Upgrade of the Trusts IT systems including the purchase and installation of wireless access units, replacement of servers and operating systems ensuring that systems are protected against the threat of cyber-attacks. Upgrading of software and the replacement of outdated PCs and devices	1,373
Christopher Home Redevelopment	The redevelopment and adaption of the Christopher Home building for the creation of the emergency care centre and the decontamination unit	917
Energy Efficiency Schemes	Continuation of the introduction of energy efficiency schemes which will reduce revenue costs at Wrightington	630
Radiology Interventional Suite	Upgrade of the Radiology Interventional Suite	505
Business Intelligence	Business Intelligence and Data Warehouse applications	430
Wrightington Research & Education Centre	Architectural, planning and surveying services for the proposed Research & Education Centre at Wrightington	311
Decommissioning of Pathology Laboratories	The demolition of pathology laboratories and the creation of a car park adding much needed spaces on the Wigan site	146
Other items		2,038
Total		**9,145**

> Post balance sheet events

In the opinion of the directors there are no post balance sheet events.

> Going concern

Based on all available evidence, the directors have a reasonable expectation that the foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

In giving this opinion, we recognise the challenging environment and we have identified those risks which will require careful management. The board has approved our 2018-19 annual plans which have been submitted to NHS Improvement. Income and expenditure plans have been prepared using national guidance on tariff and inflationary factors with income based on agreements with commissioners. We have been prudent in our assessment of efficiency targets, including cost improvement plans managed by a well-established Project Management Office, and believe that this forward plan provides a realistic assessment of the financial year ahead. Income and expenditure budgets have been set on robust and agreed principles, which mean that divisions should be able to provide high quality healthcare within the resources available, provided the cost saving targets are achieved.

Uncertainties exist in the current economic climate, however these have been reduced by agreeing a number of contracts with clinical commissioning groups, local authorities and NHS England and these payments provide a reliable stream of funding; minimising our exposure to liquidity and financing problems. Cash flow statements have been prepared using planned income and expenditure and a full range of sensitivities, re-modelled based on identified risks and reasonable mitigations which have been considered by the board.

Taking the above into account, the directors believe that it is appropriate to prepare the accounts on a going concern basis.


Your stay
with us

ACCOUNTABILITY REPORT

Directors' report

> Our board of directors operates according to the highest corporate governance standards. It is a unitary board and has a wide range of skills and experience. The non-executive directors have wide-ranging expertise and experience, including backgrounds in finance, audit, property, primary care and education. The board considers that it is balanced and complete in its composition, and appropriate to the requirements of the organisation.

1

> ROBERT ARMSTRONG,
Chairman (Independent)
Appointment 1 Nov 2014 to 31 Oct 2020

Robert has extensive experience in senior management roles, most recently with BT. He has led in the development of joint venture companies across Europe and the United States and is a passionate advocate of the "customer-led" approach.

2

> ANDREW FOSTER CBE,
Chief Executive
Permanent post

Andrew has been our Chief Executive since 2007. Before this, he spent five years as the Workforce Director General for the NHS and was the architect of Agenda for Change terms and conditions which remain in place to date. He also led on the creation of the first ever national HR plan for the NHS and the implementation of the new consultant contract.

3

> DR SANJAY ARYA,
Medical Director
Permanent post

Sanjay is a consultant interventional cardiologist by background, with interests in coronary artery disease, coronary intervention, heart failure, arrhythmia, syncope and cardiac assessment for non-cardiac surgery and professional footballers.

4

> ALISON BALSON,
Director of Workforce
Permanent post

Alison has extensive experience in managing human resources services, and has worked in the NHS for over 15 years. She is committed to demonstrating the link between staff engagement, organisational performance and patient satisfaction. Alison genuinely believes in partnership working and the need to work collegiately with trade union partners.

5

> NEIL CAMPBELL,
Senior Independent Director (Independent)
Appointment 1 Nov 2014 to 31 Oct 2020

Not pictured

Neil has been the Group Chief Executive of Alternative Futures Group, one of the top 100 charities and social businesses in the UK, since 2006. He was previously Chief Executive of NHS Argyll and Clyde and before that he was Chief Executive of NHS Grampian and Dumfries and Galloway Health Boards.

6

> DR STEVEN ELLIOT,
Non-Executive Director (Independent)
Appointment 1 Apr 2018 to 31 Mar 2021

Steven has worked as a GP since 1983 and has a special interest in headaches. He is currently a professional adviser for NHS England and a Non-Executive Director of a community-interest company.

7

> MARY FLEMING,
Director of Operations and Performance
Permanent post

Mary has a strong patient-focused operational background with extensive experience in leading service improvement and innovation across a variety of clinical disciplines. She worked in the private sector before moving into healthcare and has previously worked in acute provider organisations across Greater Manchester and Yorkshire.

8

> ROB FORSTER,
Director of Finance and Informatics/Deputy Chief Executive
Permanent post

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

9

> MICK GUYMER,
Non-Executive Director (Independent)
Appointment 1 Aug 2015 to 31 Jul 2021

Mick is a qualified accountant who has worked in the NHS for 40 years, with the last 20 years being in Director of Finance roles. He also spent almost 10 years as Project Director of a £500m private finance initiative to re-develop the Central Manchester site and relocate the Manchester Children's Hospitals.

10

> IAN HAYTHORNTHWAITE,
Non-Executive Director (Independent)
Appointment: 9 Apr 2018 to 8 Apr 2021

Ian is the Chief Operating Officer for BBC Nations and Regions, prior to which he was the Deputy Chief Executive of the North West Development Agency with responsibility for development of the Cumbria Economic Strategy. He has also previously held the role of Pro-Vice-Chancellor of the University of Central Lancashire.

11

> CAROLE HUDSON CBE,
Deputy Chair (Independent)
Appointment 1 Jul 2015 to 30 Jun 2021

Carole has extensive experience of working in local government, where she was a Chief Executive and Director of Finance for 27 years. She is a qualified accountant and has managed multi-million pound budgets as well as having responsibility for the delivery of large-scale public sector infrastructure projects.

12

> PAULINE LAW,
Director of Nursing
Permanent post

A nurse by background, Pauline has extensive nurse leadership, project management and operational management experience and has worked in the NHS for over 30 years. She has a strong community nursing background and has held senior project management roles in end of life care.

13

> LYNNE LOBLEY,
Non-Executive Director (Independent)
Appointment 26 Mar 2018 to 25 Mar 2021

Lynne's background is in education and until recently she was a member of the Senior Management Team at the Cheshire and Mersey Deanery. She has also been a member of the Deanery Integration Board and the Local Workforce Action Board. She has 20 years' experience as a NED in three very different trusts.

14

> RICHARD MUNDON,
Director of Strategy and Planning
Permanent post

Richard is an experienced public servant who has spent the majority of his career in the health sector. He spent 25 years with the Department of Health across a range of policy, management and corporate disciplines. He has experience of leading large change processes and developing performance management and planning regimes.

15

> PROF TONY WARNE,
Non-Executive Director (Independent)
Appointment 31 Oct 2016 to 30 Oct 2019

A Professor Emeritus in Mental Healthcare and former Pro-Vice Chancellor at the University of Salford, Tony is a registered nurse, nurse educator and researcher. He has worked in NHS mental health care services since 1975, both as a practitioner and service manager. He left the NHS in 1995 and his research since has been focused on inter-personal, intra-personal and extra-personal relationships using a psychodynamic and managerialist analytical discourse.

The following individuals were also directors of Wrightington, Wigan and Leigh NHS Foundation Trust during 2017-18:

> JON LLOYD
Non-Executive Director to 31 March 2018

> CHRISTINE PARKER-STUBBS
Non-Executive Director to 31 March 2018

> NEIL TURNER
Non-Executive Director to 31 March 2018

All directors are required to comply with the requirements of the "fit and proper persons test" and have made an annual declaration of compliance in this regard.

> We are committed to ensuring that the board is made up of a majority of independent non-executive directors who objectively challenge management.

> Appointment and removal of non-executive directors

Appointment and, if appropriate, removal of non-executive directors is the responsibility of the Council of Governors. When appointments are required to be made, usually for a three-year term, a Nominations and Remuneration Committee of the council oversees the process and makes recommendations as to appointment to the full council. The procedure for removal of the Chair and other non-executive directors is laid out in our constitution which is available on our website or on request from the Company Secretary.

> Division of responsibility

There is a clear division of responsibilities between the Chairman and the Chief Executive. The Chairman ensures that the board has a strategy which delivers a service that meets and exceeds the expectations of the communities we serve and that the organisation has an executive team with the ability to deliver the strategy. The Chairman facilitates the contribution of the non-executive directors and their constructive relationships with the executives. The Chief Executive is responsible for the leadership of the executive team and for implementing our strategy and delivering our overall objectives, and for ensuring that we have appropriate risk management systems in place.

> Declarations of interest

All directors have a responsibility to declare relevant interests, as defined within our constitution. These declarations are made to the Company Secretary, reported formally to the board, and entered into a register which is available to the public. A copy of the register is available on our website or on request from the Company Secretary.

> Independence of directors

The non-executive directors bring strong, independent oversight to the board and all non-executive directors are currently considered to be independent. We are committed to ensuring that the board is made up of a majority of independent non-executive directors who objectively challenge management.

The Council of Governors is responsible for all decisions to reappoint non-executive directors, and is supported in its consideration by the recommendations it receives from the Nominations and Remuneration Committee. Any recommendation to reappoint a non-executive director beyond six years follows detailed scrutiny to ensure the continued independent of the individual director and, generally speaking, such terms of office are avoided unless there are exceptional grounds for them to be considered. Any non-executive director appointed beyond six years is subject to annual reappointment and the maximum term of office is nine consecutive years.

> Performance evaluation

The board has reserved certain powers and decisions to itself; these are set out in the Schedule of Matters Reserved to the Board of Directors. This details the roles and responsibilities of the Board, Council of Governors and Sub-Committees of the Board.

The foundation trust is able to make arrangements for the exercise of any of its powers by a formally-constituted committee of directors or by individual directors, subject to such restrictions and conditions as the board thinks fit. Standing Orders for the Practice and Procedure of the Board of Directors (Annex 8 to the constitution) sets out the arrangements for the exercise of such powers under delegation.

> Attendance summary

The table below shows the attendance at board meetings for all directors in post during the 2017-18 financial year. Where directors were appointed after the year-end, they have not been included.

Name of director	A	B	Percentage attendance
Robert Armstrong, Chairman	10	11	91%
Andrew Foster, Chief Executive	10	11	91%
Sanjay Arya, Medical Director	10	11	91%
Alison Balson, Director of Workforce	9	11	82%
Neil Campbell, Non-Executive Director	9	11	82%
Mary Fleming, Director of Operations and Performance	11	11	100%
Rob Forster, Director of Finance and Informatics	10	11	91%
Mick Guymer, Non-Executive Director	10	11	91%
Carole Hudson, Non-Executive Director	11	11	100%
Pauline Law, Director of Nursing	11	11	100%
Jon Lloyd, Non-Executive Director	7	11	64%
Richard Mundon, Director of Strategy and Planning	10	11	91%
Christine Parker-Stubbs, Non-Executive Director	9	11	82%
Neil Turner, Non-Executive Director	11	11	100%
Tony Warne, Non-Executive Director	9	11	91%

A: number of meeting attended
B: number of meetings the director could have attended

> Evaluating performance and effectiveness

Each year, the board undertakes a review of its performance and effectiveness and this provides a useful opportunity for the board to take a step back and reflect.

This year, we commissioned an external review of our leadership and governance using NHS Improvement's well-led framework, and the final report from this review was received during April 2018. Deloitte was selected following a competitive tender exercise. The board considers the review to be independent because although Deloitte provides external audit services to the foundation trust, the manner in which Deloitte as a firm is constructed means that the team undertaking the review had no relationship with, nor any ability to be influenced by, the external audit team. The focus for 2018-19 will be on ensuring that the recommendations from this review are implemented and embedded within the organisation.

The review covered eight key lines of enquiry:

> Leadership capacity and capability

> Clarity of vision, strategy and plans to deliver

> Culture of high quality, sustainable care

> Clarity of roles and responsibilities to support good governance

> Management of risks, issues and performance

> Information

> Stakeholder engagement

> Learning, continuous improvement and innovation

The review noted a number of areas of good practice, including a stable and cohesive board which is aware of the need to continually refine and evolve its skills. Our vision and values were also noted to be clear, well-known and utilised in practice.

A robust appraisal process is in place for all board members and other senior executives. The Chairman appraises the Chief Executive, and the Chief Executive carries out performance reviews of the other executives. All these reports are submitted to the Remuneration Committee.

The Chairman undertakes the performance review of non-executive directors using our non-executive director competency framework and the outcomes of these appraisals are reported to the Council of Governors. During 2017-18, as in previous years, the performance review of the Chairman was led by the senior independent director in accordance with a process agreed by the Council of Governors. The outcome was then reported to the council by the senior independent director.

> Understanding the views of governors and members

Directors develop an understanding of the views of governors and members about the organisation through attendance at members' events, attendance at Council of Governors meetings and attending the annual members' meeting.

> Mandatory declarations required within the directors' report

> We have complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

> A statement describing adoption of the Better Payment Practice Code is included within the accounts.

> Information on fees and charges (income generation) is included in the accounts.

> More information on the arrangements that are in place to ensure that services are well-led can be found in our annual governance statement.

> Income disclosures as required by section 43(2A) of the National Health Service Act 2006 are included within the financial performance section of the performance report.

> So far as each director who is a director at the time the report is approved is aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware.

> Each director has taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

In making these declarations, the directors confirm that they have made such enquiries of their fellow directors and of the foundation trust's auditors for that purpose, and taken such steps (if any) for that purpose, as are required by their duty as a director of the foundation trust to exercise reasonable care, skill and diligence.

Remuneration report

> Annual statement on remuneration

I am pleased to present the directors' remuneration report for the financial year 2017-18 on behalf of the foundation trust's two remuneration committees. The Remuneration Committee is established by the Board of Directors in relation to executive directors' remuneration and other terms and conditions of service, and the Nominations and Remuneration Committee is established by the Council of Governors in relation to non-executive directors.

In accordance with the requirements of the HM Treasury Financial Reporting Manual and NHS Improvement, we have divided this report into the following parts:

- The directors' remuneration policy sets out our senior managers' remuneration policy; and
- The annual report on remuneration includes details about the directors' service contracts and sets out governance matters such as committee membership, attendance and the business transacted

> Major decisions on remuneration

The two remuneration committees aim to ensure that non-executive and executive directors' remuneration is set appropriately, taking into account relevant market conditions.

As in previous years, the remuneration for non-executive directors is based on the role that they undertake within the organisation. In 2017-18, the Council of Governors agreed to increase the remuneration for all non-executive directors by 1%, with effect from 1 April 2017, in line with the uplift provided to staff on national Agenda for Change terms and conditions.

With the exception of the Chief Executive and Medical Director, executive director remuneration is based on pay scales, with progression through the pay scale being subject to the achievement of set performance criteria. There is one pay scale for the Director of Finance and another pay scale for the remaining executive directors.

In 2017-18, the Director of Finance had reached the top of the allocated pay scale. Having reviewed market data and salary benchmarking data, the Remuneration Committee extended the existing pay scale by adding one additional pay point.

No changes were made to the remuneration of the Chief Executive or the Medical Director during 2017-18.

All executive directors are entitled to an additional car allowance payment. An 11% salary uplift is applied in respect of the Deputy Chief Executive post, which is currently held by the Director of Finance.

ROBERT ARMSTRONG
> Chairman

22 May 2018

> Senior managers' remuneration policy

The table below sets out the component parts of our remuneration package for senior managers which comprise the senior managers' remuneration policy:

Element of pay	Purpose and link to strategy	How operated	Maximum opportunity	Description of performance metrics	Changes from previous year
Base salary	To help promote the long-term success of WWL and retain high calibre executive directors.	As determined by salary scales. Increments reviewed annually and approval based on performance.	There is no prescribed maximum annual increase, however it is anticipated that directors will only move one pay point per year unless their duties fundamentally change	Individually set at the start of the year	No change
Benefits (taxable)	To help promote the long-term success of WWL and retain high calibre executive directors.	Benefits for executive directors include: Personal car allowance Pension-related benefits (annual increase in NHS pension entitlement) Non-executive directors do not receive benefits	There is no formal maximum	N/A	No change
Pension	To help promote the long-term success of WWL and retain high calibre executive directors.	We operate the standard NHS pension scheme without any exceptions	As per standard NHS pension scheme	N/A	No change
Non-executive directors' fees (including the Chairman)	To attract and retain high quality and experienced non-executive directors (including the Chairman)	The remuneration of the non-executive directors is set by the Council of Governors on the recommendation of the Nominations and Remuneration Committee, having regard to the time commitment and responsibilities associated with the role. The remuneration is reviewed annually, taking account of fees paid by other foundation trusts. Non-executive directors do not participate in any performance-related schemes nor do they receive any pension or private medical insurance or taxable benefits.	As determined by the Council of Governors	N/A	No change

> Remuneration for the year to 31 March 2018

The following tables and the fair pay multiple, which are subject to audit, show directors' remuneration for the year.

	Salary (bands of £5,000)	Taxable Benefits (to the nearest £100)	Pension related benefits (bands of £2,500)	Total bands of £5,000
Robert Armstrong, Chairman	45 - 50	0	0	45 - 50
Andrew Foster, Chief Executive	200 - 205	0	35.0 - 37.5	235 - 240
Sanjay Arya, Medical Director*	240 - 245	0	72.5 - 75.0	310 - 315
Alison Balson, Director of Workforce	105 - 110	9,200	25.0 - 27.5	145 - 150
Neil Campbell, Non-Executive Director	10 - 15	0	0	10 - 15
Mary Fleming, Director of Operations and Performance	115 - 120	0	57.5 - 60.0	170 - 175
Robert Forster, Director of Finance and Informatics	175 - 180	8,000	55.0 - 57.5	240 - 245
Mick Guymer, Non-Executive Director	10 - 15	0	0	10 - 15
Carole Hudson, Non-Executive Director	15 - 20	0	0	15 - 20
Pauline Law, Director of Nursing	115 - 120	-	60.0 - 62.5	175 - 180
Jon Lloyd, Non-Executive Director	10 - 15	0	0	10 - 15
Richard Mundon, Director of Strategy and Planning	110 - 115	8,400	30.0 - 32.5	150 - 155
Christine Parker-Stubbs, Non-Executive Director	15 - 20	0	0	15 - 20
Neil Turner, Non-Executive Director	15 - 20	0	0	15 - 20
Tony Warne, Non-Executive Director	10 - 15	0	0	10 - 15

All of the above directors were in post for the 12-month period to 31 March 2018. No annual performance or long-term performance-related bonuses were paid during the period. Taxable benefits relate to car lease contributions.

*The above remuneration includes clinical duties of £107k that are not part of the individual's management role.

> Remuneration for the year to 31 March 2017

	Salary (bands of £5,000)	Taxable Benefits (to the nearest £100)	Pension related benefits (bands of £2,500)	Total bands of £5,000
Robert Armstrong, Chairman	45 - 50	0	0	45 - 50
Andrew Foster, Chief Executive	200 - 205	0	17.5 - 20.0	220 - 225
Sanjay Arya, Acting Medical Director (from 1 Aug 2016)*	160 - 165	0	65.0 - 67.5	230 - 235
Alison Balson, Director of Workforce	100 - 105	8,500	20.5 - 22.5	130 - 135
Neil Campbell, Non-Executive Director	10 - 15	0	0	10 - 15
Mary Fleming, Director of Operations and Performance	110 - 115	0	85.0 - 87.5	195 - 200
Robert Forster, Director of Finance and Informatics	170 - 175	7,300	32.5 - 35.0	210 - 215
Mick Guymer, Non-Executive Director	10 - 15	0	0	10 - 15
Carole Hudson, Non-Executive Director	15 - 20	0	0	15 - 20
Pauline Law, Director of Nursing	110 - 115	0	95.0 - 97.5	205 - 210
Jon Lloyd, Non-Executive Director	10 - 15	0	0	10 - 15
Richard Mundon, Director of Strategy and Planning	110 - 115	6,100	25.0 - 27.5	140 - 145
Christine Parker-Stubbs, Non-Executive Director	15 - 20	0	0	15 - 20
Neil Turner, Non-Executive Director	15 - 20	0	0	15 - 20
Tony Warne, Non-Executive Director	10 - 15	0	0	10 - 15
Directors not in post as at 31 March 2018				
Jawad Husain, Act. Medical Director (from 1 Aug 2016)*	155 - 160	0	52.5 - 55.0	210 - 215
Umesh Prabhu, Medical Director (to 31 Jul 2016)	55 - 60	0	0	55 - 60

* The above directors' costs include remuneration for clinical duties that were not part of their management role. These amounted to £149k for J Husain and £156k for S Arya.

All of the above directors were in post for the 12-month period to 31 March 2017 except where indicated. No annual performance or long-term performance-related bonuses were paid during the period. Taxable benefits relate to car lease contributions.

During the year, one senior manager was paid more than £150,000. Benchmark salary information for comparative jobs within the NHS was considered at the time of appointment and it was concluded that the remuneration agreed was appropriate and reasonable for the current post holder.

> Pension entitlements for year-ended 31 March 2018

	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension at age 60 as at 31st March 2018 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31st March 2018 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31st March 2018 £000	Cash Equivalent Transfer Value at 31st March 2017 £000	Real increase in Cash Equivalent Transfer Value £000
Andrew Foster, Chief Executive	2.5 - 5.0	7.5 - 10.0	25 - 30	80 - 85	0	0	0
Sanjay Arya, Medical Director	2.5 - 5.0	12.5 - 15.0	50 - 55	160 - 165	1,139	1,023	116
Alison Balson, Director of Workforce	0 - 2.5	0	5 - 10	10 - 15	106	87	19
Robert Forster, Director of Finance	2.5 - 5.0	0	25 - 30	0	282	228	54
Mary Fleming, Director of Ops and Performance	2.5 - 5.0	2.5 - 5.0	25 - 30	75 - 80	563	484	79
Pauline Law, Director of Nursing	2.5 - 5.0	7.5 - 10.0	40 - 45	120 - 125	885	773	112
Richard Mundon, Director of Strategy and Planning	0 - 2.5	0	10 - 15	0	144	122	32

> Pension entitlements for year-ended 31 March 2017

	Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension at age 60 as at 31st March 2017 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31st March 2017 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31st March 2017 £000	Cash Equivalent Transfer Value at 31st March 2016 £000	Real increase in Cash Equivalent Transfer Value £000
Andrew Foster, Chief Executive	0 - 2.5	0 - 2.5	25 - 30	75 - 80	0	0	0
Sanjay Arya, Medical Director	2.5 - 5.0	10.0 - 12.5	50 - 55	150 - 155	1,023	877	97
Alison Balson, Director of Workforce	0 - 2.5	0	5 - 10	10 - 15	87	72	15
Robert Forster, Director of Finance	2.5 - 5.0	0	20 - 25	0	228	196	32
Mary Fleming, Director of Ops and Performance	2.5 - 5.0	7.5 - 10.0	25 - 30	75 - 80	484	397	87
Pauline Law, Director of Nursing	2.5 - 5.0	12.5 - 15.0	35 - 40	110 - 115	773	654	119
Richard Mundon, Director of Strategy and Planning	0 - 2.5	0	5 - 10	0	112	86	26
Directors not in post as at 31 March 2018							
Jawad Hussain, Acting Medical Director	2.5 - 5.0	7.5 - 10.0	45 - 50	135 - 140	929	827	68
Umesh Prabhu, Medical Director	0	0	75 - 80	225 - 230	0	0	0

Non-executive directors do not receive pensionable remuneration, therefore there are no entries in respect of pensions for non-executive directors.

> Cash equivalent transfer values

A Cash Equivalent Transfer Value (CETV) is the actuarially-assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when a member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accumulated as a consequence of their total membership of the scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV's are calculated within the guidelines and framework prescribed by the institute and Faculty of Actuaries.

> Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include 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.

During the period there were no compensation payments made to former senior managers nor any amounts payable to third parties for the services of a senior manager.

> Directors' and governors' expenses

The total number of governors in office as at 31 March 2018 was 27

The total number of directors in office as at 31 March 2018 was 16

Expenses paid to directors include all business expenses arising from the normal course of business of the Trust and are paid in accordance with the Trust's policy.

The total amount of expenses reimbursed to 7 directors during the year was £5,900 (9 directors, £5,800 in 2016-17).

The total amount of expenses reimbursed to 8 governors during the year was £1,500 (8 governors, £2,600 in 2016-17).

> Fair pay multiples

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

The banded remuneration of the highest paid director of Wrightington, Wigan and Leigh NHS Foundation Trust in the financial year 2017-18 was £310k-£315k (2016-17 £235-240k).

This was 9.6 times (2016-17, 9.77 times) the median remuneration of the workforce, which was £24,840 (2016-17, £24,304). The salary of the highest paid director includes salary payments for work undertaken in performing clinical sessions.

In 2017-18, 1 employee received remuneration in excess of the highest paid director (2016-17 1 employee). Their remuneration in 2017-18 was £275-280k (2016-17, £235-240k).

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

As in previous years, temporary agency staffs are excluded from the calculations. The calculation methodology is kept the same so that the 2017-18 results are comparable with those in previous years.

	Financial Year 2017-18	Financial Year 2016-17
Band of highest paid director's remuneration (£'000)	310 - 315	235 - 240
Median total (£)	24,840	24,304
Ratio	9.6	9.77

> Service contract obligations

The contracts of employment for all senior managers are substantive (permanent), continuation of which is subject to regular and rigorous review of performance. Such contracts contain a notice period of three months, with the exception of the Chief Executive which is six months.

> Policy on payment for loss of office

All senior managers' contracts contain a notice period of three months, with the exception of the Chief Executive's contract which contains a six-month notice period. If loss of office were to be on the grounds of redundancy, this would be calculated in line with Agenda for Change methodology and consistent with NHS redundancy terms and maximum caps. Loss of office on the grounds of gross misconduct would result in summary dismissal without payment of notice.

> Statement of consideration of employment conditions elsewhere in the foundation trust

In setting the remuneration policy for senior managers, consideration was given to the pay and conditions of employees on Agenda for Change. In determining non-incremental pay uplift for executive directors and other senior managers, consideration is given to any national pay award decisions. The remuneration for executive directors is reviewed annually, based on benchmark data and the same performance criteria that applies for incremental pay progression for all Agenda for Change staff, as set out in our Pay Progression Policy. This policy was completed in partnership with staff side and approved by the Partnership Council.

ANDREW FOSTER CBE
> Chief Executive

22 May 2018

Staff report

> We celebrated the launch of the WWL Way 4Wards on 29 September 2017 with a large-scale event attended by many staff from across the Trust.

The WWL Way 4Wards was developed in response to staff feedback and is a celebration of our heritage whilst also providing clarity around our vision for the future and purpose. This was supplemented by an interactive experience which all staff were encouraged to attend. The experience immersed staff in the history of the foundation trust, charting the journey from our beginnings to our current position and included activities to build upon our ethos of engagement and team working to achieve our purpose.

Further work has also continued to embed the WWL People Promise this year, with four core elements:

1. Employment Essentials
2. Go Engage, The WWL Way
   We will do our best to make your working life enjoyable
3. Steps 4 Wellness
   We will look after you and your health
4. WWL Route Planner
   We will help you to be the best you can be

We continued to embed our strategy across the organisation with the work plan this year reflecting its themes. To support our pledge to look after our staff, each member of staff was gifted a day's additional annual leave for use on their birthday in 2018. This acknowledged their dedication to maintaining patient care during the considerable and sustained operational pressures we have experienced throughout the course of the year.

Internally, there has been a strong focus on recruitment and retention due to the national shortages of both medical and nursing staff. Whilst we have seen some success with engaging middle grade (ST3+) doctors in our Emergency Department which has historically caused us ongoing challenge, overall some medical specialties endure consistent fluctuating staffing challenges.

There continued to be ongoing challenges in terms of nurse recruitment and retention across the organisation. We constantly review the position to understand the actions that can be taken; particularly in terms of effective recruitment and retention. We have continued to focus on the use of agency staff across the foundation trust during these challenging times. Work has been undertaken with the divisions to reduce agency costs by designing improved control mechanisms and exploring alternative workforce models.

We acknowledge that it is beneficial, in terms of both quality and cost, to reduce the use of agency staff and to have services delivered by our own substantive staff members or, where temporary workers are used, these are ideally our own staff or a resource that provides quality care but is also cost effective. A key piece of work has therefore been undertaken this year in conjunction with NHS Professionals to implement a medical bank of staff to support the organisation where rota gaps occur.

NHS Professionals has already proved to be a successful partner with our nursing bank and also across the wider Greater Manchester footprint and implementing this approach demonstrates that we have embraced the mandate to have a medical bank and to be open to collaborative arrangements with other local organisations.

Further technological transformation has and continues to take place in relation to our consultant job planning process. This year we have undertaken a focused project of work and implemented a proof of concept initiative by introducing an e-job planning platform. This also addresses the recommendations of an internal audit of job planning which had resulted in no assurance being available. The successful implementation will provide a clear and correct audit path; ensuring that our staff and services are supported by correct documentation and are paid correctly for their contribution to services and patients.

We have continued to maintain positive partnerships both internally with our divisional and staff side colleagues and externally as work continues with borough-wide health and social care partners on the workforce plan in accordance with 'The Deal for Health and Wellness' and ongoing developments in accordance with Healthier Together and the North West Sector models of care and single services.

> Employment Essentials

During 2017-18 we focused on locally appointing our nursing cohort and a further successful large-scale careers event was held, giving us the opportunity to showcase WWL. The event also resulted in us appointing approximately 40 Health Care Assistant Apprentices who have now commenced their development pathway and who will hopefully continue their career with us.

Work has commenced with our senior nurse management team to define the 2018-19 recruitment and retention strategy and, in consideration of the ongoing national and local nursing staffing challenges, to assess the potential to launch an overseas recruitment programme. Whilst there have been developments of nurse educational routes and pathways inclusive of apprenticeship standard developments, this staffing resource will not be available to respond to the immediate needs of our organisation.

In terms of medical recruitment, there have been fluctuating levels of challenge across a number of specialities in medicine and surgery. Work has been undertaken with divisions to consider alternative workforce models and we have continued to support the Earn, Learn and Return programme for overseas doctors as it further develops in size and energy. This programme has remained consistent since its inception at supporting medical gaps whilst enhancing the education and future careers of our overseas visitors.

Our human resources teams have provided dedicated support in the development of plans to establish a wholly-owned subsidiary company, WWL Solutions Limited as an operated healthcare facility to deliver estates and facilities, sterile services and procurement services. As an alternative to outsourcing or workforce reduction plans such as redundancy, this is seen as a positive route for these services although staff have raised concerns via their representative bodies. We have facilitated ongoing engagement with staff to understand and allay their concerns.

This year we also began the development of our employment brand, which aims to support long-term recruitment and retention of staff. We aim to fully understand what attracts and puts off individuals from joining or staying with WWL so that we can clearly define and build an offer that will see us as the employer they choose now and in the future, knowing they can commence and build their career with us in a way that satisfies their job role and lifestyle choices. This is supported by our Recruitment and Selection Policy, which ensures equitable consideration of all applicants, including those with protected characteristics, and our Absence Management Policy, which supports all employees to retain their employment should they develop a long-term medical condition or disability during the course of their working lives. We also continue with work to offer premium work experience programmes for the borough's future workforce and to build relationships with local education institutions.

We work in close partnership with staff side and the Local Negotiating Committee representatives to ensure that the views of our employees are taken into consideration when making decisions which may affect their interests. Where employees may be subject to changes to their terms and conditions of employment, there is a Job Security and Change Policy in place which has been agreed with staff side and with the Local Negotiating Committee. Discussion, consultation and negotiation in relation to matters affecting staff are undertaken via our Policy Development Group, the Partnership Committee and the Local Negotiating Committee.

There may be occasions when we commission the services of independent consultancy firms to assist with matters such as employee relations. Where there is a requirement to do so, we follow our Standing Financial Instructions and procurement processes to ensure that it is cost effective and provides value for money.

> Go Engage, The WWL Way

In response to an overall decline in engagement, we have developed a strategic narrative for the organisation and launched our new strategy, The WWL Way 4Wards.

To further underpin a move towards a more positive and optimistic culture, a number of initiatives have been delivered during 2017-18, including:

- staff events such as the annual Recognising Excellence Awards and the WWL Way 4Wards Launch Event, followed up with an Interactive Experience
- staff engagement listening events and forums to gather staff ideas, feedback, contributions and influence
- continued delivery of the Pioneer Teams programme. This is now into its eighth cohort and features a comprehensive staff engagement diagnostic survey and a staff engagement toolkit. Teams participating have made improvements in their engagement levels of up to 30%
- a review of all internal communications methods and a rebranding exercise
- development and implementation of a new staff intranet (Wally) and app, transforming internal communications within the foundation trust
- a continuation of the quarterly pulse check surveys which are a rich source of information from our staff in terms of their levels of engagement and identifying any areas of concern

We use a wide range of communications to ensure that key information and messages are cascaded to staff. These include the use of global emails, team brief and news brief publications, our intranet and events such as the Start of the Year and Mid-Year Conferences. We are constantly reviewing the effectiveness of these methods and looking for alternative mediums as appropriate.

Despite a number of challenges this year through internal and external organisational change, increased patient demands and financial pressure, we have continued to sustain the position of being in the top 20% of NHS organisations based on staff recommending us as a place to work and we are viewed as forward thinkers for staff engagement within the NHS. In the National Staff Survey we have sustained an engagement score of 3.95 for 4 years and we are the best performing acute trust in the Greater Manchester region.

We will continue to build on staff engagement plans to ensure the delivery of positive outcomes for staff, organisational performance and ultimately the quality of care we provide to patients.

> Steps 4 Wellness

2017-18 saw the continuation of our Steps 4 Wellness health and wellbeing programme for staff. All aspects of the programme have recently been evaluated and recommendations made as to future activity and what we should stop, start and keep doing as a result. Of the services launched in year one, those that have been received successfully, and will continue to be offered, include:

- Critical Incident Stress Management (CISM) service to manage trauma stress reactions to critical incidents
- Six-week mindful resilience programme
- Physical activity campaigns ("Lose Weight, Feel Great", health checks, mile walks, the "WWL Step Challenge", Wipeout)
- Healthy eating campaigns (e.g. Slimming World meals in the restaurants)

Over the next year, we hope to further develop the 'keeping social' element of the Steps 4 Wellness programme.

New initiatives launched in 2017-18 included:

- Salary Finance - a suite of resources to support staff to take control of their finances, manage their budget better, improve the way they save and get out of debt quicker, thus improving their financial and mental wellbeing;
- introduction of the 'power pause' concept, with further roll out of power pause packs across the organisation currently being planned.

New initiatives to be considered for 2018-19 include:

- Back rehab pilot – to promote good musculoskeletal health
- A focus on sleep health, which targets all four elements of Steps 4 Wellness
- Introduction of cycle racks at Royal Albert Edward Infirmary

We will continue to build on our work by actively engaging with staff to focus on what is important to them for their health and wellbeing and what we can all do to support ourselves to be healthy and well.

> WWL Route Planner

We are committed to ensuring that we embed and deliver on the NHS Talent for Care Strategy, developing actions and measures of success that will deliver the improved investment and development of the healthcare support workforce. This includes ensuring that people have opportunities to start their career in health or social care, develop to be the best they can be in their role and have potential for career progression.

As part of our People Promise, the WWL Route Planner has been developed, which brings together learning and development activities such as essential training and personal development reviews to career pathways which support personal and professional development into new roles.

As part of our 'Grow Your Own' strategy we have a number of initiatives to enable people who wish to pursue a career in the NHS. These include:

- a pre-degree nursing programme which takes a cohort of students at Wigan and Leigh College through a BTEC in Health and Social Care with a one-day-per-week placement at WWL in the first year and two-days-per-week in the second year
- pre-apprenticeship programmes including traineeships for young people aged 16 to 24, providing opportunities to gain qualifications and experiences within the NHS to support them to progress in their career choices

As a result of a close partnership with Job Centre Plus and Wigan and Leigh College, we are proud to be launching a pre-employment programme designed to get local people back into local jobs. 17 Wigan residents have joined the to date.

More than 30 career ambassadors who are passionate about both working in the NHS and supporting young people in their career choices have been recruited with the remit of visiting schools and colleges to help raise awareness of the varying roles in the NHS amongst children and young people.

28 learners commenced an apprenticeship programme in 2017-18 and a further 28 are in the process of being signed up. These include both new apprentice recruits and existing members of staff where an apprenticeship can support learning and growth within their current roles.

Leadership development and coaching also continue to be key priorities for us. Overall, we have signposted over 350 staff to leadership programmes to develop their leadership style and behaviours either through our suite of internally accredited programmes or by accessing leadership development opportunities through the NHS Leadership Academy. We have reviewed our current leadership offer to ensure that we what do in the future will enable our leaders and managers to effectively lead the WWL Way 4wards.

> Leading the WWL Way 4wards

Our new offer forms a leadership development pathway and incorporates 3 key elements:

- Talent - a range of leadership and management apprenticeships from Level 3 up to Level 7 Postgraduate degree open to individuals identified as having high potential in a leadership capacity;
- Nuts and Bolts - core elements required by all managers to perform effectively in their roles; and
- CPD Masterclasses - a suite of internal masterclasses hosted by guest facilitators and opportunities to attend NHS Leadership Academy programmes

There is also the potential to gain the Chartered Management Institute's Recognised Programme status for the modules that we deliver alongside our education providers, thus enabling staff to gain a CMI Recognised Internal Programme Certificate to verify their application of learning. We are looking to start discussions with education providers over the next few months as to the feasibility of this option.

As an accredited centre of the Chartered Management Institute, we will continue to provide in-house coaching and mentoring qualifications. Over 50 coaches have been trained internally to support staff in a variety of ways, including coaching support for new managers, those looking to develop in their career professionally or those who are involved in organisational change for example. In addition, around 60 managers and staff have undertaken one module of the full certificate programme, enabling them to develop their coaching skills in every day practice.

Development of mentoring skills will be more of a focus this year to be able to provide an extra level of support for our workplace apprentices.

Working collaboratively with our health and social care partners across the borough, we developed a shared leadership behaviour framework and piloted a development programme. 30 leaders across five organisations accessed the 'Be Wigan Locality Leaders' programme and evaluations show that overall leaders' confidence in their skills and knowledge across the key framework areas significantly increased after attending the programme.

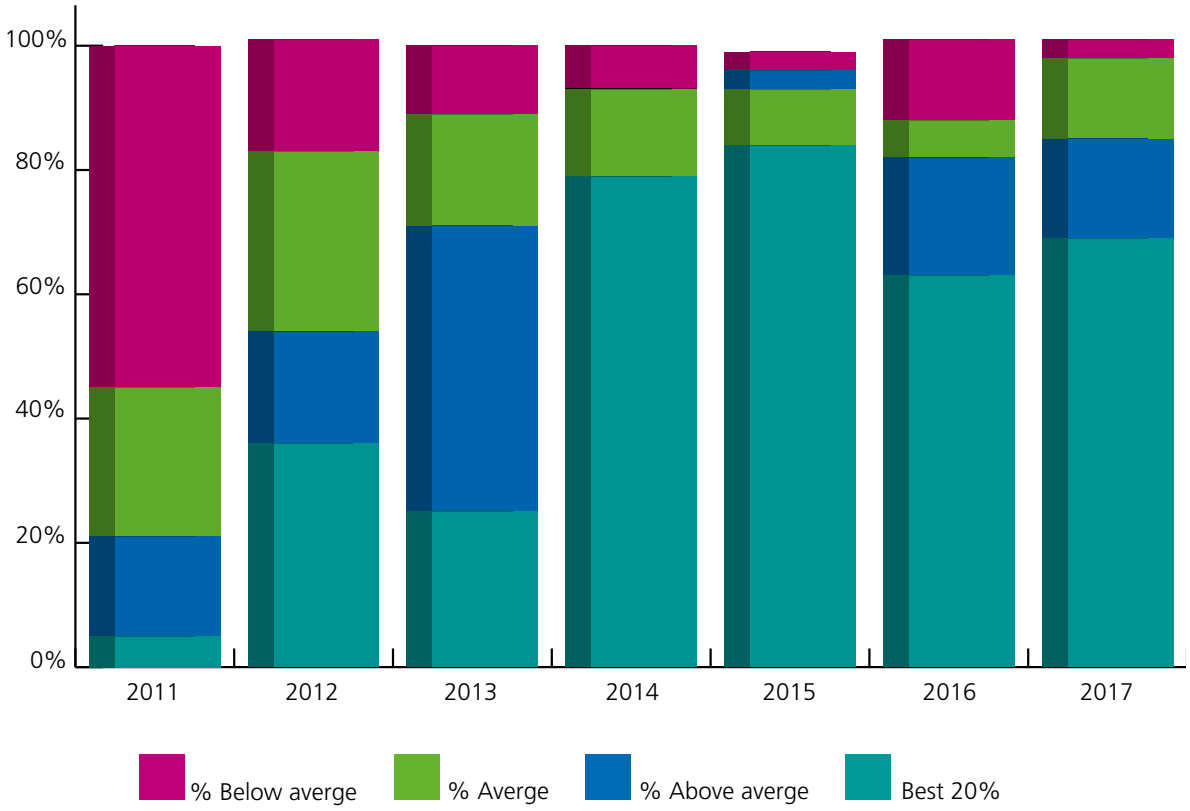
All of these initiatives are supported by our Learning Policy which ensures that access to training and development opportunities are applied consistently and equitably to all employees, including those with protected characteristics.

The WWL Way

> Staff survey

Overall the 2017 Staff Survey results paint a very positive picture and are testament to the resilience of all our staff in the face of pressures and challenge. 84% of our survey results were above average and 72% were in the top 20% for Acute Trusts. 13% of our survey results were at national average and 3% were below average. We came joint second nationally in the acute sector for overall levels of staff engagement, which reflects the significant work on staff engagement that has continued over the last 12 months. It is pleasing to note that the number of results in the best 20% have increased and results that were below average have decreased from 2016 (as evidenced in the graph below):

> Wrightington, Wigan and Leigh NHS Foundation Trust's Yearly Scores on the NHS National Staff Survey



34% of staff responded to this year's survey. This response rate is lower than our 2016 response rate of 35% and is below average compared with other Acute Trusts in England. This is likely due to the distribution of WWL's own staff engagement pulse survey which is issued to a quarter of staff on a quarterly basis. The introduction of this survey may have impacted on response rates, with staff being asked to complete the quarterly engagement survey in addition to the National Staff Survey. However the quarterly pulse survey has been of significant value to WWL over the past few years. It has enabled us to act quickly on the issues identified, ensuring that we are always aware of trends and new issues. Many Trusts do not have access to this type of staff feedback and rely solely on the National staff survey. The quarterly pulse surveys and associated actions have been integral to shaping our organisational culture, helping us become one of the best NHS Trusts to work for in the country.

Focus on promoting the importance of breaks and the need to reset and recharge as well as sleep health in decreasing stress and anxiety and improving mental health.

> Summary of performance

	2016-17 WWL	2017-18 WWL	2017-18 Acute Trust Average	Improvement/ deterioration
Response Rate	35%	34%	44%	1% deterioration
Top 5 ranking scores				
KF27 - Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	47%	59%	45%	12% improvement
KF2 - Staff satisfaction with the quality of work and care they are able to deliver	4.25	4.21	3.91	0.04 deterioration
KF4 - Staff motivation at work	4.07	4.07	3.92	Unchanged
KF22 - Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	13%	9%	15%	4% improvement
KF25 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	21%	20%	28%	1% improvement
Bottom 5 ranking scores				
KF15 – Percentage of staff satisfied with the opportunities for flexible working patterns	51%	50%	51%	1% deterioration
KF21 – Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	87%	84%	85%	3% deterioration
KF12 – Quality of appraisals	3.08	3.07	3.11	0.01 deterioration
KF26 – Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	21%	25%	25%	4% deterioration
KF17 – Percentage of staff feeling unwell due to work related stress in the last 12 months	33%	36%	36%	3% deterioration

As can be seen from our bottom ranking results, there are indications of challenges to engagement and morale identified within the national survey. In response, we will be looking to introduce a programme of initiatives with a focus on flexible working, equal opportunities (career progression), quality of appraisals, bullying and harassment and work related stress during the course of 2018.

These will include:

- Continued provision of mindfulness and resilience programmes
- Focus on promoting the importance of breaks and the need to reset and recharge as well as sleep health in decreasing stress and anxiety and improving mental health
- An assessment of the annual appraisal process to assess quality and impact
- The development of a clear leadership and career progression pathway along with the introduction of masterclasses, apprenticeships and development opportunities
- Continued consideration of flexible working applications both at the recruitment stage and during employment
- Continued promotion of the Trust's Raising Concerns policy
- Exploration of an anti-bullying learning package to be supplemented by internal awareness raising campaigns
- Encouraging the awareness and use of the Trust mediation service

The impact of these initiatives will be monitored via our quarterly pulse surveys and it is hoped that corresponding improvements would be seen in next year's National Staff Survey.

> Future priorities and targets

It is highlighted that there is much to celebrate in the 2017 survey results and we have commenced communication of these results to our staff.

The Workforce Directorate has prepared and circulated Divisional reports for discussion within Divisional Management Teams. This information will be used in conjuncture with the Pulse Check Feedback to support the local staff engagement actions plans.

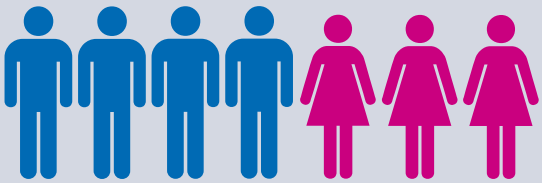
An analysis of the staff survey results by equality group will also be undertaken to identify any specific themes and 'hotspots'. This analysis is valuable and has informed previous actions such as holding Focus Group sessions with Black & Minority Ethnic and staff living with a Disability. Equality related actions from the 2017 staff survey results will be incorporated into the Equality Delivery System Action plan.

The introduction of WWL's own staff engagement pulse survey has enabled the Trust to analyse engagement trends across the year of 2017, and identify what has enabled staff engagement. The results indicate that engagement has remained fairly stable over the year, but some areas of consistent strength include staff feeling trusted and empowered in their workplace, supportive working relationships amongst teams/colleagues, and staff feeling clear about what their work responsibilities were.

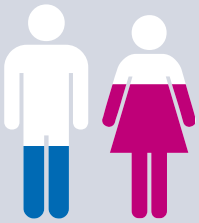
To ensure that the Trust is able to sustain high levels of engagement for a 5th year, it will be important to build further on our internal communications and engagement approaches, enhance the health and wellbeing of our staff, and improve our learning and development offers for staff. This will also be fundamental to our recruitment and retention strategy as an organisation.

> Mandatory disclosures within the staff report

Workforce gender profile as at 31 March 2018



DIRECTORS:
4 male 3 female



SENIOR MANAGERS:

62 male (32%)

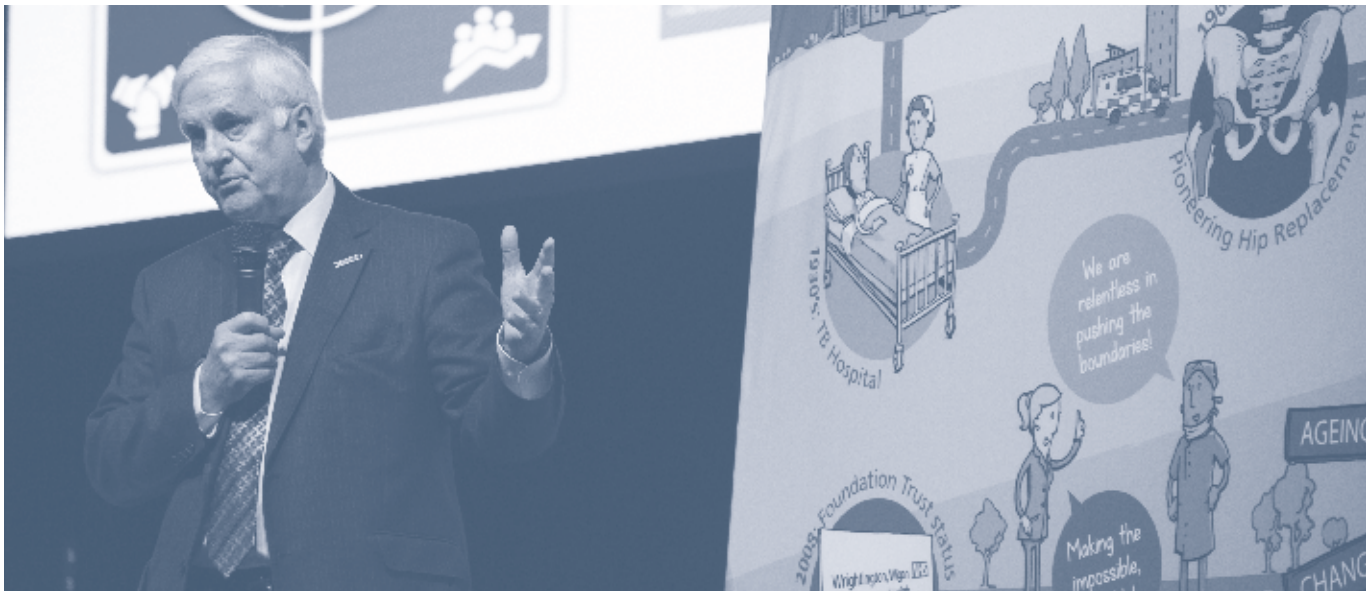
130 female (68%)

EMPLOYEES:

992 male (20%)

3,882 female (80%)

The board has 7 executive directors and 8 non-executive drectors including the Chairman as at 31 March18. Of the executive directors, 3 are female and 4 are Mmale. Of the non-executive directors, 2 are female and 6 are male. More information on the board members can be found in the Directors' Report.



Areas of consistent strength include staff feeling trusted and empowered in their workplace, supportive working relationships amongst teams/colleagues, and staff feeling clear about what their work responsibilities were.

> Sickness absence data

	2017-18	2016-17
Total days lost:	42,061	41,599
Total staff years:	4,318	4,313
Average working days lost (per WTE)	**10**	**10**

> Occupational health

Occupational health services are provided by Wellbeing Partners; a joint venture organisation between Lancashire Teaching Hospitals NHS Foundation Trust, Bolton NHS Foundation Trust and ourselves. Performance is monitored on a quarterly basis by each partner organisation and via a governance board.

An occupational health representative attends our Occupational Safety and Health Committee and Infection Prevention and Control Committee meetings and presents quarterly and annual reports at these forums.

> Counter-fraud and corruption

We employ our own Local Anti-Fraud Specialist and have a Fraud, Corruption and Bribery Policy in place which has been developed in line with NHS standards. All staff are required to successfully complete a mandatory e-learning anti-fraud module every two years, An annual fraud survey is disseminated annually and continual fraud awareness campaigns are undertaken via the intranet, news articles and presentations.

> Health and safety

The health and safety team undertake a rolling programme of health and safety support visits which are designed to provide managers with advice and guidance on compliance with health and safety matters with the overall aim of maintaining staff health, safety and welfare whilst at work.

> Time off for trade unions

Relevant union officials	
Number of employees who were relevant union officials during the relevant period:	40
Full-time equivalent employee number:	35.84

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	9
1-50%	27
51-99%	1
100%	3

Percentage of pay bill spent on facility time

Total cost of facility time:	178,309
Total pay bill:	189,478,000
Percentage total pay bill spent on facility time	0.094%

Paid trade union activities

Time paid facility and union time hours	8,319

> Employee costs

	Permanent £000	Other £000	2017-18 Total £000	2016-17 Total £000
Salaries and wages	158,046	0	**158,046**	151,127
Apprenticeship levy	718	0	**718**	
Social security costs	14,576	0	**14,576**	14,045
Employer's contributions to NHS pensions	16,856	0	**16,856**	16,267
Agency/contract staff	0	10,196	**10,196**	9,115
Total staff costs	190,196	10,196	**200,392**	190,554
Costs capitalised as part of assets	1,904	475	2,379	1,842

> Average number of employees (based on whole-time equivalents)

	Permanent Number	Other Number	2017-18 Total Number	2016-17 Total Number
Medical and dental	516	20	**536**	463
Administration and estates	1,087	25	**1,112**	1,056
Healthcare assistants and other support staff	560	0	**560**	552
Nursing, midwifery and health visiting staff	1,742	122	**1,864**	1,758
Scientific, therapeutic and technical staff	569	16	**585**	590
Agency and contract staff	3	0	**3**	71
Other	10	0	**10**	10
Total average numbers	4,487	183	**4,670**	4,593
Number of employees (WTE) engaged on capital projects	46	7	**53**	40

> Reporting of compensation schemes: exit packages 2017-18

	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)		
<£10,000	5	**5**
£10,001 - £25,000	5	**5**
£25,001 - £50,000	2	**2**
Total number of exit packages by type	12	**12**
Total resource cost (£)	**£177,000**	**£177,000**

During 2017-18, the exit packages related to a Treasury-approved mutually-agreed severance scheme.

> Exit packages 2016-17

	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)		
<£10,000	5	**5**
£10,001 - £25,000	8	**8**
£25,001 - £50,000	3	**3**
Total number of exit packages by type	16	**16**
Total resource cost (£)	**£281,000**	**£281,000**

During 2016-17, the exit packages were in line with Agenda for Change contractual terms and conditions or aTreasury-approved mutually-agreed severance scheme.

It is highlighted that there is much to celebrate in the 2017 survey results and we have commenced communication of these results to our staff.

> Reporting of high-paid off-payroll arrangements earning more than £220 per day

There were no off-payroll arrangements during the year ended 31 March 2018.

Off-payroll engagements reaching six months in duration between 1 April 2016 and 31 March 2017

No. of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	4
No. of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National insurance obligations	4
No. for whom assurance has been received	2
No. for whom assurance has not been received	2

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

During the year, one senior manager was paid more than £142,500. Benchmark salary information for comparative jobs within the NHS was considered at the time of appointment and it was concluded that the remuneration agreed was appropriate and reasonable for the current post holder.

ANDREW FOSTER CBE
> Chief Executive and Accounting Officer

22 May 2018

Disclosures set out in the NHS Foundation Trust Code of Governance

> We have applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The NHS Foundation Trust Code of Governance contains guidance on good corporate governance. NHS Improvement recognises that departure from the specific provisions of the code may be justified in particular circumstances, and reasons for any non-compliance with the code should be explained. This "comply or explain" approach has been in successful operation for many years in the private sector and within the NHS foundation trust sector.

> Council of Governors

The Council of Governors continues to play a key role in the work of the foundation trust; representing the interests of our membership and the general public.

It has a number of statutory duties, including appointing the Chairman and non-executive directors, determining their remuneration and other terms and conditions of service and approving the appointment of the Chief Executive.

The Council of Governors holds the non-executive directors to account, both individually and collectively, for the performance of the board. It also receives the annual report and accounts and contributes to our annual business planning process.

This year, the Council of Governors approved the appointment of three new non-executive directors, following detailed consideration by its Nominations and Remuneration Committee chaired by the Chair of the foundation trust, Robert Armstrong. In accordance with our constitution, the Council of Governors also approved the appointment of Neil Campbell as the new Senior Independent Director from 1 April 2018, following the departure of Christine Parker-Stubbs who had reached the end of her term of office.

The public and staff members of the council are elected from and by the foundation trust membership to serve for three years. They may stand for re-election at the end of their term of office.

> Our Council of Governors comprises 28 governors:

- > **4** public governors from the Wigan constituency
- > **4** public governors from the Leigh constituency
- > **4** public governors from the Makerfield constituency
- > **4** public governors from the Rest of England and Wales constituency
- > **1** medical and dental staff governor
- > **2** nursing and midwifery staff governors
- > **2** staff governors from the 'all other staff' constituency
- > **7** appointed governors for across our key stakeholders

> The following table provides detail of our Council of Governors throughout 2017-18:

Name	Constituency/organisation	Term of office ends (see note 1)	Attendance 2017-18 (see note 2)
Public governors			
Bill Anderton	Public: Wigan	2019	100%
Helen Ash	Public: Makerfield	2018	60%
Les Chamberlain	Public: Makerfield	2019	100%
Tom Frost	Public: Rest of England and Wales	2018	100%
Howard Gallimore	Public: Makerfield	2020	67%
Bill Greenwood	Public: Wigan	2018	80%
Pauline Gregory	Public: Wigan	2019	60%
Andrew Haworth	Public: Leigh	2018	100%
Mustapha Koriba	Public: Rest of England and Wales	2019	60%
James Lee	Public: Makerfield	2019	60%
Lisa Lymath	Public: Rest of England and Wales	2019	60%
Maggie Skilling	Public: Wigan	2018	100%
Linda Sykes	Public: Leigh	2019	100%
Corinne Taylor-Smith	Public: Leigh	2020	40%
David Thompson	Public: Rest of England and Wales	2018	100%
Mavis Welsh	Public: Leigh	2019	40%
Staff governors			
Tim Board	Staff: Medical and Dental	2018	20%
Marie Hart	Staff: Nursing and Midwifery	2018	0%
Alex Hilton	Staff: All other staff	2020	33%
Diane Lawrenson	Staff: Nursing and Midwifery	2018	20%
James Yates	Staff: All other staff	2018	40%
Appointed governors			
Dawne Gurbutt	University of Central Lancashire	2018	60%
Jean Heyes	Staff side committee	2019	20%
Reg Nash	Age UK	2018	60%
Louise Sell	North West Boroughs Partnership NHS FT	2019	20%
Syed Shah	Local Medical Committee	2020	60%
Fred Walker	Wigan Council	2019	100%
Gen Wong	Wigan Borough CCG	2019	0%

Notes:

1. The term of office of all governors ends at the conclusion of the annual members' meeting in the year shown

2. The attendance figure includes an extraordinary meeting of the Council of Governors in February 2018 to consider the appointment of new non-executive directors. There were therefore five formal meetings of the Council of Governors during 2017-18. Marie Hart was seconded to another organisation during the year.

Pauline Gregory was the lead governor until 30 October 2017 and Maggie Skilling took on the role from this date until the end of her term of office.

> Council of Governors' register of interests

All governors are required to comply with the Code of Conduct for Governors and declare any interests which may result in a potential conflict of interest in their role as a governor. A copy of the register of governors' interests can be obtained from the Company Secretary, using the contact details on page 180.

> Nominations and Remuneration Committee

The Nominations and Remuneration Committee makes recommendations to the Council of Governors on the appointment and remuneration of the Chairman and other non-executive directors and considers the independent appraisal of the Chairman.

This year, the committee has led on the recruitment of three non-executive directors on behalf of the Council of Governors and recommended the appointment of Lynne Lobley from 28 March 2018, Steven Elliot from 1 April 2018 and Ian Haythornthwaite from 9 April 2018. Each of these non-executive directors was duly appointed to their first three-year term of office.

During the year, the committee also considered the terms of office of Neil Campbell, Mick Guymer and Carole Hudson. Following a detailed review, the committee recommended that they be appointed for a further three-year term, to run consecutive to their current term of office. The main rationale for this decision was to ensure stability on the board.

> Training and development for governors

During 2017-18, we provided our governors with access to a number of training and development opportunities to further support them in their role. These included:

- externally-provided training and development such as the GovernWell programme offered by NHS Providers and regular workshops provided by Mersey Internal Audit Agency;
- regional development opportunities provided through the North West Governors' Forum, coordinated by the North West Company Secretaries Forum; and
- internal workshops and induction sessions

> Communicating with governors

There are a number of easy ways for members of the public to communicate with the Council of Governors:

governors@wwl.nhs.uk

0800 073 1477

Council of Governors
Trust Headquarters
Royal Albert Edward Infirmary
Wigan Lane
Wigan WN1 2NN

> The board's relationship with the Council of Governors and members

The board and council work together closely throughout the year. Non-executive directors are invited to attend all meetings of the council and the aim is for all non-executive directors to attend at least one meeting per year although many do attend more. The Chairman of the Board of Directors is also, as required by legislation, the Chairman of the Council of Governors.

The following directors have attended a Council of Governors meeting during 2017-18:

- Robert Armstrong
- Mary Fleming
- Robert Forster
- Andrew Foster
- Mick Guymer
- Carole Hudson
- Pauline Law
- Jon Lloyd
- Neil Turner
- Tony Warne

Our governors also elect to attend our public board meetings where they are able to see the board at work. This allows them to gain a good understanding of the unitary nature of the board and to see at first hand the challenge and scrutiny undertaken by the non-executive directors.

The Council of Governors receives copies of the agendas of all board meetings – both public and private – in advance, and copies of the minutes once approved.

A clear dispute resolution procedure is included within our constitution and this details how disagreements between the Council of Governors and the Board of Directors will be resolved. The types of decisions taken by each body are set out within our constitution, and within the core governance documents of the organisation.

> Our membership

Our membership is an essential and valuable asset. There are two membership categories: public and staff. Anyone who lives in Wigan, Leigh or Makerfield is eligible to apply for membership of the foundation trust as a public member of the respective constituency. We also welcome applications for membership from individuals who live outside of these areas to the Rest of England and Wales constituency.

Staff members automatically become a member of the foundation trust if they have been employed by us under a contract of employment which has either no fixed term, or a fixed term of at least 12 months, and they have been continuously employed by us for at least 12 months, unless they choose to opt out.

Our constitution places a small number of restrictions on membership, and these are as follows:

- it is only possible to be a member of one constituency at any one time;
- a member of staff may only be a member of a staff constituency whilst employed by us
- individuals must be at least 16 years of age to become a member; and
- the criteria set out in the constitution which prevent an individual from becoming or continuing as a member must not be satisfied

The table below provides a summary of our membership as at 31 March 2018:

Constituency	No. members
Public: Leigh	2,136
Public: Makerfield	2,360
Public: Wigan	3,000
Public: Rest of England and Wales	3,037
Staff: Medical and Dental	305
Staff: Nursing and Midwifery	1,131
Staff: All other staff	2,933
Total members:	**14,902**

In order to monitor the representativeness of our membership, we have access to a membership profiling tool which is provided by Electoral Reform Services Limited on our behalf.

In September 2017, over 70 people attended our Annual Members' Meeting and heard about how we had performed during the year, had an opportunity to ask questions of the board and the council and received a presentation from Dr Ayaz Abbasi, our Divisional Medical Director for Medicine, on the successes and challenges of the Accident and Emergency Department.

Our membership strategy was revised during 2014 and will be subject to a further review over the coming year. The 2014 strategy set a target to increase the public membership by 200 members each year, whilst maintaining the staff membership. We also place an emphasis on ensuring continued engagement with the existing membership. We are particularly mindful of the introduction of new data protection legislation this year, and NHS Providers has recently undertaken some work with Mills and Reeve to understand the impact that this could have on foundation trust memberships.

During 2018-19 we will be contacting all members to advise them of their rights under new data protection legislation. We anticipate that, as a result of this exercise, overall membership numbers will reduce during the coming year.

> The Audit Committee

The role of the Audit Committee is to provide independent assurance to the board on the effectiveness of the governance processes, risk management systems and internal controls on which the board places reliance for achieving its corporate objectives and in meeting its fiduciary responsibilities.

It is authorised by the board to investigate any activity within its terms of reference and to seek any information it requires from staff.

The committee considers both the internal and external audit work plans and receives regular updates from both sets of auditors. The committee also receives an anti-fraud update at each of its meetings. The local anti-fraud function is very important in identifying and preventing fraud and operational risks to the Trust. The Trust has a zero-tolerance policy in respect of fraud, corruption and bribery and investigations are carried out if evidence supports this. The Trust has a mandatory training eLearning anti-fraud module which has been rolled out across the Trust and all staff are required to pass this bi-annually. The Local Anti-Fraud Specialist works regularly with staff and management in identifying areas of potential fraud risk and coordinates this work with external partners. The Local Anti-Fraud Specialist has provided an updated policy for the Trust on fraud corruption; bribery and a response plan in line with NHS protect recommendations.

Deloitte LLP has continued as our external auditors for the financial year 2017-18, with the tender for the service having been undertaken during 2016-17. As mentioned within the directors' report, Deloitte LLP also conducted a review of our leadership and governance using NHS Improvement's well-led framework during the year. The auditors comply with FRC Ethical Standards for each service provided and have confirmed the steps taken to safeguard their independence and objectivity.

The value of non-audit services provided by Deloitte during 2017-18 was £38,280 (including VAT).

A key aspect of the Audit Committee's work is to consider significant issues in relation to financial statements and compliance. As part of the preparation for the audit of financial statements, Deloitte undertook a risk assessment and identified a number of risks, including:

> management override of control and the sustainability and transformation funding; and

> revenue recognition in respect of sustainability and transformation fund income

Mersey Internal Audit Agency (MIAA) carries out our internal audit function. The Audit Committee and the Director of Finance work with MIAA to agree the Internal Audit Plan and key performance indicators for assessing their performance and effectiveness. MIAA provides us with benchmarking data, updates on assurance frameworks and briefing notes on a range of current issues. In particular, MIAA provide good briefing sessions for Chairs of Audit Committees, governors and staff.

Audit Committee membership and attendance during 2017-18 was as follows:

Name	A	B	%
Carole Hudson (Chair)	7	7	100%
Neil Campbell	5	7	71%
Mick Guymer	6	7	86%
Neil Turner	7	7	100%

A: Number of meetings attended

B: Total number of meetings the director could have attended

> Remuneration Committee

The Board of Directors has established a Remuneration Committee. Its responsibilities include consideration of matters relating to the remuneration and terms and conditions of office of the executive directors, including the Chief Executive. The committee comprises all non-executive directors and is chaired by the Chairman.

Attendance during 2017-18 was as follows:

Name of director	A	B	Percentage attendance
Robert Armstrong, Chairman	1	1	100%
Neil Campbell, Non-Executive Director	1	1	100%
Mick Guymer, Non-Executive Director	0	1	0%
Carole Hudson, Non-Executive Director	1	1	100%
Jon Lloyd, Non-Executive Director	1	1	100%
Christine Parker-Stubbs, Non-Executive Director	0	1	0%
Neil Turner, Non-Executive Director	1	1	100%
Tony Warne, Non-Executive Director	1	1	100%

A: number of meeting attended
B: number of meetings the director could have attended

The Chief Executive attends the Committee in relation to discussions around board composition, succession planning, remuneration and performance of executive directors. The Chief Executive is not present during discussions relating to his own performance, remuneration or terms of service.

> Nominations and Remuneration Committee

The Council of Governors has established a Nominations and Remuneration Committee. Its responsibilities include consideration of matters relating to the appointment, remuneration and other terms and conditions of service of the non-executive directors and providing recommendations to the Council of Governors for consideration.

The committee's membership, along with their attendance during 2017-18, is given below:

Name of committee member	A	B	Percentage attendance
Robert Armstrong	1	1	100%
Bill Anderton, Public Governor	1	1	100%
Helen Ash, Public Governor	1	1	100%
Jean Heyes, Appointed Governor	1	1	100%
Reg Nash, Appointed Governor	1	1	100%
Linda Sykes, Public Governor	1	1	100%

A: Number of meetings attended
B: Total number of meetings the director could have attended

During the year, the committee engaged the services of a recruitment consultant to support it in identifying suitable non-executive director candidates for the Council of Governors' consideration.

NHS Improvement's single oversight framework

> NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support and 1 reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from quarter 3 of 2016-17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters of 2016-17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

> Segmentation

WWL is currently placed in segment 2 of NHSI's Single Oversight Framework (providers offered targeted support; potential support needed in one or more of the five themes, but not in breach of licence and/or formal action is not needed) as notified by NHS Improvement.

This segmentation information is our position as at 24 April 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

> Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4, where 1 reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the foundation trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2017-18				2016-17	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial stability	Capital service capacity	2	4	4	4	2	1
	Liquidity	1	2	2	2	3	2
Financial efficiency	I&E margin	1	4	4	4	1	1
Financial controls	Distance from financial plan	1	2	2	1	2	1
	Agency spend	1	1	1	1	2	2
	Overall scoring:	**1**	**3**	**3**	**3**	**2**	**1**

> Metrics:

Capital service capacity:
Degree to which our generated income covers our financial obligations. This metric looks at how much financial headroom we have over interest or other capital charges.

Liquidity:
Days of operating costs held in cash or cash-equivalent form. This metric assesses short term financial position, i.e. our ability to pay staff and suppliers in the immediate term.

I & E margin:
Assesses operating efficiency independent of capital structure or other factors. This metric compares earnings before interest tax and depreciation/amortisation against income.

Distance from financial plan:
Tracks our actual position against the plan we submitted to NHS Improvement at the start of the year.

Agency spend:
Tracks our spend against its agency cap for the year.

Statement of the chief executive's responsibilities as the accounting officer of Wrightington, Wigan and Leigh NHS Foundation Trust

> The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Wrightington, Wigan and Leigh NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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 Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum

ANDREW FOSTER CBE
> Chief Executive and Accounting Officer

22 May 2018

Annual governance statement

> Scope of responsibility

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

> The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Wrightington, Wigan and Leigh NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Wrightington, Wigan and Leigh NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

> Capacity to handle risk

As accounting officer, I have overall accountability and responsibility for leading risk management arrangements on behalf of the board.

Leadership arrangements for risk management are documented in the risk management strategy and further supported by the board assurance framework and individual job descriptions. The strategy outlines our approach to risk and the accountability arrangements, including the responsibilities of the board and its committees, executive directors and all employees.

Active leadership from managers at all levels to ensure effective risk management is a fundamental part of an integrated approach to quality, corporate and clinical governance, performance management and assurance. Our Risk and Environmental Management Committee is chaired by the Director of Strategy and Planning, and reviews all risks scoring 15 and above (more information on the scoring methodology used is given below). The board and its committees receive and scrutinise the risks to achieving our corporate objectives through the board assurance framework.

As part of the on-boarding process, all new members of staff are required to attend a mandatory induction and undertake e-learning training covering key elements of risk management within two months of their appointment. This is also supplemented by local induction. The training is designed to provide an awareness and understanding of the risk management strategy, the risk management process and to give practical experience of completing risk assessment paperwork. Additional training is made available to all levels of staff, covering areas such as fire safety, health and safety, moving and handling, resuscitation and first aid.

We aim to learn from good practice and we hold an annual clinical audit conference and regular 'grand rounds' for doctors to discuss specific topics and to highlight best practice.

We have a well-established governance structure, as described within our risk management strategy which is endorsed by the board.

We use the '5 steps to risk assessment' approach to

(1) identify the hazards;

(2) decide who may be harmed and how;

(3) evaluate the risk and agree necessary precautions;

(4) record and communicate findings; and

(5) review and revise.

There are specific risk assessment requirements for particular types of risks. We use a 5x5 risk matrix, whereby both the consequence and the likelihood of a risk materialising are allocated a score and multiplied to provide an overall risk score. Risks are identified through risk assessment and analysis of data from other intelligence sources such as concerns, incidents and near misses, serious incidents, never events, formal and informal complaints, litigation cases or clinical audits.

Divisional risks resulting in a risk score of 15 or more are presented at the Risk and Environmental Management Committee for discussion. The committee reviews both the risk and its score. Where the risk score remains at 15 or above, it is transferred onto the corporate risk register. If the risk

score reduces to 14 or lower, it is transferred onto the relevant divisional risk register and regularly reviewed. If subsequent escalation is required, this would follow the same process.

Risks awarded a risk score of 15 and above are managed by the relevant Deputy Director of Operations and Performance or Head of Service and the actions to address them are scrutinised on a monthly basis at the Risk and Environmental Management Committee.

Any risks that score between 20 and 25 for a three-month period are escalated to the relevant board committee using our corporate risk escalation template. Risk escalations are a standing agenda item for the Risk and Environmental Management Committee and for all committees reporting to the board. In exceptional circumstances, an escalated corporate risk could have the potential to affect long term viability of the organisation.

The board assurance framework outlines risks to the achievement of our annually-agreed corporate objectives. This includes the delivery of developing national and local priorities. Each corporate objective is allocated to a committee of the board for oversight, and these committees review the relevant entries on the board assurance framework at each meeting and make appropriate recommendations to the board. If the relevant committee is not scheduled to meet during a particular month, the relevant entries are reviewed by the executive team. The board reviews the complete board assurance framework at each meeting.

We are currently reviewing our methodology to determine our risk appetite for 2018-19 and we are aiming to identify our risk appetite for each of the risks on the board assurance framework.

This year, we commissioned Deloitte LLP to undertake an external review of our leadership and governance using NHS Improvement's well-led framework. As part of this process, we undertook a self-assessment of our performance against the 8 key lines of enquiry which was then independently reviewed by Deloitte.

This independent review was wide-ranging, and involved:

- a desktop review of documentation;
- face-to-face interviews with directors and senior managers;
- focus groups with staff and governors;
- questionnaires completed by staff, directors and governors;
- telephone interviews with external stakeholders; and
- observations of meetings

Deloitte agreed with our self-assessment that there are no major areas of concern and set out a number of recommendations to further improve our practices. We developed an action plan as a result, and we will continue to monitor our progress against this action plan during 2018-19.

During the year, we were also inspected by the Care Quality Commission, who rated us as good in the well-led domain as well as across all other domains. We also received a rating of good from NHS Improvement following an assessment of our use of resources.

The independent review concluded that we have an appropriate combination of structures and processes in place at and below board level to enable the board to be assured of the quality of care we provide. Maintaining an effective quality governance system supports our compliance against national standards. We are committed to the continuous improvement of our systems.

The key quality governance committee is the Quality and Safety Committee which is chaired by a non-executive director. This committee seeks assurance that high standards of care are provided and ensures that there are adequate and appropriate governance structures, processes and controls in place across the organisation.

Groups which report into the Quality and Safety Committee include dedicated groups around safeguarding, medicines management, infection control and health and safety. The committee reviews the minutes of divisional quality executive committees as part of a rolling programme of 'deep dives'.

Our quality strategy for the period 2017-21 was approved in April 2017. A number of quality goals are identified as part of our overarching strategy to be safe, effective and caring. These goals were agreed in consultation with internal and external stakeholders, and published in our quality report.

An important element of achieving high quality care is ensuring that our workforce has the capacity and capability to deliver improvement. We now have a well-established quality faculty and to date over 400 staff from all parts of the organisation have voluntarily signed up to be quality champions. These staff members have attended either our in-house quality improvement methods training programme or training provided by partner organisations such as AQuA or NHS QUEST.
The overarching aim of the quality faculty is to involve and encourage staff to participate in improving services for patients.

Staff are recognised for the improvements achieved through the awarding of bronze, silver and gold badges. There are a number of projects underway by quality champions who provide the driving force and resource to energise our quality plans and ensure that principles are embedded at ward and team level. The Quality Champions Committee chaired by the Chief Executive and attended by all executive directors monitors the progress of the quality champions' projects to achieve improvements and, most importantly, sustainability.

We are fully compliant with the registration requirements of the Care Quality Commission.

The quality of performance information is assessed at divisional and corporate levels through the quality executive committee structures and divisional quarterly performance reviews. Information data quality is reviewed by the Data Quality Committee.

> Compliance with Care Quality Commission registration requirements

We are fully compliant with the registration requirements of the Care Quality Commission.

We were inspected by the Care Quality Commission in November 2017 and the report of this inspection was published in March 2018. We continue to maintain regular contact with our lead inspector and quarterly engagement meetings are held, where emerging issues can be discussed and addressed at an early stage.

The Quality and Safety Committee receives an assurance report against all Care Quality Commission fundamental standards on a cyclical basis, and this is reflected on the committee's work-plan. Wards and departments also complete regular position statements against the Care Quality Commission's key lines of enquiry under the safe, effective, caring, responsive and well-led domains.

> Data security

The information governance work programme and performance against the national Information Governance Toolkit is closely monitored by the Caldicott Committee, which is chaired by the Medical Director as Caldicott Guardian.

The Director of Finance, who also attends the Caldicott Committee, is the nominated director for information risk and is the Senior Information Risk Owner.

As a public authority, we have appointed a Data Protection Officer in accordance with the requirements of the forthcoming General Data Protection Regulation. This post operates independently and reports directly to the board.

The Data Protection Officer's role is to:

- inform and advise the board and employees about their obligations to comply with the General Data Protection Regulation and other data protection laws;
- monitor compliance with the General Data Protection Regulation and other data protection laws, including managing internal data protection activities, advising on data protection impact assessments, training staff and conducting internal audits; and
- act as the first point of contact for the Information Commissioner's Office and for individuals whose data is processed.

> Our major risks

Our major risks are included on the board assurance framework and included the following for 2017-18:

- failure to achieve an improved benchmarked position for mortality;
- failure to achieve infection control trajectories;
- failure to manage expenditure on agency staffing within agreed parameters, impact of IR35 (tax legislation related to the provision of services via an intermediary) and associated impact on safe staffing levels;
- national shortage occupations and inefficient use of available resources;
- sickness absence levels and ability to reduce pay bill;
- failure to meet the accident and emergency 4-hour wait target;
- failure to deliver the 'big 12' cost improvement schemes and divisional cost improvement programmes;
- IT risks, including implementation of the electronic hospital record and our ability to respond to cyber attacks; and
- risks surrounding collaborative working, including key schemes across Greater Manchester

Our major risks for 2018-19 include:

- nurse staffing shortages
- lack of availability of beds within the foundation trust and appropriate services across the borough
- delivery of recurrent cost improvement plans;
- failure to meet the accident and emergency 4-hour wait target; and
- failure to secure sustainability and transformation funding

> Principal risks to compliance with the NHS foundation trust licence condition

The board has not identified any principal risks to compliance with provider licence condition FT4. This condition covers the effectiveness of governance structures, the responsibilities of directors and committees, the reporting lines and accountabilities between the board, its committees and the executive team.

The board is satisfied with the timeliness and accuracy of information to assess risks to compliance with the foundation trust's licence and the degree of rigour of oversight it has over performance.

> Corporate governance statement

We acknowledge that it is essential that the correct combination of structures and processes is in place at and below board level to enable the board to assure the quality of care that the organisation provides. We are committed to the continuous improvement of these structures and processes.

The review of leadership and governance undertaken this year using NHS Improvement's well-led framework identified no areas of concern and numerous areas of good practice. We have prepared an action plan to address suggested areas of further improvement, the completion of which will contribute to future years' assurance as to the board's ability to assure itself of the validity of the corporate governance statement we submit in accordance with provider licence condition FT4(8)(b).

> Risk management

Risk management is well embedded in our activities - for example, equality impact assessments are integrated into core business. Control measures are in place to ensure compliance with our obligations under equality, diversity and human rights legislation. We continue to demonstrate compliance with the general and specific duties of the Public Sector Equality Duty on an annual basis through publishing relevant equality information as part of our annual inclusion and diversity monitoring report. We also undertake an assessment of current performance against the criteria stated in the national equality delivery system on an annual basis. We have continued to review and assess performance in collaboration with staff and local stakeholders, using this framework as well as identifying priorities going forward.

Progress against our action plan and equality objectives is monitored by the Inclusion and Diversity Steering Group on a quarterly basis and is overseen by the Workforce Committee. An inclusion and diversity operational group, which reports to the steering group, meets on a bi-monthly basis and takes a lead role in supporting the delivery of the action plan.

From 1 April 2015, all NHS organisations were required to demonstrate how they are addressing race equality issues in a range of staffing areas through the nine point Workforce Race Equality Standard metric. This standard has been fully embedded within current practice. We are also working closely with Wigan Borough Clinical Commissioning Group to implement the Accessible Information Standard.

During 2017-18, we continued to undertake equality impact assessments on all policies and practices to ensure that any new or existing policies and practices do not disadvantage any group or individual.

Risk management is also embedded into the activity of the organisation through incident reporting. This is openly encouraged throughout the organisation and a 'just culture' is promoted.

We are in the top 25% of NHS organisations in relation to patient safety incidents reported to the National Reporting and Learning System and we report higher-than-average numbers of near misses. Our approach to incident management is set out in our incident reporting policy. Identification and investigation of serious incidents and never events is undertaken by the Executive Scrutiny Committee which is chaired by the Director of Nursing and attended by the Medical Director.

Key stakeholders, including patients, our public and staff membership and local partner organisations are engaged on service developments and changes. We are also working across the local health economy including engagement with Wigan Borough Clinical Commissioning Group's Locality Plan on the delivery of integrated care pathways.

We facilitate lay representation on a number of our key committees, including having governors on our Quality Champions, Quality and Safety and Workforce Committees. Governors also participate in PLACE visits, which is a nationally-recognised system for assessing the quality of the patient environment, and they also join with an executive and non-executive director in undertaking leadership and safety walks on a monthly basis.

We recognise that risk management is a two-way process between healthcare providers across the health economy. Issues raised through our internal risk management processes that impact on partner organisations are discussed in the appropriate forum so that action can be agreed.

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

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

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

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

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

We have robust arrangements in place for setting financial objectives and targets. These arrangements include ensuring the financial plan is achievable, ensuring the delivery of efficiency requirements, compliance with our provider licence and the co-ordination of financial objectives with corporate objectives as approved by the board:

- objectives are approved and monitored through a number of channels
- approval of annual budgets by the board of directors
- formal acceptance of annual budgets by delegated budget holders
- monthly reporting to the board, via its committees, on key performance indicators covering quality and safety, finance, and workforce targets
- scrutiny of divisional performance against objectives at sub-board committees
- regular divisional performance reviews
- reporting to NHS Improvement and compliance with our provider licence
- service transformation managed by a dedicated Programme Management Office
- in-year cost pressures are rigorously reviewed and challenged, and alternatives for avoiding cost pressures are always considered
- robust assessment process for business cases, including peer review; impact on quality and care; options appraisal; timed benefits; multi-layered approval and post-audit appraisal

We also participate 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 board regarding processes that are in place to ensure effective use of resources
- on-going benchmarking and tenders of operations occur throughout the year to ensure the competitiveness of service
- we use numerous data sources in order to undertake comparative analysis. This analytic either provides assurances or helps identify opportunities for improvement in care provision
- service line reporting is used by divisional managers to seek to improve financial performance
- the Carter recommendations are being reviewed and assessed to determine possible further efficiency opportunities

- CQUINs are negotiated and signed off by clinical, operational and finance director,s and operational leads are assigned for each scheme
- An on-line intelligence tool allowing individual budget holders to see their performance.

We have outsourced our transactional financial processing activities to NHS Shared Business Services, for which there is a contract in place which clearly outlines the roles and responsibilities of both organisations. We regularly review key performance indicators and we meet regularly to discuss any issues or concerns.

NHS Shared Business Services has processes and procedures in place which are compliant with central government standards as outlined in the information assurance maturity model and the NHS information governance assurance framework and it provides annual updates on the testing of controls and operations within its shared business facilities in the form of an ISAE3402 report.

> Information governance

The information governance work programme and performance against the national Information Governance Toolkit is closely monitored by our Caldicott Committee, which is chaired by the Medical Director as the Caldicott Guardian. We achieved a satisfactory score for the Information Governance Toolkit 2017-18 with a score of 83%.

Our information governance team recorded 116 information governance incidents between 1 April 2017 and 31 March 2018. Four of these were identified as a serious incidents requiring investigation at level 2 of the NHS information governance incident reporting tool. These incidents were reported to the Information Commissioner's Office and to NHS Digital.

The level 2 incidents occurring in 2017-18 relate to serious breaches of confidentiality and security where patient information has been shared inappropriately and in contravention of data protection legislation. None of these incidents remain open with the Information Commissioner's Office. Internal investigations have been undertaken for all incidents, and the Information Commissioner's Office has not pursued any enforcement action or monetary penalty for these incidents. The Information governance team works throughout the organisation to offer guidance and to support the implementation of remedial actions to address any shortfalls in controls where identified in order to manage risk. All information governance incidents are reported on Datix, our incident management system, which aligns with regulatory requirements.

Key stakeholders, including patients, our public and staff membership and local partner organisations are engaged on service developments and changes.

> Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. NHS Improvement, in exercise of the powers conferred on Monitor, has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Our purpose is to provide the best possible healthcare for our community and our vision is to make a positive difference to people's lives.

We have recently reviewed our objectives and re-emphasised our commitment to the quality and safety agenda. We are committed to improving quality and safety by adopting a 'just culture' and achieving a continual reduction in harm.

The WWL Wheel has been refreshed this year, and provides a framework to assist with the communication of future plans and measuring performance. The quality report presents a balanced view of areas of good performance and areas requiring improvement.

It is essential that we have policies and procedures in place to ensure that the services and care we provide is safe and in accordance with best practice. When drafting or reviewing policies, a consultation process is undertaken, following which they are submitted for approval by a relevant committee or group. Finally, the policy or procedure is ratified by our Policy Approval and Ratification Committee which has the responsibility of seeking assurance that correct processes have been followed and that the documents meet all formatting requirements. All policies and procedures are notified to staff via our intranet site, Wally, and are available to view and download within our online policy library.

We recognise that all our decisions - whether clinical, managerial or financial - should be based on information which is of the highest quality. We introduced a Data Quality Strategy in April 2014. Our Data Quality Committee, chaired by the Director of Operations and Performance, was established to monitor data quality standard.

Clinical quality improvements are monitored by both the Clinical Advisory Board and Professional Advisory Board. Escalation arrangements include, where necessary, referral to the Quality and Safety Committee and the board.

The Clinical Audit and Effectiveness Committee monitors an annual corporate clinical audit programme and progress against our Clinical Audit and Effectiveness Strategy. Systems and processes for clinical audit are monitored by the Audit Committee.

Complaints, serious incidents, clinical negligence claims, employee liability claims and inquests are monitored on a weekly basis by the Executive Scrutiny Committee. Membership includes the Director of Nursing, Deputy Director of Nursing, Medical Director, Responsible Officer and governance and assurance team members.

Investigations and action plans following serious incidents are reviewed and monitored by the Trust's Serious Incident Requiring Investigation Panel. Membership includes a representative from Wigan Borough Clinical Commissioning Group and a governor.

A quarterly 'Safe Effective and Caring' report is received by the Quality and Safety Committee and this is shared with our commissioners.

Each division has a quality dashboard that is monitored at Divisional Quality Executive Committee meetings, and the Audit Committee's annual work plan includes presentations on the quality dashboards from each division. Quality impact assessments are undertaken for all cost improvement proposals, which require the authorisation of the Medical Director and the Director of Nursing.

It is the responsibility of all staff to ensure timely and accurate capture of information to ensure high standards of data quality as defined in our Data Quality Policy. Information plays a key role in the management of patient care and provides the source for operational and management reporting across the organisation. Data accuracy is monitored by the Data Quality Committee via the annual audit plan where assurance or remedial plans are agreed and monitored.
We use a specific application for monitoring and managing elective waiting lists. The application is visible to all clinical services in order for them to validate their own waiting list information as well as our business intelligence team which monitors performance and compliance at an organisational level.

We have sought external assurance on the quality accounts in a similar manner to previous years. The purpose of this includes, but is not necessarily to be limited to, an evaluation of key processes and controls for managing and reporting the indicators and sample testing of the data to calculate the indicator back to supporting documentation.

> Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report included within this annual report and other performance information available to me. My review

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is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and the Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Maintaining and reviewing the effectiveness of the system of internal control has been undertaken with consideration of the following:

- the board assurance framework provides evidence of the process of the effectiveness of controls that manages the principal risks to the organisation
- the Board of Directors, Audit Committee, Quality and Safety Committee and the Risk and Environmental Management Committee and Executive Scrutiny Committee advise me on the implications of the results of my review of the effectiveness of the system of internal control. These committees also advise outside agencies in relation to serious events
- All the relevant committees within the corporate governance structure have a timetable of meetings and a reporting structure to enable issues to be escalated
- The board monitors and reviews the board assurance framework on a monthly basis. Responsibility for reviewing risks noted on the board assurance framework was devolved to the Finance and Investment Committee, Workforce Committee, Quality and Safety Committee and Board of Directors
- the Safe, Effective and Caring report, published by the governance and assurance team, is presented to the Quality and Safety Committee providing assurance to the board on effective risk controls
- the Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control acros the whole of the organisation's activities - both clinical and non-clinical - that supports the achievement of the organisation's objectives
- the Audit Committee reviews performance against the NHS Foundation Trust Code of Governance
- Clinical audit processes are a key element of maintaining and reviewing the effectiveness of the system of internal control. We have an annual corporate clinical audit programme and the Audit Committee regularly reviews clinical audit processes by receiving an annual self-assessment against national clinical audit standards and quarterly and annual clinical audit reports
- internal auditors review the board assurance framework and the effectiveness of the system of internal control as part of the internal audit work to assist in the review of effectiveness. Internal auditors reviewed the assurance framework and concluded that the organisation's assurance framework is structured to meet the NHS requirements, is visibly used by the board and clearly reflects the risks discussed by the board. 8 internal audits undertaken in 2017-18 were given limited assurance – IT asset management, Datix risk management, medical devices, attendance management, NICE quality standards, DNACPR, the hospital information system and recruitment and vacancy management. One other, relating to consultant job planning, was given a no assurance rating. Management actions have been put in place to address the issues raised in each of these areas and follow up reviews by the internal auditors have demonstrated good progress against action plans to improve systems and control in line with agreed time frames.
- The Head of Internal Audit Opinion for 2017-18 is that moderate assurance can be given that there is an adequate system of internal control, however in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk". These weaknesses in design or inconsistent application of controls have been subject to scrutiny by the Audit Committee and are subject to follow-up audits to ensure all recommendations have been completed.

> Conclusion

My review confirms that Wrightington, Wigan and Leigh NHS Foundation Trust has sound systems of internal control, with no significant internal control issues having been identified.

ANDREW FOSTER CBE
> Chief Executive and Accounting Officer

22 May 2018

QUALITY REPORT

What is a Quality Account?

> All providers of NHS Services in England are required to produce an annual Quality Account.

The purpose of a Quality Account is to inform the public about the quality of services delivered by us. Quality Accounts enable NHS Trusts to demonstrate commitment to continuous, evidence based quality improvement and to explain progress to the public.

This is our tenth Quality Account.

> Part 1:

Statement from the Chief Executive

> This year is something of a milestone as we publish our tenth Quality Account. It is a critically important document for us as it was ten years ago that we chose to pursue Quality as the overarching strategy for our services. We have always used the Darzi definition of Quality - Safe, Effective and Caring - as the basis of our corporate and divisional plans and as the basis for measuring and reporting on our progress in reducing avoidable harm and improving quality.

This is also the seventh year that we have used the WWL Wheel as a simple, visual reminder to strengthen awareness of 'Safe, Effective and Caring' and of our quality strategy amongst staff. The WWL has been updated this year (see page 9 of our Annual Report 2017-18) but quality remains at its centre. Our behaviours are now focused on being compassionate, respectful, accountable, collaborative and forward thinking. At the foundation of our new wheel sits the WWL 4Ps which are patients, people, performance and partnerships. All that we do falls under one of the 4Ps.

We continue to actively participate as a member of NHS QUEST. This is a network of foundation trusts, working collaboratively to reduce avoidable harms in hospital, to stimulate innovation and to improve staff satisfaction. We also continue to work with our partners in Greater Manchester and the Wigan Borough to drive improvements in healthcare.

As with previous Quality Accounts, we have given considerable priority to collecting and reporting facts and data to monitor our progress. These show that 2017-18 was a year of mixed results with continued improvement in some areas but modest deterioration in others, despite the enormous efforts of so many excellent staff. Why is this? In my opinion there are two major contributory factors. Firstly we have now had seven years of austerity in the public sector and the effects of repeated annual savings have begun to bite. Secondly, we see continued rise in demand for our services with greater numbers of sicker and older patients using our systems. This sometimes leads to overcrowding and extended waiting, both of which are a significant risk to patient safety and patient experience.

On infection control for example, we have reduced from 2 cases last year to just 1 case of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infection and not had a case for 11 months now. By contrast the number of Clostridium difficile rose from 22 last year to 25 and the number that were the result of lapses of care was six compared to three last year. We saw reductions elsewhere with 12 cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA) and 23 E Coli bacteraemia compared to 14 and 36 respectively in 2016-17.

Another key quality measure is Hospital Standardised Mortality Ratio (HSMR) and this has improved after disappointing figures the previous year. The most up to date year to date HSMR figure for 2017-18 is 101.9 to December 2017 compared to 115.9 for the whole of 2016-17. The absolute numbers of deaths in hospital has risen from 1340 in 2016-17 to 1363 in 2017-18, a rise of 1 per cent.

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

Safe

- We had 7 serious falls in hospital, compared to 2 the previous year
- There were zero Central Line infections, and 1 the previous year
- There have been four incidents that met the criteria for a Never Event in 2017-18 and one the previous year.
- There were no cases of Ventilator Associated Pneumonia compared to one in 2016-17
- The total number of avoidable serious harms to patients was 74 compared to 96 last year

Effective

- We continued our implementation of the new £13m Hospital Information System which is very highly regarded by users. However the roll-out to A&E had to be paused when, coinciding with the worst winter pressures, we saw a sharp deterioration in performance. This will be resumed in the Spring.
- We won major national awards for our Procurement Team (rated as number 1 in the NHS in the PEPPA score), our pioneering software system to support Staff Engagement and the Finance Team (Finance Team of the Year at the Public Finance Innovation Awards 2018).

- We successfully achieved all the national targets except for four hour waits in A&E and were in the top ten performers in the NHS for cancer and 18 weeks.

Caring

- Our annual national Picker patient survey results showed notable improvements, with those scoring 7/10 or better improving from 86% to 90%. The proportion reporting that they were "always well looked after" rose from 85% to 90%. Compared to other Trusts we scored significantly better on 17 questions and significantly worse on two.
- In the annual Patient Led Assessments of the Care Environment (PLACE) survey our overall ranking across all Acute Trusts in the NHS in England is 4th which sees a slight improvement from previous year. The overall average score has increased to 96.94% from 95.81% and we have improved scores in all but one of the 8 categories.
- Our national staff survey results also showed modest improvement and a very good performance compared to other Trusts. The proportion of staff who would recommend us as a place to work rose from 71% to 72% whilst the national average slipped from 62% to 61%.
- This year we grew the number of Quality Champions to 365, each being trained in techniques of quality improvement before taking on leadership of 198 tasks or projects since the programme started.

In March 2018 the Care Quality Commission (CQC) published the results of its unannounced inspection and Well-Led review, both conducted in November 2017. The Trust scored 'Good' overall, for each of the main domains (Safe, Effective, Caring, Responsive, Well-Led) and for each of the Hospital sites. From the 2015 inspection, the Thomas Linacre Centre retains its 'Outstanding' rating as does End of Life Care. Each of the inspected services was rated as 'Good' except for Maternity Services who were rated as 'Requires Improvement'. At the same time, NHSI's rating for Use of Resources was also announced as 'Good'. In the context of the challenging situation throughout the NHS, particularly as these inspections took place during the winter months, we are delighted that the quality of our services and our staff have been recognised in being rated 'Good' across the board.

We reported 34 serious incidents in 2017-18, two were subsequently downgraded bringing a year-end total of 32; this equals 32 in 2016-17. We received 464 formal complaints in 2017-18 compared to 453 in 2016-17, a small 3% increase. We were pleased to note a significant increase in incident reporting with a total of 11,101 datix reports in 2017-18 placing us in the top 25%, demonstrating an open and transparent reporting culture.

Over the years that we have been publishing Quality Accounts, we have aimed to build a strong safety culture all the way from the board to the level of our front line staff who deal directly with patients. We want strong leaders and managers at every level in the organisation, who are committed to quality and safety and who promote a strong and vibrant energy and sense of belonging. Culture is one of the hardest things to change and also one of the most difficult to measure but three of our programmes – Harm-Free Wards, Quality Champions and Always Events, seem to be making a clear and noticeable difference.

Two of our consultants were also recipients of Clinical Excellence Awards in December 2016; Professor Peter Kay had his Gold Award renewed and Professor Raj Murali received a new Gold Award.

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

ANDREW FOSTER CBE
> Chief Executive

22 May 2018

> Part 2:

Priorities for improvement and statements of assurances from the board

> Part 2.1: Priorities for Improvement in 2018-19

This is the **'look forward'** section of our Quality Account. In April 2017 we were delighted to publish our Quality Strategy 2017/21 outlining the framework to improve quality over the next four years. This section introduces our Quality Strategy 2017/21, provides an update on the national Sign Up to Safety Campaign and outlines the improvements we plan to take over the next year.

Quality Strategy 2017/21

Our new Quality Strategy 2017/21, published in April 2017, set the direction of travel for the next four years. The aim of the strategy is:

"To move towards zero avoidable harm by 2021 through continual reduction"

The Quality Strategy maintains our values to provide safe, effective and compassionate care. The strategy focuses on five primary drivers:

1. Excellence in clinical care
2. Engagement and networking
3. Quality improvement
4. Measuring and monitoring of safety
5. Culture

Participation in the National Sign Up to Safety Campaign

The aim of the Sign Up to safety campaign launched in 2014 is to deliver harm-free care for every patient, every time, everywhere. The Campaign champions openness and honesty, and supports everyone to improve the safety of patients.

The campaign is focusing its attention on connecting organisations and people who can then support each other to make improvements.

We 'Signed up to Safety' in August 2014. We have built elements of the national campaign into our quality and quality improvement strategies to enable sharing of best practice by working with partners but also working together to resolve common problems, often across systems.

Quality Priorities for 2018-19

We have agreed our annual priorities for 2018-19 which support our Quality Strategy 2017/21 and consider some of our challenges. The annual priorities were agreed following consultation with staff and stakeholders including Governors, Wigan Borough Clinical Commissioners Group and Healthwatch. The quality priorities, the rationale for their selection and how we plan to monitor and report progress are outlined below. All quality priorities have a timescale for achievement by 31 March 2019 and progress to achieve them is monitored by our Quality and Safety Committee.

> Patient Safety (Safe)

Priority 1:	**To complete a venous thromboembolism (VTE) risk assessment for 95% of patients admitted to hospital.**
Rationale:	Our compliance for the completion of VTE assessments for 2017-18 is 84.89%. The inclusion of this indicator was supported by all stakeholders to ensure that compliance continues to improve to 95%.
Monitoring:	Thrombosis Committee is responsible for monitoring compliance to achieve this priority.
Reporting:	Quality and Safety Committee weighted dashboard; Board of Directors Performance Report.

Priority 2:	**To achieve 95% of patients found to have sepsis receiving IV antibiotics within 1 hour in Accident and Emergency (A&E).**
Rationale:	Our compliance for patients found to have sepsis receiving IV antibiotics within 1 hour in A&E was 69.70% in quarter 4 2017-18. We achieved 96.20% in March 2018. The inclusion of this priority was supported by all stakeholders to ensure that compliance continues to improve to 95%.
Monitoring:	Quality and Safety Committee is responsible for monitoring compliance to achieve this priority.
Reporting:	Quality and Safety Committee weighted dashboard.

Priority 3:	**To reduce the numbers of falls resulting in serious harm and death.**
Rationale:	We had 7 serious falls in hospital during 2017-18, compared to 2 the previous year. We have achieved significant improvements to reduce the number of multiple fallers by 50% and the total number of falls has decreased by 19%. Our focus in 2018-19 is to continue to reduce the level of harm resulting from a fall in hospital. This priority was supported by Governors.
Monitoring:	Harm Free Care Board is responsible for monitoring the work undertaken by the Falls Improvement Group and progress to reduce harm from falls.
Reporting:	Quality and Safety Committee weighted dashboard; Board of Directors Performance Report

Priority 4:	**To achieve an overall Hospital Standardised Mortality Ratio (HSMR) of 95 and a Band 2 Summary Hospital Level Mortality Indicator (SHMI)**
Rationale:	This indicator was proposed by Wigan Borough Clinical Commissioning Group. The Trust has achieved an improvement in the benchmarked position for HSMR. The most up to date HSMR figure for 2017-18 is 101.9 to December 2017 compared to 115.9 for the whole of 2016-17. We hope that SHMI will also improve as the data time periods published catch up with HSMR. The most up to date SHMI figure for 2017-18 is 120.3 for a rolling 12 months from September 2016 to September 2016. The Trust is currently in Band 3 (Band 1 is the best performing).
Monitoring:	Mortality Group is responsible for monitoring the actions and initiatives in relation to this priority.
Reporting:	Quality and Safety Committee weighted dashboard; Board of Directors Performance Report

> Clinical Effectiveness (Effective)

PRIORITY 1:	**To achieve 95% compliance for the escalation of the deteriorating patient (triggering on MEWS)**
Rationale:	The inclusion of this priority was supported by all stakeholders to ensure that compliance continues to improve to 95%. A review of the data quality behind the compliance data has been undertaken following the selection of the priority by Governors as their Locally Determined Indicator (LDI).
Monitoring:	Harm Free Care Board is responsible for monitoring the work undertaken by the Falls Improvement Group and progress to reduce harm from falls.
Reporting:	Quality and Safety Committee weighted dashboard;

PRIORITY 2:	**To achieve 95% of patients prescribed warfarin having the correct dose prescribed**
Rationale:	Anticoagulation is a high risk medicine that can result in patient harm if not administered correctly. During 2017-18 our Clinical Lead for VTE undertook an audit to review the prescribing accuracy of two anticoagulants (Dalteparin and Apixaban). 100% compliance was achieved regarding correct dosing and administration for these prescriptions. Our focus for 2018-19 is Warfarin.
Monitoring:	Medicines Management Committee is responsible for monitoring the actions and initiatives in relation to this priority.
Reporting:	Clinical Audit to Medicines Management Committee.

PRIORITY 3	**To improve Fractured Neck of Femur Time to Appropriate Bed**
Rationale:	The inclusion of this priority relating to the pathway to ensure appropriate treatment for patients admitted with a Fractured Neck of Femur was proposed by our Quality and Safety Committee. One of the best practice standards to achieve optimal care for patients with fractured neck of femur is to be transferred to an orthopaedic bed within 4 hours of admission (National Hip Fracture Database). The Trauma Orthopaedic Group meets bi-monthly and is responsible for monitoring this. Year to date average for 2017-18 was 42.3%. The Division is working collaboratively with the 'Right Patient, Right Ward' project led by the Deputy Director of Nursing to achieve this and in keeping fractured neck of femur beds available for these types of patients to assist with improved outcomes.
Monitoring:	Trauma Orthopaedic Clinical Group is responsible for progressing and monitoring the actions in relation to this priority.
Reporting:	Trauma Orthopaedic Clinical Group to Specialist Services Divisional Quality Executive Committee

PRIORITY 4:	**To achieve a 20% reduction in patients experiencing harm as a consequence of lack of fluids**
Rationale:	Management of IV fluids was a theme identified in our annual review of deaths as an area for improvement.
Monitoring:	Harm Free Care Committee is responsible for monitoring the actions and initiatives associated with this priority.
Reporting:	Harm Free Care Committee reports to Quality and Safety Committee.

> Patient Experience (Caring)

PRIORITY 1:	**To achieve 90% of patients reporting that they were involved as much as they wanted to be in decisions about discharge from hospital.**
Rationale:	Our annual national Picker patient survey results showed notable improvement by 8% to 50% for patients reporting that they were involved as much as they wanted to be in decisions about discharge from hospital. Our real time patient experience data collected monthly demonstrates that 62.21% of patients asked during 2017-18 reported that they were involved as much as they wanted to be in decisions about discharge from hospital. We will continue to focus on improving communication with patients about their discharge. Discharge 'Always Events' have just been launched which should assist with communication.
Monitoring:	Discharge Improvement Group is responsible for monitoring the actions and initiatives in relation to this priority.
Reporting:	Board of Directors Performance Report

PRIORITY 2:	**To achieve 90% of patients reporting that they received information on medicines at discharge.**
Rationale:	This was an area identified for improvement following the publication of benchmarking information against other NHS Trusts who utilise the organisation Picker to co-ordinate their inpatient surveys. The National Inpatient Survey Results are due for publication in June 2018.
Monitoring:	Harm Free Care Board is responsible for monitoring the actions and initiatives in relation to this priority.
Reporting:	Picker and National Inpatient Survey Results

PRIORITY 3:	**To achieve an improved position regarding mothers reporting that they were given a choice about where to have their baby.**
Rationale:	Our Maternity Services performed well in the national maternity survey 2017. This priority has been selected by Maternity Services and is being monitored by the 'Better Births' process. Stakeholders noted the importance of the inclusion of a Maternity Services priority for 2018-19. The personalised maternity care budget pilot was commenced in April 2017 and of the 230 eligible women 100 % were offered choice of place of birth. However, 10.4% declined to be part of the pilot. This pilot has now been rolled out across the whole of the Maternity service with the aim to continue to achieve 100% compliance for eligible women. The Better Births National Maternity Review recommends that women receive personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information. Women should be able to choose the provider of their antenatal, intrapartum and postnatal care and be in control of exercising those choices through their own NHS Personal Maternity Care Budget.
Monitoring:	This will be monitored through the current maternity information system and data submission to national bodies such as NHS Digital who compile the Maternity Service Data Set (MSDS). The percentage of eligible women who have been offered choice of place of birth will included within the Maternity Dashboard
Reporting:	The Maternity Dashboard is monitored at Obstetrics and Gynaecology Clinical Cabinet and Divisional Quality Executive Committee in addition to Monthly data submission to National Maternity Pioneer Information Group (NMPIG).

> Part 2.2: Statements of Assurances from the Board

We are required to include formal statements of assurances from the Board of Directors which are nationally requested to give information to the public. These statements are common across all NHS Quality Accounts.

> 2.2.1: Review of Services

During 2017-18 Wrightington Wigan and Leigh NHS Foundation Trust ("WWL") provided and/or sub-contracted 67 relevant health services.

WWL has reviewed all the data available to them on the quality of care in all 67 of these relevant health services.

The income generated by the relevant health services reviewed in 2017-18 represents 93% of the total income generated from the provision of relevant health services by WWL for 2017-18.

>2.2.2: Participation in Clinical Audits

During 2017-18, 3 National Clinical Audits and 4 National Confidential Enquiries covered relevant health services that WWL provides. During that period WWL participated in 21 National Clinical Audits and 4 National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was eligible to participate in. In addition WWL participated in a further 4 National Audits (Non-NCAPOP) recommended by HQIP.

The National Clinical Audits and National Confidential Enquiries that WWL was eligible to participate in during 2017-18 listed in Appendix A.

The National Clinical Audits and National Confidential Enquiries that WWL participated in, and for which data collection was completed during 2017-18 are listed in Appendix A alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

> The reports of 6 National Clinical Audits were reviewed by the provider in 2017-18 and WWL intends to take the following actions to improve the quality of healthcare provided

Audit	Trust Actions
Acute Pancreatitis National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Actions taken following the publication of this report include the implementation of High Blood Pressure Guidelines, the development of a Transfer Policy, a review of the planned list for surgeons and an audit on the use of antibiotic prophylaxis in acute pancreatitis.
Paediatric Asthma	Further audits are to be undertaken related to readmissions, chest x-ray and antibiotic use.
Adult Asthma	The majority of the criteria are being met by services at Royal Albert Edward Infirmary. Follow-up rates are higher than the national average. Recommendations focus on the improving documentation in patient records.
Paediatric Pneumonia	The report has been reviewed and actions are under discussion.
National Cardiac Arrest Audit (NCAA)	Quarterly reports are received and regular reviews are undertaken by Resuscitation Officers. Reports are distributed to all Trust staff and periodic updates are given at audit meetings to create awareness amongst staff.
National Joint Registry (NJR)	Regular updates are provided at Audit meetings where areas for improvement are highlighted.

> The reports of 180 Local Clinical Audits were reviewed by the provider in 2017-18. A selection of these audits is outlined below and WWL has taken or intends to take the following actions to improve the quality of healthcare provided:

Audit	Trust Actions
Non-ST-Segment Myocardial Infarction (Acute Coronary Syndrome -NSTEMI)	Following the first cycle of audit actions taken included the identification of all acute coronary syndrome (ACS) patients with positive troponin, improved communication with the cardiology team and prioritisation of patients according to GRACE score (a scoring system to risk stratify patients with diagnosed ACS to estimate their in-hospital and 6-month to 3-year mortality). Following the second cycle of audit demonstrated a significant improvement for patients who had a coronary angiography within 72 hours. A structured system approach has led to an improved 'admission to angio' rate at WWL which is higher than the national average.
Early Arthritis Clinic	The existing clinic at Wrightington Hospital has been re-structured to form a dedicated multidisciplinary one-stop early arthritis clinic. An evidence based early arthritis pathway was developed. Referrals are now faxed to the Rheumatology Department on an early arthritis pro-forma to be triaged. The action taken following this audit has improved the service for patients and we are meeting the recommended standards.
Improving practice via a new Morbidity and Mortality (M & M) Analysis Tool	Following the first cycle of audit, an Ear Nose and Throat (ENT) Quality Improvement Programme was introduced that enables simple assessment of each complication using grading tools and charts. A further audit was undertaken which showed that the tool provides clinicians with the ability to quickly grade and assess complications but more importantly, to create action plans to prevent recurrence and change practice.
Management of Anaphylaxis; Assessment, referral after emergency treatment	The first cycle of audit demonstrated discrepancies in treatment. Following the audit an Anaphylaxis pro-forma was introduced and highlighted at education sessions for all post-graduate staff. The second cycle of audit demonstrated some improvement in many areas. A further audit is to be undertaken following further awareness sessions.
Visual acuity of children at discharge after amblyopia therapy	Following the audit amendments were made to procedure. Further audits were undertaken to review the revised protocol. Results demonstrated that closing the audit loop has led to a successful redesign of amblyopia management. Audit data had improved from 48% to 96.8%. Results are demonstrating the best available visual acuity figures for the management of childhood amblyopia.

Audit Actions are monitored at monthly audit meetings as well as at Divisional Quality Executive meetings. Actions are signed off as complete (on the audit database) when feedback is relayed back to the audit department by those responsible for implementing the actions.

National clinical audits are primarily funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Although National Clinical Audits are not mandatory, organisations are strongly encouraged to participate in those that relate to the services they deliver. It is mandatory to publish participation in National Clinical Audits in a Trust's Quality Account. A high level of participation provides a level of assurance that quality is taken seriously and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice. Local Clinical Audit is also important in measuring and benchmarking clinical practice against agreed standards of good professional practice.

> 2.2.3: Research

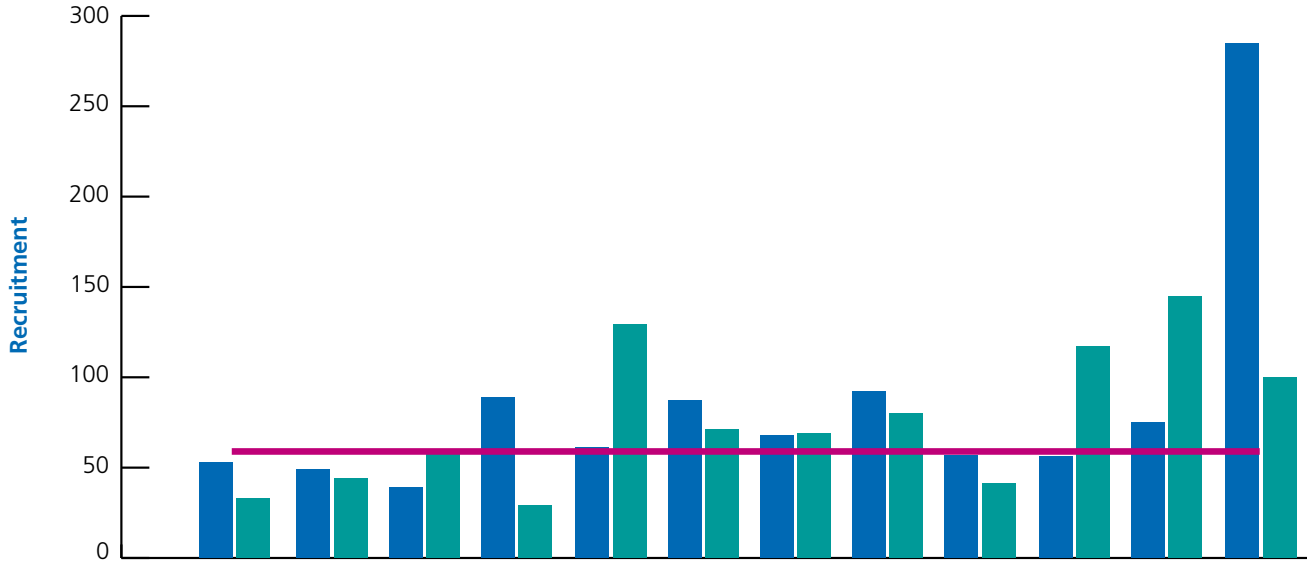
Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by WWL in 2017-18 that were recruited during that period to participate in research approved by a research ethics committee registered and adopted onto the 'National Institute for Health Research (NIHR) Portfolio') was 940, an average of 78 patients per month. The Trust target agreed with the National Institute for Health Research (NIHR) was 834 recruits.

Patient Recruitment 2017-18

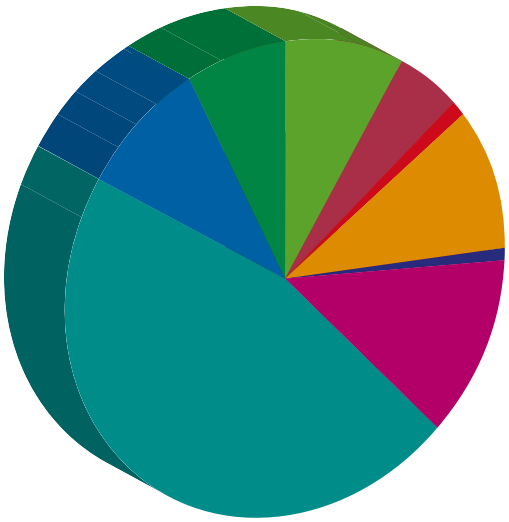
The following chart illustrates target recruitment versus actual recruitment to research studies in 2017-18.

> NIHR Performance Year to Date



	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
2016-2017	53	49	39	89	61	87	68	92	57	56	75	285
2016-2017	33	44	59	29	129	71	69	80	41	117	145	100
TARGET	60	60	60	60	60	60	60	60	60	60	60	60

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff are continually updated about the latest treatments. We were involved in conducting 92 NIHR Portfolio clinical research studies and 89 Non Portfolio studies in a variety of specialities during the year 2017-18. The chart below illustrates recruitment into National Institute for Health Research registered studies between 1 April 2017 and 31 March 2018.



> Contribution by Speciality 2017-18

- Orthopaedics **9%**
- Rheumatology **5%**
- ENT **1%**
- Medical **10%**
- Dermatology **1%**
- Paediatrics **12%**
- Gastroenterology **46%**
- Oncology **9%**
- Reproductive Health **7%**

It is globally recognised that a commitment to clinical research leads to better outcomes for patients. We are continuously scrutinised and the data provided is monitored by recognised, expert teams who ensure that confidentiality and the conduct of every trial meets European legislation. An example of the esteem held for our work at WWL is illustrated in the comment below: "*I just wanted to give you a little bit of feedback on the study after I've spent the day here monitoring. The patient notes and source data for the study are absolutely brilliant - the worksheets that you have created for every visit are invaluable too - every data point can be verified and this makes the patient notes so much easier to monitor. I honestly wish that I could use your site as an example to other sites because you have achieved a level of attention to detail for the trial data that we are constantly asking sites to strive towards*".

We have been recognised at a regional awards ceremony for our success in attracting international research projects for the benefit of our patient population.

Our Research Strategy aims to include all clinical staff in research. Every year the Research Department identifies a clinical area for promoting and supporting research. This has proved successful and areas of interest have greatly increased with strong recruitment in the following clinical specialities:

Rheumatology, Cardiology, Diabetes, Surgery, Respiratory, Paediatrics, Obstetrics, Cancer, Ear Nose and Throat (ENT), Gastroenterology, Dermatology, Musculo-skeletal and Infection Control, Fertility and Ophthalmology.

Training and Development opportunities are provided by the Research Department to support staff in conducting quality research studies in a safe and effective manner. All staff that support clinical research activity are trained in Good Clinical Practice (GCP) which is an international quality standard transposed into legally required regulations for clinical trials involving human subjects.

The development of our Research Patient Public Involvement (PPI) group influences the way that research is planned. They help to identify which research questions are important.

By influencing the way research is carried out we aim to improve the experience of people who take part in research.

Publications have resulted from both our engagement in NIHR Portfolio research and Foundation Trust supported research, which has secured Ethical Approval.

It is important that we continue to support both pilot studies in preparation for larger research projects and smaller research studies which do not qualify for adoption onto the NIHR Portfolio because they do not require access to a funding stream. This shows our commitment to transparency and our strong desire to improve patient outcomes and experience across the NHS.

The clinical research team supports all clinical teams conducting research studies, ensuring the safe care of patients and adherence to the European Directive, Good Clinical Practice guidelines and data collection standards. As a result of this expert support, the larger clinical community within the Foundation Trust is in a position to conduct a wide variety of clinical research which will ultimately provide better access to research for our patients.

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. 'Clinical research' refers to research that has received a favourable opinion from a Research Ethics Committee within the National Research Ethics Service (NRES). Trusts must keep a local record of research projects.

> 2.2.4: Goals agreed with Commissioners

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of WWL's income in 2017-18 was conditional on achieving quality improvement and innovation goals agreed between WWL and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2017-18 and for the following 12 month period are available electronically at **www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/**

WWL is estimated to receive £5.457 million in relation to CQUINS for 2017-18, in comparison with £5,66m in 2016-17. We had 6 national CQUIN schemes in 2017-18 which were as follows:

1. Staff and patient health and well-being
2. Sepsis screening and treatment and reductions in antibiotic consumption
3. Safe and proactive discharge
4. Improving services for patients attending A&E with mental health conditions
5. Introducing advice and guidance
6. Expanding the electronic referral system

There were significant achievements against a number of the schemes during 2017-18; firstly, in relation to reducing mental health related attendances at the emergency department there was a 55% reduction in attendances for patients who were identified as presenting regularly during 2016-17. This was achieved through close working between WWL and North West Boroughs Healthcare NHS Foundation Trust ensuring that effective individual strategies were put in place for each patient. During 2016-17 the identified cohort of patients accounted for 302 attendances but in 2017-18 this fell to 135. During 2017-18 these patients will continue to be monitored and a new cohort will be identified and it is hoped a similar impact can be made. Secondly, there was an improvement in the proportion of patients over 65 admitted non-electively who were discharged to their normal place of residence within 7 days. The national target was a 2.5% improvement but the Trust achieved 6%. This was achieved through close working with Wigan Council and the Trust's work in the Age Well Unit. This scheme does not continue in 2018-19 although the work itself will go on. Thirdly, the Trust achieved the healthy food and drink comfortably during the year and in fact has already met the requirements due at the end of March 2018. The Trust is one of the few to have achieved this during 2017-18. As part of the same scheme the Trust vaccinated over 74% of its frontline staff against flu against the target of 70%. The target for 2018-19 is 75% so this is expected to be achieved. The advice and guidance and e-referral service (ERS) schemes were included within the separate Paper Switch Off Programme which is linked to the contractual requirement to receive all GP referrals via ERS by 1 October 2018. The Trust achieved its local implementation date of 31st March 2018.

The main challenge was in relation to the sepsis scheme which requires all appropriate patients are screened for sepsis and that those who are found to have sepsis had antibiotics administered within one hour. Despite some early issues the screening targets were met throughout quarters three and four. However, the Trust did not achieve the 90% standard for antibiotic administration within an hour in any quarter (although it was achieved in several individual months). This was in part due to changes in the way the data was collected but also reflected the sustained pressure on unscheduled care. Each patient is now reviewed by the clinical leads for sepsis and learning points shared. This audit has also identified that most patients did receive their antibiotics within 3 hours which is the NICE standard. The sepsis scheme continues in 2018-19 and improving care for these patients is part of the Trust's Quality Strategy.

The CQUIN payment framework aims to embed quality at the heart of commissioner-provider discussions and indicates that we are actively engaged in quality improvements with our commissioners. Achievement of the CQUIN quality goals impacts on income received by WWL.

> 2.2.5: What others say about WWL

Statements from the Care Quality Commission (CQC)

WWL is required to register with the Care Quality Commission and its current registration status, at the end of 2017-18, is registration without compliance conditions.

The Care Quality Commission (CQC) has not taken enforcement action against WWL during 2017-18.

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

We were inspected by the CQC, as part of their responsive inspection programme in March 2017. The report was published by the CQC in September 2017. The CQC inspected Urgent and Emergency Services as well as services for Children and Young People. By the end of 2017-18, all of the must do and should do actions have been completed and a detailed update provided to the CQC around the improvements taken by the Trust.

When inspecting the Children's Ward (Rainbow Ward), the CQC noted significant progress since the previous inspection

in December 2015, including improved staffing levels, greater numbers of staff trained to deliver Advanced Paediatric Life Support (APLS), including care for children with tracheostomies, and an escalation process for staffing. Further actions have been completed in relation to the Paediatric Early Warning Score (PEWS) guidance and monitoring of fridge temperatures.

In relation to the Paediatric Emergency Care Centre (PECC) and Accident and Emergency (A&E), the CQC positively noted the electronic system for medicine storage and requisition which helps ensure staff had a safe and effective process in place to assist in reducing medicine errors. Controlled drugs are stored and checked correctly and staff escalate clinical concerns to medical staff efficiently. Further actions have been completed in relation to the Paediatric Early Warning Score (PEWS) guidance and availability of a paediatric nurse 24 hours 7 days a week in A&E particularly after PECC is closed at 1 am.

The CQC commented positively, advising the Trust "We were treated really well by the staff, who welcomed us in without question and wholeheartedly answered the many questions we put forward to them with a friendly and professional approach. This must have been challenging given that they had no time to prepare or source extra staff to assist us. They helped us despite having to manage and care for their patients. It really was very much noted and appreciated by us all. I hope you will pass on our thanks".

We were also inspected by the CQC in November 2017. The CQC undertook an unannounced inspection to review Urgent and Emergency Services, Maternity Services, Services for Children and Young People and Medical Care. The CQC also undertook a well-led inspection. The reports were published in March 2018.

We are proud to have maintained our "Good" provider rating overall and achieved a "Good" rating for the announced well-led Inspection. All of our hospital sites are rated as "Good" or "Outstanding", a significant achievement given the pressures that we have experienced over the winter period. Royal Albert Edward Infirmary is now rated as a "Good" hospital (an improvement from the previous rating "Requires Improvement"). Urgent and Emergency Services, Services for Children and Young People and Medical Care have made significant improvements since the last inspections and are all rated "Good" overall.

Some positive comments noted by the CQC include:

"Staff work together to benefit patients; Staff care for patients compassionately"

"Feedback from patients confirmed that staff treated them well and with kindness; Staff involved patients and those close to them in decisions about their care and treatment and provided emotional support to patients to minimise distress"

"Managers promoted a positive culture that supported and valued staff and engaged effectively. They collaborated with partner organisations effectively"

"Local systems and processes reflected a culture of improvement"

"Staff described the culture within the service as open and transparent"

"The wards were clean and equipment was well maintained. Staff followed infection control policies that managers monitored to improve practice"

"There was a cohesive and thorough multidisciplinary approach to assessing the range of people's needs, setting individual goals and providing patient-centred care"

"Staff treated patients with compassion, dignity and respect. Staff involved patients and those close to them in decisions about their care and treatment. They made sure patients were aware of their goals and plan of care"

We welcomed the constructive feedback from the CQC and inevitably the inspection did identify some areas where we can improve. Improvement plans are in place to address these and actions commenced immediately after the inspection. Maternity Services are undertaking a number of improvements following the CQC inspection which include a systematic evidence based process to calculate midwifery staffing establishment, a review of the availability of medicines and regular audits of risk assessments. Completing the actions in response to the CQC recommendations is a priority for 2018-19.

The full reports can be accessed here
www.cqc.org.uk/provider/RRF/reports

All NHS Trusts are required to register with the Care Quality Commission. The CQC undertakes checks to ensure that Trusts are meeting the Fundamental Standards and Key Lines of Enquiry (KLOE) under safe, effective, caring, responsive and well-led. If the CQC has concerns that providers are non-compliant there are a wide range of enforcement powers that it can utilise which include issuing a warning notice and suspending or cancelling registration.

> 2.2.6: NHS Number and General Medical Practice Code Validity

WWL submitted records during 2017-18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:

> 99.9% for admitted patient care.

> 99.9% for outpatient care, and

> 99.4% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:

> 100.0% for admitted patient care,

> 100.0% for outpatient care, and

> 100.0% for accident and emergency care.

The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code (Patient Registration) is essential to enable the transfer of clinical information about the patient from a Trust to the patient's General Practitioner (GP).

> 2.2.7: Information Governance Toolkit Attainment Levels

WWL's Information Governance Assessment Report overall score for 2017-18 was 83% and was graded green, a satisfactory submission.

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Information Governance Toolkit is a performance tool produced by the Department of Health (DH) and now hosted by NHS Digital. It draws together the legal rules and central guidance related to Information Governance and presents them in one place as a set of Information Governance requirements.

> 2.2.8: Clinical Coding Error Rate

WWL was not subject to the Payment by Results clinical coding audit during 2017-18 by the Audit Commission. The Audit Commission has closed.

WWL commissioned an external audit in November 2017 for assurance of the clinical coding quality:

> Primary Diagnosis Incorrect 4%

> Secondary Diagnosis Incorrect 7%

> Primary Procedures Incorrect 5%

> Secondary Procedures Incorrect 7%

The results should not be extrapolated further than the actual sample audited. 200 finished consultant episodes (FCEs) were selected by the auditor across the range of specialties and these cases were reviewed in terms of clinical coding accuracy.

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

> 2.2.9: Statement on relevance of Data Quality and your actions to improve your Data Quality

Accurate and timely data is essential to good intelligence and making sound clinical and strategic decisions. Although the Trust already had good data quality it recognises that there are always improvements that can be taken.

Over the previous twelve months the Trust has developed

its own Data Quality (DQ) app. The app provides the Trust's frontline services with clear visibility on where there are issues or areas of concern. This allows the individuals and services entering the data to investigate and remedy any issues, as well also learning for the future. This supports the NHS Get It Right First Time (GIRFT) approach and is aligned to Article 5 of the General Data Protection Regulation (GDPR).

WWL will be taking the following actions to improve data quality: Due to the success the DQ app the Trust plans to continue its development over the next twelve months adding even more checks and Key Performance Indicators (KPIs) in order to provide more assurance and even better data quality.

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. The Board of Directors is required to sign a 'Statement of Directors' Responsibilities in respect of the Quality Report part of which is to confirm that data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

> 2.2.10: Learning from Deaths

During 2017-18 1337 of WWL patients died (data to 27th March 2018). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 328 in the first quarter;
- 298 in the second quarter;
- 359 in the third quarter;
- 352 in the fourth quarter.

WWL has had a process for reviewing deaths for over eight years. WWL commenced the review of deaths in a structured way that met the Learning from Deaths Guidance published in March 2017, from October 2017 (quarter 3 2017-18) and therefore will be reporting data for two quarters.

By March 2018, 213 case record reviews and 213 investigations have been carried out in accordance with the Learning from Deaths Guidance (in quarter 3 and quarter 4 2017-18) in relation to 711 of the deaths referenced in the introduction. In 213 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was;

94 in the third quarter; 119 in the fourth quarter

4 representing, 0.6% of 711 deaths in quarter 3 and quarter 4 2017-18, of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

2 representing, % of 359 of deaths which occurred for the third
2 representing, % of 352 deaths which occurred for the fourth quarter

These numbers have been estimated using a version of the Royal College of Physicians Structured Judgement Review methodology supported by the Learning from Deaths Guidance. A summary of what WWL has learnt from case record reviews and investigations conducted in relation to deaths identified above.

A dominant theme, particularly during quarter 4 2017-18 has been hospital pressures. That is witnessed most easily by visiting A&E, but is also seen in missed components of care (such as VTE venous thromboembolism, wrong ward or missed medicines) and standard of note keeping. At the busiest times patients were initially seen by the A&E team and their next review would often be on the Post Take Ward Round having missed the medical team's first review. Slow provision of transfusion and late ERCP (a procedure that combines upper gastrointestinal (GI) endoscopy and x-rays to treat problems of the bile and pancreatic ducts) noted in other cases are also linked to the pressures the Trust has experienced. Post-operative bleeding and harm from falls, particularly for patients on warfarin, were highlighted.

A description of the actions WWL has taken in the reporting period and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period. Some of the actions taken include the following:

- Additional ERCP sessions;
- Amendments to the documentation for recording VTE risk assessments;
- Task and Finish Group established for right patient right ward;
- A review of pre-operative management of patients on Warfarin and highlighting the risk of patients on warfarin on a healthcare economy scale with Wigan Borough Clinical Commissioning Group leading work with GPs to reduce the number of frail patients who are on Warfarin.

An assessment of the impact of the actions described above which were taken by WWL during the reporting period.

The Trust's Hospital Standardised Mortality Ratio (HSMR) has started to reduce during 2017-18. The actions taken above continue to be monitored. Quality priorities for the prescribing of warfarin, VTE and reducing harm from falls have been agreed for 2018-19. The Mortality Committee, chaired by our Medical Director will continue to review actions taken.

The following statements are not applicable to the Trust:

- 0 case record reviews and 0 investigations completed after quarter 3 which related to deaths which took place before the start of the reporting period.
- 0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.
- 0 representing 0% of the patient deaths during the previous reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

This is a new section of the Quality Report that NHS Trusts are required to include. In March 2017 the National Quality Board published a document called 'National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. The purpose of the guidance was to help initiate a standardised approach to learning from deaths.

> 2.2.11: Seven Day Services

The latest available data for compliance against the priority clinical standards for seven days services was published in 2017:

- Standard 2: Time to first consultant review **82%**
  The Trust has performed better than the national average overall for two consecutive surveys.
- Standard 5: Access to diagnostic tests **84%**
  The Trust has performed better than the national average for weekdays; however, the Trust is worse than the national average for weekends. The Trust's focus for improvement is timely referrals to other hospitals, for example, interventional radiology at Preston. The development of a six day echocardiography service is in progress.
- Standard 6: Access to consultant-directed interventions **94%**
- Standard 8: Ongoing review by consultant twice daily if high dependency patients, daily for others **88%**

The Trust has performed better than the national average overall and for weekdays and slightly worse than the national average at weekends for standard 6 and standard 8. Workforce shortages have contributed to the Trust's compliance with these standards.

The time period for the next round of data collection commenced in April 2018.

Ten clinical standards for seven day services in hospitals were developed in 2013. These standards define what seven day services should achieve, no matter when or where patients are admitted. Four of the ten clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. NHS Trusts are required to include a statement in their Quality Report regarding implementation of the priority clinical standards for seven day hospital services.

> Part 2.3: Reporting against core indicators

We are required to report performance against a core set of indicators using data made available to us by NHS Digital. For each indicator, the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods, is presented in the table below. In addition, where the required data is made available by NHS Digital, a comparison is made of the numbers, percentages, values, scores or rates of each of the NHS Trusts indicators with:

a) National average for the same, and;

b) Those NHS Trusts with highest and lowest for the same.

We are required to include formal narrative outlining reasons why the data is as described and any actions to improve the data.

Mortality

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	October 2015 - September 2016	Value: 1.1419, Banding : 1	Value: 1.0034	**Best:** THE WHITTINGTON HOSPITAL NHS TRUST (RKE) - Value: 0.6897, Banding: 3 **Worst:** WYE VALLEY NHS TRUST (RLQ) - Value: 1.1638, Banding: 1
	October 2016 - September 2017	Value: 1.2028, Banding : 1	Value: 1.0037	**Best:** THE WHITTINGTON HOSPITAL NHS TRUST (RKE) - Value: 0.7270, Banding: 3 **Worst:**WYE VALLEY NHS TRUST (RLQ) - Value: 1.2473, Banding: 1
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	October 2015 - September 2016	31.0%	29.7%	**Best:** THE WHITTINGTON HOSPITAL NHS TRUST (RKE) - Value: 0.4% **Worst:**GEORGE ELIOT HOSPITAL NHS TRUST (RLT) - Value: 56.3%
	October 2016 - September 2017	29.9%	31.5%	**Best:** THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST (RCX) - Value : 11.5% **Worst:** ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST (RA2) - Value: 59.8%

Assurance Statement

WWL considers that this data is as described for the following reasons:
The Summary Hospital-Level Mortality Indicator ("SHMI") includes deaths out of hospital. The Trust recognises the benchmarked position for SHMI and is undertaking a number of actions to understand this position.

WWL intends to take the following actions to improve these indicators and, so the quality of its services, by:
Mortality remains a principal risk for the Trust. The Trust has been undertaken a joint project with Wigan Borough Clinical Commissioning Group to review deaths within 30 days of discharge. Actions were agreed and monitored by the Trust's Mortality Committee. This project is being repeated. The Mortality Committee is chaired by the Medical Director and attended by external organisations including Wigan Borough Clinical Commissioning Group, Public Health and the AQUA (an NHS health and care quality improvement organisation at the forefront of transforming the safety and quality of healthcare) to support collaborative working to address SHMI in the Wigan Borough.

Patient Reported Outcome Measures Scores (PROMs)

The Trust's patient reported outcome measures scores during the reporting period for:

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
i) Groin Hernia Surgery	April 2015 - March 2016	0.080	0.088	**Best:** BMI - THE SOMERFIELD HOSPITAL (NT438) - Value: 0.157 **Worst:** NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST (RVW) - Value: 0.021
	April 2016 - March 2017 (Final)	0.060	0.086	**Best:** NEW HALL HOSPITAL (NVC09) - Value: 0.135 **Worst:** BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST (RXL) - Value: 0.006
ii) Varicose Vein Surgery	April 2015 - March 2016	N\A	0.096	**Best:** NORTHAMPTON GENERAL HOSPITAL NHS TRUST (RNS) - Value: 0.150 **Worst:** SURREY AND SUSSEX HEALTHCARE NHS TRUST (RTP) - Value: 0.018
	April 2016 - March 2017 (Final)	N\A	0.092	**Best:** TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST (RMP) - Value: 0.155 **Worst:** ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST (RBN) - Value: 0.010
iii) Hip Replacement Surgery	April 2015 - March 2016	0.444	0.438	**Best:** NORTH DOWNS HOSPITAL (NVC11) - Value: 0.512 **Worst:** WALSALL HEALTHCARE NHS TRUST (RBK) - Value: 0.320
	April 2016 - March 2017 (Provisional)	0.442	0.445	**Best:** NUFFIELD HEALTH, CAMBRIDGE HOSPITAL (NT209) - Value: 0.537 **Worst:** NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST (RAP) - Value: 0.310
iv) Knee Replacement Surgery	April 2015 - March 2016	0.315	0.320	**Best:** SHEPTON MALLET NHS TREATMENT CENTRE (NTPH1) - Value: 0.398 **Worst:** HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST(RQX) - Value: 0.198
	April 2016 - March 2017 (Provisional)	0.328	0.324	**Best:** SPIRE WASHINGTON HOSPITAL (NT333) - Value: 0.404 **Worst:** THE SPENCER WING (RAMSGATE ROAD) (NN801) - Value: 0.242

Assurance Statement

WWL considers that this data is as described for the following reasons:

Audit and data validation to ensure completeness and accuracy of information is being undertaken.

WWL intends to take the following actions to improve these indicators and, so the quality of its services, by:

Continuing to ensure quality of data by liaising with pre-op and out-patient departments and reviewing audit figures.

Hospital Readmission:

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	April 2010 - March 2011	7.73	10.31	**Best:** EPSOM AND ST HELIER UNIVERSITY NHS TRUST (RVR) - Value: 6.41 **Worst:** ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST (RL4) - Value: 14.11
	April 2011 - March 2012	7.95	10.23	**Best:** EPSOM AND ST HELIER UNIVERSITY NHS TRUST (RVR) - Value: 6.4 **Worst:** ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST (RL4) - Value: 14.94
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 or over	April 2010 - March 2011	12.71	11.55	**Best:** SHREWSBURY AND TELFORD NHS TRUST (RXW) - Value: 9.20 **Worst:** HEART OF ENGLAND NHS FOUNDATION TRUST (RR1) - Value: 14.06
	April 2011 - March 2012	12.40	11.56	**Best:** NORFOLK AND NORWICH UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (RM1) - Value: 9:34 **Worst:** EPSOM AND ST HELIER UNIVERSITY NHS TRUST (RVR) - Value: 13.80

Comments:
Large Acute Trusts Only. No New data - Future releases suspended pending review

Assurance Statement

WWL considers that this data is as described for the following reasons:
The data made available by NHS Digital is out of date. The Trust continues to monitor readmissions internally.

WWL has taken the following actions to improve this indicator and so the quality of services by:
As the Wigan Health economy has a large proportion of elderly population (especially 75+) then avoidance of readmissions has focussed on working closely with the community teams and in Care Homes to manage conditions out of the acute site. This includes the ICS (Integrated Community Services) and Social care teams focussing on the local provision of services. Other teams such as the Alcohol Service, has acute nursing teams working in A&E and picking up the frequent attenders before they are admitted to an acute bed.

Responsiveness to Personal Needs

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The Trust's responsiveness to the personal needs of its patients during the reporting period	National Inpatient Survey 2015 - 2016	69.20%	69.60%	**Best:** THE ROYAL MARSDEN NHS FOUNDATION TRUST (RPY) - Value: 86.2% **Worst:** CROYDON HEALTH SERVICES NHS TRUST (RJ6) - Value: 58.9%
	National Inpatient Survey 2016 - 2017	65.50%	68.10%	**Best:** (RPY) THE ROYAL MARSDEN NHS FOUNDATION TRUST (RPY) - Value: 85.2% **Worst:** LEWISHAM AND GREENWICH NHS TRUST (RJ2) - Value: 60.0%

Assurance Statement

WWL considers that this data is as described for the following reasons:
We performed below national average for our responsiveness to the personal needs of its patients in the 2016 National Patient Survey. We hope this has improved in the 2017 National Patient Survey due to be published in June 2018. We acknowledge that when systems are under pressure we may not be as responsiveness to personal needs as we would wish to be for our patients.

WWL has taken the following actions to improve this score to the quality of its services by:
During the previous twelve months there have been a number of improvements following a focus on continued development of the Integrated Discharge Team. The team are supported by third sector organisations, charity organisations and local programmes to support the armed forces both currently serving personnel and families and veterans. All patients continue to receive an Expected Date of Discharge on admission. There has been a further focus on Grand Rounds during the weekends to support patients by providing a seven day service. The Discharge Always Events have recently been launched and are being communicated to all areas with patients and families opinions and options forming the essential part of these Always Events.

Friends and Family Test (Staff)

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends (Acute Trusts only)	National NHS Staff Survey 2016	76.00%	70.00%	**Best:** ROYAL DEVON AND EXETER NHS FOUNDATION TRUST (RH8), WEST SUFFOLK NHS FOUNDATION TRUST (RGR) Value: 85% **Worst:** ISLE OF WIGHT NHS TRUST (acute sector) (R1F1) : Value: 49%
	National NHS Staff Survey 2017	77.00%	70.00%	**Best:** WEST SUFFOLK NHS FOUNDATION TRUST (RGR) Value - 86% **Worst:** ISE OF WIGHT NHS TRUST (acute sector) (R1F1), NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST (RJL) - Value: 47%

Assurance Statement

WWL considers that this data is as described for the following reasons:
We have performed better than the national average for staff recommending us to friends and family as a place to be treated. We have has also scored above average for staff recommending us as a place to work. The results for both measures have improved by 1% since 2016.

We continue to seek out and act upon staff feedback. A Staff Engagement Pulse Survey is distributed quarterly to a sample of staff. The responses to these are an invaluable source of information for us in highlighting any newly emerging issues and enabling timely action to support staff. The quarterly pulse surveys and associated actions are integral to shaping the organisational culture.

The results of the quarterly pulse survey from April 2017 highlighted a decline on 2016 results in enablers of staff engagement such as clarity, mind-set, personal development, influence, perceived fairness and recognition. There was similarly a decline in engagement feelings of dedication, focus and energy, and the engagement behaviour of advocacy.

Throughout the remainder of 2017, results have plateaued although there has been some improvement in relation to the enabler of clarity (Pulse Survey July 2017) and behaviour of adaptability (Pulse Survey October 2017). The improvements in clarity can be directly linked to the restructuring and realignment of resource to ensure that internal communications are more aligned to the strategy and the launch of the WWL Way 4Wards. Whilst this is positive progress, there haven't been any corresponding improvements in the enabler of mind-set but it is hoped that this will be seen in 2018.

Overall results remain moderate to positive and the majority of staff would recommend us as a place to be treated.

WWL intends to take the following actions to improve this percentage and, so the quality of its services, by:
The pulse survey identifies that most of the factors that enable staff engagement have plateaued during 2017.

We will act on this information responsively to drive further improvements in engagement levels. There will be continued investment in health and well-being initiatives (via the Steps 4 Wellness Programme) with the aim to improve staff wellbeing, morale, resilience and energy levels. Initiatives will focus on mental, physical and social wellbeing, and creating awareness of healthy choices. Other key areas of focus will be to develop and implement a new behavioural framework, the implementation and further development of the new intranet site, to continue to review the staff engagement offering and to consider new opportunities and initiatives around Leadership training and development. Work will continue to embed the WWL Way 4Wards.

Venous Thromboembolism

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	July - September 2017	84.75%	95.25%	**Best:** ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) - Value: 100% **Worst:** MID ESSEX HOSPITAL SERVICES NHS TRUST (RQ8) - Value: 71.88%
	October - December 2017	84.85%	95.36%	**Best:** ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST (R1L) - Value: 100% **Worst:** MID ESSEX HOSPITAL SERVICES NHS TRUST (RQ8) - Value: 76.08%

Assurance Statement

WWL considers that this data is as described for the following reasons:
In 2016 we moved from one electronic patient record system to another. This led to issues collecting accurate data regarding VTE assessments.

WWL has taken the following actions to improve this percentage and so the quality of its services by:
The concerns regarding accurate data have now been resolved following the development of a new monitoring app. This has provided us with very specific data regarding ward areas and specialties and the VTE assessments for patients in those areas. This enables us to target particular areas where compliance is below the target and work with staff there to improve compliance.

Clostridium difficile (C. difficile)

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	April 2015 - March 2016	7.9	14.9	**Best:** LIVERPOOL WOMENS HOSPITAL (REP), MOORFIELDS EYE HOSPITAL (RP6) & THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL (RL1): 0.00 **Worst:** THE ROYAL MARSDEN (RPY) :67.2
	April 2016 – March 2017	14.2	13.2	**Best:** LIVERPOOL WOMENS HOSPITAL (REP), MOORFIELDS EYE HOSPITAL (RP6), THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL (RL1): 0.00 **Worst:** THE ROYAL MARSDEN (RPY): 82.7

Assurance Statement

WWL considers that this data is as described for the following reasons:
We performed less well in 2016-17 compared to 2015-16 in relation to C.difficile with 22 cases and rate of 14.2 per 100,000 bed days which was higher than the national average. There were 25 cases in 2017-18 giving a rate of 16.4. The increase in numbers for 2017-18 was the result of a large number of cases occurring in July and August 2017. Factors likely to have contributed to the increase were identified but there was no evidence of direct cross infection and the number of 'lapses in care' remains low. The numbers of C.difficile cases in quarter 4 was below trajectory. Additional actions have been taken to strengthen the pathway for C.difficile and raise staff awareness.

WWL intends to take the following actions to improve this percentage and so the quality of its services by:
We intend to continue with the current actions to improve on this rate and support the quality of services by continuing to undertake individual detailed C. difficile investigations, which assist to identify any learning to prevent future C.difficile cases.

Patient Safety Incidents

Indicator	Reporting Periods	WWL Performance	National Average	Benchmarking
The number, and where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	April - September 2016	4209 Incidents Reported (Rate per 1000 Bed Days 55.3) / 21 Serious Incidents (0.50%)	673,865 Incidents Reported (Rate per 1000 Bed Days 39.9) / 2516 Serious Incidents (0.37%)	**Best:** LUTON AND DUNSTABLE NHS FOUNDATION TRUST (RC9): Incidents Reported 2305 (Rate per 1000 bed days 21.1) / 6 Serious Incidents (0.26%) **Worst:** NORTHERN DEVON HEALTHCARE NHS TRUST (RBZ): Incidents Reported 3620 (Rate per 1000 bed days 71.8) / 30 Serious Incidents (0.83%)
	October 2016 - March 2017	4280 Incidents Reported (Rate per 1000 Bed Days 51.5) / 7 Serious Incidents (0.16%)	696,643 Incidents Reported (Rate per 1000 Bed Days 40.5) / 2623 Serious Incidents (0.38%)	**Best:** MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST (RWF): Incidents Reported 3219 (Rate per 1000 bed days 23.1) / 47 Serious Incidents (1.46%) **Worst:** WYE VALLEY NHS TRUST (RLQ): Incidents Reported 3300 (Rate per 1000 bed days 75.9) / 6 Serious Incidents (0.18%)

Assurance Statement

WWL considers that this data is as described for the following reasons:
We have reported more incidents in the second reporting period above in comparison with the first reporting period. We have a much higher rate of incidents reported per 1000 bed days than the national average. We also have a lower rate of serious harm and death incidents than the national average. We aim to promote a just culture to ensure that staff feel confident to report incidents. This is reflective in the numbers of incidents reported, particularly near misses and incidents resulting in low harm.

WWL intends to take the following actions to improve this indicator further and so the quality of services:
We continue to consider ways to improve our incident reporting processes to ensure staff feel confident and able to report incidents. Our National Staff Survey 2017 results for fairness and effectiveness of incident reporting processes were in the top 20%.


pearl
and
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patch

> Part 3:

Other information

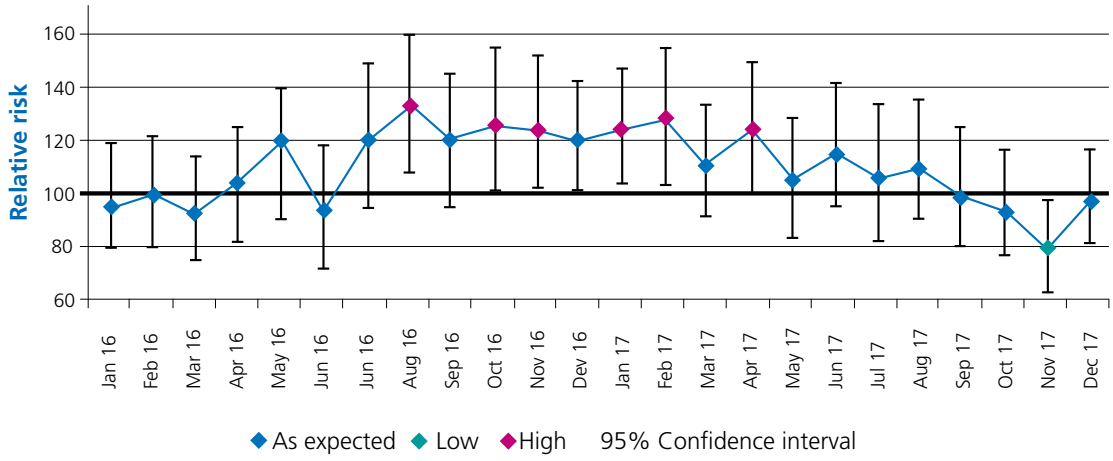
> Part 3.1: Review of Quality Performance

This section of the Quality Account provides information on our quality performance during 2017-18. Performance against the priorities identified in our previous quality account and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Risk Assessment Framework and Single Oversight Framework are outlined. We are proud of a number of initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

Performance against priorities identified for improvement in 2017-18

We agreed a number of priorities for improvement in 2017-18 published in last year's Quality Account. These were selected following the development of our Quality Strategy 2017/21 in conjunction with internal and external stakeholders.

Patient Safety (Safe)

Priority 1:	**To improve our benchmarked position for mortality [HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-Level Mortality Indicator)]**
Where we were in 2016-17	Our HSMR for 2016-17 to March 2018 was 115.9. We had the 7th highest HSMR out of the eight acute NHS Trusts in Greater Manchester. Our SHMI is 114 for a rolling 12 months from October 2015 to September 2016. The Trust has the highest SHMI in comparison with peers in Greater Manchester. Mortality will continue to be a Trust priority for 2017-18. A number of initiatives are underway which include a joint project with Wigan Borough Clinical Commissioning Group to review deaths within 30 days of discharge and benchmarking against national guidance on learning from deaths, published by the National Quality Board in March 2017.
Where we are at the end of 2017-18	HSMR: The most up to date HSMR figure for 2017-18 is 101.9 to December 2017 compared to 115.9 for the whole of 2016-17. In November and December 2017 the Trust's benchmarked position for HSMR against the eight acute NHS Trusts in Greater Manchester had improved.
HSMR **Achieved ✓**	**Diagnosis - HSMR > Mortality (in hospital) > Jan 16 to most recent > Trend (month)** **Period: Month**
SHMI **Not Achieved ✗**	

Priority 1:	Contd.
	From September 2016 - September 2017 our SHMI was 120.3 which was an improvement from the rolling twelve month period from July 2016 - July 2017. In June 2017 we established a Mortality Committee chaired by the Medical Director and attended by representatives from Public Health, Wigan Borough Clinical Commissioning Group (CCG) and AQUA (Advancing Quality Alliance). A number of work-streams have reported into this committee, for example, joint work with CCG to review deaths within 30 days of discharge, case reviews of sepsis and lung cancer, and review of AQUA's quarterly reports on mortality. Work-streams continue to be identified. We published our Mortality Review Process at the end of September 2017 and commenced the submission of quarterly mortality reports to the Board of Directors (from January 2018 presented 2017-18 Q3 data) as required by the National Learning from Deaths guidance. We are continuing to focus on reducing HSMR and SHMI during 2018-19

Priority 2:	To complete a venous thromboembolism (VTE) risk assessment for 95% of patients admitted to hospital.
Where we were in 2016-17	At the end of March 2017 compliance for VTE risk assessments being completed on admission was 89%. Our Governors selected this indicator as their Locally Determined Indicator for 2016-17 meaning that the indicator was subject to an external review of data quality.
Where we are at the end of 2017-18 **Not Achieved ✗**	In March 2018 compliance for VTE risk assessments being completed on admission to hospital was 86.94%. Year to date compliance is 84.87%. VTE risk assessment compliance is continuing as a priority in 2018-19.

Priority 3:	To reduce the numbers of falls resulting in moderate harm and serious harm.
Where we were in 2016-17	At the end of March 2017 there had been two falls resulting in serious harm and 14 falls resulting in moderate harm.
Where we are at the end of 2017-18 **Not Achieved ✗** **However, ↓ in total number of falls and multiple fallers: Achieved √**	At the end of March 2018 there had been seven serious falls and 14 falls resulting in moderate harm. We are disappointed that we have not been able to reduce harm from falls; however, the actions undertaken during 2017-18 have reduced the number of multiple fallers by 50% and the total number of falls occurring by 19%. We are continuing to focus on the reduction of harm from falls during 2018-19.

Clinical Effectiveness (Effective)

Priority 1:	**95% of patients prescribed treatment dose anticoagulation have the correct dose prescribed and have it administered appropriately.**
Where we were in 2016-17	Anticoagulation is a high risk medicine that can result in patient harm if not administered correctly. An NHS QUEST 'Clinical Community' had been established to improve anticoagulation management which we hoped would provide us with some support to more move forward. NHS QUEST is a network for Foundation Trusts who wish to focus on improving Quality and Safety.
Where we are at the end of 2017-18 **Achieved ✓**	The NHS QUEST Medicines Safety Community has unfortunately been inactive over this calendar year. There was a lack of engagement from organisations due to clinical pressures. The Clinical Lead for VTE has undertaken an audit to review the prescribing accuracy of two anticoagulants (Dalteparin and Apixaban). 100% compliance was achieved regarding correct dosing and administration for these prescriptions. We have a priority for 2018-19 specifically related to the prescribing and administration of warfarin.

Priority 2:	**To achieve 100% compliance with the identification of a deteriorating patient, appropriate frequency of observations and escalation of the deteriorating patient.**
Where we were in 2016-17	A Task and Finish Group was established during 2016-17, chaired by the Director of Nursing. Despite achieving 100% compliance for MEWS (Modified Early Warning Score) during selected months during the year, the group continued to monitor the audit results and aimed to achieve consistent achievement of compliance.
Where we are at the end of 2017-18	The final end of year audit results for compliance with the MEWS algorithm was 78%. The Task and Finish Group has focused raising awareness and achieving stated goals. The MEWS (Modified Early Warning Score) dashboard and reports have been reviewed, and sub groups have been identified. These groups are: > IT Systems: This group will collaborate with the teams responsible for our electronic patient record and business intelligence to develop ease of accessing audits, reports and what alerts can be configured and developed. > Education: This group will focus on mandating of courses, attendance and increasing access to education. > Handover: This group will standardise handover to enable clear communication and identification of MEWS and escalation.

Priority 3:	**To achieve an improvement in the results of an audit reviewing the compliance with requirements for Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)**
Where we were in 2016-17	A Task and Finish Group had been established, chaired by our Director of Nursing, to agree actions following a clinical audit of DNACPR.
Where we are at the end of 2017-18 **Partially achieved**	We commissioned an external review of DNACPR practice from Merseyside Internal Audit. The results of this were similar to the clinical audit undertaken by the Trust. Actions were implemented and a further clinical audit was undertaken. This audit demonstrated a number of improvements. We are now undertaking some targeted work to ensure that every element of the DNACPR process is completed accurately.

Patient Experience (Caring)

Priority 1:	To achieve improved benchmarked position for patients being given notice of when discharge would be.
Where we were in 2016-17	The National Patient Survey 2016 results highlighted many positive elements of patient experience. Unfortunately one question with declining results related to patients being given notice of when discharge would be.
Where we are at the end of 2017-18 **Picker patient survey results:** **Achieved ✓** **Awaiting National Patient Survey results.**	We will review the results from the National Patient Survey 2017, due for publication in June 2018, to understand whether the actions we have improved our benchmarked position. Our annual national Picker patient survey results (which provide a comparison against all Trusts utilising Picker for their surveys) showed some improvement. Implementation of the nursing discharge folders on all wards, including in Accident and Emergency, has occurred, which are discussed with patients, families and carers. The Integrated Discharge Team discuss planned and complex planned discharges with patients and families early into the patient's admission so a clear plan for the discharge date can be achieved. All third party agencies are contacted at the start of the patient journey to ensure early intervention is competed if required, this is discussed with the patient and carers. Patients and their named representative are provided with twenty four hours' notice of potential discharge. On the day of discharge both the patient and their representative are advised of discharge and this continues to be maintained at two hourly intervals.

Priority 2:	To achieve 90% of patients reporting that they were involved as much as they wanted to be in decisions about discharge from hospital.
Where we were in 2016-17	Each month the volunteers and governors undertake the real time patient experience survey. On average 160 patients take part in the survey. In 2016-17 63.8% of patients asked reported that they were involved as much as they wanted to be in decisions about discharge from hospital.
Where we are at the end of 2017-18 **Internal patient surveys:** **Not Achieved ✗** **However, an improvement in the Picker patient survey results:** **Achieved ✓**	Our annual national Picker patient survey results (which provide a comparison against all Trusts utilising Picker for their surveys) showed notable improvement by 8% to 50% for patients reporting that they were involved as much as they wanted to be in decisions about discharge from hospital. Our real time patient experience data collected monthly demonstrates that 62.21% of patients asked during 2017-18 reported that they were involved as much as they wanted to be in decisions about discharge from hospital. The multi-disciplinary team (MDT) and Integrated Discharge Team (IDT) discuss with patients, families and carers plans for discharge, ensuring preference and choice is provided if the patient is not returning to their home address. Discharge planning meetings include both the patients and their named representative to ensure all are clear of plans to ensure safe and effective discharge. Nursing staff provide patients and their representatives with the opportunity to discuss their discharge with the clinician during ward rounds to ensure there is a clear understanding of the plans. The Head of Quality is undertaking very early discussions with AQUA regarding the possibility of partnership working to consider how shared decision making and person centred care might impact on discharge and patient experience. We will continue to focus on improving communication with patients about their discharge.

Priority 3:	To develop a ward accreditation scheme.
Where we were in 2016-17	We did not have a ward accreditation programme. The aim of an accreditation programme was to provide a kite mark of high quality and performance.
Where we are at the end of 2017-18 **Achieved ✓**	The ASPIRE (Accreditation System providing improvement and recognition in the care environment) framework has been designed and piloted. The pilot has been evaluated and some changes have been made to the framework. Three wards have piloted the scheme, Ward A at Wrightington hospital, Acute Stroke Unit, RAEI and Ward 3, Leigh Infirmary. There is a programme of accreditation visits planned for 2018 - 2019. An education pack and coaching support will be provided to each area to assist with making improvements. Good practice will also be celebrated. A ward app (Caring Responsive Effective Well led Safe-CREWS) is currently being developed to support the ASPIRE.

Performance against the relevant indicators and performance thresholds set out in NHS Improvement's Single Oversight Framework

The following indicators are set out in NHS Improvement's Single Oversight Framework. The Single Oversight Framework replaced the Risk Assessment Framework in November 2016. Please note Summary Hospital-level Mortality Indicator (SHMI) and Venous Thromboembolism (VTE risk assessment) are reported in Part 2.3: Reporting against core indicators.

Key

	Performing on or above target
	Performing below trajectory; robust recovery plan required
	Failed target or significant risk of failure
↑	Improved position
↓	Worsening position
←→	Steady position

Indicator	2015-16		2016-17		2017-18	
Infection Control						
Clostridium difficile (C.difficile)	12 Threshold= 19	↑	22 Threshold= 19	↓	25 Threshold= 19	↑
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia (Threshold =0)	0	↑	3	↓	1	↓

C.difficile

Our C. difficile trajectory set by the Department of Health was 19 for 2017-18 but the Trust had 25 cases. We continue to undertake detailed individual patient reviews collaboratively with our commissioners to identify potential 'Lapses in Care' and key learning or trends. This year 6 'Lapses in Care' were identified; these related to:

> Delayed patient isolation.

> Delay in specimen collection and delayed isolation.

> Prescribing outside Antibiotic Policy and poorly labelled sample.

> Delayed use of Bristol Stool chart, prescribing outside Antibiotic Policy and delay in sample reaching the lab.

> Delayed use of Bristol Stool chart, poor documentation, delay in sampling and delay between specimen being taken to lab and result being reported.

> Antibiotic prescribing was not reviewed according to microbiology lab results.

MRSA Bacteraemia

We had 1 MRSA Bacteraemia during 2017-18 in April 2017. There have been no apparent care issues but the Trust took the opportunity to reiterate the importance of the ANTT principles in relation to Vessel Health and introduced a standard competency form for staff use.

Data Source: National Health Protection Agency data collection, as governed by standard national definitions.

Indicator	2015-16		2016-17		2017-18	
Never Events						
Number of Incidents Reported as Never Events (Threshold= 0)	0	↑	1	↓	4	↑

There were four incidents reported as Never Events at WWL during 2017-18. It is important to note (with the caveat that they remain serious incidents) that patients have not experienced serious harm directly related to these Never Events. We reported the following:

> Two wrong site surgery incidents
> One misplaced nasogastric tube incident;
> One retained foreign object incident.

We sincerely apologise to the patients involved in these Never Events. We are liaising with NHS Improvement for some support to further progress the development of LocSSIPs (local safety standards for invasive procedures) outside of Theatre. The action plans developed following the investigations are monitored by our SIRI Panel, chaired by an Executive Director. Membership of the SIRI Panel includes representatives from Wigan Borough Clinical Commissioning Group and WWL Lead Governor.

Data Source: Datix Risk Management System. 'Never Events' are governed by standard national definitions.

Indicator	2015-16		2016-17		2017-18	
Accident and Emergency (A&E)						
Maximum waiting time of four hours from arrival to admission/transfer/discharge (Threshold= 95%)	95.10%	↑	87.61%	↓	80.89%	↓

Our overall performance against the 4 hour target has declined over the last 12 months. This is in line with a declining trend both regionally and nationally. Though the overall number of attendances has not increased we did note an increase in the acuity of patients presenting in A&E who required specialist input and admission. This was further evidenced by the increase in patients presenting over the aged of 65 and patients from Nursing Homes.

In line with the national picture, we experienced extreme pressures throughout the extended winter period. The Trust has worked with system partners to formulate a system wide action plan to improve our A&E performance in 2018-19 in line with our agreed trajectory. Areas of focus in 2018-19 are improving access and availability of community services, admission avoidance and the implementation of a system wide frailty strategy.

Data Source: Management Systems Services (MSS), as governed by national standard definitions.

Indicator	2015-16		2016-17		2017-18	
Cancer Waits						
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (Threshold= 85%)	88.85% 91.3%	↓* ↓**	90.59% 93.21%	↑* ↑**	92.58% 94.28%	↑* ↑**
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service Referral (Threshold= 90%)	97.25 97.01%	↓* ↓**	100% 99.75%	↑* ↑**	98.75% 98.5%	↓* ↓**

Please note where there are two percentages for one year, one represents * after repatriation and one represents ** before repatriation. After repatriation are Greater Manchester agreed figures. Before repatriation are nationally reported figures. Greater Manchester has an integrated cancer system. A breach re-allocation policy has been agreed by all Trusts. When a breach has occurred and the pathway has involved more than one Trust, rather than sharing the breach, the whole breach can been re-allocated to one Trust if the agreed timescales for transfer or treatment have not been met.

We have continued to achieve all performance indicators for cancer care throughout 2017-18 despite a very challenging year for Cancer Services nationally. More patients are being treated within 62 days and WWL is consistently in the top ten performing trusts for this target. There has been a 9.7% increase in suspected cancer referrals from GPs; however, we have maintained performance against the 2 week wait for first appointment target. We continue to work closely with partner organisations in Greater Manchester and the Greater Manchester Cancer pathway boards. We have clinical representation from consultants and specialist cancer nurses on all the pathway boards working collaboratively with colleagues in the tertiary centres to improve patient outcomes and their experience.

Data Source: National Open Exeter System, as governed by standard national definitions.

Indicator	2015-16		2016-17		2017-18	
Referral to Treatment (RTT)						
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate-patients on an incomplete pathway (Threshold= 92%)	96.9%	↓	95.75%	↓	94.80%	↓

From October 2015 Trusts are monitored on incomplete pathways for RTT (RTT waiting times for patients whose RTT clock is running at the end of the month).

We have continued to achieve the national 18 week access targets and remains one of the highest performing Trusts in the country. We did see a slight drop in performance in 2017-18 as a result of the national directive to cancel elective activity to support unscheduled care pressures however we remained comfortably above the target of 92% which is representative of the Trust focus to provide the best possible care to our patients through low access times.

Data Source: Patient Administration System (PAS), as governed by standard national definitions.

Indicator	2015-16		2016-17		2017-18	
Diagnostic Procedures						
Maximum 6-week wait for diagnostic procedures (Threshold=99%)	99.69%	↑	99.37%	↓	99.0%	↓

The Trust has achieved the maximum 6-week wait for diagnostic procedures. Radiology continues to perform extremely well against this standard and easily achieves the 99% threshold. This is despite rising numbers of referrals and increasing complexity of examinations. The standard does not measure all Radiology examinations, but a specific selection of key examinations such as MR, CT and DEXA. For WWL that represents about 10,000 examinations per month that we are measured against (we undertake around 330,000 examinations per year).

Complaints, Patient Advice and Liaison Service and the Ombudsman

> Patient Relations and Patient Advice and Liaison Service (PALS) are dedicated to enhancing the patient, carer and relative's experience. We welcome complaints and concerns to ensure that continuous improvement to our services takes place and to improve experience through lessons learned.

The department continues to work closely with the divisions to promote a positive patient experience and to actively encourage a swift response to concerns which may be received by letter, e-mail, telephone or visitor to PALS, providing resolution in real time.

All complaints and concerns are shared at our Executive Scrutiny Committee which is held on a weekly basis. The more complex and serious complaints are reviewed and discussed in detail to ensure that a prompt decision is made regarding the progression of these complaints and, where appropriate, instigation of a concise or comprehensive investigation. These meetings also provide the opportunity to triangulate information with previous incidents, possible claims or HM Coroner Inquests.

Statistical information in respect of complaints and concerns is collected and monitored to identify trends. We continue to share statistical information from formal complaints nationally (KO41a) which is required on a quarterly basis. This includes information on the Subject of Complaint, the Services Area (in-patient; out-patient; A&E and Maternity), amongst other information for each individual site under the responsibility.

We welcome complaints to learn and reflect on how we work and to make the appropriate improvements. The following outlines actions taken and lessons learned from a sample of complaints received.

Complaints Theme and Brief Summary	Actions Taken and Lessons Learned
Communication Patient informed three members of staff before procedure they could not tolerate a particular medication; however on discharge the patient was prescribed the medication.	To ensure that clear and concise prescription requirements are documented appropriately. Process is in place for clear prescribing and checking to take place in relation to patient requests and allergies. To ensure that documentation is dealt with appropriately ensuring that any changes to patient demographic details are noted and actioned. Process in place to ensure any old labels are removed and disposed of appropriately and new labels added to avoid incorrect details being placed on patient records.
Clinical Treatment Patient insulin dependent diabetic, admitted with suspected appendicitis; following a scan patient informed by a doctor that this was not the case and a different diagnosis was advised. This was subsequently changed again.	A consultant met with the patient to apologise and to discuss the doctor's comments, actions and lessons learned. The individual involved has reflected and will use this case as a learning experience, to look at ways in the future on how this type of consultation can be improved.
Values and Behaviours Patient attended for removal of a drain and was unhappy with attitude of the staff member undertaking this procedure.	The staff member has written a reflective piece. An assessment of the technique used was observed to ensure compliance and to provide development and support.
Communication Patient was advised to fast for a local anaesthetic, and waited for 9 ½ hours to have surgery. There was no communication following the initial consultant review, and concerns were raised relating to the lack of communication from Theatres. Patient decided to leave the ward and has been since been referred to the local Podiatry Service.	A review of the Theatre list management has been undertaken; where there is change to a theatre list the printed version must be communicated to admission ward to ensure effective communication with the patients. There is currently a review to develop the scheduling and look at staggered admissions which will reduce the likelihood of this happening.
Waiting time Husband of patient unhappy at delay of operation and wife has received 3 questionnaires with questions that relate to after procedure has taken place.	Managers of the pre-operative and admissions team are to ensure they communicate clearly in regards to patient pathways changes. Staff made aware of the delay in the MDT (multidisciplinary team) discussion resulted in delays in decisions being made. Asked all staff to ensure attendance at MDT and if they are unable to attend they ask their Registrar to take the case to the MDT. Secretarial staff to keep a log of patient pathways status to ensure they are tracked and this would have been flagged.
Clinical treatment Mother of child felt doctor did not examine her son thoroughly enough and did not seem bothered (attitude). Patient taken to another Trust were she feels he got a thorough examination and diagnosis.	Investigations show that clinical care was appropriate at the time of presentation (referring to National Institute of Health and Care Excellence guidance); however, the doctor apologised for not communicating fully in respect of reassurance of the illness diagnosed at the time, and has reflected on this case for their own learning.

Improvement Plans as a result of complaints referred to the Parliamentary Health Service Ombudsman

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

The aim of the PHSO is to provide an independent, high quality complaint handling service that rights individual wrongs, drives improvement in the public service and informs public policy.

During 2017-18 the PHSO requested information regarding 5 complaints. Decisions have been received for 2 cases which have not been upheld and 3 remain under investigation. These cases relate to 2014, 2015, 2016 and 2017.

Final reports for 5 cases sent in previous years have been received; one was upheld, 2 were partially upheld and 3 were not upheld. No financial redress has been awarded in respect of these cases.

Patient Experience

We have continually achieved excellent scores for cleanliness throughout the hospitals placing us in the top 20% of Trusts in this area of assessment in the National Inpatient Survey 2017.

The Patient and Public Engagement Team continue to obtain feedback from inpatients using the Real Time Patient Experience Survey. The surveys are undertaken by our hospital volunteers and governors. The results are presented to the Board of Directors every month to monitor the corporate objective of over 90% of a positive patient experience. As a result of this monitoring there has been significant improvement in "If a family or someone close to you wanted to talk to a doctor, did they have enough opportunity to do so?" Results of the outcome of the real times surveys are located in the patient engagement section of our annual report.

Patient and Public Engagement

Patients, Carers and Governors attended two Experience Based Design events to assist with the redesign of the Rheumatology Service. Rheumatology patients spoke about their experience, drawing out the positive and the negative elements of their care with a view to bringing changes that will lead to the establishment of a gold standard patient experience. Some of the initiatives implemented in response to feedback include improvement to the information both written and verbally about certain drugs and more education around Rheumatology for GPs.

The Patient and Public Engagement Team along with the Equality and Diversity Project Lead engaged with the women for the Support for Wigan Arrivals Project to explore their experience of accessing Women's and Children's Services. The majority of the women said the services they received were excellent. Only one lady commented that she hadn't had an interpreter on her visit to the hospital. This was raised with the Quality and Safety Matron and improvements were put in place by putting on awareness raising sessions for the staff around interpreters.

The patient and public engagement campaign on "Shared Decision Making - Ask 3 Questions" continues to be successful by engaging with patients, public and staff through various touch points. The touch points include all patient information leaflets including information on Ask 3 Questions, Events and internal posters. The campaign informs and empowers patients to be involved in decisions about their care and treatment

We value the contribution of lay representatives who attend the Divisional Quality Executive Committees, Quality Champion Committee, Discharge Improvement Committee, Children's Clinical Cabinet, Infection Control Committee, Quality Champion Patient Flow Project and Patient-Led Assessments of the Care environment (PLACE) assessment, to give the patients' perspective.

We have a Patient and Public Engagement Committee. The Committee's remit is to ensure that patient and public engagement remains integral to us. The Committee is chaired by the Lead Governor with representation from Governor's key local stakeholder agencies.

We will continue with all the initiatives and activities described. Achieving a positive patient experience remains a key priority for us.

We have continually achieved excellent scores for cleanliness throughout the hospitals placing us in the top 20% of Trusts in this area of assessment in the National Inpatient Survey 2017.

Consultation with Local Groups and Partnerships

The CCG, Healthwatch Wigan and Leigh, local voluntary groups such as Think Ahead and the Local Authority work in partnership with us on the Improving Discharge Committee. Some of the improvement work implemented as part of the group is the establishment of the Integrated Discharge Team, Introduction of the Discharge Wallet and improvements to discharge letters and the launch of the Discharge Always Events. Some examples how the CCG has listened to our patient feedback and making improvements:

Service	You said	We listened
Pain management	GP education is very important (continuity, sympathy, understanding of chronic pain conditions). There were mixed experiences and feelings about primary care.	A programme of GP education has been put in place for the GPs and this will be reviewed when the programme is complete.
Rheumatology	Some patients experience difficulty getting an appointment at their own practice. It was queried whether there was enough staff in practices to make this work.	We are working with our primary care colleagues to address the issues. These comments are being addressed in the context of a wider piece of work across all providers of care in Wigan to work closer together and provide greater accessibility to patients. This means that we are now working to ensure that services provided in the community and those provided in hospitals work better together and services support each other to deliver better care to patients.
Respiratory	This report identifies a number of key findings when considering access to respiratory services. 81% of the patients responding to the survey found the patient experience of being seen by a GP before being referred to hospital excellent or good.	As part of this ongoing redesign the Healthier Wigan Partnership are recruiting members of the public living with respiratory conditions into a Lived Experience Panel.
The Patient and Public Engagement Team have worked in partnership with Wigan Borough Clinical Commissioning Group to improve outpatient pathways as a part of the Locality Plan. We engaged with patient's carers and relatives from Respiratory, Ear Nose and Throat, Ophthalmology and Cardiology Services.		

> Part 3.2: Quality Initiatives

We have introduced a number of initiatives to strengthen quality governance systems and improve the care, treatment and support provided to patients across the organisation. A summary of progress during 2017-18 is outlined below.

Staff Engagement the WWL Way

The year began with lower levels of staff engagement than seen at the beginning of 2016. The April 2017 Pulse Survey highlighted a decline in engagement measures including enablers for clarity, mind-set, personal development, influence, perceived fairness and recognition, feelings of dedication, energy levels and focus and behaviours of advocacy. Survey results for the remainder of 2017 plateaued with some improvement seen in enablers of clarity and behaviours of adaptability. Overall scores remained moderate to positive.

The staff engagement pulse survey assisted to pre-empt the outcomes of the National Staff Survey which took place from October to December 2017. The results published in March 2018 indicated some declines, particularly in relation to staff recognition and health and wellbeing at work, reducing the gap between our scores and the national average for some elements. However, in contrast to this, there was an improved or maintained score for 63% of the relevant questions and better performance against the national average on 90% of the relevant questions. WWL now ranks joint second out of 93 acute Trusts for overall staff engagement within the NHS, compared to a ranking of 10th in 2016.

Staff engagement activity continued to be delivered at full momentum in 2017 and included the following initiatives:

- The continuance of the "Steps 4 Wellness" health and wellbeing programme/campaign with a number of activities including mental health awareness, mindfulness programmes, Lose Weight Feel Great, Happy Backs and Time to Talk.
- Delivery of staff events such as the Recognising Excellence Awards and the WWL Way 4Wards Launch Event, followed up with an Interactive Experience.
- Staff engagement and organisational development work to support organisational and cultural change (e.g.implementation of the new health information system (HIS) in A&E, The development of WWL Solutions Ltd, the WWL Way 4Wards and WWL Route Planner)
- Staff engagement listening events and forums to gather staff ideas, feedback, contributions and influence
- Delivery of Cohort 6 and Cohort 7 Pioneer Teams Programme
- Review of all internal communications methods and a rebranding exercise – delivery against the strategy
- Development and implementation of a new staff intranet (Wally) and app, transforming internal communications.
- Provision of Leadership Masterclasses for senior staff
- The launch of the Apprenticeship Scheme
- Events held for careers and careers ambassadors

We continue to share our in-house developed staff engagement programme, "Go Engage", with external organisations, which includes a licence to an online "Xopa" platform that surveys staff and statistically analyses data for trends and hot spots. Managers are also able to receive training in access to "Xopa" to enable them to stay connected to staff engagement results each quarter.

We have seen a number of challenges this year in the form of organisational change (internal and external), increased patient demands and financial pressure, which have added to pressure on staff and, as a result, impacted culture. The pulse survey has enabled us to identify areas for improvement ahead of the national staff survey results, which has meant engagement plans and initiatives are continually developed and implemented. The aim is to ensure that engagement does not decline further and begins to improve, leading us from a place of "good" results to "great" results once again by the end of 2018. We will continue to build on staff engagement and wellbeing plans to ensure the delivery of positive outcomes for staff, organisational performance and ultimately the quality of care provided to patients.

Continued Recruitment and Development of the Quality Faculty

Our Quality Faculty has continued to grow during 2017-18 and there are now over 400 Quality Champions representing a wide range of disciplines and departments, working on or have completed 200 improvement projects.

All Quality Champions who complete the training programme and commence an improvement project are awarded a bronze badge. Silver and gold badges are awarded to those Champions who sustain their improvements and disseminate them to other organisations. In 2018-19 we will be adding further criteria for a gold badge to support people who have undertaken sustained improvement work but are not able to disseminate it to other organisations. In 2017, 13 silver and 6 gold awards were awarded, taking the total to 60 silver champions and 19 gold champions.

Four courses of training in quality improvement methods have been delivered during 2017/2018. In July 2017 we held an unconference to look at how the programme needed to evolve to provide for the needs of staff. These changes have been incorporated into the new Quality Improvement Strategy.

During 2017-18 the programme continues to engage with a range of disciplines including Business Intelligence, Information Technology and a wide range of clinical disciplines. Finance and understanding the cost benefits of improving quality has become an integral part of the programme. To date, cost benefits have been realised in excess of £3.4 million. These have been realised through decreased length of stay, reduced financial penalties and achievement of best practice tariff.

We held our Quality Champions Conference in September 2017 where the new silver and gold quality champions were awarded their badges. At this event quality champions were invited to present their work in a presentation or poster display. A number of individuals external to the organisation attended the event with nationally recognised key note speakers. Speakers from NWAS and the Countess of Chester NHS Foundation trust were invited to present their quality improvement journey.

During 2018-19 four further cohorts are planned in addition to supporting a further programme for junior doctors.

Leadership Quality and Safety Rounds

During 2017-18 six leadership safety rounds took place. Executive and Non-Executive members of the Board of Directors and Trust Governors visited wards and departments and held conversations with groups of staff about safety using an "appreciative inquiry" approach. Areas visited included Ince Ward, the Palliative Care Team, Community Services, Swinley Ward, Medical Records and the Estates Department. Forty four safety rounds have taken place using this approach since 2012, involving many different disciplines across four sites. During 2018-19 a further twelve visits are planned. One visit a month is planned; however, they are sometimes unable to go ahead for operational reasons, if the areas are unable to accommodate the visit.

Always Events

The Always Events are our commitment to improving the delivery of patient and family centred care. The first 10 Always Events were launched in January 2014. The Always Events are embedded within our Safe, Effective and Caring culture. Staff, patients and carers contributed to the development of the 'Always Events', identifying ten essentials of patient care that are fundamental to improving patient experience and should always happen for every patient. Their implementation has led to a positive improvement for our patients and staff. The regular weekly snap shot audits and the quarterly whole hospital site audits have continued to demonstrate stability and improvement. Discharge Always Events were introduced in 2017-18.

The HELPline

The HELPline continues to be a useful method of communication for families and loved ones to be able to contact a senior nurse when they need to discuss aspects of their loved one's care. It is intended to be a way of escalating concerns that families may feel have not been addressed adequately by ward or department staff. HELPline is a mobile phone that is carried on a rota basis between all operational divisions. The number of calls has remained fairly constant, and the majority of calls are resolved either during that point of contact or very soon afterwards.

Commissioner Quality Visits

NHS Wigan Borough Clinical Commissioning Group (CCG) has undertaken one unannounced Commissioner Quality Visit in 2017-18 to determine the experiences and views of the patients, relatives, carers and staff on services provided by Maternity Services. The Commissioner's reports following their visits are reviewed by our Quality and Safety Committee. Agreed actions are monitored by Commissioners at the joint Quality Safety and Safeguarding Committee attended by representatives from the Trust and the CCG.

The Trust welcomes the unannounced visits by the CCG and the collaborative approach taken by the CCG to improve patient and staff experience.

TalkSafe

TalkSafe
Structured Conversations to promote patient safety

TalkSafe is a programme that is focused on changing the safety culture of an organisation through structured conversations. TalkSafe has a twenty year proven history within the aviation, chemical engineering and engineering sectors.

Conversations focus on safety (safe and unsafe practice), and the potential consequences of these actions. TalkSafe uses a coaching style focused on behaviour, actions and consequences. It is designed to focus on practice prior to incidents or near misses, and focuses on organisational and system factors in addition to individual behaviours. The programme is a gateway to human factors and is focused at all levels of staff.

The Board of Directors have supported the deployment of Talksafe across the organisation. It was recognised that this would be a significant undertaking and unlikely to succeed using the current method of face to face training. Therefore the decision was taken to review the training and build a bespoke training package that will serve our needs. This training has taken the form of virtual reality with augmented face to face coaching and support from TalkSafe Champion Coaches. The films are in their final post production. The programme will be ready to launch in April 2018 with a staged deployment in conjunction with the ASPIRE programme.

> Appendix A:

National Clinical Audits and National Confidential Enquiries

The National Clinical Audits and National Confidential Enquiries that WWL has participated in during 2017-18 are as follows:

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible to partnership Y/N	Participated	Number eligible	Actual submissions
Child Health Clinical Outcome Review Programme (Chronic Neuro-disability)	Yes	Yes	5	100%
Child Health Clinical Outcome Review Programme (Young People's mental health)	Yes	Yes	4	100%
Medical and Surgical Clinical Outcome Review Programme (Acute Heart Failure)	Yes	Yes	3	67%
Medical and Surgical Clinical Outcome Review Programme (Peri-operative Diabetes)	Yes	Yes	8	Project ongoing

National Audits (NCAPOP – n = 20)	Eligible	Participated	Number eligible	Actual submissions %
Acute Coronary Syndrome (Myocardial Ischaemia National Audit Project - MINAP)	Yes	Yes	703	100%
Coronary Angioplasty/ Percutaneous Coronary Intervention (National Institute for Cardiovascular Outcomes Research - NICOR)	Yes	Yes	Data collection complete	Information not available until June 2018
Cardiac Rhythm Management (NICOR)	Yes	Yes	Data collection complete	Information not available until June 2018
National Heart Failure	Yes	Yes	330	Validated figures not yet available
Bowel Cancer	Yes	Yes	All cancer audits reported by Oncology Department services Feedback report submitted to Audit Chairs meeting showed that all relevant submissions were complete	
Head and Neck Cancer	Yes	Yes		
Lung Cancer	Yes	Yes		
National Prostate Cancer	Yes	Yes		
National Oesophago-Gastric Cancer Audit (NAOGC)	Yes	Yes		
National Diabetes Inpatient Audit (Adult) (NaDIA)	Yes	Yes	61	100%
Diabetes Pregnancy in Diabetes	Yes	No	Figures not currently available	Figures not currently available
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	147 to date	100%

National Audits (NCAPOP – n = 20)	Eligible	Participated	Number eligible	Actual submissions %
Falls and Fragility Fracture Audit Programme (FFAP) Inpatient falls	Yes	No	31	100%
National Hip Fracture Database	Yes	yes	364	100%
Inflammatory Bowel Disease (IBD)	Yes	No	Not participated due to increased workload and lack of resources.	
Learning Disability Mortality Review Programme (LeDeR Programme)	Yes	No	The Trust has reviewed its participation in this programme to meet national requirements.	
Maternal, Newborn and Infant Clinical Outcome Programme (MBRRACE)	Yes	Yes	12 (Jan to Dec)	100%
National Audit of Dementia	Yes	Yes	52	100%
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	2800	100%
National Emergency Laparotomy audit (NELA)	Yes	Yes	154	100%
National Joint Registry (NJR)	Yes	Yes	Ankles – 72 Elbow – 36 Hip – 1592 Knee – 1332 Shoulder - 215	Validated figures not available to date
National Ophthalmology Audit	Yes	Yes	1397	100%
Neonatal Intensive Care (NNAP)	Yes	Yes	310 to date	Figures not currently available
Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	No data collection during this period	
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	372	98.6%

Non-NCAPOP commissioned	Eligible	Participated	Number eligible	Actual Audit Submissions %
Female Stress Incontinence (The British Association of Urological Surgeons)	Yes	Yes	Continuous data collection	Validated data not available until June 2018 (AT)
Cystectomy (The British Association of Urological Surgeons)	Yes	Yes	Continuous data collection	Validated data not available until June 2018 (AT)
Case Mix Programme (Intensive Care National Audit and Research Centre)	Yes	Yes	527 to date	100%
Elective Surgery (National Patient Reported Outcome Measures Programme)	Yes	Yes	See section 2.3 Reporting against core indicators.	
Endocrine and Thyroid National Audit	Yes	Yes	Voluntary by individual Surgeon	

Non-NCAPOP commissioned	Eligible	Participated	Number eligible	Actual Audit Submissions %
Fractured Neck of Femur (Care in emergency departments)	Yes	Yes	52	100%
Inflammatory Bowel Disease (IBD) Registry	Yes	No	Trust not participated due to limited resource (intention to participate in next round)	
Major Trauma Audit (TARN)	Yes	Yes	Figures not currently available	Figures not currently available
National Audit of Intermediate Care	Yes	No	Did not participate	
National Cardiac Arrest Audit	Yes	Yes	88 (to Dec 17) Acute site only	100% (to Dec 17 – Q4 figures not yet available)
National Chronic Obstructive Pulmonary Disease (COPD)	Yes	Yes	931	100%
National Comparative Audit of Blood transfusion	Yes	Yes	Figures not currently available	Figures not currently available
Pain in children (Care in Emergency Department)	Yes	Yes	38	100%
Procedural Sedation in Adults (Care in Emergency Department)	Yes	Yes	33	100%
Serious Hazards of Transfusion (SHOT)	Yes	No	Did not participate due to limited resources.	
UK Parkinson's Audit	Yes	Yes	22	100%

Note: The figures above represent the information provided to the Clinical Audit Department by the relevant audit leads/ departments. Data collection for some of the audits extends beyond the date of this report therefore the figures contained within the report may not correspond with the actual validated figures published in the final audit reports.

*Trust provides services but audit currently includes selected Trusts only

> Annex A:

Statements from Healthwatch, Overview and Scrutiny Committee and Clinical Commissioning Group

> This section outlines the comments received from stakeholders on this Quality Account prior to publication.

Wigan Borough Clinical Commissioning Group

Wigan Borough Clinical Commissioning Group Response to Wrightington Wigan and Leigh NHS Foundation Trust Quality Account 2017-18

Wigan Borough Clinical Commissioning Group (the CCG) welcomes the opportunity to comment on the tenth Quality Account for Wrightinton, Wigan and Leigh NHS Foundation Trust.

The CCG has worked closely with the Trust throughout 2017-18 in what has been a challenging year for the Trust and the wider NHS to gain assurances that services are safe, effective and caring.

The CCG is pleased to note the Care Quality Commission (CQC) Inspection Report, published on 9th March 2018 rated the Trust as 'Good' overall and that all the Trust's hospital sites are now rated as 'Good' or 'Outstanding'. Maternity Services received a rating of 'Requires Improvement and the CCG has supported improvement work in this area by undertaking a Commissioner Quality Visit to the service in January 2018.

In respect of the 2017-18 quality priorities, the CCG notes that a number of objectives were not achieved. However, progress was made in some of areas including a reduction in the overall number of inpatient falls and the development of a ward accreditation scheme. Other positives in year include the delivery of a comprehensive clinical audit and research programme and continued recruitment and development of the Quality Faculty.

The publication of the Trust's Quality Strategy 2017-21 in April 2017 is welcomed. The strategy identifies the quality priorities for the next four years.

Challenges in year have included A&E performance, staffing levels, Clostridium difficile rates, venous thromboembolism risk assessments, sepsis management, issues related to implementation of the Hospital Information System (HIS), a persistently high Summary Hospital Level Mortality Indicator (SHMI) and an increase the number of Never Events. The CCG has and continues to work with the Trust to make improvements in these areas.

The CCG supports the quality priorities identified for 2018-19 and welcomes the continued focus on reducing mortality rates and increasing the number of patients who receive a venous thromboembolism risk assessment. New priorities aimed at improving the management of patients with sepsis, identifying deteriorating patients and improving the care patients with a fractured neck of femur are also welcomed.

The CCG looks forward to working in partnership with the Trust and other stakeholders during 2018-19 to ensure the continuous focus upon improvement in order to provide the best possible care for our patients.

DR TIM DALTON
> Chairman,
Wigan Borough Clinical Commissioning Group

10 May 2018

> Healthwatch Wigan and Leigh:

The Trust received the following statement from Healthwatch Wigan and Leigh on the 16th May 2018:

All local Healthwatch within Greater Manchester are currently undergoing a full review to develop a standardised framework for involvement in the Quality Account process. Therefore we are unable to provide comment at this point.

> Health and Social Care Scrutiny Committee:

Comments were sought from Overview and Scrutiny Committee; however, none were received, most likely due to local elections.

> Annex B:

Statement of directors' responsibilities in respect of the Quality Report

> The directors of Wrightington, Wigan and Leigh NHS Foundation Trust ("WWL") are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that the NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

> The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017-18 and supporting guidance;

> The content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2017 to May 2018
- Papers relating to Quality reported to the Board over the period April 2017 to May 2018
- Feedback from commissioners dated 10th May 2018
- Feedback from governors dated March 2018
- Feedback from local HealthWatch dated 16th May 2018
- Feedback from Overview and Scrutiny Committee (not received)
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2016-17
- The 2017 national patient survey (not due for publication until June 2018 therefore the Trust has been unable to reference in this report)
- The 2017 national staff survey 6th March 2018
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 2017-18
- CQC inspection report dated 9th March 2018

> The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

> The performance information reported in the Quality Account is reliable and accurate;

> There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice;

> The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and;

> The Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

ROBERT ARMSTRONG
> Chairman

22 May 2018

ANDREW FOSTER CBE
> Chief Executive

22 May 2018

> Annex C:

How to provide feedback on the account

> Feedback on the content of this report and suggestions for the content of future reports can be provided by calling the Foundation Trust Freephone Number **0800 073 1477** or by emailing: **members@wwl.nhs.uk**

> Annex D:

Independent auditor's report to the Council of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust on the quality report

> We have been engaged by the Council of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust to perform an independent assurance engagement in respect of Wrightington, Wigan and Leigh NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of Wrightington, Wigan and Leigh NHS Foundation Trust as a body, in reporting Wrightington, Wigan and Leigh NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Wrightington, Wigan and Leigh NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Accident and Emergency 4 hour wait times
- 18 week Referral to Treatment times

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the NHS foundation trust annual reporting manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the NHS foundation trust annual reporting manual and supporting guidance
- the quality report is not consistent in all material respects with the sources specified below and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the NHS foundation trust annual reporting manual and supporting guidance and the six dimensions of data quality set out in the detailed requirements for external assurance on quality reports.

We read the quality report and consider whether it addresses the content requirements of the NHS foundation trust annual reporting manual and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period April 2017 to 22 May 2018;
- papers relating to quality reported to the board over the period April 2017 to 22 May 2018;
- feedback from commissioners, dated 16 May 2018;
- feedback from governors, dated 16 May 2018;
- the trust's quarterly complaints reports published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for Q1, Q2, Q3 and Q4 of 2017-18;
- the latest national patient survey, dated 31 May 2018;
- the latest national staff survey, dated 6 March 2018;
- the report arising from the Care Quality Commission inspection on 6-8 and 28-30 November 2017, published 9 March 2018; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated April 2018

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) Assurance Engagements other than Audits or Reviews of Historical Financial Information, issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- testing key management controls
- limited testing, on a selective basis, of the data used to calculate the indicator against supporting documentation
- comparing the content requirements of the NHS foundation trust annual reporting manual to the categories reported in the quality report
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS foundation trust annual reporting manual and supporting guidance.

The scope of our assurance work has not included testing of indicators other than the selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the quality report is not prepared in all material respects in line with the criteria set out in the NHS foundation trust annual reporting manual and supporting guidance
- the quality report is not consistent in all material respects with the sources specified above and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS foundation trust annual reporting manual and supporting guidance.

Deloitte LLP

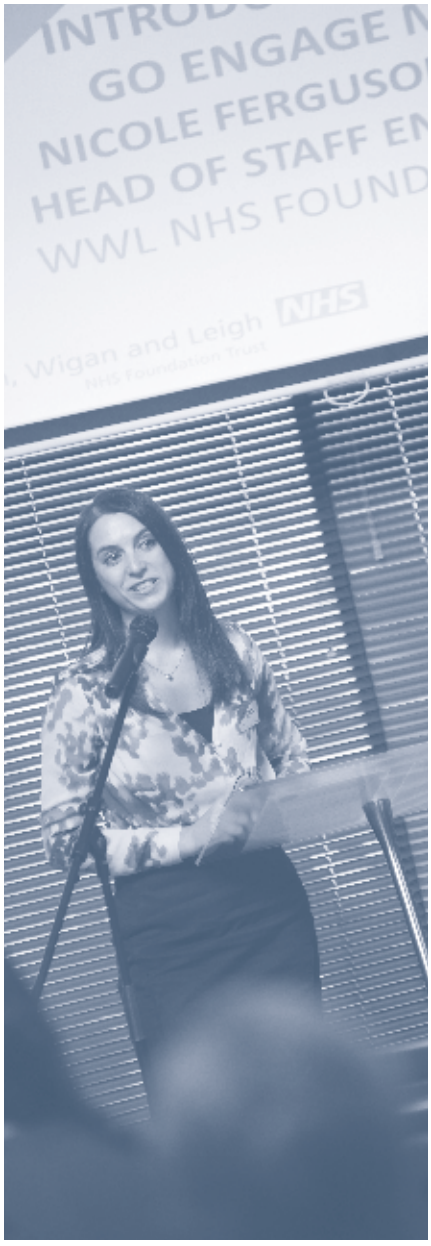
DELOITTE LLP
> Leeds

24 May 2018

INDEPENDENT AUDITOR REPORT

Independent auditor's report to the Board of Governors and Board of Directors of Wrightington, Wigan and Leigh NHS Foundation Trust

> Report on the audit of the financial statements



Opinion

In our opinion the financial statements of Wrightington, Wigan and Leigh NHS Foundation Trust (the 'foundation trust'):

- give a true and fair view of the state of the foundation trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the Statement of Comprehensive Income;
- the Statement of Financial Position;
- the Statement of Cash Flows;
- the Statement of Changes in Equity; and
- the related notes 1 to 27.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Summary of our audit approach

Key audit matters	The key audit matter that we identified in the current year was revenue recognition in respect of Sustainability and Transformation Fund (STF) income.
Materiality	The materiality that we used for the current year was £6,200,800 which was determined on the basis of 2% of operating income in the year.
Scoping	All testing of the Trust was performed by the main audit engagement team performed at the Trust's administrative offices in Wigan, led by the audit partner.
Significant changes in our approach	In the current year, we removed recognition of Payment by Results income from the revenue recognition key audit matter as the Foundation Trust now has a block contract with its largest customer, Wigan CCG. We have also removed accounting for property valuations as a key audit matter, because a full revaluation was not performed in the current year. There have been no other significant changes to our approach.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where:

- the accounting officer's use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the accounting officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of these matters.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Revenue recognition in respect of Sustainability and Transformation Fund (STF) income

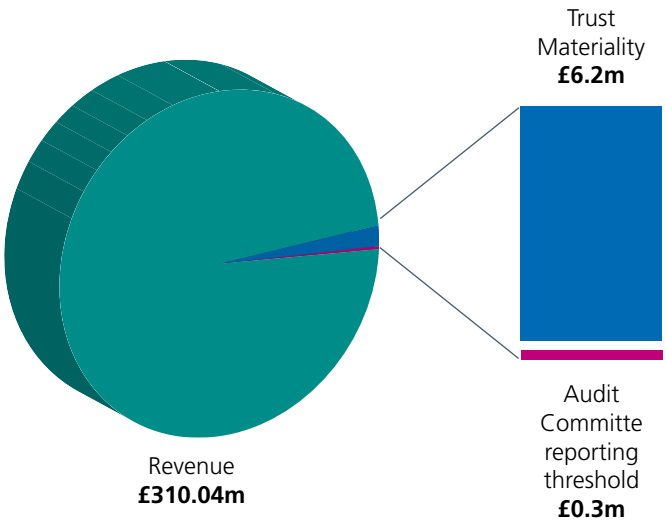
Key audit matter description	The risk of fraud in revenue recognition is a presumed risk under ISAs (UK). We have identified recognition of STF revenue as a key risk due to it being contingent upon the delivery of operational and financial targets. The A&E targets within the STF funding criteria have been flagged as a key area of concern for the Foundation Trust. Part of the STF revenue recognised in year is a material balance within accrued income at year end. STF funding is separately disclosed within the financial statement in note 13, with £12.772m recognised in the current year (of which £7.166m was accrued income at year end) and £13.493m recognised in the prior year..
How the scope of our audit responded to the key audit matter	We have documented and walked through the key control processes governing the recognition of STF income throughout the year, and the tools used to identify whether criteria has been met each quarter. We have assessed the level of STF income accrued at the year-end on the basis of year end performance and considered whether the Foundation Trust has achieved the STF criteria at the year end and, therefore, whether the final quarter of STF should be recognised where the final quarter sum is material. In addition, we have also considered the results of our quality accounts work on the key operational indicators relevant to the STF and agreed the balance of STF monies earned to correspondence with NHS Improvement.
Key observations	We consider the STF income recognised to be appropriate based on the foundation trust's performance against the STF funding criteria. We also consider the accrued income in relation to STF income in the foundation trust's Statement of Financial Position at 31 March 2018 to be appropriate.

Our application of materiality

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

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Materiality	£6,200,800 (2017: £5,950,000)
Basis for determining materiality	2% (2017: 2%) of operating income
Rationale for the benchmark applied	Operating income was chosen as a benchmark as the Foundation trust is a non-profit organisation, and operating income is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £300k (2017: £250k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the Foundation Trust and its environment, including internal control, and assessing the risks of material misstatement.

The Foundation Trust's charitable fund subsidiary (Three Wishes) is not material and therefore is not consolidated into the Foundation Trust accounts.

All testing of the Foundation Trust was performed by the main audit engagement team performed at the Foundation Trust's administrative offices in Wigan, led by the audit partner.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in respect of these matters.

Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing as applicable, matters

related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: **www.frc.org.uk/auditorsresponsibilities.** This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements

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

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Wrightington, Wigan and Leigh NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

PAUL THOMSON ACA
> Senior statutory auditor
For and on behalf of Deloitte LLP
Statutory Auditor, Leeds, United Kingdom

24 May 2018

FINANCIAL REPORT

Foreword to the accounts

> Wrightington, Wigan and Leigh NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Wrightington, Wigan and Leigh NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

ANDREW FOSTER CBE
> Chief Executive

22 May 2018

Statement of comprehensive income

	Note	2017-18 £000	2016-17 £000
Operating income from patient care activities	2	276,222	259,520
Other operating income	3	33,818	37,973
Total operating income from continuing operations		**310,040**	**297,493**
Operating expenses	4	(304,544)	(295,914)
Operating surplus from continuing operations		**5,496**	**1,579**
Finance costs			
Finance income	7	54	39
Finance expenses	8	(424)	(476)
PDC dividends payable		(3,461)	(3,792)
Net finance costs		**(3,831)**	**(4,229)**
Gains on disposal of assets	9	19	750
Surplus/(Deficit) for the year*		**1,684**	**(1,900)**
Other comprehensive income			
Will not be reclassified to income and expenditure			
Impairments		(5,061)	(13,051)
Revaluations		124	3,935
Total comprehensive (expense) for the year		**(3,253)**	**(11,016)**

*The Trust's trading position excludes net impairments of £6,949k (£15,467k, 2016-17) which are technical in nature and are excluded by the regulator in determining the organisational trading position. A reconciliation of these amounts can be found in Note 27.

Statement of financial position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	10	2,429	2,413
Property, plant and equipment	11	140,409	148,658
Trade and other receivables	16	223	169
Total non-current assets		**143,061**	**151,240**
Current assets			
Inventories	15	4,199	4,121
Trade and other receivables	16	28,388	25,230
Non-current assets for sale		0	0
Cash and cash equivalents	17	12,598	11,669
Total current assets		**45,185**	**41,020**
Current liabilities			
Trade and other payables	18	(32,202)	(28,711)
Other liabilities	19	(501)	(1,535)
Borrowings	20	(4,484)	(4,420)
Provisions	21	(295)	(329)
Total current liabilities		**(37,482)**	**(34,995)**
Total assets less current liabilities		**150,764**	**157,265**
Non-current liabilities			
Other liabilities	19	(584)	(300)
Borrowings	20	(21,932)	(25,819)
Provisions	21	(2,196)	(3,154)
Total non-current liabilities		**(24,712)**	**(29,273)**
Total assets employed		**126,052**	**127,992**
Financed by			
Public dividend capital		97,119	95,806
Revaluation reserve		17,107	22,823
Income and expenditure reserve		11,826	9,363
Total taxpayers' equity		**126,052**	**127,992**

The primary financial statements on pages 134 to 138 and the notes on pages 139 to 173 were approved by the Board of Directors and authorised for issue on 22 May 2018 and signed on its behalf by Andrew Foster, Chief Executive.

ANDREW FOSTER CBE
> Chief Executive
22 May 2018

Statement of changes in equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017	**95,806**	**22,823**	**9,363**	**127,992**
Surplus for the year	0	0	1,684	1,684
Other transfers between reserves	0	(779)	779	0
Impairments	0	(5,061)	0	(5,061)
Revaluations	0	124	0	124
Public dividend capital received	1,313	0	0	1,313
Taxpayers' equity at 31 March 2018	**97,119**	**17,107**	**11,826**	**126,052**

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016	**95,806**	**32,410**	**10,792**	**139,008**
(Deficit) for the year	0	0	(1,900)	(1,900)
Other transfers between reserves	0	(64)	64	0
Impairments	0	(407)	407	0
Revaluations	0	(13,051)	0	(13,051)
Public dividend capital received	0	3,935	0	3,935
Taxpayers' equity at 31 March 2017	**95,806**	**22,823**	**9,363**	**127,992**

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

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

Statement of cash flows

Cash flows from operating activities	Note	2017-18 £000	2016-17 £000
Operating surplus		5,496	1,579
Non-cash income and expense			
Depreciation and amortisation	4	5,955	6,479
Impairments and reversals of impairments	4	6,949	15,467
Income recognised in respect of capital donations (cash and non cash)	3	(468)	(63)
(Increase) in receivables and other assets		(3,417)	(12,556)
(Increase) in inventories		(78)	(234)
Increase in payables and other liabilities		2,483	339
(Decrease) in provisions		(994)	(386)
Net cash generated from operating activities		**15,926**	**10,625**
Cash flows used in investing activities			
Interest received		49	42
Purchase of intangible assets		(684)	(103)
Purchase of property, plant, equipment and investment property		(8,195)	(7,443)
Sales of property, plant, equipment and investment property		24	3,784
Net cash used in financing activities		**(8,806)**	**(3,720)**
Cash flows used in financing activities			
Public dividend capital received		1,313	0
Loans received		599	1,287
Loans paid		(4,422)	(2,240)
Other interest paid		(430)	(461)
PDC dividend paid		(3,251)	(4,090)
Net cash used in financing activities		**(6,191)**	**(5,504)**
Increase in cash and cash equivalents		**929**	**1,401**
Cash and cash equivalents at 1 April 2017		**11,669**	**10,268**
Cash and cash equivalents at 31 March 2018	**17**	**12,598**	**11,669**

Notes to the accounts

> Note 1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2017-18 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

> Note 1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and intangible assets.

The financial statements and associated notes have been prepared in accordance with International Financial Reporting Standards (IFRS) and International Financial Reporting Interpretation Committee (IFRIC) interpretations as endorsed by the European Union, and those parts of the Companies Act 2006 applicable to companies reporting under IFRS.

The financial statements are presented in Pounds Sterling, rounded to the nearest thousand.

> Note 1.2 Going concern

After making enquiries, the Trust's directors have a reasonable expectation that the Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing these financial statements.

> Note 1.3 Joint operations accounting

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

> Note 1.4 Accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amount of assets and liabilities that are not readily apparent from other sources.

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

The following are the areas of critical judgements that management have made in the process of applying the entity's accounting policies.

Segmental reporting

In line with IFRS 8 Operating Segments, the Board of Directors, as Chief Decision Maker, has assessed that the Trust continues to report its Annual Accounts on the basis that it operates in the healthcare segment only. The accompanying financial statements have consequently been prepared under one single operating segment.

Consolidation of Charity

Wrightington, Wigan and Leigh NHS Foundation Trust is the corporate trustee to Wrightington, Wigan and Leigh Health Services Charity (also known as Three Wishes). The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary.

The Trust has reviewed the value of Charity fund balances at 31 March 2018 and does not consider these to be of a significant value to require consolidation into the Trust accounts.

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

Asset valuation and lives

The value and remaining useful lives of land and building assets are estimated by Cushman and Wakefield (formerly DTZ Debenham Tie Leung Ltd). Valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

During the year the Trust has revalued its estate using the modern equivalent asset - alternative site methodology on the grounds that this is deemed to be a more suitable valuation methodology.

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

An item of property, plant and equipment which is surplus and is not being used to deliver services with no plan to bring it back into use is valued at fair value under IFRS 13 Fair Value Measurement, if it does not meet the requirements of IAS 40 Investment Property or IFRS 5 Non-current assets held for sale.

Software licences are depreciated over the shorter of the term of the licence and the useful economic life.

The total value of intangible and tangible fixed assets as at 31 March 2018 is £142.8m.

Interests in other entities and joint arrangements

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

The Trust has assessed its existing contracts and collaborative arrangements for 2017-18, and has determined that the only arrangements which would fall within the scope of IFRS 10, IFRS 11 Joint Arrangements or IFRS 12 Disclosure of Interests in Other Entities, are the Trust's subsidiary charity and three joint operations (Note 14).

Estimation uncertainty

The following are sources of estimation uncertainty that are not currently judged to cause a significant risk of material adjustment to the carrying amount of assets and liabilities within the next financial year.

- provisions such as those for employer and public liability legal claims;
- provision for impaired receivables, including 22.84% of accrued Injury Cost Recovery (ICR) income to reflect the average value of claims withdrawn as advised to the Department of Health by the Compensation Recovery Unit;
- employee benefits in respect of annual leave entitlement not taken at the end of the year, for which an accrual is calculated on a sample of Trust employees; and
- partially completed spells.

> Note1.5 Consolidation

Wrightington, Wigan and Leigh NHS Foundation Trust is the corporate trustee to Wrightington, Wigan and Leigh Health Services Charity (also known as Three Wishes). The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

Where the fund balances held by the Charity are deemed to be of a significant value to require consolidation, then those balances will be consolidated into the Trust Accounts.

There is no consolidation for 2017-18.

> Note 1.6 Income

The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Income in respect of services provided is recognised when and to the extent that performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale of contract.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation

has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

The Trust recognises income for incomplete patient spells. Patients admitted before 31 March but not discharged before midnight 31 March are accounted for on the basis of average length of stay for the admitting speciality minus the patient's length of stay at midnight 31 March.

Revenue grants and other contributions to expenditure

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

The value of the benefit received when accessing funds from the Government's Apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

> Note 1.7 Expenditure on goods and services

Expenditure on goods and services is recognised when and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of assets such as property, plant and equipment or stock.

> Note 1.8 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for

Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is currently being prepared and will be valued as at 31 March 2016. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

National Employment Savings Trust (NEST)

NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. NEST Corporation is the Trustee body that has overall responsibility for running NEST. It is a non-departmental public body (NDPB) operating at arm's length from government, and it reports to Parliament through the Secretary of State for Work and Pensions.

This alternative scheme is a defined contribution scheme, provided under the Trust's 'automatic enrolment' duties for a small number of employees who are excluded from actively contributing to the NHS pension scheme. Under a defined contribution plan, an entity pays fixed contributions to a separate entity (a fund) and has no obligation to pay further contributions if the fund does not hold sufficient assets to pay employee benefits.

The Trust is legally required to make a minimum contribution for opted-in employees who earn more than the qualifying earnings threshold, and the cost to the Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. That is, employer's pension costs of contributions are charged to operating expenditure as and when they become due.

> Note 1.9 Current / non-current classification

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

> Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated historical cost and the value in use where the asset is income generating.

Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets re-classified as Held for Sale are measured at the lower of their carrying amount or fair value less costs to sell.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS13 Fair Value Measurement, if it does not meet the requirements of IAS40 Investment Property or IFRS5 Non-current assets held for sale.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;

- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

A review of expected useful economic lives was undertaken during the year which resulted in changes to the useful economic lives. The revised and previous lives are detailed below:

	Current	Prior year
Development expenditure	8 years	5 years
Software	8 years	5 years

> Note 1.11 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

Property, plant and equipment assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit and are individually valued at less than £5,000 but more than £250.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Thereafter revaluations of property and land are carried out as mandated by a qualified valuer who is a member of the Royal Institute of Chartered Surveyors and in accordance with the appropriate sections of the Practice Statement ("PS") and United Kingdom Practice Statements contained within the RICS Valuation Standards. The valuations are carried out as follows.

- Interim every 3 years
- Full valuation every 5 years

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Current values in existing use are determined as follows:

- Land and non-specialised buildings - market value for existing use
- Specialised buildings - depreciated replacement cost, modern equivalent asset alternative site basis, net of VAT.

The carrying value of other existing assets will be written off over their remaining useful lives, and are carried at depreciated historic cost as this is not considered to be materially different from fair value.

The accounting entries for revaluation gains and losses are detailed below.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS13 Fair Value Measurement, if it does not meet the requirements of IAS40 Investment Property or IFRS5 Non-current assets held for sale.

During the course of the year, the Trust has set up a wholly owned subsidiary company, WWL Solutions Limited. From 2018-19, this company will provide fully managed and operated healthcare facilities to the Trust. During the year the Trust has re-valued its land and buildings using the modern equivalent asset alternative site basis, net of VAT with a valuation date of 1st April 2017. This method of valuation has been used on the basis that any re-provision of its estate would be undertaken by WWL Solutions Limited.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. The estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated at the point it becomes classified as Held for Sale. Assets in the course of construction are not depreciated until the assets are brought into use. Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by a qualified valuer recognised in accordance with RICS.

Property, plant and equipment is depreciated over the following useful lives:

- Buildings excluding dwellings 6 to 90 years
- Dwellings 26 to 54 years

A review of expected useful economic lives was undertaken during the year which resulted in changes to the useful economic lives. The revised and previous lives are detailed below:

	Current	Prior year
Engineering plant and equipment	10 to 20 yrs	5 to 15 yrs
Vehicles	10 to 13 yrs	5 yrs
Furniture	15 yrs	10 yrs
Office and IT equipment	8 yrs	5 yrs
Medical and other equipment	15 yrs	5 to 15 yrs
Mainframe - type IT installations	8 yrs	5 yrs
Software - internally developed	8 to 10 yrs	5 to 10 yrs

Revaluation gains and losses

At each reporting period end, the Trust checks whether there is any indication that any of its property plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenditure, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenditure.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:

- the impairment charged to operating expenses; and
- the balance in the revaluation reserve attributable to that asset before impairment.

An impairment arising from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that give rise to the loss are reversed. Reversals are recognised in operating expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Assets under construction

Assets under construction are measured at cost of construction as at the 31 March. Assets are reclassified to the appropriate category when they are brought into use.

De-recognition

Assets intended for disposal are reclassified as Held for Sale once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales.
- The sale must be highly probable, i.e.:

  i. management are committed to a plan to sell the asset;

  ii. an active programme has begun to find a buyer and complete the sale;

  iii. the asset is being actively marketed at a reasonable price;

  iv. the sale is expected to be completed within 12 months of the date of classification as Held for Sale; and

  v. the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as Held for Sale and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

> Note 1.12 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

> Note 1.13 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method and the weighted average cost method.

> Note 1.14 Trade receivables

Trade receivables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method, which usually equates to invoice total, less provision for impairment. A provision for impairment of trade receivables is estimated when there is objective evidence that the Foundation Trust will not be able to collect amounts due.

> Note 1.15 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

> Note 1.16 Trade payables

Trade payables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method which usually equates to invoice value.

> Note 1.17 Financial instruments

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent that, performance occurs i.e. when receipt or delivery of the goods or services is made.

De-recognition

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

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

Classification and measurement

The only category of financial assets held by the Trust is 'loans and receivables'.

The only category of financial liabilities held by the Trust is 'other financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise cash and cash equivalents, and part of NHS receivables, accrued income and other receivables.

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

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health and Social Care are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. For short term payables, amortised cost equates to invoice value. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs.

The Trust's Independent Trust Financing Facility loans are included in other financial liabilities, but are not measured at amortised cost. They are measured at historic cost, as directed by HM Treasury FReM.

Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the provision for impaired receivables.

Impairments of receivables

At each period end the Trust individually reviews receivables for recoverability. Following this review impairment is made for those receivables where there is reasonable uncertainty of obtaining settlement.

> Note 1.18 Leases

Finance leases

The Trust does not have any finance leases.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

In applying IFRIC 4 - Determining whether an arrangement contains a lease, collectively significant rental arrangements that do not have the legal status of a lease but convey the right to use an asset for payment are accounted for under the Trust's lease policy, where fulfilment of the arrangement is dependent on the use of specific assets.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

> Note 1.19 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount, for which it is probable that there will be a future outflow of cash or other resources, and a reliable estimate can be made of the amount. The amount recognised as a provision is the best estimate of the resources required to settle the obligation.

For post- employment benefits including early retirement

provisions and injury benefit provisions the HM Treasury's pension discount rate of 0.10% in real terms (0.24% 2016-17) is used.

All other provisions are subject to three separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

Short term rate: -2.42% (2016-17: -2.70%)

Medium term rate: -1.85% (2016-17: -1.95%)

Long term rate: -1.56% (2016-17: -0.80%)

> Note 1.20 Clinical negligence costs

NHS Resolution formerly NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in Note 21.1 but is not recognised in the Trust's accounts.

> Note 1.21 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution 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 as and when they become due.

> Note 1.22 Contingent assets and contingent liabilities

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in Note 22 where an inflow of economic benefits is probable.

A contingent liability is:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Contingent liabilities are not recognised, but are disclosed in Note 22, unless the probability of a transfer of economic benefits is remote.

Where the time value of money is material, contingent assets and contingent liabilities are disclosed at their present value.

> Note 1.23 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance, which represents the Department of Health's investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time the, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

- donated assets (including lottery funded assets)
- average daily cash balances held with the Government Banking Service (GBS) and National Loan Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility
- and any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment occur as a result of the audit of the annual accounts. The PDC dividend calculation is based on the Trust's group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.

> Note 1.24 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

> Note 1.25 Corporation tax

As an NHS foundation trust, Wrightington, Wigan and Leigh NHS Foundation Trust is specifically exempted from corporation tax through the Corporation Tax Act 2010. The Act provides that HM Treasury may dis-apply this exemption only through an order via a statutory instrument (secondary legislation). Such an order could only apply to activities which are deemed commercial, and arguably much of the Trust's other operating income is ancillary to the provision of healthcare, rather than being commercial in nature. No such order has been approved by a resolution of the House of Commons. There is therefore no corporation tax liability in respect of the current financial year.

> Note 1.26 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. They are disclosed in a separate note to the accounts (Note 17.1).

> Note 1.27 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

> Note 1.28 Accounting standards and amendments issued but not yet adopted in the DH GAM

The effective date of the following standards are disclosed after the standards' names; these amendments or new standards are not yet adopted by the European Union (EU) or within the FReM, and are therefore not applicable to 2017-18 accounts.

IFRS 9 Financial Instruments: [new standard] (2018-19) -This new standard will replace IAS39 and is likely to have a non-material impact on the Trust's accounts. It will replace IAS 39 Financial Instruments: Recognition and Measurement, which currently sets out the requirements for the recognition and measurement of financial instruments.

IFRS 14 Regulatory Deferral Accounts: [new standard] (2016-17) - this new standard is not applicable to Department of Health and Social Care group bodies. Not yet EU endorsed*.

IFRS 15 Revenue from contracts with customers: [new standard] (2017-18) - this new standard requires entities to recognise revenue from contracts with customers when they satisfy a performance obligation by transferring a promised good or service. Performance obligations can be satisfied over time or at a point in time. This standard is unlikely to have a material impact on how the Trust recognises income, but will have an impact on disclosures.

IFRS 16 Leases: [new standard] (2019/20) - this new standard will impact on how the Trust accounts for and discloses information in relation to its lease arrangements.

IFRS 17 Insurance contracts: [new standard] (2021/22) - this new standard replaces IFRS4 and is not applicable to Department of Health Group Bodies.

IFRIC 22 Foreign Currency Transactions and Advance Consideration: This interpretation addresses the exchange rate to use in transactions that involve advance consideration paid or received in a foreign currency. This interpretation is unlikely to impact on the Trust accounts.

IFRIC 23 Uncertainty over Income Tax Treatments: The interpretation specifies how an entity should reflect the effects of uncertainties in accounting for income taxes and is unlikely to impact on the Trust accounts.

IFRS - International Financial Reporting Standards

IFRIC - International Financial Reporting Interpretation Committee

*The European Financial Reporting Advisory Group recommended in October 2015 that the standard should not be endorsed as it is unlikely to be adopted by many EU countries.

> Note 2 Operating income from patient care activities

> Note 2.1 Income from patient care activities (by nature)

Acute services	2017-18 £000	2016-17 £000
Elective income	63,772	64,063
Non elective income	61,073	54,807
First outpatient income	20,051	28,307
Follow up outpatient income	22,129	20,016
A & E income	11,435	9,792
High cost drugs income from commissioners (excluding pass through costs)	11,103	12,414
Other NHS clinical income*	79,660	61,796
Community Services	3,219	4,126
Additional income		
Private patient income	2,760	2,373
Other clinical income**	1,020	1,826
Total income from activities	**276,222**	**259,520**

*Other NHS clinical income includes income in respect of maternity outpatients, diagnostic imaging, breast screening, audiology, chemotherapy, palliative care and community services.

**Other clinical income relates largely to income from the Compensation Recovery Unit (CRU) for third party injury claims.

> Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017-18 £000	2016-17 £000
NHS England	22,834	17,987
Clinical Commissioning Groups	238,281	231,121
Local Authorities	2,260	67
NHS Foundation Trusts***	7,719	6,146
NHS Trusts	2	0
NHS other	279	0
Non NHS: private patients	2,760	2,373
Non NHS: overseas patients (chargeable to patient)	42	84
NHS injury scheme (CRU)****	1,169	1,255
Non NHS: other	876	487
Total income from activities	**276,222**	**259,520**

***Income (£4.3m) previously recorded under Non-patient care services to other bodies has been re-classified during the period to income from NHS Foundation Trusts. Prior year comparatives have been restated.

****NHS injury scheme income is subject to a provision for doubtful debts of 22.84% (22.94%, 2016-17) to reflect expected rates of collection.

> Note 2.3 Overseas visitors

	2017-18 £000	2016-17 £000
Income recognised this year	42	84
Cash payments received in-year	20	17
Amounts added to provision for impairment of receivables	19	6
Amounts written off in-year	7	27

> Note 3 Other operating income

	2017-18 £000	2016-17 £000
Research and development	1,053	1,096
Education and training	8,611	8,030
Receipt of capital grants and donations	468	63
Charitable and other contributions to expenditure	141	80
Non-patient care services to other bodies*	1,547	2,297
Rental revenue from operating leases	150	153
Sustainability and transformation fund income**	12,772	13,493
Income in respect of staff costs where accounted on gross basis	5,131	3,104
Other income***	3,945	9,657
Total other operating income	**33,818**	**37,973**

*Income (£4.3m) previously recorded under Non-patient care services to other bodies has been re-classified during the period to income from NHS Foundation Trusts. Prior year comparatives and Note 3.1 have been restated.

**Sustainability and transformation fund income relates to the Trust's share from the national Sustainability and Transformation Fund which was created in 2016-17 to support a balanced aggregate financial position for NHS providers.

***Other income of £3.9m (£9.7m, 2016-17) includes car parking income, catering income, pharmacy income, staff accommodation rental and other miscellaneous income recharged to other NHS bodies.

> Note 3.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017-18 £000	2016-17 £000
Income from services designated as commissioner requested services	253,062	244,487
Income from services not designated as commissioner requested services	23,160	15,033
Total	**276,222**	**259,520**

Prior year comparatives in the above table have been amended. Items incorrectly classified as commissioner requested services have been re-classified as non commissioner requested services and relate to items which are not under contract.

> Note 4 Operating expenses

	2017-18 £000	2016-17 £000
Purchase of healthcare from NHS and Department of Health and Social Care (DHSC) bodies	1,703	1,894
Purchase of healthcare from non-NHS and non-DHSC bodies	627	786
Employee expenses - executive directors	1,171	1,452
Employee expenses - non-executive directors	168	166
Employee expenses - staff*	186,595	178,096
Employee expenses - temporary staff	10,196	9,115
Supplies and services - clinical	31,086	28,074
Supplies and services - general	3,941	4,527
Drug costs (inventory consumed & non-inventory purchases)	24,123	23,050
Establishment	1,943	1,690
Consultancy fees**	173	0
Transport	1,405	1,507
Premises	12,832	11,916
Increase in provision for impairment of receivables	257	106
(Decrease) in other provisions	0	(91)
Change in provisions discount rate	35	216
Operating lease expenditure (net)	1,060	1,496
Depreciation on property, plant and equipment	5,489	5,725
Amortisation on intangible assets	466	754
Impairments***	6,949	15,467
Audit fees payable to the external auditor		
audit services - statutory audit	54	40
other auditor remuneration - see Note 4.1	49	28
Internal audit and local counter fraud services	153	156
Clinical negligence	10,581	8,100
Legal fees	290	383
Insurance	406	412
Education and Training	1,057	427
Redundancy and other mutually agreed resignation schemes	0	81
Losses, ex gratia & special payments	12	(988)
Other	1,723	1,329
Total	**304,544**	**295,914**

*The Apprenticeship Levy is a levy introduced by the UK Government on 6 April 2017, requiring all employers operating in the UK, with a pay bill over £3m each year, to invest in apprenticeships. Employers are required to pay a levy of 0.5% of their bill, less an allowance of £15,000. Employers are able to access funding for apprenticeships through an account on the digital apprenticeship service.

Details of the amounts paid into the Apprenticeship Levy can be found in Note 5 Employee Benefits.

**Consultancy fees relate to the costs incurred in the establishment of an NHS owned subsidiary company WWL Solutions Ltd for which the Trust will retain 100% ownership.

***Further details of impairments can be found in Note 12.

> Note 4.1 Other auditor remuneration

Other auditor remuneration paid to the external auditor:	2017-18 £000	2016-17 £000
Audit-related assurance services	10	18
All assurance services not falling within the above	39	10
Total	**49**	**28**

> Note 4.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017-18 or 2016-17.

> Note 4.3 Better payment practice code (BPPC)

The better payment practice code gives NHS organisations a target of paying 95% of invoices within agreed payment terms or in 30 days where there are no terms agreed.

Performance for the financial year against this target is contained in the table below.

	2017-18		2016-17	
Non-NHS	**Number**	**£000**	**Number**	**£000**
Trade invoices paid in the period	62,009	150,287	65,061	141,400
Trade invoices paid within target	56,381	139,046	60,371	133,582
Percentage of trade invoices paid within target	**90.9%**	**92.5%**	**92.8%**	**94.5%**
NHS				
Trade invoices paid in the period	2,470	21,709	2,472	20,156
Trade invoices paid within target	2,127	16,202	2,093	15,324
Percentage of trade invoices paid within target	**86.1%**	**74.6%**	**84.7%**	**76.0%**
Total				
Trade invoices paid in the period	64,479	171,996	67,533	161,556
Trade invoices paid within target	58,508	155,248	62,464	148,906
Percentage of trade invoices paid within target	**90.7%**	**90.3%**	**92.5%**	**92.2%**

> Note 5 Employee benefits

	2017-18 Total £000	2016-17 Total £000
Salaries and wages	158,046	151,127
Social security costs	14,576	14,045
Apprenticeship levy*	718	0
Employer's contributions to NHS pensions	16,856	16,267
Temporary staff	10,196	9,115
Total staff costs	**200,392**	**190,554**
Costs capitalised as part of assets	2,379	1,842

*The Apprenticeship Levy is a levy introduced by the UK Government on 6 April 2017, requiring all employers operating in the UK, with a pay bill over £3m each year, to invest in apprenticeships. Employers are required to pay a levy of 0.5% of their bill, less an allowance of £15,000. Employers are able to access funding for apprenticeships through an account on the digital apprenticeship service.

A further analysis of staff costs can be found in the remuneration section of the Annual Report.

> Note 5.1 Retirements due to ill-health

During 2017-18 there were 2 early retirements from the Trust agreed on the grounds of ill-health (3, 2016-17). The estimated additional pension liabilities of these ill-health retirements is £89k (£37k, 2016-17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

> Note 5.2 Executive directors' and non-executive directors' remuneration and other benefits

	2017-18 £000	2016-17 £000
Salary	1,079	1,191
Employer's pension contributions	141	146
Taxable benefits	26	22
Total	1,246	1,359
Non-executive directors' remuneration*	153	152
Total	**1,399**	**1,511**

The total number of directors accruing benefits under the NHS Pension Scheme	**7**	**9**

* Non-executive directors are not members of the NHS Pension Scheme.
Further details of directors' remuneration can be found in the remuneration section of the Annual Report.

> Note 5.3 Employee benefits

An accrual in respect of annual leave entitlements carried forward at the Statement of Financial Position date of £0.3m has been provided for within the accounts (£0.5m, 2016-17). There were no other employee benefits during the year.

> Note 6 Operating leases

> Note 6.1 Wrightington, Wigan and Leigh NHS Foundation Trust as a lessee

Operating lease expense	2017-18 £000	2016-17 £000
Minimum lease payments	1,060	1,496
Total	**1,060**	**1,496**

Future minimum lease payments due:	31 March 2018 £000	31 March 2017 £000
- not later than one year;	1,044	116
- later than one year and not later than five years;	1,148	2,959
- later than five years.	148	589
Total	**2,340**	**3,664**

The Trust leases various premises, primarily to accommodate administrative functions, under operating leases at market rates, for periods up to 20 years.

The Trust also leases equipment and vehicles for periods not exceeding 7 years.

Leased equipment chiefly comprises complex medical equipment used in the delivery of healthcare. The majority of vehicle leases are rolling 'monthly hire' arrangements for transport between Trust sites.

Where applicable, break clauses in the Trust's lease contracts have been taken into account in the calculation of future minimum lease payments.

> Note 6.2 Wrightington, Wigan and Leigh NHS Foundation Trust as a lessor

Operating lease revenue	2017-18 £000	2016-17 £000
Minimum lease receipts	150	153
Total	**150**	**153**

Future minimum lease receipts due:	31 March 2018 £000	31 March 2017 £000
- not later than one year;	150	198
- later than one year and not later than five years;	0	243
- later than five years.	0	0
*Reversal of impairments previously credited to income are netted off against the impairment charge in operating expenditure and prior year comparatives have been restated to reflect this change.		
Total	**150**	**441**

The Trust leases areas of its Cancer Care Unit to The Christie NHS Foundation Trust.

> Note 7 Finance income

	2017-18 £000	2016-17 £000
Interest on bank accounts	54	39
Total	**54**	**39**

> Note 8 Finance expenses

Interest expense	2017-18 £000	2016-17 £000
Loans from the Department of Health and Social Care	422	454
Total interest expense	**422**	**454**
Other finance costs - unwinding of discount	2	22
Total	**424**	**476**

> Note 9 Gains on disposal of assets

	2017-18 £000	2016-17 £000
Gain on disposal of assets held for sale	19	750
Total	**19**	**750**

> Note 10 Intangible assets

> Note 10.1 Intangible assets - 2017-18

	Software licences £000	Internally generated information technology £000	Websites £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2017	**13,683**	**982**	**8**	**0**	**14,673**
Additions	686	0	25	0	711
Disposals/derecognition	(2,392)	(269)	0	0	(2,661)
Gross cost at 31 March 2018	**11,977**	**713**	**33**	**0**	**12,723**
Amortisation at 1 April 2017	**11,415**	**837**	**8**	**0**	**12,260**
Provided during the year	425	41	0	0	466
Impairments	204	25	0	0	229
Disposals/derecognition	(2,392)	(269)	0	0	(2,661)
Amortisation at 31 March 2018	**9,652**	**634**	**8**	**0**	**10,294**
Net book value at 31 March 2018	**2,325**	**79**	**25**	**0**	**2,429**
Net book value at 1 April 2017	**2,268**	**145**	**0**	**0**	**2,413**

> Note 10.2 Intangible assets - 2016-17

	Software licences £000	Internally generated information technology £000	Websites £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2016	**13,580**	**982**	**8**	**542**	**15,112**
Additions	103	0	0	0	103
Impairments					
Reclassifications	0	0	0	(542)	(542)
Valuation/gross cost at 31 March 2017	**13,683**	**982**	**8**	**0**	**14,673**
Amortisation at 1 April 2016	**10,713**	**785**	**8**	**0**	**11,506**
Provided during the year	702	52	0	0	754
Amortisation at 31 March 2017	**11,415**	**837**	**8**	**0**	**12,260**
Net book value at 31 March 2017	**2,268**	**145**	**0**	**0**	**2,413**
Net book value at 1 April 2016	**2,867**	**197**	**0**	**542**	**3,606**

A number of items of intangible assets were reclassified during the year to property, plant and equipment (Note 11.2).

> Note 10.3 Intangible assets financing 2017-18

Net book value at 31 March 2018	Software licences £000	Internally generated information technology £000	Websites £000	Intangible assets under construction £000	Total £000
Purchased	2,294	79	25	0	2,398
Donated	31	0	0	0	31
NBV total at 31 March 2018	**2,325**	**79**	**25**	**0**	**2,429**

> Note 10.4 Intangible assets financing 2016-17

Net book value 31 March 2017	Software licences £000	Internally generated information technology £000	Websites £000	Intangible assets under construction £000	Total £000
Purchased	2,268	145	0	0	2,413
NBV total at 31 March 2017	**2,268**	**145**	**0**	**0**	**2,413**

> Note 11 Property, plant and equipment

> Note 11.1 Property, plant and equipment - 2017-18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/ gross cost at 1 April 2017	**7,344**	**115,427**	**3,170**	**457**	**49,145**	**281**	**24,205**	**619**	**200,648**
Additions	0	3,168	0	662	1,154	0	3,918	0	8,902
Impairments	(160)	(11,975)	(755)	0	0	0	0	0	(12,890)
Reversals of impairments	0	262	0	0	0	0	0	0	262
Revaluations	0	43	0	0	0	0	0	0	43
Disposals/ derecognition	0	(2)	0	0	(3,475)	(86)	(420)	(177)	(4,160)
Valuation/ gross cost at 31 March 2018	**7,184**	**106,923**	**2,415**	**1,119**	**46,824**	**195**	**27,703**	**442**	**192,805**
Accumulated depreciation at 1 April 2017	**0**	**3,211**	**86**	**0**	**35,346**	**209**	**12,886**	**252**	**51,990**
Provided during the year	0	2,150	65	0	1,269	10	1,976	19	5,489
Impairments	0	(1,949)	(30)	0	924	8	58	142	(847)
Revaluations	0	(27)	(54)	0	0	0	0	0	(81)
Disposals/ derecognition	0	(2)	0	0	(3,470)	(86)	(420)	(177)	(4,155)
Accumulated depreciation at 31 March 2018	**0**	**3,383**	**67**	**0**	**34,069**	**141**	**14,500**	**236**	**52,396**
Net book value at 31 March 2018	**7,184**	**103,540**	**2,348**	**1,119**	**12,755**	**54**	**13,203**	**206**	**140,409**
Net book value at 1 April 2017	**7,344**	**112,216**	**3,084**	**457**	**13,799**	**72**	**11,319**	**367**	**148,658**

> Note 11.2 Property, plant and equipment - 2016-17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/ gross cost at 1 April 2016	**13,922**	**130,470**	**3,274**	**5,390**	**47,854**	**281**	**15,069**	**623**	**216,883**
Additions - purchased/ leased/ grants/ donations	0	2,708	0	574	1,461	0	3,069	2	7,814
Impairments	(7,710)	(21,595)	(104)	0	0	0	0	0	(29,409)
Reversals of impairments	0	889	0	0	0	0	0	0	889
Reclassifications	0	152	0	(5,507)	(164)	0	6,067	(6)	542
Revaluations	1,132	2,803	0	0	0	0	0	0	3,935
Disposals/ derecognition	0	0	0	0	(6)	0	0	0	(6)
Valuation/ gross cost at 31 March 2017	**7,344**	**115,427**	**3,170**	**457**	**49,145**	**281**	**24,205**	**619**	**200,648**
Accumulated depreciation at 1 April 2016	**0**	**978**	**1**	**0**	**33,604**	**186**	**11,299**	**205**	**46,273**
Provided during the year	0	2,233	87	0	1,748	23	1,587	47	5,725
Impairments	0	0	(2)	0	0	0	0	0	(2)
Disposals/ derecognition	0	0	0	0	(6)	0	0	0	(6)
Accumulated depreciation at 31 March 2017	**0**	**3,211**	**86**	**0**	**35,346**	**209**	**12,886**	**252**	**51,990**
Net book value at 31 March 2017	**7,344**	**112,216**	**3,084**	**457**	**13,799**	**72**	**11,319**	**367**	**148,658**
Net book value at 1 April 2016	**13,922**	**129,492**	**3,273**	**5,390**	**14,250**	**95**	**3,770**	**418**	**170,610**

A number of items of intangible assets were reclassified during the year to property, plant and equipment (Note 10.2).

> Note 11.3 Property, plant and equipment financing - 2017-18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned	7,184	101,620	2,348	1,119	12,222	54	13,125	206	137,878
Donated	0	1,920	0	0	533	0	78	0	2,531
NBV total at 31 March 2018	**7,184**	**103,540**	**2,348**	**1,119**	**12,755**	**54**	**13,203**	**206**	**140,409**

> Note 11.4 Property, plant and equipment financing - 2016-17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned	7,344	110,593	3,084	457	13,172	72	11,226	367	146,315
Donated	0	1,623	0	0	627	0	93	0	2,343
NBV total at 31 March 2017	**7,344**	**112,216**	**3,084**	**457**	**13,799**	**72**	**11,319**	**367**	**148,658**

*Reversal of impairments previously credited to income are netted off against the impairment charge in operating expenditure and prior year comparatives have been restated to reflect this change.

> Note 12 Revaluations of property, plant and equipment

The value and remaining useful lives of land and building assets are estimated by Cushman and Wakefield. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

During the course of the year, the Trust has set up a wholly owned subsidiary company, WWL Solutions Limited. From 2018-19, this company will provide fully managed and operated healthcare facilities to the Trust. During the year the Trust has re-valued its land and buildiings using the modern equivalent asset alternative site basis, net of VAT. This method of valuation has been used on the basis that any re-provision of its estate would be undertaken by WWL Solutions Limited.

The overall effect of the revaluation has been a decrease in the value of land and buildings of £8.8m.

Assets revalued have been written down to their recoverable amount within the Statement of Financial Position, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for that asset and, thereafter, to expenditure - impairment of property plant and equipment. Increases in value have been credited to the revaluation reserve unless circumstances arose whereby a reversal of an impairment was necessary. In these circumstances this has been netted off against impairments in expenditure.

The lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at its cost less any accumulated depreciation and any impairment losses. Where assets are of low value and/or have short useful economic lives, these are carried at depreciated historical cost as a proxy for current value.

During the course of the year the Trust continued to review its asset base. As a result of this exercise a number of intangible and tangible assets were impaired (£1.3m) and asset lives excluding land, buildings and dwellings were reviewed resulting in an increase in the estimated useful economic lives of assets.

At the end of the financial year the Trust impaired Mesnes Terrace car park. This impairment totalling £1.8m has arisen as a result of a borough wide car parking scheme which will result in the car park no longer being owned by the Trust.

> Note 13 Asset Lives

The following table discloses the range of remaining economic lives of assets.

	Minimum Life Years	Maximum Life Years
Buildings excluding dwellings	**8**	**92**
Dwellings	**14**	**57**
Plant and machinery	**10**	**20**
Vehicles	**10**	**13**
Information technology	**8**	**10**
Furniture and fittings	**15**	**15**

> Note 14
Disclosure of interests in other entities

The Trust has determined that, in addition to its subsidiary charity, it has interests in three joint operations. Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to assets, and obligations for liabilities relating to the arrangement. The Trust therefore includes within its financial statements its share of the assets, liabilities, income and expenses relating to its joint operations.

The Trust does not attribute levels of risk significantly above 'business as usual' with these arrangements, as the operators are all partner NHS bodies, working together within the same healthcare operating environment. In practical terms, this translates to longstanding related party relationships based in contracts and transactions, collaborative working, shared objectives and common policies.

The Trust's joint operations are detailed below.

Pathology at Wigan & Salford (PAWS)

The Trust works collaboratively with Salford Royal NHS Foundation Trust to provide pathology services to both trusts. The intention of the arrangement is to reduce running costs through centralisation and provide resilience in each trust's pathology services. The majority of activity is carried out at a Salford site, with an essential services laboratory remaining at the Trust's Wigan site.

The Trust retains the rights to assets contributed at the start of the arrangement, and new equipment is split between both trusts when purchased. As the 'host' partner, Salford Royal NHS Foundation Trust retains the obligation to pay suppliers' invoices, recharging Wrightington, Wigan and Leigh NHS Foundation Trust for its share of PAWS-related expenditure (£8.0m in year and £7.3m, 2016-17).

Sterile Services Decontamination Unit (SSDU)

In this joint working arrangement with Salford Royal NHS Foundation Trust, both trusts receive sterile services, which chiefly involves the decontamination of surgical instruments. The arrangement is similar to PAWS in that the trusts intend to reduce running costs through centralisation, provide resilience in each organisation's sterile services, and create income through selling services to other providers in the local health economy. The majority of activity is carried out at a site in Bolton with a small service retained at the Trust's Leigh site.

The Trust retains the rights to assets contributed to the arrangement. As the 'host' partner, Wrightington, Wigan and Leigh NHS Foundation Trust retains the obligation to pay the majority of suppliers' invoices, recharging Salford Royal NHS Foundation Trust, for its share of SSDU-related expenditure (£2.0m in year and £2.1m, 2016-17).

Well Being Partners

This arrangement is jointly operated by Wrightington, Wigan and Leigh NHS Foundation Trust (the 'host' operator), Lancashire Teaching Hospitals NHS Foundation Trust and Bolton NHS Foundation Trust. The collaboration is designed to provide resilience to each of the three operators' occupational health services and to create income through selling services to other bodies. The activity is carried out at all three trusts' sites with additional outreach clinics. The Trust's share of expenditure for the year was £0.8m (£0.8m, 2016-17).

> Note 15 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	844	955
Consumables	3,184	3,014
Energy	87	74
Other	84	78
Total inventories	**4,199**	**4,121**

Inventories recognised in expenses for the year were £39,755k (£38,036k, 2016-17).

> Note 16 Trade and other receivables

Current	31 March 2018 £000	31 March 2017 £000
Trade receivables	11,236	8,442
Accrued income	12,023	10,742
Provision for impaired receivables	(922)	(718)
Prepayments (non-PFI)	2,234	2,775
Interest receivable	7	2
PDC dividend receivable	152	362
VAT receivable	552	521
Other receivables	3,106	3,104
Total current trade and other receivables	**28,388**	**25,230**

The above analysis of trade and other receivables and has been updated to reflect reporting categories as advised by NHS Improvement. The majority of this change relates to receivables which were previously reported under other receivables and NHS receivables. These have been amalgamated into the category Trade receivables and prior year comparatives have been restated to reflect this change.

Non-current		
Provision for impaired receivables	(66)	(41)
Other receivables	289	210
Total non-current trade and other receivables	**223**	**169**

Of which receivables from NHS and DHSC group bodies		
Current	23,151	19,159
Non-current	0	0

The carrying amounts of trade and other receivables approximates to the fair value.

> Note 16.1 Provision for impairment of receivables

	31 March 2018 £000	31 March 2017 £000
At 1 April 2017	759	686
Increase in provision	257	106
Amounts utilised	(28)	(33)
Unused amounts reversed	0	0
At 31 March 2018	**988**	**759**

> Note 16.2 Analysis of impaired receivables

Ageing of impaired receivables	31 March 2018 £000	31 March 2017 £000
0-30 days	0	16
30-60 days	0	0
60-90 days	0	0
90-180 days	0	1
Over 180 days	453	262
Total	**453**	**279**

The above ageing of impaired receivables table does not include a provision of £536k (£480k, 2016-17) against the NHS Injury Compensation Recovery Scheme, since this is not deemed to be a financial instrument.

Ageing of non-impaired receivables past their due date	31 March 2018 £000	31 March 2017 £000
0-30 days	22,211	14,698
30-60 days	252	1,581
60-90 days	303	201
90-180 days	132	1,334
Over 180 days	854	1,458
Total	**23,752**	**19,272**

The above table does not include non instrument debtors including amounts pertaining to the NHS Injury Compensation Recovery Scheme.

> Note 17 Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017-18 £000	2016-17 £000
At 1 April 2017	**11,669**	**10,268**
Net change in year	929	1,401
At 31 March 2018	**12,598**	**11,669**
Broken down into		
Cash at commercial banks and in hand	7	11
Cash with the Government Banking Service	12,591	11,658
Total cash and cash equivalents	**12,598**	**11,669**

> Note 17.1 Third party assets held by the NHS foundation trust

During the year the Trust held cash relating to monies held on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts. The Trust also holds in the normal course of business consignment inventories which comprise orthopaedic prosthesis. These are held on Trust premises and still owned by the supplier. The Trust is only obliged to pay for these assets when they are used.

	31 March 2018 £000	31 March 2017 £000
Monies held on behalf of patients	2	5
Consignment inventories	6,390	933
Total third party assets	**6,392**	**938**

> Note 18 Trade and other payables

Current	31 March 2018 £000	31 March 2017 £000
Trade payables	7,558	6,738
Capital payables	3,259	2,993
Accruals	14,269	12,336
Receipts in advance	63	33
Social security costs	2,303	2,104
Other taxes payable	1,711	1,569
Accrued interest on loans	114	122
Other payables	2,925	2,816
Total current trade and other payables	**32,202**	**28,711**

The above analysis of trade and other payables has been updated to reflect reporting categories as advised by NHS Improvement. The majority of this change relates to trade payables which were previously reported under other payables and payables from NHS bodies. These have been amalgamated into the category - Trade payables and prior year comparatives have been restated to reflect this change.

Of which receivables from NHS and DHSC group bodies		
Current	12,559	10,621
Non-current	0	0

> Note 19 Other liabilities

Current	31 March 2018 £000	31 March 2017 £000
Deferred goods and services income	351	1,385
Other deferred income	150	150
Total other current liabilities	**501**	**1,535**

Non-current		
Deferred goods and services income	434	0
Other deferred income	150	300
Total other non-current liabilities	**584**	**300**

> Note 20 Borrowings

Current	31 March 2018 £000	31 March 2017 £000
Loans from the Department of Health and Social Care	3,769	3,768
Other loans	715	652
Total current borrowings	**4,484**	**4,420**

Non-current		
Loans from the Department of Health and Social Care	20,579	24,348
Other loans	1,353	1,471
Total non-current borrowings	**21,932**	**25,819**

The Trust has drawn down public sector energy efficiency loans totalling £3.2m with Salix Finance Limited. These loans are interest-free and have financed a number of energy-saving boiler schemes throughout the Trust. Repayments are phased to match the projected savings from the schemes. Details of the loans from the Department of Health are detailed in Note 24.

> Note 21 Provisions

	Other legal claims £000	Other £000	Total £000
At 1 April 2017	**2,513**	**970**	**3,483**
Change in the discount rate	35	0	35
Arising during the year	142	150	292
Utilised during the year	(178)	(289)	(467)
Reversed unused	(77)	(777)	(854)
Unwinding of discount	2	0	2
At 31 March 2018	**2,437**	**54**	**2,491**
Expected timing of cash flows:			
- not later than one year;	241	54	295
- later than one year and not later than five years;	504	0	504
- later than five years.	1,692	0	1,692
Total	**2,437**	**54**	**2,491**

Legal provisions of £2.4m are made up of employer's and public liability claims £0.1m (£0.2m, 2016-17) and £2.3m for the cost of permanent injury retirements (£2.3m, 2016-17).

The amount provided for employer's / public liability claims are based on actuarial assessments received from NHS Resolution (NHSR) as to their value and anticipated payment date.

Other provisions relate to pathology service staffing changes jointly agreed with Salford Royal NHS Foundation Trust.

> Note 21.1 Clinical negligence liabilities

At 31 March 2018, £176,523k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Wrightington, Wigan and Leigh NHS Foundation Trust (£134,790k, 31 March 2017).

> Note 22 Contingent assets and liabilities

Value of contingent liabilities	31 March 2018 £000	31 March 2017 £000
NHS Litigation Authority legal claims	0	(89)
Gross value of contingent liabilities	**0**	**(89)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**0**	**(89)**

Contingent liabilities relate to employers and public liability claims.

> Note 23 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	917	2,600
Total	**917**	**2,600**

Contractual capital commitments mainly relate to committed expenditure in respect of the Trust's Health Information System and de-commissioning of a pathology laboratory.

> Note 24 Financial instruments

> Note 24.1 Financial risk management

Liquidity risk

The Trust's net operating costs are incurred under annual service level agreements/contracts with Clinical Commissioning Groups (CCGs) which are financed from resources voted annually by Parliament. The Trust receives such income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff procedure cost. Monthly payments are received from CCGs based on an annual service level agreement; this arrangement reduces liquidity risk.

The Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form. Liquidity is monitored by the Board on a monthly basis through the calculation of the Use of Resources Metric as required by NHS Improvement and by the review of cash flow forecasts for the year.

The Trust has two loans financed by the Independent Trust Financing Facility. A 7 year loan for £13.5m at 0.66% fixed interest rate and a 25 year loan for £16.5m at 2.24% fixed interest rate. Repayments on the loans commenced in December 2016 and are repaid over the period of the loans. Repayments are built into the Trust's cash flow plans for the year and there is no risk that a number of significant borrowings could become repayable at one time and cause unplanned cash pressures.

The Trust has drawn down four public sector energy efficiency loans totalling £3.2m with Salix Finance Limited. These loans are interest-free and have been invested in energy-efficiency saving schemes. The savings from these schemes are matched to loan repayments and there is therefore no risk that these borrowings will cause unplanned cash pressures.

The loan repayment schedule is contained within the maturity of financial liabilities table on page 170.

Interest rate risk

All of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest other than the Trust's bank accounts which earn interest at a floating rate. The Trust is not exposed to significant interest rate risk.

Credit risk

The main source of income for the Trust is from CCGs in respect of healthcare services provided under agreements. The credit risk associated with such customers is very low.

Cash required for day to day operational purposes is held within the Trust's Government Banking Services (GBS) account. This service has minimal credit risk as balances are regularly swept into and held by the Bank of England.

The Trust regularly reviews debtor balances, and has a comprehensive system in place for pursuing past due debt. Non-NHS customers represent a small proportion of income, and the Trust is not exposed to significant credit risk in this regard.

The carrying amount of financial assets represents the maximum credit exposure. Therefore, the maximum exposure to credit risk at the Statement of Financial Position date was £24.2m (£19.7m 2016-17), being the total of the carrying amount of financial assets excluding cash.

There are no amounts held as collateral against these balances.

An analysis of aged and impaired receivables is disclosed in Note 16.2.

The movement in the provision for impaired receivables during the year is disclosed in Note 16.1. Of those assets which require a provision for their impairment, £453k (£279k, 2016-17) are impaired financial assets.

There are no (£0k, 2016-17) financial assets either impaired or non-impaired whose terms have been re-negotiated.

Currency risk

The Trust is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

> Note 24.2 Financial assets

Assets as per SoFP as at 31 March 2018	Loans and receivables £000
Trade and other receivables excluding non financial assets	24,206
Cash and cash equivalents at bank and in hand	12,598
Total at 31 March 2018	**36,804**

Assets as per SoFP as at 31 March 2017	Loans and receivables £000
Trade and other receivables excluding non financial assets	19,679
Cash and cash equivalents at bank and in hand	11,669
Total at 31 March 2017	**31,348**

> Note 24.3 Financial liabilities

Liabilities as per SoFP as at 31 March 2018	Other financial liabilities £000
Borrowings excluding finance lease and PFI liabilities	26,416
Trade and other payables excluding non financial liabilities	25,704
Total at 31 March 2018	**52,120**

Liabilities as per SoFP as at 31 March 2017	Other financial liabilities £000
Borrowings excluding finance lease and PFI liabilities	30,239
Trade and other payables excluding non financial liabilities	22,494
Provisions under contract	741
Total at 31 March 2017	**53,474**

> Note 24.4 Maturity of financial liabilities

	31 March 2018 £000
In one year or less	30,156
In more than one year but not more than two years	4,416
In more than two years but not more than five years	6,752
In more than five years	10,796
Total	**52,120**

Fair value of financial instruments

The Trust has two loans with the Department of Health. The carrying value of this borrowings liability is considered to approximate to fair value, the interest rate not being significantly different from market rate. All other financial assets and liabilities have carrying values which are not significantly different from their fair values.

> Note 25 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise.

The Trust incurred the following losses and special payments during the financial year.

	2017-18		2016-17	
Losses	**Total number of cases Number**	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Cash losses	2	0	2	22
Bad debts and claims abandoned	64	11	113	33
Stores losses and damage to property	1	2	1	(1,017)
Total losses	**67**	**13**	**116**	**(962)**
Special payments				
Ex-gratia payments	39	67	34	75
Total special payments	**39**	**67**	**34**	**75**
Total losses and special payments	**106**	**80**	**150**	**(887)**
Compensation payments received		0		2

> Note 26 Related party transactions

Wrightington, Wigan and Leigh NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. NHS Improvement (NHSI) (formerly Monitor, the Regulator of NHS Foundation Trusts and NHS Trust Development Authority), does not prepare group accounts; instead, NHSI prepares NHS Foundation Trust Consolidated Accounts, for further consolidation into the Whole of Government Accounts. NHSI has powers to control NHS Foundation Trusts, but its results are not incorporated within the consolidated accounts, and it cannot be considered to be the parent undertaking for Foundation Trusts. Although there are a number of consolidation steps between the Trust's accounts and Whole of Government Accounts, the Trust's ultimate parent is HM Government.

Whole of Government Accounts bodies

All bodies within the scope of the Whole of Government Accounts (WGA) are considered to be related parties as they fall under the common control of HM Government and Parliament. The Trust's related parties therefore include Department of Health and Social Care as the parent company, other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies, non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Trust has had a number of transactions with WGA bodies. Where the total transactions with a given counterparty are collectively significant, they are listed below. The Trust's related parties therefore include other trusts, foundation trusts, clinical commissioning groups, local authorities, central government departments, executive agencies non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Trust has had a number of transactions with WGA bodies. Listed below are those entities for which the total transactions or total balances with the Trust have been collectively significant or potentially material to the other body.

> NHS Wigan Borough CCG
> NHS England
> NHS Business Services Authority
> HM Revenue and Customs
> NHS Resolution
> Health Education England
> NHS West Lancashire CCG
> NHS Bolton CCG
> NHS Chorley and South Ribble CCG

Public dividend capital (PDC) transactions with the Department of Health and Social Care

The Trust made PDC dividend payments to the Department of Health totalling £3.2m (£4.0m, 2016-17), and is reporting a year-end PDC receivable totalling £0.2m (£0.4m, 2016-17).

Provision for impairment of receivables - related parties

No related party debts have been written off by the Trust during the year.

Charitable related parties

Wrightington, Wigan and Leigh Health Services Charity (charitable fund with registered charity number 1048659) is a subsidiary of the Trust and therefore a related party. The Trust is the Charity's Corporate Trustee which means that the Trust's Board of Directors is charged with the governance of the Charity. The Charity's sole activity is the funding of charitable capital and revenue items for the benefit of our patients and staff.

The Charity's balance as at 31 March 2018 was £1,614k (£1,386k, 2016-17) with net outgoing resources before transfers of £207k (£173k, 2016-17).

During the year the Charity incurred expenditure of £648k (£366k, 2016-17) in respect of goods and services for which the Trust was the beneficiary.

Other related parties

During the year the Trust commenced the process of setting up a wholly owned subsidiary company, WWL Solutions Limited. This subsidiary company will provide a fully managed operated healthcare facility to the Trust. As at 31st March 2018, this company has not commenced trading and therefore consolidation of the subsidiary accounts into the Trust accounts has not been undertaken. The Trust has no other subsidiaries or associates but has a registered Charity, Three Wishes. The Trust also has interests in 3 joint operations with related parties as disclosed in Note 14 and has a related party relationship with NHS Shared Business Service.

Key management personnel

During the financial year under review, no member of either the Board or senior management team, and no other party closely related to these individuals, has undertaken any material transactions with Wrightington, Wigan and Leigh NHS Foundation Trust.

One Non Executive Director is a cancer lead at NHS Salford CCG. The Trust has entered into a number of transactions with this organisation (net income £2.2m) which are considered to be "at arms length".

Key management personnel are identified as Executive Directors and Non-Executive Directors of the Trust. Details of their remuneration and other benefits can be found in Note 5.2 and the remuneration section of the Annual Report.

> Note 27 Reconciliation of deficit to trading position

	2017-18 £000	2016-17 £000
Surplus/(Deficit) for the year	1,684	(1,900)
Net impairments charged to operating expenses in the year	6,949	15,467
Trading surplus	**8,633**	**13,567**

Impairments included within operating income and expenditure relate to changes in asset values. These costs are technical in nature and are excluded from the trading position.


Wrightington, Wigan and Leigh NHS Foundation Trust
We're recruiting!
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your hospitals, your health, our priority

GLOSSARY OF TERMS

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

A&E
Accident and Emergency Department, also known as Emergency Department, based on the Royal Albert Edward Infirmary site.

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

Age Well Unit
Launched in November 2016, this is a new service providing quick and effective care aimed at reducing the time spent in hospital for patients who may benefit from a more personalised multi-disciplinary assessment. The Age Well unit, which consists of 14 beds, seven male and seven female is based at RAEI.

Always Event
The Always Events are the Trust's commitment to improving the delivery of patient and family centred care. The first 10 Always Events were launched in January 2014 following concerns raised by complaints and incidents. The Always Events are embedded within our Safe, Effective, Caring culture. 'Goodnight' Always Events and Do Not Attempt Cardio-Pulmonary Resuscitation Always Events have also been introduced. Always events are everybody's responsibility and should always happen 100% of the time.

Annual Governance Statement
This is a key feature of the organisation's annual report and accounts. It demonstrates publicly the management and control of resources and the extent to which the Trust complies with its own governance requirements, including how we have monitored and evaluated the effectiveness of our governance arrangements. It is intended to bring together into one place in the annual report all disclosures relating to governance, risk and control.

Arterial
This is of or relating to an artery or arteries.

Board of Directors
The Board of Directors at WWL: sets the overall strategic direction of the Trust; monitors our performance against objectives; provides financial stewardship financial control and financial planning; through clinical governance, ensures that we provide high quality, effective and patient-focused services; ensures high standards of corporate governance and personal conduct.

The Board is made up of:

> Non-Executive Directors (NEDs). These are paid part time appointments. NEDs bring independence, external perspectives and skills to strategy development. They help to hold the executive to account and offer scrutiny and challenge.

> Executive Team / Executive Directors. These are full time Directors of the Trust. The executive team takes the lead role in developing and implementing strategic proposals, monitoring performance and feeding back to the wider Board of Directors.

Board Assurance Framework (BAF)
Is an essential tool for the Board of WWL and is reviewed at every meeting of the Trust Board. The BAF brings together in one place all of the relevant information on the risks to the board's strategic objectives.

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

Chemotherapy
This is the treatment of disease by the use of chemical substances, especially the treatment of cancer by cytotoxic and other drugs.

CIP (Cost Improvement Programme)
These are a vital part of NHS Trust finances to deliver savings and reduce costs.

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

Clinical Commissioning Groups (CCGs)
These are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. For WWL, Wigan Borough Clinical Commissioning Group (WBCCG) is the main commissioner of services.

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

Governors provide the link between the Trust and the local community enabling the Trust to gather views from local people and feedback what is happening in the Trust. This predominantly elected body represents service users, carers, the public, staff and other interested parties. People on this council are called Governors.

Together, they:

> Represent the interests of our members and partner organisations

> Give recommendations on our long-term strategy

> Provide advice and support to the Board of Directors, which is responsible for the overall management of the Trust.

> Appoint the Chair and the Non-Executive Directors of the Board of Directors.

CQC
The Care Quality Commission (CQC) is an executive non-departmental public body of the Department of Health. It was established in 2009 to regulate and inspect health and social care services in England.

CQUIN
The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.

Dermatology
This is the branch of medicine concerned with the diagnosis and treatment of skin disorders.

Diabetes
This is a metabolic disease in which the body's inability to produce any or enough insulin causes elevated levels of glucose in the blood.

Discharge to Assess
Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'step down'.

Duty of Candour
Introduced as part of the Health and Social Care Act 2008 this regulation aims to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment.

The regulation also sets out some specific requirements that providers such as WWL must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

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.

Friends and Family Test
The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. The test helps service providers, such as the Trust, and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patients to give views after receiving care or treatment across the NHS.

General Surgery
General surgery is a surgical specialty that focuses on abdominal contents including oesophagus, stomach, small bowel, colon, liver, pancreas, gallbladder and bile ducts.

Greater Manchester Devolution
Devolution is the transfer of certain powers and responsibilities from national government to a particular geographical region i.e. Greater Manchester. In 2016 Greater Manchester was the first region in the country to take control of its combined health and social care budgets – a sum of more than £6 billion. The Trust is one of 37 members of the Greater Manchester Health and Social Care Strategic Partnership – along with all NHS and Local Authority organisations across the region.

Gynaecology
This is the branch of physiology and medicine that deals with the functions and diseases specific to women and girls, especially those affecting the reproductive system.

Healthier Together
Healthier Together has been looking at how patients will receive health and care in the future. The Healthier Together programme is a key part of the wider programme for health and social care reform across Greater Manchester. Clinically led by health and social care professionals, the programme aims to provide the best health and care for the people of Greater Manchester.

HIS
Hospital Information System.

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

IM&T
Information Management and Technology

Integrated Community Services / Integrated Community Nursing and Therapy
Community based nurses, other health professionals and social workers are now working together as part of a new, single team across Wigan, Ashton and Leigh to improve care and support for patients.

The Integrated Community Service (ICS) brings together NHS staff based in the community with local council health and adult

social care staff to provide support to patients in their place of residence.

When under development, this service was known as Integrated Community Nursing and Therapy.

Integrated Discharge Team
The Integrated Discharge Team is made up of a group of professionals from both Social Care and Health who are co-located at Wigan Hospital and collaboratively work together to ensure the safe and timely discharge of patients from the Trust.

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

Locality Plans/Wigan Borough Locality Plan
A core element of Greater Manchester Devolution; each Borough in Greater Manchester is required to have a plan that details how the health and care system will be transformed to deliver improved health outcomes within a financially sustainable resource base.

Wigan's Locality Plan is called "Further, Faster Towards 2020"

Maxillo-facial (Max-Fax)
Oral and Maxillofacial Surgery is a specialty that deals with conditions affecting the head and neck.

MDT (Multi-Disciplinary Team)
This is a meeting of a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

Methicillin-resistant Staphylococcus aureus (MRSA)
Staphylococcus aureus (SA) is a common type of bacteria that live harmlessly, as a colonisation, in the nose or on the skin of around 25-30% of people. It is important to remember that MRSA rarely causes problems for fit and healthy people. Many people carry MRSA without knowing it and never experience any ill effects. These people are said to be colonised with MRSA rather than being infected with it.

In most cases, MRSA only poses a threat when it has the opportunity to get inside the body and cause an infection; this is called a bacteraemia.

National Inpatient Survey
NHS Inpatient Survey was developed by the Picker Institute in 2002 and forms part of the CQC National Survey Programme. The survey ask patients about their experiences of communications with doctors and nurses, hospital cleanliness, hospital food and discharge arrangements.

Never events
Never Events are a particular type of serious incident that meet all the following criteria: wholly preventable; has the potential to cause serious patient harm or death; There is evidence that the category of Never Event has occurred in the past; occurrence of the Never Event is easily recognised and clearly defined.

NHS England (NHSE)
NHS England leads the National Health Service (NHS) in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.

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

There are three main strands to NHS Improvement'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.

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 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.

Wrightington, Wigan and Leigh is an NHS Foundation Trust, and so are close partners such as Bolton NHS Foundation Trust and Salford Royal NHS Foundation Trust.

NICE
National Institute for Health Care Excellence is a statutory agency which provides national guidance and advice to improve health and social care

Obstetrics
This is the branch of medicine and surgery concerned with childbirth and the care of women giving birth.

Oncology
This is the study and treatment of tumours.

Ophthalmology
This is the branch of medicine concerned with the study and treatment of disorders and diseases of the eye.

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

Paediatrics
This is the branch of medicine dealing with children and their diseases.

PAWS
This stands for Pathology at Wigan and Salford, a joint service between the two organisations.

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.

Radiology
This is the medical speciality that uses radioactive substances in the diagnosis and treatment of disease, especially the use of X-rays.

RCOG
This is the Royal College of Obstetricians and Gynaecologists.

Real Time Patient Experience Survey
The Real Time Survey is a regular survey of inpatients on our medical, surgical and postnatal wards. It runs alongside the Friends and Family Test as one of the main ways for the Trust to gather regular patient feedback. WWL has a dedicated team of volunteers who visit the wards each week to interview patients. The volunteers carry out face to face interviews with patients.

Rheumatology
This is the study of rheumatism, arthritis, and other disorders of the joints, muscles, and ligaments.

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.

Seven Day Services
This is an initiative to make routine hospital services available 7 days a week.

SPR (Specialist Registrar)
A Specialist Registrar or SpR is a doctor who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant.

Specialist Orthopaedic Alliance
Is a partnership of five hospital trusts that have specialisms within Orthopaedics. The Specialist Orthopaedic Alliance is leading the vanguard activity to establish a National Orthopaedic Alliance

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

Surgical Assessment Lounge (SAL)
SAL is the elective admissions lounge for all surgical patients at WWL. Patients admitted for day case surgery will also return to SAL after their operation before being discharged.

Surgical Assessment Unit (SAU)
This is an 8 bed unit on the Orrell Ward at RAEI. Patients are transferred to this unit for assessment by doctors from the Surgical team. The unit is run by a senior nurse and a care support worker.

Sustainability and Transformation plans (STP)
The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. These proposals, called sustainability and transformation plans (STPs), are place-based and built around the needs of the local population.

Wigan is part of the Greater Manchester area where Greater Manchester Health and Social Care Devolution is responsible for the Greater Manchester Strategic Plan.

Ultrasound
This is sound or other vibrations having an ultrasonic frequency, particularly as used in medical imaging.

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.

Vascular
This is relating to, affecting, or consisting of a vessel or vessels, especially those that carry blood.

Vanguard
In 2015 NHS England announced a programme for new models of care focussing on integration, this scheme is called Vanguard. WWL successfully applied with SRFT to be a vanguard project.

Venous Thromboembolism (VTE)
This is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis or DVT. If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism or PE.

NHS

Wrightington, Wigan and Leigh

NHS Foundation Trust

If you have any queries regarding this report, or wish to make contact with any of the directors or governors, please contact:

PAUL HOWARD
Company Secretary
Trust Headquarters
Royal Albert Edward Infirmary
Wigan Lane
Wigan
WN1 2NN

01942 822027

paul.howard@wwl.nhs.uk

www.wwl.nhs.uk