HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

WARRINGTON & HALTON HOSPITALS NHS FOUNDATION TRUST
ANNUAL REPORT & ACCOUNTS 2017/18

Warrington and Halton Hospitals NHS Foundation Trust Annual Report and Accounts 2017 / 18

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ANNUAL REPORT 2017-18

Warrington and Halton Hospitals NHS Foundation Trust's Annual Report for the period 1st April 2017 to 31st March 2018

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CHAPTER 1

Performance Report

Overview

I present our Annual Report for the 2017-18 year which has been one of the most challenging to date.

I begin by paying tribute to the compassion, determination and sheer resilience of our wonderful staff who, in the face of unprecedented challenge, have continued to work so hard to deliver the very best care for our patients. I have put on record that the 2017-18 winter pressures have been the worst I have experienced in my 30 years in the NHS. I also pay tribute to the many thousands of patients who crossed our doors this year for their patience and unstinting support of their local hospitals and their praise for the staff who have worked so hard to care for them under such pressures.

The year has been a game of two halves for WHH with some real highs and disappointing lows. Among many highs we celebrated our Maternity Service being recognised as Maternity Service of the Year by the Royal College of Midwives. Celebrations continue as we prepare for a Royal visit to commemorate this in May 2018. Our Midwifery Led Unit is a best-in-class service for the women who chose to deliver their babies in hospital and we are working on plans to offer even more choice in the future. This is in line with the *Better Births Strategy* to which I had the privilege of contributing as part of Baroness Cumberledge's national review.

There were yet more highs with our teams being recognised on the national stage as finalists in the prestigious Patient Safety Awards in the *Infection Prevention and Control* and *Perioperative and Surgical Care* categories. We won't know until the summer just how successful they are but to be acknowledged among the very best in the country is testament enough. We also sent teams to the finals of the Health Service Journal's Value and Improvement Awards where they were recognised for *Community Service Redesign* and the British Medical Journal Awards for the same project as well as for *Clinical Leadership*.

We have pushed forward with our investment in technology and the Trust Board approved the funding to add an Electronic Medicines Prescribing module to our electronic patient record system. This has significant patient safety benefits which will continue after the patient has left our care when we join *PharmOutcome*s, a system that enables our Pharmacy to inform community pharmacist when a patient has been admitted to hospital and send medication updates at the point of discharge. This is the result of a successful collaboration with NHS England and the North West Academic Health Science Network.

Intensive work by our teams and our mortality review group has paid dividends and we are pleased to report mortality rates in the 'as or below expected' range. For the two indicators we have reduced the Hospital Standardised Mortality Rate (HSMR) from a high of 115 (above expected) in April 2016 down to 101 (as expected) in February 2018. For Summary Hospital-level Mortality rate (SHMI) indicator we have reduced this from a high of 118 in 2015 (above expected) to 103 in February 2018 (as expected) – the lowest it has been for many years. While never a nice indicator to discuss this provides yet further confidence in our patients of the high quality, safe care being practiced every day in this Trust.

Similarly, our low infection control rates are the result of sustained focus across both our organisation and partners in the community. There was one reported case of MRSA in the year – our first case in nearly two years and 21 hospital onset cases of Clostridium Difficile against the annual threshold of 27 cases. Work to significantly reduce the impact of sepsis through early identification and treatment has been exceptional with more than 90% patients in the ED consistently screened/given timely antibiotics for this aggressive, potentially life-threatening condition.

Focusing on our patients' experience we moved the national patient survey, the *Friends and Family Test*, to a digital platform which has hugely increased feedback through the use of text messaging and automated voice calls. More importantly, the platform is live and ward/service specific so we can monitor feedback in real time enabling us to make swift interventions based on patients' recent experiences.

We are extending this excellent system in April 2018 with a pre-appointment, two-way text reminder service. This will allow our busy patients to confirm their attendance, cancel or rebook their appointments 'on the move'. As well as providing an important reminder service we anticipate that this will significantly reduce our 'Did Not Attends' which in 2016-17 cost the Trust over £1m in lost appointments but more importantly prevented other patients from taking up appointment slots.

Arriving for their Outpatient Appointment patients can now check in digitally rather than waiting in line with the *MiCheckIn* facility at a number of kiosks. This is further supported by the introduction of patient and visitor Wi-Fi across all of our hospitals – the result of a £200K grant from NHS Digital – and which we know will make a huge difference to those having to spend even a short time with us.

It is worth noting that with increasing global reliance on technology there are associated risks and the NHS fell victim to the large cyber-attack in May 2017 where the *WannaCry* ransomware virus affected a number of organisations around the world. This Trust had applied the patches released by Microsoft earlier in the year and was consequently not infected; but we did take down a number of our systems as a precaution over the weekend period. Fortunately our patient care was not affected and we were able to return to business as usual with the restoration of email after the weekend.

More widely we have pushed forward with our partners in the Borough of Halton as part of the Halton Healthy New Town development, one of NHS England's 10 demonstrator sites. Healthy New Towns intend to shape the health of communities, and to rethink how health and care services are delivered by uniting public health, NHS providers and commissioners, planning and housing development to plan and build healthier places. Halton Lea is unique in that it is the only new town with a hospital at its heart, offering even more opportunity to build good health and wellbeing into the community and create a real legacy for future generations.

The initial design and plans for the Halton Hospital and Wellbeing Campus were unveiled in March 2018 to a wide range of staff, patients, elected members, local residents, members of the public and interest groups and their feedback and input welcomed. While our bid for £40m capital to NHS England was not successful during the spring round of capital funding we intend to refine and resubmit our bid for the autumn 2018 round. We remain fully committed to building a state-of-the art integrated primary, secondary and mental health facility complemented by rehabilitation and community wellbeing facilities for the benefit of patients, staff and people of Runcorn.

Work on a new hospital for Halton naturally turned discussions to the ageing facility that is Warrington Hospital, where some parts of the building are more than 100 years old and where annual maintenance costs significantly eat into scarce budgets. At the end of the financial year a large fire in the roof of Kendrick Wing, the oldest part of the hospital and home of Ophthalmology and many support services, left a considerable part of this wing of the hospital out of action and this will be the case for some months. Once again our staff rose to the challenge and after an extremely efficient and safe evacuation of all patients and staff our teams worked around the clock to ensure we had the Ophthalmology service temporarily relocated and up and running just 84 hours later, with all affected patients rebooked.

We are grateful to Warrington Borough Council, the Overview and Scrutiny Committee our MPs, staff and our local community for their continued support of our desire to provide a modern, purpose-built hospital for the people of Warrington. This includes discussions about the potential siting of the new hospital - which may indeed include the existing site. While it is very early days we intend to maintain momentum – particularly given the aspirations of the town and the planned, significant growth in population, housing and business laid out in the Council's Local Delivery Plan.

While these many initiatives and celebrations continue into the new financial year, we are never far away from the pressures and challenges facing today's health and social care. As described, this was one of the worst winters on record for the NHS as we received significantly increased numbers of acutely unwell patients who required emergency care and admission. At the same time we struggled to discharge medically optimised patients (ie those whose acute care with us was complete) into their next care environment. This naturally had a domino effect on our ability to see, treat, admit or discharge patients presenting at the Emergency Department within the national standard of 95% within 4-hours. This situation was reflected widely across the country and while we did not achieve the standard we did perform better than both the regional and national average thanks to an amazing whole-team effort.

Whist winter was extremely difficult, another very difficult situation arose with our Spinal Surgery Service. In September we took the decision to voluntarily suspend the service pending an internal serious case review. The decision was taken following four serious (but unrelated) incidents and followed an earlier voluntary, temporary suspension of complex spinal surgeries. Together with our commissioners (NHS Warrington CCG and NHS England Specialist Commissioning) we commissioned an independent expert review from the Royal College of Surgeons. The outcomes of this review were received at year end and a programme of sharing with those patients and families affected is being carried out.

The suspension of the service, and the transfer of all of the Trust's spinal patients to other providers, has caused considerable inconvenience and distress to our patients and for this we are profoundly sorry. With our commissioners we are working to ensure that the recommendations from the report are fully considered and incorporated in the wider context of how spinal surgery services will be delivered in Cheshire and Merseyside in the future. This will include defining the role of this Trust in keeping access for patients to spinal surgery services as close to home as possible.

The process of shaping the future configuration of specialist spinal services across the whole of Cheshire and Merseyside has already begun, led by NHS England's GIRFT (Getting it Right First Time) team, with leading consultants, Chief Executives and other senior clinical leads. Spinal surgery services at this Trust remain suspended pending the outcome of these wider discussions on the future delivery of specialist spinal services across the region.

We experienced a further blow with the arrival of the CQC report in October, following a 3-day announced inspection in March 2017. We were extremely disappointed to be assessed as 'Requiring Improvement' overall but where our Care was assessed as 'GOOD'. Our Urgent & Emergency care, Surgery, Services for Children and Young People and End of Life Care at Warrington Hospital were all rated as 'GOOD' as were Urgent & Emergency Care, Medical Care and Surgery at Halton hospitals. Our staff in these services are justifiably proud.

Recognising that our patients and staff deserve nothing less than a 'GOOD' rating, we have embarked on an organisation-wide change journey called '*Getting to Good, Moving to Outstanding'*. We have updated our strategy to reflect our 'Outstanding' ambitions and our mission changed to '*We will be OUTSTANDING for our patients, our communities and each other'.* We are remedying our shortcomings, we are investing (where appropriate) in our aging estate to ensure it is an acceptable environment to treat patients; we will launch our Quality Academy, we are embedding the highest quality and safety of care at every level and throughout every staff group - so that everyone knows how and is empowered to make a difference for our patients – every time. We believe this is the single most important thing we can do for our patients and I have every confidence in Team WHH to embrace this task so that together we can take the Trust to where it deserves to be – *Moving to Outstanding*.

The unprecedented levels of activity, the suspension of our spinal service, and the premium cost of winter all had an adverse effect on our financial position and on our ability to deliver the planned level of cost improvement. For the year we reported a £14.7m deficit, which included £4.3m Sustainability and Transformation Funding. This deficit has resulted in the requirement for additional cash from the Department of Health in the form of working capital loans.

The financial sustainability of this Trust is inextricably linked to the success of our local health and social care economies and we are working in partnership to create integrated care systems in both Warrington and Halton. *Warrington Together* and *One Halton* will see commissioners, provider trusts, primary care, local government and others come together to work on models of placed-based care as a seamless unit. We will take collective responsibility for managing our scarce resources, delivering NHS standards, and improving the health of the populations we serve.

While working locally toward becoming Integrated Care Systems we also collaborate as part of the wider Cheshire and Merseyside Health and Care Partnership of which I had the privilege of being Chief Officer for part of the year. On this macro level we are the second largest Health and Care Partnership in the country and we are all working together to:

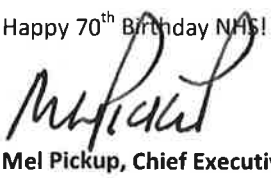
- Support people to live better quality lives by actively promoting the things that will have a positive effect on health and wellbeing and reduce reliance on services.
- Work together with partners in local government and the voluntary sector to develop joined up models of care, outside of hospital, to give people the support they need in the right place, from the right professionals at the right time.
- Design modern, high quality hospital services; reducing variation in quality and ensuring a clinical and financially sustainable hospital system.
- Become more efficient by reducing costs in corporate services and maximising the efficiency of clinical support services.

There are few that would question what extreme challenges face our precious NHS in the future, but 2018 gives us a platinum opportunity to pause and recognise all that is great about this national treasure. It is 70 years since Aneurin Bevan, the then Health Secretary, launched the NHS at Park Hospital in Manchester (now Trafford General Hospital). For the first time, hospitals, doctors, nurses, pharmacists, opticians and dentists were all brought together under one umbrella to provide services for free at the point of delivery.

There is so much to celebrate about what is one of the most envied healthcare systems in the world. The NHS has played its part in eradicating diseases such as polio and diphtheria and pioneered new treatments including carrying out the first liver, heart and lung transplant. Not least, it is also the UK's largest employer with 1.5 million staff drawn from all over the world.

As I write this our staff are already well into the throes of planning for our big birthday – ably supported by our patients, community and the many wonderful volunteers who give their time freely to help us take care of our patients. I look forward to July where we will be off on our '*Moving to Outstanding*' journey, pushing ahead with our plans for our new hospitals and working with our local, regional and national partners to ensure that our services remain safe and sustainable and here for the future. Most of all I look forward to once again seeing our amazing TeamWHH do what they do best – caring for our patients and each other – but this time complete with party hat and birthday cake!

Happy 70th Birthday NHS!



Mel Pickup, Chief Executive

Statement of the purpose and activities of the Trust

The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England. The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes. The Trust may provide goods and services for any purposes related to:-

- the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
- The promotion and protection of public health.

The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

The purpose of this Performance Overview is to give the reader a short summary that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

A brief history of the Trust and its statutory background.

Our Trust comprises three acute (secondary) care hospitals across two sites in the Boroughs of Warrington and Halton, making us part of the mid-Mersey health economy.

Warrington Hospital is the home of all of our emergency and complex surgical care, our 'hot' site, while Halton General Hospital in Runcorn is a centre of excellence for planned routine surgery. The Cheshire and Merseyside Treatment Centre (CMTC) is home to our orthopaedic surgery services based on the Halton General site. Although each hospital focuses on particular aspects of care, we provide outpatient clinics for all our specialties and diagnostic (scanning) services at both Warrington and Halton sites so patients can access their appointments closer to home wherever possible. We also provide some outpatient services in the local community.

Warrington Hospital

Warrington Hospital focuses on emergency and specialist care and has all the backup services required to treat patients with a range of complex medical and surgical conditions and provides a full range of expert inpatient and outpatient services. Warrington Hospital is home to our accident and emergency department and maternity services as well as specialist critical care, stroke, cardiac and surgical units.

Halton Hospital

A range of planned care for medical and surgical conditions is provided at Halton Hospital delivering both inpatient and outpatient services. Without the pressured environment of its emergency care sister; Halton is a warm, friendly and welcoming environment for expert surgical care. The hospital is also home to the extremely successful Runcorn Urgent Care Centre that provides a range of minor emergency care services for local people until 8pm daily. We also provide some chemotherapy services on site at the CanTreat Chemotherapy Centre and the site is home to the Delamere Macmillan Unit.

Cheshire & Merseyside Treatment Centre

The Cheshire and Merseyside Treatment Centre is the home of orthopaedic surgery and treatment services located on the Halton Hospital campus. Here we perform a wide range of surgeries including hand, foot operations, joint replacements and spinal back surgery. We treat complex sports injuries (sports medicine) and provide other bone and joint care services. The centre was purpose-built for orthopaedic surgery and it is an extremely popular choice in the region for surgery with excellent patient feedback.

Our place in the wider health economy

In delivering the Five Year Forward View we are part of the Cheshire and Merseyside Health and Care Partnership (formerly Sustainability and Transformation Plan) the second largest in the country.

Our Vital Statistics

- We serve a population of 330K across both boroughs
- We saw approximately 112K A&E visits and circa 30K Urgent Care visits in year
- We deliver 500,000 individual patient appointments, procedures and stays
- We have circa 540 beds across 2 sites: 431 acute care inpatient, day case and specialist beds at Warrington; 44 elective surgical beds and 22 intermediate care beds at Halton and 42 T&O beds at CMTC
- We have a bespoke Forget-Me-Not unit where we deliver acute care for patients with dementia
- We employ around 4,200 strong workforce comprising 52 nationalities
- We are proud to have been named as one of the 100 Best Places to Work in the NHS - Health Service Journal
- Our Maternity service was awarded 'Best Maternity Service in the UK' by the RCM
- We have three key commissioners: Warrington CCG (main), Halton CCG and NHS England Specialist Commissioning
- We have an annual turnover of over £210 million
- Around 3,000 babies are born at Warrington Hospital each year

About the Trust

Warrington and Halton Hospitals NHS Foundation Trust was created on 1 December 2008 from what was formerly known as North Cheshire Hospitals NHS Trust.

Warrington General Hospital was created from the workhouse in 1898. In 1929 it was renamed Warrington Borough Hospital and to this day is referred to as *the Borough* by many people. There were two other hospitals on the site; Aikin Street (an infectious diseases hospital) and Whitecross Hospital, which was run by the military. In 1973 a decision was taken to merge all three hospitals into Warrington District General Hospital. The current hospital has grown in four stages since then.

- Aikin Street was demolished in the 1970s to make way for Appleton Wing of the current hospital (where the A&E, medical wards and theatres are located) which was phase A of the new General.
- Burtonwood Wing opened in 1988 with the stroke, elderly care and children's wards.
- The main building of Whitecross Hospital was demolished in the late 1980s to make way for the Croft Wing which opened in 1994 and houses maternity and women's services.
- The Daresbury Wing opened in 1998 and was surgical unit with single rooms.

In 1993 the government decided to separate the role of health authorities and hospitals and the hospital was handed over from Warrington Health Authority to the newly formed Warrington Hospital NHS Trust. North Cheshire Hospitals NHS Trust was formed by the merger of Warrington Hospital NHS Trust and Halton General Hospital NHS Trust in 2001.

The hospital has undergone significant development over recent years with a rebuilt accident and emergency and coronary care unit and refurbishment of most of the wards. A new critical care unit costing £6.25 million opened in February 2009 and in late 2010 new endoscopy and eye surgery units opened in the Appleton Wing.

In September 1976, Halton General Hospital was opened in Runcorn. It was a newly built 70-inpatient-bed hospital, next door to Runcorn Shopping City (now called Halton Lea Shopping) and part of the development of Runcorn New Town. Halton Health Authority passed control of the hospital to the newly formed Halton General Hospitals NHS Trust in 1993. In 2001 North Cheshire Hospital NHS Trust was formed by the merger of Halton General Hospital NHS Trust and Warrington Hospital NHS Trust.

In 2006 a reconfiguration of services saw the Trust's emergency and acute medical care work centralised at Warrington Hospital and planned surgical work move to Halton General. Although Halton has never had a full accident and emergency department is now home to a state-of-the-art Urgent Care Centre where nurse-led care is available for minor injuries and ailments. A new operating theatre opened at the hospital in 2007 to provide extra surgical services. In 2008 new step down care wards, a renal dialysis unit and an expanded chemotherapy centre opened.

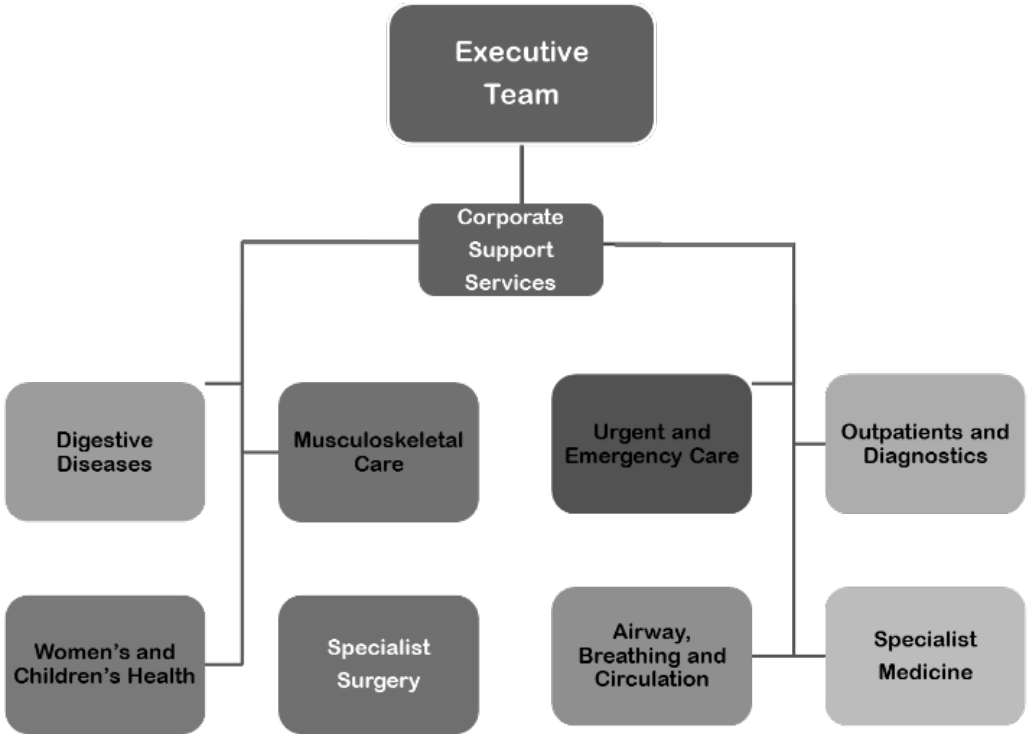
The Trust took ownership of the neighbouring Cheshire and Merseyside Treatment Centre in July 2012. The centre was previously home to a private healthcare provider. It has four operating theatres, 44 inpatient beds and a range of clinic, physio and scanning facilities and the Trust's orthopaedic surgery services are based there - moving from Warrington Hospital in autumn 2012. The Trust became a Foundation Trust in 2008 and has circa 14K members.

Our Objectives

Our Strategic Objectives:

1. To ensure that all care is rated among the top quartile in the North West of England for patient safety, clinical outcomes and patient experience
2. To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients
3. To deliver well managed, value for money, sustainable services
4. To work with our partners to consolidate and develop sustainable, high quality care as part of a thriving health economy for the future.

How we are organised



Issues and Risks that could affect the Trust in delivering its objectives

The key issues and risks that could affect the Trust in delivering its objectives are as below. These risks are recorded on the Board Assurance Framework and are scrutinised quarterly by the Board, Quality Assurance Committee and the Audit Committee. In addition, any new risks, or changes to risk ratings, are provided in a monthly update to the Board through associated committees**.** These risks vary on an ongoing basis and are downgraded or upgraded as a result of changing circumstances and the implementation of mitigations. These risks are valid at time of producing this report, April 2018. The organisations has identified the following strategic risks (Red risks rated at 15 and above)

Red Risks (ie scored at 15 and above)

1. Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.

2. Financial Sustainability
   a) Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.
   b) Failure to deliver the financial position and a surplus places doubt over the future sustainability of the Trust. There is a risk that current and future loans cannot be repaid and this puts into question if the Trust is a going concern

3. Failure to deliver national and local performance targets will impact on patient care, reputation and financial position

4. Failure to provide a spinal service for the local population, caused by a voluntary suspension of the service amid potential governance concerns, resulting in poor patient experience, potential safety concerns for those patients with delayed procedures or follow ups, reputational damage and potential regulatory and contractual issues.

5. Failure to have insufficient anaesthetic cover on critical care, due to insufficient middle grade/registrar doctors to cover the 2nd and 3rd tier on calls, resulting in potential patient safety issues, operational impact and financial pressures due to locum costs

6. Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets

7. Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the Trust

8. Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data

9. Lack of assurance regarding the Trust's safeguarding agenda being implemented across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations

10. Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position

11. Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.

Going Concern Disclosure

The Trust must, in preparing the annual statement of accounts, undertake an assessment of its ability to continue as a going concern. In making this assessment, the Trust should take into account all information about the future that is available at the time at which the judgement is made.

The final 2018/19 Annual Plan was submitted on 30 April 2018.

The preparation of the income statement, cash flow statement and the resulting statement of financial plan is predicated on a number of national and local factors and assumptions regarding both income and expenditure and profiled accordingly.

The planned level of activity undertaken for its commissioners and therefore the planned level of income is derived after due consideration of a range of factors, including:

- 2017/18 forecast outturn
- Changes in demography and demand
- National Payment by Results rules and regulations
- Changes to national tariff structure and prices
- Commissioning Intentions
- Receipt of Provider Sustainability Funding

The day to day operations of the Trust are funded from agreed contracts with NHS commissioners. The uncertainty in the current economic climate has been mitigated by agreeing a number of contracts with Clinical Commissioning Groups, Local Authorities and NHS England for a further year and these payments provide a reliable stream of funding minimising the Trust's exposure to liquidity and financing problems.

The planned expenditure within the approved plan is derived after due consideration of a range of factors, including:

- Pay awards and incremental increases
- National Insurance and pension contribution changes
- Current budgetary pressures
- Inflationary increases for insurance premiums, drugs, utilities and general non pay
- Financial consequences of both capital and revenue developments
- Cost savings requirements
- Impact of activity levels and commissioning intentions

The main financial headlines resulting from application of the above factors that form the basis of the final 2018/19 Annual Plan are as follows:

- A planned operating deficit of £24.6m and control total deficit of £24.4m
- No Provider Sustainability Funding received
- Cost savings target totalling £7.0m (equivalent to 3.0% of turnover)
- Current working capital loans totalling £65.6m (this is comprised of a £14.2m loan in 2015/16, a £7.9m loan in 2016/17, a £16.8m loan in 2017/18 and a £24.4m loan in 2018/19 to support planned and actual deficits together with a £2.3m in 2017/18 to support aged creditors). The 2015/16 loan is due for repayment in November 2018 and a replacement loan will be required.
- Capital expenditure totalling £10.0million
- Planned closing cash balance of £1.2 million (in line with the terms and conditions of the working capital loan).

The Trust believes that it has been realistic in its assessment of efficiency targets and therefore believes that this forward plan provides a realistic assessment of the Trust's position in 2018/19.

Cash flow statements take into account the planned deficit, capital expenditure, repayment of Public Dividend Capital and movements in working balances.

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Notwithstanding the 2018/19 planned deficit referred to above, the Trust does not have any evidence indicating that the going concern basis is not appropriate as the Trust has not been informed by NHS Improvement that there is any prospect of intervention or dissolution within the next 12 months.

In terms of the sustainable provision of services, there has been no indication from the Department of Health that the Trust will not continue to be a going concern although the Trust does require a working capital loan to meet its operational cash obligations.

In 2018/19 the Trust will seek additional cash support via a working capital loan from the Department of Health. The Department of Health has not yet confirmed this support with this factor representing a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. However, the Directors, having made appropriate enquiries, have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

The Board will consider for 2018/19 a resolution enabling the Chief Executive to draw down loans within defined parameters, as recommended by the Department of Health, to assist the Trust in accessing working capital finance once the board have agreed the loan value as appropriate.

As directed by the 2018/19 Department of Health Group Accounting Manual the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

Performance Report

The Trust's annual plan for 2017-18 was the delivery vehicle for our five year strategic plan - underpinned by the four strategic objectives which represent our core activities. Key Performance Indicators, aligned to the strategic objectives, are monitored by the Trust Operations Board, the Executive Team and the Trust Board.

Strategic Objectives

1. **To ensure that all care is rated amongst the top quartile in the North West of England** for patient safety clinical outcomes and patient experience. This will ensure we maintain a focus on continuously improving the quality of services, work to decrease variations in care and improve health outcomes.
2. **To have a committed skilled and highly engaged workforce** who feel valued supported and developed and who work together to care for our patients. This will enable us to become a model employer ensuring we attract and retain high quality people to deliver high quality services.
3. **Deliver well managed, value-for-money, sustainable services.** This will ensure that we remain here for our communities over the long term.
4. **To work with our partners to consolidate and develop sustainable, high quality care** as part of a thriving health economy for the future. We will work within the LHE to develop integrated care services by working to reduce admissions and support the provision of care closer to home, improve the care of frail older people and reduce the reliance on secondary care out-patient services.

The Trust's key performance measures are established against the QPS framework i.e. Quality, People and Sustainability which underpins delivery of the strategic objectives.

Quality

- Healthcare Acquired Infections
- Mortality indicators
- High risk incidents
- Safety Thermometer (harm free care: pressure ulcers, falls, catheter-acquired UTI's and VTE
- CQUIN-linked indicators (sepsis, antimicrobial stewardship)
- Falls
- Pressure ulcers
- Patient experience – Friends and Family
- Complaints
- Staffing

Performance indicators

- Diagnostic Waiting Times
- Referral to Treatment
- A&E Waiting Times
- Cancer referrals and treatments
- Ambulance handover times
- Discharge summaries

People

- Sickness absence
- Return to work interviews
- Recruitment
- Turnover
- Non-contracted pay
- Essential training
- Clinical training
- Performance Development Reviews

Sustainability

- Cash Balance
- Capital programme
- Financial position
- Use of resources rating
- Cost improvement plan
- Better payment practice code
- Agency spending

Activity and Performance

During 2017-18 A&E Attendances increased by 3.7% and non-elective admissions decreased by 8.0%.

The age and morbidity of the patients we saw and treated continued to increase, reflecting the demographics of the population we serve. This put significant pressure on our resources, specifically beds, and the local health economy's ability to discharge patients. We continue to work very closely with our health and social care partners to transform patient pathways, to increase care closer to home or in the community whilst minimising hospital attendances and admissions.

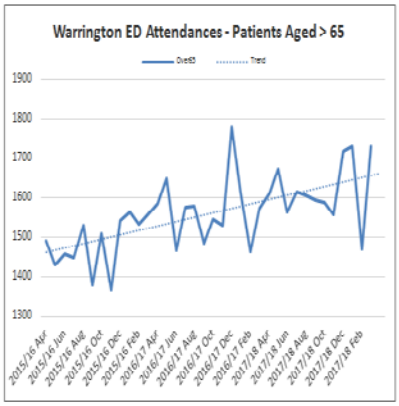
Activity Variance

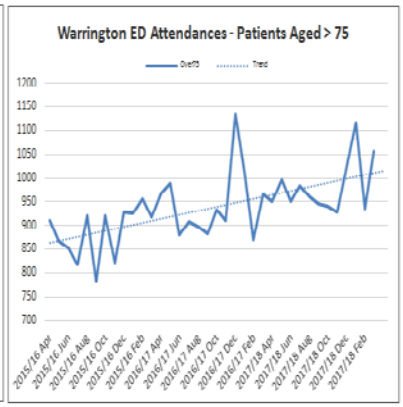
Activity	2015/16	% change 15/16 vs 14/15	2016/17	% change 16/17 vs 15/16	2017/18	% change 17/18 vs 16/17
Elective Inpatient Discharges	5,461	-1.2%	5288	-3.2%	4929	-6.8%
Elective Day Cases Discharges	31,429	-4.8%	31633	0.6%	28926	-8.6%
Non-Elective Discharges	38,542	-3.1%	42771	11.0%	39670	-7.3%
New Outpatient Attendances	117,912	-4.4%	109259	-7.3%	103,138	-5.6%
A&E Attendances	105,450	2.8%	108,889	3.3%	112,928	3.7%

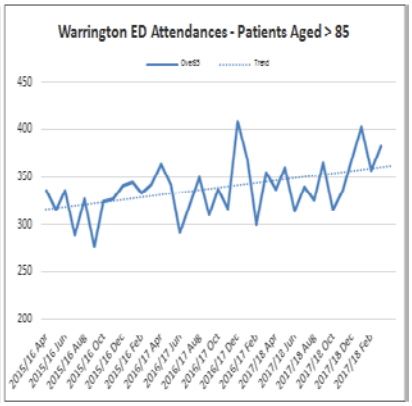
Delivering the Four Hour Standard

It is an expectation that all patients who attend accident and emergency are seen and treated within four hours. Nationally the target is 95% and the majority of acute Trusts have struggled to achieve this target in year. The chart below illustrates our performance in seeing and treating patients within this time. While the Trust performed well compared to peers it did not achieve the 95% national standard and closed with a performance of 88.67% ytd.

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
A&E & MIU (including Widnes Walk-in)	% Departed <=4hrs	>=95%	91.41%	92.81%	90.38%	91.55%	92.82%	94.39%	90.93%	92.71%	89.47%	87.50%	83.78%	86.88%	85.56%	83.81%	81.95%	83.74%	88.67%
	* Number of attendances		10457	11211	10971	32639	11282	10597	10677	32556	11193	10989	11556	33738	11411	10176	11943	33530	132463
	* Number of patients breaching 4hrs		898	806	1055	2759	810	595	968	2373	1179	1374	1874	4427	1648	1648	2156	5452	15011



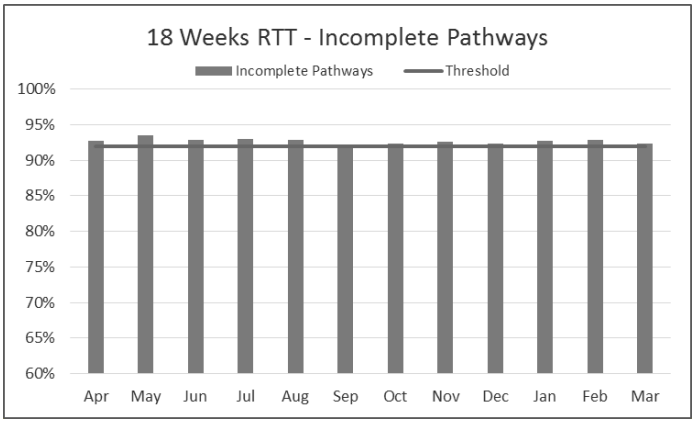




Waiting Times

The Referral to Treatment (RTT) operational standard for England focused on the number of incomplete pathways less than 18 weeks. The Trust achieved the 18 week referral to treatment target consistently throughout 2017-18, against a target of 92%; this is difficult and challenging but supports care being delivered in a timely manner.

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
RTT - 18 Weeks	Incomplete Pathways % <18 Weeks	>=90%	92.71%	93.48%	92.86%		92.95%	92.83%	92.06%		92.29%	92.60%	92.33%		92.69%	92.82%	92.35%		
	* Number of Incomplete pathways		19591	20017	19912		20277	18899	19160		19330	19331	18941		18835	19042	18852		
	* Number of patients waiting 18+ weeks		1429	1305	1421		1429	1355	1522		1490	1430	1452		1376	1368	1443		
	* Number of patients waiting 52+ weeks	0	0	0	0		0	0	0		0	0	0		0	0	0		



Delayed Transfers of Care

Delayed transfers of care (DTOC) occur when a patient that is medically fit to be discharged from hospital is unable to do so. In year we worked extensively with our partners across the health and social care economy to ensure that patients were supported to return home or on to more appropriate care settings once their acute care was complete thus ensuring that beds remained available for incoming patients.

The successful discharge of frail older patients following emergency admission to hospital relies on effective joint working between NHS, social care partners and the independent sector. Early assessment and review using the most appropriate multi-disciplinary team at the point of entry to urgent and acute services was

essential for frail older patients to ensure a timely and appropriate diagnosis is made, and then a plan for discharge can be implemented.

The table below shows the number of delayed patients in our hospital beds on the last Thursday of every month, which is the current measure all Trusts use and report to NHS England. It also shows the number of days the patients remain delayed in a hospital bed awaiting ongoing care.

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Number of patients delayed on the last Thursday of each month	33	27	35	18	23	83	219
Total days lost in month	507	503	497	537	558	563	3165
Number of occupied bed days (patients aged 18+)	14401	14110	15185	14690	14839	16860	90085
Days lost as % of occupied bed days	3.52%	3.56%	3.27%	3.66%	3.76%	3.34%	3.51%
Average daily bed days lost	16	17	16	17	20	18	105
Average general and acute occupied beds (including Critical care, excluding Neonatal, Paediatrics and Day case beds)	496	492	489	529	549	552	3108

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
Number of patients delayed on the last Thursday of each month	21	14	41	36	27	40	179
Total days lost in month	664	455	610	791	644	701	3865
Number of occupied bed days (patients aged 18+)	14497	14765	13560	15629	12965	17203	88619
Days lost as % of occupied bed days	4.58%	3.08%	4.50%	5.06%	4.97%	4.07%	4.36%
Average daily bed days lost	21	15	20	26	23	23	127
Average general and acute occupied beds (including Critical care, excluding Neonatal, Paediatrics and Day case beds)	491	482	489	535	515	517	3029

National Targets and Regulatory Requirements

Below is a summary of all the national targets and regulatory requirements that we were expected to achieve and performance against each target for the past four years. The Trust improved and achieved performance against the % of cancer patients waiting a maximum of 2 months from urgent GP referral to treatment for both quarters three and four, however failed to achieve this at the start of the year in both quarters one and two, meaning overall achieving just over 82% against the 85% standard. Causal factors have been resolved and plans are in place to deliver the high performance we have delivered for our patients consistently in previous years.

Performance against national target and regulatory requirements 2017/18

National Targets and Minimum Standards	Target	Target 2017/18	2017/18	2016/17	2015/16	2014/15
Infection Control	Number of clostridium difficile cases 17/18, 16/17 & 15/16 are the numbers due to lapses in care	<= 27	2	11	10	31
	Number of MRSA blood stream infection cases	0	1	0	2	3
Access to Cancer Services	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	98.17%	97.60%	99.33%	98.67%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti-cancer drugs)	98%	98.17%	100.00%	100.00%	99.81%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	94%	98.20%	95.24%	99.00%	99.14%
	% of cancer patients waiting a maximum of 2 months from urgent GP referral to treatment - Open Exeter	85%	82.81%	84.04%	85.77%	88.26%
	% of cancer patients waiting a maximum of 2 months from urgent GP referral to treatment - Reallocation	85%	81.01%	83.09%	85.00%	88.38%
	% of cancer patients waiting a maximum of 2 months from the consultant screening service referral to treatment	90%	97.35%	100.00%	96.88%	99.52%
	% of cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen	93%	93.91%	93.33%	93.88%	94.04%
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen	93%	91.51%	91.30%	93.20%	93.45%
Access To Treatment	18 weeks Referral to Treatment – admitted		78.52%	81.49%	90.70%	92.34%
	18 weeks Referral to Treatment – non-admitted		92.46%	94.03%	96.42%	97.61%
	18 weeks Referral to Treatment – patients on incomplete pathway End of March position	92%	92.35%	93.01%	92.50%	93.60%
Access to A&E	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	95%	88.67%	90.60%	88.09%	89.75%
Access for patients with a learning disability	The Trust provides self-certification that it meets the requirements to provide access to healthcare for patients with a learning disability	N/A	YES	YES	YES	
Cancelled operations on the day for a non-clinical reason	Number of Cancellations not offered a date for readmission within 28 days	0	4	9	16	
	% of in-patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital	<= 2%	0.84%	0.55%	1.02%	1.32%
	% of those patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not readmitted within 28 days		8.08%	11.17%	8.74%	2.81%

Financial Performance

The Trust recorded a £14.7m deficit for the year, which included £4.3m Sustainability and Transformation Funding. This deficit has resulted in the requirement for additional cash from the Department of Health in the form of working capital loans.

The deficit was £11m above the planned £3.7m deficit (the 'control total') agreed at the start of the year with NHS Improvement. Some of the elements contributing to the higher than planned deficit include: The suspension of spinal services (£2.3m including costs in year), failure to realise the October-March STF monies (£4.6m), loss of income due to mandated cancellation of elective activity during winter (£0.7m), cost-improvement plan shortfall (£5.3m), pay including agency costs (£3.5m) and fines and penalties levied by commissioners (£1.8m).

The annual cost savings target was a very ambitious £10.5m and savings achieved for the year were £5.1m, a shortfall of £5.4m. The annual capital programme was £7.5m and the actual spend for the year was £5.8m. The cash balance was £1.2m which is in line with the balance required under the terms and conditions of the working capital loan agreement.

Sustainability and climate change at the Trust

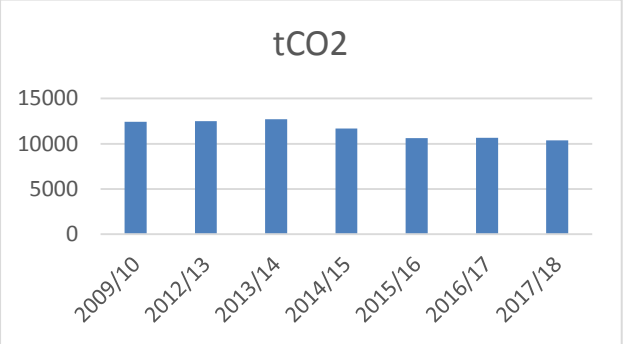
One of the Trust's key objectives is around sustainability and a key part of that is around carbon reduction and climate change. As the largest single organisation in the UK, the NHS is responsible for major consumption of resources emitting around 18 million tonnes of CO2 every year. It is therefore incumbent on all NHS organisations to lead, both by example and in practice, in making sustainability a strategic priority. 2017-18 has seen the Trust develop and introduce measures and initiatives that have enabled the organisation to continue to make progress on the sustainability and carbon management agenda. The combined heat and power units on both the Halton and Warrington sites are now in full operation, producing electricity and hot water which is utilised within its heating and hot water systems, plus, feeding the excess electricity generated and not used by the Trust back into the National Grid.

The Trust has reduced its Carbon Footprint (from the baseline year 2009/10) by 16.5% based on the 2017-2018 energy consumption figures. The aims and objectives of the Trust's sustainability strategy, as encompassed by the Trust's Sustainable Development Management Plan, are to:

- Reduce the Trust's carbon footprint in line with the Trust's Carbon Management Plan.
- Ensure that all resources are used effectively and economically, thus releasing more funding to be spent directly on patient care
- Minimise the environmental impact of the Trust's activities on both the local and global Environments
- Maximise the efficient use of water resources
- Minimise waste streams and limit the impact of waste disposal
- Ensure that the Trust manages the built environment to encourage sustainable development and low carbon usage
- Empower all staff to deliver high quality care now, that does not compromise our ability to do so in the future
- Work with all our stakeholders and partners to create strong partnerships to promote and implement the changes required to begin the transition towards a low carbon healthcare economy
- Ensure good governance and continue to embed sustainability into the cultural agenda of the organisation
- Continue to develop our awareness of sustainability and carbon issues including the development of a low carbon healthcare economy, mandatory sustainability and carbon emission reporting, carbon taxation and carbon trading

Sustainability performance summary

In 2012/13 the Trust increased its building footprint with the purchase of the CMTC Building at Halton. The graph and table below summarises the Trusts position with regard to its tCO^2 reduction and its current energy consumption:



	2017-18	
	Total usage	**Cost (£)**
Water	**101,251m3**	**£407,658**
Electricity	**3,443 tCO2**	**£912,319**
Gas	**8,333 tCO2**	**£974,247**

Waste Production and Control

Healthcare waste produced by the Trust is managed in accordance with HTM 07 01, *Safe Management of Healthcare Waste Guidance* and current waste legislation. This is supported by up to date policies/procedures and the procurement of external waste contractors, to safely collect, transport and dispose of healthcare waste from Trust premises. This takes into account the Waste Management Hierarchy, (Sustainability Model), with the aim to reduce carbon emissions and achieve Zero Landfill requirements for the Trust. This Trust recycles 100% of domestic/household waste, cardboard waste, and confidential/clean office waste.

Future priorities and targets around sustainability

The Trust continues to focus on its Carbon Management Plan (CMP), developed under the NHS Carbon Management Programme, which contains the following Low Carbon Vision:

"Warrington and Halton Hospitals NHS Foundation Trust will become a leading carbon management and sustainability partner within the local community and across regional public sector carbon management / sustainability networks. The Trust will work with staff, patients, suppliers and key stakeholders to achieve and where possible exceed the ambitious carbon reduction targets set by the NHS."

As a consequence the Trust identified, developed and reviewed the potential implementation of a large number of carbon saving schemes in order to achieve the nationally set targets.

- The Trust then successfully entered tranche 1.5 of the NHS Carbon and Energy Fund (CEF) scheme procurement process to install Combined Heating and Power (CHP) on both the Warrington and Halton hospital sites. CHP plant would provide the Trust with both heat and electricity generated on site, resulting in both financial and carbon savings. This scheme is now fully operational.
- The CEF Scheme process investigated the potential installation of energy efficient lighting schemes across the Trust which was also implemented.
- Following on from the CEF Scheme and working in partnership with Cynergin, the Trust invested in further energy efficient lighting on its Car Parks.
- The Trust has implemented a Sustainable Procurement Policy.

Social, Community and Human Rights Issues

The Trust takes its position in the local community as a major employer seriously. Various relationships have already been established with schools and colleges as the Trust recognises that its future workforce will largely be provided from the local community. Where possible, work experience placements are arranged which allows students to see first-hand the type of roles available and whether there are career opportunities that meet their expectations.

The Trust offers attractive pay and conditions of service and other benefits where salary sacrifice arrangements can be made for lease cars, childcare vouchers, car parking and cycle to work. Applications are welcomed from all protected characteristics to ensure that we practice our commitment to equality and diversity. This is reflected in our Recruitment and Selection Policy and Disability Equality Policy. The Trust has an Equality and Diversity Specialist whose responsibility is to ensure that human rights in the Trust are promoted and maintained. In April 2016 the Trust produced its first Statutory Statement on Modern Slavery and this is published on the Trust website.

The Trust participates with the 'Good Corporate Citizen Guide' and is proud that for its 'Workforce' it has maintained its compliance score of 79% which is significantly above the North West average.

The Trust's compliance with Anti-bribery guidance, policies and effectiveness of these policies

The Trust has in place an Anti-Fraud, Bribery and Corruption Policy. This policy has been produced by the Anti-Fraud Specialist (AFS) and is intended to provide a guide for all employees [regardless of position], contractors, consultants, vendors and other internal and external stakeholders who have a professional or business relationship with the Trust, on what fraud, bribery and corruption matters are in the NHS; what everyone's responsibility is to prevent fraud, bribery and corruption; and also how to report concerns and/or suspicions with the intention of reducing fraud to a minimum within the Trust.

This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to employees who may identify suspected fraud, corruption or bribery. It provides a framework for responding to suspicions of fraud, bribery and corruption, advice and information on various aspects of fraud, bribery and corruption and implications of an investigation. It is not intended to provide a comprehensive approach to preventing and detecting fraud, bribery and corruption

In addition to this and included within the Trust's Standing Financial Instructions is a Standards of Business Conduct and Gifts and Hospitality Policy. This sets out the responsibilities of all staff on the standards of business conduct that are expected. The Secretary to the Board has designated responsibility for maintaining the register of declared interests. The register is available to the public on the Trust's website. Annual declarations are required to be completed by staff with the power to either enter into contracts and/or who are involved in decision making on an annual basis and there is a gifts and hospitality register held by the Trust.

Compliance with the Modern Slavery Act 2015

The Trust employs over 4,200 staff and the vast majority of these staff are employed either under pay, terms and conditions of service established nationally under Agenda for Change or Medical and Dental provisions. A small number of staff, which comprise the Trust Board and very senior managers, are employed under local pay, terms and conditions of service which are established by the Remuneration Committee of the Board.

All staff are appointed subject to meeting the NHS Standards on Employment Checks which includes references, health Checks, DBS checks, immigration checks and Identity checks. In addition, during 2015/16 the Trust has developed a number of values and behaviours which are being fully implemented from 1 April 2016. The Trust expects its existing staff to comply with these standards and all future appointments will be expected to demonstrate these attributes as part

of the appointment process. This ensures that the Trust can be confident, before staff commence with the Trust, that we know some background about our staff and that they have a legal right to work for the Trust.

By adopting the national pay, terms and conditions of service, the Trust has the assurance that all staff will be treated fairly and will comply with the various legislation. This includes the assurance that staff received at least, the National Minimum Wage during 2015/16 and from April 2016 the new National Living Wage.

The Trust has various employment policies and procedures in place designed to provide guidance and advice to staff and managers but to also comply with employment legislation. Every policy is impact assessed from an Equality and Diversity perspective and although this does not currently make reference to the Modern Slavery Act 2015, this will be amended during 2016/17 and new policies/procedures and those being reviewed/updated, will be assessed in the future to consider this aspect.

The Trust does have specific policies in place to deal with the Safeguarding of Children and Vulnerable Adults but does not have a specific policy on the Modern Slavery Act and does not feel the need to develop one. However, should the Trust become aware of any issue covered under the Modern Slavery Act, it would immediately report the matter to the Police.

The Trust has an extensive training and development programme which is based on a minimum requirement to complete all statutory and mandatory training and other ad-hoc training which staff are required to undertake for their various roles. Training needs are identified through Individual Performance Development Reviews and a Personal Development Plan produced. Not all staff will require the same awareness and training but in relation to the Modern Slavery Act, the Procurement Team will receive this as a priority.

The Trust employs an Equality and Diversity Specialist who will take the lead on the Modern Slavery Act and where possible the Trust does support awareness raising events both locally and nationally on such matters as the disabled, Gay and Lesbians and Honour Crime and Forced Marriages. Consideration will be given to increased awareness on the Modern Slavery Act during 2016/17.

Important events since year end

1. The Trust suffered a fire in its Kendrick Wing on 23 March 2018. A small number of Ophthalmology outpatient appointments were cancelled, however quickly rearranged which has resulted in minimal disruption to the provision of care to patients. Additionally, the resulting impairment of the building (£445k) is reflected in the financial statements.

2. Sustainability and Transformation Funding: The Trust was notified by NHS Improvement on 20 April 2018 that it was entitled to a £1.838m ‘share’ of the STF General Incentive Scheme and which has been included in the 17/18 annual accounts.

ACCOUNTABILITY REPORT

Directors' Report

At 31st March 2018 the Trust Board declares that it has a full complement of non-executive and executive directors, with all voting and non-voting positions substantively filled. The Board is assured about its balance in terms of gender, with eight female and eight male directors in total, of which voting members comprise 5 females and 6 males. In addition, the directors have complementary skill sets and many have considerable prior Board-level experience across both public and private sectors. The Trust Board believes it is therefore appropriately comprised and satisfies the requirements to lead the NHS Foundation Trust.

The Board evaluates its performance, its committees and its directors, including the chairperson, on an ongoing basis. The Board underwent an independent, Well Led assessment conducted by Deloitte LLP between January and March 2017 which provided written and verbal feedback to the Board in April 2017. Following this a comprehensive action plan was developed, the progress of which was received by the Board on a quarterly basis. In undertaking this work, the Trust affirms that the supplier, Deloitte LLP, has no other connection to the Trust.

At each Board Meeting an anonymous meeting effectiveness review takes place, the results of which are discussed at the following meeting and 'rolling tracker' of performance maintained. Annual reports are received from each of the committees to the Board.

All directors undergo an annual appraisal with periodic reviews to monitor progress. The Council of Governors undertakes the Chairman's appraisal annually which comprises a 360 degree survey of executive and non-executive directors and the Council of Governors plus a 1:1 meeting with the Senior Independent Director.

The appointment and removal of the Chair, Deputy Chair and other Non-executive Directors is laid down in the Foundation Trust's Constitution and where:

24.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-executive Directors and shall appoint one of the Non-executive Directors as the Deputy Chair of the Trust.

24.2 Removal of the Chair, Deputy Chair or another Non-executive Director shall require the approval of three quarters of the members of the Council of Governors.

The Board of Directors for the reporting period:

1. Non-Executive Directors

Steve McGuirk – Chairman CBE, QFSM, DL, MA BA (Hons), BSc, FRSA, FIFireE

Steve McGuirk joined us as chairman in April 2015. Steve, who lives in Warrington, joined the fire service in 1976. He retired from his role as county fire officer and chief executive of Greater Manchester Fire and Rescue Service in 2015. He was previously county Fire Officer and Chief Executive for Cheshire Fire and Rescue Service before taking on the post in Greater Manchester in 2009. He has also been a Board member and President of the Chief Fire Officers Association and has been the principal adviser on fire and rescue matters to the Local Government Association. He was awarded the long service and good conduct medal in 1996, the Queen's Fire Service Medal in 2002, and the CBE in 2005. He has also gained extensive experience in governance of public authorities. In October 2017 Steve was appointed as an expert witness to the Grenfell Enquiry. His Term of Office was extended for a second term of office in March 2018 for a further three years to March 2021.

Terry Atherton – Deputy Chair

Terry Atherton joined the Trust Board as a Non-Executive Director in July 2014 and is Chair of the Finance & Sustainability Committee. Terry worked for NatWest Bank for 35 years leading large teams and profit centres across the North West and North Wales. For the last 14 years he has worked with the both the public and private sector in a number of Board positions in a Non-Executive capacity. Terry was appointed Chair of Trafford Primary Care Trust in 2009 and following the national NHS reorganisations, he became Vice-Chair of the cluster of ten Greater Manchester PCTs with specific responsibilities for oversight of the workforce of 2,700 and of service redesign initiatives. He was appointed in January 2013 as Independent Chair of the Morecambe Bay "Better Care Together" Programme before joining the Trust. Terry lives in Cheshire. Terry's Term of Office was extended for a second term of office in June 2017 for a further three years to June 2020.

Ian Jones – Senior Independent Director

Ian Jones joined the Trust Board as a Non-Executive Director in July 2014 and is Chair of the Audit Committee. Ian is also the Senior Independent Director. After a career of over 35 years in the banking sector as regional corporate director for RBS, Ian changed direction in 2003 to take on wider interests and put something back. He is a Non-Executive Director of several charities in the education sector. Ian served as Vice Chair and Treasurer of the Liverpool School of Tropical Medicine for 12 years, until the end of his term of tenure at the end of 2016. Ian is the Chair of The Liverpool Institute for Performing Arts. Ian has lived in Warrington for over 20 years. Ian's Term of Office was extended for a second term of office in June 2017 for a further three years to June 2020.

Anita Wainwright

Anita Wainwright joined the Trust Board as a Non-Executive director in January 2015. A very experienced human resources and organisational development professional Anita has worked in both the public and private sector in the North West for over 35 years, gaining experience in the nuclear and gas industries; financial services; the fire service and the Environment Agency before joining the NHS. She was appointed as Director of HR and OD at University Hospital South Manchester in 2012 and in 2014 was seconded to Tameside Hospital to support their improvement programme. Anita has lived in Warrington for over 25 years and both her sons were born at Warrington Hospital. Anita's Term of Office was extended for a second term of office in December 2017 for a further three years to December 2020.

Dr Margaret Bamforth

Margaret Bamforth joined the Trust Board as Non-Executive Director in May 2016 and is Chair of the Quality Assurance Committee. Margaret qualified from Liverpool Medical School and completed her training as a Child and Adolescent Psychiatrist in Manchester. She practiced as a Consultant Child and Adolescent Psychiatrist in Halton for 22 years, before retiring from clinical practice. She has always had a strong interest in Medical Education and continued to work as an Associate Postgraduate Dean for Mersey Deanery and subsequently HENW, following her retirement. She has an interest in leadership and mentoring and is an Associate Tutor at Edge Hill University. Margaret has lived in Lymm for over 30 years and her three sons attended Lymm High School. She has strong links to the local community, both through her personal and work commitments.

Professor Jean-Noel Ezingeard

Jean-Noel Ezingeard joined the Trust Board as a Non-Executive Director in April 2017 and is Chair of the Charitable Funds Committee. Professor Ezingeard is Deputy Vice-Chancellor of Manchester Metropolitan University where he supports the Vice-Chancellor in ensuring the successful strategic functioning of the University. He has overall responsibility for the size and shape of all undergraduate and postgraduate taught programmes across the University and for the general development of an academic portfolio that appropriately reflects the needs of employers and the local economy. He is an Engineering Science graduate from Ecole Centrale de Lille - an Engineering Grande Ecole. He later obtained an MSc in Advanced Manufacturing Systems and his PhD from Brunel University. Before joining Manchester Met he was Executive Dean of Kingston Business School in London where he oversaw a £30m transformation of the School's buildings, a significant growth in research activity and enhancements to teaching and the curriculum. As Executive Dean he continued to teach on the MBA programme and to supervise doctoral students. His early career was as a Lecturer at Brunel University and Course Director for the Special Engineering Programme. He was then appointed as a Member of Faculty at Henley Business School where he later served as Professor of Processes and Systems Management and Academic Dean (Associate Dean for Faculty). He researches in the area of technology management, applied to Information Systems, Information Assurance and Security, and Logistics Information Management.

Executive Directors – Voting

Melany Pickup - Chief Executive

Melany was appointed as Chief Executive of the Trust in February 2011. Mel qualified as a registered general nurse in 1990 and after a number of clinical roles, worked in management before moving back into a professional nursing leadership role. In 1998 Mel became the Deputy Director of Nursing at Doncaster and Bassetlaw Hospitals NHS Trust and was appointed Director of Nursing and Quality at Rotherham General Hospitals NHS Trust in 2001. Mel then moved to Wrightington, Wigan and Leigh NHS Trust in 2003 to take up the post of Director of Nursing and Governance, a role in which she later became Director of Operations and Deputy Chief Executive. Mel was Chief Executive of The Walton Centre NHS Foundation Trust from January 2007 prior to her appointment with Warrington and Halton Hospitals.

Professor Simon Constable – Executive Medical Director & Deputy Chief Executive

Simon Constable joined the Trust as Medical Director in February 2015. He is a Consultant Physician and Honorary Senior Lecturer in Clinical Pharmacology at the University of Liverpool. He studied medicine at Guy's and St Thomas' Hospitals in London. Undertaking postgraduate training in London, the Midlands and New Zealand, he was appointed as Lecturer in Clinical Pharmacology & Therapeutics at the University of Liverpool before becoming the Medical Director of a clinical research unit in Manchester undertaking early-phase clinical trials on behalf of the international pharmaceutical and biotechnology industries. Simon returned to the NHS full-time in 2010 as a Consultant Physician in Acute Medicine at the Royal Liverpool and Broadgreen University Hospitals NHS Trust where he became Clinical Director and then Divisional Medical Director. Prior to taking up the post at Warrington and Halton, Simon has worked with the NHS Leadership Academy, Harvard University and the Institute for Healthcare Improvement on clinical leadership, employee engagement and transformational change within the NHS. Simon was appointed Deputy Chief Executive with effect from 1st March 2016.

Andrea McGee (nee Chadwick) - Director of Finance & Commercial Development

Andrea was appointed Director of Finance & Commercial Development from February 2016. Andrea joined the Trust from Calderstones Partnership NHS FT where she had been seconded from Mersey Care NHS Foundation Trust as Director of Finance and Information. She is a qualified accountant (ACCA) and has worked for the NHS for over 20 years. During this time Andrea has gained experience working within acute, mental health, learning disability, community and ambulance services and has led finance, estates and information teams. Andrea is a strong supporter of staff development and has received personal and team awards for finance staff development in the North west and nationally. Andrea lives in Warrington with her husband Kevin, daughter Ruby and Bruce their dog and enjoys going for walks in the Lake District with her family.

Kimberley Salmon-Jamieson – Chief Nurse

Kimberley joined our Trust in September 2016, having previously held the position of Deputy Chief Nurse at Pennine Acute NHS Trust. With 20 years of experience working as a nurse in the NHS, she has enjoyed a

variety of management and nursing roles, gaining a reputation for enthusiasm and energy. Prior to working for Pennine, she was Deputy Chief Nurse at University Hospital South Manchester NHS Foundation Trust. Her first management role was at Salford Royal NHS Foundation Trust where she had previously worked as Advanced Nurse for a long period of time. Her interests in the health sector include patient safety and experience, service development and education.

Chris Evans – Chief Operating Officer

Chris Evans joined the Trust in March 2018 from Salford Royal where he was Managing Director of Salford Health and Social Care. Prior to that Chris was at the University Hospital of South Manchester as Manager for the Women & Children's Division. He commenced his NHS career in 2002 undertaking a range of administrative posts locally within what was Salford Primary Care Trust. Subsequently, Chris developed his managerial career and gained experiences working throughout the region at both Central Manchester University Hospitals and The Christie. He has managed a variety of clinical services including, Renal Medicine, Heart Care, Acute Medicine, Young Oncology, Haematology, Breast, Obstetrics & Gynaecology and Paediatrics.

Sharon Gilligan – Chief Operating Officer
(To April 2017)

Jan Ross – Acting Chief Operating Officer
From 1 May 2017 to 7 January 2018

Lucy Gardner – Acting Chief Operating Officer
January and February 2018

Additional Executive Directors (non-voting)

Jason DaCosta, Director of Information Management and Technology

Jason was appointed as director of IT in February 2013. With extensive NHS and private sector experience, Jason brings both a managerial, operational and clinical engagement background to the Trust with a view to moving us forward towards a paperless environment by 2015. Prior to this appointment Jason has been head of IM&T at both ambulance service and acute and PCT Trusts before he headed up various health consulting groups.

Roger Wilson - Director of Human Resources
(To May 2017)

Michelle Cloney, Director of Human Resources and Organisational Development

Michelle was appointed Director of HR&OD after occupying the interim position since March 2017. Prior to joining the Trust she was Associate Director of Workforce at Pennine Lancashire Transformation Programme and Senior Responsible Officer for Workforce, Organisational Development and Leadership working across organisational boundaries within East Lancashire & Blackburn with Darwen, including both Clinical Commissioning Groups, two Local Authorities, one Acute Hospital and one Mental Health Trust. Michelle has worked in the NHS since 1984 initially joining the nursing profession and through this developed a passion for developing staff so they could deliver excellent care to patients and service users. In 1997 she moved into Human Resources & Organisational Development and has gained extensive knowledge and experience in the management of HR services, employee engagement, staff wellbeing, and multi-professional education. Michelle is committed to supporting staff to put our patients at the heart of all we do and to enable them to recognise the Trust as a great place to work and receive care.

Pat McLaren - Director of Community Engagement Company Secretary Designate

Pat joined the Trust in December 2015 as director of community engagement, a new position dedicated to expanding and supporting our relationships with the communities and people who use, work, visit, volunteer, support, commission, partner or donate to our hospitals. Commencing her NHS career as a biomedical scientist, Pat moved into communications, marketing and engagement in the healthcare and health sciences sectors over two decades ago. She has lived and worked in healthcare across the UK, USA, Middle East, India, Pakistan and Australia with all types of organisations from private sector global brands to public sector. She joined us from Barnsley Hospital and earlier from Alder Hey Children's Hospital where as communications lead she led the formal public consultation for the new hospital in the park.

Lucy Gardner - Director of Transformation

Lucy joined the Trust in February 2016 from her role as a Director in Ernst & Young (EY)'s healthcare advisory practice. Her role as Director of Transformation is a new role, designed to lead transformation across the

Trust and work with partner organisations to deliver change, enabling sustainable healthcare locally. Lucy started her career 12 years ago as an NHS General Management Trainee, gaining a Master's degree in health and social care leadership and management. In the 12 years she has held a number of operational management roles within the NHS and subsequently, in her role at EY, led large scale change programmes to deliver significant financial, quality and performance benefits within healthcare.

Dr Alex Crowe – Medical Director

Dr Alex Crowe is a consultant nephrologist who was appointed as Deputy Medical Director for WHH in December 2016 and Medical Director in October 2017. Alex is also the Trust's Clinical Chief Information Officer and current medical appraiser for NHS England and supports the Royal College of Physicians for a number of courses such as Physicians as Educators, Mentoring, Appraisal and Revalidation and Leadership. He joined the Trust in 2016 from Arrowe Park Hospital and Countess of Chester Hospitals where he was Consultant Nephrologist. He was also the renal Lead for Cheshire and Merseyside networks. He has also worked as a Secondary Care Doctor in Manchester, involved in promoting Healthcare Devolution in Manchester. He trained at St Thomas' Hospital, London.

During the reporting period there were interim arrangements in place for the role of Director of HR & OD from 1 March 2017 to October 2017 when a substantive appointment was made and Chief Operating Officer from May 2017 to December 2017 when a substantive appointment was made

Register of interests

A register of significant interests of both directors and governors which may conflict with their responsibilities is available from the Company Secretary upon request.

DISCLOSURE REPORT

1. Income disclosures as required by section 43(2A) of the NHS Act 2006

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. Warrington and Halton Hospitals NHS Foundation Trust has complied with this requirement and is satisfied that the income received from provision of non-NHS goods and services does not have any significant impact on the provision of NHS goods and services for the purposes of the health service in England.

2. Disclosure relating to member and public engagement

The Council has engaged with the Trust's membership through the *Your Hospitals* member publication which was received by post to each registered household. In addition, it hosted a number of conversation cafes under the brand 'What Matters To Me?'. It further hosted the Annual General Members Meeting in September 2017.

The Council has plans to engage with the membership and public in Q1 of 2018-19 on the Trust's refreshed Strategy, which was updated to reflect the Trust's ambition to become an 'Outstanding' Trust following the CQC's disappointing 'Requires Improvement' assessment in October 2017. They will do this through the Trust's annual member communication '*Your Hospitals'* which, in the NHS 70th year, will be a commemorative, souvenir edition mailed to 9K homes. Views will then be reported to the Board by the Council of Governors.

3. Disclosure relating to Quality Governance

Quality assurance and governance is described more fully in the Annual Governance statement at Annex 5, however the Board has an established Quality Assurance Committee chaired by a clinical Non-Executive Director. In year the Risk Management Strategy was refreshed and the Board Assurance Framework similarly updated and aligned to each of the Board's Committees. The QAC liaises closely with the Audit Committee to ensure the strategic risk register and Board Assurance Framework drives the internal audit plan and to provide the Audit Committee with assurance regarding systems of internal control. The Committee also put in place processes to oversee the impact of cost efficiencies, by ensuring updates of Quality Impact Assessments were given on at least a quarterly basis. It continued to monitor the statutory and regulatory requirements relating to quality governance throughout the year including monitoring of Care Quality Commission preparedness work, national audit activity, NICE guidance, national surveys, quality KPIs, complaints improvement etc.

4. **Statement of Disclosure to Auditors**

In accordance with the requirements of the Companies (Audit, Investigations and Community Enterprise) Act 2004, the Trust confirms that for each individual who was a director at the time that the director's report was approved, that:

- so far as each of the Trust directors is aware, there is no relevant audit information of which the Trust's auditor is unaware; and
- 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 Trust's auditor is aware of that information.

For the purposes of this declaration:

- relevant audit information means information needed by the Trust's auditor in connection with preparing their report; and
- that each director has made such enquiries of his/her fellow directors and taken such other steps (if any) for that purpose, as are required by his/her duty as a director of the Trust to exercise reasonable care, skill and diligence.

Additional reporting information

Additional information or statements which fall into other sections within the annual report and accounts are noted/ signposted below:

- The Trust has not made any political donations during the year
- There have been no significant activities in the field of research and development during the year
- A statement that accounting policies for pensions and other retirement benefits are set out in the accounts and details of senior employees' remuneration can be found in the Remuneration Report
- Trust policies on employment and training of disabled persons can be found in the Accountability Report - Staff Report
- Details of sickness absence data can be found in the Accountability Report - Staff Report
- The statements relating to compliance with the cost allocation and charging guidance issued by HM Treasury can be found in the Financial Statements
- Details of the Trust's approach to communications with its employees can be found in Accountability Report - Staff Report
- Details of the Trust's financial risk management objectives and policies and exposure to price, credit, liquidity and cash flow risk can be found in the financial accounts section

Related Party Transactions
The Trust has a number of significant contractual relationships with other NHS organisations which are essential to business. A list of the organisations with whom the Trust holds the largest contracts is included in the financial accounts.

Appointment of External Auditors

The Trust's External Auditor is Grant Thornton. The company commenced a three-year term in January 2017 following a competitive market review process overseen by the Council of Governors.

Better Payment Practice Code:

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 2017/18 and 2016/17 was as follows:

	2017-18 Number	**2017-18 £000**	**2016-17 Number**	**2016-17 £000**
Non-NHS trade invoices paid in the year	45,312	73,205	47,274	71,531
Non-NHS trade invoices paid within target	13,787	32,703	14,308	39,167
Percentage of non-NHS trade invoices paid within agreed payment terms or in 30 days	**30%**	**45%**	**30%**	**55%**
NHS trade invoices paid in the year	1,891	15,560	1,968	14,648
NHS trade invoices paid within target	313	7,624	315	5,953
Percentage of NHS trade invoices paid within agreed payment terms or in 30 days	**17%**	**49%**	**16%**	**41%**

The total paid within 2017/18 for late payment of commercial debt was £72k (£3k in 2016/17).

Disclosures relating to NHS Improvement's Well Led Framework

As part of a commitment to simplifying regulatory approaches, NHS Improvement worked closely with the Care Quality Commission (CQC) to bring together their respective approaches to the Well-Led key line of enquiry (KLOE). This resulted in a new, wholly joint Well-Led Framework structured around eight key lines of enquiry introduced in year.

The Trust has begun implementing the new guidance which builds on its work undertaken under the previous framework. In April 2017 the Trust received its external Well Led assessment which concurred with its own assessment as 'Amber-Green'. An action plan to address 31 recommendations was developed progressed by Executive Director leads, reporting to Trust Board.

Work on a further self- and external assessment to incorporate the four additional domains of the Well Led framework is underway and will provide further assurance that the Trust is well led through:

1. Its leadership capacity and capability to deliver high quality sustainable care
2. Its clear vision and credible strategy to deliver high quality sustainable care to people and robust plans to deliver
3. Its culture of high quality sustainable care
4. The clear responsibilities, roles and systems of accountability to support good governance and management
5. The clear and effective processes for managing risks, issues and performance
6. Appropriate and accurate information that is being effectively processed, challenged and acted upon
7. The people who use services, public, staff and external partners are being engaged and involved to support high quality sustainable services
8. Its robust systems and processes for learning, continuous improvement and innovation.

Further information on these assurances can be found in the Annual Governance Statement and the Quality Report.

The Trust's Stakeholders

The Trust has a duty to fully engage with stakeholders and members to ensure that we are listening to their views on our services, quality and quality priorities moving forward.

The quality improvement priorities were discussed with a host of representatives from key organisations including Governors, Warrington and Halton Clinical Commissioning Groups, along with our own staff including non-executive directors. See the Quality Report.

The Trust continued to play an active part of the Cheshire and Merseyside Health and Care Partnership (formerly STP) as well as locally through One Halton and Warrington Together the place-based local delivery systems bringing together local government, health and social care and the third sector organisations. Together we continue to focus on the long term sustainability of our healthcare services across the region and within boroughs alongside improving quality of care, reducing unwarranted variation, redesigning pathways, delivering the 7-day service agenda, working towards single teams with single leadership structures and operating models, across multiple sites.

Throughout the year the Trust was a key partner in the Halton Healthy New Town project which saw meaningful engagement with staff and local communities around the vision for the Halton Lea development of which Halton General and CMTC hospitals are at the centre. Towards year end our work accelerated with the latest designs for the Hospital and Wellbeing Campus and Master Plan for the wider Halton Lea and well attended staff, elected member and public meetings were held.

Planned engagement with stakeholder and partner organisations' participation includes an active Patient Experience Committee, a sub-committee of the Board's Quality Assurance Committee and where partners, Governors, members of staff and public are encouraged to raise issues, be involved in determining solutions and input to all aspects of risk management. Input from both Warrington Healthwatch and Halton Healthwatch continues to provide patient and public involvement on a range of issues.

A Governor-led '*What Matters to Me*' initiative commenced in year with drop in Conversation cafes

hosted by our Council of Governors. This enabled patients and visitors to engage on an individual level on issues such as Outpatients and the Halton Healthy New Town plans.

We continued into our second year with Wellbeing Enterprises/Halton Voluntary Action which provides professional volunteer management services to our hospitals – WHH Volunteers. Here the focus is on improving our volunteer recruitment and experience as well as working with wards and departments to successfully deploy volunteers for the benefit of our patients.

Finally, The Equality & Diversity Sub Committee (EDSC) engages, advises and endorses a range of initiatives, reports and actions and meets quarterly. It has internal and external stakeholder membership, with active involvement from patient representatives and members of third sector bodies, these include:

- Deaf Resource Centre
- Halton Disability Partnership
- Warrington Carers (WIRED)
- The British Red Cross
- Warrington Health Watch
- Warrington Disability Partnership
- Halton Health Watch
- Halton Carers Centre
- DIAL House Chester
- Warrington Hate Crime Prevention Group
- Cheshire Equality Leads Forum
- Warrington Homeless (YMCA)
- North West Equality and Diversity Leads Group
- City of Sanctuary
- Warrington Borough Council

Signed

Mel Pickup, Chief Executive
Date
24.5.18

Directors' Report

Board Member Terms

Board Member (Voting)	Term of Office
Steve McGuirk (Chairman)	01.04.15-31.03.18 Extension 01.04.2018-31.03.2021
Ian Jones	01.07.15-30.06.17 Extension 01.07.2017-30.06.2020
Terry Atherton	01.07.14-30.06.17 Extension 01.07.2017-30.06.2020
Anita Wainwright	01.01.15-31.12.17 Extension 01.01.2018- 30.12.2020
Dr Margaret Bamforth	01.05.16-03.04.19
Jean-Noel Ezingeard	26.04.17-25.04.20
Mel Pickup (CEO) *	From 15.02.11
Prof Simon Constable	From 02.02.15
Sharon Gilligan	From 01.12.15 to 28.4.17
Kimberley Salmon-Jamieson	From 07.09.16
Andrea McGee (nee Chadwick)	From 01.02.16
Jan Ross**	Acting COO From 1.5.17 to 7.1.18
Chris Evans	From 1.3.18
Non-Voting Directors	
Roger Wilson	From 02.02.15 to 04.05.17
Jason DaCosta	From 04.02.13
Pat McLaren	From 01.12.15
Lucy Gardner ***	From 01.02.16
Michelle Cloney	Interim from 01.03.17 Substantive 1.11.17
Dr Alex Crowe Medical Director	From 1.10.17

The service contracts of all executive (voting and non-voting) and non-executive directors contain the following obligations:

- Adhere to the standards of conduct as articulated in the 'Code of Conduct for NHS Managers', NHS Codes of Practice and the provisions of the National Health Service Trust Regulations 1990 and other relevant codes such as the Standards of Business Conduct
- Abide by the Trust's Standing Instructions
- Meet the obligations of the Fit and Proper Persons requirements laid down in the Health and Social Care Act 2008 and subsequent amendments
- Make any disclosures or declarations during the tenure of employment which may affect or influence any of these obligations

**Mel Pickup was appointed as Senior Responsible Officer of the Cheshire & Merseyside Health and Care Partnership on 18 September 2017. She shares her working week between CEO of Warrington & Halton Hospitals NHS Foundation Trust (the Trust) and SRO of the C&M Health and Care Partnership and the Trust is reimbursed for her time and associated costs, including backfill. The taxable benefit and performance related bonus shown for Mel Pickup are wholly attributable to the role of SRO.*

*** Jan Ross commenced a secondment to Southport and Ormskirk NHS Trust on 8.1.18*

**** Lucy Gardner was Acting Chief Operating Officer in January and February 2018 and was therefore a voting Board member for that period.*

Attendance at Board of Director Meetings and Sub-Committees 1 April 2017-31 March 2018

Attendance (actual/maximum possible)

Board Member	Term of Appointment	Trust Board 10 meetings	Audit Committee 5 meetings	Quality Assurance Committee 10 meetings	Finance & Sustainability Committee 12 meetings	Strategic People Committee (to 08/2017)
Non-executive Directors (Voting)						
Steve McGuirk (Chairman)	01.04.15-31.03.18	10/10	-	-	-	-
Jean-Noel Ezingeard *(wef 04/2017)*	26.04.17-25.04.20	8 /9	1/3	4/6	-	-
Ian Jones	01.07.07-30.06.20	10/10	4/5	7/10	3/12	1 / 2
Terry Atherton	01.07.17-30.06.20	10/10	5/5	-	12/12	-
Anita Wainwright	01.01.18-30.12.20	8/10	3/5	-	10/12	2/2
Dr Margaret Bamforth	01.05.16-30.04.19	9/10	4/5	10/12	-	1 / 2
Executive Directors (Voting)						
Mel Pickup	-	10/10	1/5	-	-	-
Prof Simon Constable	-	7/10	-	7/10	8/12	0/2
Andrea McGee (nee Chadwick)		10/10	5/5	-	11/12	-
Kimberley Salmon-Jamieson		9/10	-	10/10	10/12	0/2
Sharon Gilligan		0/1		0/1	0/1	
Jan Ross (Acting)	01.05.17– 07.01.18	6/7	1/1	4/6	7/8	1/2
Lucy Gardner (Acting)	01.2018 – 02.2018	2/2	-	1/1	2/2	
Chris Evans (*wef 1.03.2018)*		1/1	-	1/1	1/1	-

Non-executive directors may be appointed or terminated according to the Foundation Trust's Constitution:

Board of Directors – appointment and removal of Chair, Deputy Chair and other Non-executive Directors

24.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-executive Directors and shall appoint one of the Non-executive Directors as the Deputy Chair of the Trust.

24.2 Removal of the Chair, Deputy Chair or another Non-executive Director shall require the approval of three quarters of the members of the Council of Governors.

The Work of the Audit Committee

Member	Attendance (Actual v Max)
Ian Jones, Non-Executive Director & Chair	4/5
Dr Margaret Bamforth, Non-Executive Director	4/5
Terry Atherton, Non-Executive Director	5/5
Anita Wainwright, Non-Executive Director	3/5
Jean-Noel Ezingeard, Non-Executive Director	1/3

The Audit Committee is required to report annually to the Board and to the Council of Governors outlining the work it has undertaken during the year and where necessary, highlighting any areas of concern. The Audit Committee is responsible on behalf of the Board for independently reviewing the systems of integrated governance, risk management, assurance and internal control. The Committee's activities cover the whole of the Trust's governance agenda, not just the finances, and is in support of the achievement of the Trust's objectives.

During the reporting period, the Committee has been composed of at least three Non-Executive Directors with a quorum of two. Non-executive Ian Jones is Chair of the Audit Committee (since 1st December 2014.) The required relevant and recent financial experience and background necessary for the membership of the Audit Committee is met by the Chair. During the year the Committee met five times.

Regular attendees at the Committee Meetings were the Trust's external auditors Grant Thornton (External Auditors from January 2017), Mersey Internal Audit Agency (MIAA - Internal Audit and Counter-Fraud Services), the Director of Finance & Commercial Development and the Company Secretary designate.

In year the significant issues that the committee considered in relation to financial statements, operations and compliance were as below, they were addressed through inclusion in the Internal Audit work plan and assurance sought for each element.

- Significant Assurance was provided by the internal auditors in respect of Combined Financial Systems and the use of the IG Toolkit.
- Limited Assurance was given in respect of the processes surrounding the use of Bank and Agency – Medical Locums
- Limited Assurance was given in respect of a Review of Cancer Data.
- Significant Assurance was given in respect of the Capital Assets Review.
- Limited Assurance was given in respect of the Medical Equipment Review
- The Conflict of Interest Register was reviewed
- Payroll Review. Significant Assurance level
- Financial System Significant Assurance level.

In addition, the Committee had concerns about the Trust's pay bill and requested that a quarterly report be added to its annual work plan relating to recruitment of senior posts at Band 8C and above and appointment and term of contract for all interim posts.

Terms of Reference

The Committee's Terms of Reference were reviewed and agreed in February 2018 to ensure they continue to remain fit-for-purpose.

Governance and Risk Management

During the year the Trust approved its Risk Management Strategy and refined its Board Assurance Framework to provide more detail around the Trust's key strategic risks and any movement on the underlying risk scores through regular Board updates. The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a **Moderate Assurance** rating from the Head of Internal Audit (HOIA).

System of Internal Control

The Trust's Governance Structure, refreshed in August 2017, aligns the Trust's various governance groups to the Trust Board committees. The Board Assurance Framework provides an overview of the internal control environment and evidence of the effectiveness of the controls that manage the risks to the Trust in achieving its strategic objectives as identified in the annual plan, The Audit Committee is charged by the Board in reviewing and evaluating the system of internal control through the delivery of the internal audit plan. The Chair of the Audit Committee provides an annual report of the work of the Committee to the Board as well as periodic escalation reports following each meeting.

Internal Audit Activities

MIAA acted as Internal Auditors for the Trust during the year. Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is agreed with the Committee and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the Committee uses a three cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency.

Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting. The assurance level for each audit completed during the year are listed below:

Significant Assurance	**Limited Assurance**	**Advisory Support and Guidance Provided to:**
• Capital Assets • Combined Financial • Systems • Outpatients • Payroll • IG Toolkit • Mortality	• Multidisciplinary Team Meetings • Medical Devices • Patient Falls • Incident Reporting and Duty of Candour • Cancer Data • Junior Doctors Contract • Consent	• Cyber Security • General Data Protection Regulations • Conflict of Interest review

An Assurance Framework opinion test against NHS best practice was undertaken and the standards were met.

External Audit

Grant Thornton commenced its 3-year term as Auditors to the Trust in January 2017 following a competitive procurement exercise and review and recommendation by the Council of Governors. During the year the Auditors reported on the 2016-17 Financial Statements and Quality Accounts. No material or significant issues were raised in respect of these Statements and Accounts. Technical support has been provided on an ongoing basis to the Committee and the Trust and representatives of Grant Thornton attended each Audit Committee.

Anti-Fraud Activity

The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Counter Fraud Service (CFS) working to a programme agreed with the Audit Committee. The role of CFS is to assist in creating an anti-fraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures.

Pro-active work has also included induction and awareness training along with ensuring Trust policies and procedures incorporate, where applicable, anti-fraud measures including the Anti-Fraud, Bribery and Corruption Policy. The Audit Committee received regular progress reports from the CFS and also received an annual report. No significant cases or issues of Anti-Fraud took place or were identified during the year.

REMUNERATION REPORT

Statement from the Chairman of the Nominations and Remuneration Committee

For the purposes of the remuneration report the term senior managers relates to those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust and covers the chair, the executive and non-executive directors of the Trust (collectively the directors).

The Board of directors delegates the responsibility to a Board Nominations and Remuneration Committee (committee) to make decisions regarding the nomination, appointment, remuneration and conditions of service for executive directors including the Chief Executive. This committee also has general oversight of the Trust's pay policies, but only determines the reward package for directors and staff not covered by agenda for change. The vast majority of staff remuneration, including the first layer of management below Board level, is covered by the NHS Agenda for Change pay structure.

Nominations

In year the Committee considered and approved the following:

- Interim arrangements for the COO following the departure of Ms Gilligan (internal, acting role)
- Interim arrangements for the Director HR&OD following the departure of Mr Wilson (external, secondment)
- Appointment of substantive Director HR&OD – competitive process
- Appointment of substantive COO – competitive process

Remuneration

The committee is responsible to the Board in setting the remuneration and conditions of service include provisions for other benefits as well as arrangements for termination of employment for the executive directors. It also considers all ex-gratia payments and redundancy payments. During the year under review the committee did not approve any special termination arrangements for senior managers, and no such awards have been made to past senior managers.

The chief executive and executive directors participate in annual performance reviews and appraisals undertaken by the Trust chair and chief executive respectively and individual objectives set are linked to the Trust's corporate and strategic objectives. The setting of non-executive directors pay is the responsibility of the council of governors through its own Nomination and Remuneration Committee (the NARC). As the Trust does not have a remuneration policy for directors it has not been required to consult with employees.

The membership of this Board committee comprises of the chair and all the non-executive directors with the attendance of the chief executive (except for matters concerning her own employment and conditions) and the Director of HR & OD and Company Secretary.

During 2017-18, the committee met as below:

Member	Attendance (Actual v Max)
Steve McGuirk, Chairman Non-Executive Director + Chair	6/7
Ian Jones, Non-Executive Director	7/7
Margaret Bamforth, Non-Executive Director	6/7
Terry Atherton, Non-Executive Director	7/7
Anita Wainwright, Non-Executive Director	6/7
Jean-Noel Ezingeard, Non-Executive Director (wef April 2017)	6/7

Persons or organisations that provided advice to the Remuneration Committee in year were:

Mersey Internal Audit Association - Independent Audit.	Commissioned by the Committee to conduct Audit into Exit Payments.
Hill Dickinson LLP - Independent, professional legal organisation	Attendance requested by the Committee at various points throughout the period – to provide advice relating to Employment Law.
Jackie Green, Independent HR Advisor - Independent HR Advisor – references sought	Commissioned by the Committee to conduct investigation relating to Employment issues
Ken Hutchinson, Independent HR Advisor - Independent Investigator – references sought	Commissioned by the Committee to conduct investigation relating to Employment issues

SENIOR MANAGER REMUNERATION POLICY

On 2nd June 2015, the Secretary of State for Health wrote formally to the Chairs of all NHS Provider Trusts, NHS Foundation Trusts and Clinical Commissioning Groups in relation to the pay for very senior managers (defined as Chief Executives and Executive Directors) and the need to ensure that executive pay remains proportionate and justifiable.

The Trust's executive pay structure is very simple and includes only basic pay. All pay is taxed at source and there are no bonus payments. Salaries are benchmarked against the NHS Providers national report and similar Trusts in the Cheshire and Merseyside region. All new appointments are sourced at the benchmark level and adjustments are made only if the market rate or existing salary indicates this is necessary.

During the year under review the Chief Executive Officer received a performance related bonus which was wholly attributable to her role as Senior Responsible Officer of the Cheshire & Merseyside Healthcare Partnership. Full details of the award are contained within the remuneration report.

Directors of the Trust are employed on a permanent contract basis. During the year appointments to the Board were made to the role of the Chief Operating Officer (voting) and the Director of Human Resources and Organisation Development (non-voting). Required notice periods are six months. Where salaries of very senior managers exceed £142,500 per annum, these have been reviewed and found to be appropriate to match market rate, maintain relativities with other very senior manager posts and to match pay in the jobs from which individuals were recruited.

Performance Appraisal

Performance of the Executive Directors is assessed and managed through regular appraisal against predetermined objectives along with one to one reviews with the Chief Executive. Similarly, the Chairman holds one-to-one's with the Chief Executive. Any deficit in performance is identified during these regular meetings. Serious performance issues are managed via our organisational performance capability management policy.

Performance of the Non-Executive Directors is assessed and managed through regular appraisal by the Chairman against predetermined objectives along with regular one to one reviews with each NED. Any deficit in performance is identified during these regular meetings along with opportunities for regular professional development.

Appraisals led by the Chairman - for the Chief Executive and Non-Executive Directors – are also used as an opportunity to identify continuing professional development needs. No performance payment element has been paid to any of the Trust's Executive Directors during the year. Equally, there have been no payments to both Executive and Non-Executive Directors for loss of office.

Provisions for Termination of Contract

There are no special contractual compensation provisions for early termination of Executive Directors' contracts. Early termination by reason of redundancy is subject to the normal provisions of the Agenda for Change (AfC): NHS Terms and Conditions of Service Handbook (Section 16). For those above the minimum retirement age, early termination by reason of redundancy is in accordance with the NHS Pension

Scheme. Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.

The principles for determining how payments for loss of office will be approached, including: how each component will be calculated and whether, and if so how, the circumstances of the loss of office and the senior manager's performance are relevant to any exercise of discretion would all be considered on a case by case basis by the Remuneration Committee and would be approved by NHS Improvement in advance

The Trust is required to report what constitutes the senior managers' remuneration policy in tabular format set out below. At the date of completion of this Annual Report there have been no changes to this policy and no future changes are anticipated:

Components of Remuneration Package of Executive and Non-Executive Directors	Basic pay in accordance with their contract of employment (executive) and letters of appointment (non-executive)
Components of Remuneration that is relevant to the short and long term Strategic Objectives of the Trust	The directors do not receive any remuneration tailored towards the achievement of Strategic Objectives.
Explanation of how the Components of Remuneration operate	Basic pay of the executive directors is determined by the Board Nominations and Remuneration Committee, taking into account past performance, future objectives, market conditions and comparable remuneration information from Trusts within the locality. Basic pay of the non-executive directors is determined by the Governor Nominations and Remuneration Committee.
Maximum amount that could be paid in respect of the component	Maximum payable is the director's annual salaries as determined by the relevant Nominations and Remuneration Committee.
Payment for loss of office	Notice periods are included in all directors' contracts and is currently set at six months. Payments in lieu of notice are contained within the contract of employment and are subject to tax and national insurance deductions. Payments made other than through notice periods are set out in the Organisational Change policy i.e. through redundancy/mutually agreed severance schemes. All payments to any staff member outside contractual terms are scrutinised by the Board's Nominations and Remuneration Committee.
Explanation of any provisions for recovery	If an individual is overpaid in error, there is a contracted right to recover the overpayment.

Annual report on Directors Remuneration - Year ended 31 March 2018 (and comparison year ended 31 March 2017) (Audited)

The following table includes salary, benefits-in-kind and all pension related benefits received (whether in cash or otherwise) by each director during the year under review. Pension related benefits included here is the annual increase (expressed in £2,500 bands) in pension entitlement less any contributions paid by employees.

	2017-18					2016-17			
	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All performance related bonuses (bands of £5,000)	All Pension-related Benefits (bands of £2,500) (6)	**Total (bands of £5,000)**	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All Pension-related benefits (bands of £2500) (5)	**Total (bands £5,000)**
	£000	£	£000	£000	**£000**	£000	£	£000	**£000**
Executive Directors									
Mel Pickup (1) Chief Executive	165-170	8,600	5-10	32.5-35	**220-225**	160-165		5-7.5	**170-175**
Karen Dawber Director of Nursing and Organisational Development Until 19.8.2016						45-50		2.5-5	**45-50**
Prof Simon Constable (2) Medical Director/ Deputy Chief Executive until 17.09.17 Executive Medical Director/Deputy Chief Executive from 18.09.17	170-175	4,200		-	**170-175**	145-150	3,700	2.5-5	**150-155**
Dr Alex Crowe (3) Medical Director from 18.09.17	80-85			17.5-20	**100-105**				
Jason DaCosta (4) Director of Information Technology	80-85				**80-85**	75-80			**75-80**

	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All performance related bonuses (bands of £5,000)	All Pension-related Benefits (bands of £2500) (5)	**Total (bands of £5,000)**	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All Pension-related benefits (bands of £2500) (5)	**Total (bands £5,000)**
	£000	£	£000	£000	**£000**	£000	£	£000	**£000**
Lucy Gardner Director of Transformation/ Acting Chief Operating Officer from 08.01.18 until 28.02.17	120-125			37.5-40	**155-160**	110-115		25-27.5	**135-140**
Roger Wilson Director of Human Resources and Organisational Development Until 04.05.17	10-15			-	**10-15**	105-110		5-7.5	**115-120**
Michelle Cloney (5) Director of Human Resources and Organisational Development From 06.03.2017	95-100			17.5-20	**112.5-115**	5-10			**5-10**
Andrea McGee Director of Finance and Commercial Development	125-130			50-52.5	**175-180**	120-125		140-142.5	**260-265**
Sharon Gilligan Chief Operating Officer Until 28.04.17	70-75			-	**70-75**	115-120		27.5-30	**145-150**
Chris Evans Chief Operating Officer From 01.03.18	5-10			2.5-5	**10-15**				
Pat McLaren Director of Community Engagement and Corporate Affairs	85-90			7.5-10	**95-100**	80-85		7.5-10	**90-95**
Kimberley Salmon-Jamieson Chief Nurse From 07.09.16	115-120			-	**115-120**	65-70		117.5-120	**180-185**
Interim/Acting Executive Directors									
Jan Ross (3) Acting Chief Operating Officer From 01.05.17 - Until 07.01.18	65-70			67.5-70	**135-140**				

	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	Performance related bonuses (bands of £5,000)	All Pension-related Benefits (bands of £2500) (5)	**Total (bands of £5,000)**	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All Pension-related benefits (bands of £2500) (5)	**Total (bands £5,000)**
	£000	£	£000	£000	**£000**	£000	£	£000	**£000**
Chairman and Non-Executive Directors									
Steve McGuirk Chairman From 01.04.2015	40-45				**40-45**	40-45			**40-45**
Lynne Lobley Non-Executive Director Until 30.11.2016						5-10			**5-10**
Prof Jean-Noel Ezingeard Non-Executive Director From 26.04.17	10-15				**10-15**				
Ian Jones Non-Executive Director	10-15				**10-15**	10-15			**10-15**
Terry Atherton Non-Executive Director	10-15				**10-15**	10-15			**10-15**
Anita Wainwright Non-Executive Director Reappointed 01.01.18	10-15				**10-15**	10-15			**10-15**
Dr Margaret Bamforth Non-Executive Director From 01.06.2016	10-15				**10-15**	10-15			**10-15**

Notes:

(1) Mel Pickup was appointed as Senior Responsible Officer (SRO) of the Cheshire and Merseyside Healthcare Partnership on 18.09.17. She shares her working week between the CEO of Warrington and Halton Hospitals NHS Foundation Trust (the Trust) and SRO of the Cheshire and Merseyside Healthcare Partnership. The Trust is reimbursed for her time and associated costs. The taxable benefit and performance related bonus shown are wholly attributable to the role of SRO.

(2) The total banded remuneration for the Deputy Chief Executive/Executive Medical Director during the year under review was (165-170). The table above includes a single arrears payment of £5,000 Clinical Excellence Award made in 2015 and arrears payment relating to the £6,000 per annum pay award upon appointment to Deputy CEO effective 1.4.16. (This uplift required HM Treasury approval which was received in November 2017)

(3) Refers to time in post as a Director.

(4) One fifth of Jason DaCosta's salary is recharged to Warrington CCG. The table above shows remuneration net of this recharge.

(5) Michelle Cloney was substantively employed by the Trust from 01.11.17. Prior to this she was engaged via another entity. Director's salary and fees include salary and payments made to the other entity rather than to the individual directly.

(6) Pension related benefits are calculated using the HMRC method derived from s229 of the Finance Act 2004. This is an annualised figure, adjusted to reflect the time in post as a Director. This may appear unusually high where an employee has been a director for part of a year or, for the first full year that they have been a director. Where the pension related benefit in year is a loss the figure is reported as zero.

Pension Entitlements Year ended 31 March 2018 (Audited)

Name and title	Real increase in pension at pension age (bands of £2,500)(1)	Real increase in pension lump sum at pension age (bands of £2,500)(1)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2017	Real increase in Cash Equivalent Transfer Value (1)	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mel Pickup Chief Executive	2.5-5	-	65-70	175-180	1,060	99	1,184	
Prof Simon Constable Executive Medical Director/ Deputy Chief Executive	0-2.5	-	20-25	40-45	298	-	294	
Dr Alex Crowe(2) Medical Director	0-2.5	0-2.5	45-50	120-125	776	27	845	
Lucy Gardner Director of Transformation/Acting Chief Operating Officer	2.5-5	-	0-5	0-5	19	21	41	
Roger Wilson Director of Human Resources and Organisational Development	0-2.5	-	35-40	100-105	672	3	717	
Michelle Cloney (3) Director of Human Resources and Organisational Development	0-2.5	0-2.5	30-35	85-90	561	20	622	
Andrea McGee Director of Finance and Commercial Development	2.5-5	2.5-5	40-45	105-110	589	81	684	
Sharon Gilligan Chief Operating Officer	0-2.5	-	20-25	55-60	323	2	349	
Chris Evans Chief Operating Officer	0-2.5	0-2.5	20-25	45-50	204	2	234	
Jan Ross Acting Chief Operating Officer	2.5-5	0-2.5	25-30	65-70	336	36	397	
Pat McLaren Director of Community Engagement and Corporate Affairs	0-2.5	2.5-5	10-15	35-40	231	32	268	
Kimberley Salmon-Jamieson Chief Nurse	0-2.5	-	35-40	85-90	480	40	531	

Notes:

(1) This is an annualised figure, adjusted to reflect the time in post as a Director. Where the real increase reflects a loss in year the figure is reported as zero.

(2) Dr Alex Crowe was not an Executive Director before 2017/18. There are no comparative figures for the previous financial year.

(3) Michelle Cloney was substantively employed by the Trust from 01.11.17. Prior to this she was engaged via another entity. The real increases reported are attributable to her employment at the Trust.

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

Total remuneration

During the year the following total amount of payments made by the Trust to the Executive and Non-Executive Directors.

	2017-18 £000	**2016-17 £000**
Remuneration including employers national insurance contribution for Executive and Non-Executive Directors	1,531	1,206
Employers contribution to pension in relation to executive directors	135	121

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

Expenses paid to Directors and Governors (Unaudited)

Expenses paid to Directors of the Trust include all business expenses arising from the normal course of business of the Trust and are paid in accordance with the Trust's policy. Non-Executive Directors are also reimbursed reasonable expenses relating to their work as Directors of the Trust.

Expenses paid to Governors are made in accordance with the Trust's constitution and related to the work as Governors of the Trust. Governors do not receive any other payments from the Trust. All Governors have a responsibility to ensure that they incur only reasonable expenses, which includes travel costs for attendance at, for example, Council of Governors and committee meetings held at the Trust or for attendance at training courses and conferences and that the cost to the Trust is kept as low as possible. The table below states the total amount of expenses reimbursed to Directors and Governors for 2017/18 and comparative figures for 2016/17.

	Number in Office	Number claiming expenses during the year	**Total expenses Claimed**	Number in Office	Number claiming expenses during the year	**Total expenses Claimed**
	2017-18 Number	2017-18 Number	**2017/18 £**	2016-17 Number	2016-17 Number	**2016-17 £**
Directors	19	11	**6,776**	17	10	**4,100**
Governors	27	5	**583**	20	5	**800**
Total	**46**	**16**	**7,359**	**37**	**15**	**4,900**

Fair Pay Multiple (Audited)

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.

The mid-point of the banded remuneration of the highest-paid director in Warrington & Halton Hospitals NHS Foundation Trust in the financial year 2017/18 was £187,500 (2016/17 £162,500). The highest-paid director in 2017/18 and 2016/17 was the Chief Executive Officer.

In 2017/18 the highest-paid director earned 9.44 times (7.24 times in 2016/17) the median remuneration of the workforce, which was £19,852 (£22,458 in 2016/17). The increase in the midpoint of the banded remuneration of the highest director was due to taxable benefits and performance related bonus paid on behalf of the Cheshire and Merseyside Healthcare Partnership.

In 2017/18, 8 employees (20 employees in 2016/17) received remuneration in excess of the mid-point of the banded remuneration of the highest-paid director. Remuneration in excess of the highest-paid director ranged from £191,750 to £285,516 (£162,664 to £291,525 in 2016/17).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions or the cash equivalent transfer value of pensions. In the case of agency staff, figures have been generated by annualising invoices for agency staff in post as at 31 March 2018.

Signed

Mel Pickup, Chief Executive

Date: 24.5.18

The Council of Governors

The Council of Governors is made up of the following representative constituencies:

- 16 Public Governors - elected by the Trust's public membership who represent the local community.
- 5 Staff Governors - elected by the Trust's staff members, whom they represent
- 6 Partner Governors - nominated by partner organisations who work closely with the Trust

Governor Elections
A Governor election was carried out in Oct-Nov 2017 to appoint or renew governor terms in seven constituencies.

Understanding the views of the governors, members and the public

The Board recognises the value and importance of engaging with governors in order that the governors may properly fulfil their role as a conduit between the Board and the Trust's members, the public and stakeholders.

The Board and Council of Governors meet regularly and enjoy a strong and working relationship. Each is kept advised of the other's progress through the chair and includes standing items at both the Board meeting and council of governors meeting for the chair to share any views or issues raised by directors, governors and members.

Any disputes or disagreements between the Board and the Council of Governors is set out in the Trust's Constitution section 9: Resolution of Disputes with Board of Directors.

Members of the Board are invited to attend all Council of Governors meetings (four per year) and some Governor committees to provide input and support. Each committee of the Council is supported by relevant executive directors and senior managers from the Trust who report openly and collaboratively on the activities and performance of the Trust.

The Governors Nominations and Remuneration Committee met to appoint a new non-executive director, review the extension to second terms of four non-executive directors, including the reappointment of the Chairman, and to conduct the Chairman's appraisal. The role of this committee is outlined in more detail in the Remuneration Report.

The Council of Governors receive copies of all Board meeting agenda and minutes in accordance with the requirements of the Health and Social Care Act 2012 and the Trust's Constitution. All governors (and members of the public) are able to observe the meeting of the Board held in public in order to understand the issues raised at the Trust Board. Governors are encouraged to attend the Board meetings in order to observe the non-executive directors' performance at the meetings in challenging and scrutinising reports presented by the executive directors. This helps the Governors to discharge their duty in holding the non-executive directors, individually and collectively, to account for the performance of the Board.

The Chair provides informal briefings to governors through a monthly informal question and answer session for governors to raise matters outside of the formal council meeting.

At governors' meetings there is a standing item for public and staff governors to feedback any issues from constituency members. Issues raised at constituency meetings and through communications from members to governors is discussed at governor meeting.

The Council has the following statutory powers and responsibilities:

- hold the non-executive directors to account individually and collectively for the performance of the Board;
- the appointment and, if appropriate, removal the Chair;
- the appointment and, if appropriate, remove the other non-executive directors;
- approve the remuneration and allowances, and other terms and conditions of office, of the chair and other non-executive directors;
- approve the appointment of the Chief Executive on recommendation from the Board Nominations and Remuneration Committee;
- appoint, re-appoint and, if appropriate, remove the Auditor;
- receive the annual report and accounts and any report on these provided by the auditor;

- approve any 'significant transactions' as defined within the Trust's constitution;
- approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
- decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions; and
- approve amendments to the Trust's constitution.

In addition to the statutory responsibilities, the CoG focuses on the following activities:

- Contribute to the business planning process and the development of forward plans for the Trust in co-operation with the Board of Directors;
- Represent the interests of the communities served by the Trust and ensure they are appropriately represented;
- Consult with members and reflects the view of the membership; and
- Develop and maintain the Trust's membership and engagement strategy.

The Council has plans to engage with the membership and public in Q1 of 2018-19 on the Trust's refreshed Strategy, which was updated to reflect the Trust's ambition to become an 'Outstanding' Trust following the CQC's disappointing 'Requires Improvement' assessment in October 2017. They will do this through the Trust's annual member communication '*Your Hospitals'* which, in the NHS 70th year, will be a commemorative, souvenir edition mailed to 9K homes. Views will then be reported to the Board by the Council of Governors.

All committees are attended by non-executive and executive directors and senior management who provide advice and support in order for the committee to carry out its functions in the provision assurance to the council. A full list of governor attendance at governor committee meetings is available on the Trust internet site www.whh.nhs.uk.

Other meetings and involvement

Alongside the formal meetings and committees, number of briefing sessions and workshops have taken place to both inform the governors of Trust initiatives and work programmes and gain their views and support.

In line with the requirements of the Provider Licence all governors have made 'Fit and Proper Person Test' declarations.

The Council of Governors between 1st April 2017 and 31st March 2018 comprised:

Constituency	Governor	Term	Term Ends
Daresbury, Windmill Hill, Norton North, Castlefields	Alison Kinross	1	30/06/2018
Beechwood, Mersey, Heath, Grange	Joe Whyte	1	30/06/2018
Norton South, Halton Brook, Halton Lea **(Vacant since Feb 2017)**			
Appleton, Farnworth, Hough Green, Halton View, Birchfield	Colin McKenzie	1	23/12/2019
Broadheath, Ditton, Hale, Kingsway, Riverside	Kenneth Dow	1	30/06/2018
Lymm, Grappenhall, Thelwall	Jeanette Scott	1	30/11/2017
Lymm, Grappenhall, Thelwall	Ryan Newman	1	30/11/2020
Appleton, Stockton Heath, Hatton, Stretton and Walton	Sue Kennedy	1	30/11/2017
Appleton, Stockton Heath, Hatton, Stretton and Walton	Nick Stafford	1	30/11/2020
Penketh and Cuerdley, Great Sankey North, Great Sankey South	Peter Harvey	2	30/11/2017
Penketh and Cuerdley, Great Sankey North, Great Sankey South	Paul Bradshaw	1	30/11/2020
Culcheth, Glazebury and Croft, Poulton North	Keith Bland MBE	1	23/12/2019
Latchford East, Latchford West, Poulton South	Carol Astley	2	30/06/2018
Bewsey and Whitecross, Fairfield and Howley	Phil Chadwick	1	30/06/2018
Poplars and Hulme, Orford	Alf Clemo	2	30/11/2017
Poplars and Hulme, Orford	Colin Jenkins	1	30/11/2020
Birchwood, Rixton and Woolston	Anne M Robinson	1	23/12/2019
Burtonwood and Winwick, Whittle Hall, Westbrook	Norman Holding **(Lead Governor)**	1	30/06/2018
Rest of England and Wales (2 seats) (**Vacant since October 2016**)			
Medical and Dental	Dr Helen Bowers	1	23/12/2019
Nursing and Midwifery	TBC	1	23/12/2019
Staff - Support	Sue Bennett	2	30/11/2017
Staff - Support	Peter Beesley	1	30/11/2020
Clinical Scientist or Allied Health Professionals	Louise Spence	1	23/12/2019
Estates, Administration, Managerial	Mark Ashton	2	30/11/2020
Halton Borough Council	Cllr P Lloyd Jones	2014	n/a
Warrington Borough Council	Cllr Pat Wright	2011	n/a
Wolves Foundation	Neil Kelly	2013	n/a
University of Chester	Dr Mike Brownsell	2017	n/a
Widnes Vikings	John Hughes	2017	n/a
Partner 6 (**vacant)**			

Membership & Attendance of the Council of Governors and Sub-Committees

Governor	Council of Governors	Quality In Care Committee	Nominations & Remuneration Committee	Governors Engagement Group
Steve McGuirk, Chair	4/4	-	3/3	-
Alison Kinross Daresbury, Windmill Hill, Norton North, Castlefields	4/4	3/4	3/3	4/4
Joe Whyte Beechwood, Mersey, Heath, Grange	0/4	0/4	0/3	0/4
Vacant since February 2017 Norton South, Halton Brook, Halton Lea	-	-	-	-
Sue Kennedy *(to November 2017)* Appleton, Farnworth, Hough Green, Halton View, Birchfield	4/4	1/4	1/3	1/4
Colin McKenzie Appleton, Farnworth, Hough Green, Halton View, Birchfield	3/4	1/4	0/3	1/4
Kenneth Dow Broadheath, Ditton, Hale, Kingsway, Riverside	1/4	1/4	0/3	1/4
Nick Stafford *(elected December 2017)* Appleton, Stockton Heath, Hatton, Stretton and Walton	0/1	0/1	0/1	0/1
Peter Harvey *(to November 2017)* Penketh Cuerdly, Great Sankey North, Great Sankey South	3/3	1/4	0/3	1/4
Paul Bradshaw *(elected December 2017)* Penketh Cuerdly, Great Sankey North, Great Sankey South	1/1	0/1	1/1	0/4
Keith Bland MBE Culcheth, Glazebury and Croft, Poulton North	4/4	0/4	2/3	4/4
Carol Astley Latchford East, Latchford West, Poulton South	1/4	0/4	0/3	0/4
Phil Chadwick *(until 15 March 2018)* Bewsey and Whitecross, Fairfield and Howley	2/4	0/4	0/3	1/4
Alf Clemo (*until November 2017*) Colin Jenkins(*elected December 2017)* Poplars and Hulme, Orford	1/4 1/1	1/4 /1	1/1 1/1	3/4 0/1
Anne Robinson Birchwood, Rixton and Woolston	4/4	3/4	0/3	2/4
Norman Holding LEAD GOVERNOR Burtonwood and Winwick, Whittle Hall, Westbrook	3/4	2/4	3/3	2/4
Jim Henderson *(to November 2017)* North Mersey Vacant since 1.12.2017	1/3	0/4	0/2	0/4
Rest of England and Wales Vacant since October 2016	-	-	-	-
Dr Helen Bowers Medical Staff	0/4	0/4	0/3	0/4
TBC Nursing and Midwifery	-	-	-	-
Sue Bennet (*until November 2017*) Peter Beesley *(elected December 2017)* Support Staff	1/4 1/1	1/4 0/1	0/1 0/1	0/1 0/1
Louise Spence Clinical Scientist or Allied Health Professionals	4/4	1/4	0/3	0/4
Mark Ashton Estates, Administrative & Managerial	3/4	0/4	3/3	2/4
Warrington Borough Council Cllr Pat Wright	2/4	0/4	0/3	0/4
Halton Borough Council Cllr Peter Lloyd Jones	3/4	3/4	2/3	1/4
Warrington Wolves Charitable Foundation Neil Kelly	0/4	0/4	0/3	0/4
John Hughes Appointed December 2017 Widnes Vikings	1/1	0/1	0/1	1/1
University of Chester Dr Mike Brownsell, Appointed 01.02.17	1/4	1/4	0/3	0/4
Partner 6 Vacant	-	-	-	-

Changes to the Foundation Trust Constitution in Year

The Council of Governors engaged in resolving a number of initiatives to enhance our member and public engagement which have necessitated amendments to our Constitution. As per Article 45 'Amendment to the Constitution' the Trust may make amendments to its constitution if more than half of the members of the Board of Directors of the Trust voting approve the request. Following the support of the Council of Governors on 15th February 2018, the Trust Board unanimously agreed on 28th March 2018, that the following amendments should be made to the Trust's Constitution:

1. Merge Area 15 with the 'Rest of England and Wales' and correspondingly increase the number of Governors affiliated with the 'Rest of England and Wales' from one to two Governors.
2. Change to the existing public partners to the following:

- Warrington Collegiate (Including 1 co-opted young person rep)
- Warrington Borough Council
- Halton Borough Council
- University of Chester
- Warrington Wolves
- Widnes Vikings (NEW)

Further to these amendments to the Constitution, and in order to stabilise the Council of Governors in terms of turnover per year, and reduce costs associated with Governor Elections, the Council of Governors supported, and the Trust Board approved the following:

3. Reduce the tenure of those elected in June 2018 from 3 years to 2 years 5 months to align all future elections to November;
4. Reduce the existing tenures of five Governors whose tenures end in either December 2019 or December 2020 to conclude in November of the same year, therefore aligning future elections.

Two further amendments were made reflecting the incoming General Data Protection Regulations:

5. Change to Registers to reflect the non-publication of members' details on register – in accordance with new General Data Protection Legislation effective May 2018 approved by Council on 20.7.17
6. Changes to Register of Members approved 20.7.17 by Council

A register of interests for the Council of Governors is available on request at the address below.

Governors may be contacted at:

Warrington and Halton Hospitals NHS Foundation Trust
Foundation Trust Office
Kendrick Wing
Warrington Hospital
Lovely Lane
Warrington WA5 1QG
Telephone – 01925 662139
E-Mail – whh.foundation@nhs.net

The Foundation Trust Membership

As an NHS Foundation Trust, Warrington and Halton Hospitals has a membership scheme that means that members of the public and staff can become members of the Trust. Members play a key role in the hospitals providing input into what services they want their hospitals to provide. They do this by electing Public and Staff Governors who represent the membership's views and therefore that of the local community.

Eligibility, constituencies and boundaries for membership

There are two constituencies of membership for Warrington and Halton Hospitals NHS Foundation Trust – the public constituency and the staff constituency. The public constituency comprises of those members that live in one of the public constituencies. The staff constituency is divided into 5 classes, staff automatically become Staff Members unless they choose to opt-out of the membership:

(1) Medical
(2) Nursing and Midwifery
(3) Support
(4) Clinical Scientist or Allied Health Professional
(5) Estates, Administrative and Managerial

Membership size and movement

Total Membership at 31st March 2018 = 15,309		
Public Constituency	Last Year (2017/18)	2018-19 estimated
At year start (April 1)	11,221	10946
New Members	7	250
Members Leaving	282	1000
At Year End	10,946	10196
Staff Constituency	Last Year (2017/18)	2018-19 estimated
New Members	513	-
Members Leaving	455	-
Affiliate Members	Last Year (2017/18)	2018-19 estimated
At year start (April 1)	263	261
At Year End	261	0

- *Predicting changes to our membership in the public constituency for the 2018-19 year is problematic at this stage due to the potential impact of the EU General Data Protection Regulation which becomes enforceable on May 25th 2018. We currently contact our members by post or by email (not more than four times per year) because they have a legitimate interest in the Trust and have registered as Foundation Trust members. Around 15% of our members prefer email correspondence and may of course elect to opt out of our contact programme and members will be contacted with new privacy notices which will explain the legal basis for the processing of their personal data in relation to Foundation Trust membership. For this reason we have elected to adopt a cautious approach when estimating this data.*

- Following changes to the FT Constitution in March 2018 creating a single 'Rest of England and Wales' constitution all affiliate members (a constituency originally created for those individuals that did not live in one of the original 16 constituencies) will be moved into the Rest of England and Wales constituency.

Staff Report

Our Trust would not be able to provide the high quality services without the dedication, hard work and high standards of professionalism demonstrated by all of our staff.

Under our QPS framework, people are one of the key underlying elements of our framework. The Trust prides itself on its ability to attract the highest calibre of staff and aims to provide an environment that encourages staff to continuously develop and update their skills.

Staff can access a range of benefits, including access to onsite health and wellbeing and counselling services and a range of training and education opportunities.

The Trust works closely with trade union/ professional organisation staff representatives through its Joint Negotiating and Consultative Committee. The group meets every two months as a forum for consultation and negotiation on a range of issues that are of common interest to managers and employees.

Full minutes of each meeting are available through either trade union representatives or the human resources department.

People Strategy

The People Strategy translates the Trust's Strategic Plan into practice, providing both direction and detail of how the people aspects of our overall strategy will be achieved and helps to further embed our organisational values and behaviours.

It recognises that steps have been made across the organisation and allows us to build upon solid foundations developing the ethos that 'our People are central to our success'. By engaging, empowering and recognising our workforce we will make sure they can give their best and continuously drive improvement in the delivery of services. Good management and strong leadership will lead to more engaged staff and ultimately better patient care.

The People Strategy focuses on 5 interlinked principles:

1. Engage - *Create a progressive, engaging & healthy working environment*
2. Attract - *Attract and recruit the best staff*
3. Retain – *Retain and reward staff through recognition of their value*
4. Develop –*Develop and support all staff to achieve their potential.*
5. Perform – *Enable the delivery high quality safe healthcare*

The governance around the people agenda has been strengthened, with regular 'People Dashboard' reports to the Workforce Committee, which show good progress on many of the action points within the strategy.

Staffing statistics

Staff in post at year-end

Below is a breakdown of the number of male and female directors, senior managers and other employees. For the purposes of this report, senior managers are at Agenda for Change Band 8a and above, and include both general and clinical managers.

	Male	Female
Directors (Executive and Non-Executive)	**8**	**8**
Senior Managers (Band 8a and above)	**50**	**139**
Other employees	**698**	**3462**
Total of all staff	**755**	**3610**

Average number of employees

The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year.

	2017/18	2017/18	2017/18	2016/17
Staff Category	**Permanently Employed**	**Other**	**Total**	**Total**
Medical and dental	384	31	**415**	411
Administration and estates	858	8	**866**	817
Healthcare assistants and other support staff	816	83	**899**	790
Nursing, midwifery and health visiting staff	957	105	**1,062**	1,065
Scientific, therapeutic and technical staff	563	27	**590**	553
Total	**3,578**	**254**	**3,832**	3,636

Staff Costs

	2017/18		2016/17
	Total		Total
	£000		£000
Salaries and wages	**128,244**		**122,832**
Social security costs	**11,922**		**11,480**
Apprenticeship levy	**586**		**0**
Pension costs (employer contributions to NHS Pensions)	**14,201**		**13,389**
Termination benefits	39		123
Bank and agency staff	**18,906**		**16,609**
Total employee benefit expenses	**173,898**		**164,433**
Less costs capitalised as part of assets	**(158)**		**(173)**
Total per employee expenses in Note 4.	**173,740**		**164,260**

Employee costs include staff costs of £158k (£173k in 2016/17) which have been capitalised as part of the Trust's capital programme. These amounts are excluded from employee expenses (Note 5.1). The employee expenses table above is for executive directors, staff costs and redundancy payments only. It excludes non-executive directors.

Attendance Management

The Trust has a comprehensive Attendance Management Policy to deal with sickness absence. This ensures that staff are supported through referrals to our Staff Health and Wellbeing service where early access to counselling and physiotherapy services are provided. Managers conduct regular Return to Work (RTW) Interviews to ensure that they understand any health issues affecting their staff and that they are appropriately supported. Compliance with RTW interviews is at 79% but there is an expectation that the target of 85% should be achieved and action plans are in place to improve this.

The main reason for sickness absence is stress/anxiety/depression which accounts for over 25% of absence. The Trust recognises that more needs to be done to address these mental health issues and during 2018/19 it is planned to introduce fully trained Mental Health First Aiders across the Trust and Mental Health Staff Champions who will help identify mental health issues with staff and ensure that they receive the correct support and/or referred for professional support or self-help.

The following table shows the number of average days lost per employee which also shows a very slight decrease from the previous year (please note that these figures are based on the 2017 calendar year as requested by Department of Health/NHSI):

Staff sickness absence	**2017**	**2016**
	Number	**Number**
Total days lost	57,918	58,631
Total staff years	3,444	3,479
Average working days lost (per WTE)	**10**	**17**

Trust HR Policies and Procedures

During 2017/18 the Trust has reviewed and updated the following policies and procedures:

- Recruitment and Selection Policy
- Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy
- Managing Conflicts of Interest in the NHS Policy
- Policy for the Payment of Travel and Expenses
- Disciplinary Rules Appendix
- Maintaining High Professional Standards Policy
- Organisational Change Policy
- Guidelines for Referral of a Registrant to the Nursing and Midwifery Council
- Exit Payments Policy
- MARS Framework
- Remediation Policy
- Attendance Management Policy
- Flexible Working Policy
- Paternity and Partner Leave Policy
- Adoption Leave Policy
- Training and Development Policy
- Performance Improvement Policy
- Strengthening Medical Appraisal Policy
- Overtime Policy
- Retirement and Long Service Policy
- Work Experience Policy

All Trust policies and procedures, including the above, are required to be impact assessed from an equality perspective.

Equality and Diversity with emphasis on Disability

The Trust is committed to fully supporting all persons with disabilities. The Trust has an Equality & Diversity Sub Committee that regularly address disability issues faced by both staff and patients. The group has active input into concerns affecting disabled people with regards to policy, practice and patient care. The group also addresses the need to support carers and involve them in decision making.

The Equality & Diversity Sub Committee (EDSC) is chaired by the Director of Human Resources and Organisational Development who in turn reports to the Board and advises and endorses a range of initiatives, reports and actions. Among EDSC members are Warrington Disability Partnership, WIRED and Halton Carers Centre. Initiatives in 2017 included a formal proposal accepted at Board for an official staff disability network. In addition focus groups for disabled staff ran throughout 2017 and its feedback included as part of EDS2 assessments and resulting action plan. These focus groups were facilitated by Warrington Disability Partnership to improve staff confidence. Warrington Disability Partnership also delivered training to managers on making 'reasonable adjustments'.

In 2017/2018 the Trust liaised extensively with additional external stakeholders to increase awareness and understanding of equality issues, these include:

- Warrington Hate Crime Prevention Group
- Better Together in Cheshire
- Karma Nirvana
- Healthwatch
- Warrington Ethnic Communities Association
- Cheshire Equality Leads Forum
- North West Equality and Diversity Leads Group
- Warrington Borough Council

The Trust has supported Warrington Disability Awareness Day (DAD) in 2017 to help show empathy and understanding to people with disabilities, both staff and patients alike. The Trust is proud to have supported this event for 8 years.

The Trust is aware of its obligations with regards to the upcoming Workforce Disability Equality Standard (WDES) and is committed to achieving its successful implementation.

The Trust has sent staff representatives to participate in metric workshops with NHS England to help support this initiative as well as ensuring relevant staff attend appropriate training at NHS England WDES events. The Trust strives to support career progression and make reasonable adjustments to enable all staff to achieve their full potential regardless of disability or any other protected characteristic. The Trust has extensive external disability networks that provide advice and direction in how to best support disabled staff. The Trust has also a Workplace Health and Wellbeing Department who support staff under the Staff Health and Wellbeing Agenda

Applications for employment made by disabled people

The Trust has successfully achieved the 'Disability Confident' standard in 2017. Our Workforce Equality Analysis Report (WEAR) published in January 2018 was able to demonstrate that the Trust supported applications from disabled staff, and found no evidence of discrimination.

In addition, the Trust is able to collect information from NHS Jobs regarding the nature of disabilities of applicants. This provides the Trust with data to see which disabilities are likely to be more commonplace among employees and enables us to determine how best to offer support.

The Trust will utilise this information going forward to support the WDES in 2018.

The Trust has also demonstrated commitment to providing work experience opportunities to disabled people.

Continuing employment for people who have become disabled during employment.

The Trust is committed to supporting staff to remain in employment whenever possible and offer advice and support from both Human Resources (HR) and the Health and Wellbeing Department with regards to applying reasonable adjustments. There are options for employees returning from long term sickness to return to work under a phased return with the support of

their manager and the Health and Wellbeing Department. There are various policies in place to assist and protect disabled staff:

Dignity at Work Policy
Grievance Procedure
Flexible Working Policy
Equal Opportunities Policy
Disability Equality Policy

In addition, the Trust has hosted several events for staff who have become carers for disabled friends or relatives to help support their change in circumstances and provide information. These events have been run by Halton Carers Centre.

Both Halton Carers Centre and WIRED attend the Trust regularly to speak to staff, patients and Carers. The internal intranet system, the extranet, now has information for staff on financial and practical support for Carers.

The Trust run Health and Wellbeing Events for staff throughout the year with various information stalls on disability and health related subjects.

Policies applied during the financial year for the training and development of disabled employees

The Trust achieved a status of 'Excelling' for the second year running in the 2018 EDS2 assessment with regards to flexible working considerations for staff and a first 'excelling' with regards to protection from harassment and abuse.

The Equality Specialist continues to attend several information sessions on the Workforce Disability Equality Scheme (WDES) to ensure support for the career progression of disabled staff within the NHS.

During 2018 the Trust will continue to prepare for the new WDES.

Action taken to provide employees systematically with information on matters of concern to them as employees

The internal intranet system, the extranet, has information for staff on financial and practical support for Carers.

Information on Disability related issues, practical and financial support from stakeholders including Warrington Disability Partnership and Carers UK is also communicated to staff via the extranet, Team Brief, The *weekly*, information stalls and at the Trusts 'Grand Round' where a comprehensive session on *understanding reasonable adjustments* ran in 2017.

All policies discussed above are freely accessible to employees via the extranet, their manager and HR.

Communication and engagement with staff

We have continued to communicate with our staff through a variety of methods always being mindful of our mantra of open and honest communication. The Trust has a range of regular communications using mixed media platforms such as the monthly Team Brief, the emailed weekly update and regular communication on urgent issues of safety and of interest. The Trust's Executive team further author their own messages on a rolling basis.

We continue to embrace social media with Twitter and Facebook and now Instagram featuring in our internal and external communication tools. Our Executive Directors continue to regularly 'walk the floor' to spend time with staff to listen to their concerns and this influences decision making in the Trust. Team Brief continues to be an open invite to all our staff and attendance has increased throughout the year. Team brief was moved to the Thursday and Friday immediately following Trust Board to ensure that the information was as up to date as possible. It continues to be presented by our Chief Executive and is based around our QPS framework including the very latest Performance Dashboards. Team Brief is also an opportunity to for the Trust to reflect on best practice and celebrate achievement.

In our People Strategy last year we set out a desire to engage staff to contribute to issues that affect them, encouraging contributions to improvements and innovation, effective, clear continuous communication at all levels throughout the organisation, and giving all staff a voice.

This year we have worked hard to introduce WHH People Champions across the organisation.
A People Champion is a member of staff who has volunteered to be the link with Communications and Engagement and their work areas. We held an induction conference in October and now have over 70 active People Champions across the Trust representing both clinical and non-clinical area.

The People Champions themselves choose how they want information communicated to them; this included the introduction of a Staff Council. This is a monthly forum where ideas and concerns can be aired and tested. Suggestions have led to the extension of the Christmas Executive visits to include a night shift and the group has been working together to devise a plan to appropriately celebrate the NHS 70th Birthday in a way all that staff can take part.

Throughout the year, our staff have made outstanding contributions to improving the experience of patients and staff and making a real difference to their lives and clearly demonstrating our WHH behaviours in practice. We continue to have a strong Team and Employee of the month system directly linked to the behaviours with some excellent practice recognised throughout the year. This continues to work neatly with our behaviour badges which are awarded for examples of specific behaviours, we are waiting for our first member of staff to achieve all 5 badges. All of these achievements are recognised at Team brief.

Some of these achievements were also celebrated at our annual staff 'Thank You' Awards. With over 150 nomiantions from staff, patiens and visitors this year's Awards were strongly contested.

Mandatory training

In June 2016 the Trust expanded its reporting of mandatory training to the Board to include 'Essential training' and 'Clinical Training'. 'Essential Training' incorporates: Corporate Induction, Dementia Awareness, Fire Safety, Health and Safety and Moving and Handling. 'Clinical Training' incorporates: Infection Control, Resuscitation, Safeguarding Procedures (Adults) Level 1 & 2 and Safeguarding Procedures (Children) Level 1 & 2. The Trust has largely managed to maintain high levels of compliance against a target of 85% although Clinical Training did dip over the winter period due to operational pressures. The table below shows the position at March 2018 compared with March 2017.

From March 2018 the Trust has decided to adopt the way that Mandatory Training topics are classified and reported, in order to bring the Trust in line with the Health Education England (HEE) Core Skills Framework. The Mandatory Training under the Core Skills Framework includes the following topics:

- **Conflict Resolution**
- **Equality and Diversity**
- **Fire Safety**
- **Health and Safety**
- **Infection Prevention & Control**
- **Information Governance**
- **Moving and Handling**
- **Preventing Radicalisation**
- **Resuscitation**
- **Safeguarding Adults**
- **Safeguarding Children**

The figures that will be reported in the Annual Report for 2018/19 will reflect the new Core Skills Framework

	March 2017	**March 2018**
Essential Training	*89.20%*	**86.92%**
Clinical Training	*86.20%*	**82.84%**

Health and Safety

The Trust has in place an integrated risk self-assessment tool. This tool was introduced at the beginning of March 2018 and incorporates all Health and Safety regulations and CQC fundamental standards. All managers assess their compliance with each standard and provide evidence to support this. Where there is partial or non-compliance, a risk assessment is developed.

The Trust monitors the Health and Safety element of this tool by carrying out annual audits of each Ward/Department.

All areas of Health and Safety are monitored, discussed and reviewed at the Health and Safety Sub Committee. The Committee meets on a bi-monthly basis and is responsible for ensuring that an effective Health and Safety Policy is implemented throughout the Trust. This provides assurance to the Board that Health and Safety Risks are being managed appropriately.

A bi-monthly report is presented at each Health and Safety Sub Committee meeting and an annual report is presented to the Quality Committee.

Workforce Health and Wellbeing

Our Workplace Health and Wellbeing Team (WHAW) deliver our Occupational Health service and have responsibility for staff health and wellbeing. The Department is SEQOHS accredited and is a nurse led unit, with a team of fully qualified occupational health nurses. We also have an experienced physiotherapy and counselling service. The department purchases an external provider for the doctor element of the service who are members and fellows of the faculty of Occupational Health Medicine.

The department provides management referrals, management support and advice, health surveillance, new employment assessment and clearance with recommendations, advice and signposting to external services, wellbeing campaigns, physiotherapy, counselling and many more interventions not listed. WHAW support the continuing 'fit to care' and the health and wellbeing CQUIN. The work can broadly be broken down into the following areas of focus:

1. **Management referral / self-referrals support.**
   This year we have undertaken 3881 management referral and self-referral appointments. This is higher than previous years. Stress continues to be the greatest cause of sickness reported on ESR. As a result of this, human resources and WHAW are working together to highlight 'hot-spot' areas and offering support and advice with the aim to reduce the sickness rates within these areas. The staff counsellor is also offering support in these areas on how to manage stress.

   Both individual staff members and management continue to be offered immediate access to the department at such times when there is a need for crisis intervention/management. We continue to offer ongoing advice and support to managers at this time, ensuring that members of staff are assessed, supported and signposted to the appropriate external support services such as A&E, GP, external mental health services as required and appropriate follow up is arranged.

2. **Health Surveillance**
   Health surveillance remains similar from previous years with 183 interventions, including, night workers assessment, latex assessment, visual screening, lung assessments and audiometry screening.

3. **Musculoskeletal (MSK)**
   The Trust continues to provide an excellent staff physiotherapy service, offering staff members a quick and easy accessible service within the working environment. Support is also being offered via telephone consultation with any following appointments being triaged to suit the need of the individual. There is also provision to offer acupuncture treatment and other treatments such as ultrasound as assessed by the specialist physiotherapist. The physiotherapy service also continues to offer ergonomic workstation assessments and

advice and support to both staff members and managers on such matters.

4. **Mental Health**

Our senior counsellor is now offering a wider range of services across the Trust. She is trained in hypnotherapy and can now offer this intervention in a wider remit. This has allowed us to look at broader mental health issues and resilience. She has also recently successfully completed her mental health "first aid trainers" course with another member of staff currently in the process of this training. This training will facilitate them to teach other members of staff Trust wide to become mental health first aiders, with a plan to promote this during mental health awareness week in May 18. Alongside the provision of one to one counselling support, some of our work this year has included:

- Volunteer counsellors to support the service.
- Improving the range of training opportunities available to increase the understanding of mental health issues in the Trust, this includes the ongoing training for 'mental health first aid'. There are plans in place to promote this alongside the mental health awareness week in May and to then roll this training out across the Trust from June 18.
- Introduction of Mental Health Awareness training to our Preceptorship Training programme
- Ward manager Mental Health Awareness training sessions
- Specialist involvement in our Healthy Worker Course and Essential Manager Training.
- Awareness sessions and 'drop-in sessions' within their own clinical area for all staff.
- Hypnotherapy and relaxation therapy and a plan to offer 'post traumatic therapy'.

5. **Health Campaigns**

Each month the WHAW offer health promotional advice and events on each site of the Trust, for example: 'love your heart', blood pressure checks, the flu campaign, stress and your heart. This year we have achieved and exceeded the DOH and CQUIN target of 75% in regards to the flu campaign. We successfully finished the campaign with our final figure reaching 85.5% of frontline staff vaccinated within the Trust at the end of our 17/18 flu campaign.

6. **Needle Stick Injury**

We continue to liaise closely and continue to report on numbers and trends that are apparent in relation to needle-stick injuries within the Trust. We continue to attend and support the needle-stick working group, addressing any areas of concern in relation to injuries, areas of incidents, equipment and any areas of concern in relation to non-compliance in relation to the Blood Bourne Virus Policy.

7. **Health and Wellbeing**

We support the Trust 'wellbeing days' and continue to liaise and work closely alongside the workforce strategy and engagement team. We continue to co-ordinate services such as smoke cessation services on both sites.

Countering fraud

In relation to fraud risks to the organisation, the Trust agrees an annual counter fraud plan using a nominated and nationally Accredited Local Counter Fraud Specialist (LCFS) via its Internal Audit provider Mersey Internal Audit Agency (MIAA). The Trust's plan is based on a generic plan covering seven areas of activity including anti-fraud culture and deference to fraud produced by NHS Protect who take the national lead on NHS fraud related matters. This approach is supplemented by a local risk assessment that examines local fraud vulnerabilities.

Regular monitoring of counter fraud activity is undertaken via the Trust's audit committee on a regular basis via progress reports and an annual report of counter fraud activity. This monitoring process includes the identification of any fraudulent activity against the Trust.

During 2017/18 MIAA commenced investigations into three potential fraud issues, one of which has been closed and the remaining two still continuing.

Expenditure on Consultancy

The Trust has incurred the following expenditure on consultancy services.

	2017/18	2016/17
Total expenditure (£000's)	1,000	933

Expenditure of £300K was for the provision of Trust management advice and assistance outside the 'business as usual' environment and covers strategy, financial, organisation and change management and IM&T services. Expenditure of £700K was for the provision of consultancy services on behalf of the Cheshire and Merseyside Health and Care Partnership (formerly STP) which has been hosted by the Trust since 18th September 2017.

Disclosures set out in the NHS Foundation Trust Code of Governance

The directors are responsible for the preparation of annual report and annual accounts. The Board of Directors considers the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

The Trust Board has overall responsibility for the administration of sound corporate governance throughout the Trust and recognises the importance of a strong reputation. The purpose of the Code is to assist Foundation Trust Boards to ensure good governance and to improve their governance practices by bringing together the best practice of public and private sector corporate governance.

The Code imposes some disclosure requirements on Foundation Trusts and Boards are expected to observe the Code or to explain where they do not comply. It includes a number of main and supporting principles and provisions and Foundation Trusts are required to publish a statement in the Annual Report confirming how these have been applied.

Warrington and Halton Hospitals NHS Foundation Trust has 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. It declares there is one item that is partially compliant and will be fully so by the Annual General Members Meeting in September 2018.

Part of schedule A	Relating to	Code of Governance ref	Requirement	Comply or Explain
2: Disclose	Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. *The Council has plans to engage with the membership and public in Q1 of 2018-19 on the Trust's refreshed Strategy, which was updated to reflect the Trust's ambition to become an 'Outstanding' Trust following the CQC's disappointing 'Requires Improvement' assessment in October 2017. They will do this through the Trust's annual member communication 'Your Hospitals' which, in the NHS 70th year, will be a commemorative, souvenir edition mailed to 9K homes. Views will then be reported to the Board by the Council of Governors.*	Partially compliant: (See P44)

Annex 1

Staff exit packages

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change and the NHS Pension Scheme. Exit costs are accounted for in full in the year of departure. Where the organisation has agreed early retirements, the additional costs are met by the Warrington and Halton Hospitals and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in the table.

The table below discloses the number and value of exit packages agreed in 2017/18.

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000	Number	£000	Number	£000	Number	£000
<£10,000	1	8			1	8		
£10,00 – £25,000	2	31			2	31		
£25,001 – £50,000								
£50,001 – £100,000								
Total	**3**	**39**			**3**	**39**		

The number and value of exit packages agreed in 2016/17 are listed in the table below for comparison.

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000	Number	£000	Number	£000	Number	£000
<£10,000								
£10,00 – £25,000			1	13	1	13		
£25,001 – £50,000	1	31	1	26	2	57		
£50,001 – £100,000			1	51	1	51		
Total	**1**	**31**	**3**	**90**	**4**	**121**		

Analysis of other departures

The table below discloses the number of non-compulsory departures which attracted an exit package in the year, and the values of the associated payments. Values for the previous financial year are listed for comparison.

	2017/18	2017/18	2016/17	2016/17
	Number of Agreements	**Total Value of Agreements**	**Number of Agreements**	**Total Value of Agreements**
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs				
Mutually agreed resignations (MARS) contractual costs			2	77
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice (1)	15	99	1	13
Exit payments following Employment Tribunals or court orders				
Non-contractual payments requiring HMT approval				
Total	15	99	**3**	**90**
Of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary				

Notes:

(1) Includes a contractual payment in lieu of notice of £59k made to a member of the Trust's Executive Committee. The payment was made in accordance with the Trust's Senior Management Remuneration Policy as outlined on page 37.

Annex 2 NHS Staff Survey 2017

One of the tools that we use to monitor staff engagement is the national NHS Staff Survey which is conducted each year by the Trust, the results of which are used by the Care Quality Commission, our commissioners and others to assess our performance.

An external provider must undertake the survey and Quality Health undertook the survey on behalf of the Trust. Trusts are only required to survey a sample of randomly selected staff however, this year the Trust decided that all staff should have the opportunity to complete the survey. The average response rate nationally was 45%, ours was 46%, 8% higher than last year with over 1800 members of staff taking part.

Almost half the responses for 2017 are better than the national average with only 1 finding in the bottom 20% of acute Trusts compared to 2 in 2016 and 7 in 2015. We believe that our work on staff engagement and health and wellbeing is having a positive effect on these results.

The 2017 staff survey shows positive results in the following areas:

- Although not in line with the national average, there was an increase in the percentage of staff who would recommend us to family and friends as a place to work or receive care or treatment
- Staff reported very low levels of discrimination and rated the Trust in the top 20% of Trusts for equal opportunities.
- Staff felt that support from immediate mangers was above average
- Staff said that the recognition they received from managers and the organisation was better than average
- Staff felt that managers take an interest in their health and well-being

The survey also highlights areas for us to work on. The focus for improvement being: the likelihood of staff recommending the Trust as a place to work or receive treatment; staff motivation and reporting procedures. Whilst there have been some improvements these have not been significant shifts and work will continue during 2018/2019.

The survey results have been shared with the Board and the Workforce Committee (sub-committee of the Trust Operational Board Board). After discussing the results, the Board have agreed a new approach to employee engagement which will involve working closely with staff across the Trust to achieve high impact and sustainable improvements.

Staff survey report overall response rates

	2016	**2017**		**Trust improvement/ deterioration in year**
Response rate	*Trust*	**Trust**	**National Average for acute Trusts**	
	38%	**46%**	**45%**	Improvement of 8 percentage points

Areas of significant improvement

Overall the Trust performs particularly well in relation to bullying and harassment and in 2017 there was a significant improvement in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months, placing the Trust in the best 20% of acute Trusts.

There was a decline in the percentage of staff reporting errors, near misses or incidents in the last month and this will be a key area of focus for the Trust going forward.

Summary of Performance

The top five ranking scores for 2017 and how they compare against the national average:

	2016	2017		Trust improvement / deterioration in year
	Trust	**Trust**	**Benchmarking against acute Trusts averages**	
KF20. Percentage of staff experiencing discrimination at work in the last 12 months	**8%**	**8%**	**12%**	No change
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**26%**	**23%**	**28%**	Improvement of 3 percentage points
KF16. Percentage of staff working extra hours	**67%**	**66%**	**72%**	Deterioration of 1 percentage point
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	**91%**	**89%**	**85%**	Deterioration of 2 percentage points
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	**50%**	**48%**	**52%**	Improvement of 2 percentage points

The bottom five ranking scores for 2017 and how they compare against the national average:

Bottom 5 Ranking Scores				
	2016	**2017**		**Trust improvement / deterioration in year**
	Trust	**Trust**	**Benchmarking against acute Trusts averages**	

KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	**92%**	**87%**	**90%**	Deterioration of 5 percentage points
KF1. Staff recommendation of the organisation as a place to work or receive treatment	**3.57**	**3.61**	**3.75**	Improvement of 0.04
KF30 Fairness and effectiveness of procedures for reporting errors , near misses and incidents	**3.65**	**3.66**	**3.73**	Improvement of 0.01
KF23. Percentage of staff experiencing physical violence from staff in last 12 months	**2%**	**3%**	**2%**	Deterioration of 1 percentage point
KF7. Percentage of staff able to contribute towards improvements at work	**69%**	**69%**	**70%**	No change

Conclusions from the staff survey and action plans for the future

In order to achieve high impact and sustainable improvements the HR and OD Directorate will support the Trust Board to bring the workforce together in an event to promote innovation around the staff survey results. The event will adopt the principles of a 'Hackathon' to create the condition where staff are able to work together to think differently and creatively about making 'WHH A Great Place to Work'.

The event will focus on the following key themes from the staff survey:

- Errors and Incidents
- Recommendation of the Trust as a place to receive care
- Recommendation of the Trust as a place to work
- Motivation at work

Staff will be encouraged to be involved in taking ideas forward and outcomes will be communicated through the People's Champion's via a 'We Said, We Did' campaign.

In addition, each CBU / Department will receive a presentation on the survey results for their areas to facilitate a discussion on how will this be addressed within their teams. They will be supported to do so by the HR and OD Directorate.

Annex 3 – 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.

Segmentation

The Trust is currently assigned to segment 2 of the framework. This segmentation information is the Trust's position as at 18 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 Trust disclosed above might not be the same as the overall finance score here.

This segmentation information is the Trust's position as at 31st March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Metric	2017-18 Quarter 3 Rating	2017-18 Quarter 4 Rating
Capital service cover	4	4
Liquidity	4	4
I&E Margin	4	4
I&E Variance from plan	4	4
Agency spend	2	2
Overall scoring	**4**	**4**

Annex 4 Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Warrington and Halton Hospitals 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 [name] 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 Warrington and Halton Hospitals 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.

Signed

Mel Pickup, Chief Executive

Date: 24.5.18

Annex 5 – 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*.

Overview:

Operationally the Trust has continued to regularly report its performance against a range of national standards. It has consistently met the Referral to Treatment pathway, waiting times for Diagnostics and the majority of Cancer targets. However, the ability to see, assess, discharge or admit patients within 4-hours remained a significant challenge (like the majority of Trusts where deterioration in this standard was seen regionally and nationally.) The winter period was the most challenging to date with an increase in the acuity of patients attending the Emergency Department and emergency admissions above expected levels. This was consistent with peers in the Cheshire and Merseyside region. In addition, for some months the achievement of the cancer 62 days urgent referral target was not achieved. The Trust continues to focus on improving performance in these areas through enhanced scrutiny and the implementation of associated action plans.

The Trust Board continues to monitor and scrutinise the financial position of the Trust and regular updates are provided at Board meetings. Detailed review is undertaken by the Finance and Sustainability Committee. The financial position at year end was a deficit of £14.7m deficit which included £4.3m Sustainability and Transformation Funding. This deficit has resulted in the requirement for additional cash from the Department of Health in the form of working capital loans to support the deficit and the payment of creditors. The successful delivery of cost saving plans has been one key focus for the Board throughout 2017/18 with the achievement of £5.1 against a plan of £10.5m.

There were some changes to the Executive Team in year with the departure of the Chief Operating Officer in April and the Director of Human Resources and Organisation Development. Both positions were filled by interim/acting appointments until substantive appointment to Director HR&OD in November 2017 and the Chief Operating Officer in March 2018. Within the senior management structure a combination of internal and external opportunities/circumstances made it clear that the Trust needed to modify its organisation structure to:

- Streamline the structure to provide greater support to and empowerment and development of the Clinical Business Units to face the challenges in 2017-18 and beyond
- More closely align CBUs with the delivery of the Quality Strategy
- Fully address findings of the CQC inspection, specifically relating to leadership and ward-to-board governance
- Prepare and enable the Trust to be an 'outstanding' Well-Led organisation building on the new Well Led Framework co-created by the CQC and NHS Improvement

This was modification was approved by the Trust Board in December 2017 and implemented from 1st February 2018.

More widely the Trust is part of the Cheshire and Merseyside Health and Care Partnership and the author is the Senior Responsible Officer for the whole system integration. As such, the Trust now acts as host for the C&M Health and Care Partnership (formerly STP). In Warrington, plans are being progressed to establish an Accountable Care Organisation, *Warrington Together*, with representation across all health providers, to address demand and capacity, similarly in Halton Borough where *One Halton* is being progressed.

The Trust remains indebted to its Council of Governors where the 26-strong Council volunteers time to support the organisation in governance, patient and public engagement and achievement of its quality priorities. In year there was a public and staff governor election with six new Governors joining the Council in December. A bespoke Governor Induction Day was held in February 2018 and the Lead Governor has joined the Lead Governors Association. Further bespoke development opportunities included the Quality Strategy development day and various health-economy specific external events offered by the Trust's internal auditor. The Governors are to be commended for enhanced communications and engagement with membership and the public in year through the refreshed 'Your Hospitals' newsletter and their contribution to a number of 'What Matters to Me?' conversation cafes as well as ongoing commitment to their Governor Observation Visits to wards and departments.

Disclosures relating to NHS Improvement's Well Led Framework

As part of a commitment to simplifying regulatory approaches, NHS Improvement worked closely with the Care Quality Commission (CQC) to bring together their respective approaches to the Well-Led key line of enquiry (KLOE). This resulted in a new, wholly joint Well-Led Framework structured around eight key lines of enquiry introduced in year.

The Trust has begun implementing the new guidance which builds on its work undertaken under the previous framework. In April 2017 the Trust received its external Well Led assessment which concurred with its own assessment as 'Amber-Green'. An action plan to address 31 recommendations was developed progressed by Executive Director leads, reporting to Trust Board.

Work on a further self- and external assessment to incorporate the four additional domains of the Well Led framework is underway and will provide further assurance that the Trust is well led through:

1. Its leadership capacity and capability to deliver high quality sustainable care
2. Its clear vision and credible strategy to deliver high quality sustainable care to people and robust plans to deliver
3. Its culture of high quality sustainable care
4. The clear responsibilities, roles and systems of accountability to support good governance and management
5. The clear and effective processes for managing risks, issues and performance
6. Appropriate and accurate information that is being effectively processed, challenged and acted upon
7. The people who use services, public, staff and external partners are being engaged and involved to support high quality sustainable services
8. Its robust systems and processes for learning, continuous improvement and innovation

Risk Management and Controls

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 Warrington and Halton Hospitals 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 Warrington and Halton Hospitals 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

- **Leadership and accountability** The Board of Directors provides leadership on the overall governance agenda. The Quality Assurance Committee is the committee of the Board of Directors that oversees the risk management activity of the Trust and ensures that the correct strategy is adopted for managing risk; controls are present and effective; and action plans are robust

for those risks that are scored 15 and above. The executive lead for risk management is the Chief Nurse. The supporting system for managing risk has been delegated to the Director of Integrated Governance and Quality. Additional support is provided to the Trust's risk management systems through designated governance managers and audit and governance leads within the clinical business units.

- **Strategic Risk Management** During the year the Trust has updated its Risk Management Strategy to strengthen its systems of control and management. It also fully appraised its key strategic risks and refreshed its Board Assurance Framework which is reviewed by the Board on a quarterly basis and the Quality Assurance Committee on a bi-monthly basis. In year there was further alignment of the relevant elements of the Board Assurance Framework to the committees of the board. A bi-monthly update on any new or changed strategic risks is provided to the Board.

  The refreshed Risk Management Strategy provides a framework for managing risk across the Trust in line with best practice and Department of Health guidance. The Strategy describes the process for managing risks and the roles and responsibilities of the Board of Directors, its Committees and that of all staff and provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the Trust. The refreshed Strategy focused on escalation, governing management of risk, a change to a new risk management system, development of a self-assessment tool, introduction of a Risk Review Group and development of a training programme for identified staff and managers.

  Local risk registers are monitored and maintained locally within the divisions/clinical business units which enables risk management decision-making to occur as near as practicable to the risk source. For those risks that cannot be managed locally these are escalated to the appropriate manager and are included in the appropriate corporate departments or divisions risk register.

All risks below 12 are managed locally by each Ward/Departmental Manager. This can be managed by risk assessments and/or local risk registers and should be reviewed at least annually.

All risks of 12 are placed on CIRIS (moving to Datix) by the relevant CBU/Department. Each risk has an identified Lead who will review the risk to ensure any actions are implemented and reviewed at the Patient Safety and Clinical Effectiveness sub-committee.

All risks of 15 or above are reported through Risk Review Group which makes recommendations to the Quality Assurance Committee which has an overarching role to ensure that significant issues arising review of the register are brought to the attention of the Board of Directors. The Board of Directors receives the Risk Register with the Board Assurance Framework quarterly during each financial year.

The Trust employs a number of systems to ensure that risk management is embedded within the organisation including business planning, performance management frameworks and clinical information systems. Regular reports are also available to the various committees responsible for aspects of risk management.

There are a number of corporate policies and procedures in place to support risk management, covering the management of incidents, risk assessment and consent and general risk management arrangements.

The Trust encourages stakeholder and partner organisations' participation and has developed an active Patient Experience Committee**.** Partners and Governors are encouraged to raise issues, be involved in determining solutions and input to all aspects of risk management.

The Trust has a Board Assurance Framework in place which is reviewed by the Board of Directors, and includes: the identification of the key risks to the achievement of the strategic objectives, CQC fundamental standards and the Provider Licence and the systems in place to manage/mitigate these risks; the control systems in place to manage the key risks; the identification of sources of internal and external assurances evidencing the management of risk; and evidence of compliance with equality, diversity and human rights legislation. The Board Assurance Framework is reviewed quarterly by the Board of Directors and the Audit Committee, and bi-monthly by the Quality Assurance Committee, who provides additional challenge and scrutiny of the risks identified. It is outward as well as inward looking and the Board have discussions about the organisation's tolerance level for risk.

The Board Committees are supported in their risk management role by their reporting committees and groups:

The Quality Assurance Committee is chaired by a Non-Executive Director and following the revision of the Risk Management Strategy this committee has overseen the Trust's strategic risks as the designated Board Committee responsible for risk. This committee has liaised closely with the Audit Committee to ensure the strategic risk register and Board Assurance Framework drives the internal audit plan and to provide the Audit Committee with assurance regarding systems of internal control.

In addition the Quality Assurance Committee convened the Risk Review Group, to ensure that there was scrutiny of departmental, speciality and Clinical Business Unit risk registers, and that appropriate escalation processes are in place to the Board. The Committee also put in place processes to oversee the impact of cost efficiencies, by ensuring updates of Quality Impact Assessments were given on at least a quarterly basis, with more frequent updates if warranted. It continued to monitor the statutory and regulatory requirements relating to quality governance throughout the year including monitoring of Care Quality Commission preparedness work, national audit activity, NICE guidance, national surveys, quality KPIs, complaints improvement etc. To fulfil the responsibilities it has a number of sub-committees reporting to it including:

- Patient safety and clinical effectiveness
- Patient experience
- Medicines governance
- Complaints quality assurance
- Risk review
- Health and safety
- Infection control
- Information governance and corporate records

The Audit Committee, chaired by and made up of Non-Executive Directors, provides an independent overview of the governance arrangements by giving assurance to the Trust Board on the working of all Board Committees. It scrutinises the Annual Governance statement, Board Assurance Framework and aligns internal audit plan to risks in the Trust.

CBU-level Governance arrangements are in place to ensure identification, monitoring and scrutiny of risks

- **Training:**

Training is provided to staff on risk assessment and management through a number of sources. The Trust's corporate induction programme ensures all new staff (including consultant appointments) are made aware of the Trust's risk management systems and processes and staff are provided with an information leaflet at the time of induction. Risk assessment and management training is provided to all levels of staff within the organisation based upon the requirements of the position and role held, toward the end of the year a new risk management system was introduced with training being rolled out across departments and services.

The Trust provides a comprehensive mandatory training programme that covers a wide variety of risk management processes, including but not limited to; health and safety; fire; manual handling; security; information governance; resuscitation; records management and blood transfusion.

Mandatory training rates are reported to the Workforce Committee, the Board of Directors and the Council of Governors through one of its committees, the Quality in Care Committee. Training-needs analysis of staff continues to be reviewed to ensure relevant training is directed to those members of staff that require specific training for their role within the Trust and that learning, improvement and lessons learned from untoward events are brought to the attention of staff.

Investigation training is aligned to root-cause analysis is provided within the framework of NHS England. The training is underpinned by the required levels of investigation. For serious incidents (level two investigations) the lead investigating officers are outside of the area where the incident has occurred. No person can lead an investigation unless they have received training on the relevant principles.

- **The risk and control framework**

Incidents, complaints, claims, Coroners' Inquests and patient feedback are routinely analysed to identify lessons for learning and improve internal control. To enhance learning and improve governance, the Trust actively pursues external peer review of all serious incidents should this be necessary.

Learning and improvement from incidents, complaints, claims and coroners inquests has been a particular focus for the Trust and help to improve internal control. Incidents, complaints, PALS, Claims, Coroner inquests, external agency, Risk KPIs are reported through the Quality Assurance Committee via its sub-committees, CBU-level reports; and shared with the lead Commissioners as part of the Quality Contract. Lessons for learning are also disseminated to staff using a variety of methods including:

Safety alerts and Safety Briefings Safety alerts are circulated with the morning all-staff bulletin/extranet and *The Week* to raise immediate awareness of risks that may lead to errors and therefore reduce the risk to patients, staff, visitors and contractors in the future. They are produced following a review of incidents or following information provided by staff within the Trust or from external agencies. These are included in Safety Briefings at shift handover for clinical staff.

Sharing and Learning Together This newsletter is aimed at all staff and covers a range of topics under one 'umbrella' title. Learning from investigations and Coroners' Inquests are shared and a new staff extranet platform has enabled fast and easy access to learnings, risk management systems, safety alerts and procedures, duty of candour and speak out safely information. The Trust actively encourages networking and has strong links with relevant central bodies, such as the Care Quality Commission (CQC), the National

Learning and Reporting System (NRLS), and Health and Safety Executive (HSE).

Review of effectiveness of internal control

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the quality committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Some of the work undertaken and the roles of the Board and Committees in this process:

- The internal audit plan is a risk-based plan which is devised in consultation with the executive team, led by the Director of Finance and under guidance from the Audit Committee. The Audit Committee approves the plan at the beginning of each year. Progress reports are then presented to the Committee at each meeting with the facility to highlight any major issues. The Chair of the Audit Committee can, in turn, quickly raise any areas of concern at the Board via a Key Issue Report and minutes are also considered by the Board. He also produces an annual report on the work of the Committee.
- The Board reviews the refreshed Board Assurance Framework and integrated key Risk Register on a quarterly cycle. The Board Assurance Framework is also received by the Quality and Audit Committees
- The Executive Management Team meet weekly and has a process whereby key issues such as performance management, action plans arising from external reviews and risk management are considered if there is a need.
- All relevant committees have a clear cycle of business and reporting structure to allow issues to be escalated from 'ward to board'

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the work of internal and external audit, the external review processes for the clinical negligence scheme along with the NHS Resolution and the Care Quality Commission. Improvements made in year include:

- A comprehensive refresh of the Trust's Risk Management Strategy
- Further development of the Board Assurance Framework and the Risk Register
- A refresh of the organisation's key strategic risks supplemented by bi-monthly updates on additions or changes to key risks
- Investment in a new risk management system which is being rolled out Trust-wide incorporating training.

Board of Directors: The Board Assurance Framework provides an overview of the internal control environment and evidence of the effectiveness of the controls that manage the risks to the Trust in achieving its strategic objectives as identified in the annual plan.

Audit Committee: The Audit Committee reviews the effectiveness of internal control through the delivery of the internal audit plan. The Chair of the Audit Committee has provided an annual report of the work of the Committee that supports my opinion that there are effective processes in place for maintaining and reviewing the effectiveness of internal control.

Clinical Audit: Clinical Audit is an integral part of the Trust's internal control framework. An annual programme of clinical audit is developed involving all clinical business units. Clinical audit priorities are aligned to the Trust's clinical risk profile, compliance requirements under the provisions of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, and national clinical audit priorities or service reviews. The Trust has adopted the Health Research Authority (HRA) procedures which moved the emphasis towards acceptance of HRA assessment within the framework of research governance, strict legislation and recognised good clinical practice and local assessment of capability and capacity to run a study.

Internal Audit

MIAA acted as Internal Auditors for the Trust during the year. Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is agreed with the Executive Team via the Director of Finance and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the Committee uses a three cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency. Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

The Head of Internal Audit issued an overall opinion for 2017-18 of **Moderate Assurance** noting 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 gaps in assurance are being addressed as a matter of urgency and action plans are in place to return each element to significant assurance. The HOIA confirmed continued compliance with the definition of internal audit (as set out in the Trust's Internal Audit Charter), code of ethics and professional standards. The HOIA also confirmed organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

External Audit

External audit provides independent assurance on the Accounts, Annual Report, Annual Governance Statement and on the Annual Quality Report. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the work of internal and external audit, the external review processes for the clinical negligence scheme for Trusts along with NHS Resolution and the Care Quality Commission.

The Foundation Trust Code of Governance

The Trust has completed its NHS Foundation Trust Code of Governance (the Code) for 2017-18 under the principle of 'comply or explain'. It is pleasing to note that work undertaken in 2016-17 to address non-compliance in three areas (A.5.6; A.5.7 and C.3.8) enables the Trust to declare full compliance with provisions of the Code for the 2017-18. The principle risks to compliance with the Foundation Trust license and actions identified to mitigate these are as follows:

Code (4) Non-Executive Directors: As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non-executive directors should also promote the functioning of the board as a unitary board:

- **Provision:** In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channel of chairperson, chief executive, finance director or Trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.

- **Mitigating actions:** The Council of Governors approved the appointment of the SID 2016. The SID regularly attends meetings of the Council of Governors.

- **Provision:** The chairperson should hold meetings with the non-executive directors without the executives present. Led by the senior independent director, the non-executive directors should meet without the chairperson at least annually to appraise the chairperson's performance and on such other occasions as are deemed appropriate.

  Mitigating actions: The Chairman has met with Non-Executive Directors without the Executives present during the year. The SID leads the appraisal process for the Chair annually and reports to the Council of Governors' Nominations-Remuneration Committee on the outcome. The Committee in turn reports to the full Council.

- **Provision:** Where directors have concerns that cannot be resolved about the running of the NHS foundation Trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chairperson for circulation to the board, if they have any such concerns.

  Mitigating actions: The Trust values embrace NHS values and underpin the Trust's strategic objectives and the leadership approach taken by the organisation. The role of the Senior Independent Director and Company Secretary in supporting and escalating concerns where appropriate is clearly defined within the Constitution and within the role descriptions. All Board members are encouraged to articulate their views in Board meetings and the minutes clearly and accurately reflect this.

The Trust is able to assure itself of the validity of its Corporate Governance Statement, required under NHS foundation Trust condition 4(8)(b) through its Annual Governance Statement (this document), its Code of Governance self-assessment evidence and its Head of Internal Audit Opinion.

Compliance with License Conditions

The Trust commenced the year under continued enforcement (conditions placed on its License by Monitor in 2015-16 pursuant to its powers under s106 of the Health & Social Care Act 2012) for Continuity of Services Risk Rating of 1, absence of recovery plan and reliance on external support to develop a turnaround plan and historic performance issues such as delivery of CIP). Following sustained progress to deliver its services on a clinically, operationally and financially sustainable basis a full Certificate of Compliance with License was issued by NHS Improvement in December 2017.

The Trust continues to work towards financial balance and long-term sustainability, monitors its performance based upon the Single Oversight Framework and is compliant with the UK Corporate Governance Code. It is committed to maintaining regulatory compliance, including improving its CQC rating to 'Good' in the short term and uses feedback from external assessment or inspections as a learning opportunity, building

this into immediate and future improvement plans.

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

The Trust has been assessed as being in 'Segment 2' by the regulator NHS Improvement, meaning the Trust is offered targeted support. This position improved in December 2017 from segment 3 where the Trust had been receiving mandated support.

The Trust has performance management processes in place that review the economy, efficiency and effectiveness of the use of resources. The Executive Team reviews the operational performance of the Trust and monitors this through the Trust Operational Board, and leads the Trust's identification and implementation of Cost Improvement Plans (CIPs). Monthly reports to the Board provide updates on performance throughout the year, ensuring service delivery and cost improvements without jeopardising patient safety – schemes are underpinned by Quality Impact Assessments. Part of the remit of the Finance and Sustainability Committee, which meets monthly, is to support the Trust Board in gaining assurances on the economy, efficiency and effectiveness of the use of resources.

The Trust has a policy and governance framework in place to guide staff on the appropriate use of resources through its *Standing Orders*, *Standing Financial Instructions* and *Schemes of Delegation*. In addition, there is a robust system for developing and routinely reviewing policies and procedures and staff are appropriately updated and guided or trained on their application.

Independent assurance is provided through the Trust's internal audit programme and the work undertaken by MIAA Counter fraud, reports from which are reviewed by the Audit Committee. In addition, further assurance on the use of resources is obtained from external agencies, including the external auditors and the regulators.

Financial Governance

The Trust recorded a £14.7m deficit for the year, which included £4.3m Sustainability and Transformation Funding. This deficit has resulted in the requirement for additional cash from the Department of Health in the form of working capital loans.

The deficit was £11m above the planned £3.7m deficit (the 'control total') agreed at the start of the year with NHS Improvement. Some of the elements contributing to the higher than planned deficit include: The suspension of spinal services (£2.3m including costs in year), failure to realise the October-March STF monies (£4.6m), loss of income due to mandated cancellation of elective activity during winter (£0.7m), cost-improvement plan shortfall (£5.3m), pay including agency costs (£3.5m) and fines and penalties levied by commissioners (£1.8m).

The annual cost savings target was a very ambitious £10.5m and savings achieved for the year were £5.1m, a shortfall of £5.4m. The annual capital programme was £7.5m and the actual spend for the year was £5.8m. The cash balance was £1.2m which is in line with the balance required under the terms and conditions of the working capital loan agreement.

While the final outturn position was £11m above the original control total, I am satisfied that there were no failures in financial governance. The Finance and Performance committee scrutinised the financial position of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report. In addition, the Board reviewed position and challenged mitigations on a monthly basis. Where there were any concerns the Audit Committee was asked to take action, such as a further level of scrutiny of senior appointments and the engagement of interims in relation to the Trust's pay bill. In January the Board of Directors received a recommendation and approved the change to the 2017/18 forecast outturn based on the Month 10 financial position. The revised position was submitted to NHSI on 15 February 2018. Throughout the year the Trust received 'additional support' from NHSI (as a segment 2 Trust) and this took the form of Performance Review Meetings which NHSI convened at the Trust quarterly. The financial position and associated mitigations were rigorously tested as part of these review meetings.

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*. In preparing the Quality Report, directors have satisfied 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 March 2018
    - The Integrated Performance Dashboard (Quality, Operational Performance, Workforce and Finance) which is scrutinised at the Trust Operational Board and provided for assurance monthly to Trust Board. Data quality is underpinned by a dedicated validation team and the Data Quality Policy.
    - Papers relating to Quality reported to the Board over the period April 2017 to March 2018
    - Feedback from the Trust's Commissioners, Warrington Clinical Commissioning Group and Halton Clinical Commissioning Group
    - Feedback from Governors
    - Feedback from local Healthwatch organisations, Healthwatch Halton and Healthwatch Warrington
    - Feedback from Overview and Scrutiny Committee
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The 2017 national staff survey
    - The Head of Internal Audit's annual opinion over the Trust's control environment for 2017-18

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Report has been prepared in accordance with 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.

CQC Inspection and Assessment

The Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The CQC inspected Warrington and Halton Hospitals NHS Foundation Trust from 6-10th March 2017 and the final report was received in October 2017. During the visit the CQC looked at the quality and safety of the care provided, based on whether the service is: Safe, Effective, Caring, Responsive and Well-led. The Trust was rated as 'Good' for Caring but was very disappointed to be assessed as 'Requires Improvement' for the remaining key lines of enquiry. A robust and comprehensive action plan has been developed which is being overseen by a '*Getting to Good, Moving to Outstanding' Steering Group*' which reports on progress to the Quality Assurance Committee and the Trust Board. Specific work-streams have been developed to drive improvement actions and identify training/development/ infrastructure/capital investment needs and where the improvement actions (must dos, should dos) are being managed closely with timelines and leads identified.

The CQC has not taken enforcement action against the Trust during the year and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period. The Foundation Trust remains fully compliant with the registration requirements of the Care Quality Commission.

Other significant external inspections

Following the identification of a number of (apparently unrelated) Serious Incidents over a six month period within the Trust's Spinal Surgery Service a decision was taken by The Trust to suspend the service. The Royal College of Surgeons was invited by the Trust, Warrington NHS CCG and NHS England Specialist Commissioning to undertake a review which it did in November 2017. At 31st March 2018 the service remained suspended pending the receipt of the full report, its sharing with the families and patients affected and a decision jointly made by commissioners and the Trust about the future of this service at our hospitals.

As commissioners and as a provider we are committed to working together to ensure that the recommendations from the report are fully considered and incorporated in the wider context of how spinal surgery services will be delivered in Cheshire & Merseyside in the future. This will include defining the role of Warrington and Halton Hospitals in keeping access for patients to spinal surgery services as close to home as possible. Alternative providers remain in place to take Warrington and Halton patient referrals for the immediate future.

The process of shaping the future configuration of specialist spinal services across the whole of Cheshire and Merseyside has already begun with a meeting in February 2018 and led by NHS England's GIRFT (Getting it Right First Time) team, attended by leading consultants, Chief Executives and other senior clinical leads.

At time of writing there are ongoing investigations into the service and the specific patient cases. We remain committed to being as open and transparent as possible (within the boundaries of the Data Protection Act) as soon as we are able to provide further information.

Information Governance

In year there have been no incidents of data loss which were classified as level 2 serious incident requiring investigation. On this basis no incidents have necessitated Information Commissioner's Office (ICO) intervention. Risks to information, including information security and cyber-security risks, are managed and controlled through the use of NHS Digital's newly implemented Data Security and Protection Toolkit and the Trust's Risk Management Strategy.

The Trust uses the Data Security and Protection Toolkit in conjunction with the Datix Risk Management system to inform the work of its

Information Governance and Corporate Records Sub-Committee. The Information Governance and Corporate Records Sub-Committee is accountable to the Quality Assurance Committee which is a sub-committee of the Trust board. The Trust's Senior Information Risk Owner chairs the Information Governance and Corporate Records Sub-Committee which is also attended by the Trust's Caldicott Guardian.

The Director of IT is the Trust's Senior Information Risk Owner (SIRO) and this individual acts as the board level lead for information risk within Warrington and Halton Hospitals NHS Foundation Trust. Any areas of weakness in relation to the management of information risk which are identified, or highlighted by internal audit review, The Trust engaged with its internal auditors, Mersey Internal Audit Agency, in 2017 to assess the work required in preparation for changes to UK Data Protection Legislation as part of UK implementation of the General Data Protection Regulation (GDPR) in May 2018. Continuing compliance with the requirements of the new UK Data Protection legislation will be monitored as part of the Trust's use of the NHS Digital Data Security and Protection Toolkit.

are then targeted with action plans to ensure that we continue to strive to be information governance assured.

Since the cyber-attack in May 2017 which affected the NHS the Trust has engaged in a programme of work to improve its cyber-security. We have performed Cyber Essentials Plus and Cyber Baseline audits and have worked closely with NHS Digital to action the CareCERT cyber-security bulletins which NHS Digital release when critical cyber-security work is required. The Trust has updated its anti-virus and firewall protection in light of the cyber-attack and is enhancing its networks further during 2018 by implementing an enhanced web-filtering product.

In 2017-18 the Trust's Information Governance assessment score was 68% and was graded as satisfactory. The Trust was subject to an assurance review of its Information Governance self-assessment by the Mersey Internal Audit Agency in March 2018. Following review of the available evidence to support the IG Toolkit returns for 2017/18 the Trust was provided with a Significant Assurance rating and the resulting audit report will be published on the Trust's public-facing website.

NHS Pension Scheme

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

Equality, Diversity and Human Rights

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

Carbon Reduction

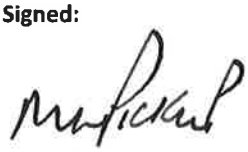
The foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and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

Conclusion

In preparing this statement I have considered the corporate, quality and clinical governance infrastructure, functionality and effectiveness in place at the Trust. This was strengthened in year through the creation of a Trust Operational Board (replacing the clinical operations board and which now reports, through the Chief Executive's briefing, to the Trust Board), the increase in frequency to monthly of the Patient Safety and Clinical Effectiveness sub-committee (reporting to the Board's Quality Assurance committee) and the increase in Audit Committee meetings from five to six per year.

While the Trust did not achieve its financial forecast and elected to suspend its Spinal Surgery Service pending consideration of its future in the wider regional context of spinal service provision, I do not believe there were any significant internal control issues in the 2017-18 year.

Signed:



Mel Pickup, Chief Executive

Date: 24.5.18

Annex 6 Off-payroll arrangements disclosure requirements

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months:

Number of existing engagements as of 31 March 2018 Of which...	4
Number that have existed for less than one year at time of reporting.	1
Number that have existed for between one and two years at time of reporting.	0
Number that have existed for between two and three years at time of reporting.	1
Number that have existed for between three and four years at time of reporting.	2
Number that have existed for four or more years at time of reporting.	0

Existing off-payroll engagements, outlined above, were assessed as to whether they fell within the IR35 legislation changes in April 2017 by completing the HMRC tool and all were found to be outside of the regulations.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018 Of which:	0
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	19

Statement on the Trust's policy on the use of off-payroll arrangements.

During 2017/18 the Trust has developed a 'Temporary Staffing Policy' which clearly explains the process for obtaining approval to appoint temporary staff and that managers should ensure, where possible, staff are employed directly and where staff are appointed externally, they comply with the IR35 legislation introduced in April 2017. In exceptional circumstances where staff are engaged externally who fall outside of the IR35 legislation, the Trust has used the HMRC tool to make this assessment to ensure that any risk is minimised.

Quality Account

Report 2017/18

Contents

Annex 2

NB: Please note that this Quality Report which is required by Parliament is also published on NHS Choices as the Quality Account under Department of Health guidance.

Quality Account

Quality is our number one priority.

Our quality report sets out how we have performed against the targets we set last year and what we will achieve in the coming year.

1. Statement of Quality from the Chief Executive

Mel Pickup, Chief Executive

Warrington and Halton Hospitals NHS Foundation Trust is dedicated to *creating tomorrow's healthcare today*, firstly by the provision of high quality care and clinical excellence which puts the patient at the centre of everything we do, and secondly by ensuring we are in the best possible position to respond to the challenges facing the NHS and delivering what our population needs from their NHS.

This five year vision for the future of our hospitals, and our way forward, has been established to ensure that we become the most clinically and financially successful integrated healthcare provider in the mid-Mersey region.

We welcome this opportunity of demonstrating, through our Quality Report, to our patients, their families and the wider public, the relentless focus that our staff have on continuously improving the quality of our services.

Throughout 2017/2018, progress has been achieved through the hard work, commitment and dedication of every single member of staff. We have continued to see and treat an increasing number of patients, with more complex needs, on both a planned and emergency basis.

Within the reporting year the Trust has continued to work towards achieving all national targets from the operating framework.

Within the reporting year the Trust has continued to work towards achieving all national targets from the operating framework. The national target for referral to treatment targets look at the waiting times for patients waiting to start treatment at the end of each month. I am pleased to say that in 2017/18 we had achieved 92.35% of patients being seen within 18 weeks against a target of 92%. In relation to the Accident & Emergency 4 hour access target of 95%, which is recognised nationally as a challenging target, we did not achieve the 95% target set. NHS Improvement set an individual performance target for the Trust of 91.5% which we unfortunately did not achieve as the end of year result was 88.67%. The Trust had achieved the majority of all cancer targets by the end of 2017/18. However, this data is still awaiting validation.

With regards to health care acquired infections (HCAI) during 2017/18, the Trust threshold was 0 cases of MRSA bacteraemia and despite the continued focus on managing HCAI, the Trust reported 1 case of MRSA bacteraemia against a threshold of 0. In relation to Clostridium difficile the Trust reported 24 hospital onset cases against the annual threshold of 27 cases. The CCG review panel consider the cases and have deemed that 2 of the 15 cases between Q1 and Q3 were due to lapses in care. Cases from Q4 will be reviewed in May.

The Trust also carefully monitors MSSA bacteraemia and E. coli bacteraemia. The Trust reported 17 hospital onset cases of MSSA bacteraemia during the financial year. This is a marginal increase of 3 cases compared to the previous financial year. These cases are under review to identify any areas for care improvement. The Trust reported 36 hospital onset cases of E. coli bacteraemia. Partnership working is in place across the health economy. The Trust is working with community partners to progress the action plans.

A revised, easy to follow sepsis pathway has been developed and implemented by the sepsis team. The sepsis team have trained staff to screen and treat patients in relation to sepsis and through this we have seen screening rates increase to 100% in ED and 98% for inpatients from 94% and 76% in 2016/17 respectively, which saves valuable time in being able to diagnose and treat patients, which is key to reduction of mortality from sepsis.

We have also made significant progress in relation to pressure ulcers. We reported 1 Grade 4 pressure ulcer in 2016/17 and 5 grade 3 pressure ulcers. I am pleased to report that we have not reported any grade 4 pressure ulcers in 2017/18 and only 2 grade 3 pressure ulcers. Monthly panel meetings are in place to ratify RCAs identifying whether the pressure ulcer was deemed to be avoidable or unavoidable and hospital or community acquired. Learning from these panels is disseminated via lessons learned flyers.

The Care Quality Commission (CQC), the body responsible for checking that all hospitals in England and Wales meet national standards, inspected Warrington and Halton Hospitals NHS Foundation Trust from 7th – 10th March 2017. They assessed the quality and safety of the care we provide, based on the things that matter to people. They looked at whether our service is safe; effective; caring; responsive to people's needs and well-led. The trust has been given an overall rating of 'requires improvement' by the CQC, following a series of announced and unannounced inspections. The CQC noted that there had been progress since the previous inspection with improvements noted in urgent and emergency care, maternity outpatients and diagnostics and critical care. Whilst the Trust was pleased that the CQC had identified improvements from the previous inspection, we fully recognise now that this improvement journey needs to be sustained and continue. We have therefore launched our Getting to Good, Moving to Outstanding Programme which sets out areas where we are going to focus on, to ensure that our patients, public and staff get the Good to Outstanding hospital that they deserve.

In 2017-2018 the Trust was involved in conducting 78 clinical research studies in research in oncology, surgery, reproductive health, anaesthetics, emergency medicine, rheumatology, gastroenterology, as well as paediatric and other studies.

Research and Development at the Trust is currently mainly supported through external income from the North West Coast Local Research Network together with income obtained through grants and commercial work; the majority of this research being nationally adopted studies as part of the National Institute for Health Research (NIHR). The Trust has worked with the network and other health providers over the year to increase NIHR clinical research activity and participation in research.

During the year the Trust has piloted links with the clinical business units to develop research and development. It has also continued to work within the HRA procedures which moved the emphasis towards acceptance of HRA assessment within the framework of research governance, strict legislation and recognised good clinical practice and local assessment of capability and capacity to run a study.

Most of the research carried out by the Trust is funded by the NIHR. For 2017-2018 the Trust received £380,000 which funds nine research nurses to support Principal Investigators with recruitment and to assist with the management of NIHR studies ensuring that the study runs safely and in accordance with the approved protocol.

Looking ahead to 2018/19, we will continue to drive the Trust's quality strategy improvement priorities. These are as follows:

Priority 1 - We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.

Priority 2 - We will improve outcomes, based on evidence and deliver care in the right place, first time, every time.

Priority 3 - We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, well fed and well cared for.

The areas we have chosen to focus on as priority areas are; making adult areas more child friendly, Improve Rapid Discharge Process for End of Life Care patients, Bereavement Services, Safer Surgery, E-Prescribing, Increase Incident Reporting, Diagnostics, Ward Accreditation and Discharge summaries.

The areas we have chosen as our priorities are based upon national and local drivers and are also based on our internal governance intelligence, identifying areas for improvement. There is also an emphasis on working across organisational boundaries and in partnership to ensure that we can provide the best patient pathways that we can.

In conclusion, this Quality Report evidences that, whilst we have made significant progress in improving the care and services we deliver to our patients, we are committed through our priorities and quality measures for 2018/19 to continue these improvements and show our commitment in providing high quality care to our local communities.

I am pleased to present this year's Quality Report and the outline of the governance processes that has allowed me and the Trust Board to authorise this document as a true and actual account of quality at Warrington and Halton Hospitals NHS Foundation Trust.

Signed by the Chief Executive to confirm that, to the best of her knowledge, the information in this document is accurate.

Mel Pickup

Chief Executive

May 2018

1.1 Introduction from the Chief Nurse and Executive Medical Director

Professor Simon Constable
Deputy Chief Executive and
Executive Medical Director
(Medical Lead for Quality)

Kimberley Salmon-Jamieson
Chief Nurse

At the end of 2017/18 we started working on a new quality strategy for the Trust; the purpose of which is to set out our ambitions for quality in a way that is meaningful and serves as a statement of intent that patients, carers, staff, commissioners and other stakeholders can use to hold the Trust Board to account for the delivery of high quality services. In order to develop this strategy, we have held engagement meetings with staff and stakeholders, and worked with our governors to ensure that we priorities what matters to our patients.

The Quality Strategy sets out our firm commitment to improving the quality of care for our patients and how we will make this a reality, in terms of equipping our staff with the right policies, processes, skills and environment to deliver quality patient care, every day.

It is important to recognise we have made many improvements to the safety and quality of patient care. However, there is recognition that we have further to go, to ensure we are providing the best care that we can to our patients.

Our aim is to ensure that all staff who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good outcomes for our patients.

In order to enable delivery of this Quality Strategy, the Trust is launching a Quality Academy.

The key objectives for the Quality Academy are to help foster a culture of learning and continuous improvement by:

- Ensuring staff are trained in Quality Improvement methodology, for example 'Plan, Do, Study, Act' (PDSA) methodology;
- Encourage innovation and increase R&D profile within and outside the Trust;

- Support us to use knowledge management to move toward best practice in all of our services

As you would expect, the strategy has influenced our choice of quality objectives for 2017/18, which you can read more about in this report.

The objectives and commitments set out in the Quality Strategy will be reviewed on an annual basis to ensure our plans and key projects support the delivery of this strategy in practice.

In summary, our strategy says that we will reduce patients' falls in hospital, reconcile all medications, reduce healthcare acquired infections, and assess all patients for the risk of Venous Thromboembolism. We will adopt a culture of innovative research and development, focus on outcomes for patients and foster a culture of Quality Improvement. We will listen and learn from patient feedback, communicate in line with our values, ensure partnership working and to simplify the patient processes to ensure they are designed to support the patient.

The Quality Strategy is being approved and launched in May 2018. We look forward to working with staff to support the implementation of this strategy. Together we will report measurable success in this Annual Quality Account and commit to celebrating our achievements year on year.

Quality Academy
Warrington and Halton Hospitals
NHS Foundation Trust

Quality Improvement
Warrington and Halton Hospitals
NHS Foundation Trust

Professor Simon Constable
Deputy Chief Executive
And Executive Medical Director
(Medical Lead for Quality)
May 2018

Kimberley Salmon-Jamieson
Chief Nurse
May 2018

Part 2. Improvement Priorities & Statement of Assurance from Board

Warrington and Halton Hospitals NHS Foundation Trust provides services at Warrington Hospital, Halton General Hospital and the Cheshire and Merseyside Treatment Centre, located in the North West of England. The Trust has a budget of nearly £215 million each year, employs over 4,200 staff and provides nearly 500,000 appointments or treatments each year. The majority of our emergency care and complex surgical care is based at Warrington Hospital, whilst Halton General Hospital in Runcorn is a centre of excellence for routine surgery. The Cheshire and Merseyside Treatment Centre is home to our orthopaedic surgery and treatment services located on the Halton campus.

Our vision is laid out in our five year strategy document creating tomorrow's healthcare today. It explains how we want to be the most clinically and financially successful integrated health care provider in our part of the region. We work to a number of nationally and locally set targets - including our own QPS (Quality, People and Sustainability) framework, to ensure that service users receive the care they need when they need it, and importantly to the highest national quality and safety standards. We also provide, like all NHS trusts, those services within a financial budget, which we are responsible for delivering. Some of the challenges we have set ourselves are:

- **Using technology to improve health** - introducing new IT that will free up more time to care for our staff
- **Development of our services** - working in new ways and through collaboration so your town's hospitals have a secure future
- **Delivering quality** - a series of clear measures to ensure quality is amongst the very best in the NHS at your hospital

2.1 Organisational Structure

Our organisational structure allows us to be more responsive to challenges through improved clinical engagement, strong and resilient leadership at all levels, with an emphasis on responsibility and accountability to achieve transformation and innovation. The structure was developed collaboratively and facilitates the clinical specialities to work more closely within Clinical Business Units (CBU). It embraces the concept of true leadership synergy between the 'triumvirate' which brings together lead doctors, nurses/allied health professionals and managers working seamlessly with the wider corporate teams responsible for the clinical, operational and financial functioning of their CBU. The CBUs are built around the needs of the patients and their pathways and, through innovation and collaboration with partners, the Trust aims to improve access and quality of care whilst minimising costs. Each CBU is a vehicle for greater devolvement of accountability and responsibility and allows decision making to take place closer to the patient/professional interface.

2.2 Priorities for improvement - Improvement Priorities for 2017-2018 update

All of the following improvement priorities and quality indicators were identified following a review of the domains of quality and our commitment to achieving them was reported in the 2016/2017 Quality Report.

The progress of each priority is discussed on a quarterly basis. Where possible we include performance indicators to measure and benchmark progress and they are reported on a monthly basis via the Quality Dashboard to the board.

The Trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care. The following section includes a report on progress with our improvement priorities for 2017/2018 which were:

Priority 1 – Patient Safety - We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks. Priority 1 is supported via the Patient Safety indicators relating to Safer Surgery, Falls and Sepsis. All three patient safety indicators aim to reduce harm and focus on no avoidable deaths.

Priority 2 – Clinical Effectiveness - We will improve outcomes, based on evidence and deliver care in the right place, first time, and every time. Priority 2 is supported via the Clinical Effectiveness indicators relating to Safe Discharge, Mortality and Lessons Learned. All three clinical effectiveness indicators aim to improve outcomes based on evidence and deliver care in the right place, first time, every time.

Priority 3 – Patient Experience - We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for. Priority 3 is supported via the Patient Experience indicators relating to Mental Health, PALs & Complaints and Patient Experience Strategy implementation plan roll out. All three Patient Experience indicators aim to improve outcomes based on the patient and their experience.

2.2.1 Priority 1 - Patient Safety; *We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.*

Safer Surgery -2017/18

- Improvement in staff culture was measured in the Safety Culture Survey
- Delivery of Quality Improvement programmes including the WHO checklist and all appropriate areas having established LocSSIPs (Local Safety Standards for Invasive Procedures)
- No Never Events to occur (These are negative outcomes in medical care that are clearly preventable)

Safer Surgery - Performance:

One of our major priorities as a Trust for 2017/2018 was a '**Safety Culture Initiative'**, which incorporated national safer surgery and intervention initiatives.

The safety culture initiative focused on all areas, clinical and non-clinical, as all roles in the NHS contribute to delivering safe and effective care for our patients.

Upon completion of the analysis of the findings of the survey the following recommendations were made;

Recommendation 1 – Ensure that communications regarding patient safety are co-ordinated on a regular basis to staff – commencing with feedback from this survey.
Lead – Deputy Director of Governance & Quality/Director of Communications
Update – Staff were given feedback regarding the survey, outlining actions that were going to be taken following on from the survey and staff feedback. In addition there are regular publications to staff regarding safety, including monthly Serious Incident newsletters to staff within CBUs and also quarterly Learning from Experience reports and publications. The Safety Huddles have also been reviewed to ensure that safety messages can be communicated appropriately to staff in wards and departments.

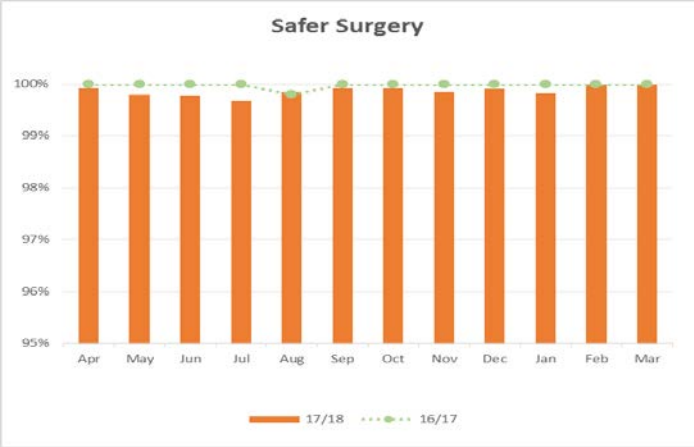
Recommendation 2 – As part of the safer invasive procedure quality collaborative, relaunch new processes for WHO/LoCSSIPs within the Trust, which includes communication/training materials and training regarding human factors.
Lead – Chief of Staff, Surgery, Women's & Children's / Director of Governance & Quality
Update - There was a relaunch event of NatSSIPs in Quarter 3, led by the Chief of Staff for Surgery, Women's and Children. Senior medical and clinical staff were invited who undertake invasive procedures in non-theatre areas. Examples of NAtSSIPs were worked upon and a gap analysis undertaken. This work was presented to Patient Safety & Effectiveness Sub Committee in Quarter 4 of 17/18 and showed that in relation to LocSSIPs there are 71 procedures relevant to WHHFT, with 11 procedure templates awaiting completion in 2018/19. The implementation team have provided supportive documentation for the development of these safety standards, a LOCSSIP workshop and support from a theatre manager with experience in NATSSIP's. A task and Finish group will develop, oversee and progress the action plan towards full implementation over the next 12 months.

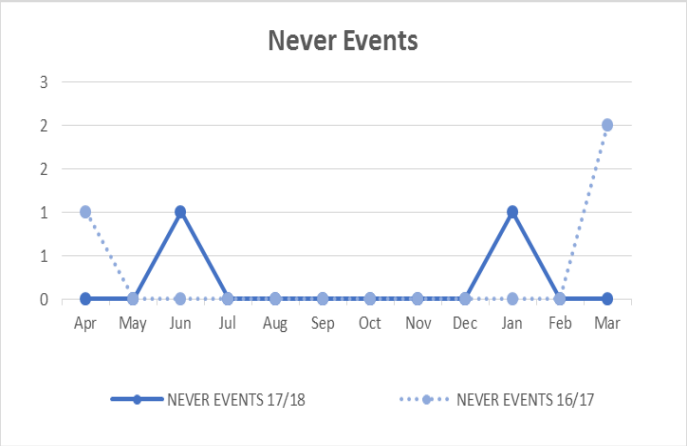
Recommendation 3 – Ensure the Trust policy improvement plan is presented to Patient Safety & Effectiveness Sub Committee
Lead – Director of Governance & Quality
Update - The Trust Policy Improvement Plan was presented to Trust Quality & Assurance Committee in February 2018. A Clinical Policy Group has been convened, which will report to Patient Safety & Effectiveness Sub Committee, to ensure that the improvement plan can be taken forward within the Trust.

Recommendation 4 – Ensure that the Learning Framework for the Trust is presented by end October 2017 – with an implementation plan, which includes focus on feedback from incidents
Lead - Director of Governance & Quality /Associate Medical Director Quality
Update – The Trust Learning Framework has been developed and approved in Quarter 3. This is now being implemented via ensuring robust investigations, SMART (Specific, measurable, achievable, realistic, timely) action planning, learning audits, increased communications regarding safety and via increased safety monitoring in the Trust.

The Safe Surgery check list (WHO checklist) is monitored through ORMIS BI and checked and validated by the Head of Theatre Services. The audit is reported and monitored by the Board through the Integrated Performance Report.

The graphs below demonstrate the findings of the audit during 2017/18 and the number of Never Events that have occurred in year.





Falls – Reduction of injurious inpatient falls and increase the reporting of patient falls

Falls – Background:

Falls was identified as a priority in 2017/18, as it was noted to be a theme in the Trust's incidents and complaints received, as such the Trust put a trajectory in place for 2017/18 of a 10% reduction in falls, based on 2016/17 data.

Falls – How progress was monitored, measured and reported:

- Results in relation to the action plan following implementation will be reported through divisional governance structures and the IPR for Board
- Dashboards from the IPR and Quality Committee will also track Falls figures

Falls– Performance:

For 2017/18, 868 falls were recorded within the Trust, 17 of those falls were recorded as moderate or above with 10 being externally reported as a serious incident review. Of those serious incidents 7 resulted as a Neck of Femur fracture.

The Trust wide action plan for falls prevention is in place in addition to which a review and update of the identified actions and additional results from the National Audit of inpatient falls has provided

areas of practice for targeted improvement We further support the National Audit of inpatient falls by conducting a local audit of equipment which highlighted areas for action.

The table below demonstrates comparisons of total number of all Trust falls and in patient ward falls only for 2016/17 and 2017/18 and the associated reduction.

	2016/17	2017/18	Increase/Decrease
All Falls	990	868	12% reduction
Ward only falls	885	753	14% reduction

A total of 10 inpatient falls have resulted in a serious incident review. Of those, 8 have been completed with the remaining 2 reports due for completion in May 2018.

A review of the incidents has identified common themes in relation to:

- Assessment of patients and their associated risk of falling
- Application and use of falls prevention equipment namely falls alarm and bed rails
- Ambiguity in relation to enhanced care provision
- Specialist medicine have the highest number of falls resulting in serious incident

An increase in falls was noted in Q4 2018 on a number of wards across the Trust. Teaching has commenced in relation to correct assessment and equipment usage awareness which has been provided by members of the PEF team and the moving and handling co-ordinator.

The audit identified variation in available equipment (falls alarms and sensor pads) across the wards when audited in March 2018. This has since been rectified; however an inventory of falls prevention equipment is currently being compiled by the Trust moving and handling co-ordinator to be held centrally.

To further support staff and patients the following initiatives are also in in place relating to falls;

- New Falls Policy was approved and was ratified at Patient Safety and Effectiveness Sub Committee in January 2018.
- Ward safety huddles/Handovers focusing on patients with risk of falls
- Fall prevention information folders/boards are available in each clinical area
- SWARM (post fall review) involving a multidisciplinary team is ongoing and ward based training is continuing
- Weekly harm free meetings lead by ward managers, lead nurses, and matrons, fall champions
- Falls champions have been identified in each ward
- Falls champions day training Undertaken on Oct 31st 2017. The main focus of the training day was on Falls prevention measure, Best falls prevention collaborative, New falls documentation, MCA/DOL related to falls, Medication related to falls, Vision and fall and post fall care management

- Monthly falls data collected via Datix, which is reported to the Falls Prevention Group for scrutiny and review.
- Staggered breaks to ensure appropriate nursing cover to ensure enhanced 1.1s can take place for high risk patients
- Falls walk rounds in clinical areas
- Falls data on Quality and Safety dashboard
- MCA/DOLS audit for falls and sedation
- Volunteer utilised, allocated as per high falls risk areas
- Pooled HCAs, allocated as per staff shortage and high falls risk areas
- Medication review of patients who are at a high risk of falls within 48 hours of admission
- The Pharmacy Team have completed a high risk falls medication list as a reference for use in clinical areas
- Medication and falls teaching for Foundation Year doctors has been completed by the Pharmacy team
- Ophthalmology team - bedside vision tests training in November/December and to continue in 2018
- Bedside vision assessment in relation to falls prevention documents
- Grand Round on falls by Frailty team undertaken on 3rd November 2017
- Falls e-learning module in place
- Falls simulation training for doctors monthly
- Separate falls training for induction from January 2018, it was previously incorporated with Moving and Handling training
- Yellow socks to prevent slipping, as per the falls risk assessment and if appropriate for the patient
- Yellow blankets to be used to alert staff that the patient is a falls risk
- Stealth Falls mats/alarm trials on B14 and B12. The system trialled has additional benefits in that, the pads are under mattress/chair cushion, making them more comfortable, not negating any pressure reliving solutions used with a patient, are more hygienic, and encourage greater patient compliance
- Bed trials completed. New beds across the Trust by April 2018.
- Falls prevention Group to meet monthly from 2018 (At present meeting Bi-monthly)

Sepsis – Ensuring timely identification and treatment of sepsis, as per the Sepsis care bundle

Sepsis – Background:

Sepsis work continues to be a key deliverable for the Trust. Sepsis is a National CQUIN and is a local priority regarding harm reduction.

Sepsis – How progress was monitored, measured and reported:

Timely identification of sepsis in emergency departments

- Timely treatment for sepsis in emergency departments and acute inpatient settings
- Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.
- Reduction in antibiotic consumption per 1,000 admissions.

Sepsis – Performance:

The Sepsis team was been established, this includes: Trust Sepsis Clinical Lead, Sepsis Nurse Specialists, A&E and AMU Practice Education Facilitators and a pharmacist. The Team is working to educate, empower and facilitate all healthcare professionals in the recognition and delivery of sepsis care across the Trust and to educate the public on how to spot the early signs of sepsis.

Work conducted in the year is as follows;

Baseline Assessment

A baseline assessment has been completed against the recommendations of the NCEPOD report (2015) and NICE Guidelines (2016). The Trust was 93% compliant. To ensure 100% compliance the Sepsis Nurses have revised the Trust Sepsis Guidelines and screening pathways and these were ratified at the Patient Safety and Clinical Effectiveness Committee in September 2017.

A new adult Sepsis screening and action tool (pathway) was introduced trust-wide in September 2017. This reflects the NICE Guidelines on 'Red Flag Sepsis'.

Adult Pathway

The adult pathway is also used for the management of neutropenic sepsis in oncology and haematology. Practice within oncology and haematology has been reassessed against both NICE Sepsis and Neutropenic Sepsis Guidelines and the trust is 100% compliant with these.

New age specific paediatric pathways have been trialled over the winter. Feedback from the trial is currently being reviewed by the Paediatric Team.

Maternity have also developed a pathway and this has been in use since May 2017, with the team collecting data prospectively, reporting quarterly at their Governance meeting.

Establishment of Sepsis Steering Group / Sepsis Newsletter / Sepsis Awareness

A Sepsis Steering Group has been established with terms of reference and agreed membership from key work streams and divisional representatives, to encourage shared ownership across the Trust. The group is chaired by the Deputy Chief Nurse and meets monthly and reports to the Patient Safety and Clinical effectiveness Sub-Committee.

In the first year the Steering Group has focused on systems and processes. The membership, terms of reference are currently being revised to ensure the changes implemented become embedded and sustained moving forward, with a focus on patient outcomes.

To date, 4 sepsis awareness days have been held with a stand in the main entrance, highlighting sepsis care across the trust, one of these being at Halton during September The Awareness days were published widely across Communication platforms.

A Sepsis Newsletter was launched in June, with issue 3 being published in December Copies of the newsletter are available on the Trusts' extranet.

Like many other Trusts, we do not have a clear understanding of the number of patients harmed by sepsis but recognise the need to address the harms caused by sepsis. Work has commenced on a sepsis - themed mortality review to establish our baseline level of harm. Once determined the team will apply quality improvement methodology to systematically reduce harm between 2018 and 2019. It is planned that this work will be reported at the Patient Safety and Clinical Effectiveness Committee in May 2018, and incorporates data with regards to full compliance with Sepsis 6.

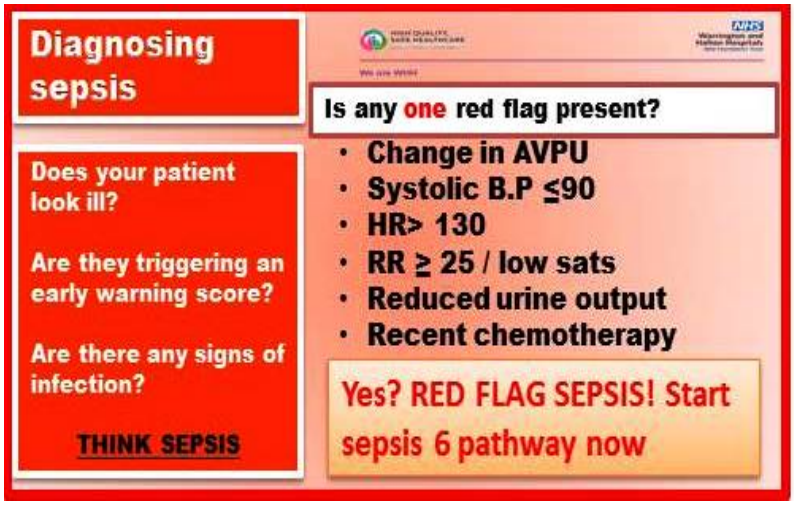
The team are actively involved in the review of complaints and serious incidents. From April 2018 this learning will be shared at the Sepsis Steering Group to facilitate learning trust-wide.

Education and development

Since April the Sepsis Nurses have undertaken focused education sessions for staff working across the Trust, including permanent night staff. The Chief Nurse, Divisional Associate Directors of Nursing and Matrons have supported the release of staff for training. To date 934 members of staff have received sepsis training including Medical, Nursing and Allied Health Professionals, Training is recorded on the Electronic Staff Record.

A sepsis e-learning module went live in July 2017. Mandatory annual completion is recorded on the ESR. An aide memoire has been developed for use by staff at the bedside to support decision making.

Aide-Memoire



E-Learning Module

Education within the Emergency Department, ITU, Paediatrics and Maternity continues to be undertaken by the Clinical Education teams in those areas. Separate registers are maintained by ITU, Paediatrics and Maternity.

Sepsis Ambassadors have been identified in each clinical area, their role being to monitor compliance with training, continuous bed side training to facilitate real-time learning.

Links with the Clinical Education Team have been established with the aim of incorporating sepsis training into established educational programmes including, but not exhaustive - clinical skills Thursday, nursing and medical induction, AIMS, simulation, and HCA development courses. A monthly Sepsis Simulation day was introduced in September 2017 and has been well attended.

In December 2017, a cross speciality Sepsis presentation was presented at the grand round.

Patient and Carer involvement

A sepsis information leaflet has been developed and is available on the extranet. In addition patient and user information leaflets have been purchased from the Sepsis Trust and are distributed to patients, carers and staff on sepsis awareness days. A paediatric leaflet is currently being developed. A patient who was treated for sepsis and his wife have both presented their stories at different forums including the Trust Board, to facilitate learning.

Equipment

Each clinical area now has either a dedicated sepsis trolley or sepsis box, which contain all the relevant equipment to perform sepsis in a timely manner. Housekeepers are playing an active role in ensuring the sepsis bags are stocked and equipment is readily available in clinical areas. Sepsis order sets have been developed on ICE and are available for use in ED and Inpatient areas.

ED have introduced a designated sepsis cubicle, where patients are seen on average within 30 minutes.

Not only have staff raised the profile of sepsis across the Trust through sepsis awareness days but also in the local community through newspaper articles, local radio and training with Community Staff.

Sepsis Trolley and Sepsis Bag

Emergency Department Sepsis Cubicle

Antimicrobial Stewardship

The team work closely with the antibiotic pharmacist, microbiology to review prescribed antibiotics within the 72 hour time frame required for the , ensuring patients are on the most appropriate antibiotic if continued treatment is required.

Supporting Work

Working with Microbiology and Infection Control the team have revised the Blood Culture policy and culture bottles used in the Trust. The team is currently supporting work on the reduction of gram negative bacteraemia. The Sepsis Team has been involved in reviewing the UTI pathways

Work has started with the Coding Team to identify the problems encountered when coding for sepsis. Early indications suggest this is directly linked to the documentation of sepsis diagnosis, causative organisms and co-morbidities in line with ICD codes.

In addition, we have been working with the Associate Directors of Nursing and Acute Care Team in revising the observation policy to incorporate NEWS 2.

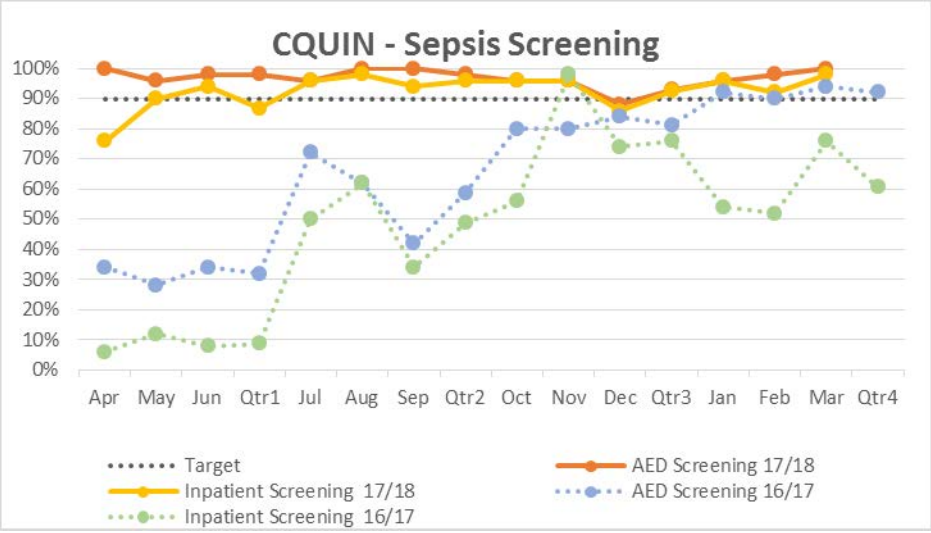
Moving Forward

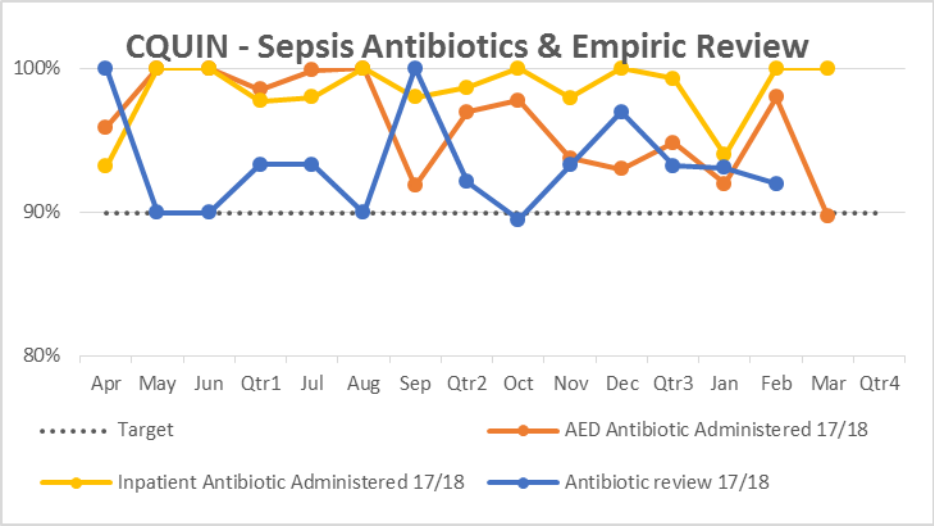
The Trust is currently working towards the implementation of electronic recording of observations and e-prescribing. Work is ongoing to include prompts for screening and completion of the sepsis pathway when a patients observations trigger for sepsis. The antimicrobial pharmacist is working with IT to ensure prompts for antibiotic review between 24-72 hours, including the collection of information on clinical decisions regarding antibiotic treatment. Both these initiatives will support the screening, treatment and ongoing management of patients with sepsis.

The work undertaken at the Trust was recognised and praised by the Health Secretary, Jeremy Hunt, when he visited the Trust in October 2017.

The CQUIN results are monitored via the Board and Quality Committee Dashboards. The tables below show the results for the year. Since April 2017 a number of initiatives have been implemented to ensure significant improvements in the screening and administration of antibiotics within one hour. The data below shows the improvement from May 2017 onwards and that this improvement with the exception of December 2017 has been sustained. The drop in performance in December 2017 can be attributed to an increase in attendance of extremely sick patients to both ED and the Acute Medical Unit, where 80% of patients are identified, screened and treated for sepsis nationally. It has been widely publicised throughout the NHS that winter pressures have had an impact on patient flow. Initiatives were implemented in ED and this has been shown in achieving the 90% targets in January and February 2018. The Trust has consistently achieved the 90% targets for each quarter through 2017-2018.

The above work combined means better patients outcomes in relation to sepsis and it also key to the reduction of mortality from sepsis.





2.2.2 Priority 2. – *Clinical Effectiveness* - *We will improve outcomes, based on evidence and deliver care in the right place, first time, and every time*

Supporting Proactive and Safe Discharge

Supporting Proactive and Safe Discharge - Background:

This is a system wide priority to ensure reduction of delayed transfers of care and admissions avoidance.

This priority is linked to a National CQUIN for 2017/18.

Supporting Proactive and Safe Discharge - How progress was monitored, measured and reported:

- Monthly CQUIN meetings will track the progress of the work and escalate to Quality Committee.
- Results in relation to the CQUIN will be reported through divisional governance structures and the Board dashboard.

Supporting Proactive and Safe Discharge - Performance:

A working group has been established, this includes: CBU Manager Specialist Medicine, Lead AHP, Clinical Director Specialist Medicine and representatives from Warrington and Halton CCGs, Bridgewater Trust and representatives from various Care Homes.

The work underway during the year is as follows;

- Bridgewater Pathways that have been received will be rolled out to the Discharge Facilitators and Ward Managers in the form of a Pathways Pack
- A section of the internal Extranet will be created to contain Discharge information for WHH staff
- We are currently assessing the current clinical system Lorenzo to see if we can add a field which contains the details of any other services that the patient received i.e. Community Matron, Social Services
- We now monitor delayed discharges due to a Community Service issue via the White Board E-Outcomes

- We are planning to invite Bridgewater and NHS-Care home providers to a front of house event where we will publicise this joint working and allow staff the opportunity to liaise with these external colleagues to share knowledge of services

Part of the ongoing work was to have *'demonstrable and credible planning in place to make the required preparations (e.g. by upgrading IT systems and training staff) so that the Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017'*. IM&T established a Task & Finish Group and liaised with DXC, the company who make the system amends; as of September 2017 we were able to collect and return data from the ECDS.

The Lorenzo (v2.12 SP1) system upgrade occurred on the 7th November 2017, and reports demonstrate that we are achieving the following targets;

- Chief Complaint target >= target 95%
- Diagnosis code >= target 95%

The target we aimed to achieve was for over 47.5% of patients being discharged to their usual place of residence within 3-7 days of admission of patients aged 65+ admitted via a non-elective route; At the end of 2017/18 we were achieving 41.41% of patients being discharged.

Mortality – implementation of the revised national mortality review processes

Mortality – Background:

The Care Quality Commission (CQC) published its review "*Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England*" in December 2016. The report made a number of recommendations as to how we can improve how we learn when we review the care provided to our patients that have died.

In response to the recommendations, the Trust has written a policy that ensures we meet these. We review patients who have died under our care using two different methods: one is a review of the patient's care via their case notes and the other involves interviewing staff to gain further information, alongside the case note review.

Mortality – Performance:

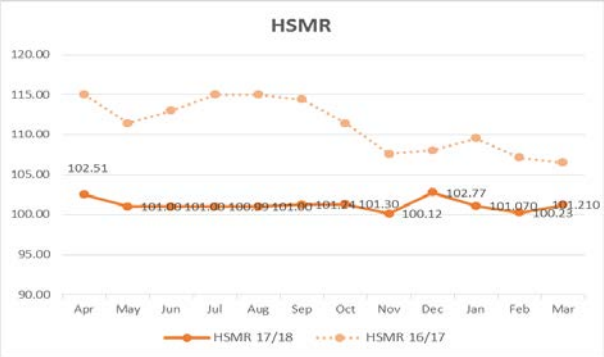
The Trust has a Mortality Review Group which is a team of clinical staff that have received national training in reviewing patients care to make sure we learn and can make future improvements. The group discuss cases and identify a number of improvements that are required to make sure that future patients have the best and most appropriate care. The group also look at the care patients that may be nearing the end of their life received and make suggestions which will make future patients' stay as comfortable as possible.

In September 2017 the Learning from Deaths Policy was written and approved by Trust Board. We then looked at the staff who attend our Mortality Review Group to make sure we had the right knowledge and expertise to review care and make suggestions for future improvements. In order to make sure the members of Mortality Review Group had the right skills to review, we had three

members of Warrington & Halton NHS Foundation Hospitals who received national training from the Royal College of Physicians who then were able to train the Mortality Review Group.

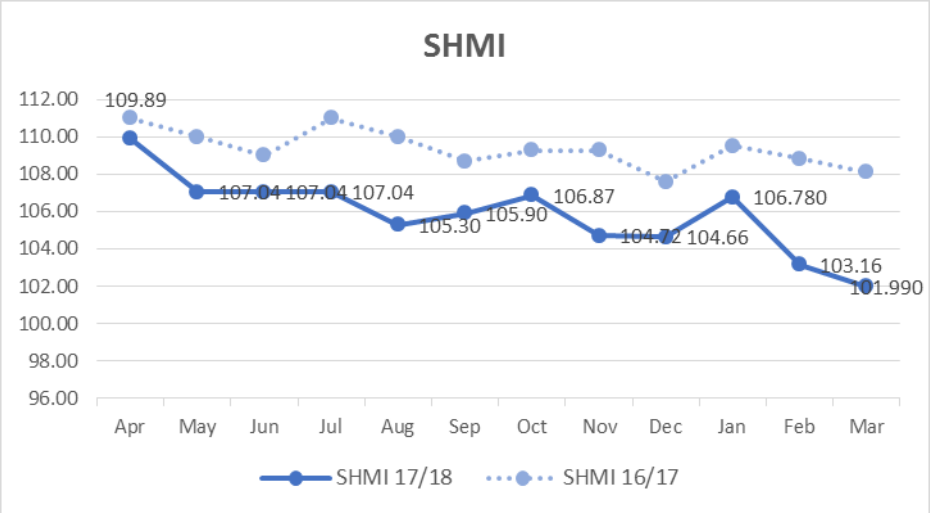
The tables below detail the results year to date;

HSMR data 2017/18



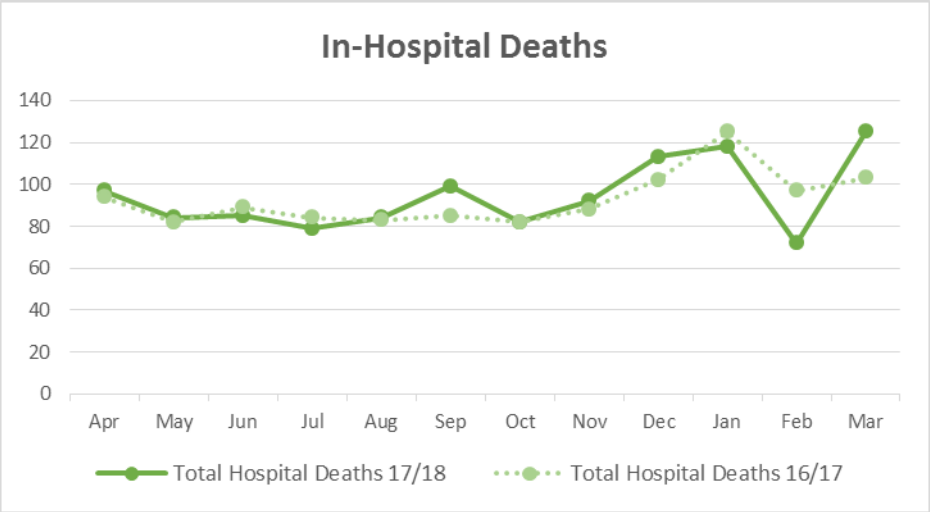
Our HSMR has remained generally static over the past financial year, due to ensuring we correctly code our patients being treated palliative. There have been singular instances from mortality reviews which have indicated that earlier recognition of end of life could have been put into place prior to the patient dying. However, these instances are unlikely to have brought our HSMR down further. Recent HED reports and a quarterly mortality report by AQuA have indicated that our recording of comorbidities can be improved as it is one of the lowest in the region. Correcting this will ensure our HSMR falls further as having all of the patient's comorbidities recorded may well turn an "observed" death into an "expected" death using the risk adjustments.

SHMI data 2017/18



Similarly, our SHMI has remained fairly static over the past financial year and has improved significantly since 2016/17.

In-hospital deaths 2017/18



We screen all deaths within the Trust to ascertain if any harm has been caused. For the deaths screened year to date no harm was identified.

Lessons Learned – Implement a Lessons Learned Framework within the Trust

Lessons Learned – Background:

The aim of this priority is to ensure that we share, locally and Trust-wide, the key learning, improvements and best practice identified from all our means of review. Significant work will be completed over the next 12 months to improve governance systems and processes to promote learning.

Lessons Learned – How progress was monitored, measured and reported:

- Monthly reporting via Quality Committee
- Improvements within the Trust's 'Datix' risk management system
- Establish a structured Lessons Learned Framework

Lessons Learned – Performance:

The Trust has made progress in relation to systems and processes with regards to lessons learned.
What we have completed so far:

- Significant work has been completed in the last 6-12 months on review of the governance systems and processes which promote learning; incidents, serious incidents, complaints, inquests, claims, clinical audit and the Trust's risk management system.
- Training has been put in place for staff, to ensure investigations are conducted appropriate when an incident or complaint happens.
- The trust currently liaises externally with AQUA, NHSI and Stanford to help take forward quality improvement work- this will be further enhanced and rolled out across the Trust.
- In addition work has been undertaken with regard to the Trust Datix system, to ensure all learning information with regard to incidents, complaints, claims and inquests, is logged on the same system, to ensure aggregate analysis. Significant investment has been agreed in the Datix system to further promote this.
- A 'Learning from Experience' report is presented quarterly, looking at aggregate analysis of incidents, complaints and claims with recommendations.

- A monthly Lessons Learned bulletin for SIs is developed for each division.
- Quarterly lessons learned publication has been developed, identifying learning across incidents, complaints, claims and inquests.
- Safety huddles are being rolled out, with key messages including learning.
- A Lessons Learned Framework has been developed and was approved by Trust Quality and Assurance Committee in Quarter3.
- The Quality Academy will be launched in May 2018 supporting and facilitating quality improvement work across the Trust and giving staff the quality improvement skills to help empower and support change at a local level. This will also bring together quality improvement work that is ongoing. Work will also span across the quality and transformation agenda as there are some streams of work e.g. Getting it Right First Time which supports quality improvement and also supports the transformation/efficiency agenda.

2.2.3 Priority 3. – *Patient Experience* - *We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for*

To improve the Trust's responsiveness to complainants and overall experience for patients/relatives/public to raise concerns

Responsiveness to complainants and overall experience for patients/relatives/public to raise concerns - Background:

The Trust has an improvement plan in place regarding management of complaints, in relation to timeliness, quality of responses and learning. There will be new policies and processes and therefore in 2017-18 we are focusing on the development, implementation and effectiveness of these new processes. The new policy has been ratified and as in the process of being rolled out across the CBUs.

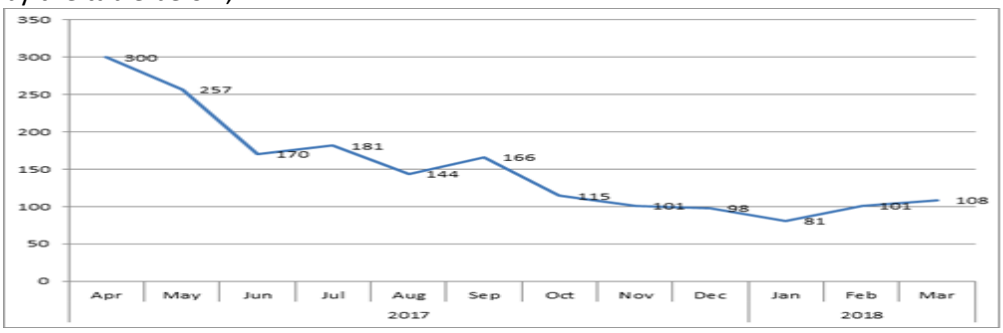
Responsiveness to complainants and overall experience for patients/relatives/public to raise concerns - How progress was monitored, measured and reported:

Complaints results were reported through divisional governance structures and the Board and Quality Committee dashboards.

Responsiveness to complainants and overall experience for patients/relatives/public to raise concerns - Performance:

- The backlog of complaints in the Trust has significantly reduced, as evident in the graph below, with the Trust closing 656 complaints in year
- The Trust now has one open complaint that is over 6 months which will be closed by the time this report is published; this represents a significant improvement from the baseline position that we started from when we set this a quality priority;
- The timeliness of responses to complainants has improved increasing from 26.7% in Q1 to 50.4% in Q4; the Trust is pleased the significant improvement and recognises that going forward, now the complaints backlog is reduced, we will work toward 100% of responding to our complainants in time. This is so important to ensure that we resolve things as quickly as we can to ensure we learn lessons and implement changes.

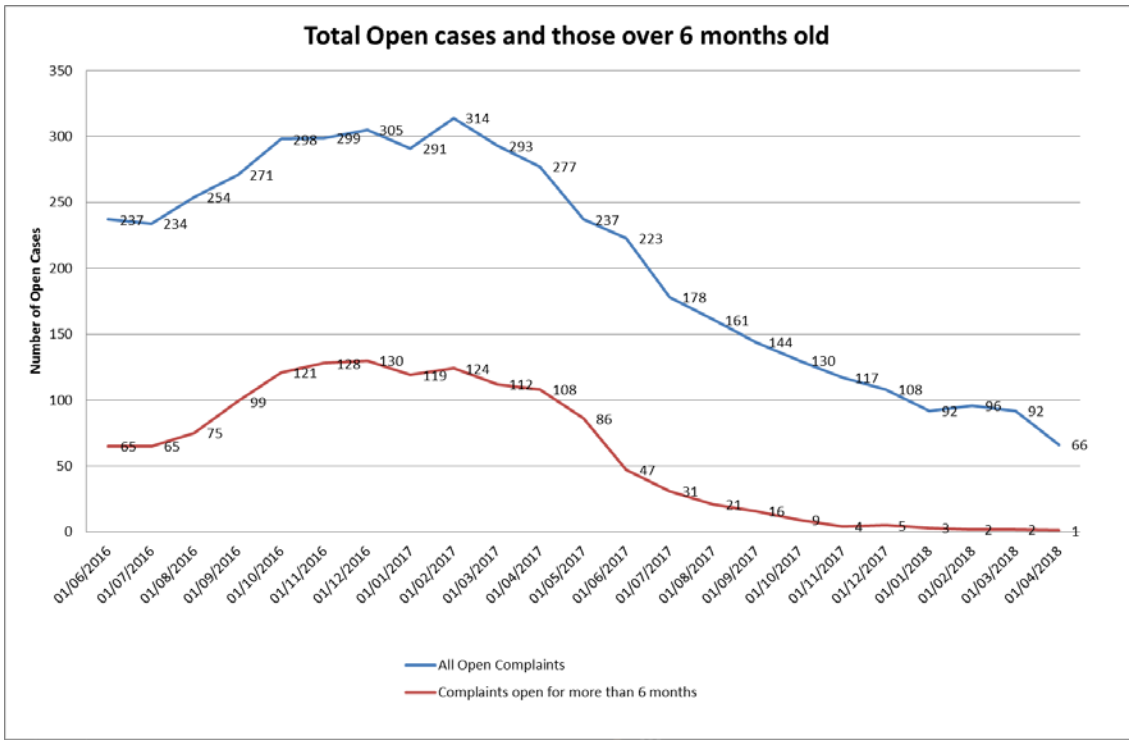
- In addition to an improvement in the responsiveness to complaints, we have also seen a dramatic decrease in the average number of days a complaint is open for, as demonstrated by the table below;



- The new Complaints and Concerns policy has been approved by Board and is being rolled out across the Trust; this focuses on ensuring that we engage our public who which to raise concerns and that senior staff in the clinical services speak to people who raise concerns, so that our patients/families can hear an apology and be assured that action is being taken where necessary.
- A new policy and a new process was developed and is being rolled out across the Trust on how the Trust deals with complaints, to ensure it was more person centred;
- Training was provided to staff to ensure they were trained on the Trust's new complainants policies and processes and on good complaints handling;
- A Quality Assurance Group led by the Trust Chairman was developed to review the quality of our complaints responses and to promote accountability of leading the complaints agenda at senior management level within the clinical services;
- An improvement in how the Trust responds to PALS concerns was seen in the year. Of the 1397 PALS received, 1365 of them have been closed to date;
- We have improved lesson learning from complaints and compliance of actions arising through audits.
- Datix Web is currently being finalised and will then be rolled out across the Trust. This will improve the functionality of Datix and allow governance information to be readily available to managers across the Trust.
- We learn from out complaints to ensure that we prevent the same complaint re-occurring. Examples of learning from 2017/18 are;
    - Complaints have highlighted issues in relation to end of life. Due to the revision of the governance structures this learning can now be shared through the End of Life Steering Group and the Speciality M&M meetings. This allows for learning to be shared through these speciality meetings and also through to the wards and staff involved. This is turn allows for greater learning from complaints.
    - Attitude - following a complaint regarding the attitude and manner of the Emergency Department Reception Staff all reception staff employed within the department had to attend further Customer Service Training during September and October 2017. During these training sessions, topics of discussion included attitudes and behaviours.
    - Diagnosis issues - following a complaint regarding the detailed diagnosis of an abscess on a patients breast, an education session was organized for new Junior Doctors on the management of mastitis and breast abscesses in both breastfeeding and non-breastfeeding ladies. This formed part of the formal Junior Doctor Education Programme during September 2017.
    - Maternity experience – following a complaint regarding a poor experience specifically around breast feeding, training has been arranged for the staff in relation

to breast feeding and the complaint will be shared at the Maternity Mandatory Study Day.

The table below details the trajectories for complaints performance over the last 12 months and provides an up to date position for complaints year to date.



Patient Experience Strategy

Patient Experience Strategy- Background:

The patient experience strategy relates to the QPS framework under the focus of 'Quality' and as such supports our goals to keep the patients at the centre of everything we do, by:

- Listening to our patients and carers
- Learning together from their feedback
- Leading change based on patient experiences
- Ensuring our patients are consistently put first as we continuously improve our communication, care, environment, and processes.

Patient Experience Strategy- How progress was monitored, measured and reported:

- Patient Experience Sub-committee via the relevant sub-groups.
- Results will be reported through divisional governance structures and the IPR for Board.

Patient Experience Strategy- Performance:

Appointment of Head of Patient Experience

The Head of Patient Experience commenced her role in the Trust on the 8th January 2018 and will be involved with leading on the Patient Experience Strategy.

Governors Patient Experience

The Governors undertake an unannounced monthly ward visit utilizing their newly created template, which focusses on confidence scores across a range of observations. On one visit in Q3 to A&E, Main/Minors/Paediatrics, the Governors reported "enthusiasm of staff and the management of A&E was phenomenal, which was reinforced by Family & Friends comments on the situation. The sepsis protocol was evident and the triage process and care and comfort rounds were all remarked on"

National Inpatient Action Plan

The National Inpatient Survey key themes had been reviewed and the areas where results were disappointing have been scrutinised during Quarter 3, with a Dip Test survey being undertaken in Nov 2017. The results demonstrate improvements in some of the criteria when compared to previous surveys but communication and planning care for discharge still require improvement.

There has been significant work been undertaken by the divisions, with the implementation of the five work streams of the Patient Experience strategy, led by Lead Nurses and Allied Health Professionals, who provide monthly updates to the Patient Experience Sub Committee. Examples of the initiatives include;

- Reducing noise at night campaign
- The implementation of the Always Event NHSE Toolkit.
- Staff from WHH attended the Always Event in Nov 2017 and the Trust will be joining the pilot group in Feb 2018 to progress the launch and implementation of specific Always Events across the departments.

Patient Stories

Patient stories continue to be utilised at Trust Board and Sub Board Committee levels. The newly appointed Head of Patient Experience will be working towards developing a database repository of patient stories where different topics and/or themes will be highlighted. In addition, will continue to explore and develop alternative ways that we can source, capture and present the stories e.g. Quarterly video Patient Stories.

Volunteer Services

We continue to recruit volunteers to the Trust, covering a range of roles and activities from telephone call reminder service to helping within a ward environment. An essential component of the "Helping Hands" initiative, delivering much valued support to front line staff has been provided by willing volunteers. The numbers of volunteers recruited has exceeded the trajectory set as of Dec

2017 and the opportunities to develop the role is ongoing e.g. bleep volunteers to be piloted in the Diabetic Foot Clinic in Jan 2018.

Senior Nurse Walk Around

Monthly walk arounds are now under way led by the Chief Nurse, focusing on a particular chosen topic or theme each month. CCG Representatives join the senior nursing team to supplement the group.

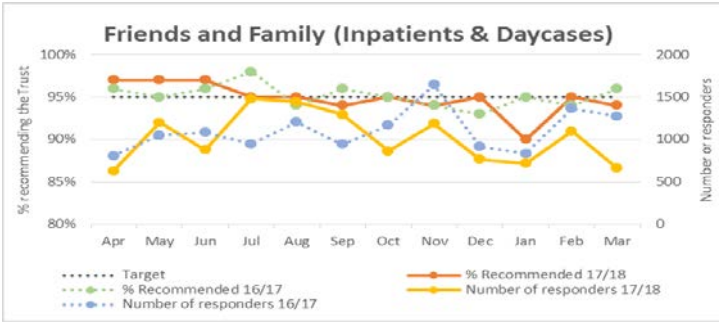
Friends and Family

The implementation of SMS text messaging for the Friends & Family test which initially generated an increased response rate has remained fairly constant in Q3. Long waits in A&E has been identified as a root cause of the declining recommendation rate. However, with operational work around patient flow, such as "The Perfect Week", it is hoped that there will be a positive upturn of recommendations by Q4.

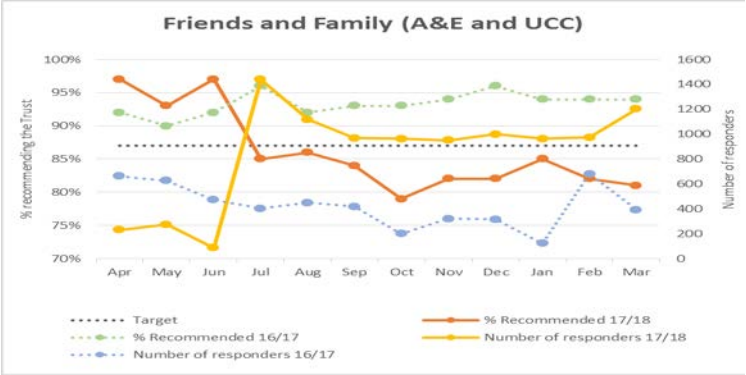
A review of the maternity FFT process is being reviewed with the likely implementation of SMS text messaging within Q4.

The Patient Experience Lead is reviewing all elements of FFT, to ensure there are robust processes in place at a local level to ensure we aim for maximum acquisition of the FFT cards across the organisation and staff are able to understand & appreciate the value of understanding patients experience and analysing the data provided.

The table below shows the results for the percentage of Inpatients and day case patients recommending the Trust. Patients are asked - How likely are you to recommend our ward to friends and family if they needed similar care or treatment?



The table below shows the results for the percentage of AED (Accident and Emergency Department) patients recommending the Trust. Patients are asked - How likely are you to recommend our AED to friends and family if they needed similar care or treatment?



Patient Experience for those patients with mental health needs who attend A&E

Patient Experience for those patients with mental health needs who attend A&E - Background:

Improving services for people with Mental Health needs who present to A&E.
This priority is linked to a National CQUIN for 2017/18.

Patient Experience for those patients with mental health needs who attend A&E - How progress was monitored, measured and reported:

Monthly CQUIN meetings tracked the progress of the work and escalate to Quality Committee.

Patient Experience for those patients with mental health needs who attend A&E - Performance:

A meeting has been held with colleagues from Mental Health and the CCGs in order to identify the cohort of patients that we will monitor. A joint governance group has been established and a further meeting is to be arranged to start the process of creating individual care plans for those patients.

An update on areas of work conducted during the year is as follows;

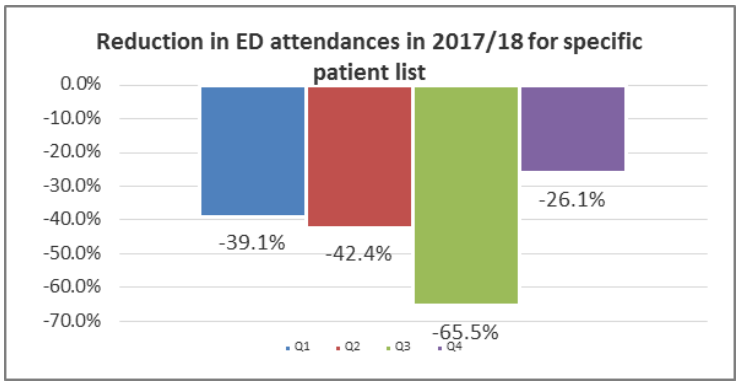
- A work group has continued with representatives from the Trust, Mental Health and the CCGs.
- MDTs have continued for the patients within the cohort; care plans are shared with other key partners where appropriate.
- Where MDTs establish a physical health need a repeat MDT will be held with the physical health consultant.
- The new Emergency Care Data Set has replaced the CDS type 010 across Emergency Departments in England. WHH started work as an early adopter for this new way of working and as such implemented the new system in the Emergency Department in October 2017; earlier than the December roll out time for other Trust's. The new Emergency Care Data Set will deliver the following benefits:
    - Improved patient outcomes through better information and information exchange including a reduction in risk by improving communication and increased use of existing information-sharing mechanisms, e.g. the Summary Care Record.
    - Improved quality of data collected in Emergency Departments relating to patient presentation, diagnosis, discharge and follow up, which will facilitate improved

healthcare commissioning and the effective delivery of future healthcare policy and strategy.

- Improved communication between health professionals, which will enable accurate measurement, costing and remuneration of acute healthcare, specifically an improvement in the understanding of the cost and value of Emergency Care.

- Due to the changes in the way we code the Mental Health data in the Emergency Department we will wait until Q4 to complete an audit. However, a review is underway between NWBH and WHH to look at the new national codes in order to develop a presentation for clinical staff to assist them with how they code a mental health diagnosis. However, we have discussed the coding of each attendance of the selected cohort and raised issues where appropriate with the ED Consultant to review.
- MDTs and follow up MDTs have been completed throughout the quarter and updates on the patient journeys of the cohort were also presented on 30th November to the CCG's.
- Performance data from the WHH team is provided to NWBH and monitored in case MDT's for certain patient's need to be brought forwards.

The graph below shows the reduction in ED attendances for the cohort of patients selected for *Improving Services for people with mental health needs who present to A&E CQUIN* in 2017/18. We achieved an overall reduction of 43.8% in attendances for the selected cohort of patients against a target of 20%.



2.3 Improvement Priorities and Quality Indicators for 2018/2019 - How we identify our priorities – stakeholder engagement

The Trust has a duty to fully engage with stakeholders and members to ensure that we are listening to their views on quality and quality priorities moving forward. The priorities have been identified through receiving feedback and regular engagement with governors, staff, patients, the public, and commissioners of NHS services, overseeing scrutiny groups and other stakeholders. Progress on the planned improvements will be reported through the Trust's assurance committees, via Quality in Care - Governors and ultimately through to Trust Board. A Quality Strategy event has also been held to discuss and agree priorities and to discuss the quality aspects of these priorities.

Our staff, governors, members and patients are the eyes and ears of the organisation and their views are constantly sought to ensure that we are focussing on the things that will make the most difference. We surveyed staff, patients and visitors, through the Staff Survey and the Friends and Family Test and from those results we capture the views of the staff and wider public in relation to the range of priorities.

2.4 Improvement Priorities for 2018–2019

The Trust Board, in partnership with staff and Governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2018-19 will continue to be:

Priority 1 – Patient Safety - We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.

Priority 2 – Clinical Effectiveness - We will improve outcomes, based on evidence and deliver care in the right place, first time, and every time.

Priority 3 – Patient Experience - We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for.

In order to embed the above improvement priorities, we have established nine local quality indictors to support their implementation.

Priority 1 is supported via the Patient Safety indicators relating to Safer Surgery, E-Prescribing and Increase Incident Reporting. All three patient safety indicators aim to reduce harm and focus on no avoidable deaths.

Priority 2 is supported via the Clinical Effectiveness indicators relating to Diagnostics, Ward Accreditation and Improving the quality and timeliness of discharge summaries. All three clinical effectiveness indicators aim to improve outcomes based on evidence and deliver care in the right place, first time, every time.

Priority 3 is supported via the Patient Experience indicators relating to Making adult areas within the hospital more child friendly, Improve the Rapid Discharge Process for End of Life Care patients and Ensure that Bereavement Services are equipped to provide a caring and compassionate service, offering support and reassurance, information and guidance. All three Patient Experience indicators aim to improve outcomes based on the patient and their experience.

Full details of the Patient Safety, Clinical Effectiveness and Patient Experience indictors can be seen in the sections below.

2.5 Local Quality Indicators 2018/2019

The Trust board, in partnership with staff and Governors, has reviewed performance data relating to quality of care and agreed that in addition to our improvement priorities that our quality indicators for 2018/2019 will include:

Patient Safety 2018/2019

- Safer Surgery - Ensure that the Trust fully embraces the culture of safer surgery in theatres and in those areas that undertake invasive procedures and continues to embed the quality priority work in 2017/18.
- Medicines Optimisation - improving patient safety by decreasing prescribing errors and saving time and resource
- Increase Incident Reporting – Ensure that we continue to encourage staff to report incidents, to promote a learning culture, and to ensure we don't miss opportunities to learn from mistakes and make changes to protect patients from harm

Clinical Effectiveness 2018/2019

- Diagnostics – Review the Trust Diagnostics Policy, to ensure consistent processes are in place across the Trust, supported by technology and ensure staff are trained in those processes and procedures.
- Ward Accreditation – Develop a Ward Accreditation Scheme within the Trust, to engage staff and empower leadership to ensure we deliver the highest standards of healthcare for our patients.
- Discharge – Improve the quality and timeliness of discharge summaries, to ensure seamless communication and care with primary care

Patient Experience 2018/2019

- Making adult areas within the hospital more child friendly to increase the overall experience for patients/relatives/public
- Improve the Rapid Discharge Process for End of Life Care patients, so that if patients chose to die out of hospital, we can facilitate this in a dignified and timely manner.
- Ensure that the Trust has processes and services in place to support families and loved ones following a bereavement, , offering appropriate support and reassurance, information and guidance

Patient Safety Priorities	
Safer Surgery - Ensure that the Trust fully embraces the culture of safer surgery in theatres and in those areas that undertake invasive procedures and continues to embed the quality priority work in 2017/18.	
Why we chose this priority	**What success will look like**
Safety Culture and Quality Improvements in Safer Surgery will include theatres and how we have implemented the National Safer Surgery for Invasive Procedures (NatSSIPs) agenda. This was identified as a priority as a result of high profile incidents and near misses.	Training being rolled out in LocSSIPs across the Trust. Full assurance that LocSSIPs are being implemented consistently and that safety culture in theatre and in non-theatre settings is in place. No Never Events. No Never Events to occur.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – The Trust Policy is approved regarding NatSSIPs within the Trust, all appropriate areas have LoCSSIPs, and a training programme for NatSSIPs/LocSSIPs is in place, with a risk assessment	WHO checklists will be monitored via the IPR Dashboard that is presented to Board. A quarterly Quality Report will track

being conducted to influence training roll out plan. Quarter 2 - 25% of high risk areas have been trained. Quarter 3 – 50% of areas have been trained and audits have commenced in those high risk areas, to ensure processes and safety culture is in place. Quarter 4 – 100% of areas have been trained and an audit plan is in place to audit all areas.	milestones for the Quality Account priorities.
Medicines Optimisation - improving patient safety by decreasing prescribing errors and saving time and resource	
Why we chose this priority	**What success will look like**
This was identified as a priority as part of the Trust Pharmacy Transformation and Informatics Programmes. The Board agreed investment to implement an e-prescribing system to enable the Trust to transform its medicines processes.	A decrease in the number of medication errors and incidents of the type seen with prescribing / administering medication on paper charts. Implementation of medicines process changes that improve the patient experience and support patient flow from an operational management perspective. Access to information that supports quality and safety activities.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 - Development of a Programme approach regarding e- prescribing. Quarter 2 - Identify areas to pilot and development of a roll out plan. Quarter 3 – Implementation and monitoring of plan. Quarter 4 – Report on improvement.	Dashboards will also track medication incidents. A quarterly Quality Report will track milestones for the Quality Account priorities.
Increase Incident Reporting – Ensure that we continue to encourage staff to report incidents, to promote a learning culture, and to ensure we don't miss opportunities to learn from mistakes and make changes to protect patients from harm	
Why we chose this priority	**What success will look like**
This was identified as a priority to ensure that we are aware where any patient could have been harmed or has suffered any level of harm following an incident.	Increase in the number of incidents being reported which will be monitored via the IPR Dashboard that is presented to Board.

This was also identified in the Trust Staff Survey as an area that requires improvement.	
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Identify a baseline in accordance with 2017/18 incidents data. Work with clinical staff and managerial staff in the Clinical Business Units and CBUs and Corporate services to identify what are the issues with regard to incident reporting in the Trust and how we can improve it. Quarter 2-3 – Develop an improvement plan and implement. Quarter 4 – Report progress and again consult with staff as to what further improvements can be made.	Weekly incident meetings will track the progress of the work and escalate to Quality Committee. Incidents data will be reported through divisional governance structures and the IPR for Board. A quarterly Quality Report will track milestones for the Quality Account priorities. Staff Survey action plan report will report to Workforce Sub Committee and Operational Board.
Clinical Effectiveness Priorities	
Review the Trust Diagnostics Policy, to ensure consistent processes are in place across the Trust, supported by technology and ensure staff are trained in those processes and procedures.	
Why we chose this priority	**What success will look like**
This was identified following a cluster analysis of incidents and complaints, where it showed that whilst we had policies and processes in place for following up diagnostic tests, theses needed to be consistently applied, with the requirement for more robust technology, training, monitoring and reporting to be in place.	Having a Trust wide Policy for Diagnostics in place, a training programme, technology to support this and ultimately a having no incidents where a contributory factor or root cause of the incident occurring is related to diagnostic systems and processes.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 - Development of a Task & Finish Group to review Trust Policy and processes regarding Diagnostic Tests. Quarter 2 - Development of a staff communication, education and training programme for the revised policy standards. Quarter 3 – Ensure the new policy standards are embedded. Quarter 4 – Audit implementation of the revised policy	A report on Diagnostic testing will be developed to ensure Consultants, clinical staff and service leadership are able to monitor these standards. A quarterly Quality Report will track milestones for the Quality Account priorities.

standards in high risk areas.	
Ward Accreditation – Develop a Ward Accreditation Scheme within the Trust, to engage staff and empower leadership to ensure we deliver the highest standards of healthcare for our patients.	
Why we chose this priority	**What success will look like**
Ward accreditation has been selected as a priority to increase the quality of care on our wards.	All wards will be measured against a set of quality standards agreed by the Nursing and Midwifery Committee.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Finalise the new ward accreditation process and commence with a pilot within the Trust. Quarter 2 – 3 - Commence the accreditation process and monitor compliance. Quarter 2 25% of all wards will be have gone through the accreditation process, Quarter 3- 50% Quarter 4 –100% of all wards will have gone through the accreditation process and report on overall results.	Each ward team will be supported to develop and implement an improvement action plan to further enhance the quality of care and patient experience before their next ward inspection. A quarterly Quality Report will track milestones for the Quality Account priorities.
Discharge – Improve the quality and timeliness of discharge summaries, to ensure seamless communication and care with primary care	
Why we chose this priority	**What success will look like**
The aim of this priority is to improve the quality and timeliness of discharge summaries.	An improvement of quality and timeliness of discharge summaries following an audit and baseline position being established. Timely and quality discharges in place for all of our patients.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Development of a Task and Finish Group with clinical staff from the Trust and GP representation; review incident and complaints data regarding discharge and undertake an audit of quality of discharge summaries to set a baseline and inform an action plan for improvement. Quarter 2-3 –Implementation of action plan. Quarter 4 – Undertake a follow up audit and show improvement of timeliness and quality, based on	A quarterly Quality Report will track milestones for the Quality Account priorities.

targets sets following the development of the baseline position.	

Patient Experience Priorities

Making adult areas within the hospital more child friendly to increase the overall experience for patients/relatives/public

Why we chose this priority	What success will look like
This was identified as a priority following our last CQC Inspection. Also this links in to the patient experience strategy and as such supports our goals to keep the patients at the centre of everything we do, by: • Listening to our patients and carers • Learning together from their feedback • Leading change based on patient experiences	Feedback from children and their families who use the service is positive on the changes we have made. CQC follow up inspection confirms that we have/are in the process of implementing this.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Undertake a gap analysis of all adult areas and what is required regarding ensuring they are child friendly. Quarter 2- Development of a Children's Group within the Trust to help develop a plan regarding taking forward actions to ensure adult areas where children are seen are child friendly. Quarter 3 – Implement actions identified and development of business cases where further resource may be required. Quarter 4 – ensure the plan is fully implemented and feedback is sought from children and their families regarding the improvements made.	Via the Trust Patient Experience Sub Committee. A quarterly Quality Report will track milestones for the Quality Account priorities.

Improve the Rapid Discharge Process for End of Life Care patients, so that if patients chose to die out of hospital, we can facilitate this in a dignified and timely manner.

Why we chose this priority	What success will look like
This was identified as a priority following our last CQC Inspection. Also this links in to our End of Life strategy as we are committed to support patients to die in a dignified manner, supported to make choices as to where they wish this to be, and ensuring that we can respond to those wishes.	This is a system wide piece of work, so success is working in partnership to ensure there is a system wide policy and that processes in place can respond to facilitate rapid discharge from hospital to allow people to die in their place of choice.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 /Quarter 2 – Work with our partners (commissioners, Local Authority, Hospices etc.) to review our policies and procedures in place to ensure rapid discharge from hospital to support End of Life Choices for patients. Quarter 3 – Implementation and communication and training of the policy and processes agreed. Quarter 4 – review effectiveness of the system for rapid discharge for those End of Life patients who express a wish to not die in hospital, by auditing and engaging with families who this has affected.	Via the Trust Patient Experience Sub Committee and Trust End of Life Steering Group. A quarterly Quality Report will track milestones for the Quality Account priorities.
Ensure that the Trust has processes and services in place to support families and loved ones following bereavement, offering appropriate support and reassurance, information and guidance.	
Why we chose this priority	**What success will look like**
This has been identified following discussions with families through the complaints, incidents and inquest processes. It is a natural action following on from the Trust's development of a Learning from Deaths Process, which was part of the 17/18 Quality Priorities. This priority aims to ensure that whilst we are investigating and learning from deaths, we ensure we engage and support families that are bereaved in a co-ordinated way.	Families and loved ones feel supported following a bereavement. Any questions that they may have following the death of their loved one, can be addressed. IF there is an investigation or inquest process, families are supported and we ensure that the bereavement team in the Trust and the governance team work in a joined up way, to ensure the best support and communication we can provide.
Implementation Plan	**How progress will be monitored and reported**

Quarter1- Ensure the Bereavement Service within the Trust moves under the management of the Patient Experience Manager. Review processes within the Trust of how we support families through the bereavement process and any subsequent investigation. Quarter 2- Develop a task and finish group to review current Trust processes and what we could do better. Seek feedback from people who have been bereaved and what support from the Trust felt like for them. Development of an action plan. Quarter3 – Implementation of the actions. Quarter 4 – Report on improvements and again seek feedback from people who have been bereaved to assess effectiveness of change.	Via seeking feedback from those who have been bereaved to assess what improvements are required and how effective any changes have been. A quarterly Quality Report will track milestones for the Quality Account priorities.

2.6 Statements of Assurance from the Board

During 2017/18 the Warrington and Halton Hospitals NHS Foundation Trust provided and/or sub-contracted seven relevant health services.

The Warrington and Halton Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed represents 100 per cent of the total income generated from the provision of relevant health services by the Warrington and Halton Hospitals NHS Foundation Trust for 2017/18.

2.7 Data Quality

The data is reviewed through the Board of Directors monthly review of the Quality Dashboard. The data reviewed covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Our success in achieving the improvement priorities will be measured, where possible, by using nationally benchmarked information from the NHS Information Centre; Healthcare Evaluation Data (HED system); Advancing Quality Alliance (AQuA); NHS England datasets including the Safety Thermometer; Friends and Family, Dementia and VTE Risk Assessments and national survey results. The trust also uses measurement tools that are clinically recognised for example the pressure ulcer classification tool of the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP).

The processes that we use to monitor and record our progress have been, or are scheduled to be, audited by Mersey Internal Audit Agency to provide assurance on the accuracy of the data collection methods employed.

2.8 Participation in National Clinical Audits and National Confidential Enquiries 2017/18

During 2017/18, 39 National Clinical Audits and 4 National Confidential Enquiries covered relevant health services that Warrington and Halton Hospitals NHS Foundation Trust provides.

During that period Warrington and Halton Hospitals NHS Foundation Trust participated in 94% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries, in which it was eligible to participate.

The National Clinical Audits and National Confidential Enquiries that Warrington and Halton Hospitals NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:-

	National Clinical Audit & Enquiry Project name
1	Endocrine and Thyroid National Audit
2	Nephrectomy audit
3	Stress Urinary Incontinence Audit
4	Fractured Neck of Femur
5	Pain in Children
6	Procedural Sedation
7	Bowel Cancer
8	Cardiac Rhythm Management
9	Case Mix Programme (CMP)
10	Child Health Clinical Outcome Review Programme
11	Paediatric Diabetes
12	Elective Surgery (National PROMs Programme)
13	Falls and Fragility Fractures Audit Programme (FFFAP)
14	Inflammatory Bowel Disease (IBD) Programme
15	Learning Disability Mortality Review Programme (LeDeR)
16	Medical and Surgical Clinical Outcome Review Programme
17	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
18	Cardiac Rhythm Management (CRM)
19	National Heart Failure Audit
20	National Comparative Audit of Blood Transfusion programme
21	National Audit of Breast Cancer in Older Patients (NABCOP)
22	National Maternity and Perinatal Audit

	National Clinical Audit & Enquiry Project name
23	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme
24	National Ophthalmology Audit
25	UK Parkinson's Audit
26	Neonatal Intensive and Special Care (NNAP)
27	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
28	National Lung Cancer Audit (NLCA)
29	Sentinel Stroke National Audit programme (SSNAP)
30	Bowel Cancer (NBOCAP)
31	National Prostate Cancer Audit
32	Head and Neck Cancer Audit
33	National Emergency Laparotomy Audit (NELA)
34	Oesophago-gastric Cancer (NAOGC)
35	Major Trauma Audit
36	Renal Replacement Therapy (Renal Registry)
37	7 Day Service Audit – NHS England
38	Learning Disability Mortality Review Programme

	National Confidential Enquiries
1	Young People Mental Health
2	Cancer in Children, teens and Young Adults
3	Acute Heart Failure
4	Perioperative Diabetes

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust participated in, and from which data collection was completed in, and for which data collection was completed during 2017/18, are listed below alongside the number of

cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2017/18
Endocrine and Thyroid National Audit	No	NA	NA
Nephrectomy audit	√	√	Data is currently unavailable
Female Stress Urinary Incontinence Audit	No	NA	NA
Elective Surgery (National PROMs Programme) Pre-operative All procedures: Groin Hernia Hip Replacement Knee Replacement Varicose Vein Post-operative All procedures: Groin Hernia Hip Replacement Knee Replacement Varicose Vein	√ √	√ √	Data is still being collated and analysed
National Diabetes Audit - Adults	√	√	100%
National Joint Registry (NJR) Hips Knees Ankles Elbows Shoulders	√	√	Data is still being collated and analysed
Inflammatory Bowel Disease (IBD) programme	√	√	Data is currently unavailable
Case Mix Programme (CMP) ICNARC	√	√	631 cases submitted April – December 2017. Data is still being collated and analysed
National Cardiac Arrest Audit (NCAA)	√	√	Data is still being collated and analysed

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2017/18
Maternal, New born and Infant Clinical Outcome Review Programme	√	√	
Child Health Clinical Outcome Review Programme	√	√	Data is currently unavailable
Medical and Surgical Clinical Outcome Review Programme	√	√	Data is currently unavailable
National Audit of Breast Cancer in Older Patients	√	√	100%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	√	√	Data is still being collated and analysed
Cardiac Rhythm Management (CRM)	√	√	Data is currently unavailable
National Heart Failure Audit	√	√	Data is still being collated and analysed
National Comparative Audit of Blood Transfusion programme 2017 Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	√	√	23 (100%) cases submitted
Fractured Neck of Femur – care in emergency departments	√	√	100 (100%) cases submitted
Pain in Children - care in emergency departments	√	√	64 (100%) cases submitted
Procedural sign off - care in emergency departments	√	√	96 (100%) cases submitted
National Ophthalmology Audit	√	√	Data is currently unavailable
Diabetes (Paediatric) (NPDA)	√	√	Data is currently unavailable
Neonatal Intensive and Special Care (NNAP)	√	√	Data is currently unavailable
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	√	√	Data is still being collated and analysed

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2017/18
National Lung Cancer Audit (NLCA)	√	√	Data is still being collated and analysed
Sentinel Stroke National Audit programme (SSNAP)	√	√	Data is currently unavailable
Falls and Fragility Fractures Audit programme (FFFAP)	√	√	Data is still being collated and analysed
Bowel Cancer (NBOCAP)	√	√	Data is still being collated and analysed
National Prostate Cancer Audit	√	√	Data is still being collated and analysed
Head and Neck Cancer Audit	√	√	Data is still being collated via Aintree
National Emergency Laparotomy Audit (NELA)	√	√	100% cases submitted
Oesophago-gastric Cancer (NAOGC)	√	√	Data is still being collated and analysed
Major Trauma Audit	√	√	100%+ (2017)
Renal Replacement Therapy (Renal Registry)	√	√	Data is currently unavailable. Warrington data received via Liverpool
7 Day Service Audit	√	√	194 (100%) cases submitted
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	√	√	Data is currently unavailable
UK Parkinson's Audit	√	√	10 (33%) cases submitted
Learning Disability Mortality Review Programme (LeDeR)	√	√	Data is currently unavailable

National Confidential Enquiries

	Participated	Data collected 2017/2018	% Cases submitted 2017/2018
Young People Mental Health	√	√	No patient cases included
Cancer in Children, teens and Young Adults	√	√	No patient cases included

Acute Heart Failure	√	√	75%
Perioperative Diabetes	√	√	Data is still finalised

2.8.1 National Clinical Audit

The reports of 21 national clinical audits were reviewed by the provider in 2017/18 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Quality Improvement Action Plan
TARN: Major Trauma: The Trauma Audit & Research Network	Secure assistance for TARN co-ordinator
	Introduction of the fast track Head Injury form in ED triage
	Audit times to CT for Trauma and HI
National Emergency Laparotomy Audit (NELA)	Expansion and formalisation of NELA QIP Group with developed Terms of Reference – membership to include A&E, Radiology & ITU consultant colleagues, and to include monitoring of QI projects and link with Mortality Review Group
	Roll out of emergency laparotomy pathway to ED and SAU
Neonatal Intensive and Special Care (NNAP)	For the NNAP to be reported as part of the quality report to the Matron on a monthly basis
	For a month awareness of Badgernet imputing of data roles and responsibilities
	Safety brief alert on the importance of documentation
	Breastfeeding team developed who have been visiting mums on ward and developed expression log
	Importance of the admission observations being recorded within the 1st hour and reported correctly to be on safety brief on the unit.
	Continue monitoring rate of line infections. Process in place with infection control team to investigate if any increase in infection rate
	Increased awareness of magnesium sulphate field on Badgernet
Royal College of Emergency Medicine (RCEM) – Consultant sign off	Education around documentation of senior discussion prior to discharge to be included in local induction of ED junior doctor intake
	Local re-audit of RCEM standards for consultant sign-off
Royal College of Emergency Medicine (RCEM) -Sepsis	Launch of new sepsis pathway
	Education provided to staff around use of new pathway, including fluid balance monitoring
Royal College of Emergency Medicine (RCEM) Moderate and severe asthma	Review current asthma pathways to ensure 2016 BTS/SIGN and RCEM compliant
	Feedback asthma pathway update via ED audit newsletter
	Discussion with ED nursing team regarding undertaking of adult vital signs audit
	Discussion with ED nursing team regarding undertaking of adult vital signs audit
National Pregnancy in Diabetes (NPID)	Poster on pre-conception advice for all GP practices – approved by CCG/WHH diabetes working group
	Audit pre-conception advice
	Add pre-conception advice to diabetes management algorithm going to all Warrington GPs
	Pre-conception leaflets available to all GPs and diabetes team at WHH
	Look at mode and gestation at delivery for all patients in 2016 with pre-

	gestational diabetes
	Look at number of babies large for gestation age based on individual grow charts
National Diabetes Transition Audit	Meetings held with CCGs
	Issues re. clinic capacity and psychological input provision to be placed on Risk Register
National Diabetes Audit 2015-16. Report 2a and 2b: complications and mortality (complications of diabetes and association between disease and preceding care) England and Wales	Audit demonstrating the monitoring of poor attendance amongst 16-25 year olds and attempts to re-engage non-attenders
National Diabetes Audit: Insulin Pumps 2015-16	Funding insulin pumps for WHH patients
	Create extra capacity in diabetes clinics for diabetes patients
	Train an extra Diabetes Specialist Nurse for adult pump patients
Myocardial Ischaemia National Audit Project (MINAP)	Ensure real time data is available to monitor treatment of NSTEMI patients
	Review and implementation of Cardiac Chest Pain pathway
Heart Failure	Put staff in place to meet NICE recommendations
	Business case developed for 0.2 B6 WTE Audit Nurse to support Heart Failure data
	Development of report to guide compliance with BPT for acute heart failure
	Development of business case for cardiac rehabilitation for Warrington residents to comply with NICE standards
National Audit of Breast Cancer in Older People	Business case for fourth breast cancer care nurse
	Discussion re. introduction of intraoperative sentinel lymph node biopsy at next breast audit/governance meeting
	Specialty to undertake review as to whether issue of lack of elderly care review should be placed on Risk Register (if not already on)
National Dementia Audit	Implement dementia friendly hot snack boxes Trustwide
National Audit of Inpatient Falls	Audit to validate National Audit of Inpatient Falls (following meeting to review tools etc)
MBRRACE-UK Perinatal Mortality: 2015 births	Discussion with Reporter to complete information of cause of death as 'unknown' if cause not known
National Maternity and Perinatal Audit	Provision of education to midwifery staff to record smoking status at birth
	Undertake checks as to why Lorenzo episiotomy data is not migrated to NMPA
	Checks as to why Lorenzo breast milk data is not migrated to NMPA
MBRRACE: Term, singleton, intrapartum stillbirth and intrapartum-related neonatal deaths	Amend 'Care of women in labour' guideline to include homebirths
	Trust is exceeding the achievable performance threshold of ≥ 99.0% for all three standards
National Ophthalmology Database Audit	Agree on risk score for cataracts, and reach consensus as to how this can be extracted for audit
	Safety brief education to nurses re. requirement for recording of post-op data on Medisoft
National Joint Registry	Audit data to be checked for unmatched records
National Hip Fracture Database	Re-establishment of Neck of Femur pathway
	Recruitment of second Orthopaedic Trauma Co-ordinator
	Undertake audit of NOF pathway

	Discussion with risk lead regarding Risk Register inclusion over Orthopaedic bed base and documentation time
	Add NOF pathway audit to Orthopaedics audit plan
National Bowel Cancer Audit	Secure Pharmacy and Endoscopy representatives at discussions regarding provision of bowel prep, to enable patients to go straight to test
	Review of Enhanced Recovery Pathway in face of bed pressures and to include discussion regarding the possibility of a dedicated Enhanced Recovery bay and nurse

2.8.2 Local Clinical Audit

The reports of 163 local clinical audits were reviewed by the provider in 2017/18 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided as detailed in the tables below;

Children's Health

Audit	Action
Paediatric Observations in ED	Urgent awareness of the below amongst the Paediatric ED nursing staff: • Ensuring patients receive their initial assessment within 15 minutes • Nursing staff need to be aware of the pathways • There needs to be a culture change regarding blood sugar testing. All initial observations should be completed electronically, and not by hand.
Paediatric Head Injuries:	Assurance provided, re-audit in 2 years
Insulin pump in the reduction of HbA1c:	Actions awaited
HSP Henoch- Schonlein Purpura	Actions awaited
Adherence to Guidelines for children with Diabetic Ketoacidosis	Disseminate the audit result to medical staff – induction / governance email
	Assurance provided, re-audit in 3 years
Meningococcal Septicaemia and timely use of antibiotics	Assurance provided, a re-audit will be scheduled
Admission Clerking History	Update admission clerking proforma
Audit on outcome for CYP with T1DM who are transitioned from Paediatric to Young person's clinic over last 2 years.	Share the findings to CYP team both at Halton and Warrington
	To converse a meeting to discuss about improving the practice

	Assurance provided, a re-audit will be scheduled
Audit of children with complex needs:	Introduce weekly proforma for ward rounds
Concerns form pathway	Create electronic version of the concerns for completion in Lorenzo
	Raise awareness / launch of above concerns form
	Invite Social Care and Police to attend Peer Reviews to share learning from CP medicals
	Encourage sharing of outcomes and strategy meeting minutes from social care
	Support staff by attending strategy meetings where possible
Child sexual exploitation:	Assurance provided, a re-audit will be scheduled
Development dysplasia hips (DDH) – Quality Improvement project	Assurance provided, a re-audit will be scheduled
Paediatric ESR record keeping	Action plan awaited from audit lead following internal review
Review of standards for paediatric imaging in non-accidental injury (NAI)	Actions plan awaited from audit lead following internal review
Children not brought for appointments	Develop a joint policy with Bridgewater NHS, re-launch the completed policy and circulate trust wide
	To complete this audit annually – to comply with section 11 self- assessment tool
Audiological assessment of children referred with meningitis	Annual audit to be undertaken 2018/19
Length of time from referral / initial appointment to diagnosis of Autism Spectrum Disorder	Annual audit to be undertaken 2018/19

Emergency Care

Audit	Action
PERC score and pulmonary embolism	Audit presented at Emergency Care audit meeting where assurance was provided

Head Injury	Audit presented at Emergency Care audit meeting where assurance was provided
Emergency Care Nursing Documentation	Audit presented at Emergency Care audit meeting where assurance was provided. Audit to be completed on 6 monthly basis
Medical Documentation in Emergency Care	Action plan awaited from audit lead following internal review
ENP Documentation Audit – Warrington	Action plan awaited from audit lead following internal review
Halton ENP Documentation	Action plan awaited from audit lead following internal review
Warrington A&E Reception: Documentation Audit	Action plan awaited from audit lead following internal review
Initial Assessments in the Paediatric ED	Highlight to staff re. measurement of blood sugar at internal Emergency Care meetings Assurance provided, a re-audit will be scheduled

ENT

Audit	Action
Head & Neck lump clinic – 2nd cycle	Monitor the adherence of 2 week wait. Schedule andan audit to be conducted in 2-3 years' time
Post op tonsillectomy bleeding and readmissions	Action plan awaited from audit lead following internal review
Voice Therapy Outcome	Continue to consistently use all three outcome measures pre and post therapy. To record GRBAS at each session to capture change for patients who do not attend or who do not need final review appointments. To schedule a re-audit compliance in collecting outcome measures. To schedule audit of outcome measures for group versus individual therapy

	for muscle tension dysphonia
Grommet Review	Audit presented at ENT audit meeting where assurance was provided
Tonsillectomies	Assurance provided, a re-audit will be scheduled
Patient satisfaction (Outpatient)	Action plan awaited from audit lead following internal review
Delegated consent in the ENT department	Assurance provided, a re-audit will be scheduled
Chronic Rhinosinusitis	Action plan awaited from audit lead following internal review
Patients admitted with epistaxis on Atorvastatin	Audit presented at ENT audit meeting where assurance was provided
National head and neck cancer referral study	Awaiting publication of NICE recommendations
Quality of e discharge summaries	Audit presented at ENT audit meeting where assurance was provided

Joint women and children's

Audit	Action
Antenatal detection of SGA	Action plan awaited from audit lead following internal review
Fetal Renal pelvic dilation	Assurance provided, a re-audit will be scheduled
Shoulder Dystocia	To circulate the presentation to all staff so that they are able to see the specific areas requiring improvement
	Forward to the Lorenzo team the case note numbers of those not recorded on the data system as a shoulder dystocia so that they can ensure the system is amended
	Assurance provided, a re-audit will be scheduled
Audit on cooling	Action plan awaited from audit lead following internal review

Audit on NIPE	Assurance provided. Monitor results from improved hip screening service over next quarter
AQUA Quarterly Safety report	The quarterly Aqua safety report was discussed actions are: 1) Audit of Neonatal readmissions 2) Audit of elective LSCS
Neonatal readmissions to Paediatric ward (within 28 days of life)	Action plan awaited from audit lead following internal review

Joint Medicine and Emergency Care

Audit	Action
Medicine Information on Discharge	Assurance provided, a re-audit will be scheduled Development of specific drug information leaflet
DNACPR Audit	Assurance provided, a re-audit will be scheduled

Joint Trauma

Audit	Action
Thoracic Injuries	Liaise with Radiology Hub re: CT Chest requests for thoracic injury out-of-hours.
Silver Trauma	Development of two-tier Trauma Call Activation Criteria: Major Trauma and Silver Trauma

Joint Women's Health and Anaesthetic

Audit	Action
Timing of Elective C sections	Action plan awaited from audit lead following internal review
Management of sepsis in pregnancy and postnatal period	Provision of Sepsis box for ANDU
	Assurance provided, a re-audit will be scheduled

Joint Children and Emergency Care

Audit	Action
Possible deflection of patient from PAU to PART	Disseminate findings to Paediatric Network
Bronchiolitis Audit	Update Bronchiolitis guidelines

Joint Surgical and Anaesthetics

Audit	Action
NELA quality improvement	Audit presented at relevant audit meeting where assurance was provided
Rib fractures admitted under General Surgical team:	Action plan awaited from audit lead following internal review

Medical - Cardiology

Audit	Action
Quality assurance of stress echo service	Audit presented at Patient Safety meeting where assurance was provided
Driving advice given to cardiology patients	Audit presented at relevant audit meeting where assurance was provided

Medical Combined

Audit	Action
End of life Care 2016	Review of current education delivered
	Lorenzo and use of Individual Plan of Care
	Schedule a Preferred place of care audit – using side rooms
	Individual plan of care and support for the dying patient – document audit
PJ Paralysis Audit	Feeding up and cascading down the information
	Rolling out PJ Paralysis Campaign 13th November
	Targeting areas for improvement e.g. turning own PJs into clothes
	Re Audit and present March 2018
Hypercalcemia of Malignancy	Review of these guidelines alongside generalised hypercalcaemia guidelines and NICE guidelines

	Education and publicity about this – consider use of “desktop” messages
	Review finalized regional standards and guidelines when published
Diabetes in Last Days of Life	Once regional standards and guidelines are finalized review of these in relation to WHH policy
	Support of actively dying patients with an IPOC tends to highlight areas for review which included glycemic management
DNACPR information from the regional palliative care Audit	Work absorbed intoCQC action plan
Hypo glycaemia and Prescribing errors audit	Action plan awaited from audit lead following internal review
Phlebotomy on AMU	Audit presented at relevant audit meeting where assurance was provided

Medical – Diabetes and Endocrinology

Audit	Action
Insulin Errors – Prescribing	Identified need for training for junior doctors. Training dates confirmed F1/F2 sessions
	Identified need for education for ward based nurses – Mandatory training from January 2018 with 3 sessions per month. (action completed Nov 2017)
	Personalised ward teaching offered to areas when necessary if ward trending or significant risk identified (8-12 on datix risk). (On going action)
	Ongoing daily assessment of good practice with regard to prescribing and identifying errors

Medical - Gastroenterology

Audit	Action
Adherence rate of CIWA score	Training and education of relevant health care Professionals.

	Setting up alcohol pathway Link Nurses and sharing responsibility of implementation and adherence of CIWA Pathway
	Installing CIWA chart on the Lorenzo system for health care staff to update.
PEG	Assurance provided, a re-audit will be scheduled in two years

Medical – Respiratory

Audit	Action
Review of oxygen prescription and use on ward A7	Action plan awaited from audit lead following internal review
Drug requests by the respiratory team to GP's in CCG	Audit presented at relevant audit meeting where assurance was provided
Domiciliary Visit (DV) Audit	Audit presented at relevant audit meeting where assurance was provided
Pulmonary Rehabilitation Programme 2015.2016-Halton	Action plan awaited from audit lead following internal review

Opthalmology

Audit	Action
Prematurity of retinopathy screening	Audit presented at relevant audit meeting where assurance was provided
Refractive Outcome following cataract surgery 2017	Improve quality and quantity of data entered into Medisoft EPR
	Assess if A-constant is appropriate for RayOne lens
	Assurance provided, a re-audit will be scheduled in 18 months
Review of AMD Service 2016	Action plan awaited from audit lead following internal review
Stroke Service Review – re audit	Action plan awaited from audit lead following internal review
Cataract surgery and complications	Action plan awaited from audit lead following internal review

WEEP Clinic	Audit presented at relevant audit meeting where assurance was provided
Vision Screening	Audit presented at relevant audit meeting where assurance was provided
Fundus Fluorescein Angiogram Requests	Assurance provided, a re-audit will be scheduled
Audit of new referrals to diabetic retinopathy clinic	Action plan awaited from audit lead following internal review
Glaucoma new patient compliance with NICE guidance	Assurance provided, a re-audit will be scheduled
Nurse led glaucoma clinic	Audit presented at relevant audit meeting where assurance was provided
Great and late starts	Action plan awaited from audit lead following internal review
ROP screening	Action plan awaited from audit lead following internal review
Paediatric Optometry and Orthoptic-led Primary Care Clinics	Action plan awaited from audit lead following internal review

Trauma and Orthopaedic

Audit	Action
MR Scan in Spinal Clinics – Re-audit	To increase the number of pre-arranged MR Scans
Post-op hip Audit	Action plan awaited from audit lead following internal review
Prescribing of VTE prophylaxis in T&O patients	Action plan awaited from audit lead following internal review
Management of spinal infection:	Action plan awaited from audit lead following internal review
Paediatric medial epicondyle fracture management: A National Audit	Action plan awaited from audit lead following internal review
Nice Hip Fracture (QS16)	Action plan awaited from audit lead following internal review
Orthopaedic baby hip service	Additional clinic to service demand approx. 4-8 new patient slots extra per month.

	Follow up clinic set up to reduce demand on baby clinic appointment slots.
Accuracy of trauma theatre documentation ORMIS Re-audit	Assurance provided, a re-audit will be scheduled Trainee names to be added to ORMIS
Medical complications in elective T&O patients at CMTC and their management	Assurance provided, a re-audit will be scheduled
Re audit of compliance with NICE VTE prophylaxis for patients in lower limb POP	Assurance provided, a re-audit will be scheduled Change to Lorenzo VTE
Quality of GP referrals to lower limb clinics	Audit presented at relevant audit meeting where assurance was provided
Peri operative temperature (NICE guidance CG65):	Action plan awaited from audit lead following internal review
Post fall documentation re audit	Action plan awaited from audit lead following internal review
LOS following bunion surgery	Present this audit and discuss with the ward staff at CMTC to further identify the reason for not discharging a patient when they appear to be medically fit for discharge. Re-audit collecting the data prospectively to determine any real time reasons for delaying discharge.
Audit on surgical time versus total theatre time for carpel tunnel syndrome:	Assurance provided, a re-audit will be scheduled
Hip fracture patients who had insertion of urinary catheter	Assurance provided, a re-audit will be scheduled
Outcome of Uncompartmental Knee Replacement (UKR)	Audit presented at relevant audit meeting where assurance was provided
Outcome of knee osteotomy (20104):	Audit presented at relevant audit meeting where assurance was provided
Post operative transfusion in hip fracture patients – re audit	Audit presented at relevant audit meeting where assurance was provided
Management of fracture NOF	As with National Hip Fracture Database report

PROMS outcome of TKR	Action plan awaited from audit lead following internal review
Hip fracture analgesia	To take the audit to fracture neck of femur focus group (improve ward targets)
	To take audit to ED (to improve ED targets)
	Assurance provided, a re-audit will be scheduled

Pathology

Audit	Action
How well we implement the laboratory aspects of NICE guidance on Myeloma on diagnosis and management	Re-audit the laboratory investigations and present in May 2018
	To request Myeloma FISH in addition to other tests in suspected Myeloma patients bone marrows and to continue to request other tests as per NICE CG35
Breast Cancer Screening	Re-audit in 18 months with: Larger cohort of cases Two specific groups Screen detected cases Symptomatic cases
A microbiology audit on rapid MRSA screening by PCR method	Inform the T&O and Maternity Clinical Directors / Clinical Leads and both CBU managers on withdrawal of rapid screening from these areas
An audit on effectiveness of antibiotic ward rounds	Audit presented at relevant audit meeting where assurance was provided
An audit of the management and treatment of infective endocarditis	Audit presented at relevant audit meeting where assurance was provided
Thyroid cytology correlation audit	To ensure all Thyroid FNA reports include a Thy code
	To discuss the advantages and disadvantages of limiting the number of pathologists reporting Thyroid FNA samples at the next departmental meeting

	To discuss the advantages and disadvantages of double reporting Thyroid FNA samples at the next departmental meeting
	Perform and present a Thyroid FNA re audit in 1 year
Adequacy of patient consent for interventional radiological procedures by	Audit presented at relevant audit meeting where assurance was provided
CT head dose audit	Audit presented at relevant audit meeting where assurance was provided
Hot Reporting for Fractures	Implement a process to ensure backfill/holiday cover for Advanced Practitioners to enable them to report a greater proportion of A&E work Work in conjunction with the Consultant capacity plan Review of Advanced Practitioner job plans/additional Advanced Practitioners Re-audit once changes have been implemented
An audit on Patient Satisfaction in CT and MRI	Repeat survey in 1 year with larger cohort Revision of information leaflets Ensure patients are aware they have the right to decline exam Ensure risk/ benefits of scans are discussed Ensure all staff introduce themselves
An audit on Rectal Cancer – Radiology and Pathology Correlation	Bear in mind for future reporting that we generally under-call N stage Post Treatment MRI scans should be restaged: as recommended after last audit Re-audit in 2 years to compare results: see if improvement when restaging post neoadjuvant treatment

Radiology

Audit	Action
Review of practice against RCR standards for NAI imaging	Assurance provided, a re-audit will be scheduled
The Radiological investigation of suspected physical abuse in children	Update local policy
Mammography in Implants…Review of our current practice	Assurance provided, a re-audit will be scheduled

Interventional Radiology WHO checklist re audit	Assurance provided, a re-audit will be scheduled
Hydrodilatation of the shoulder	Audit presented at relevant audit meeting where assurance was provided
Added value of diffusion weighted sequence in MRI detection of prostate cancer	Share findings with Urology. PIRADS for MDT users

Surgical

Audit	Action
Record Keeping / Documentation Audit:	Modify acceptable abbreviations Make accepted abbreviations more easily accessible. TAC cards should automatically identify the user. Edit audit questions to ensure answers available from Lorenzo.
Update of practice & outcomes of implant breast reconstruction:	Action plan awaited from audit lead following internal review
Patient Call Bell response time and Discharge checklist information	We have revised the staffing to ensure more support workers are on duty to answer the call bells. The doctors have been informed to ensure the discharge summaries give a concise summary of the patients care.
Mechanical Thromboprophylaxis - The forgotten component of VTE: Re-Audit	Re-audit following implementation - How has electronic VTE assessment affected the results with an emphasis on reassessment within 24hr on admission?
VTE assessment in acute surgical admissions – re audit	Audit presented at relevant audit meeting where assurance was provided

Urology

Audit	Actions
Bladder Botox injections, complications and side effects	Audit presented at relevant audit meeting where assurance was provided
Theatre Starting Time in Day Surgery at Halton General Hospital	Audit presented at relevant audit meeting where assurance was provided

Pathway for referral/review of patients with suspected / Acute testicular torsion	Urology team to re-audit following new pathway
Outcome of Nephrectomies	Need to implement enhanced recovery program
Urinary catheter discharge advice questionnaire	Provide further education to all staff on the discharge process Ward/department visits – target areas Poster displays Band 6/7 meetings
	Advertise the use and importance of the passport on the screensaver and the HUB
	Educate the patients on the use of the passport and ensure they bring it to appointments Add a reminder sticker to the front of the passport
	Re: audit the process Bullens delivery company to audit the service locally Audit the use from community
Discharge summary	Audit presented at relevant audit meeting where assurance was provided
TURP follow up	Audit presented at relevant audit meeting where assurance was provided

Women's Health

Audit	Action
Perinatal Mental Health	Audit presented at relevant audit meeting where assurance was provided
PICO dressing and wound infection	Audit presented at relevant audit meeting where assurance was provided
Fetal Movement	Proformas to be placed in more accessible location and available to all junior and senior doctors on call.
	Proformas were only completed in 11/19 ANDU/LW admissions Matron has taken stats back to Labour Ward staff to increase compliance

	with the use of the proforma
	Re audit use of proforma in 2 years
CO monitoring in pregnancy	Audit presented at relevant audit meeting where assurance was provided
Magnesium Sulphate in preterm labour	Audit presented at relevant audit meeting where assurance was provided
WHO checklist in OPD	Audit presented at relevant audit meeting where assurance was provided
Post LSCS analgesia	Audit presented at relevant audit meeting where assurance was provided
Out of hours E pregnancy and acute gynaecology screening	Business case for gynae assessment unit with sonographer support out of hours
Induction of labour	Development of a new IOL proforma
	Consultant ward round once daily on IOL bay
	Develop process for a phone call from Midwife to patient after being sent home following IOL
Elective C Section	Audit presented at relevant audit meeting where assurance was provided
VTE risk assessment peripartum	VTE RA at pre op for elective CS
	Amend guideline to reflect practice
Colposcopy record keeping	Relaunch checklist in GOPD & procedure clinics
	Audit use of local checklist in hysteroscopy and GOPD
	Re-audit use of local checklist in colposcopy
Cervical smears under GA	Develop guideline for taking difficult smears
	Re-circulate guideline for Colposcopy referrals
	Develop guideline for management of low risk women with challenging smears
Patient flow through Antenatal day unit	Audit presented at relevant audit meeting where assurance was provided
Medical record keeping and e-discharges:	Audit presented at relevant audit meeting where assurance was provided
Rapid access pelvic assessment clinic (RAPAC)	New guidance for triage Improve 2 week wait Communicate results to GPs

	Guidance of ovarian cysts in post-menopausal women Separate audit for hysteroscopy Audit of cancer breaches
Indications for C Section in pregnant diabetic patients and if corticosteroids were given appropriately and assessment BM control	Audit on corticosteroids and glycaemic control 2018
Colposcopy Services	Investigation into waiting times breach Re-audit
Maternity Triage	Undertake audit of antenatal triage
Quality of consent process and documentation	Action plan awaited from audit lead following internal review
Acute Gynaecology activity	Action plan awaited from audit lead following internal review

Critical Care and Anaesthetics

Audit	Action
Epidemiology and outcomes of post-cardiac arrest patients admitted to ICU	Ratification of developed guidance for neurological prognostication following cardiac arrest
	Ratification of developed guidance for temperature management
Trends in admissions, outcomes and organ support in ICU 2009-2017	Review and amend ICU pathway for home discharges
NEWS audit	Roll out of NEWS 2 across Trust
	Single point lesson to cascade to all wards – now evolved to ward based teaching for NEWS 2
	Establish with clinical educators/PEFs with regards to training
IV fluids audit	Introduce IV fluid prescription chart into Recovery
	Provision of education on appropriate fluid prescribing, documentation of IV fluid management plans and appropriate fluid charts
	Re-audit of IV fluids and expanding to look at fluid prescribing in other

	operations
ITU Fridge audit	Action plan awaited from audit lead following internal review
Patient satisfaction	Action plan awaited from audit lead following internal review
PCT on ICU	Action plan awaited from audit lead following internal review
Infection Control	Action plan awaited from audit lead following internal review
Review of pre-op investigations	Implementation of pre-op assessment proforma
	Audit of appropriateness of pre-op assessments and anaesthetic review

2.9 Participation in Clinical Research and Development

The number of patients receiving relevant health services provided or sub- contracted by Warrington and Halton Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 665.

Warrington and Halton Hospitals NHS Foundation Trust recognises that participation in clinical research demonstrates our commitment to improving the quality of care we offer both by helping ensure our clinical staff stay abreast of the latest possible treatment options and because active participation in research leads to successful patient outcomes.

In 2017-2018 the Trust was involved in conducting 78 clinical research studies in research in oncology, surgery, reproductive health, anaesthetics, emergency medicine, rheumatology, gastroenterology, as well as paediatric and other studies.

Research and Development at the Trust is currently mainly supported through external income from the North West Coast Local Research Network together with income obtained through grants and commercial work; the majority of this research being nationally adopted studies as part of the National Institute for Health Research (NIHR). The Trust has worked with the network and other health providers over the year to increase NIHR clinical research activity and participation in research.

During the year the Trust has piloted links with the clinical business units to develop research and development. It has also continued to work within the Health Research Authority (HRA) procedures which moved the emphasis towards acceptance of HRA assessment within the framework of research governance, strict legislation and recognised good clinical practice and local assessment of capability and capacity to run a study.

Most of the research carried out by the Trust is funded by the NIHR. For 2017-2018 the Trust received £380,000 which funds nine research nurses to support Principal Investigators with recruitment and to assist with the management of NIHR studies ensuring that the study runs safely and in accordance with the approved protocol.

2.10 The CQUIN Framework

The Commissioning for Quality and Innovation (CQUIN) framework forms one part of the overall approach on quality, which includes: defining and measuring quality, publishing information, recognising and rewarding quality, improving quality, safeguarding quality and staying ahead.

The aim of the CQUIN payment framework is to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion. The framework is intended to ensure contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing the commissioners to link a specific modest proportion of providers' contract income to the achievement of locally agreed goals.

A proportion of Warrington and Halton Hospitals NHS Foundation Trust's income in 2017/2018 was conditional upon achieving quality improvement and innovation goals agreed between Warrington and Halton Hospitals NHS Foundation Trust 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 payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at www.whh.nhs.uk.

The monetary total for the amount of income in 2017/18, conditional upon achieving quality improvement and innovation goals, meeting the 16/17 control total and engaging in the STP was £4,516,897 with a monetary total for the associated payment in 2017/18 of £4,292,779 received. In 2016/17, the trust received a monetary total for the CQUINs of £4,126,057 against a target of £4,476,672.

The Trust had the following CQUIN goals in 2017/2018 which reflected national priorities and Department of Health initiatives.

CQUIN Report 2017/18

No.	Name	% of contract value	Total estimated final value
	NATIONAL CQUINS		
1	**NHS Staff Health and Wellbeing**	0.25%	£448,166
1a	Improvement of health and wellbeing of NHS staff.		
1b	Healthy food for NHS staff, visitors and patient.		
1c	Improving the uptake of flu vaccinations for front line staff within Providers.		
2	**Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)**	0.25%	£448,166
2a	Timely identification of patients with sepsis in emergency departments and acute inpatient settings.		
2b	Timely treatment of patients with sepsis in emergency departments and acute inpatient settings.		
2c	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.		
2d	Reduction in antibiotic consumption per 1,000 admissions.		
3	**Supporting proactive and safe discharge**	0.25%	£448,166
4	**Improving services for people with mental health needs who present to A&E**	0.25%	£448,166
5	**Offering advice and guidance (A&G)**	0.25%	£448,166
6	**NHS e-Referrals**	0.25%	£448,166
7	**Preventing ill health by risky behaviours - alcohol and tobacco**	N/A	N/A

7a	Tobacco Screening. Percentage of unique adult patients who are screened for smoking status AND whose results are recorded.		
7b	Tobacco Brief Advice. Percentage of unique patients who smoke AND are given very brief advice		
7c	Tobacco referral and medication offer. Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication.		
7d	Alcohol Screening. Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems.		
7e	Alcohol Brief Advice or referral. Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral.		
	NHS ENGLAND CQUINS		
8	**Breast Screening Programme Clerical Staff Development (Health Promotion Role)**		£33,504
9	**Dental**		£52,870
9a	Referral Management.		
9b	Managed Clinical Networks (MCNS).		
	SPECIALLY COMMISSIONED CQUINS		
10	**Hospital Pharmacy Transformation and Medicines Optimisation**	40.00%	£33,798
11	**Nationally standardised dose banding for adult intravenous**	60.00%	£50,697

2.11 Care Quality Commission (CQC) Registration

Warrington and Halton Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Warrington and Halton Hospitals NHS Foundation Trust during 2017-2018.

The Trust is registered to provide the following services:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury

Warrington and Halton Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

2.12CQC Inspections

The Trust was inspected by the CQC in March 2017. During their visit they looked at the quality and safety of the care we provide, based on the things that matter to people. They looked at whether our service is:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

The key lines of enquiry were investigated using pre-visit information, the onsite inspection and local information about us – including seeking patient, staff and visitor views. In November 2017 the CQC published our report which included a rating by specialty; location and an overall rating for the trust from the inspection.

The trust can report that the CQC rated Halton Hospital as **Good** and Warrington Hospital as **Requires Improvement**. They rated the domain of Caring in the Trust as Good across the board in all of its services.

The trust was given an overall rating of **'Requires Improvement'** by the CQC. At the time of the inspection, the Trust implemented a lot of improvements. An action plan is in place within the Trust following receipt of the CQC action plan with actions at service and Trust level. This has formed our Getting to Good, Moving to Outstanding vision and priorities within the Trust. This is monitored by a monthly meeting, which has been convened to oversee the action plan implementation.

2.13 Trust Data Quality

Warrington and Halton Hospitals NHS Foundation Trust submitted records during April – February 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:

Admitted Patient Care	99.8%
Outpatient Care	99.9%
A&E Care	99.2%

The percentage of records in the published data which included the patient's valid General Medical Practice code was:

Admitted Patient Care	100%
Outpatient Care	100%
A&E Care	100%

*March data was not available at the time of writing this report.

Warrington and Halton Hospitals NHS Foundation Trust will be taking the following actions to improve the data quality. The Trust's data quality team work closely with operational teams to ensure data collected Trust wide on our systems is accurate and completeness.

A detailed action plan supports improvement in key areas relating to general data quality, Trust key performance indicators, finance and contract performance. Progress against the Data Quality work plan is monitored by the Data Quality and Management Steering Group, which reports to the Finance and Sustainability Committee.

2.14 Information Governance

Warrington and Halton Hospitals NHS Foundation Trust's Information Governance Assessment overall score for 2017/18 was 68%, and was graded as green ('satisfactory').

During the 2018/19 financial year, progress against the Information Governance work plan and associated action plans will be monitored by the Information Governance and Corporate Records Sub-Committee which reports to the Quality Committee.

The Trust's most recent Information Governance Assurance review took place in 2017 and was carried out by the Mersey Internal Audit Agency. Following review of the available evidence the Trust was provided with a Significant Assurance rating.

Part of the work conducted with Mersey Internal Audit Agency was to assess the work required in preparation for changes to UK Data Protection Legislation as part of UK implementation of the General Data Protection Regulation (GDPR) in May 2018. Continuing compliance with the requirements of the new UK Data Protection legislation will be monitored as part of the Trust's use of the NHS Digital Data Security and Protection Toolkit.

2.15 Clinical Coding/Payment by Results (PBR)

Warrington and Halton Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

Warrington and Halton Hospitals NHS Foundation Trust will be taking the following actions to improve data quality;

- Continuous engagement with clinicians to improve documentation and clinically coded data.
- Working with clinicians to migrate from handwritten to digital operation notes.
- On-going programme of internal clinical coding staff audits.
- Supporting the mortality review group with documentation and clinical coding reviews.
- Continuous training and updating of skills for clinical coders.
- Targeted specialty documentation and clinical coding audits.
- Collaboration with Informatics to enhance the usability of Lorenzo to improve the coding process.
- Highlight data quality issues for resolution to the Application Support Team.

2.16 Learning from deaths

During 1st April 2017 to 31st March 2018, 1118 of WHH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 266 in the first quarter;

- 262 in the second quarter;
- 287 in the third quarter;
- 303 in the fourth quarter

By 31st March 2018, 33 care record reviews and 32 investigations have been carried out in relation to 1,118 of the deaths included above.

In 9 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 as follows:

12 in the first quarter;

9 in the second quarter;

13 in the third quarter;

22 in the fourth quarter

14 representing 1.25% 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. It should be noted that 9 investigations are still in progress and are awaiting conclusion.

In relation to each quarter, this consisted of:

5 representing 1.88% for the first quarter;

5 representing 1.9% for the second quarter;

4 representing 1.39% for the third quarter, with 1 case still under investigation;

0 representing 0% for the fourth quarter with 8 cases still under investigation

Below, is a summary of the learning and actions from case record reviews and root cause analysis investigations conducted in the Trust in relation to the deaths identified above:

What did we Learn?	What actions did we take?	Impact
Incident reporting and investigation Need to improve systems for incident reporting and investigation and to provide feedback and support to staff that report incidents and are involved in investigations	• Revision of incident reporting and investigation procedures, including strengthening of the 72hr review process has been undertaken. • 2 day programme of RCA training delivered for senior clinicians and managers in 2017. • Investment identified to update the Trust investigation and complaints system with a planned programme of training for staff during 2018/19 • Learning from Deaths Policy developed and process for mortality review revised to include Structured Judgement Review	

	• Processes for providing feedback and de-brief to staff post-investigation have been reviewed. • Patient/ family liaison role developed and senior staff appointed for each serious incident investigation. • Investigation Lead Manager appointed in 2018 to support staff education, improvements in the quality of investigations and improve outcomes and learning from investigation	
Sepsis: Identification and treatment of patients with sepsis in line with Sepsis 6	• Sepsis Team has been established and have worked to implement Sepsis 6 and pathways across the organisation and with a focus in the Emergency Department (ED). • Training programme delivered Trust wide for clinical teams. • The Emergency Department now has a dedicated sepsis cubicle in to support the timely treatment of patients diagnosed with sepsis.	• Improvements in compliance with appropriate treatment
Falls prevention: Falls assessments and observation of patients who are at risk of falls has not been optimal for some patients	• Appointment of a Falls Specialist Nurse in June 2017 to lead the falls prevention programme • Frailty Specialist Nurse appointed in November 2017 • Review of falls risk assessments and policy • Training on falls prevention • Falls Group developed • SWARM initiative introduced – an immediate huddle of ward staff occurs following a fall to help re-assess the patient and prevent further harm. • Weekly harm free care meetings have been introduced with the ward team and Matron/ lead nurse to discuss falls • Review and trial of falls prevention devices and equipment • Development of enhanced care procedures and documentation for vulnerable patients • Programme to purchase new bed stock underway • Review of staffing and acuity in wards with high reporting of falls	
Mental Health and Learning Disability	• Appointment of 2 Learning Disability Nurse roles within the Safeguarding	

The assessment and experience of patients presenting with a history or diagnosis of mental health or learning disabilities needs to be improved in some areas of the Trust.	Team to support and educate staff • Project lead role developed to support review of MH polices, systems and process for patient assessment and treatment • CQUIN developed to monitor and identify patients who are frequent attenders • Planned investment in training to provide a programme of training for staff to improve knowledge and understanding in 2018/19 • Mental Health Triage Tool introduced in ED to support and improve patient assessment	
Diagnostics: Improvements required in systems for requesting, reporting and reviewing diagnostic tests and procedures.	• Diagnostics Policy and new SOPs developed • Diagnostics Task and Finish Group established	
Multidisciplinary meetings: Improvements required in the function, structure and communication for some MDTs	• Internal audit commissioned and actions developed from this • Review of local procedures so Trust standards can be established for documentation, function and communication of outcomes and action from MDTs	
Processes for preoperative assessment require review	• Policy and assessment procedures under review • Clinical skills programme and competency assessments for preoperative nurses established • 2 stage consent process to be reviewed	
Deteriorating patients	• NEWS 2 Policy to be introduced • Review of the process for resetting the NEWS Trigger Score in the current policy has been undertaken and communicated Trust wide • Task and finish group established	
The quality of handover and communication has been identified as an issue in some investigations.	• The handover (SBAR) document and communication tool and policy have been reviewed and revised. • Process for handover in ED and Urgent Care reviewed and strengthened	
Policies, guidelines and procedures:	• Urinary Tract Infection (UTI) pathway	

Raise awareness and knowledge for diagnosing and treating patients presenting with urinary tract infection	reviewed and implemented to ensure patients are correctly diagnosed and receive appropriate care and treatment.	
Pelvic (transabdominal) ultrasounds in female patients where there is a difficulty in diagnosis should have an immediate transvaginal scan, if appropriate.	• Guideline developed for ultrasound of the pelvis indicating the process for proceeding to TV (transvaginal) scan.	
Process for reviewing and escalating radiology discrepancies and ensuring these are aligned to Trust investigation and escalation processes	• Amendment of Radiology Discrepancy policy and reporting procedures	

Any actions and improvements that have been made by the Mortality Review Group are being reviewed during 2018 and 2019 to see whether they have had the desired impact. These actions will be reported to the Patient Safety & Clinical Effectiveness Sub-Committee.

2 case record reviews and 0 investigations completed after 1st April 2018 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 more likely than not to have been due to problems in the care provided to the patient.

14 representing 1.25% % of the patient deaths during 1st April 2017 to 31st March 2018 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.17 Core Quality Indicators 2017/2018

The 2012 Quality Account Amendment Regulations (10) state that Trusts are required to report against a core set of quality indicators using the following standardised statement set out as follows:

Where the necessary data is made available to the Trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) are included for each of those listed with:-

- The national average for the data.
- The NHS Trusts and NHS foundation Trusts with the highest and lowest of the same, for the reporting period.
- Present, in a table format, the percentage/proportion/score/rate/number for at least the last two reporting periods.

Trusts are only required to include indicators that are relevant to the services they provide.

2.18 Summary Hospital-Level Mortality Indicator (SHMI)

The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period was:

SHMI

DATE PERIOD	TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
July 2016 – June 2017	112.32	2	122.77	72.61	100
October 2015 – September 2016	108.52	2	116.02	68.91	100
July 2015 – June 2016	110.12	1	117.45	70.03	100
April 2015 – March 2016	112.44	1	118.50	68.00	100
January 2015 – December 2015	117.94	1	117.94	68.00	100
October 2014 – September 2015	114.08	1	117.74	65.16	100
July 2014 – June 2015	114.36	1	120.89	66.05	100
April 2014 – March 2015	114.45	1	120.98	66.96	100
January 2014 – December 2014	115.58	1	124.34	65.53	100
October 2013 – September 2014	111.21	2	119.82	59.66	100
July 2013 – June 2014	109.40	2	119.80	54.10	100
April 2013 – March 2014	108.20	2	119.70	53.90	100
January 2013 – December 2013	109.20	2	117.60	62.40	100
October 2012 – September 2013	110.21	2	118.59	63.01	100
July 2012 – June 2013	112.06	2	115.63	62.59	100
April 2012 – March 2013	112.90	1	116.97	65.23	100
January 2012 – December 2012	110.69	2	119.19	70.30	100

NB: This information is re-based so there may be a variation from HED monthly reporting.

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset, which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data (HED) benchmarking system to facilitate further analysis. Trusts are banded 1-3 as follows:-

1. The Trust's mortality rate is 'higher than expected'
2. The Trust's mortality rate is 'as expected'
3. Where the Trust's mortality rate is 'lower than expected'

SHMI – Mortality Rates

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust-level across the NHS in England. This indicator is produced and published quarterly, as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die at the Trust, or within 30 days of being discharged, and the number that would be expected to die, on the basis of average England figures. A number below 100 indicates fewer than the expected numbers of deaths, and a number above 100 would suggest a higher than expected number of deaths.

The Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by monitoring mortality ratios on a monthly basis using the HED system and reported an 'as expected' score in the rolling 12 month periods from July 2016 – June 2017.

The SHMI is one of two mortality measures used in the NHS, the other being HSMR (Hospital Standardised Mortality Ratio), which is 101.99 for the latest data period available (March 2018). This is within the range of 'as expected'.

Mortality ratios are complex indicators and there are multiple factors that contribute to the overall score, including the quality of our documentation and coding.

2.19 Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period

Deaths with Palliative Care Coding

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
July 2016 – June 2017	41.7%	31.1%	58.6%	11.2%
October 2015 - September 2016	28.80%	27.29%	95.23%	1.04%
July 2015 - June 2016	25.38%	26.76%	94.73%	0.27%
April 2015 – March 2016	23.48%	26.05%	96.20%	0.27%
January 2015 – December 2015	25.49%	25%	99%	0.26%
October 2014 - September 2015	27.5%	23.7%	52.8%	10.1%
July 2014 - June 2015	28.2%	23.1%	47.8%	9.3%
April 2014 – March 2015	27.5%	22.5%	46.2%	7.7%
January 2014 – December 2014	27.6%	22.3%	44.6%	6.7%
October 2013 - September 2014	26.4%	21.7%	46.7%	6.1%
July 2013 - June 2014	30.5%	24.6%	49%	7.4%
April 2013 – March 2014	27.7%	23.6%	48.5%	6.4%
January 2013 – December 2013	22.8%	22%	46.9%	1.3%
October 2012 - September 2013	19.9%	20.9%	44.9%	2.7%
July 2012 - June 2013	18.9%	20.3%	44.1%	4.2%
April 2012 – March 2013	17.2%	19.9%	44%	0.1%
January 2012 – December 2012	14.4%	19.1%	42.7%	0.1%

*The palliative care indicator is a contextual indicator.

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data benchmarking system to facilitate further analysis.

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the rate and so the quality of its services by investigating the detail behind the ratio numbers, we identified that our rate of service provision was the lowest in the North West prior to 2012/2013, and we have worked hard to now be in a position in which we compare favourably with local peers. The Trust was below the England average but has improved over the years to a steady rate, which is comparable with the England average.

We now have a Head of Clinical Coding & Service Development in place since May 2016 and a lot of improvement work has been conducted around correctly coding our palliative patients. A report was written in 2016 which identifies patients who have received palliative care and have supporting documentation in Lorenzo. This report is used monthly by the Clinical Coding team to ensure 100% palliative care coding compliance.

2.20 Patient reported outcome measures (PROMs) for (i) groin hernia surgery, (ii)* varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery.

***PROMs also exist for varicose vein; however the Trust does not undertake this procedure**

This data is made available to the Trust by the Health and Social Care Information Centre with regard to the Trust's patient reported outcome measures scores for— groin hernia surgery, varicose vein surgery, hip replacement surgery, and knee replacement surgery, during the reporting period were:-

Patient Reported Outcome Scores

		Groin hernia	Hip replacement	Knee replacement
Year	Level	Average health gain	Average health gain	Average health gain
2015/2016	Trust	0.081	0.429	0.345
2015/2016	England	0.088	0.439	0.321
2014/2015	Trust	0.065	0.414	0.315
2014/2015	England	0.084	0.436	0.357
2013/2014	Trust	0.062	0.415	0.335
2013/2014	England	0.085	0.436	0.323
2012/2013	Trust	0.062	0.428	0.357
2012/2013	England	0.085	0.438	0.318
2011/2012	Trust	0.084	0.438	0.310
2011/2012	England	0.087	0.416	0.302

http://digital.nhs.uk/catalogue/PUB22172

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason in that the PROMs data is a nationally agreed dataset. The data is collected, processed, analysed and reported to the Health and Social Care Information Centre by a number of organisations, including hospital Trusts which perform PROMs procedures. PROMs calculate the health gains after surgical treatment using pre and post-operative surveys. The Health and Social Care Information Centre is responsible for scoring and publishing of PROMs data as well as linking it to other data sets such as Hospital Episodes Statistics.

Warrington and Halton Hospitals NHS Foundation Trust intends to improve the rate and so the quality of its services by ensuring that PROMs data will be monitored by the Patient Experience Sub-Committee.

2.21 Emergency readmissions to hospital within 28 days of discharge

NB: This data is not available on HSCIC and the technical specification for the dataset is not available so the Trust cannot replicate the data using local information.

It has been acknowledged that an error was made in the drafting of the regulations and that the split of patients for this indicator should be

0 to 15; and

16 or over,

This indicator on the HSCIC Indicator Portal was last updated in December 2013 and the proposed update that was due to take place in August 2016 was postponed, therefore there is no up to date information.

Emergency readmissions to hospital within 28 days of discharge (age 16<) *

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2016/2017	*	*	*	*
2015/2016	*	*	*	*
2014/2015	*	*	*	*
2013/2014	*	*	*	*
2012/2013	*	*	*	*
2011/2012	13.58	10.01	13.58	5.10
2010/2011	12.08	10.15	13.94	5.85
2009/2010	11.77	10.18	14.44	6.38

NB: Information Centre provides data by 16> not 15>

* Data for 2012/17 is not available from the Information Centre

https://beta.digital.nhs.uk/data-and-information/publications/clinical-indicators/compendium-of-population-health-indicators/compendium-hospital-care/current/emergency-readmissions-to-hospital-within-28-days-of-discharge

Emergency readmissions to hospital within 28 days of discharge (age 16>) *

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2014/2015	*	*	*	*
2013/2014	*	*	*	*
2012/2013	*	*	*	*
2011/2012	12.44	11.45	13.50	8.96
2010/2011	11.66	11.42	12.94	7.6
2009/2010	11.75	11.16	13.17	7.3

NB: Information Centre provides data by 16> not 15>. Data relates to medium sized acute Trusts.

* Data for 2012/16 is not available from the Information Centre

https://beta.digital.nhs.uk/data-and-information/publications/clinical-indicators/compendium-of-population-health-indicators/compendium-hospital-care/current/emergency-readmissions-to-hospital-within-28-days-of-discharge

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data benchmarking system to facilitate further analysis.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this data and so the quality of its services, by reporting all data to the Trust Board and the Clinical Operational Board.

2.22 National inpatient survey – personal needs

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2016/2017	65.7	68.1	85.2	60
2015/2016	70.9	69.6	86.2	54.4
2014/2015	72.0	68.9	86.1	59.1
2013/2014	69.4	68.7	84.2	54.4
2012/2013	66.7	68.1	84.4	57.4
2011/2012	66.2	67.4	85	56.5
2010/2011	67.4	67.3	82.6	56.7

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, central to the Trust ethos is the view that patients deserve high-quality healthcare, and patients' views and experiences are integral to successful improvement efforts. As such it employs Quality Health to undertake a robust and comprehensive survey of patients experience on an annual basis.

The National Inpatient Survey key themes had been reviewed in full and have been scrutinised. There has been significant work been undertaken by the divisions, with the implementation of the five work streams of the Patient Experience strategy, led by Lead Nurses and Allied Health Professionals, who provide monthly updates to the Patient Experience Sub Committee.

2.23 Percentage of staff who would recommend the provider to friends or family needing care

The data is made available to the Trust by the Health and Social Care Information Centre via the National NHS Staff Survey Coordination Centre with regard to 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.

Staff who would recommend the provider to friends or family needing care by percentage

DATE	TRUST	ACUTE TRUSTS
2017	60%	71%
2016	57%	70%
2015	54%	70%

2014	61%	65%
2013	65%	67%
2012	58%	65%
2011	57%	65%

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason, in that this report presents the findings of the 2017 national NHS staff survey conducted by Quality Health on behalf of the trust. Quality Health utilises high quality research methodology and mixed method collection resulting in a 46% response rate.

This year the Trust decided to give all staff the opportunity to respond to the staff survey rather than a statically representative sample. Therefore with a response rate of 46% over 1800 WHH staff responded to the survey. The response rate also indicates an increase of 8% on the 2016 survey and improves the trusts performance. The trusts view is that the results are statistically representative.

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve to improve this score and so the quality of its services by using the percentage of staff recommending the trust as a place of work and treatment within the staff survey alongside the quarterly staff friends and family test results. In order to achieve high impact and sustainable improvements the Trust will adopt a more strategic, 'OD' approach. This approach will link in with the 'Cultural Change and Leadership' programme headed up by the Director of HR and OD and will engage the workforce in thinking differently and creatively about these themes.

2.24 Percentage of admitted patients risk-assessed for Venous Thromboembolism

The data made available to the National Health Service Trust or NHS foundation Trust by the National Commissioning Board with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Venous Thromboembolism (VTE) – percentage of risk assessments undertaken

Year	Level	Q1	Q2	Q3	Q4
2017/2018	Trust	95.18%	95.88%	95.24%	**
	National Average	95.20%	95.25%	95.36%	**
	Highest	100%	100%	100%	**
	Lowest	51.38%	71.88%	76.08%	**
2016/2017	Trust	90.19%	92.50%	90.19%	90.19%
	National Average	95.73%	95.51%	95.74%	95.74%
	Highest	100%	100%	100%	100%
	Lowest	80.61%	72.14%	80.61%	80.61%
2015/2016	Trust	96.6%	96.1%	88.56%	88.37%
	National Average	96%	95.9%	95.5%	95.53%
	Highest	100%	100%	100%	100%

	Lowest	86.1%	75%	61.5%	48.63%
2014/2015	Trust	95.70%	95.60%	95.00%	95.93%
	National Average	96.00%	96.10%	96.00%	96.00%
	Highest	100%	100%	100%	100%
	Lowest	87.20%	86.40%	81.00%	79.23%
2013/2014	Trust	95.54%.	95.60%	96.50%	96.00%
	National Average	95.39%	95.69%	95.80%	96.00%
	Highest	100%	100%	100%	100%
	Lowest	78.78%	81.70%	77.70%	79.00%
2012/2013	Trust	95.40%	95.10%	94.00%	93.90%
	National Average	93.40%	93.80%	94.00%	94.20%
	Highest	100%	100%	100%	100%
	Lowest	80.80%	80.90%	84.60%	87.90%
2011/2012	Trust	95.60%	96.20%	95.40%	96.20%
	National Average	81.00%	88.00%	91.00%	93.00%
	Highest	***	***	100%	100%
	Lowest	***	***	32.40%	69.80%

** = This data is not currently available from NHS Improvement.

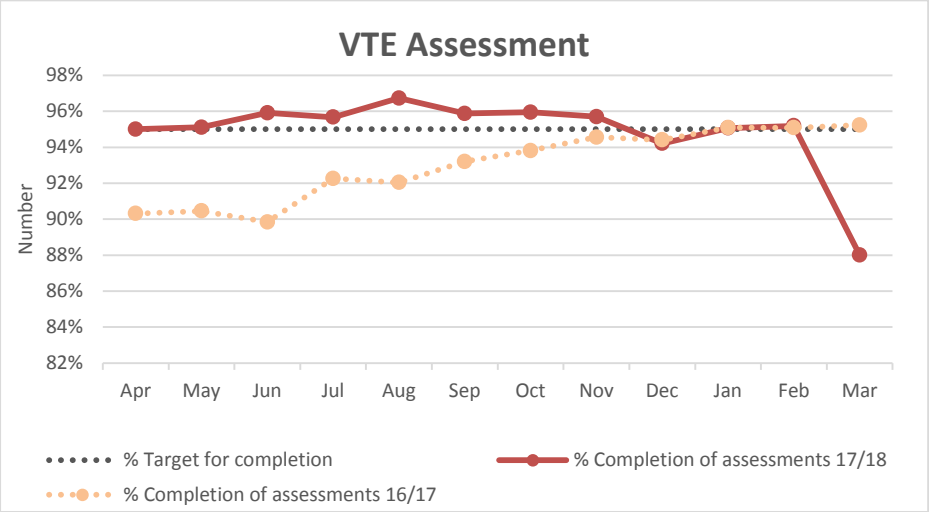
*** = This data has been archived and is unavailable.

The Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons in that this is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency.

Warrington and Halton Hospitals NHS Foundation Trust has a well-developed system for undertaking risk assessments on admission and ensuring the data is collated corporately and incorporated into the Quality Dashboard for monthly review and monitoring by both the Quality Committee and Trust board. Following introduction of Lorenzo VTE risk assessment rate dropped, issues were identified and actions taken and the trust is now achieving the 95% risk assessment completion target**.**

It is recognised that early identification of patients at risk of developing VTE can be very effective in minimising the occurrence of the condition. More than half of all VTE events are associated with prior hospitalisation.

In 2010 Department of Health, through Commission for Quality and Innovation Payment Framework (CQUIN), set mandatory target for all trusts to achieve at least 90% VTE risk assessment completion on admission for all hospitalised patients. This target was increased to 95% in April 2013. March 2018 compliance against the national target is not yet finalised and validated and will be subject to change. The graph below demonstrates submitted validated data up to February 2018.



It is the role of the medical staff who admits adult patients to complete the VTE assessment on the electronic patient record (Lorenzo). The patient is reviewed within 14 hours by a consultant (Royal College Standards and the VTE status should be checked for completion at this stage. A daily pivot table is produced from DWARF systems and the ward clerks provide a list of patients on each ward who are missing an assessment. This is highlighted to
the doctor for completion. The VTE specialist nurse follows up missed assessments to ensure timely completion.

There is no real time feedback as to whether a VTE assessment form has been completed but the DWARF report producing the pivot table is updated daily at midnight. This report however does not state if a VTE has been completed within 24 hours, ONLY if it has been completed or not. VTE forms in Lorenzo must be attached to an IP (inpatient) or ED (Emergency Department) encounter. ED and IP encounters are linked on Lorenzo as a single
episode. Clinical indicators give a visual representative of whether or not a patient has had a
VTE form completed for the whole ward. Currently indicators only work at encounter level consequently patients with a VTE form completed in ED will show as not having a VTE form completed when admitted to a ward (as there is no VTE form attached to the inpatient encounter). This means there has to be a manual validation by the VTE specialist nurse. Ideally, clinical indicators need to work at episode level.

Currently the VTE specialist nurse is informed of all hospital acquired thrombotic episodes (HAT). HAT is recorded onto the Trust Datix system and RCA carried out by responsible consultant and the root cause identified. The case is discussed at thrombosis group and if the root cause is deemed preventable duty of candour is completed.

The trust has established a Thrombosis group chaired by a Consultant O/G and there is regular attendance from ED, Orthopaedics. Engagement of other key clinicians has proved difficult over the past few years but the group will aim to address this.

2.25 Treating Rate of C. difficile per 100,000 bed days amongst patients aged two years and over

The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to 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.

Warrington & Halton NHS Trust Clostridium difficile infections per 100,000 bed days

DATE	TRUST	NATIONAL
2016/2017	33.9	36.7
2015/2016	33.3	40.8
2014/2015	35.4	41.0
2013/2014	29.5	39.0

https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

The Warrington and Halton Hospitals NHS Foundation Trust considers that the data is as described for the following reasons there is a robust system for data entry and validation which ensures all cases are entered onto the data Capture system.

The Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

- Action plan in place to reduce Clostridium difficile
- Participation in the national AMR CQUIN
- Participation in European Antibiotic Awareness Day
- Fidaxomicin used for treatment of patients with recurrent Clostridium difficile infection
- Antimicrobial steering group with feedback to Clinicians on incidences of antimicrobial prescribing non-compliance
- Surveillance of cases/monitoring for increased incidences in defined locations
- Improvements to methods of investigation for Clostridium difficile cases
- Cohort isolation facility maintained to manage cases
- Increase in ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment and single point lessons on Clostridium difficile and use of SIGHT mnemonic
- Environment Group re-established to monitor and direct improvements in standards of cleanliness
- Action plan in place to reduce MRSA and MSSA bacteraemia cases
- Participation in the national Sepsis CQUIN to promote timely blood culture sampling and IV antibiotic treatment
- Revision to post infection review template for bacteraemia cases
- Review of all MRSA positive cases and advice provided on suppression therapy and where required antibiotic treatment

2.26 Patient Safety Incidents

The data is made available to the Trust by the National Reporting and Learning System with regard to 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.

Patient Safety Incidents – Rate of incidents per 1000 bed days

DATE	TRUST	TRUST NUMBER	MEDIAN	LOWEST	HIGHEST
Oct 2016 – Mar 2017	40.24	3780	40.14	23.13	68.97

DATE	TRUST	TRUST NUMBER	MEDIAN	LOWEST	HIGHEST
April 2016 – September2016	37.78	3643	40.02	21.15	71.81
Oct 2015 – Mar 2016	38.62	3706	39.31	14.77	75.91
April 2015 – September 2015	39.41	3721	38.25	18.07	74.67
Oct 2014 - Mar 2015	38.6	3584	35.3	3.6	82.2
April 2014 – September 2014	36.89	3339	35.89	0.24	74.96
October 2013 – March 2014	37.1	3513	33.3	5.8	74.9

NB: NRLS Report provides median rate of incidents per 1000 bed days reported by all non-specialist acute Trusts.

Patient Safety Incidents Severe Harm / Death – Rate

DATE	TRUST	NATIONAL	LOWEST	HIGHEST
Severe Harm and Death Oct 2016 – Mar 2017	0.29% (11)	0.4% (Non-specialist acutes only)	0.03% (1)	2.13% (62)
Severe Harm and Death April 2016 – September 2016	0.3% (10)	0.4% (Non-specialist acutes only)	0% (0)	1.9% (111)
Severe Harm and Death Oct 2015 – Mar 2016	0.1% (2)	0.4% (Non-specialist acutes only)	0% (0)	2.8% (122)
Severe Harm and Death April 2015 – September 2015	0.4% (15)	0.4 (Non-specialist acutes only)	0.03% (1)	3.6% (111)
Severe Harm & Death October 2014 - March 2015	0.1% (5)	0.5% (non-specialist acutes only)	0.05% (2)	5.19% (128)

Severe Harm & Death April 2014 – September 2014	0.1% (5)	0.5% (non-specialist acutes only)	0% (0)	1.85% (97)
Severe Harm & Death October 2013 – March 2014	0.17% (6)	Clarify scope	0.03% (1)	1.47% (72)
Severe Harm & Death April 2013 – September 2013	1.08% (42)	Clarify scope	0% (0)	3.10% (106)
Severe Harm & Death October 2012 – March 2013	0%	0.05%	0%	0.2%
Severe Harm April 2012 – September 2012	**0.15% (4)	*<1%	0 0%	61 3.1%
Death April 2012 – September 2012	0.0% (1)	*<1%	0 0%	34 1.3%
Severe Harm October 2011 – March 2012	0.2% (4)	*<1%	1 0%	80 3%
Death October 2011 – March 2012	0.0% (0)	*<1%	0 0%	14 0.6%

NB - The Trust has reported by actual number & percentage by highest/lowest rates please note these will not necessarily be the same Trusts.

NB - *National = Severe Harm and Death combined. **Please see comments.

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons in that it downloads all incidents via DATIX to the National Reporting and Learning System within the agreed timescales.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, Warrington and Halton Hospitals NHS Foundation Trust has:

Completed investigations to the appropriate level dependant on the severity of the clinical incidents reported

Shared analysis, learning and improvement identified from clinical incidents across the Trust via the following routes:

- Quarterly Governance Reports

- Trust wide safety alerts and notifications
- Safety briefings in clinical areas
- Amendments to policy
- Weekly and Monthly meetings with Governance Managers to manage the incident process

Quality Report Part 3 - Trust Overview of Quality

Patients are at the centre of everything we do and providing high quality service for every one of our patients is at the heart of our organisation.

Pictured above are the Child Health Team; winners of the Excellence in Patient Care Award 2018.

Our team of the year were rated as "Good" by the CQC, and winners of the 2017 Flu Race. They work together as a family, putting the child and their family first at all times.

The team provide excellence in patient care though superb leadership, effective teamwork and 100% commitment to the service and each other

3.1 Introduction - Patient Safety, Clinical Effectiveness & Patient Experience

Our aim is to be a learning organisation that consistently transforms practice by continuous learning in order to provide the best possible health care. The Trust's strategic objective is to ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience.

To support our overall aim we have developed a Quality Strategy to ensure that all staff who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good outcomes for our patients.

The Quality strategy has been developed based first and foremost to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be. With the above care model in mind we use the following three priority domains: **patient safety, clinical effectiveness** and **patient experience**.

As part of the Quality Strategy we have developed Patient Safety Pledges which are;

We will have **safe systems** of work in place – all staff will work with robust clinical policies, procedures, safe equipment, have training to enable them to competently their job and work within appropriate Health & Safety processes;

We will ensure that we **minimise harm for patients**, specifically pledging to deliver;

- A 20% reduction in falls for our patients who stay in hospital.
- 100% medicines reconciliation when patients come into hospital and promotion of safe prescribing and administration of medicines.
- A 10% reduction in Hospital Acquired Infections – particularly focusing on safe catheter care and implementation of the Trust's Urinary Tract Infection (UTI) pathway.
- 100% of patients having sepsis screening and being treated appropriately.
- 100% patients to have a Venous Thromboembolism (VTE) assessment and to have appropriate treatment.

We will have systems in place to ensure that we are a **learning organisation** and we will foster a culture of continuous learning and Quality Improvement.

Clinical Effectiveness Pledges which are;

We will ensure that we providing care that is **evidence based** and that we adopt a culture of innovative and research and development within the Trust, to always look to provide the best for our patients.

We will ensure that we are focused on **outcome**s for patients and that are benchmarking/peer reviewing ourselves against the 'best in class'.

We will ensure that we foster a culture of **Quality Improvement** and we provide our staff with the information, training, systems and empowerment to make changes to our services to benefit our patients and public that we serve.

Patient Experience Pledges which are;

Listening, learning and Leading Change – We believe every patient should have the opportunity to give feedback about their experience and we promise to use this to improve care and services.

Communicating in line with our values - We believe our patients should be first in everything we do and we promise to communicate based on what matters most to you

Partnership Working and Needs Based Care – We believe every patient should experience care and treatment in the right environment and we promise to continuously improve what you can see, do, hear and feel during your stay.

Simplifying patient focused processes - We believe that our processes should be designed to support our patients and we promise to develop these so that everything is simple, done in a timely manner and easy to understand.

In line with our Trust values, we will **Work Together** in **Excellence**, commit to being **Accountable and Responsible** as **Role Models** and **Embrace Change** for each of the quality priorities.

As previously mentioned in the introduction to this report the Trust is launching a Quality Academy to help foster a culture of learning and continuous improvement using Quality Improvement methodology.

Key to ensuring that we are addressing the right issues with regard to the service we provide is to actively seek, listen and act on feedback received from our patients, the public, our staff and groups such as Governors, Healthwatch and Overviews and Scrutiny Committees.

The Quality Academy therefore will link to work being undertaken with the Patient Experience and patient involvement agenda to ensure that the patient voice is integral to Quality Improvement.

Also the Quality Academy will work with Workforce & Organisational Development, to ensure that staff can engage in the agenda and are given the empowerment and support to make improvements in their work.

We continue to work collaboratively with patients and staff to provide open and honest care, and through implementing quality improvements, further reduce the harm that patients sometimes experience when they are in our care.

3.2 Data Sources

Intelligent information is collated from, whenever possible, sources which can be benchmarked with other organisations in order to indicate the Trust's performance in relation to others. The Trust submits and utilises data from the Health and Social Care Information Centre (HSCIC) which includes for example Patient Reported Outcome Measures (PROMs) in England whereby patients undergoing elective inpatient surgery for four common elective procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery) funded by the English NHS are asked to complete questionnaires before and after their operations to assess their perceived improvement in health.

The Trust also subscribes to Datix, which is web-based patient safety software for healthcare risk management. It delivers the safety, risk and governance modules which enable the Trust to have a comprehensive oversight of our risk management activities including incident reporting and complaints, compliments, comments and concerns.

In addition to this the Trust has invested in a clinically-led benchmarking system called Healthcare Evaluation Data (HED), an online solution delivering information, which enables the Trust to drive clinical performance in o der to improve patient care.

The Trust submits data to the NHS Safety Thermometer which was developed as a point of care survey instrument, providing a 'temperature check' on harm that can be used alongside other measures of harm in providing a care environment free of harm for our patients. The Trust undertakes a monthly survey on one day of all appropriate patients, to collect data on pressure ulcers, falls, urinary tract infection (UTI) in patients with catheters and VTE. The Safety Thermometer measures the percentage of patients who have experienced harm in relation to any of these issues and allows the Trust to identify weaknesses; make changes to practice and measure improvement.

Other sources of information come from Friends and Family; Inpatient, Outpatient and Staff Surveys and in-house sources including audit and transparency surveys.

3.3 Quality Dashboard 2017/2018

The clinical indicators in the Quality Dashboard have been reviewed in line with the revised requirements for 2017/2018 in relation to the:-

- CQUINs – National
- NHSI KPI
- Quality Contract
- Quality Account - Improvement Priorities
- Quality Account – Quality Indicators
- Care Quality Commission
- Sign up to Safety – national patient safety topics
- Open and Honest

This is part of a wider review of quality to align reporting with the committee structure under safety; effectiveness and experience and reporting to the Quality Committee to provide assurance on progress. The information on this Quality Dashboard is also shared with our Governors and commissioners of services to demonstrate how care for patients is delivered and sustained improvements are maintained.

Since April 2016 the Board has received an integrated performance dashboard which triangulates data on workforce, quality and financial information.

3.4 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the Trust based on performance in 2017/18 against a minimum of 3 indicators for each area of quality namely patient safety; clinical effectiveness and patient experience. These indicators were selected by the Board in consultation with stakeholders and discussions with the Quality in Care Committee of the Council of Governors. In the main, the Trust has employed indicators which are deemed to be of local and national importance to the quality of care for patients.

The report provides an explanation of the underlying reason(s) for selection and wherever possible we refer to historical data and benchmarked data if available, to enable readers to understand our progress over time and performance compared to other providers. We have also referenced the data sources for the indicators and if applicable included whether the data is governed by standard national definitions.

Where available comparative and benchmark data has been included and unless otherwise stated the indicators are not governed by standard national definitions and the source of the data is the Trust's local systems and may only be available across two reporting years as such more historical data has not been included.

The improvement priorities and quality indicators were monitored and recorded via the Quality Dashboard and the Improvement Priority Quarterly Report reported to the Quality Committee.

The quality indicators for 2017/18 included:

Patient Safety

- Safer Surgery
- Falls
- Sepsis

Clinical Effectiveness

- Supporting proactive and safe discharge
- Mortality review
- Lessons learned

Patient Experience

- Complaints
- Patient Experience Strategy
- Patient Experience for those patients with mental health needs who attend A&E

The above indicators have been reported in section 2 of this report.

3.5 Parliamentary and Health Service Ombudsman (PHSO)

The PHSO is a free and independent service, set up by Parliament. Their role is to investigate complaints were individuals feel they have been unfairly treated or have received poor service from government departments; other public organisations and the NHS in England. The PHSO make the final decisions on complaints about these public services for individuals.

Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. However, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate further and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and / or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

The table below details the PHSO and Hospital and Community Health Services Complaints Collection (KO41a) data for local Trusts until the end of quarter 2, 2016/17 for PHSO data (no publication date) and until the end of quarter 2, 2016/17 for Hospital and Community Health Services Complaints Collection (KO41a) data (published March 2017).

An appropriate comparison is the rate of conversion for complaints to PHSO enquiries which runs at 15.5%. This is in line with other local trusts except St Helens and Knowsley Teaching Hospitals NHS Trust, which currently runs at a conversion of 8.2% and Wrightington, Wigan and Leigh NHS Foundation Trust, which currently runs at a conversion of 6.1%.

Trust	Complaints Received by the PHSO 2016/17 (Q1 & Q2)	Complaints Accepted for investigation by the PHSO 2016/17 (Q1 & Q2)	Fully or Partially Upheld 2016/17 (Q1 & Q2)	Not upheld 2016/17 (Q1 & Q2)	Total Complaints Reported (KO41) 2016/17 (Q1 & Q2)	% of complaints converting to PHSO Enquiries 2016/17 (Q1 & Q2)
Warrington & Halton Hospital NHS Foundation Trust	35	12	7	4	225	15.5%
St Helens and Knowsley Teaching Hospitals NHS Trust	12	8	3	2	146	8.2%
Wirral University Teaching Hospital	26	7	1	3	174	14.9%

Wrightington, Wigan and Leigh NHS Foundation Trust	13	6	5	6	213	6.1%
Countess of Chester Hospital NHS Foundation Trust	16	4	2	1	110	14.54%

*https://www.ombudsman.org.uk/organisations-we-investigate/what-our-data-tells-us/quarterly-reports-complaints-about-nhs-trusts/complaints-about-acute-trusts-april-september-2016 & https://digital.nhs.uk/catalogue/PUB22793

The formal information relating to cases from 2017/18 is due to be published in September 2018. The table below details the progress of cases over the year within the Trust.

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
PHSO cases received	0	2	0	0	1	1	0	1	1	1	0	1
PHSO cases closed	0	1	1	2	0	0	0	0	0	0	0	2
Ongoing PHSO Cases	7	8	8	8	6	7	7	8	7	9	8	8

3.6 National Survey Results 2017 - National Inpatient Survey 2017 (published but under embargo, date to be confirmed)

Listening to patients' views is essential to providing a patient-centred health service. The annual National Inpatient Survey is a Care Quality Commission (CQC) requirement with the aim of obtaining feedback to improve local services for the benefit of the patients and the public. Survey results are reported to the CQC, who use the information as part of the Hospital Intelligent Monitoring. Patients are eligible for the survey if they are aged over 16 years or older, and have spent at least one night in hospital, and were not admitted to maternity or psychiatric units.

The 2017 Inpatient survey was undertaken by Quality Health, on behalf of the Trust and covers all aspects of patient's admission, care and treatment, operations and procedures and discharge from hospital from the inpatient specialties of General Surgery; Urology; Trauma and Orthopaedics, Cardiology, Acute Internal Medicine, Stroke and Respiratory Medicine. The initial results of the Inpatient Survey (2017) were received in March 2018. 1250 patients were randomly selected during an inpatient stay in July 2017 and 35% responded compared to a response rate of 40% last year.

The NHS in patient survey provides the Trust with intelligence around the overall patient experience and it is vital that we review and act upon this information to address poor performance.

The Picker Institute coordinates all the national results on behalf of the CQC, who publish reports which include benchmarks against best and worst performance. Seventy-six questions are asked

and categorized into twelve domains as follows:

- Admission to hospital
- A&E Department
- Waiting List and Planned Admission
- All types of Admission
- The Hospital and Ward
- Doctors
- Nurses
- Your Care and Treatment
- Operations and Procedures
- Leaving Hospital
- Overall views on care and Services
- About you

The following are the main headlines for 2017 benchmarked against 2016 results:

The Trust has deteriorated by 5% or more on the following questions: Higher is better		
	2016	**2017**
Patients did not have to wait a long time to get a bed on a ward	67.0%	70.5%
Patients got enough help from staff to eat their meals	67.6%	72.2%
Patient felt that there were enough nurses on duty	68.3%	75.9%
Hospital staff worked well together	85.7%	90.5%
Hospital staff did not give contradictory information	81.9%	84.3%
Patients were able to find somebody to talk to about their worries and fears	54.4%	53.3%
Patients thought that staff did everything to control their pain	79.8%	83.0%
Length of time to get help after using the call button	59%	Question was not asked in 2017
Leaving hospital		
Patients were given enough notice about their	68.7%	76.0%

discharge		
Discharge not delayed due to wait for medicines/ to see a Dr/ for ambulance	61.1%	60.7% 
Discharge delayed for no longer than four hours	72.9%	69% 
Staff explained the purpose of medication in an understandable way	78.7%	82.6% 
Staff explained about the medication side effects to be aware of	44.7%	48.8% 
Patients were told in an understandable way how to take their medication	78.9%	84.1% 
Patients were told about what danger signals to watch for after their return	54.8%	50.6% 
Hospital staff took the home situation into account when planning discharge	69.1%	75.2% 
Patients were told who to contact if they were worried about their condition after they had left hospital	72.2%	77.6% 
Overall		
Patients received information on how to complain to the hospital about the care they received	22%	22.9% 

The Trust performed significantly better than the national average in the top 20% of Trusts in relation to "Hospital staff worked well together". The Trust has improved results for 13 of the 18 questions. The main themes to focus on are in relation to leaving "hospital and discharge".
The WHH Patient Experience Strategy aligns work streams to address the highlighted themes within the Inpatient Survey and will provide a biannual update to the Quality Committee via the Patient Experience Sub Committee.

3.7 Care Opinion

Care Opinion (formerly Patient Opinion) was founded in 2005, and is an independent non-profit feedback platform for health services. Its philosophy is to support honest and meaningful conversations between patients and health services, with the view that patient feedback can help make health services better. Basically health service users can share their story of using a health service; patient opinion will send their story to staff so that they can learn from it; the Trust can offer a response with the ultimate goal being to help staff change services.

Patients can submit their comments directly onto the Care Opinion website, or can post comments on Care Opinion via a form on the NHS Choices website and both websites publish the comments.

Both websites provide feedback on how users rate the service in terms of whether they would recommend our hospital friends and family if they needed similar care and treatment; cleanliness; staff co-operation; dignity and respect; involvement in decisions; and same sex accommodation.

However, NHS Choices provides an overall star rating of 1 – 5 stars and for 2017/18 the Trust was rated 3 .5 stars by 181 respondents for Warrington Hospital and 5 stars by 64 respondents for Halton Hospital.

A review of Care Opinion indicates that 12 people would recommend this service and 9 people would not recommend this service.

Cleanliness (3.6/5)		**18 ratings**
Environment (3.8/5)		**20 ratings**
Information (3.4/5)		**19 ratings**
Involved (3/5)		**37 ratings**
Listening (3.4/5)		**20 ratings**
Medical (2.9/5)		**18 ratings**
Nursing (3.2/5)		**16 ratings**
Parking (2.6/5)		**18 ratings**
Respect (3.2/5)		**37 ratings**
Timeliness (3.2/5)		**37 ratings**

The Trust is committed to acknowledging all comments and if the service user expresses concerns we will try to address them in our response or encourage the reviewer to contact the PALS Team for further discussions.

3.8 Friends and Family

The NHS Friends and Family Test is an opportunity for patients to leave feedback on their care and treatment they received at Warrington and Halton NHS Foundation Trust. The feedback will be used to review our services from the patient perspective and enable us to celebrate success and drive improvements in care.

When patients visit our Accident and Emergency (A&E) Department for treatment, or are admitted to hospital, they are asked to complete a short postcard questionnaire when they are discharged. They basically tell us how likely they are to recommend the ward/ A&E department to friends and family if they needed similar care or treatment. The patient's response is anonymous and they will be able to post the card into the confidential box on their way out of the ward or A&E. The boxes

are emptied regularly to process the information and provide reports to the ward manager and matron.

If a patient is unable to answer the question, a friend or family member is welcome to respond on their behalf. Users are also asked to rate their responses and this is translated into a rating which is reported through to the board via the Quality Dashboard.

The Trust has procured a new FFT contract in order to improve the process and increase the response rate e.g. text services.

The results for 2016/2018 are as follows:

Friends and Family scores 2016/18

	Inpatient 2016/17	Inpatient 2017/18	A&E 2016/17	A&E 2017/18
Apr	96	97	90	97
May	95	97	90	93
Jun	96	97	92	97
Jul	98	95	96	85
Aug	94	95	92	86
Sept	96	94	93	84
Oct	95	95	93	79
Nov	94	94	94	82
Dec	93	95	96	82
Jan	95	90	94	85
Feb	94	95	94	82
Mar	96	94	94	81

The ratings are published on both NHS Choices and in the Open and Honest publication which is published on the NHS England Trust websites.

3.9 Duty of Candour

In February 2017, an audit of Duty of Candour was undertaken, and the Trust could not demonstrate a central monitoring system for Duty of Candour and that the Trust was routinely complying with the requirement of notification by letter within 10 days of becoming aware that a patient had been moderately or severely harmed. During 2017/18, the Clinical Governance team have developed processes to ensure that monitoring is in place by utilising and reporting through the Trust incident system, Datix. To support this process, weekly monitoring reports are provided for the Executive and operational teams and compliance is monitored by the Clinical Governance team at their weekly investigation meeting. Compliance with Duty of Candour is also reported monthly to the Patient Safety & Clinical Effectiveness Sub-Committee. As part of ongoing investment and improvement in the Datix incident system, the Clinical Governance team will continue to review and refine the process for capturing and monitoring Duty of Candour.

In order to ensure that staff are aware and understand the importance of Duty of Candour, the staff guidance leaflet has been updated and is sent out as part of the induction pack for each new member of staff. During April 2017 the Trust legal advisors also provided training to raise awareness for Duty of Candour.

For each new serious incident (SI) investigation, a patient or family liaison officer is now appointed to provide support and advice. The Trust will continue to further develop this role in 2018 and a programme of training for senior clinical staff who will undertake the patient/ family liaison officer role has commenced. From April 2018, a Lead Investigation Manager will also commence in post to

lead on and develop Trust SI investigations. A critical part of this role will be to provide support and advice to the liaison officer and to ensure that compliance with Duty of Candour is being fulfilled for each investigation.

3.10 Staff Survey Indicators

The most recent NHS Staff Survey results for indicators KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that Trust provides equal opportunities for career progression or promotion) are as follows;

In relation to the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (KF26) the Trust score was 22%, a slight improvement in year, placing WHH in the best 20% of Acute Trusts. The indicator for the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (KF21) was 89% above the national average for acute Trusts and puts the Trust's results in the top 20% of all acute Trusts.

3.11 Local Quality Initiatives

Be at the heart of quality improvement at our hospitals

At WHH we are committed to improving quality for our patients. We also know that the best ideas come from our staff who deliver care and services across our hospitals.

We've introduced Quality Improvement Champions (QIC) at the Trust. It gives staff from all levels and all disciplines the chance to receive exclusive training & development so they have the tools to put ideas that will improve care into action.

It's open to everyone to apply for. If successful, staff become part of an exclusive network of champions, fully supported by the Trust.

The table below details ongoing Local Quality Improvement initiatives with an update where one is available;

Quality Improvement Champion	Local Quality Initiative and update
Rachel Birley, Urology Nurse Practitioner	**Implementation of a Urinary Catheter Passport:** Aim of project was to provide improved communication regarding care of catheters at home, thereby reducing the risk of infection and increasing patient involvement in their care. **Update:** The passport has been launched. The work undertaken by Rachel has resulted in a change of supplier to ensure continuity of product from hospital to community. The company now supplying the equipment have also agreed to meet the cost of the passport

	production.
Kate McCrystal, Business Analyst	**Improvement of the utilisation of Paediatric Outpatients slots**. Aim of project was to provide a better service for users, reduce DNA rates and waiting times and improve data quality. **Update:** Project helped to support the development of the 'Courtesy Callers' scheme now in place which continues to see a positive impact on DNAs.
Shilpa Patil, Specialty Doctor	**Review of the Rapid Access Clinic venue for patients referred to ENT post trauma via A&E**. Current provision only on the Warrington site. **Update:** The project is looking at moving one of these to the Halton site to provide patients access to services closer to home.
Alysha Budd, Specialist Orthoptist	**Improving Staff Confidence to make every contact count**. **Update:** Embedding health promotion messages into patient contact, linked with 'Every Contact Counts'.
Sandra Caine, Emergency Nurse Practitioner	**Discharging patients with IVs into community to avoid unnecessary admission**. Focus is on the upskilling of staff within the Runcorn Urgent Care Centre to prepare them for the implementation of the IV therapy pathways. **Update:** The work undertaken has now extended to other pathways. Staff have been identified, trained and been provided with the opportunity to work in Warrington ED to practice skills. Further upskilling for Urgent Care Staff has been provided resulting in patients receiving timely treatment they require before being transferred to Warrington for admission if required. The IV drug therapy aspect has been less successful due to the lack of capacity within the community teams to accept these patients. This has resulted in some being admitted unnecessarily (particularly during out of hours and at weekends).
Rebecca Hossbach, Acting Matron	**Recruitment improvement for Acute Care Services.** The aim of the project was to ensure that we recruit the right staff in the right place at the right time. **Update:** This project is now part of the trust wide recruitment and retention project.
Karen Lord, Deputy Clinical Lead in Ultrasound	**Revision of information provided to patients booked in for ultrasound outpatient appointments** The aim was to ensure that patients attend at right time, correct site and prepared for procedure.

	Update: This project resulted in a change to the appointment letters in Ultrasound which provide clearer information on pelvic preparation prior to scan and also makes it clearer which hospital site to attend. Anecdotally, there has been an improvement. Currently in the process of collecting data for DNA rates and patient preparation time to support this.
Andrea Reynolds, Acute Care Nurse Specialist	**Looking at issue of inappropriate MET calls to Acute Care team following observations of patients on wards.** **Update:** The results to date have been varied mainly due to a high turnover of new staff and increased number of MET calls in general. However a teaching programme around recording of NEWS in progress of rolling out by the team and continued monitoring of MET calls and appropriate education provided as required.
Lindsay Watkinson, Advanced Practice Radiographer	**Improving the AQ Pneumonia pathway within Radiology**. Looking at X-ray section of pneumonia care pathway to ensure trust meets required timescales for procedure. **Update:** Compliance of 1 hour timescales has reached 80% (10% increase in baseline figure). Documentation of delays compliance rose from 6% to 45%.
James Whitfield, Exercise Physiologist, Cardiac Rehabilitation	**Review of Fitness Test prior to Cardiac Rehabilitation.** Testing a patient's cardiovascular fitness prior to starting Cardiac Rehab, gives the service a bench mark and helps in the design of exercises chosen. For patients it helps to motivate them once the test is repeated post rehab. Currently the test doesn't challenge every patient and doesn't give the service a relevant measure for all patients to help us design a programme. **Update:** The proposal is to bring in a cycle test, which gives us a test that challenges all patients. A further benefit to this change is that the functional test can be delivered in a smaller room, increasing capacity to deliver to more patients, which can help to lower waiting times.
Rupali Gleeson, Senior Radiographer	**Improving Access to Breast Screening Services for All.** The project aim is to increase the levels of dignity within Breast Screening and also provide women with additional support needs increased support to the service. Women, with Learning Difficulties and other Additional Support Needs were not always receiving the support they needed to either have Breast Screening or an alternative method of screening. **Update:** New processes have been put in place to provide

	gowns for all women accessing the service and women with Additional Support Needs are provided with a longer appointment time at a static site where more staff and resources are available. The Breast Screening team are also working with the Safeguarding Liaison Nurse to work with the clients to increase the chances of a successful process. Moving forward, Standard Operating Procedures for women with additional support needs are being developed to ensure consistency and further audits planned to ascertain success.
David Kelly, Governance & Patient Safety Support Officer	**Review of the Duty of Candour Reporting Procedure.** It is essential that we give patients/their families and advocates, truthful, accurate, and timely information when their treatment or care does not go to plan or when unintended or unexpected incidents occur. Through this project, I aim to be able to ensure Duty of Candour is completed and evidenced within 10 working days for all appropriate incidents. By not complying with this, there is a reputational risk that the trust is not being open and honest with patients. Prior to this project, the trust was unable to fully monitor Duty of Candour compliance. Issues with Duty of Candour can lead to anxiety for patients and families, in which some cases can be extremely damaging for trust reputation. I aim to have 100% compliance for all incidents appropriate for Duty of Candour to be applied. **Update:** We are consistently achieving 100% compliance for Duty of Candour; this is evidenced on Datix and shown on the trust dashboard. Duty of Candour is now monitored on a weekly basis.
Robert Gargon, Specialist Orthoptist	**Improve Attendance Figures in Orthoptic clinics.** Attendance to our clinics is particularly important for children as they have a visual development period until approximately the age of 7 years of age. This means that if certain visual problems are not treated within this period then their vision will remain poor for the rest of their lives. Our worst DNA rates are as high as 40%. I am to reduce this to <35% in the first instance by October 2017. I hope to achieve this by improving our communication with parents and offering appointments at more convenient times for parents. **Update:** First evening clinic held, 100% attendance. Great feedback received, 5 out of 6 requested similar time for next appointment. To date, there have been 6 evening clinics with 30 patients

	booked, 28 have attended, 2 DNAs giving an attendance rate of 92% and a DNA rate of 8%. I have been doing call reminders a week in advance for the regular afternoon clinics for the last couple of months and the DNA rates are lower for June, July and August in comparison to last year. I set out to reduce the DNA rate from 40% last year to <35% by October and it is currently at 34% so on track.
Local Quality Initiatives that are due to commence in 2018/19	
Pearl Arnold, Sister, SAU	Patients admitted to SAU via A&E may already have had analgesia. PGD not appropriate if patient has already had analgesia, therefore a change to medication chart is needed. Multimodal ladder of analgesia commended in A&E to continue.
Emma Child, Librarian, KES	Requests for literature searches from Acute Care less than other divisions. Looking at ways to raise awareness and support for CBUs.
Louise Critchley, Midwife	Focussing on safeguarding aspects in Community Midwifery.
Rebecca Di Scala, Sister, ITU	Review of information for relatives about ICU. Change from information booklets to a computer screen in relatives' room.
Paula Edge, Specialist Nurse Practitioner, Ophthalmics	To improve the quality of our Ophthalmic service that grows to meet the needs of our ophthalmic patients, by the department being more efficient and the team having improved knowledge.
Debra Fenney, Staff Nurse, Ward B4	To review the literature provided to patients having undergone day surgery at Halton.
Susan Lynam, Staff Nurse B1 Halton	Reduction in depression medication by providing earlier discharge and increased participation in activity on intermediate care ward.
Anais Mason, Sister Ward A1	Skin Bundle - To develop the right paperwork that will deliver the right care to our patients.
Kate McKendrick, Staff Nurse, Ward A5	The process for highlighting available beds is very much a lengthy exercise with numerous calls and different phone calls all day. The same question is asked. We can standardise and streamline the interactions to improve patient flow to become proactive rather than reactive.

	Staff becoming very stressed regarding the duplication of information requested regarding beds.
Sharron Neilson, Nurse Manager, A&E	Review of the turnaround time for emergency ambulance handovers in ED.
Lynn Shaw, Sister Ward A3	Review of communication in respect of discharge plans, providing time for a MDT drop in session for discussion and questioning.
Melanie Thompson, Staff Nurse, Ward A7	To ensure that all patients requiring oxygen have it prescribed and delivered correctly and safely. All patients requiring oxygen will have a wristband applied with target saturations.

A special mention goes Quality Improvement Champion Lorna Smith, ENT Nurse Specialist who also won the Excellence in Innovation, Improvement and Efficiency Award in the 2018 staff Thank You awards for her work regarding the Implementation of a Tracheostomy Passport.

The aim of the project is to improve education and communication with tracheostomy patients in the community. By implementing a tracheostomy passport with daily guidance and a log of tracheostomy tube changes. It aims to reduce the number of un-necessary hospital attenders and admissions for patient with a blocked tracheostomy tube.

Tracheostomy passports have now been printed and handed out to patients with an audit due to be commenced to assess if the patient has brought their passport into hospital.

- New community supplies company (countrywide) – with home delivery service
- Ongoing change in policy for tracheostomy training for staff- working with physio
- Ongoing development of Discharge SOP for tracheostomy patients
- A laryngectomy passport is in the process of being implemented with additional support for Speech and language therapist Heather Harrison which is awaiting ratification
- A tracheostomy clinic has being established for any tracheostomy patients needing tube changes/ education/support.
- Tracheostomy link group meets quarterly for cohort wards- physio, S&LT, critical care outreach, A7,A8, ITU, A&E and theatre – community nurses have also been invited and they meet to discuss trache related issues/ training/ equipment etc.
- In progress to locate Warrington care homes for trache patients
- E-learning package available for trache training – additional training to support tracheostomy training simulation day
- Trache competencies developed for staff who have attended trache training day
- Attended patient first exhibition- shared tracheostomy passport with other NHS trusts- Wales, Ormskirk, Aintree, Liverpool Royal and Northern Ireland.

3.12 Patient Stories - In their own words… our patients share their experiences of our Trust

Patient J's Story;

'I was admitted to Warrington Hospital in October 2017 with stomach pain which was diagnosed 2 weeks later as a collapsed bowel. Due to being 23 weeks pregnant I spent those interim 2 weeks being cared for by the maternity unit, with a significant portion spent on the Delivery Suite.

Although all the staff we encountered during my staff were kind and compassionate people. Both my husband and I agreed that the care given by our midwife, Laura, was exceptional. Considering that my condition would ordinarily have been dealt with by the surgical team and was I imagine, outside of the usual scope of the midwife role, her calm competence made us feel as at ease as possible during a very confusing and worrying time.

It was Laura who was present on my final morning on the Delivery Suite when I was eventually diagnosed and taken for my surgery. Despite the department being busy as always, I will never forget how she stayed with me while I tried to comprehend the consent forms and implications of the surgery for myself and my baby. I truly felt like she had nowhere else in the world more important to be.

I have an enormous list of general surgeons, obstetricians, midwives, healthcare assistants, physiotherapists and nurses to whom I am indebted and in awe of saving not only my life but my dream of being a mum.'

The Parents Story;

'Our baby has attended Warrington Hospital Children's Ward since he was 6 months old due to severe kidney problems.

From being admitted via A&E following various GP visits the Children's Ward Staff took us under their wing and took a huge weight off our shoulders instantly on admission. They all listened to us as, parents knowing our son best, and knew something wasn't right.

The staff from Auxiliaries, nursing assistants, nurses, staff nurses, sisters, doctors and consultants were all very welcoming, attentive, caring, listened to us and nothing was a problem for any requests we had.

If it wasn't for the GREAT team you have there we dread to think what story be would be telling.'

3.13 Performance against key national priorities (Please see table below)

Performance against the relevant indicators and performance thresholds set out in Appendix A of Monitor's risk assessment framework'. Where any of these indicators have already been reported on in Part 2 of the quality report, in accordance with the Quality Accounts Regulations, they do not need to be repeated here.

Mar-18

Monitor Access Targets & Outcomes - 2017/18

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Target or Indicator		Threshold	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	N/A	79.01%	81.45%	79.37%		79.67%	79.36%	78.53%		75.02%	73.86%	75.80%		82.72%	79.67%	77.72%	
	Non-admitted patients	95%	N/A	92.78%	95.02%	92.46%		92.27%	92.07%	92.92%		92.05%	91.62%	92.25%		92.05%	91.50%	92.32%	
	Incomplete Pathways	92%	1.0	92.71%	93.48%	92.86%		92.95%	92.83%	92.06%		92.29%	92.60%	92.33%		92.69%	92.82%	92.35%	
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	91.41%	92.81%	90.38%	91.55%	92.82%	94.39%	90.93%	92.71%	89.47%	87.50%	83.78%	86.88%	85.56%	83.51%	81.95%	83.74%
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0 (Failure for either = failure against the overall target)	84.00%	64.20%	79.78%	75.00%	87.88%	81.71%	85.71%	84.86%	87.50%	82.50%	91.04%	86.73%	85.58%	80.26%	86.15%	84.08%
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	90%		100.00%	100.00%	100.00%	100.00%	100.00%	96.30%	100.00%	98.41%	90.91%	91.67%	100.00%	93.18%	95.45%	100.00%	100.00%	98.39%
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		82.00%	69.14%	78.05%	75.59%	85.94%	79.27%	82.09%	82.16%	87.50%	84.42%	91.04%	87.50%	88.35%	80.26%	95.31%	87.65%
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.91%	91.67%	100.00%	93.18%	95.45%	94.44%	100.00%	96.83%
All Cancers:31-day wait for second or subsequent treatment	Surgery	>94%	1.0 (Failure for any of the 3 = failure against the overall target)	87.50%	91.67%	100.00%	91.89%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	97.32%
	Anti Cancer Drug Treatments	>98%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Radiotherapy (not performed at this Trust)	>94%																	
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	94.64%	95.24%	100.00%	96.91%	98.41%	98.53%	100.00%	98.93%	98.15%	98.39%	100.00%	98.76%	98.59%	95.00%	100.00%	97.89%
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.95%	93.93%	95.18%	94.33%	94.53%	93.00%	94.10%	93.84%	93.73%	93.44%	95.38%	94.10%	92.31%	93.35%	94.02%	93.34%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		79.59%	88.16%	92.00%	87.50%	93.44%	94.94%	95.16%	94.55%	94.29%	81.63%	93.42%	90.77%	93.55%	98.31%	94.44%	95.43%

Target or Indicator		Threshold	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Clostridium Difficile - Hospital acquired **(CUMULATIVE)**	Due to lapses in care	27 (for the Yr)	1.0 **	0	0	0	0	0	0	0	0	1	2	2	2	2	2	2	2
	Not due to lapses in care			1	4	4	4	5	7	11	11	11	13	14	11	14	14	14	14
	Cumulative Total (including: due to lapses in care, not due to lapses in care, and cases under review)			1	4	4	4	5	7	11	11	12	15	16	16	19	21	24	24
	Under Review	Cumulative Qtr1: 7 Qtr2: 14 Qtr3: 21 Qtr4: 27		0	0	0	0	0	0	0	0	0	0	0	0	3	5	8	8
Service Performance Score				**5.0**	**5.0**	**3.0**	**4.0**	**1.0**	**2.0**	**1.0**	**2.0**	**1.0**	**3.0**	**1.0**	**2.0**	**2.0**	**3.0**	**1.0**	**2.0**

NHS foundation trusts failing to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters, will trigger a governance concern, potentially leading to investigation and enforcement action

18 Weeks Referral to Treatment

Performance is measured on an aggregate (rather than specialty) basis and NHS foundation trusts are required to meet the threshold on a monthly basis.

Consequently, any failure in one month is considered to be a quarterly failure for the purposes of the Risk Assessment Framework.

Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process.

Failure against any threshold will score 1.0, but the overall impact will be capped at 2.0

**** Clostridium Difficile**

Monitor's annual de minimis limit for cases of C-Diff is set at 12. However, Monitor may consider scoring cases of <12 if Public Health England indicates multiple outbreaks

Monitor will assess NHS foundation trusts for breaches of the C. difficile objective against their objective at each quarter using a cumulative year-to-date trajectory.

Criteria	Will a score be applied
Where the number of cases is less than or equal to the de minimis limit	No
If a trust exceeds the de minimis limit, but remains within the in-year trajectory# for the national objective	No
If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective	Yes
If a trust exceeds its national objective above the de minimis limit	Yes

Assessed at: 25% of the annual centrally-set objective at quarter 1; 50% at quarter 2; 75% at quarter 3; and 100% at quarter 4 (all rounded to the nearest whole number, with any ending in 0.5 rounded up).

Monitor will not accept a trust's own internal phasing of their annual objective or that agreed with their commissioners.

The above Referral to Treatment targets include non NHS commissioned pathways. The nationally published Referral to Treatment figures shows that as a Trust we achieved a year end result of 92.35%. Monthly data is as follows;

Incomplete Pathways All Patients	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% <18 weeks	92%	92.71%	93.48%	92.86%	92.95%	92.83%	92.06%	92.29%	92.60%	92.33%	92.69%	92.82%	92.35%

Month	%<4HRs (inc Widnes Walk-in)	%<4HRs (exc Widnes Walk-in)
Apr	91.41%	90.32%
May	92.81%	91.93%
Jun	90.38%	89.16%
Jul	92.82%	91.81%
Aug	94.39%	93.68%
Sep	90.93%	89.55%
Oct	89.47%	88.08%
Nov	87.50%	85.70%
Dec	83.78%	80.58%
Jan	85.56%	82.99%
Feb	83.81%	80.54%
Mar	81.95%	78.56%
Total	88.67%	87.00%

The table above details ED 4hr performance including and excluding the Widnes walk-in centre activity.

3.14 Governors' visits

The Governors' Council has initiated a series of unannounced visits to ward and department areas to observe issues of care and treatment in order to provide assurance to them and, importantly, to their constituents about the quality of service provided by the Trust.

A summary, provided by the Trust's Lead Governor, is available within section 4.

3.15 Training & Appraisal

Training and Appraisal Completion

	Target	**Year End Results**
Mandatory Training		
Health & Safety	85%	88.20%
Fire Safety	85%	79.86%
Manual Handling	85%	87.49%
Additional Fire Safety and Manual Handling sessions are in place to improve these figures.		
Staff Appraisal		
Non-medical		
Medical & Dental staff	85%	90%
Medical & Dental (excluding consultants)		
Consultants		

Each division are now being performance monitored on a monthly basis to identify improvements they have made to compliance with training requirements. Divisions have been reminded of the need to make further progress and Clinical Leads will be giving this matter greater priority.

3.16 Quality Report request for External Assurance

Warrington and Halton NHS FT has requested the Trust auditors Grant Thornton UK LLP to undertake substantive sample testing of two mandated indicators and one local indicator (as selected by the governors) included in the quality report as follows;

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

VTE (Venous thromboembolism).

Annex 1 Quality Report Statements

Statements from Clinical Commissioning Groups, Healthwatch and Overview and Scrutiny Committees 2017/2018

Statements from the following stakeholders are presented within this document unedited by the Trust and are produced verbatim.

1.1 Statement from Warrington Clinical Commissioning Group

NHS
Warrington
Clinical Commissioning Group

Arpley House
110 Birchwood Boulevard
Arpley House
Birchwood
Warrington
WA3 7QH

www.warringtonccg.nhs.uk

☎ 01925 843690
Please Ask For: Dawn Chalmers
E-mail:dawn.chalmers@nhs.net

Our ref : DC/SLL

Date : May 2018

Ms M Pickup
Chief Executive
Warrington & Halton Hospitals NHS
Foundation Trust
Warrington Hospital
Lovely Lane
Warrington
Cheshire

Dear Mel

Quality Accounts 2017 – 2018

I am writing to express my thanks for the submission of Warrington and Halton Hospitals NHS Foundation Trust Quality Report for 2017-2018 and for the presentation given by Kimberley Salmon-Jamieson, Chief Nurse and John Goodenough, Deputy Chief Nurse to local stakeholders on 30th May 2018. This letter provides the response from NHS Warrington Clinical Commissioning Group to the Quality Report 2017-2018.

NHS Warrington CCG understands the pressures and challenges for the Trust and the local health economy in the last year and would like to congratulate and thank the Trust for the level of partnership working and support throughout the year.

NHS Warrington CCG noted the Priorities and progress made in 2017 – 2018:

Priority 1 – Patient Safety – to reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks. It was noted that this priority is supported via the Patient Safety indicators relating to Safer Surgery, Falls and Sepsis. All three patient safety indicators have aimed to reduce harm and focus on no avoidable deaths.

Priority 2 – Clinical Effectiveness – to improve outcomes, based on evidence and deliver care in the right place, first time, and every time. It was noted that this priority is supported via the Clinical Effectiveness indicators relating to Safe Discharge, Mortality and Lessons Learned. All three clinical effectiveness indicators have aimed to improve outcomes based on evidence and deliver care in the right place, first time, every time.

Priority 3 – Patient Experience – to focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and the trust have aimed to get the basics right so that patients will be warm, clean, and well cared for. It was noted that this priority was supported via the Patient Experience indicators relating to Mental Health, PALs & Complaints and Patient Experience Strategy implementation plan roll out. All three Patient Experience indicators have aimed to improve outcomes based on the patient

Stakeholders acknowledged the update with regard to the Care Quality Commission (CQC) Inspection which took place in 2017 in which they assessed the quality and safety of the care provided by the trust, based on the things that matter to people. They looked at whether your services are safe; effective; caring; responsive to people's needs and well-led and the Trust was given an overall rating of 'requires improvement' following a series of announced and unannounced inspections by the CQC. However stakeholders would have liked to have seen more of this reflected within the account.

Stakeholders noted that improvements have been made in mental health attendance at Accident and Emergency, sepsis care, complaint handling and falls and whilst this is positive, it was clear to see that the Trust recognise now that this improvement journey needs to be sustained and continue.

NHS Warrington CCG noted the Trusts Improvement Priorities for 2018 – 2019:

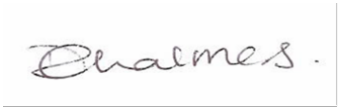
- Priority 1 – To reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.
- Priority 2 – To improve outcomes, based on evidence and deliver care in the right place, first time, every time.
- Priority 3 – To focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, well fed and well cared for.

The areas the Trust have chosen to focus on as priority areas are; making adult areas more child friendly, Improve Rapid Discharge Process for End of Life Care patients, Bereavement Services, Safer Surgery, E-Prescribing, Increase Incident Reporting, Diagnostics, Ward Accreditation and Discharge summaries and we look forward to progress made in these areas over the coming year.

NHS Warrington CCG recognises the challenges for providers in the coming year but we look forward to working with the Trust during 2018-2019 to deliver continued improvement in service quality, safety and patient experience and also on the partnership work as we move forward with our Warrington Together model of service delivery.

NHS Warrington CCG would like to congratulate the trust on the hard work of its staff and their commitment to the care of the people of Warrington thanking local staff and managers for their on-going commitment locally and for the opportunity to comment on the draft Quality Account for 2017/2018.

Yours sincerely



Deputy Chief Nurse
Quality Lead

1.2 Statement from Halton Clinical Commissioning Group

NHS
Halton Clinical Commissioning Group

First Floor
Runcorn Town Hall
Heath Road
Runcorn
Cheshire
WA7 5TD

Tel: 01928 593479
www.haltonccg.nhs.uk

21st May 2018

Ms M Pickup
Chief Executive
Warrington and Halton Hospitals NHS
Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Dear Mel,

Quality Accounts 2017 - 2018

I am writing to express my thanks for the submission of Warrington and Halton Hospitals NHS Foundation Trust Quality Report for 2017-2018 and for the presentation given by Kimberley Salmon-Jamieson, Chief Nurse and Ursula Martin, Director of Governance to local stakeholders on 8th May 2018. This letter provides the response from NHS Halton Clinical Commissioning Group to the Quality Report 2017-2018.

NHS Halton CCG understands the pressures and challenges for the Trust and the local health economy in the last year and would like to congratulate and thank the Trust for the level of partnership working and support in this year.

NHS Halton CCG noted the Priorities and progress made in 2017 – 2018:

Priority 1 – Patient Safety – to reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks. It was noted that this priority is supported via the Patient Safety indicators relating to Safer Surgery, Falls and Sepsis. All three patient safety indicators have aimed to reduce harm and focus on no avoidable deaths.

Priority 2 – Clinical Effectiveness – to improve outcomes, based on evidence and deliver care in the right place, first time, and every time. It was noted that this priority is supported via the Clinical Effectiveness indicators relating to Safe Discharge, Mortality and Lessons Learned. All three clinical effectiveness indicators have aimed to improve outcomes based on evidence and deliver care in the right place, first time, every time.

Priority 3 – Patient Experience – to focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and the trust have aimed to get the basics right so that patients will be warm, clean, and well cared for. It was noted that this priority was supported via the Patient Experience indicators relating to Mental Health, PALs & Complaints and Patient Experience Strategy implementation plan roll out. All three Patient Experience indicators have aimed to improve outcomes based on the patient and their experience.

Stakeholders acknowledged the update with regard to the Care Quality Commission (CQC) Inspection which took place in 2017 in which they assessed the quality and safety of the care provided by the trust, based on the things that matter to people. They looked at whether your services are safe; effective; caring; responsive to people's needs and well-led and the Trust was given an overall rating of 'requires improvement' following a series of announced and unannounced

Stakeholders noted that improvements have been made in urgent and emergency care, maternity outpatients and diagnostics and critical care and whilst this is positive, it was clear to see that the Trust recognise now that this improvement journey needs to be sustained and continue. The launch of the Getting to Good, Moving to Outstanding Programme was welcomed and seen as an area of good practise.

NHS Halton CCG noted the Trusts Improvement Priorities for 2018 – 2019:

- Priority 1 – To reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.
- Priority 2 – To improve outcomes, based on evidence and deliver care in the right place, first time, every time.
- Priority 3 – To focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, well fed and well cared for.

The areas the Trust have chosen to focus on as priority areas are; making adult areas more child friendly, Improve Rapid Discharge Process for End of Life Care patients, Bereavement Services, Safer Surgery, E-Prescribing, Increase Incident Reporting, Diagnostics, Ward Accreditation and Discharge summaries and we look forward to progress made in these areas over the coming year.

NHS Halton CCG recognises the challenges for providers in the coming year but we look forward to working with the Trust during 2018-2019 to deliver continued improvement in service quality, safety and patient experience and also on the partnership work as we move forward with our One Halton model of service delivery.

NHS Halton CCG would like to congratulate the trust on the hard work of its staff and their commitment to the care of the people of Halton thanking local staff and managers for their on-going commitment locally and for the opportunity to comment on the draft Quality Account for 2017/2018.

Yours sincerely,

Michelle Creed.

Michelle Creed
Chief Nurse

1.3 Statement from the Halton Health Policy Performance Board

HALTON
BOROUGH COUNCIL

Ms M Pickup
Chief Executive
Warrington and Halton Hospitals NHS
Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Our Ref	DD/WHHFT
If you telephone please ask for	Debbie Downer
Your ref	
Date	14th May 2018
E-mail address	Debbie.downer @halton.gov.uk

Dear Ms Pickup

Quality Accounts 2017 - 2018

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 10th May that your colleagues Kimberley Salmon-Jamieson and Ursula Martin attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

During the year 2017/18 the Board were pleased to note that the Trust made progress against the following areas;

Patient Safety;

- Safer Surgery - Evidence of avoidable harm, attitudes and practices need to change to promote safer surgery and invasive procedures. The introduction of a Safety Culture Initiative focussing on clinical and non-clinical areas.
- Falls - Reduce injurious inpatient falls and increase the reporting of patient falls. A 12% reduction in falls was reported.
- Sepsis – Reducing the impact of serious infections (Antimicrobial resistance and Sepsis). There was a significant improvement in patients screened and treated for sepsis within an hour.

Clinical Effectiveness;

- Mortality – Monitor and improve mortality rates. HSMR and SHMI mortality rate consistently remains within the 'as expected' range.

Patient Experience;

- Mental Health – Improving services for people with mental health needs who present to A&E. Achieved a reduction of attendance to ED by 42% with a cohort of patients who frequently attend by multi-disciplinary working and identifying appropriate care in the community.

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www.halton.gov.uk

HALTON
BOROUGH COUNCIL

The Board are pleased to note the following Improvement Priorities for 2018 – 2019:

Priority 1 – Patient Safety;

- Safer Surgery - Ensure that the Trust fully embraces the culture of safer surgery in theatres and in those areas that undertake invasive procedures.
- E-Prescribing – Improving patient safety by decreasing prescribing errors and saving time and resource.
- Increase Incident Reporting – Learn from mistakes and make changes to protect patients from harm.

Priority 2 - Clinical Effectiveness and Outcomes;

- Diagnostics – Review policies and roll out training.
- Ward Accreditation – To engage staff and empower leadership.
- Discharge – Improve the quality and timeliness of discharge summaries.

Priority 3 - Patient Experience

- Making adult areas within the hospital more child friendly to increase the overall experience for patients/relatives/public.
- Improve the Rapid Discharge Process for End of Life Care patients.
- Ensure that Bereavement Services are equipped to provide a caring and compassionate service, offering support and reassurance, information and guidance.

The Board were also interested to hear of Warrington and Halton Hospitals NHS Foundation Trust's plans to expand the discharge lounge.

The Board would like to thank Warrington and Halton Hospitals NHS Foundation Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Councillor Joan Lowe
Chair, Health Policy and Performance Board

It's all happening **IN HALTON**
Communities Directorate
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
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1.4 Statement from Warrington Healthwatch

Healthwatch Warrington
The Gateway
89 Sankey Street
Warrington
WA1 1SR
Tel 01925 246892

contact@healthwatchwarrington.co.uk
www.healthwatchwarrington.co.uk

18th May 2018

Re: Healthwatch Warrington's Response to Warrington and Halton Hospitals NHS Foundation Trust's Draft Quality Account 2017 - 2018 (May 2018)

Healthwatch Warrington is pleased to have the opportunity to review Warrington and Halton Hospitals' 2017 – 2018 Quality Account (QA) and reflect on the current and future priorities in the document.

As Warrington's consumer champion for health and social care, we recognise the impact that patient experiences have in shaping the quality and safety of services. It is positive to see that the QA has a clear focus from the start - to ensure that quality is a fundamental component within the Trust. The statement from the Chief Executive gives thanks to the commitment and hard work of staff within the Hospitals, which is a sentiment often shared through the feedback we receive as a Healthwatch. The Chief Executive also acknowledges that there are areas where the Trust is not meeting its targets e.g. 4 hour targets within A&E, which are discussed later in the QA. The Trust is also acknowledged as working on a programme towards achieving good (and thereafter outstanding) status as a Trust, which is again a focus for the general public following the published 'Requires Improvement' rating by the CQC.

Looking back at the Trust's performance in relation to its priorities in 2017 – 2018, we are pleased to see that different areas of improvement have been acknowledged within Safety, Clinical Effectiveness and Patient Experience, and these have been identified in partnership with other individuals, stakeholders and members. Though Healthwatch is not referenced here, we are one of many local partners who have continued to engage with the Trust via sub-groups throughout 2017/18, and have supported development of the Trust's Patient Experience Strategy and Quality themes through our involvement.

The report format looks to be clearer and more readable than in previous years, with some terms and phrases better explained and detailed, which is to be commended. Inclusion of a Glossary within the QA is also welcomed, but could benefit from reference throughout the document to ensure reader comprehension. There are still some terms, however, that could benefit from a more simple explanation within the Glossary e.g. MSSA, to move away from clinical terminology and make it more meaningful for readers, as this is a public document.

In regards to Safety (Priority 1), the QA indicates that the Trust is working towards a Safety Culture Initiative to incorporate national and local learning, with a feedback process to ensure learning and outcomes are shared more effectively. Falls are also identified as an area of progress, with 868 recorded throughout the year - the QA states that a proportion of falls resulted in serious or moderate harm, which must be adequately addressed to reduce this risk in future. The QA shows a 12% reduction in all falls recorded since 2016/17, and a 14% reduction in ward only falls, above the target of a 10% reduction. Serious incident review themes are insightful here, highlighting trends around; assessments, use of equipment, ambiguity re: enhanced care provision, and areas of increased risk within the Trust. The QA highlights an increase in falls noted in Q4 2018 on a number of wards (seemingly attributed to equipment and assessments) which requires further work to prevent this continuing into next year. There must also be work to reduce inconsistency across wards to ensure any trends like this are effectively addressed. Falls Champions on wards are a positive step, as is training alongside this. Though falls are not an ongoing priority for 2018/19, we hope that this work continues and progress made will be maintained and further built upon. Sepsis focus has continued throughout the year, with guidelines, awareness raising and training. Sepsis Nurses are key to helping support this work and continuing this success for future years, as is highlighted by the results and screening success so far.

The QA highlights that in 2017 – 2018 in Clinical Effectiveness (Priority 2), the Trust continues to focus on Safe and Effective Discharge for patients, through partner work (e.g. Bridgewater) outside of the Trust. There is some reference given to delayed discharge but further detail and interrogation of this data could identify themes and any gaps in awareness of services or provision. A key area of understanding and measuring safety and quality of service is also seen through lessons learned from deaths and serious incidents. The QA in Priority 2 focusses on policy and implementation of the revised national mortality review processes, which will be used to inform change for patients and focus on avoidable deaths. It is also identified that earlier recognition of end of life could have been put into place prior to patients dying, which is an area for future improvement, with an aim to enhancing on the Lessons Learned Framework in the last priority.

Patient Experience (Priority 3), highlights that the Trust is working to respond better and more effectively to complaints, with focus on patient-centred care through 'No decision about me without me'. It would be useful here to have complaints data to compare the Trust's performance against 2016/17, and to see how current focus has affected change. Though some examples are given re: learning from complaints e.g. End of Life Care, staff attitude, it would be beneficial to also see overall trends and themes across the Trust. We, as a Healthwatch, look forward to working with the Trust's Head of Patient Experience and Complaints Manager in future, and will continue to share our intelligence to work towards positive outcomes for patients. The Trust QA overall makes limited reference to support for Carers, which Healthwatch is aware is an essential element in Hospital. We also know that support available to carers (e.g. discharge support, parking) must be shared and promoted

widely to enhance carer (and patient) experience while receiving care. Hopefully this will be considered moving forwards. This Priority refers to attendance of patients with mental health needs at A&E, and shows a significant decline throughout 2017/18. Though there is reference within the QA to working alongside this patient cohort to more effectively support needs and achieve better outcomes, there should also be focus given as to why patients are attending A&E (to help identify any gaps in provision e.g. after hours support). Though figures show a decline by up to 65.5% in Q3, there is a need to ensure that patients with mental health needs no longer attending A&E are still effectively and safely supported by other services.

Moving forwards into 2018 – 2019, it's positive to see that the Trust continues to focus on Safety through; avoidable deaths, safer surgery, medicines optimisation (and reduction in errors), and increasing incident reporting to promote a learning culture. The Trust will continue to focus on Effectiveness moving forwards through; diagnostics and sharing good practice through ward accreditation, alongside a continued focus on discharge. Patient experience will also continue to develop through; Rapid Discharge for patients at end of life, as well as compassionate care, support, advice and guidance from bereavement services. Each priority is clearly identified with; clear rationale, what success will look like, how it will be implemented, and details on how it will be measured. This will be helpful to review at a glance in next year's QA.

Some detail within the QA is not included e.g. Impact (following on from actions undertaken) in Learning from Deaths, which is key to understand and measure quality of service, with 1,118 patient deaths occurring throughout 2017/18. As such, we are unable to comment on this area within the QA. Similarly, some data from Q2, Q3 and Q4 from 2017/18 re: tables and benchmarking for SHMI, Palliative Care Coding, and data for PROMS is not included, so we are unable to comment on the Trust's performance in relation to previous years and benchmarked against National data. This is also the case for Emergency Readmissions to Hospital, and the National Inpatient Survey – personal needs, where data is not given for 2017/18, and as such we are unable to comment on this area. Certain Patient Safety data for 2017/18 re: C Diff per 100,000 bed days is not provided, nor is Patient Safety Incidents (Rate of incidents per 1,000 bed days), or the Patient Safety Incidents Severe Harm/Death Rate and as such we are unable to provide comment on how the Trust compares with the National picture in these tables. Priority 3 focusses on Patient Experience for the forthcoming year, including PHSO data of complaints. This data is unavailable for 2017/18 (due to be published in Sept 2018) but current information available in the QA indicates approximately 20 ongoing complaints per quarter with around 2 received by the PHSO per quarter. If this is correct, it could indicate reductions on 2016/17 figures but this cannot be confirmed until final data is published, and as such, we are unable to comment.

The National Inpatient Survey 2017 (published but under embargo) indicates a 35% response rate, a 5% decrease compared to last year. It indicates that the Trust has performed well in some areas including; reduced time waiting to get a ward bed (a move of 3.5%), enough staff support to eat meals (an increase of 4.6%), and enough nurses on duty (an increase of 7.6%). Respondents also felt that staff worked and

communicated better (both with patients and each other), including timely notice of discharge. Pain management was felt to be better supported and medication purpose, guidance, and awareness of side effects were all an improvement on last year, which is positive. Patients also fed back, however, that there were some key areas for improvement – 53.3% felt they were able to find someone to talk to about worries or concerns, a reduction of 1.1% since last year. Patients also fed back that they experienced delays in discharge (for medications, ambulances etc) more than in the previous year (a change of 0.4%), while discharges delayed by no more than 4 hours decreased by 3.9%. Patients also fed back that they were not as informed about danger signals of their conditions to look out for (with a decrease of 4.2%). We hope priorities for 2018/19 will look to address the areas which have performed less favourably.

The QA refers to Care Opinion and their 5 'star rating' to measure patient feedback, yet there is no reference to similar rating systems used by Healthwatch Warrington, Halton, and neighbouring Healthwatch. In future this data could also be used to inform the QA. The Trust has a clear focus on developing quality with Local Quality Initiatives, using leads within the Trust workforce and clear implementation and updates for each area e.g. Implementation of a Urinary Catheter Passport. Successful partner work around Tracheostomy care is also positive, both within and beyond the Trust. There is mention of some positive patient stories and feedback, though some more examples of how poor experience have informed change would also be beneficial. Lastly, the QA highlights the Trust's Performance against key national priorities at a glance – performance against the A&E 4 hour target has fallen continually below the 95% target. Though this is a national issue, we hope the Trust will continue to address this moving forwards. Around 5-6 months out of 12 also fall below the national targets of the 62 day wait for first treatment of all cancers (85%), for both pre and post local breach re-allocation, which must be addressed. Referral to treatment waiting time for admitted and non-admitted patients also consistently falls below the targets of 90% and 95% respectively. Next year's progress to address these objectives will be key to ensuring the Trust can perform more in line with future targets and better support patients.

Overall the QA shows a willingness to learn and develop but there are some areas which require more in-depth information and detail to quantify this and understand how the Trust will measure progress and improvements. In the year ahead, we look forward to supporting public engagement and strengthening the voice of patients, carers and relatives by encouraging public participation in events both by and including the Trust, including our annual Healthwatch Quality Accounts Involvement Day. We look forward to hearing from the Trust and being involved in future developments.

Yours faithfully,

Lydia Thompson
Chief Executive Officer
Healthwatch Warrington

1.5 Statement from Warrington Health and Well Being Overview and Scrutiny Committee

This statement was requested but not received.

1.6 Statement from the Halton Healthwatch

Commentary on Warrington & Halton Hospitals NHS FT
Quality Account 2018-19

We welcome this opportunity to provide a commentary on Warrington & Halton Hospitals NHS Foundation Trust Quality Account for 2018-19.

The Trust is to be congratulated on a comprehensive report which gives a good overview of the work carried out by the Trust to improve the quality of its services. For clarity though we feel that a highlighted statement as to whether priority targets for the previous year were 'fully met', 'partially met' or 'not met' would be of benefit to the reader.

In responding to this year's Quality Account we have tried to answer the following questions:

1. Does the draft Quality Account reflect people's real experiences as told to local Healthwatch by service users and their families and carers over the past year?

2. From what people have told Healthwatch Halton, is there evidence that any of the basic things are not being done well by the provider?

3. Is it clear from the draft Quality Account that there is a learning culture within the Trust that allows people's real experiences to be captured and used to enable the provider to get better at what it does year on year?

4. Are the priorities for improvement as set out in the draft Quality Account challenging enough to drive improvement and it is clear how improvement has been measured in the past and how it will be measured in the future?

From the feedback we've received on the Trust through our website feedback centre, and during our outreach work in the local community, we believe that overall this year's Quality Account reflects people's real experiences of using the service.

We are pleased to note the three improvement priorities for 2017-18 have been carried forward to be the priorities for 2018-19.

We welcome the good clear explanation on the action taken by the Trust to reduce the number of outstanding complaints that were over 6 months old. In our role on the Trust's Patient Experience Sub Committee we have noticed the willingness to learn and improve from the complaints brought to the Trust during the past 12 months.

The work that has taken place to reduce incidents of sepsis within the trust during the past year is also to be praised.

The Quality Account states that, *'Like many Trusts we do not have a clear understanding of the numbers of patients harmed by sepsis'.* We would like to see the Trust complete its work on the sepsis - themed mortality review as soon as possible and we look forward to seeing further improvements recorded in the next Quality Account.

While it appears that the Trust gets the basics right most of the time, from the feedback we've received from the public we feel there is still room for improvement in a number of areas.

We'd like to see continued improvement in the discharge of patients. We noted the that the Trust had failed to reach the target they had aimed for of, *'over 47.5% of patients being discharged to their usual place of residence within 3-7 days of admission of patients aged 65+ admitted via a non-elective route'*. At the end of 2017/18 they were achieving 41.41% of patients being discharged.

The improvement in the timeliness of responses to complainants from 26.7% in Q1 to 50.4% in Q4 is big step in the right direction. While this is a very positive sign we'd like to see a definite timescale given for the Trust to reply to 100% of complainants on time rather than the vague statement included in the report of *'we will work toward 100% of responding to our complainants in time'.*

We noted that only 22.9% of patients received information on how to complain to the hospital if needed. This seems a very low figure. From information collected by the Healthwatch network, we know that people are often unsure how to make a complaint about a service. If only 1 in 5 people are given this information by the Trust this situation is unlikely to improve.

Under the NHS Standard Contract there is a requirement for a provider to *'provide clear information to Service Users, their Carers and representatives, and to the public, displayed prominently in the Services Environment as appropriate, on how to make a complaint or to provide other feedback and on how to contact Local Healthwatch.'* We would be willing to work with the Trust to help improve this figure over next 12 months.

We note the inclusion in the report of patient feedback ratings collected via NHS Choices and Care Opinion. As an addition we would suggest that the Trust work with Healthwatch Halton and Healthwatch Warrington to include the patient feedback ratings collected by both Healthwatch.

From the information to hand in the draft copy of the Quality Account, and our experience of working with the Trust this year and in previous years, we feel the priorities for improvement as set out in the draft Quality Account offer a realistic opportunity to drive improvement. We also believe it is generally clear from reading the

Quality Account how improvements have been measured in the past and how they will be measured for these priorities.

During the next 12 months we will continue to offer challenge to the Trust on key priorities and work with it wherever we can to help improve the experience of patients who use both local hospitals.

Kind regards

Dave Wilson & Jude Burrows
Healthwatch Halton Quality Account Leads

21 May 2018

1.7 Statement from the Trust's Council of Governors 2017/2018

Statement from the Trust's Council of Governors 2017/2018

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Account for 2017/18.

The Quality Report is very detailed and thorough and assists the Governors in holding the Non-Executive Directors to account for the performance of the Board of Directors.

As Governors one of our prime roles, is to focus on quality. As part of the Council's governance structure it meets regularly at its Governor Quality in Care Group. At the Governor Quality in Care Group, the Governors receive the latest performance information and have the chance to analyse it and raise questions.

The formal public governor's council meeting programme is a small part of the governors' work in the trust. The Governors have a number of committees which they lead on, which allows them to bring information and views to the main council meeting. Other agenda items include updates from those committees and other topics of interest.

The Governors strongly support the emphasis on patient safety, patient experience and clinical effectiveness documented throughout the Quality Report. Patients, their relatives, carers and the hospital's key stakeholders have all identified these as three areas of paramount importance.

For the coming year, the Governors agree with the priorities established. The Patient Safety Priority relating to increasing incident reporting will ensure that we don't miss opportunities to learn from mistakes and will allow the Trust to make changes to protect patients from harm. The Patient Experience Priority to make adult areas more child friendly will increase the overall experience for patients, relatives and the public. Finally, Governors see the Clinical Effectiveness Priority regarding the implementation of the new WHH Ward Accreditation Scheme as an important initiative that the Trust is establishing to improve the experience for both patients and staff alike.

The Governors are happy that the 2017/18 Quality Report provides data that is more meaningful, understandable and clearer to all, the report shows indicating trends, and comparisons with the previous year statistics. For the coming year the Governors will review the Quality Report quarterly at our Quality in Care Group thus being up to date through out the year.

Governors find the format and section headings helpful. The Quality Report contains considerable detail commensurate with the complex and diverse range of services provided by an Acute Hospital Trust. The Governors believe the Quality Report to be accurate. The graphs and accompanying explanations help the public and members to understand clearly the progress made in many areas of patient safety and patient care.

Governors encourage all Trust members and others who are interested in our hospitals and their performance to read the Quality Report.

Annex 2: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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 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 date of signing this statement
    - Papers relating to Quality reported to the Board over the period April 2017 to date of signing this statement
    - Feedback from the Commissioners, Warrington Clinical Commissioning Group dated May 2018 and Halton Clinical Commissioning Group dated 21st May 2018
    - Feedback from Governors dated May 2018
    - Feedback from local Healthwatch organisations, Healthwatch Halton dated 22nd May 2018 and Healthwatch Warrington dated 18th May 2018
    - Feedback from Overview and Scrutiny Committee was requested but no response received
    - Feedback from Halton Borough Council dated 16th May 2018
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2018
    - The 2017 national inpatient survey under embargo until June
    - The 2017 national staff survey published 2018
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2018
    - CQC inspection report dated November 2017

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with 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

Date..... **ON BEHALF OF** Steve McGuirk **Chairman**

24.5.18

24 May 2018..... Mel Pickup **Chief Executive**

[NB: sign and date in any colour ink except black]

Independent Auditor's Limited Assurance Report to the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust on the Annual Quality Report.

Independent Practitioner's Limited Assurance Report to the Council of Governors of Warrington and Halton NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Warrington and Halton NHS Foundation Trust to perform an independent limited assurance engagement in respect of Warrington and Halton NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report ") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

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

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge
- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

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

Respective responsibilities of the directors and Practitioner

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 2017/18' and supporting guidance 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 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; 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 2017/18' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' 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 1 April 2017 to 25 May 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 25 May 2018;
- feedback from commissioners dated 21/05/2018;
- feedback from local Healthwatch organisations dated 18/5/2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated April 2018;
- the national patient survey 2017;
- the national staff survey 2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment for 2017/18; and
- the Care Quality Commission inspection report dated 27/11/2017.

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

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Warrington and Halton NHS Foundation Trust as a body, to assist the Council of Governors in reporting Warrington and Halton 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 that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Warrington and Halton NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- 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 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Warrington and Halton NHS Foundation Trust.

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

Basis for qualified conclusion

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

- Accuracy – our testing identified 3 cases out of the 25 cases tested where the clock stop date had been recorded incorrectly.
- Validity – our testing identified 2 cases out of the 25 cases tested where the cases should not have been included within the indicator per the national definition.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 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 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP

4 Hardman Square
Spinningfields
Manchester, M3 3EB

25th May 2018

Appendix

Glossary

Appraisal	method by which the job performance of an employee is evaluated
Care quality commission (CQC)	Independent regulator of all health and social care services in England. They inspect these services to make sure that care provided by them meets national standards of quality and safety.
Clinical audit	Is a process that has been defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Clinical commissioning group (CCCG)	Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Clostridium difficile (C diff)	A Clostridium difficile infection (CDI) is a type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital. (CMCLRN) Cheshire and Merseyside Comprehensive Local Research Network
Commissioning for Quality and Innovation (CQUIN)	This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
Friends and Family test (FFT)	Since April 2013, the following FFT question has been asked in all NHS Inpatient and A&E departments across England and, from October 2013, all providers of NHS funded maternity services have also been asking women the same question at different points throughout their care : "How likely are you to recommend our [ward/A&E department/maternity service] to friends and family if they needed similar care or treatment?"
Governors	Governors form an integral part of the governance structure that exists in all NHS foundation trusts; they are the direct representatives of local community interests in foundation trusts
Healthwatch	Healthwatch is a body that enables the collective views of the people who use NHS and social care services to influence policy.
Healthcare evaluation data (HED)	Clinical benchmarking system to support clinical experts in more effective management of clinical performance.
Hospital episode statistics (HES)	Is a database containing information about patients treated at NHS providers in England.
Hospital Standardised Mortality Review	Is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

(HSMR)	
Information governance	Ensures necessary safeguards for, and appropriate use of, patient and personal information.
Mandatory training	The Organisation has an obligation to meet its statutory and mandatory requirements to comply with requirements of external bodies e.g. Health & Safety Executive (HSE), training is provided to ensure that staff are competent in statutory and mandatory
MRSA	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
MSSA	Methicillin-sensitive *Staphylococcus aureus* (MSSA) is a bacteraemia caused by Staphylococcus aureus which is a serious infection associated with high morbidity and mortality and often results in metastatic infections such as infective endocarditis, which have a negative impact on patient outcomes
National confidential enquiries (NCEPOD)	The purpose of NCEPOD is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by: reviewing the management of patients; undertaking confidential surveys and research; by maintaining and improving the quality of patient care; and by publishing and generally making available the results of such activities.
NHS Improvement	NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
National inpatient survey	Collects feedback on the experiences of over 64,500 people who were admitted to an NHS hospital in 2016.
National institute for health and clinical excellence (NICE)	Is responsible for developing a series of national clinical guidelines to secure consistent, high quality, evidence based care for patients using the National Health Service.
National institute of health research (NIHR)	Organisation supporting the NHS.
National patient safety agency (NPSA)	Lead and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.
National reporting and learning system (NRLS)	Is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.
Never Events	Are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHS outcomes framework	Reflects the vision set out in the White Paper and contains a number of

	indicators selected to provide a balanced coverage of NHS activity. To act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.
Open and Honest	North of England Trusts produces and publishes monthly reports on key areas of healthcare quality.
Palliative care	Focuses on the relief of pain and other symptoms and problems experienced in serious illness. The goal of palliative care is to improve quality of life, by increasing comfort, promoting dignity and providing a support system to the person who is ill and those close to them.
Patient Reported Outcome Measures (PROMs)	Provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life.
Payment by results (PBR)	Provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for case mix.
Safety thermometer	Is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
Summary hospital-level indicator (SHMI)	reports mortality at trust level across the NHS in England using standard and transparent methodology.
Urinary tract infection (UTI)	is an infection that affects part of the urinary tract
Venous thromboembolism (VTE)	A venous thrombosis or phlebothrombosis is a blood clot (thrombus) that forms within a vein. A classical venous thrombosis is deep vein thrombosis (DVT), which can break off (embolize), and become a life-threatening pulmonary embolism (PE).

Trust name:	Warrington and Halton Hospitals NHS Foundation Trust
This year:	2017/18
This year ended:	31 March 2018
This year beginning:	1 April 2017

Foreword to the accounts for the year 1 April 2017 to 31 March 2018

Warrington and Halton Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Warrington & Halton Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Mel Pickup
Chief Executive
24-May-18

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	2017/18 £000	2016/17 £000
Income from activities	3	209,235	202,832
Other operating income	3	25,496	30,490
Operating income	3	**234,731**	**233,322**
Operating expenses	4	(246,412)	(237,930)
OPERATING DEFICIT		**(11,681)**	**(4,608)**
FINANCE INCOME / (EXPENSE)			
Finance income - interest receivable	7	30	20
Finance expense - interest payable	8	(536)	(461)
PDC dividends payable		(2,465)	(3,010)
NET FINANCE COSTS		**(2,971)**	**(3,451)**
Net losses on disposal of assets	9	(4)	(201)
DEFICIT FOR THE FINANCIAL YEAR		**(14,656)**	**(8,260)**
Other comprehensive expense			
Items that will not be reclassified to income and expenditure			
Net impairment losses on property, plant and equipment	10	8,229	(11,791)
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(6,427)**	**(20,051)**
Allocation of losses for the period			
(a) Deficit for the period attributable to:			
(i) non-controlling interest, and		0	0
(ii) owners of the parent.		(14,656)	(8,260)
TOTAL		**(14,656)**	**(8,260)**
(b) Total comprehensive expense for the period attributable to:			
(i) non-controlling interest, and		0	0
(ii) owners of the parent.		(6,427)	(20,051)
TOTAL		**(6,427)**	**(20,051)**

The notes on pages 5 to 37 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

	NOTE	31 March 2018 £000	31 March 2017 £000
NON-CURRENT ASSETS			
Intangible assets	11	2,461	2,308
Property, plant and equipment	12	126,634	117,890
Trade and other receivables	15	907	991
Total non-current assets		**130,002**	**121,189**
CURRENT ASSETS			
Inventories	14	3,264	3,437
Trade and other receivables	15	11,969	13,163
Cash and cash equivalents	17	2,209	1,201
Total current assets		**17,442**	**17,801**
CURRENT LIABILITIES			
Trade and other payables	18	(23,209)	(19,338)
Borrowings	20	(14,665)	(454)
Provisions	22	(420)	(279)
Other liabilities	19	(2,361)	(1,137)
Total current liabilities		**(40,655)**	**(21,208)**
Total assets less current liabilities		**106,789**	**117,782**
NON-CURRENT LIABILITIES			
Borrowings	20	(22,238)	(28,152)
Provisions	22	(1,315)	(1,377)
Total non-current liabilities		**(23,553)**	**(29,529)**
TOTAL ASSETS EMPLOYED		**83,236**	**88,253**
TAXPAYERS' EQUITY			
Public dividend capital		89,152	87,742
Revaluation reserve		30,707	22,478
Income and expenditure reserve		(36,623)	(21,967)
TOTAL TAXPAYERS' EQUITY		**83,236**	**88,253**

The primary accounts on pages 1 to 4 and the notes on pages 5 to 37 were approved by the Board of Directors on 24 May 2018 and signed on its behalf by Mel Pickup, Chief Executive.

Signed:  Date: 24 May 2018

Mel Pickup
Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2018

	Total Taxpayers' Equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity as at 1 April 2017	88,253	87,742	22,478	(21,967)
Deficit for the year	(14,656)	0	0	(14,656)
Transfers between reserves	0	0	0	0
Net impairment losses on property, plant and equipment	8,229	0	8,229	0
Revaluation gains on property, plant and equipment	0	0	0	0
Public Dividend Capital received	1,410	1,410	0	0
Public Dividend Capital repaid	0	0	0	0
Taxpayers' equity as at 31 March 2018	**83,236**	**89,152**	**30,707**	**(36,623)**

	Total Taxpayers' Equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity as at 1 April 2016	108,304	87,742	34,269	(13,707)
Deficit for the year	(8,260)	0	0	(8,260)
Transfers between reserves	0	0	0	0
Net impairment losses on property, plant and equipment	(11,791)	0	(11,791)	0
Revaluation gains on property, plant and equipment	0	0	0	0
Public Dividend Capital received	0	0	0	0
Public Dividend Capital repaid	0	0	0	0
Taxpayers' equity as at 31 March 2017	**88,253**	**87,742**	**22,478**	**(21,967)**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating deficit from continuing operations		**(11,681)**	**(4,608)**
Non-cash income and expense			
Depreciation and amortisation	4	5,583	5,102
Impairments	4	(449)	3,007
Income recognised in respect of capital donations	3	(59)	(114)
(Increase) / decrease in trade and other receivables	15	982	(4,122)
(Increase) / decrease in inventories	14	173	(2)
Increase / (decrease) in trade and other payables	18	4,452	(3,414)
Increase / (decrease) in other liabilities	19	1,224	(955)
Increase / (decrease) in provisions	22	79	(42)
Other movements in operating cash flows		18	23
Net cash used in operations		**322**	**(5,125)**
Cash flows from investing activities			
Interest received	7	30	20
Purchase of intangible assets	11	(808)	(558)
Purchase of property, plant and equipment	12	(4,749)	(4,017)
Sales of property, plant and equipment		0	74
Receipt of cash donations to purchase capital assets	3	59	114
Net cash used in investing activities		**(5,468)**	**(4,367)**
Cash flows from financing activities			
Public Dividend Capital received		1,410	0
Movement in loans from Department of Health and Social Care	20	8,645	11,811
Capital element of finance lease	20	(347)	(337)
Interest paid	8	(505)	(446)
Interest element of finance lease	8	(25)	(37)
Public Dividend Capital dividend paid		(3,024)	(2,881)
Net cash used in financing activities		**6,154**	**8,110**
Increase / (Decrease) in cash and cash equivalents		1,008	(1,382)
Cash and cash equivalents as at 1 April		1,201	2,583
Cash and cash equivalents as at 31 March	17	**2,209**	**1,201**

NOTES TO THE ACCOUNTS

1. Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. 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 accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

Going concern

The Trust must, in preparing the annual statement of accounts, undertake an assessment of its ability to continue as a going concern. In making this assessment, the Trust should take into account all information about the future that is available at the time at which the judgement is made.

The draft 2018/19 Annual Plan was submitted to NHSI on 8 March 2018. The final 2018/19 Annual Plan was submitted on 30 April 2018.

The preparation of the income statement, cash flow statement and the resulting statement of financial plan is predicated on a number of national and local factors and assumptions regarding both income and expenditure and profiled accordingly.

The planned level of activity undertaken for its commissioners and therefore the planned level of income is derived after due consideration of a range of factors, including:

- 2017/18 forecast outturn
- Changes in demography and demand
- National Payment by Results rules and regulations
- Changes to national tariff structure and prices
- Commissioning Intentions
- Receipt of Provider Sustainability Funding

The day to day operations of the Trust are funded from agreed contracts with NHS commissioners. The uncertainty in the current economic climate has been mitigated by agreeing a number of contracts with Clinical Commissioning Groups, Local Authorities and NHS England for a further year and these payments provide a reliable stream of funding minimising the Trust's exposure to liquidity and financing problems.

The planned expenditure within the approved plan is derived after due consideration of a range of factors, including:

- Pay awards and incremental increases
- National Insurance and pension contribution changes
- Current budgetary pressures
- Inflationary increases for insurance premiums, drugs, utilities and general non pay
- Financial consequences of both capital and revenue developments
- Cost savings requirements
- Impact of activity levels and commissioning intentions

1 Going concern (continued)

The main financial headlines resulting from application of the above factors that form the basis of the final 2018/19 Annual Plan are as follows:

- A planned deficit of £24.6m
- No Provider Sustainability Funding received
- Cost savings target totalling £7.0m (equivalent to 3.0% of turnover)
- Current working capital loans totalling £65.6m (this is comprised of a £14.2m loan in 2015/16, a £7.9m loan in 2016/17, a £16.8m loan in 2017/18 and a £24.4m loan in 2018/19 to support planned and actual deficits together with a £2.3m loan in 2017/18 to support aged creditors). The 2015/16 loan is due for repayment in November 2018 and a replacement loan will be required.
- Capital expenditure totalling £10.0m
- Planned closing cash balance of £1.2m (in line with the terms and conditions of the working capital loan)

The Trust believes that it has been realistic in its assessment of efficiency targets and therefore believes that this forward plan provides a realistic assessment of the Trust's position in 2018/19.

Cash flow statements take into account the planned deficit, capital expenditure, repayment of Public Dividend Capital and movements in working balances.

Notwithstanding the 2018/19 planned deficit referred to above, the Trust does not have any evidence indicating that the going concern basis is not appropriate as the Trust has not been informed by NHS Improvement that there is any prospect of intervention or dissolution within the next 12 months.

In terms of the sustainable provision of services, there has been no indication from the Department of Health that the Trust will not continue to be a going concern although the Trust does require a working capital loan to meet its operational cash obligations.

The Directors will seek additional support from the Department of Health for 2018/19 of £24m. The Department of Health has not confirmed this support with this factor representing a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. However, the Directors, having made appropriate enquiries, have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

The Board will consider for 2018/19 a resolution enabling the Chief Executive to draw down loans within defined parameters, as recommended by the Department of Health, to assist the Trust in accessing working capital finance once the board have agreed the loan value as appropriate.

As directed by the 2018/19 Department of Health Group Accounting Manual the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

1.1 Key sources of judgement and estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the judgements that management have made in the process of applying the Trust's accounting policies, together with the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting period that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

1.1 Key sources of judgement and estimation uncertainty (continued)

Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

The pension provision relating to former employees, including directors, has been calculated using the life expectancy estimates from the Government's actuarial tables.

The legal claims provision relates to employer and public liability claims and expected costs are advised by the NHS Resolution. The Trust accepts financial liability for the value of each claim up to the excess defined within the policy.

Provision for impairment of receivables

A provision for impairment of receivables has been made for amounts which are uncertain to be received from NHS and non-NHS organisations as at 31 March 2018. The provision includes 22.84% (22.94% for 2016/17) of accrued Injury Cost Recovery (ICR) income to reflect the average value of claims withdrawn as advised by the Department of Health's Compensation Recovery Unit (CRU).

Asset valuations and lives

The value and remaining useful lives of land and building assets are estimated by Cushman & Wakefield who provide professional valuation services. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. Valuations are carried out primarily on the basis of Depreciated Replacement Cost based on modern equivalent for specialised operational property (property rarely sold on the open market) and Current Value in Existing Use for non-specialised operational property.

The Trust commissioned Cushman & Wakefield to provide a 'desk top' revaluation for land and buildings and a review of asset lives for buildings as at 1 April 2017 and 31 March 2018, on the basis that a reprovision of services would be provided from a single site.

The changes following revaluation have been reflected with the 2017/18 annual accounts. A full asset valuation is undertaken every five years with an annual 'desk top' valuation being undertaken in the intervening years. Market Value was used in arriving at fair value for the assets subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

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.

Software licences are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Employee benefits

The cost of annual leave entitlement not taken is accrued at the year end. Accruals are calculated using actual entitlement outstanding for Trust employees based on actual point of their salary band (Note 5.1).

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable.

The main source of income for the Trust is from NHS commissioners, mainly Clinical Commissioning Groups (CCGs), for the provision of healthcare services. This income is recognised on discharge of patient for all NHS commissioners.

1.2 Income (continued)

Where income is received for a specific activity that is to be delivered in a future financial year that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

The Trust receives income under the (ICR) Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for example by an insurer. The Trust recognises the income when it receives notification from the Department of Health's CRU 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 to reflect the average value of claims withdrawn.

The main sources of other operating income are from the Department of Health, Health Education England, NHS Trusts, NHS Foundation Trusts and Local Authorities.

1.3 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the accounts 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.

1.3 Expenditure on employee benefits (continued)

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 to be carried out as at 31 March 2016 and is currently being prepared. 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.

1.4 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 a non-current asset such as an intangible asset or an item of property, plant and equipment.

1.5 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset, if it meets the above conditions.

Measurement

Intangible assets are initially recognised 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 replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of International Accounting Standard (IAS) 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.5 Intangible assets (continued)

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.6 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 will be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
  - collectively, a number of items which have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
  - items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

The whole of a site is designated as the property asset with the land, the separate buildings upon it and the external works being the main components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment is initially measured at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and where it would meet the location requirements of the service being provided an alternative site valuation can be used. The Trust commissioned Cushman & Wakefield to undertake a 'desk top' valuation and review of assets lives as at 1 April 2017 and further review of values as at 31 March 2018, on the basis that a reprovision of services would be provided from a single site. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of Financial Position date. Fair values are determined as follows:

- Land and non specialised buildings - market value for existing use.
- Specialised buildings - depreciated replacement cost.
- Equipment - depreciated historical cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

1.6 Property, plant and equipment (continued)

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenses.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income / expenses'.

Impairments

At the end of the financial year the Trust reviews whether there is any indication that any of its assets have suffered an impairment loss. If there is an 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.

In accordance with the GAM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses, and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenditure 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, such as unforeseen obsolescence, are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains and classed as 'other operating income'.

1.6 Property, plant and equipment (continued)

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales and the sale must be highly probable i.e. management are committed to a plan to sell the asset, an active programme has begun to find a buyer and complete the sale, the asset is being actively marketed at a reasonable price, the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

Donated, government grant and other grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation / grant is credited in full to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation / grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Contingent rents are recognised in operating expenses in the period in which they are incurred.

1.7 Leases (continued)

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula, which is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.9 Cash and cash equivalents

Cash is defined as 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 the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. Interest earned on bank accounts is recorded as interest receivable in the periods to which it relates. Balances exclude monies held in bank accounts belonging to patients (Note 17).

1.10 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount, for which it is probable that there will be a future outflow of cash or other resources, and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk adjusted cash flows are discounted using HM Treasury's discount rates. Early retirement provisions and injury benefit provisions have both been discounted using the HM Treasury's pension discount rate of 0.10% (0.24% in 2016/17) in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution (Note 4) to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to operating expenses. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is not recognised in the Trust's accounts (Note 22).

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions and any excesses payable in respect of successful claims are charged to operating expenses as and when the liability arises.

1.11 Value added tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.12 Corporation tax

Warrington and Halton Hospitals NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is temporarily exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA). Accordingly, the Trust will become within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare and where the profits exceed £50,000 per annum. However, there is no tax liability in respect of the current financial year (£nil in 2016/17).

1.13 Foreign exchange

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expenditure in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.14 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with requirements of HM Treasury's FReM (Note 17).

1.15 Public dividend capital (PDC) and PDC dividend

PDC is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.50%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (ii) average daily cleared cash balances held with Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the unaudited version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.16 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in operating expenses 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).

However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.17 Consolidation

The Trust is the corporate Trustee to Warrington & Halton Hospitals NHS FT Charitable Fund. The Trust has assessed its' relationship to the charitable fund and determined it to be 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 effect 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 Financial Reporting Standard (FRS) 102.

The Trust has opted not to consolidate charitable funds with the main Trust Accounts in 2017/18 because they are immaterial. This will be reviewed each year for appropriateness.

1.18 Other subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published accounts of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains / losses are eliminated in full on consolidation.

Subsidiaries classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

1.19 Interests in other entities

Associates

Associate entities are those over which the Trust has the power to exercise a significant influence and are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trusts share of the entities profit or loss or other gains and losses (e.g. revaluation gains on the entities property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g. share dividends are received by the Trust from the associate.

Associates which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.19 Interests in other entities (continued)

Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

Joint operations

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

1.20 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities that arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases (Note 1.7).

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

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

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

Classification and measurement

Financial assets are categorised as fair value through income and expenditure, loans and receivables or available-for-sale financial assets.

Financial liabilities are classified as fair value through income and expenditure or as other financial liabilities.

Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. The Trust does not hold any financial assets or financial liabilities at fair value through income and expenditure.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market and are included in current assets.

The Trust's loans and receivables comprise: a working capital loan and capital loan from the Department of Health, cash at bank and in hand, NHS receivables and part of accrued income and other receivables.

1.20 Financial instruments and financial liabilities (continued)

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

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

The Trust does not hold any available-for-sale financial assets.

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.

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 the Statement of Comprehensive Income.

Impairment of financial assets

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of the impaired receivables provision account (Note 15).

At each period end the Trust reviews trade receivables for recoverability and makes a provision for those debts which it believes recovery of the amount outstanding is doubtful. Receivables deemed irrecoverable are written off on a quarterly basis and reported to the Trust's Audit Committee.

1.21 Reserves

Public dividend capital

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

1.21 Reserves (continued)

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 also recognised in operating expenses. 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.

1.22 Segmental reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The Trust's chief operating decision maker, responsible for providing strategic direction and decisions, allocating resources and assessing performance of the operating segments, is the Board of Directors.

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

1.24 Accounting standards and interpretations issued but not yet adopted

The GAM does not require the following Standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19.

IFRS 9 (Financial Instruments) - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 15 (Revenue from Contracts with Customers) - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS - International Financial Reporting Standard

2. Operating segments

The Trust has considered segmental reporting and the Chief Executive and the Board receive sufficient and appropriate high level information to enable the business to be managed effectively and to monitor and manage the strategic aims of the Trust. Sufficiently detailed information is used by middle and lower management to ensure effective management at an operational level. Neither of these are sufficiently discrete to profile operating segments,as defined by IFRS 8, that would enable a user of these financial statements to evaluate the nature and financial effects of the business activities that this Trust undertakes. Therefore, the Trust has decided that it has one operating segment for healthcare.

3. Operating income

3.1 Operating income : by nature	2017/18 £000	2016/17 £000
Income from activities		
Elective income	33,477	36,566
Non elective income	62,154	59,260
Outpatient income	33,082	35,082
A & E income	13,371	11,698
Other NHS clinical income	65,969	58,934
Income for non-commissioner requested services		
Private patient and overseas patients income	108	98
Other non-protected clinical income	1,074	1,194
Total income from activities	**209,235**	**202,832**

3.2 Operating income : by source	2017/18 £000	2016/17 £000
Income from activities		
NHS England	15,789	13,708
Clinical Commissioning Groups	188,328	184,582
NHS Foundation Trusts	778	732
NHS Trusts	9	1
Local Authorities	1,995	1,996
Department of Health and Social Care	0	0
NHS Other	248	270
Non NHS : private patients	50	54
Non NHS : overseas patients	58	44
Injury cost recovery scheme	1,074	1,194
Non NHS Other	906	251
Total income from activities	**209,235**	**202,832**

All income from activities relates, in its entirety, to continuing operations for 2017/18 and 2016/17.

3. Operating income (continued)

3.3 Overseas visitors (relating to patients charged directly by the Trust)

	2017/18 £000	2016/17 £000
Income recognised this year	58	44
Cash payments received in-year	61	32
Amounts added to provision for impairment of receivables	0	6
Amounts written off in-year	0	10

3.4 Other operating income

	2017/18 £000	2016/17 £000
Education and training	9,480	8,636
Education and training - Notional income from apprenticeship fund	31	0
Cash donations / grants for the purchase of assets	59	114
Non-patient care services to other bodies	593	827
Sustainability and transformation fund	4,298	9,891
Income in respect of staff costs where accounted on gross basis	2,248	2,540
Rental revenue from operating leases	233	231
Other *	8,554	8,251
Total other operating income	**25,496**	**30,490**

All other operating income relates, in its entirety, to continuing operations for 2017/18 and 2016/17.

*** Analysis of other operating income 'other'**		
Car parking	1,863	1,808
Catering	173	178
Pharmacy sales	48	673
Property rentals	29	120
Staff accommodation rentals	42	120
Estates recharges	815	910
Information Technology recharges	392	190
Clinical tests	1,727	1,764
Other	3,465	2,488
Total other operating income 'other'	**8,554**	**8,251**

3.5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of Trust failure. This information is provided in the table below:-

	2017/18 £000	2016/17 £000
Income from services designated as commissioner requested services	208,053	201,540
Income from services not designated as commissioner requested services	1,182	1,292
Total	**209,235**	**202,832**

3.6 Fees and charges

There have been no fees and charges, the aggregate of all schemes that, individually, have had a cost exceeding £1m in either 2017/18 or 2016/17.

4. Operating expenditure

4.1 Operating expenses	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	485	335
Purchase of healthcare from non-NHS and non-DHSC bodies	0	417
Staff and executive directors costs	173,717	164,137
Remuneration (non-executive directors)	115	110
Supplies and services (clinical; excluding drug costs)	19,772	19,349
Supplies and services (general)	2,599	2,497
Drug costs	16,587	15,999
Consultancy costs	1,000	933
Establishment	2,056	1,970
Premises (business rates)	1,067	983
Premises (other)	7,307	7,676
Transport (business travel only)	279	281
Transport (including patient travel)	629	581
Depreciation on property, plant and equipment	4,928	4,550
Amortisation on intangible assets	655	552
Net impairments	(449)	3,007
Increase in impairment of receivables	111	60
Change in provisions discount rate	14	100
Audit services (statutory audit)	58	62
Other auditor remuneration (external auditor only) - analysis in note 4.2	6	7
Internal audit costs	95	95
Clinical negligence premiums	11,592	10,557
Legal fees	211	200
Insurance	92	98
Education and training - non-staff	962	919
Education and training - notional expenditure funded from apprenticeship fund	31	0
Operating lease expenditure	1,987	2,002
Redundancy	39	123
Losses and special payments	221	19
Other expenditure	246	311
Total operating expenses	**246,412**	**237,930**

All operating expenses relate, in their entirety, to continuing operations for 2017/18 and 2016/17.

4.2 Other audit remuneration

The total paid to the Trust's external auditors for other remuneration amounted to £6k (2016/17 £7k).

4.3 Limitation on auditor's liability

The external auditors' liability is limited to £2m. The scope of work for the external auditors is to provide a statutory audit of annual accounts and report and provide opinion on them to the Trust and the Trust's Council of Governors. This will be conducted in accordance with the Audit Code for NHS Foundation Trusts (the Audit Code) issued by Monitor in accordance with paragraph 24 of schedule 7 of the National Health Service Act 2006 schedule 10 of the National Health Service Act 2006 with due regard to the Comptroller and Auditor General's Code of Audit Practice (the Code) issued by the National Audit Office (NAO) in April 2015.

5. Staff

5.1 Employee expenses

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	128,145	122,832
Social security costs	11,922	11,480
Apprenticeship levy	586	0
Pension costs (employer contributions to NHS Pensions)	14,201	13,389
Pension costs (other)	16	0
Termination benefits	138	123
Bank and agency staff	18,906	16,609
Total employee benefit expenses	**173,914**	**164,433**
Less costs capitalised as part of assets	(158)	(173)
Total per employee expenses in Note 4.	**173,756**	**164,260**

Employee costs include staff costs of £158k (£173k in 2016/17) which have been capitalised as part of the Trust's capital programme. These amounts are excluded from employee expenses (Note 5.1). The employee expenses table above is for executive directors, staff costs and redundancy payments only. It excludes non-executive directors.

An accrual in respect of the cost of annual leave entitlement carried forward at the Statement of Financial Position date of £123k has been provided for within the accounts (£360k as at 31 March 2017).

5.2 Early retirements due to ill-health

One member of staff retired early on ill-health grounds during the year at an additional cost of £106k (two members of staff at a cost of £191k for the year ending 31 March 2017). The cost of ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

6. Operating leases

6.1 Operating lease income

	2017/18 £000	2016/17 £000
Lease receipts recognised as income in the year	233	231
Total	**233**	**231**

Future minimum lease receipts due:	2017/18 £000	2016/17 £000
- Not later than one year	195	213
- Later than one year and not later than five years	781	775
- Later than five years	6,512	6,695
Total	**7,488**	**7,683**

6.2 Operating lease payments and commitments

Lease payments recognised as an expense in year:	2017/18 £000	2016/17 £000
Minimum lease payments	1,959	1,976
Contingent rents	28	26
Total	**1,987**	**2,002**

Future minimum lease payments due	2017/18 £000	2016/17 £000
On land leases:		
Not later than one year	94	94
Later than one year and not later than five years	204	288
Later than five years	0	10
Total	**298**	**392**
On building leases:		
Not later than one year	174	171
Later than one year and not later than five years	692	684
Later than five years	1,253	1,411
Total	**2,119**	**2,266**
On other leases:		
Not later than one year	1,610	1,638
Later than one year and not later than five years	3,601	4,563
Later than five years	4,629	5,544
Total	**9,840**	**11,745**
On all leases:		
Not later than one year	1,878	1,903
Later than one year and not later than five years	4,497	5,535
Later than five years	5,882	6,965
Total	**12,257**	**14,403**

7. Finance revenue

	2017/18 £000	2016/17 £000
Interest on bank accounts	30	20
Total	**30**	**20**

8. Financing expenditure

8.1 Finance expenditure

	2017/18 £000	2016/17 £000
Capital Loans with the Department of Health	26	27
Working Capital Loans with the Department of Health	407	395
Interest on Finance Lease Obligations	25	36
Interest on Late Payment of Debt	72	3
Interest other	6	0
Total interest expense	**536**	**461**
Unwinding of discount on provisions	0	0
Other finance costs	0	0
Total finance expenditure	**536**	**461**

8.2 The Late Payment of Commercial Debts (Interest) Act 1998

The total paid within 2017/18 for late payment of commercial debt was £72k (£3k in 2016/17).

9. Other Gains / (Losses)

	£000	2016/17 £000
Gains on disposal of other property, plant and equipment	0	45
Losses on disposal of other property, plant and equipment	(4)	(246)
Total net losses on disposal of assets	**(4)**	**(201)**

10. Impairment of assets

	2017/18		
Impairments due to change in market price:	**Net Impairments £000**	**Impairments £000**	**Reversals of Impairments £000**
Loss or damage from normal operations	0	0	0
Unforseen obsolescence	0	0	0
Loss as a result of a catastrophe	146	146	0
Change in market price	(595)	646	(1,241)
	(449)	792	(1,241)
Impairments charged to operating expenses			
Impairments charged to the revaluation reserve	(8,229)	1,251	(9,480)
Total impairments due to change in market price	**(8,678)**	**2,043**	**(10,721)**

	2016/17		
Impairments due to change in market price:	**Net Impairments £000**	**Impairments £000**	**Reversals of Impairments £000**
Loss or damage from normal operations	0	0	0
Unforseen obsolescence	0	0	0
Loss as a result of a catastrophe	0	0	0
Change in market price	3,007	3,023	(16)
	3,007	3,023	(16)
Impairments charged to operating expenses			
Impairments charged to the revaluation reserve	11,791	14,605	(2,814)
Total impairments due to change in market price	**14,798**	**17,628**	**(2,830)**

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 insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. Valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Current Value in Existing Use for non-specialised operational property.

The Trust instructed Cushman & Wakefield to provide a full revaluation of land and buildings as at 1 April 2017. The changes have been reflected with the 2017/18 annual accounts. A further 'desk top' revaluation exercise, including an assessment of asset lives in respect of buildings, was completed by Cushman & Wakefield with a prospective date of 31 March 2018, which was applied to the accounts on 31 March 2018. Both these valuations were carried out on the basis that the Trust's services could be reprovided for on a single site.

A full asset valuation is undertaken every five years with an annual 'desk top' valuation being undertaken in the intervening years. Any increase in valuation which reverses a previous impairment has been credited to other operating income, to the extent of what has been charged there already relating to the asset. Any remaining balance has been credited to the revaluation reserve.

The Trust suffered a fire in its Kendrick Wing on 23 March 2018. Cushman & Wakefield undertook additional valuations of this element of the Warrington site with the resulting impairment in value of the building being reflected in the impairment figures in note 10.

11. Intangible assets

	Software licences £000
Cost as at 1 April 2017	**3,702**
Additions - purchased	808
Additions - donated	0
Impairments	0
Disposals	0
Cost as at 31 March 2018	**4,510**
Accumulated amortisation as at 1 April 2017	**1,394**
Provided during the year	655
Disposals	0
Accumulated amortisation as at 31 March 2018	**2,049**
Cost as at 1 April 2016	**3,161**
Additions - purchased	558
Additions - donated	0
Impairments	0
Disposals	(17)
Cost as at 31 March 2017	**3,702**
Accumulated amortisation as at 1 April 2016	**842**
Provided during the year	552
Disposals	0
Accumulated amortisation as at 31 March 2017	**1,394**
Net book value as at 31 March 2018	**2,461**
Net book value as at 31 March 2017	**2,308**

All intangible assets are owned assets.

	Minimum Life Years	Maximum Life Years
Software licences	1	10

12. Property, plant and equipment

12.1 Property, plant and equipment 2017/18	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation as at 1 April 2017	**152,372**	**10,500**	**109,014**	**1,538**	**1,253**	**18,088**	**101**	**11,049**	**829**
Additions - purchased	4,939	0	2,610	9	8	1,750	0	507	55
Additions - leased	0	0	0	0	0	0	0	0	0
Additions - donation of physical assets (non-cash)	0	0	0	0	0	0	0	0	0
Additions - assets purchased from cash donations	59	0	17	0	0	42	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve	(1,251)	0	(1,251)	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	0	0	0	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	9,480	1,750	7,641	89	0	0	0	0	0
Revaluations	(19,954)	0	(19,585)	(369)	0	0	0	0	0
Disposals	(296)	0	0	0	0	(290)	0	0	(6)
Cost or valuation as at 31 March 2018	**145,349**	**12,250**	**98,446**	**1,267**	**1,261**	**19,590**	**101**	**11,556**	**878**
Accumulated depreciation as at 1 April 2017	**34,482**	**0**	**18,091**	**333**	**0**	**10,496**	**43**	**5,139**	**380**
Provided during the year	4,928	0	1,941	38	0	1,427	13	1,426	83
Impairments charged to operating expenses	792	0	792	0	0	0	0	0	0
Impairments charged to the revaluation reserve	0	0	0	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	(1,241)	0	(1,239)	(2)	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	0	0	0	0	0	0	0	0	0
Revaluations	(19,954)	0	(19,585)	(369)	0	0	0	0	0
Disposals	(292)	0	0	0	0	(286)	0	0	(6)
Accumulated depreciation as at 31 March 2018	**18,715**	**0**	**0**	**0**	**0**	**11,637**	**56**	**6,565**	**457**
Net book value as at 31 March 2018	**126,634**	**12,250**	**98,446**	**1,267**	**1,261**	**7,953**	**45**	**4,991**	**421**

12.2 Property, plant and equipment 2016/17	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation as at 1 April 2016	**160,738**	**12,475**	**117,357**	**1,512**	**1,253**	**17,541**	**101**	**9,670**	**829**
Additions - purchased	4,341	0	1,418	5	0	1,534	0	1,384	0
Additions - leased	0	0	0	0	0	0	0	0	0
Additions - donation of physical assets (non-cash)	0	0	0	0	0	0	0	0	0
Additions - assets purchased from cash donations	114	0	76	0	0	38	0	0	0
Impairments charged to revaluation reserve	(14,605)	(2,705)	(11,893)	(7)	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	2,814	730	2,056	28	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Disposals	(1,030)	0	0	0	0	(1,025)	0	(5)	0
Cost or valuation as at 31 March 2017	**152,372**	**10,500**	**109,014**	**1,538**	**1,253**	**18,088**	**101**	**11,049**	**829**
Accumulated depreciation as at 1 April 2016	**27,697**	**0**	**13,198**	**301**	**0**	**9,983**	**30**	**3,888**	**297**
Provided during the year	4,550	0	1,886	32	0	1,283	13	1,253	83
Impairments charged to operating expenses	3,023	0	3,023	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	(16)	0	(16)	0	0	0	0	0	0
Disposals	(772)	0	0	0	0	(770)	0	(2)	0
Accumulated depreciation as at 31 March 2017	**34,482**	**0**	**18,091**	**333**	**0**	**10,496**	**43**	**5,139**	**380**
Net book value as at 31 March 2017	**117,890**	**10,500**	**90,923**	**1,205**	**1,253**	**7,592**	**58**	**5,910**	**449**

12.3 Property, plant and equipment financing	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value as at 31 March 2018									
Owned	123,900	12,250	96,474	1,267	1,261	7,546	45	4,680	377
Finance Leased	311	0	0	0	0	0	0	311	0
Government Granted	835	0	678	0	0	157	0	0	0
Donated	1,588	0	1,294	0	0	250	0	0	44
Total net book value as at 31 March 2018	**126,634**	**12,250**	**98,446**	**1,267**	**1,261**	**7,953**	**45**	**4,991**	**421**
Net book value as at 31 March 2017									
Owned	115,054	10,500	89,055	1,205	1,253	7,127	58	5,460	396
Finance Leased	450	0	0	0	0	0	0	450	0
Government Granted	736	0	546	0	0	190	0	0	0
Donated	1,650	0	1,322	0	0	275	0	0	53
Total net book value as at 31 March 2017	**117,890**	**10,500**	**90,923**	**1,205**	**1,253**	**7,592**	**58**	**5,910**	**449**

13. Economic lives of non-current assets

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.

The following table discloses the range of economic lives of various assets.

	Minimum Life Years	Maximum Life Years
Land	250	250
Buildings excluding dwellings	1	82
Dwellings	10	40
Plant and machinery	1	15
Transport and equipment	4	10
Information technology	1	14
Furniture and fittings	1	10

14. Inventories

14.1 Inventory movements 2017/18

	Total £000	Drugs £000	Consumables £000
Carrying value at 1 April 2017	3,437	1,080	2,357
Additions	38,785	16,650	22,135
Inventories consumed (recognised in expenses)	(38,958)	(16,587)	(22,371)
Total as at 31 March 2018	**3,264**	**1,143**	**2,121**

14.2 Inventory movements 2016/17

	Total £000	Drugs £000	Consumables £000
Carrying value at 1 April 2016	3,435	1,162	2,273
Additions	33,336	13,316	20,020
Inventories consumed (recognised in expenses)	(33,334)	(13,398)	(19,936)
Total as at 31 March 2017	**3,437**	**1,080**	**2,357**

15. Trade and other receivables

Current	2017/18 £000	2016/17 £000
Trade receivables	4,343	1,485
Provision for impairment of receivables	(568)	(431)
Prepayments	1,812	1,834
Accrued income	3,165	6,923
PDC dividend receivable	809	250
VAT receivable	742	696
Other receivables	2,521	2,406
Total current trade and other receivables	**12,824**	**13,163**
Non current		
Provision for impairment of receivables	(269)	(295)
Other receivables	1,176	1,286
Total non current trade and other receivables	**907**	**991**
Total trade and other receivables	**13,731**	**14,154**

Provision for impairment of receivables	2017/18 £000	2016/17 £000
As at 1 April	726	666
Increase in provision	111	60
As at 31 March	**837**	**726**

16. Analysis of financial assets past due date or impaired

Analysis of impaired financial assets	2017/18 Trade & other receivables* £000	2016/17 Trade & other receivables* £000
0 - 30 days	0	1
30 - 60 days	8	3
60 - 90 days	4	0
90 - 180 days	4	7
Over 180 days	821	715
Total	**837**	**726**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	1,820	1,821
30 - 60 days	349	125
60 - 90 days	300	283
90 - 180 days	41	783
Over 180 days	371	156
Total	**2,881**	**3,168**

*Includes provision for impairment of receivables in respect of income due from the CRU of £668k (£664k in 2016/17).

The Trust reviews all outstanding receivables at the end of the reporting year and makes a provision for those debts where it believes recovery of the outstanding amount is unlikely. Decisions are made after taking into consideration previous experience of the debtor, the age of the debt, the risk associated with that particular class of debtor and discussions with the debt management team of the Trust's shared business services provider.

17. Cash and cash equivalents

	2017/18 £000	2016/17 £000
As at 1 April	1,201	2,583
Net change in year	1,008	(1,382)
As at 31 March	**2,209**	**1,201**
Breakdown of cash and cash equivalents		
Cash at commercial banks and in hand	12	26
Cash with the Government Banking Service	2,197	1,175
Cash and cash equivalents as at 31 March	**2,209**	**1,201**
Third party assets held by the Trust	**19**	**15**

As at the 31 March 2018 the Trust held £19k (£15k as at 31 March 2017) within the Trust bank accounts which related to patient monies held by the Trust on behalf of patients and staff lottery. This has been excluded from the cash at bank and in hand figure above.

Additionally, under a hosting arrangement, the Trust held £965k as at the 31 March 2018 within the Trust bank accounts on behalf of Health and Care Partnership for Cheshire and Merseyside.

18. Trade and other payables

	2017/18	2016/17
Current	**£000**	**£000**
NHS trade payables	13,717	10,150
Trade payables capital	813	564
Accruals	4,122	5,473
Social security costs	1,517	1,559
Other taxes payable	1,650	1,374
Accrued interest on loans	131	106
Other payables	2,114	112
Total trade and other payables	**24,064**	**19,338**

19. Other liabilities

	2017/18	2016/17
Current	**£000**	**£000**
Deferred income	2,361	1,137
Total other liabilities	**2,361**	**1,137**

20. Borrowings

	2017/18	2016/17
Current	**£000**	**£000**
Capital loans from the Department of Health	107	106
Working capital loans from the Department of Health	14,200	0
Obligations under finance leases	358	348
Total current borrowing	**14,665**	**454**
Non current		
Capital loans from the Department of Health	1,280	1,386
Working capital loans from the Department of Health	20,669	26,119
Obligations under finance leases	289	647
Total non current borrowing	**22,238**	**28,152**

During 2017/18 the Trust obtained further net working capital loans from the Department of Health totalling £8.75m (shown at note 20), at an interest rate of 1.50%. This new loan funding is repayable in full in 2020/21.

21. Finance Leases

	2017/18	2016/17
Gross lease liabilities	**£000**	**£000**
of which liabilities are due:		
- not later than one year;	372	373
- later than one year and not later than five years;	292	664
- later than five years.	0	0
Finance charges allocated to future periods	(17)	(42)
Total gross lease liabilities	**647**	**995**
Net lease liabilities		
of which payable:		
- not later than one year;	358	348
- later than one year and not later than five years;	289	647
- later than five years.	0	0
Total net lease liabilities	**647**	**995**

22. Provisions

Movements in provisions for liabilities and charges	2017/18 Total £000	Legal £000	Other £000	Pensions £000
As at 1 April 2017	1,656	81	81	1,494
Change in the discount rate	14	0	0	14
Arising during the year	295	63	190	42
Utilised during the year	(230)	(33)	(81)	(116)
As at 31 March 2018	**1,735**	**111**	**190**	**1,434**
Expected timing of cash flows:				
Within one year	420	111	190	119
Between one and five years	1,315	0	0	1,315
After five years	0	0	0	0
Total	**1,735**	**111**	**190**	**1,434**

Movements in provisions for liabilities and charges	2016/17 Total £000	Legal £000	Other £000	Pensions £000
As at 1 April 2016	1,698	246	0	1,452
Change in the discount rate	100	0	0	100
Arising during the year	264	124	81	59
Utilised during the year	(231)	(114)	0	(117)
Reversed unused	(175)	(175)	0	0
As at 31 March 2017	**1,656**	**81**	**81**	**1,494**
Expected timing of cash flows:				
Within one year	279	81	81	117
Between one and five years	467	0	0	467
After five years	910	0	0	910
Total	**1,656**	**81**	**81**	**1,494**

The pensions provision relates to early retirement costs in line with the NHS Business Service Authority - Pensions Division. Legal claims relates to third party legal claims advised by NHS Resolution. These claims are generally expected to be settled within one year but may exceptionally take two years to settle.

Clinical negligence and employee liabilities

£94.0m is included in the provisions of NHS Resolution as at 31 March 2018 in respect of clinical negligence and employer's liabilities of the Trust (£99.2m as at 31 March 2017).

23. Contingent liabilities

Value of contingent liabilities	31 March 2018 £000	31 March 2017 £000
NHS Resolution legal claims	(58)	(39)
Gross value of contingent liabilities	**(58)**	**(39)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(58)**	**(39)**

23. Contingent liabilities (continued)

The Trust suffered a fire on 23 March 2018 which affected a part of the hospital that housed clinical and administration services. The 2017/18 accounts contain costs incurred to 31 March 2018 but the majority of the resulting expenditure will fall in 2018/19. The value of this expenditure is unknown at this point in time but it is expected to be material.

The Trust is anticipating that it will need to make a payment in 2017/18 in respect of an employment matter. The value of which is unknown at this point in time but it is expected to be material.

24. Financial instruments

24.1 Financial assets by category

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total
	£000	£000	£000	£000	£000
Assets included in Statement of Financial Position as at 31 March 2018					
Trade and other receivables	7,712	0	0	0	7,712
Other investments / financial assets	0	0	0	0	0
Cash and cash equivalents	2,209	0	0	0	2,209
Total as at 31 March 2018	**9,921**	**0**	**0**	**0**	**9,921**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total
	£000	£000	£000	£000	£000
Assets included in Statement of Financial Position as at 31 March 2017					
Trade and other receivables	9,145	0	0	0	9,145
Other investments / financial assets	0	0	0	0	0
Cash and cash equivalents	1,201	0	0	0	1,201
Total as at 31 March 2017	**10,346**	**0**	**0**	**0**	**10,346**

24.2 Financial liabilities by category

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities included in Statement of Financial Position as at 31 March			
Borrowings excluding finance lease and PFI liabilities	36,256	0	36,256
Obligations under finance leases	647	0	647
Trade and other payables excluding non financial liabilities	18,931	0	18,931
Other financial liabilities	0	0	0
Provisions under contract	301	0	301
Total as at 31 March 2018	**56,135**	**0**	**56,135**

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities included in Statement of Financial Position as at 31 March			
Borrowings excluding finance lease and PFI liabilities	27,611	0	27,611
Obligations under finance leases	995	0	995
Trade and other payables excluding non financial liabilities	16,405	0	16,405
Other financial liabilities	0	0	0
Provisions under contract	162	0	162
Total as at 31 March 2017	**45,173**	**0**	**45,173**

24.3 Maturity of financial liabilities

	Total 31 March 2018 £000	Total 31 March 2017 £000
Financial liabilities fall due in:		
In one year or less	33,911	17,021
In more than one year but not more than two years	9,903	14,654
In more than two years but not more than five years	11,468	12,539
In more than five years	853	959
Total	**56,135**	**45,173**

25. Contractual Capital Commitments

The Trust has contractual capital commitments of £0.6m as at 31 March 2018 (£1.2m as at 31 March 2017). This includes, £0.3m for estates work, £0.2m for installation of new IT systems and £0.1m for new equipment.

26. Related party disclosures

26.1 Related party transactions

Value of transactions with other related parties in 2017/18	Revenue £000	Expenditure £000
Value of transactions with other related parties:		
Charitable funds (where not consolidated)	32	0
Other bodies or persons outside the whole of government accounting boundary	0	0
Total value of transactions with related parties in 2017/18	**32**	**0**

Value of transactions with other related parties in 2016/17	Revenue £000	Expenditure £000
Value of transactions with other related parties:		
Charitable funds (where not consolidated)	32	0
Other bodies or persons outside the whole of government accounting boundary	0	0
Total value of transactions with related parties in 2016/17	**32**	**0**

26.2 Related party balances

Value of balances with other related parties as at 31 March 2018	Receivables £000	Payables £000
Value of transactions with other related parties:		
Charitable funds (where not consolidated)	8	0
Other bodies or persons outside the whole of government accounting boundary	0	0
Total value of balances with other related parties as at 31 March 2018	**8**	**0**

Value of balances with other related parties as at 31 March 2017	Receivables £000	Payables £000
Value of transactions with other related parties:		
Charitable funds (where not consolidated)	40	0
Other bodies or persons outside the whole of government accounting boundary	10	0
Total value of balances with other related parties as at 31 March 2017	**50**	**0**

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 are part of the DH group of bodies such that the Department of Health is the parent department, and they fall under the common control of HM Government and Parliament. The GAM interprets IAS 24 (Related Party Dosclosures) such that no information needs to be given about transactions relating to DH group bodies.

In line with this, these related parties notes only collect details of transactions and balances with bodies or persons outside of the whole of government accounts boundary.

For related parties within the DH group of bodies, where transactions and balances need not be reported, that have a material relationship with the Trust (income and/or expenditure greater than £10m) are listed below:-

NHS Warrington CCG
NHS Halton CCG
NHS Resolution

27. Events after the reporting period

There were no events after the reporting period that require noting.

28. Losses and special payments

	2017/18 Total Number	2017/18 Total £000
Losses		
Cash losses	54	20
Fruitless payments	8	56
Bad debts and claims abandoned	21	7
Stores losses and damage to property	28	73
Total losses	**111**	**156**
Special payments		
Ex-gratia payments	45	63
Total special payments	**45**	**63**
Total losses and special payments	**156**	**219**
Compensation payments received		**16**

	2016/17 Total number of cases Number	2016/17 Total value of cases £000
Losses		
Cash losses	16	5
Fruitless payments	13	7
Bad debts and claims abandoned	8	12
Stores losses and damage to property	10	(3)
Total losses	**47**	**21**
Special payments		
Ex-gratia payments	42	139
Total special payments	**42**	**139**
Total losses and special payments	**89**	**160**
Compensation payments received		**22**

There were no individual cases exceeding £300k in either 2017/18 or 2016/17.

29. Financial instruments

Liquidity risk

The Trust's net operating costs are incurred under annual service level agreements / contracts with commissioners which are financed from resources voted annually by Parliament. The Trust receives such income in accordance with national tariff payment system, 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 Commissioners based on the annual contract values; 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.

Interest rate risk

All of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest and the Trust is not therefore exposed to significant interest rate risk.

Credit risk

The main source of income for the Trust is from Clinical Commissioning Groups in respect of healthcare services provided under contract and Service Level Agreements. The credit risk associated with such customers is negligible.

The Trust has minimal exposure to credit risk as all cash balances are held within the Government Banking Services (GBS) account which generates additional cash through an applied interest rate. The Trust does not hold cash in any other investment institution on a short or long term basis.

Before entering into new contracts with non NHS customers, checks are made regarding creditworthiness. The Trust also 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. There are no amounts held as collateral against these balances.

An analysis of aged and impaired receivables is disclosed in Note 16.

The movement in the provision for impaired receivables during the year is disclosed in Note 15. Of those assets which require a provision for their impairment nil (£2k in 2016/17) are impaired financial assets.

There are no (nil in 2016/17) financial assets that would otherwise be past due or impaired whose terms have been renegotiated.

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.

All financial assets and liabilities are held in sterling and are shown at book value, which is not significantly different from fair value.

We are WHH

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

22nd May 2018

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester

Dear Sirs

Warrington and Halton Hospitals NHS Foundation Trust
Financial Statements for the year ended 31 March 2018

This representation letter is provided in connection with the audit of the financial statements of Warrington and Halton Hospitals NHS Foundation Trust for the year ended 31 March 2018 for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects in accordance with International Financial Reporting Standards, the NHS Foundation Trust Annual Reporting Manual issued by NHS and the Department of Health and Social Care Group Accounting Manual 2017-18.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i As Trust Board members, we have fulfilled our responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with International Financial Reporting Standards, the NHS Foundation Trust Annual Reporting Manual (the ARM) and the Department of Health and Social Care Group Accounting Manual 2017-18 (GAM); in particular the financial statements are fairly presented in accordance therewith.

ii We have complied with the requirements of all statutory directions affecting the Trust and these matters have been appropriately reflected and disclosed in the financial statements.

iii The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of the Care Quality Commission or other regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

iv We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

v Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

vi In calculating the amount of income to be recognised in the financial statements from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be derived by the Trust in accordance with the International Financial Reporting

Chairman: Steve McGuirk CBE DL ● Chief Executive: Mel Pickup
Andrea McGee, Executive Offices, Tel: 01925 662298 Ext: 2298 EA: Brenda Jackson
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Email: andrea.mcgee@nhs.net www.whh.nhs.uk

Standards and the GAM. We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with International Financial Reporting Standards and the GAM, and adequately disclosed in the financial statements. There are no other material judgements that need to be disclosed.

vii We acknowledge our responsibility to participate in the Department of Health and Social Care's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

viii Except as disclosed in the financial statements:

a there are no unrecorded liabilities, actual or contingent

b none of the assets of the Trust has been assigned, pledged or mortgaged

c there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

ix Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

x All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the GAM require adjustment or disclosure have been adjusted or disclosed.

xi Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards.

xii We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

Information Provided

xiii We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
b. additional information that you have requested from us for the purpose of your audit; and
c. unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

xiv We have communicated to you all deficiencies in internal control of which management is aware.

xv All transactions have been recorded in the accounting records and are reflected in the financial statements.

xvi We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

Andrea McGee, Executive Offices, Tel: 01925 662298 Ext: 2298 EA: Brenda Jackson
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Email: andrea.mcgee@nhs.net www.whh.nhs.uk

xvii We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the Trust and involves:

a. management;
b. employees who have significant roles in internal control; or
c. others where the fraud could have a material effect on the financial statements.

xviii We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

xix We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xx We have disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which we are aware.

xxi We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

xxv The Trust will require an additional cash loan of £24,444 m in 2018/19 to maintain current payment performance assuming that it delivers its savings plan. Although the Trust has not received formal notification of future financing, this has always been available in the past in accordance with the need of the Trust to meet all essential liabilities and there is no indication that this will not continue. If the Trust fails to deliver its savings plan in full or its financial deficits are greater than planned in 2018/19 then further cash loans will be required. As the Trust's continuing operational stability depends on finance that has not yet been approved this represents a material uncertainty for the Trust.

Although these factors represent a material uncertainty that may cast significant doubt over the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the GAM, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future.

Annual Report

xxii The disclosures within the Annual Report fairly reflect our understanding of the Trust's financial and operating performance over the period covered by the financial statements.

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Warrington and Halton Hospitals NHS Foundation Trust, Lovely Lane, Warrington, WA5 1QG
Email: andrea.mcgee@nhs.net www.whh.nhs.uk

Annual Governance Statement

xxiii We are satisfied that the Governance Statement fairly reflects the Trust's risk assurance framework and we confirm that we are not aware of any significant risks that are not disclosed within the Governance Statement.

Approval

The approval of this letter of representation was minuted by the Trust's Board at its meeting on **24 May 2018**.

Yours faithfully

Name.....

Position.....CEO.....

Date.....24.5.18.....

Name.....

Position.....

Date.....24.5.18.....

Signed on behalf of the Governing Body

Chairman: Steve McGuirk CBE DL • Chief Executive: Mel Pickup

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Warrington and Halton Hospitals NHS Foundation Trust, Lovely Lane, Warrington, WA5 1QG
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Warrington and Halton Hospitals NHS Foundation Trust (WARRINGTON / RWW)

I&E

Trust Accounts Consolidation Schedules

STATEMENT OF COMPREHENSIVE INCOME		A02CY01	A02PY01
	Expected sign	SoCI 2017/18 £000	SoCI 2016/17 £000
Operating income from patient care activities	+	209,235	202,832
Other operating income	+	25,496	30,490
Operating expenses	-	(246,412)	(237,930)
OPERATING SURPLUS / (DEFICIT)	+/-	**(11,681)**	**(4,608)**
FINANCE COSTS			
Finance income	+	30	20
Finance expense	-	(536)	(461)
PDC dividend charge	-	(2,465)	(3,010)
NET FINANCE COSTS	+/-	**(2,971)**	**(3,451)**
Other gains/(losses)	+/-	(4)	(201)
Share of profit/(loss) of associates/ joint ventures	+/-		
Gains/(losses) from transfers by absorption	+/-	0	
Corporation tax expense	-		
SURPLUS/(DEFICIT) FROM CONTINUING OPERATIONS	+/-	**(14,656)**	**(8,260)**
Surplus/(deficit) from discontinued operations and the gain/(loss) on disposal of discontinued operations	+/-	0	0
SURPLUS/(DEFICIT) FOR THE YEAR	+/-	**(14,656)**	**(8,260)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	-	8,229	(11,791)
Revaluations	+/-	0	0
Share of comprehensive income from associates and joint ventures	+/-	0	0
Other recognised gains and losses	+/-	0	0
Remeasurements of net defined benefit pension scheme liability / asset	+/-	0	0
Other reserve movements	+/-	0	0
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on available-for-sale financial investments	+/-	0	0
Recycling gains/(losses) on available-for-sale financial investments	+/-	0	0
Foreign exchange gains/(losses) recognised directly in OCI	+/-	0	0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD	+/-	**(6,427)**	**(20,051)**

Note: Allocation of surplus/ (deficit) for the period:		A02CY01	A02PY01
	Expected sign	2017/18 £000	2016/17 £000
(a) Surplus/ (deficit) for the period attributable to:			
(i) non-controlling interest, and	+/-		
(ii) owners of the parent	+/-	(14,656)	(8,260)
TOTAL	+/-	**(14,656)**	**(8,260)**
(b) total comprehensive income/ (expense) for the period attributable to:			
(i) non-controlling interest, and	+/-		
(ii) owners of the parent	+/-	(6,427)	(20,051)
TOTAL	+/-	**(6,427)**	**(20,051)**

Table: Adjusted financial performance		A02CY01	Maincode
	Expected sign	2017/18 £000	Subcode
Surplus / (deficit) for the period (before consolidation of charity)	+/-	(14,656)	SCI0270
Add back all I&E impairments / (reversals)	+/-	(449)	SCI0280
Adjust (gains) / losses on transfers by absorption	+/-	0	SCI0290
Surplus / (deficit) before impairments and transfers	+/-	**(15,105)**	SCI0300
Retain impact of DEL I&E (impairments) / reversals	+/-	0	SCI0310
Remove capital donations / grants I&E impact	+/-	95	SCI0320
Prior period adjustments	+/-	0	SCI0330
Remove impact of 1617 STF post accounts reallocation	-	0	SCI0331
CQUIN Risk Reserve - 1617 CT non achievement adjustment	+/-	0	SCI0334
Remove non-cash element of on-SoFP pension costs *i*	+/-	0	SCI0335
Adjusted financial performance surplus / (deficit)	+/-	**(15,010)**	SCI0340
Adjusted financial performance excluding STF	+/-	**(19,308)**	SCI0366

Warrington and Halton Hospitals NHS Foundation Trust (WARRINGTON / RWW)

Balance Sheet

Trust Accounts Consolidation Schedules

STATEMENT OF FINANCIAL POSITION	Expected sign	A03CY01 SoFP 31 Mar 2018 £000	A03PY01 SoFP 31 Mar 2017 £000	Maincode / Subcode
Non-current assets				
Intangible assets	+	2,461	2,308	BAL1100
Property, plant and equipment	+	126,634	117,890	BAL1110
Investment property	+	0	0	BAL1120
Investments in joint ventures and associates	+	0	0	BAL1130
Other investments / financial assets	+	0	0	BAL1140
Trade and other receivables	+	907	991	BAL1150
Other assets	+	0	0	BAL1170
Total non-current assets	+	**130,002**	**121,189**	BAL1180
Current assets				
Inventories	+	3,264	3,437	BAL1190
Trade and other receivables	+	12,824	13,163	BAL1200
Other investments / financial assets	+	0	0	BAL1210
Other assets	+	0	0	BAL1220
Non-current assets for sale and assets in disposal groups	+	0	0	BAL1230
Cash and cash equivalents	+	2,209	1,201	BAL1240
Total current assets	+	**18,297**	**17,801**	BAL1250
Current liabilities				
Trade and other payables	-	(24,064)	(19,338)	BAL1260
Borrowings	-	(14,665)	(454)	BAL1270
Other financial liabilities	-	0	0	BAL1280
Provisions	-	(420)	(279)	BAL1290
Other liabilities	-	(2,361)	(1,137)	BAL1300
Liabilities in disposal groups	-	0	0	BAL1310
Total current liabilities	-	**(41,510)**	**(21,208)**	BAL1320
Total assets less current liabilities	+/-	**106,789**	**117,782**	BAL1330
Non-current liabilities				
Trade and other payables	-	0	0	BAL1340
Borrowings	-	(22,238)	(28,152)	BAL1350
Other financial liabilities	-	0	0	BAL1360
Provisions	-	(1,315)	(1,377)	BAL1370
Other liabilities	-	0	0	BAL1380
Total non-current liabilities	-	**(23,553)**	**(29,529)**	BAL1390
Total assets employed	+/-	**83,236**	**88,253**	BAL1400
Financed by				
Taxpayers' equity				
Public dividend capital	+	89,152	87,742	BAL1410
Revaluation reserve	+	30,707	22,478	BAL1420
Available for sale investments reserve	+	0	0	BAL1430
Other reserves	+/-	0	0	BAL1440
Merger reserve	+/-	0	0	BAL1450
Income and expenditure reserve	+/-	(36,623)	(21,967)	BAL1460
Others' equity				
Non-controlling Interest	+	0	0	BAL1470
Charitable fund reserves	+	0	0	BAL1490
Total taxpayers' and others' equity	+/-	**83,236**	**88,253**	BAL1500

Warrington and Halton Hospitals NHS Foundation Trust (WARRINGTON / RWW)

Cash Flow

Trust Accounts Consolidation Schedules

This cash flow statement is prepared on a group basis (after the consolidation of charitable funds). charity, the SoCF is reconciled back to a position before the consolidation of a charity in the following year monitoring.

STATEMENT OF CASH FLOWS		Expected sign	A05CY01 2017/18 £000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations		+/-	(11,681)
Operating surplus/(deficit) of discontinued operations		+/-	0
Operating surplus/(deficit)		+/-	**(11,681)**
Non-cash or non-operating income and expense:			
Depreciation and amortisation		+	5,583
Impairments and reversals		+	(449)
Income recognised in respect of capital donations (cash and non-cash)	*i*	-	(59)
Amortisation of PFI deferred income / credit		-	0
On SoFP pension liability - employer contributions paid less net charge to the SOCI	*i*	+/-	0
(Increase)/decrease in trade and other receivables		+/-	982
(Increase)/decrease in other assets		+/-	0
(Increase)/decrease in inventories		+/-	173
Increase/(decrease) in trade and other payables		+/-	4,452
Increase/(decrease) in other liabilities		+/-	1,224
Increase/(decrease) in provisions		+/-	79
Movements in charitable fund working capital		+/-	0
Corporation tax (paid) / received		+/-	
Movements in operating cash flows of discontinued operations		+/-	
NHS charitable funds: other movements in operating cash flows		+/-	0
Other movements in operating cash flows		+/-	18
Net cash generated from / (used in) operations		+/-	**322**
Cash flows from investing activities			
Interest received		+	30
Purchase of financial assets / investments		-	
Proceeds from sales / settlements of financial assets / investments	*i*	+	
Purchase of intangible assets		-	(808)
Proceeds from sales of intangible assets		+	
Purchase of property, plant and equipment and investment property		-	(4,749)
Proceeds from sales of property, plant and equipment and investment property		+	
Receipt of cash donations to purchase capital assets	*i*	+	59
Prepayment of PFI capital contributions (cash payments)		-	
NHS charitable funds: net cash flows from investing activities		+/-	0
Cash flows attributable to investing activities of discontinued operations		+/-	
Cash movement from acquisitions of business units and subsidiaries (not absorption transfers)		+/-	
Cash movement from disposals of business units and subsidiaries (not absorption transfers)		+/-	
Net cash generated from/(used in) investing activities		+/-	**(5,468)**
Cash flows from financing activities			
Public dividend capital received		+	1,410
Public dividend capital repaid		-	0
Movement in loans from the Department of Health and Social Care		+/-	8,645
Movement in other loans		+/-	0
Other capital receipts		+	
Capital element of finance lease rental payments		-	(347)
Capital element of PFI, LIFT and other service concession payments		-	
Interest paid		-	(505)
Interest element of finance lease		-	(25)
Interest element of PFI, LIFT and other service concession obligations	*i*	-	
PDC dividend (paid)/refunded		+/-	(3,024)
Cash flows attributable to financing activities of discontinued operations		+/-	
NHS charitable funds: net cash flows from financing activities		+/-	0
Cash flows from (used in) other financing activities	*i*	+/-	
Net cash generated from/(used in) financing activities		+/-	**6,154**
Increase/(decrease) in cash and cash equivalents		+/-	**1,008**
Cash and cash equivalents at 1 April - brought forward		+/-	1,201
Prior period adjustments		+/-	
Cash and cash equivalents at 1 April - restated		+/-	**1,201**

Cash and cash equivalents at start of period for new FTs		+/-	0
Cash and cash equivalents transferred by absorption	*i*	+/-	0
Unrealised gains/(losses) on foreign exchange		+/-	
Cash transferred to NHS foundation trust upon authorisation as FT		+/-	0
Cash and cash equivalents at 31 March		+/-	**2,209**

Table CF1: Reconciliation of Statement of Financial Position to working balances adjustment in Cash Flow		**Expected sign**	**A05CY01 2017/18 £000**
(Increase)/decrease in trade and other receivables as per SOFP		+/-	423
Adjustments for receivables movements not related to operating cash flows:			
Less: movement in charitable fund receivables (separately disclosed)		+/-	0
Less: movement in receivables arising upon authorisation as FT in-year (operating balances only)	*i*	+/-	0
Increase/(decrease) in capital receivables/prepayments (non-operating)		+/-	0
Add back capital debtors written off in the year	*i*	+	
Increase/(decrease) in interest receivable (non-operating)		+/-	0
Increase/(decrease) in PDC dividend receivable (non-operating)		+/-	559
Increase/(decrease) resulting from absorption transfers (operating balances only)	*i*	+/-	0
Other adjustments (freetext explanation required)		+/-	
(Increase)/decrease in receivables per the SOCF		+/-	**982**
(Increase)/decrease in other assets per SoFP		+/-	0
Adjustments for other asset movements not related to operating cash flows:			
Less: movement in other assets arising upon authorisation as FT in-year (operating balances only)	*i*	+/-	0
Less: movement in short term PFI finance lease asset		+/-	0
Less: movement in on-SoFP Pension scheme asset		+/-	0
Less: movement from absorption transfers (operating balances only)	*i*	+/-	0
Other adjustments (freetext explanation required)		+/-	
Increase/(decrease) in other assets per the SOCF		+/-	**0**
Increase/(decrease) in trade and other payables per SoFP		+/-	4,726
Adjustments for payables movements not related to operating cash flows:			
Less: movement in charitable fund payables (separately disclosed)		+/-	0
Less: movement in payables arising upon authorisation as FT in-year (operating balances only)	*i*	+/-	0
Less: movement in capital payables (non-operating)		+/-	(249)
Less: movement in interest payable (non-operating)		+/-	(25)
Less: movement in PDC dividend payable (non-operating)		+/-	0
Less: movement from absorption transfers (operating balances only)	*i*	+/-	0
Other adjustments (freetext explanation required)	*i*	+/-	
Increase/(decrease) in payables per the SOCF		+/-	**4,452**
Increase/(decrease) in other liabilities per SOFP		+/-	1,224
Adjustments for other liabilities movements not related to operating cash flows:			
Less: movement in charitable fund other liabilities (separately disclosed)		+/-	0
Less: movement in other liabilities arising upon authorisation as FT in-year		+/-	0
Less: movement in on-SoFP pension scheme liability		+/-	0
Less: amortisation of PFI deferred income / credits (already adjusted as non-cash income above)		+	0
Less: movement in other liabilities resulting from absorption transfers		+/-	0
Other adjustments (freetext explanation required)		+/-	
Increase/(decrease) in other liabilities per SOCF		+/-	**1,224**
Increase/(decrease) in provisions per SOFP		+/-	79
Adjustments for non-operating provisions movements:			
Less: movement in charitable fund provisions (separately disclosed)		+/-	0
Less: movement in provisions arising upon authorisation as FT in-year		+/-	0
Less: movement in provisions resulting from absorption transfers		+/-	0
Less: Unwinding of discount on provisions (not in operating surplus/deficit)		-	0
Other adjustments (freetext explanation required)		+/-	
Increase/(decrease) in provisions per the SOCF		+/-	**79**
(Increase)/decrease in inventories per SOFP		+/-	173
Adjustments for non-operating inventories movements:			
Less: movement in charitable fund inventories (separately disclosed)		+/-	0
Less: movement in inventories upon authorisation as FT in-year		+/-	0
Less: movement in inventories resulting from absorption transfers		+/-	0
Other adjustments (should not be required)		+/-	
(Increase)/decrease in inventories per the SOCF		+/-	**173**

Table CF2: Reconciliation of Statement of Financial Position movements to investing cash flows		Expected sign	A05CY01 2017/18 £000
Interest received:			
Interest recognised in year		+	30
Opening interest receivable		+	0
Less: closing interest receivable		-	0
Less: movement in interest receivable arising on authorisation as FT in-year		+/-	0
Transfer of interest receivable under absorption accounting		+/-	0
Other adjustments (freetext explanation required)		+/-	
Interest received per the SOCF		+/-	**30**
Purchase of PPE and investment properties:			
PPE additions (per TAC14)	*i*	-	(4,998)
Investment property additions (per TAC15)		-	0
Opening capital creditors		-	(564)
Opening capital prepayments (including PFI capital lifecycle)	*i*	+	0
Less closing capital creditors		+	813
Less closing capital prepayments (including PFI capital lifecycle)	*i*	-	0
Less: movement in capital creditors arising on authorisation as FT in-year	*i*	+/-	0
Less: capital creditors transferred under absorption accounting	*i*	+/-	0
Movement in PFI lifecycle assets received in advance		+/-	0
Other adjustments (freetext explanation required)	*i*	+/-	
Purchase of PPE and investment properties per the SOCF		-	**(4,749)**
Purchase of intangible assets:			
Intangible additions (per TAC13)	*i*	-	(808)
Opening capital creditors		-	0

Warrington and Halton Hospitals NHS Foundation Trust (WARRINGTON / RWW)

TAC51 AGS info

Trust Accounts Consolidation Schedules

0	Unanswered questions
0	Uncleared checks

Please provide summary information from the provider's annual governance statement to aid NHS Improvement's preparation of the consolidated provider sector governance statement.

This tab only needs to be completed for the final audited submission at month 12.

Guidance on annual governance statement requirements for NHS trusts can be found at (entry 26 February): https://improvement.nhs.uk/resources/financial-reporting/

Guidance on annual governance statement requirements for NHS foundation trusts can be found at: https://improvement.nhs.uk/resources/nhs-foundation-trust-annual-reporting-manual-201718/

AGS: Purpose of system of internal control / risk and control framework

		Yes / No (select)	Please explain if 'no'	Checks
A1	Does the provider confirm in the AGS that the provider had adequate systems of internal control in place for the financial year and up to the date of approval of the annual report and accounts?	Yes		OK

AGS: Conclusion section: significant internal control issues

The conclusion section of the AGS must either state that no significant internal control issues have been identified in the AGS, or clearly list the individual significant internal control issues. Note this is not a disclosure of 'risks'. Please refer to guidance linked above for more details.

		Yes / No (select)	Details of significant internal control issues	
B1	Has the provider disclosed any significant internal control issues in its AGS? (These should be summarised in the 'Conclusion' section of the AGS)	No		OK
B2	If 'Yes' to B1, please give details below (rows will expand to fit text):			
	Significant internal control issue 1: please summarise the issue			OK
	Significant internal control issue 2: please summarise the issue			
	Significant internal control issue 3: please summarise the issue			
	Significant internal control issue 4: please summarise the issue			
	Significant internal control issue 5: please summarise the issue			
	Significant internal control issue 6: please summarise the issue			
	Significant internal control issue 7: please summarise the issue			

Warrington and Halton Hospitals NHS Foundation Trust (WARRINGTON / RWW)
TAC01 Confirmations
Trust Accounts Consolidation Schedules

	Confirmation question	Response
Basis of preparation and status of TACS		
1	Has the organisation departed from the accounting requirements of IFRS or the accounting policies / requirements set out in the Group Accounting Manual 2017/18 as it applies to 2016/17 and 2017/18?	No
	If yes, please set out the implications of the non-compliance in the free-text schedule (TAC34 Free text)	#N/A
2	Have the comparatives included in the TACS been revised from those disclosed in the final 2016/17 audited FTC/FMA?	No
	If yes, please provide details of any other prior period adjustments in the free-text schedule - prior period adjustments (TAC33 PPAs). Failure to do so will likely lead to follow-up questions from NHS Improvement.	#N/A
	If your restatement relates solely to disclosure, presentation or reclassification then please explain below.	
3	Is the information in this form based on audited accounts (respond 'No' if this is your unaudited submission or at month 9)?	Yes - audited
Group structure and charities		
4	Has the organisation accounted for an interest in a non-consolidated subsidiary, joint venture or associate (excluding any charitable funds)?	No
	If yes, please provide the details of the joint venture, associate or non-consolidated subsidiary on TAC15 Investments & groups.	#N/A
	Please also complete questions 4.1 to 4.3 on TAC34 Free text where applicable.	#N/A
5	Has the organisation submitted TACs which consolidates any subsidiaries (excluding any charitable funds)?	No
	If yes, please provide details of the consolidated bodies on TAC15 Investments & groups.	#N/A
	Also please detail any non-controlling interests (and note the subsidiary these relate to):	
	Please also complete questions 5.1 to 5.3 on TAC34 Free text where applicable.	#N/A
6	Has the organisation consolidated an NHS charitable fund within these TACs?	No
	If yes, please ensure sheet TAC40 Charity - consol has been completed in full.	#N/A
6a	Does the organisation have any linked charities not consolidated within these TACs?	Yes

	Confirmation question	Response
6b	If yes to 6a, does the charity / all non-consolidated linked charities have arrangements to report directly to the Department of Health and Social Care as an independent charity with non-corporate trustees?	No
	If no to 6b, please ensure summary financial information is provided on TAC41 Charity - non-consol.	#N/A
	If yes to 6b, do NOT complete sheet TAC41 Charity - non-consol, as the information will be collected directly from the charity by the Department of Health and Social Care.	

Transactions and risks

7	Has the organisation entered into any transactions not on an arm's length basis?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	#N/A
8	Has the organisation entered into any arrangements involving the pledging of financial assets as collateral?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	#N/A
9	Has the organisation entered into any hedging transactions?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	#N/A
10	Has the organisation completed a transfer of services, either divesting or receiving, accounted for as a 'transfer by absorption' in the year?	No
	If yes, please provide details on worksheet TAC30 Transfers.	#N/A
11	Has the organisation been involved with any mergers or other business combinations during the year (excluding transfers by absorption - see q10 above)?	No
	If yes, please provide details of any transactions in the free-text schedule (TAC34 Free text).	#N/A
12	Has the organisation been dissolved prior to 31 Mar 2018?	No
13	Do the financial statements disclose significant exposure to the following types of financial risk?	
	a) Credit risk:	No
	b) Liquidity risk:	Yes
	c) Market risk:	No

Warrington and Halton Hospitals NHS Foundation Trust (WARRINGTON / RWW)
TAC01 Confirmations
Trust Accounts Consolidation Schedules

Confirmation question		Response
	d) Foreign currency risk:	No
	If yes to a,b,c or d please provide details in the free-text schedule (TAC34 Free text).	Go to Freetext
Other accounting arrangements		
14	Is the organisation an admitted member of a defined benefit scheme other than the NHS Pension Scheme e.g. a Local Government Pension Scheme?	No
14a	If yes, does the organisation account for it as a defined benefit scheme in the accounts and these TACs (i.e. on SoFP)?	n/a
	If yes to both 14 and 14a, please complete worksheet TAC26 Pension and provide the name of the pension fund(s) here (e.g. Leicestershire County Council Pension Fund):	
	If yes to 14 and no to 14a, i.e. the organisation is a member of such a scheme but does not account for it as such, please give details in the free-text schedule (TAC34 Free text).	Go to Freetext
15	Other than PFI, LIFT and other service concession arrangements disclosed in TAC25 Off-SoFP PFI, has the organisaction entered into any other off balance sheet arrangements?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	Go to Freetext

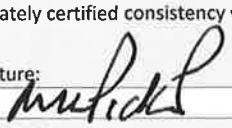
For M12 audited submission only: please print this sheet and have it signed by the Chief Executive (no electronic signatures - these boxes are not editable). The signed sheet should be scanned and uploaded to the NHSI portal with the audited TAC and accounts submission

Warrington and Halton Hospitals NHS Foundation Trust

Chief Executive:

I confirm that these schedules are the final audited TAC schedules submitted to NHSI via the trust portal and upon which I have separately certified consistency with the audited accounts

Signature:



Print name:

Mel Pickup

Validation summary	
0	Validation fails
0	JoCs requiring explanation

Trust Accounts Consolidation (TAC) Summarisation Schedules for Warrington and Halton Hospitals NHS Foundation Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2017/18 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:
   - the financial records maintained by the NHS foundation trust
   - accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
   - the template accounting policies for NHS foundation trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.
2. I certify that the TAC schedules are internally consistent and that there are no validation errors.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS foundation trust

Andrea McGee, Director of Finance

24 May 2018

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the foundation trust is required to submit to NHS Improvement.
2. I have reviewed the schedules and agree the statements made by the Director of Finance above.

Mel Pickup, Chief Executive

24 May 2018

Independent auditor's report to the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Warrington and Halton Hospitals NHS Foundation Trust (the 'Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/2018; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

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 Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including 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.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty related to going concern

We draw attention to note 1 in the financial statements, which discloses that the Directors are seeking additional support from the Department of Health and Social Care for 2018/19 of £24.4 million. As stated in

note 1, the Department of Health and Social Care has not, at the date of our report, confirmed this support. This is in addition to the existing level of Department of Health and Social Care support which was £39.4m as at the end of 2017/18.

These events or conditions, along with the other matters explained in note 1, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

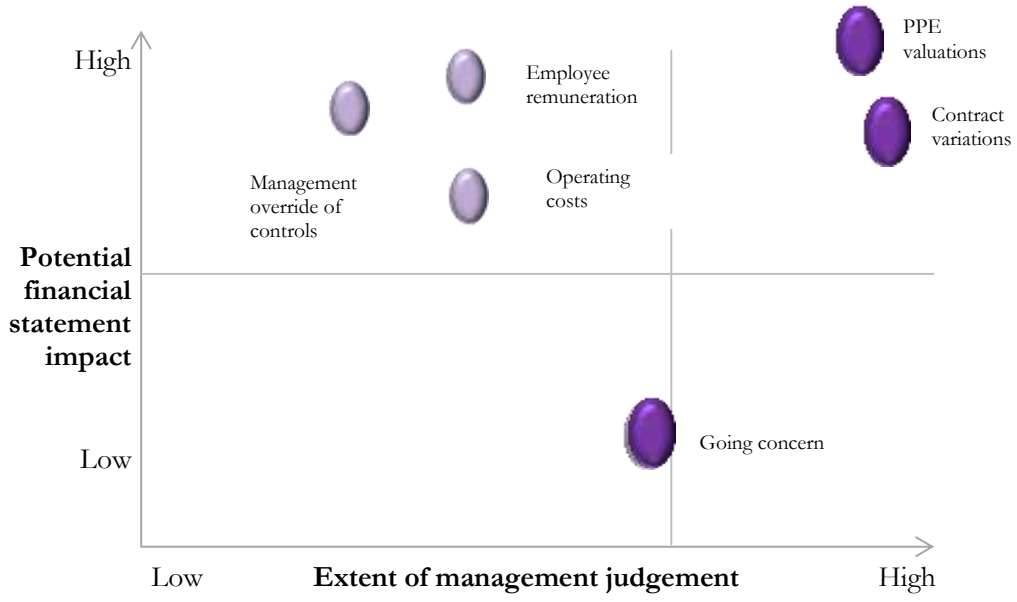
Overview of our audit approach

- Overall materiality: £4,164,000 which represents 1.75% of the Trust's 2016/17 gross operating expenses
- Key audit matters were identified as:
  - Material uncertainty related to going concern
  - Occurrence and accuracy of income from contract variations
  - Valuation of property, plant and equipment

We have tested and obtained sufficient appropriate audit assurance for the Trust's material income and expenditure streams, assets and liabilities.

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that 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. In addition to the matter described in the Material Uncertainty Related to Going Concern section, we have determined the matters described below to be the key audit matters to be communicated in our report.

Key Audit Matter	How the matter was addressed in the audit
Risk 1 **Occurrence and accuracy of income from contract variations** Approximately 89% of the Trust's income is from patient care activities and contracts with NHS commissioners. These contracts include the rates for and the level of patient care activity to be undertaken by the Trust. Any patient care activities provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by the commissioners. We have identified the occurrence and accuracy of income from contract variations as a significant risk, which was one of the most significant assessed risks of material misstatement..	Our audit work included, but was not restricted to: • gaining an understanding of the Trust's system for accounting for income from contract variations and evaluating the design of the associated controls; • evaluating the appropriateness of the Trust's accounting policy for recognition of income from patient care activities and assessing its compliance with the Department of Health's Group Accounting Manual 2017-18; • on a sample basis agreeing amounts recognised as income in the financial statements to signed contracts, and reviewing contract variations to supporting documentation. The Trust's accounting policy on recognition of income from patient care activities is shown in note 1.2 to the financial statements and related disclosures are included in note 3.1. **Key observations** We obtained sufficient audit evidence to conclude that: • the Trust's accounting policy for income from patient activities is in accordance with the Department of Health and Social Care Group Accounting Manual 2017-18 and has been properly applied • income from patient care activities is not materially misstated.
Risk 2 **Valuation of property, plant and equipment** The Trust uses an external valuer to revalue its property, plant and equipment on an annual basis. This represents a significant estimate by management in the financial statements. We therefore identified the valuation of property, plant and equipment as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • assessing the competence, objectivity and capabilities of the valuer used by the Trust; • evaluating management's processes and assumptions for the calculation of the estimate and the appropriateness of the instructions issued to the valuer, the basis of valuations and the scope of their work; • for a sample of assets revalued in the year, agreeing the valuation in the valuer's report to the Trust's asset register and the financial statements; • challenging the information and assumptions used by the valuer to ensure it was complete and accurate. The Trust's accounting policy on property, plant and equipment is shown in note 1.6 to the financial statements and related disclosures are included in note 12. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the valuation was appropriate and the assumptions and processes used by management in determining the estimate were reasonable

Key Audit Matter	How the matter was addressed in the audit
	• the valuation of property disclosed in the financial statements is reasonable.

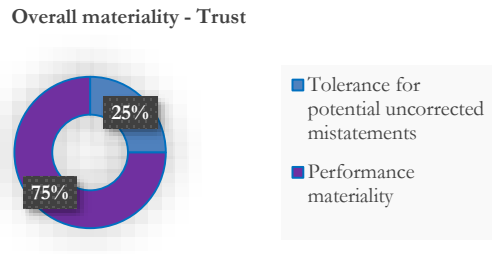
Our application of materiality

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 in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£4,164,000 which is 1.75% of the Trust's 2016/17 gross operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue. Materiality for the current year is the same as we determined for the year ended 31 March 2017 as we did not identify any significant changes in the Trust or the environment in which its operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Specific materiality	Disclosures of senior manager remuneration in the Remuneration Report: £27,000 based on 1.75% of the total executive and non-executive directors remuneration. Disclosure of related party transactions: £700 based on 1.75% of total related party transactions expenditure.
Communication of misstatements to the Audit Committee	£208,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business. It included an evaluation of the Trust's internal controls including relevant IT systems and controls over key financial systems.

Our work involved obtaining evidence about the amounts and disclosures in the financial statements to give us reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. The scope of our audit included:

- undertaking an interim audit visit where we obtained an understanding of and evaluated the Trust's overall control environment relevant to the preparation of the financial statements, including its IT systems, completed walk through tests of the Trust's controls operating in key financial systems where we consider that there is a risk of material misstatement to the financial statements and performed interim testing on a sample basis of operating expenditure and non healthcare income.
- performing year end testing on the Trust's financial statements, which focussed on gaining assurance around the Trust's material income streams and operating cost, testing the Trust's employee remuneration cost and the notes to the accounts to ensure that they were compliant with the Department of Health and Social Care's Group Accounting Manual for 2017/18.
- We tested and obtained sufficient appropriate audit assurance for the Trust's material income and expenditure streams, assets and liabilities.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report, set out on pages 2 to 82 ,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 of the Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources 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 this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable set out on page 60 in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- Audit Committee reporting set out on page 32 in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does appropriately

address matters communicated by us to the Audit Committee and is materially consistent with our knowledge obtained in the audit.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual 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

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities, set out on page 67, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2017/18, 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 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 Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

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 Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matter described in the basis for qualified conclusion section of our report, we are satisfied that, in all significant respects, Warrington and Halton Hospitals NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matter:

- The Trust incurred a deficit of £14.7 million in 2017/18, compared to a planned deficit of £3.8 million. Unprecedented levels of activity, the suspension of the spinal service, and the premium cost of winter, had an adverse effect on the Trust's financial position. This had an impact on the Trust's ability to deliver its planned level of cost savings and its expected access to income of £4.6 million from the Sustainability and Transformation Fund. The Trust also requested revenue support from the Department of Health and Social Care during the year of £17.3 million. As at the 30th April 2018, the Trust forecasts that it will need to continue to rely on revenue support in 2018/19 and will have a working capital loan requirement of £63.8m.

This matter identifies weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures. This issue is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

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

Mark Heap

Mark Heap
Director

for and on behalf of Grant Thornton UK LLP

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB

25th May 2018

INDEPENDENT AUDITOR'S STATEMENT TO THE DIRECTORS OF WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST ON THE NHS FOUNDATION TRUST CONSOLIDATION SCHEDULES

We have examined the consolidation schedules designated TAC02 to TAC29 for tables outlined in red, excluding TAC05A and TAC23 of Warrington and Halton Hospitals NHS Foundation Trust for the year ended 31 March 2018, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This statement is made solely to the Board of Directors of Warrington and Halton Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and paragraph 4.2 of the Code of Audit Practice. Our work has been undertaken so that we might state to the Accountable Officer those matters we are required to state to them in a consistency statement and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Accountable Officer as a body, for our audit work, for this statement, or for the opinions we have formed.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the consolidation schedules which are also included in the audited financial statements. Auditors are required to report on any differences over £300,000 between the audited financial statements and the consolidation schedules.

1. Unqualified audit opinion on the audited financial statements; no differences identified:

The figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.

Grant Thornton UK LLP

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester

25th May 2018