Warrington and Halton Hospitals NHS Foundation Trust

Annual Report and Accounts

2013-2014

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

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1. Chairman's report

Allan Massey, trust chairman

Welcome to our annual report for 2013 to 2014. This will actually be my final introduction to an annual report for the trust as I enter my final year as chairman of the trust. It has been a fantastic privilege to be the chairman of the trust over the last 11 years.

It's been a time of great change for our trust and there is a lot to reflect on. During that time we have reconfigured services, moved to NHS Foundation Trust status, delivered real improvements to the facilities in our hospitals and most importantly have improved clinical care.

We now have two vibrant hospital sites, each specialising in providing the highest quality service to our patients. Through this annual report you can read more about what we have done over the last year to take our services forward. We have seen impressive improvements in the majority of the quality indicators we have been working on – with reductions in falls, pressure ulcers and urinary tract infections for example. We have also seen work around reducing mortality rates take affect over the year. This will continue and we are striving to be a top performer in this area. It's a topic that we have focused on in our trust board meetings each month and we have been pleased to see the trust mortality rate falling over the year.

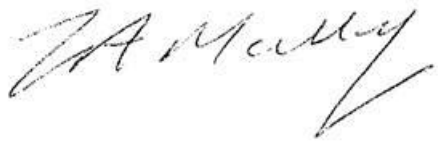
The last year has seen us face a particular challenge around finance. This is sadly not a unique situation in the NHS and many trusts have faced the same challenge in 2013-2014. To meet the national efficiency targets we had to meet a saving of over £11million in the year here and that has not been easy. We worked in partnership with our staff to deliver cost improvement plans to deliver this challenge, keeping them involved and informed throughout the year. Over 700 staff shared their own bright ideas about how we could save money and contribute to the challenge and I believe that this open approach has been reflected in our improved staff engagement scores in the NHS Staff Survey for 2013.

At the end of the year we saw a deficit of £2.8 million at the trust but we have a clear forward looking plan for the future to move back into surplus over the coming years.

What is really important to note is that the financial situation we faced has not stopped us investing in quality. As a board we took a clear decision about this. In the last year we were able to invest in our maternity services, create a truly pioneering dementia care facility and also invest in extra staff in key areas. This has helped us to ensure we met the operational framework targets for the year – including the very challenging A&E access target that many trusts failed to achieve.

None of this would be possible without the work and commitment of our staff. This includes our volunteers, our governors and also our members. As this is my final annual report I would like to take the opportunity to thank each and every member of the team for playing

their part in making Warrington and Halton Hospitals the trust that it is. I know the trust will continue to be successful in the future.



Allan Massey
Chairman
28th May 2014

New CQC risk ratings and inspections highlight our safe service.

The trust welcomed the publication of new, publically available, risk rating reports on NHS hospitals when the independent regulator of health services the Care Quality Commission (CQC) published full risk profiles and bandings for NHS Trusts for the first time in October 2013.

It is part of a system known as Intelligent Monitoring and is based on **150 indicators** that look at a range of information including patient experience, staff experience and statistical measures of performance including detailed mortality rates, waiting time and access information, patient feedback and actual CQC inspection results.

The CQC have banded each hospital trust into one of six categories based on the risk that people may not be receiving safe, effective, high quality care - with band 1 being the highest risk and band 6 the lowest risk. Warrington and Halton Hospitals was placed in Band 5 of the six bands – highlighting the quality and safety of our services.

The CQC also carried out unannounced inspections at Halton General Hospital campus (including the Cheshire and Merseyside Treatment Centre – pictured above) and Warrington Hospital in 2013-2014 with the trust meeting all standards assessed against.

2.Background to the trust

About Warrington and Halton Hospitals

Warrington and Halton Hospitals is an NHS Foundation Trust providing services from Warrington Hospital, Halton General Hospital and the Cheshire and Merseyside Treatment Centre in the North West of England. We were formed in 2008 after North Cheshire Hospitals NHS Trust gained NHS foundation trust status. In accordance with the trust's Constitution the trust's principal activity is the provision of goods and services for the purpose of the health service in England.

Our mission is to provide **High Quality, Safe Healthcare** and our staff work together to provide excellent health care services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas. We are responsible for a budget of around £210 million each year, manage over 4,100 staff and provide access to care for over 500,000 patients so there is a lot to know about us and how we work.

Our trust has come a long way over the last few years. We have performed well clinically and made major improvements to patient safety. Waiting times have been slashed, we've reduced infections by over 90%, achieved NHS Foundation Trust status and seen a wide range of new state-of-the-art facilities opened to provide first class NHS care to the people of Warrington, Runcorn, Widnes and the surrounding areas.

Based on feedback from our Governors, members, patients, staff and the public we developed the QPS framework for helping us to deliver our longer term vision in 2012 – 2013. It is underpinned by a range of improvements that we want to deliver to further improve our services. Nationally, it promises to be a period of change for the NHS in difficult economic times. We want to be in a position to continue to grow our services and take opportunities to provide our care in new ways for the benefit of our patients.

Despite these challenges, our local focus is very much on safety, quality and continual improvement so that you can take pride in your hospitals, the services we provide and the people who work in them.

That's why our overall mission is to provide **high quality, safe healthcare**. This mission guides the work of our trust board, council of governors and clinical and corporate teams.

QPS - Quality, People and Sustainability

QPS is a simple framework to help us achieve in three key areas that are important to patients and staff alike. These are quality, people and sustainability. It helps us to focus our work and shape our plans for the future.

The three elements of QPS are:

Excellence for our patients – Includes safety, effectiveness and experience

Caring for our staff – About our workforce, how we engage with you and how we develop leadership and help enhance your careers and use your skills

Here for our community – A focus on good governance, financial viability, the profile and perception of the trust and growth.

Each area has a remit of work, backed by targets and improvements we want to see. For example, **quality** is underpinned by real improvements like reductions in infection, pressure ulcers and falls; **people** by improvements in how our staff perceive us, how we engage with them and reductions in sickness; and **sustainability** by improvements in our role in the community, governance standards and stable finances.

Did you know?

- There are over 630 beds across our hospitals
- 4,198 staff work across our wards and departments
- We serve a core local population of 329,500 people (125,800 in Halton and 203,700 in Warrington)
- We provide almost 500,000 individual appointments, procedures and stays in hospital each year
- We became an NHS Foundation Trust in December 2008 and have over 13,000 public members
- Before December 2008 we were known as North Cheshire Hospitals NHS Trust.

Three hospitals, two sites, one great team

The majority of our emergency care and complex surgical care is based at **Warrington Hospital,** whilst **Halton General Hospital i**n Runcorn is a centre of excellence for routine surgery. The **Cheshire and Merseyside Treatment Centre** is home to our orthopaedic surgery services on the Halton General site.

Although each hospital site specialises in particular aspects of care, we provide outpatient clinics for all our specialties and diagnostic (scanning) services at both Warrington and Halton so people can access their initial appointments close 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. Many new departments and facilities have opened at the hospital over the last few years and it provides a full range of expert inpatient and outpatient services.

Warrington Hospital is home to our accident and emergency department and maternity services. If your surgery or care might require extra support or a high level of specialist care it is likely to be carried out at Warrington. The hospital is also home to specialist critical care, stroke, cardiac and surgical units.

Halton General Hospital

A range of care for medical and surgical conditions is provided at Halton General Hospital and it houses a mix of inpatient and outpatient services. It provides a fantastic, friendly environment for expert surgical care. If your surgery is non-complex and does not require a long hospital stay it is likely to be carried out at Halton General.

The hospital is home to a minor injuries unit (open 9am to 10pm every day) which provides a range of minor emergency care services for local people and the hospital provides x-ray facilities until 8pm. A step down ward at the hospital is designed for patients who have had surgery or emergency medical care but who require some further support before going home. We provide chemotherapy services on site and the hospital is home to the Delamere Macmillan Unit that provides cancer support and advice.

The Cheshire and Merseyside Treatment Centre

The Cheshire and Merseyside Treatment Centre - also known as the CMTC - is our home for orthopaedic surgery and treatment services on the Halton General Hospital campus. We provide surgery ranging from hand and foot operations through to spinal back surgery and hip and knee replacement operations at the centre - as well as sports injuries (sports medicine) and other bone and joint care.

The centre was purpose built for orthopaedic surgery and was originally opened in 2006 as a home for a private health provider who was contracted to the NHS until 2011. We were delighted to be able to re-open the centre for local patients in 2013 and move our orthopaedic services to their new home. It is an extremely popular choice for surgery with excellent patient feedback.

Our executive directors

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. After a number of clinical roles, she 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.

Simon Wright - Chief Operating Officer and Deputy Chief Executive

Simon was appointed as director at the trust in June 2007. Simon started his management career with nine years in the independent health sector before joining The Walton Centre for Neurology and Neurosurgery NHS Trust in 1997. He joined Salford Royal Hospitals Trust in 2001 and oversaw the integration of Greater Manchester Neurosciences, followed by extending the surgical specialties brief as general manager. The general manager post was changed to associate director with an operating budget of £70m and 1,800 staff. Simon has an MSc from Lancaster University. He is married with a son and enjoys music, sport and reading. He took on the role of deputy chief executive in July 2013.

Tim Barlow - Director of Finance and Commercial Development

Tim joined the trust in September 2013 from Trafford Clinical Commissioning Group where he was chief operating officer and chief financial officer. He had previously held the role of director of finance, contracting and performance in Trafford Primary Care Trust. He is a graduate certified accountant with an MBA from Manchester Business School. Tim’s background before joining NHS Trafford consisted of 26 years’ experience, in a variety of senior finance roles within large Private sector organisations including UK finance director for both Thomas Cook and MyTravel PLC and subsequently the finance director for the merged Thomas Cook Airlines.

Jason DaCosta - Director of Information 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.

Karen Dawber - Director of Nursing and Organisational Development

Karen joined the trust as director of governance and workforce in January 2012. She became director of nursing and organisational development in May 2013. Karen has extensive NHS experience, both managerial, operational and clinical, starting her career as a paediatric nurse at Manchester Children's Hospitals. Prior to this appointment Karen has been a director of nursing at both The Walton Centre and Alder Hey Children's hospital. Karen lives with her partner and has one daughter and enjoys reading, walking and caravanning. Karen has been involved in regional and national initiatives including 'Energising for Excellence'.

Dr Paul Hughes - Medical Director

Dr Paul Hughes joined the trust as medical director in February 2014. He studied Medicine in Manchester and was commissioned as a medical officer in the Royal Air Force in 1989. An anaesthetist and intensivist, during his training he served in Germany and was deployed to conflicts in Kosovo and Iraq, and was part of the Royal Air Force Critical Air Support Team repatriating sick and injured servicemen/women from all over the world. He was appointed as consultant in neuroanaesthesia & critical care at Leeds General Infirmary in 2003. He retired from the RAF as Wing Commander in 2005 and moved to take up a consultant post in Wrexham, becoming clinical lead for intensive care, clinical director in anaesthesia, associate medical director for informatics and assistant medical director for Betsi Cadwaladr University Health Board. Prior to taking up post in the trust he has been medical director & director of clinical services for the Welsh Ambulance Service NHS Trust since 2011.

Our non-executive directors

Allan Massey – Chairman

Allan Massey was appointed chairman in December 2004. Allan started his career in 1965 in a civil engineering company in Warrington before working in a variety of private sector accountancy roles, culminating in works accounting manager for a major manufacturing company. In 1982 Allan moved to the public sector and worked in local government with Warrington Borough Council as treasury manager - managing a portfolio of over £500 million. He became a local councillor in 1997 at Halton Borough Council with executive board portfolios for social care and health, education and lifelong learning and business efficiency. Allan was appointed deputy chair of Halton NHS Primary Care Trust in 2002 before joining our trust as chairman. Allan lives in Runcorn and is married to a health service professional. The Chairman has no other commitments outside of his work at the trust.

Lynne Lobley

Lynne joined in December 2009, having held previous non-executive director appointments on the Boards of the Walton Centre NHS Foundation Trust and Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust in Shropshire. She is also the lay member of the Senior Management Team of Mersey Deanery which is responsible for commissioning and quality managing post-graduate medical education and training in the region. In addition, she has considerable executive level experience within the Further and Higher Education sector, in both academic and management roles.

Rory Adam

Rory Adam joined the trust in December 2007. After studying engineering at university Rory worked in the oil industry, firstly in construction, then technical audit, commercial areas and eventually in finance where he qualified as a chartered management accountant. He moved to Warrington in 1996 and spent five years as finance director of local healthcare company Fresenius Kabi. During this time Rory also qualified as a chartered director with the Institute of Directors. He then acted as a management consultant including assignments in the food manufacturing industry, international logistics, and agency provision of health care and social care personnel. In 2008 Rory joined Protomed, a new company set up to develop its unique Biodose medication management system which allows pharmacists to pre-prepare multi prescription liquid and solid medicines for elderly and chronically ill patients in care homes and at home.

Clare Briegal

Clare Briegal joined as a non-executive director in November 2008. Clare is a general manager and marketing consultant. She began her career as a research scientist for a US medical products firm and then transferred to a sales & marketing role. Clare returned to the UK and held a number of senior sales & marketing positions with ICI Acrylics and then Twyford Bathrooms where she was appointed Marketing Director in 1999. She became Managing Director of Trendsetter Home Furnishings in 2002 and set up her own on-line business, ilovemyduvet.co.uk, in 2005. Clare has been acting chief executive of the International Netball Federation since September 2013 – a position she has been permanently appointed to in early 2014. Clare has an MBA from Manchester Business School, an MA in Natural Sciences from the University of Cambridge and an MA in Biochemistry from Bryn Mawr College, USA. She has lived in Warrington since 1995.

Dr Mike Lynch

Dr Mike Lynch joined the trust as non-executive director in July 2013. Mike trained extensively in the United Kingdom and the United States and was a consultant at St Helen's and Knowsley Hospitals from 1982 in general medicine and rheumatology, becoming medical director at the trust. Mike worked with Warrington and Halton Hospitals as interim clinical director of unscheduled care in 2012 and 2013 before becoming a non-executive director with the trust.

Carol Withenshaw

Carol Withenshaw was appointed as non-executive director in 2007. Carol is also the trust's senior independent director. Carol is a health care management consultant and acts as chair of the National Clinical Homecare Association (NCHA) and is a member of National Homecare Medicines Committee (NHMC). Carol started her career at Greenall Whitley Brewery PLC from 1969, becoming group training manager in 1984. In 1988 she moved to the Fresenius Healthcare Group and worked in a range of senior management roles before becoming operations director. Carol then became managing director of Fresenius' Calea UK subsidiary and was responsible for developing and launching the new business which provides specialist support services to the NHS for patients and health care professionals in community and hospital settings.

Delivering our new maternity ward in 2013-2014.

The labour ward at Warrington Hospital now has some of the best facilities in the region after the completion of our £450k refurbishment work to improve birth options for local women in June 2013.

The funding has provided en-suite facilities of toilet and showers in the individual labour ward rooms. The existing bathrooms on the ward have been upgraded with brand new suites. There is also a new midwifery-led, low-risk birthing suite within the unit; these are for women who have had a trouble free pregnancy and who want to have an active birth. Two of the rooms in this area have birthing pools for a water birth option.

We now have a new induction of labour bay, which enables a birthing partner to stay overnight with mum to be, to support her in the early stages of labour.

In addition, we have also refurbished our facilities for aromatherapy, reflexology and hypnotherapy-birthing services, which provide greater choice in birthing plans for parents like the Osman's from Runcorn (pictured above) who welcomed the first set of twins born on the new look unit.

3. Strategic Report & Business Review

Review of the business 2013-2014

3.1 Financial performance

Financial position at the end of the year

During 2013-2014 the trust had an operating income of **£212,729,000** (2012-2013; operating income £208,366,000). The trust finished the year with a reported deficit of **£2,849,000**. In the previous year 2012-2013 the trust had a deficit of £1,109,000.

Copies of the full accounts of the trust are included in this report and are available on the following websites:

- www.whh.nhs.uk
- www.monitor-nhsft.gov.uk

The year-end position of a deficit of £2,849,000 was £4,001,000 worse than the planned surplus at the beginning of the year of £1,152,000.

Each NHS Foundation Trust is given a financial risk rating by Monitor – the Independent Regulator of NHS Foundation Trusts. Based on these financial results the trust has been assessed a **Continuity of Services Risk Rating of 3**, which is lower than the planned rating of 4.

Financial summary and narrative

Warrington and Halton Hospitals NHS Foundation Trust was established on 1st December 2008, and therefore the financial results represent the fifth complete financial year as an NHS Foundation Trust. This section aims to provide an overview of the financial position of the trust and is supplemented by the information provided in the full accounts in this document.

The trust faced a significant financial challenge during 2013-2014. At the start of the year the trust had identified the need to meet an £11,000,000 cost improvement programme challenge to meet national efficiency and other locally set targets.

In November 2013 the trust decided to place itself in 'internal turnaround' to help address potential shortfalls in the financial position. Ernst and Young were brought in to the trust to assess the trust's cost improvement programme and give reassurance of the long term financial position and a possible shortfall of up to £6,000,000 against plan. Monitor were informed of the position and actions being taken to address this and the trust board agreed to deliver a re-targeted end of year position of a deficit of £2,935,000.

Through working to control costs through the final months of the year the trust was able to deliver a final deficit of £2,849,000.

Summary: Actual Income and Expenditure results compared with plan

Narrative	Planned £000	Actual £000	Variance £000
Operating Income	208,887	212,729	3,842
Operating Expenses excl. impairments and restructuring costs	(203,223)	(210,837)	(7,614)
Restructuring costs	(600)	0	600
Impairments	0	(697)	(697)
Operating surplus	**5,064**	**1,195**	**(3,869)**
Finance Costs	(3,912)	(4,044)	(132)
Surplus (Deficit)	**1,152**	**(2,849)**	**(4,001)**

The trust finished the year with a reported deficit of £2,849,000. The reported deficit of includes a non-cash charge of £697,000 relating to impairments of fixed assets. This is an adjustment for the impairment of fixed assets no longer in use at the trust as at 31 March 2014.

Q. What did we get paid for?

Operating income

The total operating income generated in the year was £212,729,000. An analysis of income is provided in the table below.

	2013/14 £000	2012/13 £000
Income from commissioner requested services		
Elective income	40,571	37,401
Non elective income	62,357	67,302
Outpatient income	32,702	32,457
A & E income	10,164	10,496
Other NHS clinical income	47,377	41,197
Income from non-commissioner requested services		
Private patient income	145	132
Other non-protected clinical income	1,317	1,669
Total income from activities	**194,633**	**190,654**
Other operating income		
Education and training	7,469	7,363
Non-patient care services to other bodies	1,979	2,478
Charitable and other donations	799	153
Reversal of impairments	149	0
Other	7,700	7,718

Total other operating income	**18,096**	**17,712**
Total operating income	**212,729**	**208,366**

The definition of other operating income includes income relating to training and education, research and development and the provision of non-healthcare goods and services to both NHS and non NHS bodies. This non-healthcare income supplements the income generated from healthcare services and therefore allows the trust to maximise the income potential and associated investment opportunities. The time and resource incurred in generating this income is not delivered from clinical resources, so does not impact on the amount of time and resource available to deliver healthcare services and generate the associated income.

Q. Where did our money come from?

Income from clinical activities

The majority of income was received from Clinical Commissioning Groups for health care services provided to patients.

	2013/14 £000	2012/13 £000
Primary Care Trusts	0	188,706
Clinical Commissioning Groups	179,164	0
NHS England	10,573	
NHS Other	1,435	147
Local Authorities	1,999	0
Non NHS: private patients	145	132
ICR income	1,317	1,669
Total	**194,633**	**190,654**

Q. Where did we spend our money?

Operating expenses

The total operating expenses incurred in the year were **£211,534,000** with the majority of expenses incurred on salaries and wages (employee payroll costs). An analysis of operating expenses is provided in the table below.

	2013/14 Total £000	2012/13 Total £000
Services from other NHS bodies	104	159
Purchase of healthcare from non NHS bodies	7	713
Employee costs - executive directors	785	932
Employee costs - non-executive directors	117	117
Employee costs - staff	148,994	145,369
Employee costs - termination costs	0	100
Drug costs	12,387	10,812
Supplies and services - clinical (excluding drug costs)	18,863	18,154
Supplies and services - general	2,546	2,631
Establishment	2,280	2,100
Transport (business travel only)	287	267

Transport (other)	640	415
Premises	9,090	8,560
Rentals under operating leases	436	411
Increase/ in bad debt provision	141	75
Change in provisions discount rate	26	0
Depreciation on property plant and equipment	5,804	5,530
Amortisation of intangible assets	54	60
Impairments of property plant and equipment	697	1,989
Audit fees - statutory audit - Audit Commission	0	3
Audit fees - statutory audit - PricewaterhouseCoopers LLP	57	67
All other non-audit services - PricewaterhouseCoopers LLP	0	49
Clinical negligence premiums	5,453	4,466
Legal fees	147	254
Consultancy costs	622	410
Training courses and conferences	616	723
Patient travel	17	18
Commercial insurance	135	129
Losses, ex gratia & special payments	6	5
Other	1,223	1,071
TOTAL	**211,534**	**205,589**

Q. How safe are the trust's finances?

Performance against Monitor's Risk Assessment Framework.

In order to assess whether the financial situation of the Trust placed services at risk, Monitor introduced a Continuity of Services Risk Rating as part of the Risk Assessment Framework which was effective from 1st October 2013.

The Continuity of Services Risk Rating incorporates two measures of financial robustness, liquidity and capital servicing capacity. The metrics are set out below and assess the financial risks to the Trust based on its historical financial performance, with 1 representing the highest risk and 4 representing the lowest risk.

The assessment is completed monthly and verified by Monitor quarterly. The metrics resulting from the annual accounts are detailed in the table below and for year the risk rating is 3.

The NHS is facing significant financial challenges over the next few years which is reflected in the annual planning assumptions over the next two years. The trust is planning for a £1.5m deficit in 14/15 and a £1.0m deficit in 15/16, both of which are reliant upon significant cost reductions. It is then anticipated that the trust returns to a position of break even or better over the next three year period. The financial modelling undertaken by the trust shows that even allowing for a deficit in the next two years there is sufficient cash available to meet its financial obligations and deliver a continuity of services risk rating 3.

Risk Rating metrics as at 31st March 2014.

Metric	Q3 Rating	Q4 Rating
Capital Servicing Capacity	1	2

Liquidity	3	4
Overall Rating	**2**	**3**

Going concern basis

The accounts have been prepared on a going concern basis. This decision has been made by the directors of the trust on the basis that after making enquiries the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason we continue to adopt the going concern basis in preparing the accounts.

The directors confirm that the trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Principal risks and uncertainties during the year

The trust continues to face risks to achieving its strategic objectives and developments and has established and maintained a comprehensive Assurance Framework and supporting Corporate Risk Register to identify, understand and manage risk.

The Assurance Framework and Corporate Risk Register are subject to regular review and appraisal to ensure risks and reduction of risk are managed proactively. Systems and controls have been established to manage the risks, which are monitored by the Board on a regular basis following review at the trust's Governance Committee.

In accordance with the risk management strategy the trust keeps under constant review all potential significant risk exposures. The trust's strategic plan has been assessed to identify future risk exposure. These risks are reported within the trust's Strategic Plan, which is reviewed by the Board of Directors and submitted to Monitor.

In summary the significant risks facing the organisation relate to:

Delivery of the Quality Strategy

- Operational pressures and capacity of the workforce might limit the trust's ability to implement and maintain the changes required
- Failure to reduce the level of harm events
- Failure to provide a robust response to the Francis Report action plans
- Failure to maintain the required momentum for the delivery of the plans
- Challenge in delivering Clinical Commissioning Group designed quality indicators

Delivery of the Financial Strategy

- Managing the financial impact of the transfer of vascular services from Warrington to the designated specialist units as part of the regional vascular review
- Delivering £11,931,000 cost savings required to meet our financial plan in 2014-2015 and avoiding slippage

- Ensuring the planned productivity and service improvements are delivered
- Managing down our inpatient length of stay and delivering improvements for our patients, which will improve quality and will also reduce our bed capacity and save money
- Achieving our contract performance and quality improvement targets for Clinical Commissioning Groups (CCGs) to avoid financial penalties

3.2 Operational performance

Over the last few years, the trust has successfully delivered significant changes to the way in which we provide services which has allowed us to both improve the quality of services to our patients and to ensure that we use the resources available to us as efficiently as possible.

During 2013-2014 we have continued to strengthen and perform well on quality by investing in our staff in key areas. We have strengthened our clinical teams with more doctors, more nurses and more allied health professionals recruited in key targeted areas of the trust. Staff numbers (headcount and whole time equivalent) have grown during the year.

Importantly in terms of quality, the trust has invested in new facilities and services within maternity and dementia and in the use of information technology (IT) to support enhanced clinical delivery. We have developed new strategies for nursing, dementia and quality.

We have performed well in relation to external assessment by the Care Quality Commission and have implemented the Friends and Family initiative across inpatient; accident and emergency and maternity services.

In 2013-2014, the trust's improvement priorities were:

- Reduction in medication errors related to insulin
- Zero tolerance to hospital acquired MRSA bloodstream infections
- Reduction in catheter associated Urinary Tract Infections
- Reduction in incidents that result in severe or catastrophic harm
- 62 day cancer access target
- Reducing mortality rates
- Pressure Ulcers – reduction

The trust is pleased to report an improving performance across each of these areas for 2013-2014 with the exception of the number of reported hospital acquired MRSA bloodstream infections where the trust is reporting three cases against a threshold of zero (an increase from 2012-2013 when performance was one MRSA against a threshold of three).

Some key performance targets in year:

A&E

The trust achieved the 95% A&E access target for the year 2013-2014 – with a final figure of 95.55% for the trust across the year. This is an excellent achievement for A&E and minor injuries as many hospitals struggled to meet the target over the year.

Mortality

We are in expected ranges for both mortality measures – SHMI and HSMR. We have continued to see a trajectory of reduction in both key mortality rates of HSMR and SHMI across the year.

18 week referral to treatment

The trust delivered its commitment for access from GP referral to treatment for the people of Warrington and Halton in under 18wks for over 90% of all referrals for the 6th year in a row. In addition we have seen the second and third phase of the planned transfer of activity across to Halton with orthopaedics and spines in phase II and the remaining general surgery, urology, breast and gynaecology in phase III. This has successfully seen our trust achieving 18wks for orthopaedics in January and continuing to receive the highest patient's ratings for surgery of any hospital across the North West.

Cancer

We remain one of a very small group of trusts who has achieved all nationally set cancer targets throughout 2013. This year saw the introduction of a new local rule on allocation of breaches at day 42 on a cancer pathway. This has seen many hospital trusts failing at least one of the national access targets. Our trust has worked incredibly hard to continue to deliver this commitment and target.

Infection Control

One area where we have struggled this year has been around infection control against a very challenging baseline target for the trust. As mentioned above, there were three cases of MRSA bacteraemia against our nationally set target to have zero in year. There were 31 cases of hospital acquired C-difficile where our target for the year was no more than 19. The trust reviewed each case and there was no cluster of related outbreaks of C-difficile so these were individual cases. NHS England has said that the trust is performing well in terms of infection control against a very low threshold and that that threshold has been increased for 2014-2015. However, the trust has committed to returning to our previous excellent performance in this area of work which has seen infection rates fall by around 90% in the previous five years.

Full detail on performance in each of these areas is included in the Quality Report in Section 5.

The trust has also delivered continued excellent performance against national access targets in spite of challenges that have been experienced in other NHS organisations. The trust successfully delivered the 18 week waiting time target performance for both admitted and non-admitted patients throughout the year as well as maintaining achieving the four hour accident and emergency waiting target in each quarter and for the year.

When assessed by the Care Quality Commission as part of the Hospital Intelligent Monitoring initiative, the trust received an inspection priority banding of 5 based on the likelihood that people may not be receiving safe, effective, high quality care (where 1 is the highest risk and 6 is the lowest risk). This reflects an excellent performance for our organisation and one that we are extremely proud to achieve.

3.2.1 Trends and factors likely to affect the foundation trust's future development, performance and position.

The upcoming five-year period is likely to be one of the most turbulent and transformational in the history of the National Health Service.

The recurrent affordability challenge for the NHS will see our organisation start each year over the next five years with a significant cost improvement target. The impact of service reconfigurations, specifically the relocation of specialist services into tertiary centres and the better co-ordination of locally delivered community services, represent a key financial risk to the trust with the potential to see legacy costs remain in the organisation as services transform.

The trust recognises the scale of the financial challenge that we are facing over the course of the next two years and beyond and as such we have detailed what we believe are challenging financial targets but that recognise our organisational capabilities, the specific challenges that we face within our health economy over this period and our previous track record in delivering cost improvements though large scale change.

The trust faces significant financial challenges in both the short and long term periods due to a combination of national efficiency requirements and local pressures. The trust is planning a deficit of £1.5m in 2014-2015 - which reduces by £0.5m to £1.0m in 2015-2016.

In 2014-2015 the £1.5m deficit is predicated on the achievement of a £11.9m cost savings target primarily due to the national efficiency requirement (£8.4m), the impact of the transfer of vascular services to a new regional network centre (£1.3m), an increase in the NHSLA premium (£1.3m) and the current underlying deficit (£5.3m), partially offset by the assumed receipt of winter monies (£1.5m), a reduction in pay award and incremental drift (£0.8m) due to the recent government response to the proposed pay award and service expansion / growth. A deficit of £1.5m will deliver a continuity of services risk rating of 3 by 31st March 2015.

In 2015-2016 the £1m deficit is predicated on the achievement of a £11.5m cost savings target primarily due to the national efficiency requirement (£9.5m), full recovery of the 2014-2015 winter monies (£1.5m) and partial recovery of the 2014-2015 deficit (£0.5m). A deficit of £1m will again deliver a continuity of services risk rating of 3 by 31st March 2016.

In recognition of the fact that specialist services are increasingly likely to be transferring out of the district general hospital sector and into specialist units - and that both of our local commissioners have expressed firm intentions to commission more care closer to patients homes in the future - it is extremely unlikely that the current configuration of acute and community providers will remain unchanged over the next two to five years.

For this reason, the trust recognises the importance of maintaining an active dialogue with all local partners and agencies to allow us a degree of agility when working to deliver large-scale transformational change programmes.

Local commissioners have indicated a preference as part of their strategic plans to move away from primarily hospital based models of care with a strong focus on integration of services across the health and social care spectrum. There is also a desire to redesign care pathways around the needs

of the patient and their carers so that they are easier to navigate, promote high quality, equity, accessibility and choice.

Whilst these key strategic aims are fully supported by the trust, a key risk is in managing the transition from hospital-based models of care without destabilising continuity of care. The trust will be looking to commissioners to support us in delivering that continuity through identified transitional funding arrangements and through taking a pragmatic approach to awarding contracts via the Transforming Community Services agenda when contracts are eligible for renewal.

3.2.2 Regulatory ratings

Care Quality Commission visits and action plans

The Care Quality Commission has made two unannounced visits to the trust in 2013-2014 as part of its on-going inspections programme. The trust met all standards it was assessed against.

Halton General Hospital – general inspection October 2013

- Inspectors from the CQC spent two days at Halton General from 1st October 2013 October as part of their unannounced inspection programme. The team included inspectors and also a member of the public who spoke to patients. They visited wards and departments observing care in practice and spoke in depth to both staff and patients. The inspection started with an evening visit to the Minor Injuries Unit and also took in the wards at the main hospital. The trust's Cheshire and Merseyside Treatment Centre on the site, which has reopened as an orthopaedic surgery centre, was also visited.
- The report found that care at Halton met all of the essential standards that they look for in their four core areas of consent to care and treatment; care and welfare of patients; management of medicines; and staffing.
- The report shows that patients are well cared for, communicated with and their needs met at Halton. Patients spoken to felt that they had a full and clear understanding of their individual programmes of care and treatment. They commented that they felt they were given sufficient details and answers to any questions they may have, which they felt allowed them to make informed decisions.
- Inspectors noted a person-centred approach to care and treatment, both in the written records examined and in their observations of the interaction between staff and patients that demonstrated consultation and engagement with each patient as an individual. Medicines were managed appropriately and patients were seen to be given excellent pain relief. They also found that the trust has the right staff in post on the wards with staff morale seen to be high.

Warrington Hospital – themed inspection on dementia care January 2014

- Inspectors from the CQC inspected Warrington Hospital on 28th January 2014 in an unannounced themed inspection looking at quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. They went to the Accident and Emergency Department and elderly care wards. They spoke with staff on the wards and departments they visited, observed care being delivered and spoke with patients and family members. The CQC's inspectors were accompanied by an 'expert-by-experience' – someone who has personal experience of using, or caring for someone who uses, this type of care service.
- The inspection found the hospital met all three standards it was measured against - Care and welfare of people who use services; Cooperating with other providers; and Assessing and monitoring the quality of service provision.

- The report says that people the team spoke with told them they were happy with the service they received in the hospital. Comments from patients to the team included ‘The staff seem very jolly with my relative, and chat with her whilst they make sure she is alright’, ‘The staff have been very caring and informative about the medical condition and treatment for this’ and 'The staff have been great with him all the time he has been here’. The report also says that care they observed was delivered by nursing staff in a kind and responsive manner. They saw that family members were involved in discussions about their relatives.
- The inspectors also saw that the hospital had a process to ensure that people with dementia who had different support needs were identified on admission and provided with care and treatment that met their individual needs. They tracked four patient's pathways through the hospital and found that this was effective.
- Most of the staff inspectors spoke with had received training specifically related to dementia care and they all spoke positively about this.

The Care Quality Commission has not taken enforcement action against Warrington and Halton Hospitals NHS Foundation Trust during 2014-2015.

Care Quality Commission intelligent monitoring

In 2013-2014, the Care Quality Commission introduced a system called Intelligent Monitoring. The CQC use intelligent monitoring of more than 150 different indicators to direct resources to where they are most needed. CQC analysts have developed this monitoring to give their inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust. Together with local information from partners and the public, this monitoring helps the CQC to decide when, where and what to inspect.

The CQC ranks all NHS Trusts into one of six bandings – with 1 meaning highest potential risk to patients and quality of case (and thus priority need for inspection) and 6 being the lowest potential risk. The trust was placed in **Band 5** – showing a positive low risk of potential risk to our patients.

Quality standards achieved in year

During the year, the trust achieved **Maternity CNST Level 3**. The maternity unit at Warrington and Halton Hospitals achieved CNST Level 3 status after the assessment that took place in March 2013.

The NHS Litigation Authority (NHSLA) provides an 'insurance scheme' to NHS Trusts against claims for clinical negligence through the Clinical Negligence Scheme for Trusts (CNST). Trusts have to meet standards of care that show they are promoting and using effective risk management to minimise the risk of harm to patients. Because of the nature of claims in NHS maternity services (where payments for incidents are high as they often have to support the baby in later life), a separate set of CNST standards are in place for maternity services.

Each standard covers an area of risk and has ten specific underpinning criteria, each with detailed breakdown, against which trusts are assessed. The NHSLA assessors visited and assessed notes retrospectively and live notes and fetal heart recordings on the labour ward and antenatal and postnatal ward.

Trusts can score from Level 0 (lowest) to Level 3 (highest). The trust has moved from Level 2 to Level 3 following the assessment. In practical terms it demonstrates the high standard of care we provide to our local population.

Monitor ratings

Monitor, the Independent Regulator of Foundation Trusts, has created a forward-looking, risk-based system of regulation which informs the intensity of monitoring. It identifies actual and potential financial and non-financial problems, and deals with them effectively.

Monitor requires each foundation trust board to submit an annual plan and quarterly reports. Performance is monitored against these plans to identify where potential and actual problems might arise. Monitor publishes quarterly and annual reports on these submissions and assigns each foundation trust with an annual and quarterly risk rating. These risk ratings are designed to indicate the risk of a failure to comply with the terms of authorisation. There were three ratings during 2013/14: a **Governance Rating;** a **Financial Risk Rating** (Quarters one and two); and a **Continuity of Service rating** (Quarters three and four).

The **Governance Rating** describes the effectiveness of an NHS foundation trust's leadership. Monitor use performance measures such as whether foundation trusts are meeting national targets and standards together with a range of governance measures.

Monitor considers these areas when assessing the annual and quarterly governance risk ratings which they publish for each trust:

- **Legality of constitution** – NHS foundation trust constitutions are legal documents that describe how each is governed
- **Growing a representative membership** – NHS foundation trusts are accountable to their local communities and must have plans in place to develop and grow a representative membership
- **Appropriate board roles and structures** - Monitor checks whether the appropriate roles exist and are filled within each NHS foundation trust. Monitor also look for evidence that a collaborative but challenging relationship exists between the board of governors and the board of directors, and the executive and non-executive members of the board of directors
- **Co-operation with NHS bodies and local authorities** – NHS foundation trusts have a duty as part of their terms of authorisation to cooperate with a range of NHS bodies and with local authorities
- **Clinical quality** – NHS foundation trusts board of directors must be satisfied, and certify to Monitor, that their NHS foundation trust has effective measures and arrangements in place to monitor and continually improve the quality of healthcare it provides
- **Service performance (healthcare targets and standards)** – NHS foundation trusts board of directors have to confirm to Monitor that plans are in place to ensure that priority targets and standards will be met continually
- **Other risk management processes** – NHS foundation trusts board of directors must address and resolve any risks that have been identified. If issues are outstanding, the board must demonstrate to Monitor that robust plans are in place to address them.

Financial risk ratings (FRR) are allocated to all FTs based on key financial information. A rating of 5 reflects the lowest level of financial risk and a rating of 1 the greatest. The trust was assessed against this rating for quarters one and two.

When assessing financial risk, Monitor assigns quarterly and annual risk ratings using a set of metrics that looks at four criteria Achievement of plan; underlying performance; financial efficiency; and liquidity. The risk rating is forward-looking and is intended to reflect the likelihood of an actual or potential financial breach of the foundation trust's Provider Licence.

Monitor also assigns a rating for **mandatory services**. Mandatory services are the services which each NHS foundation trust must provide as detailed in their terms of authorisation. There are specific processes which must be followed if an NHS Foundation Trust wishes to request a change in these services or to dispose of assets required to provide these services.

Continuity of services risk rating (COS) states Monitor's view of the risk facing a provider of key NHS services. There are four rating categories ranging from 1, which represents the most serious risk, to 4, representing the least risk. The rating is calculated using two financial metrics, liquidity and capital servicing capacity.

This new continuity of services risk rating is not calculated and used in the same way as the financial risk rating that was applied to NHS foundation trusts in quarters one and two of 2013/14. The FRR was intended to identify breaches of trusts' terms of authorisation on financial grounds, the continuity of services risk rating identifies the level of risk to the ongoing availability of key services. The trust was assessed against this rating for quarters three and four.

Warrington and Halton Hospitals NHS Foundation Trust performance against Monitor risk ratings

	Annual Plan 2013/14	Q1 2013/2014	Q2 2013/2014	Q3 2013/2014	Q4 2013/2014
Under the Compliance Framework					
Financial risk rating	3	2	2		
Governance risk rating	Green	Green	Narrative*		
Under the Risk assessment framework					
Continuity of service rating	4			2	3
Governance rating	Green			Green	Green

** Narrative - The Trust's governance rating was held at a narrative rating, until Monitor decided whether or not to open an investigation. Monitor decided not to open a formal investigation and in Q3 the trust reverted to green rated.*

	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Under the Compliance Framework					
Financial risk rating	3	3	3	3	3
Governance risk rating	Green	Green	Green	Green	Green

3.3 Our strategy

The trust has outlined an ambitious yet realistic strategy moving forward into the two-year period of 2014-2016 and beyond. This strategy is summarised in our operational business plan submitted to Monitor in April 2014. This forms the first two years of our five year strategic plan which is being developed for submission to Monitor in June 2014.

The principal objectives of our 2014-2016 plan are to support an organisational vision to **become the most financially and clinically successful provider in the mid-Mersey region by 2019**.

This will be achieved through continued focus on our values and through further development of priority schemes that have been identified through a robust planning process at the end of 2013-2014.

Key deliverable in our business model include:

- Achievement of 2.5% service growth through repatriation of market share across a range of specialities by 2016
- Development of specialist *centres of excellence* consolidating excellent practice across a range of existing in trauma & orthopaedics, spinal surgery, cardiology (including development of percutaneous cardiac intervention service) and gastrointestinal endoscopy
- Improvements to our non-elective services and pathways including the development of ambulatory care pathways to achieve a continued reduction in non-elective admissions of 1% in 2014-2015 and a commitment to work with commissioners to deliver further reductions in subsequent years
- Achieving sustainability and enhancing quality through improved integration of services across the local health economy. The trust is planning to continue to improve its HSMR/SHMI performance throughout this period with a stretch target to see both mortality indicators reduce to levels below the regional and national average.

The trust has developed three strategic reform pillars within the business model of:

COMMUNITY REFORM	Looking at our role in helping prevent patients needing hospital admission and improving discharge. This includes working with commissioners and local health economy partners to speed up the development of

	community based services that reduce the dependency on acute hospital care for patients.
ELECTIVE REFORM	Making best use of the two hospital sites and balancing elective and emergency care. This includes changing the elective and non-elective mix across our two sites, and optimising the use of the Halton campus.
EMERGENCY REFORM	Allowing us to better deal with demand on our front-end services. This includes investment in our services to allow us to better manage the demand on A&E and emergency/acute medicine as well as a programme of pathway reform.

The following key strategic themes emerged through the planning process. These themes have been used as the basis from which our clinical divisions' operational plans for 2014-2016 have been created.

Priority Area	High Level Description	Identified Metrics
Increasing Market Share	Looking to grow new opportunities either by better promoting our services to existing referrers or by seeking new referral sources from surrounding areas such as Widnes and Frodsham and Helsby.	2.5% increase in revenue through growing market share by 2016.
Maximising the Utilisation of the Halton Campus	Expanding the scope of current service provision at our Halton Campus (Halton General Hospital and Cheshire & Merseyside Treatment Centre) by reviewing current clinical criteria and developing enhanced urgent care services from Halton General Hospital site.	Transfer of activity to Halton Campus equivalent to 12,000 procedures per annum.
Improved Integration of Services	Working more closely with other providers of health and social care services in the community and in other acute settings to better integrate pathways for patients and for greater reciprocal benefit.	Metrics to be determined via Better Care Fund
Improving Emergency Flow	Work with commissioners and primary and community care providers to better manage emergency demand into the	Continued reduction in non-elective admissions equivalent

	hospital and improve access to services to facilitate earlier discharge, especially for patients with complex needs.	to 1%-1.5% per annum for period up to 2016.
Better Pathway Management	Looking at our clinical pathways to ensure that they are designed with patients' needs in mind to deliver optimum care and outcomes.	Reduction in non-elective re-admissions with improvements to be seen incrementally on a quarterly basis.
Enhanced community based provision of services	Actively seek out opportunities to extend our role as provider of services within the community.	Successfully winning new community services with value of £3m over this period.
Develop Partnerships	Look to develop business partnerships with other NHS or private providers where there are clear clinical and commercial benefits to doing so.	New organisational alliances formed with local GP consortia and join ventures or formalised partnerships in place with other providers to deliver services.
24/7 Model for Emergency Care	Extend current care provision for emergency patients to ensure equity of access to decision making and diagnostic support 24/7	Reduction in variation against key quality metrics over 7 day period.
Developing Specialist *Centres of Excellence*	Develop specialised services such as enhanced Cardiology interventions, Spinal Surgery and Gastrointestinal Endoscopy to provide better access to our patients and improve our competitive advantage.	Increased market share performance in • T&O • Spinal • Cardiology • GI Services

These priority areas for clinical development are backed by a range of corporate strategies, including:

- ***IM&T Strategy*** - *T*he trust is progressing its four year IM&T strategy implemented in 2013. This strategy is focussed on achieving improving the ability to integrate services whilst providing better value for money and include improved wireless infrastructure, roll out of mobile hardware to support paperless processes and E-Prescribing and electronic medicines management.
- ***Workforce Strategies*** – Supporting the clinical divisions in the management of change as a result of organisational design projects, developing a forward looking workforce plan and introducing changes such as competency based workforce review, electronic staff rostering and 12 hour shifts implementation
- ***Estates Strategy*** - The trust is currently progressing its short, medium and long term estate strategy which will allow it to ensure its future is sustainable in terms of its size and building stock, as well as working in conjunction with the Carbon Energy Fund to reduce its carbon footprint in line with Department of Health guidelines by 2015.

3.4 Environmental matters

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.

The 2013-2014 financial year has seen the trust continue to develop and introduce measures and initiatives that will enable the organisation to continue to make steady progress on the sustainability and carbon management agenda into the future. The trust 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. The CHP plant will provide the trust with both heat and electricity generated on site. The installation of such low/zero carbon technology will result in both financial and carbon savings. Work has been taking place on site to install the technology during the latter part of the financial year.

Our full performance around sustainability will be published in June 2014 and be available on our website.

3.5 Our staff

Our trust would not be able to provide the high quality services for which it is recognised 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 occupational health and counselling services and a range of training and education opportunities.

The trust works closely with trade union staff representatives and unions 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.

Staffing statistics

Staff in post at year-end

	31st March 2013	**31st March 2014**
Total Staff in Post	*4,125*	**4,198**
Whole Time Equivalents	*3,394*	**3,414**

Sickness absence

	31st March 2013	**31st March 2014**
Cumulative figure	*4.12 %*	**4.13%**

Breakdown of the number of male and female directors; and employees

	Male	**Female**
Directors (Executive and Non-Executive)	7	5
All employees	809	3,389

Communication and engagement with staff

Open and honest communication with staff is vital and in 2013-2014, communication with staff was tested like never before. The significant financial challenge the trust faced to achieve its efficiency savings and associated cost improvement plan required the support and understanding of all staff – particularly as roles were potentially at risk.

The trust embarked on an intensive communications exercise to actively inform and, most importantly, involve staff in the challenge. Over 500 staff attended specially organised team brief sessions to communicate the reality of the financial challenge at the start of the financial year.

The trust felt that the open and honest approach to the financial challenge was the right thing to do. Staff were actively encouraged to ask questions and contribute their own ideas to support the challenge through a scheme called *Bright Ideas*. More than 700 ideas were submitted through the scheme during the year. Each and every idea submitted by staff was explored and, where appropriate, put into action.

Close working relationships were also established with the staff side representatives through the process and updates on the financial position were communicated to staff throughout the year through the trust's other main internal communications channels – the weekly email brief called The Week and The Hub – the trust's intranet site.

In November 2013, when the trust placed itself into *internal turnaround* to help to address the increasing financial pressures that it faced, staff were again communicated with clearly throughout the process so they understood the challenge and reasons for carrying out the actions. Joint letters from the chief executive and staff side chair were sent to every staff member to keep them up to date on the process and encourage understanding and support for the actions that were being taken.

Alongside the focus on the financial challenge during the year, the trust has also placed an emphasis on providing clear performance and quality information to all staff. From the launch of our dementia campaign to encourage better awareness and care for patients with dementia, through to actions to promote understanding and reduction of mortality figures – information is made available to all staff.

Saying Thank You to our staff

Saying thank you to our staff is an important part of our communications programme. Nurses, domestic staff, volunteer groups and whole ward teams were amongst the winners in the trust's annual staff awards in September 2013 following nominations from patients, visitors and fellow staff members.

The hospitals' fifth annual staff Thank You awards event took place saw over 250 staff attend an event to hear the winners announced from seven categories that were open to nominations. Over 150 nominations were submitted for the awards this year. Around half of them were from patients and visitors who wanted staff who had cared for them and their families to receive some extra recognition for their work.

Team of the year winners were Ward A7 at Warrington Hospital who were nominated by the relatives of a patient for the care they gave their father in the final stages of his fight against cancer. They described the care and attention they received as 'simply first class, 100 per cent of the time'. End of life care was also featured in the **innovation and efficiency** award won by nurse Joanne Meredith from the palliative care team. She introduced a new system that helps ensure patients whose prognosis is uncertain to get the support they need in making decisions about their care.

In the **excellence in patient care** award trauma coordinator Sue Wilde took first place for the care she provides in supporting patients who have needed often life-changing emergency surgery after accidents. In the **supporting excellence in patient care** award the radiology booking team across the hospitals won for their work in coordinating over 200,000 scans and tests each year for local patients whilst keeping waiting times amongst the lowest in the NHS.

The League of Friends at Warrington Hospital won the new **volunteer of the year** award for their fundraising and patient support services and acting intensive care matron Natalie Crosby was awarded **leader of the year** for her work on the unit in providing the best care for seriously ill patients.

The **employee of the year** went to one of the unsung support teams behind the scenes at the hospitals. Cheryl Holbrook and the domestic and portering team were nominated for their work in supporting every ward move that takes place at the hospitals- making sure that wards reopen on time with the minimum of fuss. Their role has been essential with lots of moves taking place as the trust has upgraded wards with new windows, buzzer systems and temporarily moved maternity whilst refurbishment has taken place.

More than 30 staff at the hospitals who have reached 30, 35 or 40 years' unbroken service with the trust also received NHS long service awards as well.

Mandatory training

Our mandatory training figures were largely in line with the improvements made to compliance in the previous year 2012-2013. It should be noted that the internal turnaround process saw non-essential training postponed for a period to assist the financial position – with courses reinstated in April 2014.

	2012-2013	**2013-2014**
Health & Safety	*85%*	**88%**
Fire Safety	*72%*	**75%**
Manual Handling	*74%*	**75%**
Non-medical staff appraisal	*70%*	**69%**

The NHS Staff Survey 2013

Each year all NHS Trusts in England are required by the Care Quality Commission to conduct an annual staff survey. An external provider must undertake the survey and Quality Health once again undertook the survey on behalf of the trust.

The trust followed the Care Quality Commission guidance and 850 staff were randomly selected to participate in the survey. The results from the survey are used to compare the trust with other acute trusts in England and to form part of the trust's Annual Health Check and the Health and Safety Executive standards for workplace stress. 391 completed questionnaires were returned, representing a response rate of 46% - an increase of 2% from 2012.

Staff survey report overall response rates

	2012		**2013**		**Trust improvement/ deterioration in year**
Response rate	*Trust*	*National Average*	**Trust**	**National Average**	

	44%	*49%*	**46%**	**49%**	Increase by 2%

The survey results for 2013 are based on 28 key findings, the same number as in 2012. The trust has continued to see the highest proportion of key themes falling in the best 20% of trusts, better than average or better than last year.

	2011 (38 key themes)	*2012 (28 key themes)*	**2013 (28 key themes)**
Best 20% of trusts, better than average or better than year listed above.	*21*	*16*	**19**
Middle (average) 60% of trusts;	*7*	*8*	**6**
Worst 20% of trusts, worse than average or worse than year listed above.	*10*	*4*	**3**

Areas of significant statistical change

In comparison to trust performance in the 2012 survey, improvement has been demonstrated in 12 areas to a level considered by CQC analysis to show a statistical significant positive change. In three areas there has been a statistical significant negative change.

The areas of statistical significant change were:

Positive change	Negative change
% of staff experiencing physical violence from staff in last 12 months	% of staff receiving health and safety training in the last 12 months
% of staff feeling satisfied with the quality of work and patient care they are able to deliver	% suffering work related stress in the last 12 months
% staff feeling they work in an effective team	% of staff working extra hours
% of staffing having well-structured appraisals	
Support from immediate mangers	
% reporting errors, near misses or incidents witnessed in the last month	
Fairness and effectiveness of incident reporting procedures.	
% able to contribute towards improvements at work	
Staff job satisfaction	
Staff recommendation of the trust as a place to work or receive treatment	
Staff motivation at work	
% having equality and diversity training in the last 12 months	

The trust's highest ranking four scores were:

NHS staff survey 2013 – Trust performance, top four ranking scores

	2012		2013		Trust improvement / deterioration in year
Top 4 Ranking Scores	*Trust*	*National average*	**Trust**	**National Average**	
Number of staff feeling that they had support from their immediate managers	*3.69*	*3.61*	**3.79**	**3.64**	Improvement of 0.1 against rating.
Percentage of staff working extra hours	*66%*	*70%*	**62%**	**70%**	Improvement (decrease) of 4%
Staff job satisfaction	*3.63*	*3.58*	**3.72**	**3.60**	Improvement of 0.9 against rating.
Effective team working	*3.75*	*3.72*	**3.85**	**3.74**	Improvement of 0.1 against rating.

The trust's lowest ranking four scores were:

NHS staff survey 2013 – Trust performance, bottom four ranking scores

	2012		2013		Trust Improvement/ deterioration in year
Bottom 4 Ranking Scores	*Trust*	*National average*	**Trust**	**National Average**	
Percentage of staff receiving health and safety training in last 12 months	*53%*	*74%*	**60%**	**76%**	Improvement of 7%
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	*91%*	*90%*	**87%**	**90%**	Deterioration of 4%
Percentage of staff having equality and diversity training in the last 12 months	*42%*	*55%*	**46%**	**60%**	Improvement of 4%
Percentage of staff feeling pressure in the last 3 months to	29%	*29%*	**28%**	**28%**	Improvement (decrease) of 1%

attend work when feeling unwell					

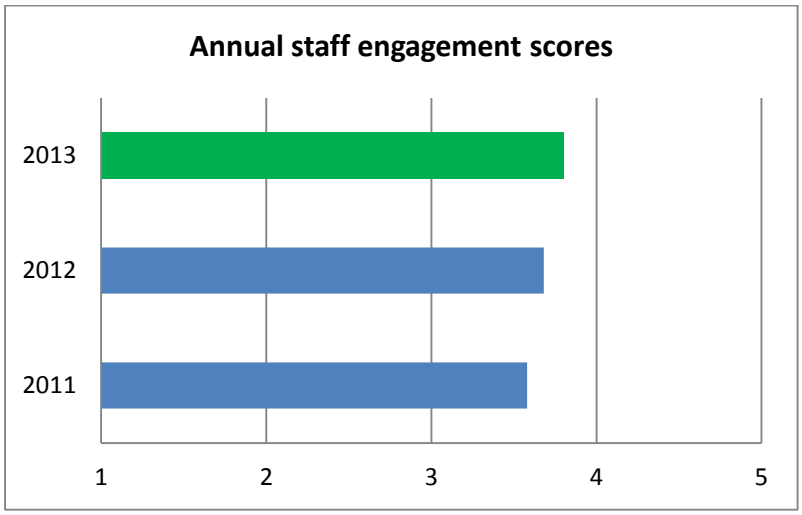
Conclusions from the staff survey and action plans for the future

Overall, the trust was delighted to see the positive shifts in the staff survey in 2013. The trust has seen the overall **staff engagement** score increase significantly and now ranks above (better than) average for the first time.

This is significant as two years ago in 2011, results the trust's level of staff engagement had deteriorated. The staff engagement score is generated from the results of nine questions from the survey which are aggregated into three key findings:

- Staff able to contribute towards improvements at work (we score in the top 20%)
- Staff recommendation of the trust as a place to work or receive treatment (we score in the middle 60%)
- Staff motivation at work (we score in the top 20%)

The trust's scores over the last three years for staff engagement showing the positive trajectory is shown below:



Although attending **Health and Safety training** in the last 12 months was noted as a concern, our trust determines this training as mandatory every three years so many staff will not have had this training in the last 12 months but are actually compliant with the trust's own mandatory training policies. Similarly although Equality and Diversity training was highlighted as a concern, this also has had a mandatory requirement of three years and as such respondents will not have had training in the last 12 months but may still be compliant.

As part of our action plan around the staff survey the trust is looking at its peers to assess how health and safety and equality and diversity training is structured at other organisations. There is also a piece of work being done on the training requirements by the head of health and safety.

The trust will also be communicating the importance of **reporting every incident** in a timely manner to all staff and we except to see an improvement in this score in future surveys.

Nationally the NHS has gone through and continues to experience a significant period of change and heightened anxiety and it should be reflected that our own trust is moving into another period or organisational change. The staff survey recognises that the percentage of staff suffering work-related stress in the last 12 months or work pressures is below the national average for acute trusts. It is important to balance the needs of the business with the pressures on staff and as such it is important that the actions we have already implemented are built as the trust moves forward.

In view of the findings above, the trust's strategic workforce committee will be giving consideration to a range of proposed actions to inform on-going development of action plans for continued sustained improvement.

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. 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.

There are no matters to disclose in relation to fraud or corruption.

Health and Safety

The trust has seen a significant change over the past year with increasing emphasis on compliance with Care Quality Commission (CQC), the Francis Report, moving towards NHSLA assessment Level 3 and health & safety compliance. The health and safety team have become well established over the past two years and this year has seen a greater focus on audit and the quality of risk assessments. The team has continued to follow the health and safety strategy and has successfully developed a comprehensive plan with a project time line providing bi- monthly updates to the board Quality Governance Committee

3.6 Stakeholder relations

The trust is an active participant in quality and safety work undertaken across the health economy both with lead commissioners and neighbouring provider units.

Over the year, the trust has seen the attendance of its Partner Governors increase at formal Council of Governors meetings – the result of a restructuring of its partner governor roles that took place in 2012-2013. New links have been built with organisations that our new partner governors represent including our local university, voluntary organisations and leading sports team.

A great deal of work has been undertaken with the newly formed Clinical Commissioning Groups (CCGs) in the locality. A positive, yet challenging, relationship has developed with Warrington CCG,

our lead commissioning body that has seen joint work on reducing hospital emergency admission and other key projects. Partnership with Halton CCG has seen plans developed for new urgent care centres in Runcorn (at Halton General Hospital) and Widnes that will open in September 2014.

The trust has continued to host a community wide Transformational Change Board through 2013-2014. This group brings together leaders from all the health and social care organisations locally to agree strategy around some of the major transformational changes required in the area. It has helped ensure good partnership working and early agreement on actions required to make change a reality.

We also enjoy a positive relationship with our local Members of Parliament all of whom have had regular meetings the chief executive of the trust over the last 12 months.

Our two local HealthWatch organisations in Warrington and Halton have provided external scrutiny by undertaking visits with formal reports that identify both areas of good practice as well as areas for improvement. Their involvement in larger pieces of work such as improving discharge and in membership of the Patient Experience Group at the trust has been particularly valuable.

The trust has developed strong relationships with organisations who provide support for carers in our local communities. Using Foundation Trust status as a driver, the trust has actively promoted itself to the members of Warrington Carers Centre and Halton Carers and has run a weekly drop in session for carers in the Foundation Trust membership office at Warrington Hospital.

At the end of the financial year, the trust's communications and membership committee has written to voluntary and community groups across the Warrington and Halton area to offer to meet and build even stronger links as we move forward as an NHS Foundation Trust.

3.7 Equality, diversity and human rights

As a trust we have been striving to ensure fairness and equality in access to health care and employment. The trust meets all statutory obligations with regard to the general duty of the Equality Act 2010.

In order to demonstrate this, in 2013 we formulated and published our **Equality Strategy 2013-2017**. This outlines the steps we are taking to reduce inequalities and shape developments. The strategy is based around our equality objectives developed with engagement from stakeholders from protected groups. They are:

- Promote positive relations between people who share a protected characteristic and people who do not.
- Develop data collection and equality profile reports for staff to cover all protected characteristics and publicise findings.
- In conjunction with the local community organisations that support people across the protected characteristics, undertake engagement and involvement activities, to facilitate stakeholder inclusion in the review, monitoring and planning of services, functions and policies.
- Progress the equality governance framework to provide assurance mechanisms for demonstrating equality duty adherence and embedding equality and human rights within mainstream functions.

- Services, information and resources can be accessed by all Patients and this is in evidence, across all the protected characteristics.

In 2014, we published our **Equality Duty Assurance Report** that sets out how we endeavour to meet the public sector equality duty.

This is published on our website www.whh.nhs.uk alongside our Equality Strategy and our workforce equality analysis report.

As an employer the trust is committed to a vision of respect for the individual. We strive to promote diversity and equality of opportunity in employment, welcoming applications from all sectors of the community. We also hold the Positive about Disabilities Two Tick Employer Award, which ensures that disabled people are not disadvantaged in the workplace.

It is important that the trust appoint the most appropriate person for the job and that opportunity for development and promotion are available to everyone. Full and fair consideration is given to applications for employment by disabled persons. We are committed to supporting employees who become disabled during their employment including any adaptations to their working life and providing suitable training. The trust's equality and diversity policies ensure that all employees adhere to these principles.

The accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006.

Mel Pickup
Chief Executive
28th May 2014

Delivering timely emergency care.

We were delighted to achieve the accident and emergency four hour target in each quarter of the year in 2013-2014 – all thanks to the fantastic effort of our staff and redesign of our services.

Across the NHS, many trusts experienced difficulties in meeting the target over the year but in A&E at Warrington Hospital and minor injuries at Halton General Hospital we were able to deliver the target despite some times of increased pressure on the service.

The investment we put into our emergency services using our foundation trust freedoms in 2012-2013 supported the unit to deal with patients in a better way over the year. We also continued to invest in our staff in emergency care in both A&E and our acute medical unit.

Partnership working also played a key role with our programme of work with Warrington CCG helping to reduce emergency admissions and also provide GP support in A&E to triage patients to the right place for their care. During the year plans were also announced with Halton CCG to develop urgent care services in Runcorn and Widnes in partnership with ourselves and other providers.

Halton General's minor injuries unit will be the hub for one of two of these urgent care centres that are due to open in September 2014. They will increase the local provision of urgent care for residents.

4. Directors' and corporate governance report

This section and subsequent sections set out the role and activities of the board and explains how the trust is governed.

Board of directors

During the period 1st April 2013 to 31st March 2014, the following were members of the trust's board of directors:

Name	Title	
Allan Massey	Chairman	
Allan Mackie	Deputy Chair	*Term of office ended 30 June 2014*
Rory Adam	Non-Executive Director	
Clare Briegal	Non-Executive Director/ Deputy Chair	
Lynne Lobley	Non-Executive Director	
Carol Withenshaw	Non-Executive Director	
Dr Mike Lynch	Non-Executive Director	Started 31st July 2013
Mel Pickup	Chief Executive	
Karen Dawber(1)	Director Nursing and Organisational Development	
Simon Wright(2)	Chief Operating Officer and Deputy Chief Executive	
Jason DaCosta (3)	Director of Information Technology	
Jonathan Stephens	Director of Finance and Deputy Chief Executive	Resigned 31 May 2013
Steve Barrow(4)	Interim Director of Finance	Started 1st June 2013 until 10th September 2013.
Tim Barlow	Director of Finance and Commercial Development	Started 11th September 2013
Phil Cantrell	Medical Director	Resigned 13th May 2013
Mark Halliwell (5)	Interim Medical Director	Started 14th May 2013 until 31 January 2014.
Paul Hughes	Medical Director	Started 1st February 2014.

(1) Following the resignation of David Melia, Karen Dawber was appointed to the temporary post of Interim Director of Nursing on 14th January 2013 in addition to her role as Director of Governance and Workforce. On the 16th May 2013 the Board Nominations and Remuneration Committee approved the creation of the position of Director of Nursing and Organisational Development which combined of the roles of Director of Nursing and Director of Governance and Workforce and Karen Dawber was appointed to that position effective from 1 April 2013.

(2) The Board Nominations and Remuneration Committee approved the appointment of Simon Wright, in addition to his role of Chief Operating Officer, as the Trusts Deputy Chief Executive from 1 June 2013.

(3) Jason DaCosta is a non-voting Executive Director
(4) Steve Barrow was appointed Acting Finance Director from 1st June 2014 following the resignation of Jonathan Stephens. Steve Barrow held the position until the permanent Director of Finance was appointed on 11th September 2013
(5) Mark Halliwell was appointed interim Medical Director from 14th May 2013 following the resignation from the Post of Dr Phil Cantrell. Mark Halliwell held the position until the permanent Medical Director was appointed on 1st February 2014.

Directors' responsibility for preparing the financial statements

The directors consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.

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.

Compliance with the code of governance

The board of directors (board) is committed to achieving the highest standards of governance within the trust and has established processes to enable it to comply with Monitor's New NHS Foundation trust Code of Governance (code) published during December 2013 for implementation from 1 January 2014. The code requires Foundation Trusts to make a full disclosure on their governance arrangements for the financial year 2013-14. The code also requires the board to explain how the main principles and supporting principles of the code have been applied. The information satisfying this requirement can be found throughout the Annual Report and Accounts. Furthermore the trust is required to provide a statement either confirming compliance with the provisions of the code or where appropriate, an explanation in each case why the trust has departed from the code. The trust's response to this requirement can be found on page 50.

The code also requires the directors to make specified information available in the annual report, or to provide certain descriptions of governance arrangements. The annual report addresses these requirements, placing much of the information and appropriate statements in the content of the report.

Board meetings and attendance

The board met 10 times during the year. Attendance at the meetings is included in the table below. The board also holds two formal development days during the year and shorter development workshops on the day of the board meetings.

Board of Directors	24th April 2013	28th May 2013	26th June 2013	31st July 2013	2nd October 2013	30th October 2013	27th November 2013	29th January 2014	26th February 2014	26th March 2014
Chair and Chief Executive										
Chairman **Allan Massey**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive **Mel Pickup**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Executive Directors										
Chief Operating Officer/Deputy Chief Executive **Simon Wright**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Director of Nursing & Organisational Development **Karen Dawber**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Director of Finance/Deputy Chief Executive **Jonathan Stephens** (until 31st May 2013)	✓	✓	·	·	·	·	·	·	·	·
Acting Director of Finance **Steve Barrow** (1st June 2013 - 10th September 2013)	·	·	·	·	·	·	·	·	·	·
Director of Finance and Commercial Development **Tim Barlow** (from 11th September 2013)	·	·	·	·	✓	✓	✓	✓	✓	✓
Medical Director **Phil Cantrell** **(**until 13th May 2013)	✓	·	·	·	·	·	·	·	·	·
Interim Medical Director **Mark Halliwell** (from 14th May - 31st January 2014)	·	✓	·	✓	·	✓	✓	✓	·	·
Medical Director Designate **Paul Hughes** (from 1st February 2014)	·	·	·	·	·	·	·	·	✓	✓
Director of Information Technology **Jason DaCosta**	✓	✓	✓	·	✓	✓	✓	✓	✓	✓
Non-Executive Directors										
Non-Executive Director & Deputy Chair **Allan Mackie** (until 30th June 2013)	✓	✓	✓	·	·	·	·	·	·	·
Non-Executive Director **Mike Lynch** (from 31st July 2013)	·	·	·	·	✓	✓	✓	✓	✓	✓
Non-Executive Director & Deputy Chair **Clare Briegal**	✓	✓	✓	✓	✓	✓	✓	✓	✓	·
Non-Executive Director & Senior Independent Non-Executive Director **Carol Withenshaw**	✓	✓	✓	·	✓	✓	✓	✓	✓	✓
Non-Executive Director **Lynne Lobley**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Non-Executive Director **Rory Adam**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

How the board operates

During the year under review the board comprised of the chairman, chief executive, senior independent director, five independent non-executive directors, four voting executive directors and one non-voting executive director. The trust is committed to having a diverse board in terms of gender and diversity of experience, skill, knowledge and background. The biographical details of the directors together with details of the deputy chair and senior independent director can be found in section 2. Of the 12 serving members on the board as at 31 March 2014, 5 are female and 7 are male. During the year the structure and composition of the executive directors changed following the resignation of the Director of Nursing (January 2013), the Director of Commercial Development (March 2013), the Medical Director (May 2013) and the resignation of the Finance Director and Deputy Chief Executive (May 2013). The board Nominations and Remuneration Committee considered, at its meetings in April and May, the composition of the executive team taking into account the requirements of the trust and skill mix of the executive and agreed to the amalgamation of the role of Director of Finance with that of the vacant position of Director of Commercial Development and the role of Director of Nursing with the role of Director of Governance and Workforce. The Chief Operating Officer took up the role of Deputy Chief Executive following the resignation of the Finance Director and Deputy Chief Executive.

During the year the term of office of Allan Mackie, non-executive director and deputy chair ended and the council of governors appointed Dr Mike Lynch as the replacement independent Non-executive director (also see Section 10). Dr Lynch has a wealth of experience both as a clinician and at board level of NHS acute trust and complemented the non-executive representation on the board in the provision of challenge and scrutiny on clinical matters as well as operational and strategy matters.

The board have a collective responsibility for the setting the strategic direction and the effective stewardship of the trust's affairs and ensures that the trust complies with its terms of authorisation, constitution, mandatory guidance and contractual and statutory duties; provides effective and proactive leadership of the trust within a robust governance framework of clearly defined internal controls and risk management processes; and approves the trust's annual and operational plans, taking into account the views of governors; sets the trust's vision, values and standards of conduct and behaviour, ensuring that its obligations to stakeholders, including patients and members are met; ensures the quality and safety of services, research and education and application of clinical governance standards including those set by Monitor, the Care Quality Commission, NHS Litigation Authority and other relevant bodies. The board has a formal schedule of matters reserved for board decisions; these are included in the trust's scheme of reservation and delegations.

The unitary nature of the board means that non-executive directors and executive directors share the same liability and the same responsibility to challenge board decisions and development of the trust operations and strategy. The board delegates operational management and the execution of strategy to its executive team and has established an integrated governance committee structure to provide it with assurances that it is discharging its responsibilities. The formal Schedule of matters reserved also includes the responsibilities of the council of governors as set out in statute and within the trust's constitution (additional details can also be found in section 7 of the report).

All directors have full and timely access to relevant information to enable them to discharge their responsibilities. The board meets ten times during the year and at each meeting reviews the trust's

key performance information, including reports on quality and safety, patient experience and care, operational activity, financial analyses and strategic matters.

The board monitors compliance with objectives and is responsible for approving major capital investment and any borrowing. It meets with the council of governors, senior clinicians and divisional managers, and uses external advisors when necessary.

The proceedings at all board and committee meetings are fully recorded through a process that allows any director's concerns to be recorded in the minutes and assurances provided. The board meetings are held in public and minutes of these meetings and papers are published on the trust's public website.

Directors are able to seek individual professional advice or training at the trust's expense in the furtherance of their duties. The directors and governors have direct access to advice from the trust secretary who ensures that the board meetings, council of governors meetings and committee meetings procedures are followed and applicable regulations are complied with. The appointment or removal of the trust secretary is a matter for the board as a whole in consultation with the council of governors.

Balance, completeness and appropriateness

There is a clear division of responsibilities between the chair and chief executive, which has been agreed by both parties and the board. The chair is responsible for the leadership of the board and council of governors, ensuring their effectiveness individually, collectively and mutually. The chair is also responsible for ensuring that members of the board and council receive accurate, timely and clear information appropriate for their respective duties and for effective communication with patients, members, clients, staff and other stakeholders. It is the chair's role to facilitate the effective contribution of all directors, ensuring that constructive relationships exist between them and the council of governors. The chief executive is responsible for the performance of the executive directors, the day to day running of the trust and implementing and delivery of the trust's approved strategy and policies.

In accordance with the code of governance, all non-executive directors are considered to be independent, including the chair. The board however recognises that Dr Mike Lynch prior to his appointment as a non-executive director was employed by the trust on a temporary contract for nine months as an Associate Medical Director in the trust's Unscheduled Care Division. The board and the council of governors do not believe that this previous appointment would impact on his role as an independent non-executive director of the trust.

In line with Monitor's guidance, the terms of office of directors appointed to the antecedent NHS trust are not considered material in the calculation of the length of office served in the trust. The directors' biographical details (section 2) set out in this report demonstrate the wide range of skills and experience that they bring to the board. The trust's non-executive directors have each signed a letter of appointment to formalise their terms of appointment.

The executive directors are experienced and are collectively responsible for drafting the various strategies that formed the trust's application for foundation trust status. These strategies were agreed by the whole board and now form the basis of the relationship with the regulator. All directors are equally accountable for the proper management of the trust's affairs.

Following the review of the executive team undertaken during the year, the board believes it has a good balance of skills, experience and length of service, however it recognises the value of succession planning for board members. The board Nominations and Remuneration Committee will lead a process during 2014/15 on succession planning of executive directors. The trust has a programme of board appraisal, individual appraisal and appointment or re-appointment to ensure the stability, succession, effectiveness and improve performance of the board.

Evaluation of board and committees

In 2013-14 the board undertook its annual review. The methodology used involved responses to statements populated on a survey and the findings of the review reported to the board during two board development workshop. An action plan arising from the workshops has been developed. The board also undertook a review of its board committee structure to bring it in line with the guiding principles of its Quality, People, and Sustainability (QPS) framework.

The board recognised that there was not a requirement to do a wholesale change of the structure however felt that given the financial issues facing the trust a Finance and Sustainability Committee would be formed to provide the board with assurance with regard to finance (including CIP & Capital), strategy, marketing and information technology. The board had received assurance from the Monitor Stage 2 review undertaken by KPMG LLP that indicated that the Governance Structure in place was able to support the delivery of quality of care to service users and recommended that the structure should not change as it supported the governance of the trust. There was recognition however that the board desired to align the committee structure with its QPS framework, which KPMG had cited to Monitor as notable practice.

During the year each committee of the board assesses on an on-going basis its performance in order to address any areas of weakness. The evaluation exercise undertaken by the board to evaluate its collective performance and that of its committees showed that good progress had been made but that there remained further opportunity to continue to raise the collective performance of the board.

In addition to the board and committees, all directors were subject to appraisal in 2013-14. In the case of the chief executive the appraisal was led by the chair; for the executive directors by the chief executive; for the non-executive directors by the chair and for the chair by the senior independent director. All members of the council of governors and board had the opportunity to contribute to the chair's evaluation and would, as part of the process, be able to contribute towards the appraisal of the non-executive directors.

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.

Members of the board attend all council of governors meetings (six per year) and non-executive directors attend on a rota basis, all council of governor committees to provide input and support to the committee. Each committee of the council is supported by executive directors and senior managers from the trust who report openly and collaboratively on the activities and performance of the trust.

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. Non-executive directors also attend on a rota basis, all council of governor committees to provide input and support to the committee on matters raised at the board, this provides the governors with additional opportunity to address any concerns they may have with non-executive directors that may have arisen during a board meeting or within the trust.

The chair provides informal and formal updates and ad hoc briefings to governors and attends with the chief executive a bi-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 trust has also held had a number of board to governor workshops to discuss issues with the governors. The workshops considered the priorities of the trusts annual plan 2014-2016 and consider the priorities of the Quality Accounts 2014-2015. For further details on the workshops and other aspects of the governors' work please see section 8.

Independent advice of the trust secretary is available to all directors and governors in relation to all matters associated with the business of the board or council of governors. In line with the requirements of the Provider Licence all directors and governors have met the 'fit and proper' person test.

Register of interests

A register of significant interests of directors and governors which may conflict with their responsibilities is available from the trust secretary and on our internet site www.whh.nhs.uk.

Board committees

The board has three statutory committees; The Charitable Funds committee and the Audit committee, both chaired by an independent non-executive director and the Nominations and Remuneration committee, chaired by the trust Chair. There are four additional committees; the Quality Governance Committee; the Strategic People Committee; the Charitable Funds Committee

and the Finance and Sustainability Committee. Each works closely with the Audit committee but report directly to the board by way of exception reporting and sharing of minutes. Urgent matters are escalated by the committee chair to the board as deemed appropriate. Each committee is chaired by an independent non-executive director.

For further details on the work of the Audit Committee see section 4a and the Nominations and Remuneration Committee see section 8 of the report.

Quality Governance committee

The Quality Governance Committee is accountable to the board for ensuring that the integrated governance framework is implemented throughout the organisation, so providing assurance that organisational risks are being managed appropriately and that quality and safety is adhered to. The committee meets bi-monthly and is chaired by a non-executive director. Its core membership includes the executive directors, the associate director of governance, divisional medical representatives, associate divisional directors, the chief pharmacist and the head of allied health professionals. The committee receives reports on risks with a current score of 15 and above to ensure integration into the trust Risk Register and ensure actions are being taken to mitigate or eradicate these risks. Reports are also received from sub-committees including Infection Control, Clinical Governance, Audit and Quality, Safety and Risk and Information Governance and Corporate Records, on behalf of the board. As part of an annual work plan the Quality Governance committee regularly receives information on serious incidents including lessons learned and examples of good practice.

Strategic People committee

The Strategic People committee is responsible for overseeing the trust's policies, strategies and procedures relating to the trust's requirements as Model Employer and the objective to be the employer of choice for the healthcare the trust delivers and provide assurance to the board on the management of risks relating to those objectives. The committee is chaired by a non-executive director and membership includes the director of nursing and organisational development (executive lead), the chief operating officer, medical director and management leads across the trust's activities. Meetings are held bi-monthly and receive reports from: Education; Equality and Diversity; Staff Engagement & Wellbeing; Joint Negotiating Consultative committee; Joint Local Negotiating committee; and Education Governance.

Finance and Sustainability committee

The Finance and Sustainability Committee ensures a robust approach to the monitoring and delivery of the trust's financial and operational planning, performance and strategic and business development. The committee meets monthly and is chaired by a non-executive director. Membership of the committee includes one additional non-executive director and all the executive directors. The deputy director of finance, deputy director strategy and commercial development and the associate director of estates would normally attend the meetings and associate directors from division and corporate areas are required to attend at the request of the committee.

The Charitable Funds committee

The Charitable Funds Committee comprises of a non-executive chair, all the non-executive directors, the director of finance and commercial development, the head of financial services, the associate director of communications, the director of nursing (or failing her the deputy director of nursing)

and a public governor. The committee is responsible for the effective management of the Warrington and Halton Hospitals NHS Foundation trust Charitable Fund (Charity No. 1051858) of which Warrington and Halton Hospitals NHS Foundation trust is the corporate trustee. The objective of the charity is to provide for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by Warrington and Halton Hospitals NHS Foundation trust.

In accordance with current reporting requirements the trust is required to consolidate the results of the charity for the 2013-14. However following consideration of the external audit plan, the Audit Committee recognised that the fund size was below the de minimis levels for the trust and therefore agreed that the charity would not be consolidated in the accounts on the basis of materiality.

Meeting the new code of governance

The board continues to seek to comply with the new code and has reviewed compliance against the provisions of the code. There is one area of the code where the trust is declaring noncompliance:

Provision B.6.2 requires that there should be an external evaluation of the Board of Directors at least every three years. This is a new provision of the code that came into effect from 1st January 2014. Monitor has undertaken a consultation process which will inform the publication of guidance on Board Leadership and Governance Framework. Following publication of the guidance the board will look to implement best practice as appropriate. The board last completed a full external evaluation in 2008 as part of its preparatory work for foundation trust status.

Further details of how the Trust has applied the Code principles and complied with its provisions are set out within this section and throughout this annual report. The table below sets out Monitors Code of Governance where the trust is required to provide supporting explanations.

	Code of Governance reporting requirement	Where in the report
A.1.1	This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Directors Section 4 Governors Section 7
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	Biographical details Section2 Directors Section 4 Remuneration Section 8 Audit Committee Section 4a
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Governors section 7
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Directors Section 4
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Biographical details Section2 and reference to register Directors Section 4
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Remuneration Section 8
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	Biographical details Section2
B.5.	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.	Directors Section 4 Governors Section 7

B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Directors Section 4 Governors Section 7
B.6.2	Where an external facilitator is used for reviews of governance, they should be identified and a statement made as to whether they have any other connection with the trust.	Directors Section 4
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider 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. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Directors Section 4 External Auditors statement Annual Governance Statement Section 10
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Annual Governance Statement Section 10
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Audit Report Annual Governance Statement Section 10
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not required although reference to the re-appointment of External auditor in the Directors Section 4
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities.	Audit Committee Section 4a
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable – This requirement would be addressed at point of appointment should it arise.
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Directors Report Section 4 Governors Section 7
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Membership section 6

Additional information

The trust has not made any political donations during the year.

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

- A statement that accounting policies for pensions and other retirement benefits are set out in note 1.4 to the accounts and details of senior employees' remuneration can be found in section 8; Remuneration Report.
- Details of future developments and strategic direction of the trust can be found in section 3; Strategic Report.
- Trust policies on employment and training of disabled persons can be found in section 3; Equality and Diversity.
- Details of the trust's approach to communications with its employees can be found in section 3; communication with employees.
- 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 note 18 of the annual accounts.

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 accounts.

Appointment of External Auditors

The trust appointed PricewaterhouseCoopers LLP as the external auditor of the accounts at a meeting of the Governor's Council on 15th September 2011 for an initial period of three years, with an option to extend for a further two years. This option to extend is currently being considered by the Audit Committee for recommendation to the Council of Governors.

Mel Pickup
Chief Executive
28th May 2014

4.1 Audit committee

The audit committee comprises solely of independent non-executive directors. It is chaired by Rory Adam, FCMA. The other members of the committee are the remaining non-executive directors; Lynne Lobley; Allan Mackie (to 30 June 2013); Carol Withenshaw; Clare Briegal and Mike Lynch (from 31 July 2013).

The committee met five times during the year and attendance at the meetings is shown in the table below. The director of finance and commercial development, head of financial services and the external and internal auditors are usually in attendance at meetings of the committee. Executive directors and other managers are required to attend for specific items, as is the local counter fraud specialist.

Copies of the terms of reference of the Audit committee can be obtained from the trust secretary and on our internet site www.warringtonandhaltonhospitals.nhs.uk in the about us/corporate and trust board section.

Attendance at Audit committee by meeting

	29h April	28th May	9th September	18th November	3rd February
Rory Adam	✓	✓	✓	✓	✓
Carol Withenshaw	✓	-	✓	✓	✓
Clare Briegal	✓	✓	✓	✓	✓
Allan Mackie (to 30 June 2013)	✓	✓	-	-	-
Lynne Lobley	✓	✓	✓	✓	✓
Mike Lynch (from 31 July 2013)	-	-	✓	✓	-

The work of the committee in 2013/14 has been to review the effectiveness of the organisation and its systems of governance, risk management and internal control through a programme of work involving the challenge and scrutiny of assurances provided by internal audit, external audit, local counter fraud officer, trust managers, finance staff and the clinical audit team. The committee follows a work programme along with agreement of the internal audit and counter fraud work plans.

Principal Review Areas in 2013/14

The narrative below sets out the principal areas of review and significant issues considered by the committee during 2013/14 reflecting the key objectives set out in its terms of reference.

Internal Control and Risk Management
The committee has reviewed relevant disclosure statements for 2013/14, in particular the draft Annual Governance Statement, MIAA board Assurance Framework opinion which when combined together with receipt of the Head of Internal Audit Opinion, external audit opinion and other appropriate independent assurances provides assurances on the trusts Internal Control and Risk Management processes.

Internal Audit
Throughout the year, the committee has worked effectively with internal audit to ensure that the design and operation of the trust's internal control processes are sufficiently robust.

The committee reviewed and approved the detailed programme of work for 2013/14 at its April 2013 meeting. This included a range of key risks identified through discussion with Management and Executives and review of the Board Assurance Framework. Reviews were identified across a range of areas, including financial systems, IM&T, Performance, Clinical Quality, Workforce, Governance and Risk. At the November meeting the committee approved the Internal Audit Charter which is mandated through the Public Sector Internal Audit Standards (2013) and is a formal document that defines the internal audit activity, purpose, authority and responsibility.

The committee has considered the major findings of internal audit and where appropriate has sought management assurance that remedial action has been taken. In instances where 'limited assurance' is assigned to a review, the committee requests management attendance at the next meeting by the responsible manager to provide assurance to the committee that the management action would be carried out. This strengthens the committee's response to major audit findings and ensures that any control weaknesses are understood by the Audit committee and, through the integrated governance route the board, are addressed in a timely manner.

The committee has given considerable attention to the importance of follow up of reviews in respect of internal audit work and recommendations in order to gain assurance that appropriate management action had been implemented.

Counter Fraud
The committee reviewed and approved the counter fraud work plan for 2013/14 at its meeting in April 2013. During the course of the year, the committee also regularly reviewed updates on proactive counter fraud work.

External Audit
The committee routinely received progress reports from the external auditor, including an update annual accounts audit timetable and programme of work, updates on key emerging national issues and developments which may be of interest to committee members alongside a number of challenge questions in respect of these emerging issues which the committee may wish to consider. The value of external audit services for the year was £57K (2012/13, £67K).

Financial Assurance
The committee has reviewed the accounting policies and annual financial statements prior to submission to the board and considered these to be accurate. It has ensured that all external audit recommendations have been addressed.

Other Assurance
The committee routinely received reports during 2013/14 on Losses and Special Payments and Single Source Tender Waivers, bad debts and changes to the trust's standing financial instruments and Scheme of Delegations.

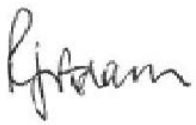
The committee receives reports from the chair of each of the board Committees on any areas of concern that may need to be addressed by the board. Each committee produced a formal annual report for consideration by the board.

During the year the committee met privately with the internal and external auditors, without the presence of a trust officer.

There is a policy in place for the provision of non-audit services by the external auditor, in recognition of the need to safeguard auditor objectivity and independence. During 2013/14, the auditor has not been engaged in any non-audit activity.

The committee reviews its effectiveness through use of a discussion between members of the committee in closed meeting, following which the Chair reports any areas of concern that may need to be addressed on the effectiveness of the committee.

The trust's external auditors, PricewaterhouseCoopers LLP, were appointed by the council of governors in September 2011 following a formal procurement exercise for a three year period with an option to extend the appointment for a further period of two years. Any extension of appointment would require the approval of the council of governors following recommendation from the audit committee.



Rory Adam, Chairman
Audit Committee
28th May 2014

Delivering on quality by reducing mortality rates.

Through the year we have kept our focus on improving quality of services for our patients and their families and have continued to invest in our care alongside managing the challenging financial position in the trust.

One of the most significant achievements has been the reduction in our mortality rates. During the year we were named as one of seven NHS trusts with a higher than expected SHMI (Summary Hospital-level Mortality Indicator) according to figures from the previous year.

Work had already been well underway to look at factors that were causing this and to use mortality scores to improve quality in the hospitals. This included reviewing the trust's care pathways and best practice care bundles to ensure a high standard of care for every patient, every time; Implementation of a robust mortality review process and use of the outcomes to drive improvement across our clinical teams.

By the latest published figures at the end of 2013-2014, the trust had improved to being within the expected range for its mortality scores with an impressive trajectory of reduction. All of the trust's mortality figures are also openly available via an 'app' created to share this information to staff and patients alike to increase openness and transparency. It is accessible through our website.

5.Quality Report

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.

Quality Report Part 1. Statement of Quality from the Chief Executive.

Warrington and Halton Hospitals NHS Foundation Trust is dedicated to the provision of high quality care and clinical excellence which puts the patient at the centre of everything we do. Our highly skilled workforce strives to produce the best outcomes for patients through reviewing and re-designing services and through the delivery of patient focussed clinical care. We therefore welcome this opportunity of demonstrating through our Quality Report to patients, their families, and the wider public the relentless focus that the trust has on improving the quality of our services.

Importantly, we believe that our staff, governors, members and patients are the eyes and ears of the organisation and through this positive engagement we ensure their views and observations are captured to guarantee that we are focussing on the things that will make the most difference in supporting our ethos of high quality care for all.

The trust provides services to the community across two sites. Warrington Hospital provides acute and emergency facilities including Accident & Emergency, intensive care, maternity, medicine, surgical services, paediatrics, outpatients and a full range of diagnostic and back up services. The Halton campus provides a range of diagnostic, intermediate care, elective surgical, antenatal and outpatient services including a minor injuries unit for local patients. The Cheshire and Merseyside Treatment Centre at Halton General provides orthopaedic surgery for both sites and includes a diagnostics centre with facility for magnetic resonance imaging (MRI) and computerised tomography (CT) scanning.

During 2013/2014 we have continued to strengthen and perform well on quality, we have invested in our staff by strengthening our clinical teams – more doctors, more nurses and more allied health professionals. The trust has developed a framework of more devolved management through the divisions which is supported by a range of leadership programmes. We have also introduced the *Bright Ideas* scheme to support partnership working with staff in order to develop ideas to enhance quality and reduce costs.

In 2013/14 we introduced the *Improving Quality: Patient Safety; Experience and Clinical Effectiveness Strategy*, which includes within its framework essential indicators which will require consistent review and monitoring to ensure a safe, high quality organisation. These indicators will be monitored closely throughout 2014/15 and beyond. Quality performance information is reviewed and discussed within our governance structures at the following forums:

- Clinical Governance, Audit and Quality Sub-Committee
- Quality in Care Committee (Governors)
- Infection Control Sub-Committee
- Safety and Risk Sub Committee
- Meetings of the Board of Directors
- Meetings with the commissioners of the trust's services

The trust has a robust performance management framework and within the year it has continued to monitor services across the three domains of quality: patient safety, clinical effectiveness and patient experience. Quality performance information is reviewed and discussed within our governance structures and reported on a monthly basis to the trust board. The trust meets on a monthly basis with Commissioners in order to discuss performance against quality performance measures including Commissioning for Quality and Innovation measures (CQUINs) contained within the Contract for Healthcare Services.

This report also offers the trust an opportunity to describe a range of quality initiatives which are central to our strategic framework of QPS - Quality, People, and Sustainability. Importantly, to support and provide assurance to this process we have established dynamic systems for continuously monitoring and improving the quality of our care and services.

This report charts progress on our quality improvement priorities established for 2013-2014, the priorities were identified through feedback and regular engagement with staff, patients, the public, and commissioners of NHS services, scrutiny group and other stakeholders. Progress on the planned improvements is reported through the trust's assurance committees, via the Council of Governors and ultimately through to trust board.

In 2013-2014, our improvement priorities were:

- Zero tolerance to hospital acquired MRSA bloodstream infections
- Reduction in incidents that result in severe or catastrophic harm
- Pressure Ulcers – reduction
- Reduction in medication errors that are related to insulin.
- Reduction in catheter associated UTI's
- 62 day cancer access target
- SHMI – Mortality Rates
- Commissioner priorities – Commissioning for Quality and Innovation measures.

We are pleased to report significant improvements within the improvement priorities during 2013-2014.

Excellent progress has been made in the management of pressure ulcers and the trust has worked hard to achieve a 67% reduction in the development of avoidable grade 3 pressure ulcers and a 33% reduction in the incidence of all grade 2 pressure ulcers (for this grade a distinction is not made between unavoidable and avoidable). However, we want to improve this even further. The

management of pressure ulcers is an important aspect of care and will therefore continue as an improvement priority for 2014-2015.

The report details the great progress made in the reduction in medication insulin incidents of 10.5%, and a 20% reduction in the actual number of catheterised patients who developed urinary infection during 2013-2014.

The trust performed well in almost all our improvement priorities, with the exception of the number of reported hospital acquired MRSA bloodstream infections where the trust is reporting 3 cases against a threshold of 0 (an increase from 2012-2013 when performance was 1 MRSA against a threshold of 3) and Clostridium difficile where the trust is reporting 31 cases of hospital acquired Clostridium difficile infections against a threshold of 19 compared to 19 cases against a trajectory of 40 for 2012-2013. Reducing hospital acquired infection remains a high priority and the infection prevention and control team continue to review processes to support the further reduction of HCAIs.

The trust was disappointed when it was named in October 2013 (for the period April 2012 – March 2013), as one of seven NHS trusts who had a higher than expected SHMI, at 112.9. We had already recognised that this was a key area for improvement. We created a number of work streams to evaluate aspects of mortality and thus identified it as a key priority for improvement in 2013/2014. Following a significant focus on mortality reduction in the trust, we are very pleased to report that since the January 2014 HSCIC publication (for the period July 2012 – June 2013) the trust has had an 'as expected' SHMI score. The latest SHMI score available (HED system) is 105 for the period February 2013 – January 2014. The SHMI is one of two mortality measures used in the NHS, the other being HSMR (Hospital Standardised Mortality Ratio), which is 98 for the latest data period available (March 2013 – February 2014).

The trust continues to perform well across all activity including meeting the Accident and Emergency (A&E) four hour waits and we are delighted that A&E has achieved the year end 95% access target for 2013-2014. This is a great achievement and should not be underestimated especially given that many trusts are expected to fail the target this year. The team has worked incredibly hard to ensure compliance with the target.

We understand that the time from when a suspicion of cancer to obtaining a diagnosis and treatment is raised is a particularly distressing and anxious time for both the patient and their family. The 62-day target intends to ensure that these patients are prioritised to receive the tests and procedures they need to confirm or refute cancer diagnosis as quickly as possible, and if cancer is diagnosed to begin treatment as soon as possible. The target is to achieve 85% of patients diagnosed with cancer starting treatment within 62 days of urgent referral with a suspicion of cancer or referral through A&E. In 2013-2014, Warrington and Halton Hospitals NHS Foundation Trust met its National Target and Minimum standards for patients urgently referred with a suspicion of cancer began treatment within 62 days of their referral by GP (Open Exeter Position).

We are delighted to report that the trust has invested in new services including maternity, dementia and the use of IM&T to support enhanced clinical delivery. To underpin these services and changes

in the way we work have also developed a suite of new strategy documents for nursing, dementia, information management and technology (IM&T) and quality. We have successfully implemented the Friends and Family initiative across inpatient; accident and emergency and maternity services, investment in an infrastructure to support this initiative has resulted in a substantial increase in service user participation.

We have taken the opportunity throughout 2013-2014 to review our patient experience services and have invested in the team to ensure that we can provide timely responses to complaints and concerns. We are pleased to report a 26% reduction in the number of written complaints received and are now working toward ensuring that the learning from what we are told by our patients is embedded in every day work. We have been very fortunate to have patient experience representatives on some of our committees, and a particular example of this has been in the area of dementia where their input to service development has been invaluable.

Dementia care was also selected as an area of focus for 2013-2014 with the specific aim of promoting the development of a culture within the organisation where everyone will be able to recognise and help the many patients who now present with dementia. At this trust staff, are dedicated, to providing the best possible care for patients with dementia. Our dementia strategy sets out the framework by which we will achieve this. Within the strategy we have identified ten key areas which are underpinned by action plans monitored by our dementia steering group. Over the past year we have ensured that Dementia Champions are in place at board level with our director of nursing and organisational development leading the way for those patients who are amongst our most vulnerable.

The trust, recognising the importance of ensuring that our environment is dementia friendly used the Kings Fund toolkits to assess how 'dementia friendly' our wards are. These results were then used to inform our successful bid to the Kings Fund in April 2013, where we were awarded £1.04m to improve the environment for patient with dementia. **Work has now been completed on our £1 million specialist ward which is now open for acute patients with dementia at Warrington Hospital.**

In February the trust held a Quality Improvement Forward Planning event with all key stakeholders to provide information on progress with quality improvement priorities and quality indicators for 2013/2014 as well as planning and agreeing a selection of improvement priorities for 2014/2015 to take back for discussion with the board.

We were visited by the Care Quality Commission on two occasions during 2013/14 and have performed well in relation to external assessment by the Care Quality Commission.

We have engaged throughout the year with our partner organisations to update them on the progress made toward achieving our improvement priorities throughout the year. Early in 2014 we invited our partners to attend an event to discuss the improvement priorities for 2014/15. We were delighted that approximately 25 representatives from key stakeholder organisations including Warrington Healthwatch; Halton Healthwatch; Warrington Borough Council; Governors; Assistant Director of Nursing and Quality at Cheshire, Warrington and Wirral Area Team NHS England and the external auditors for the trust Price Waterhouse and Coopers (PWC) attended the event. Through a

programme of consultation it has been agreed that our quality improvement priorities for 2014/2015 will be:-

- Complaints – To improve the percentage of complaints responded to within timescales agreed with the patient. To provide detailed reports on themes and lessons learned as a result of complaints.
- Falls – Establish a 10% reduction for falls resulting in moderate - catastrophic harm.
- Improvement in lowest performing indicators in In-Patient Survey – develop plans to make improvements in areas where we fall below national average and have not demonstrated improvement in past two years
- Pressure ulcers – continue work on reducing pressure ulcers.
- Advancing Quality (AQ) Stroke and Pneumonia measures - Work streams to increase compliance with stroke and pneumonia measures to improve patient outcomes.

In conclusion, this Quality Report evidences that we have made encouraging progress in improving the care and services we deliver to our patients, furthermore it demonstrates our determination to continue to improve all our services so that we can show our commitment 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
28th May 2014

Quality Report Part 2. Improvement Priorities & Statement of Assurance from Board

Introduction - Quality People and Sustainability

It is acknowledged by the NHS Trust Development Authority (2013) that the long-planned reforms to the NHS are now in place; "the publication of the report into the serious failings at Mid-Staffordshire NHS Foundation Trust has rightly brought both the quality of care the NHS provides and the accountability for its delivery into a sharper focus than ever before; and the constrained financial environment in which we operate gets tougher as we enter into the business end of delivering quality and productivity improvement plans. How each and every NHS Trust Board responds to the challenges the new environment poses will be critical to their ability to deliver high quality services for their patients and communities – not just for the year ahead but also for the medium and long term. Creating the conditions for success –defining what that looks like, ensuring each organisation can draw on the necessary support to deliver their ambitions, and having clarity on the accountability for delivering it – will be essential to supporting NHS Trust Boards to meet that challenge".

To support this challenge of creating a balance between quality, staff and financial constraints the trust has a strategic framework to improve the performance of the organisation called Quality, People, and Sustainability (QPS). This QPS framework which was developed in consultation with our staff and governors enables us to continue to deliver good performance whilst striving to make year on year improvements.

QPS Framework

Over the last few years, we have successfully delivered significant changes to the way in which we provide services which has allowed us to both improve the quality of services to our patients and to ensure that we use the resources available to us as efficiently as possible. The development of QPS gives the trust a framework through which we can ensure the future quality and sustainability of our services and the development of our people. During the year we have continued to strengthen and perform well on quality by investing in our staff in key areas, by strengthening our clinical teams – more doctors, more nurses and more allied health professionals. Leadership programmes are in place including more devolved management through the divisions. We also introduced the "Bright Ideas" scheme in order to work in partnership with staff to avoid redundancies and develop ideas.

Importantly in terms of quality the trust has invested in services including maternity, dementia, CMTC and the use of IM&T to support enhanced clinical delivery and we have developed new strategies for nursing, dementia and quality. We have performed well in relation to external assessment by the Care Quality Commission and have implemented the Friends and Family initiative across inpatient; accident and emergency and maternity services, investment in an infrastructure to support this initiative has resulted in a substantial increase in service user participation. The trust meets on a monthly basis with Commissioners in order to discuss performance against quality performance measures contained within the Contract for Healthcare Services.

However, for 2013/2014 we needed to find savings of at least £11m to meet national NHS efficiency savings targets and in March 2013 we launched our Sustainability Challenge for 2013/2014. We were committed to working in partnership with staff to look at the challenge and ensure that permanent staff would not be affected if at all possible. Work was carried out from March through to May to identify posts from our vacancies that could be removed to save money and this objective has been achieved with minimal impact on permanent staff in the trust. However sustainability was also dependent on the successful delivery of our cost improvement programmes (CIP) schemes and delivering the savings and efficiencies which was difficult to achieve, as such by the end of 2013 we put in place a system of internal financial turnaround until the end of March 2014 in order to take greater and tighter control of the situation.

At the end of 2013/2014 the trust can report that it completed the financial year with a £2.8m deficit which is rolled into next year. The trust has developed a two year plan and for 2014/2015, it is targeting a £1.5m deficit which will require cost savings of £12m.

Clearly 2013-2014 has been a challenging year for the trust but we have worked hard to ensure that the patients we support get the right care, when they need it at the right time on the most suitable site. Importantly, the trust has been successful in achieving all national targets from the operating framework for 2013-2014 in spite of a deteriorating national position. We achieved the 95% Accident & Emergency access target for the year– with a final figure of 95.55% across the year and also the 18 week referral to treatment target. The trust is pleased to report that it has delivered 18wks for over 90% of all referrals for the 6th year in a row.

Improving Quality

During the reporting year we have introduced the “Improving Quality: Patient Safety; Experience and Clinical Effectiveness Strategy”, which includes within its framework essential indicators which will require consistent review and monitoring to ensure a safe, high quality organisation. Our mission is to provide 'High Quality, Safe Healthcare'. To enable us to achieve this, we have four strategic objectives. They are:

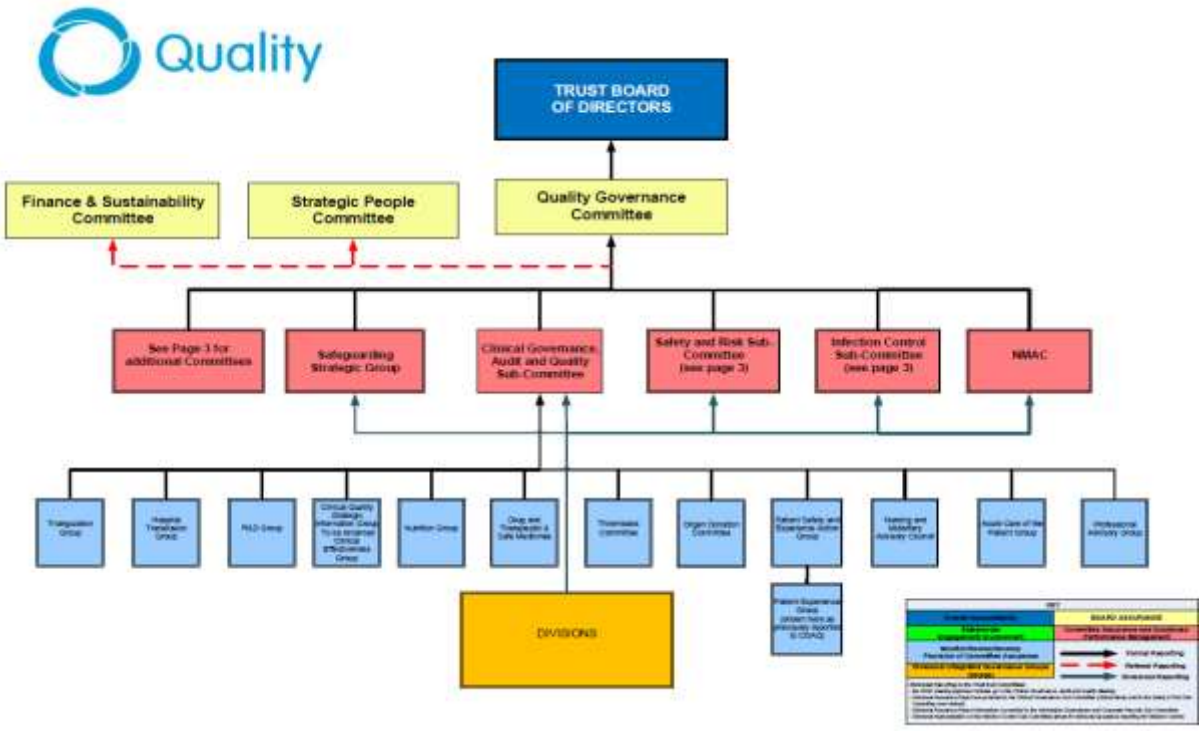
- **To ensure all patients are safe in our care.**
- **To give our patients the best possible experience.**
- To be the employer of choice for the health care we deliver.
- To provide sustainable local health care services.

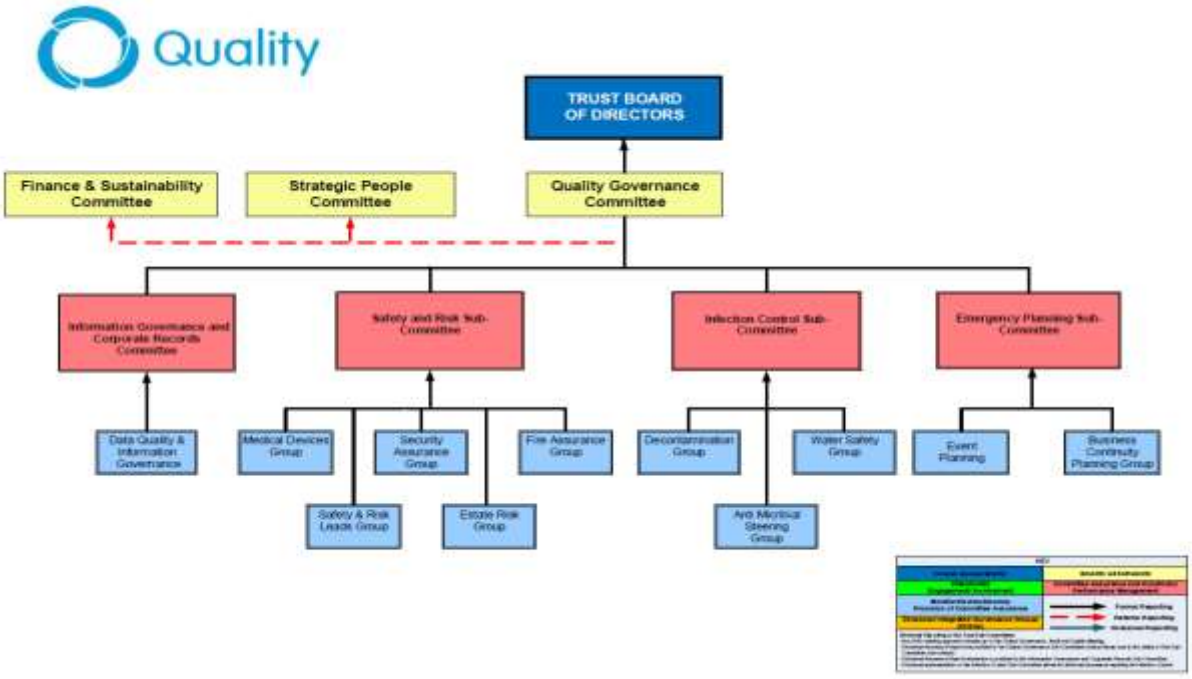
The “Improving Quality” Strategy underpins these four objectives, aiming to deliver high quality safe healthcare in a timely and responsive manner, provided in high quality, safe therapeutic environments and maintaining compassionate and respectful care. It draws together the various initiatives to deliver a clear plan of how the trust will work to achieve this.

These objectives are delivered using the framework of QPS and the strategy aims to deliver the Quality arm from the QPS. The quality performance information is reviewed and discussed within our governance structures as shown below:

- Quality Governance Committee
- Clinical Governance, Audit and Quality Sub-Committee
- Patient Safety and Experience Action Group
- Quality in Care Committee (Governors)
- Infection Control Sub-Committee
- Meetings of the Board of Directors
- Meetings with the commissioners of the trust’s service

Quality Governance Structure





2.1 Improvement Priorities

2.1.1 Improvement Priorities for 2013-2014

All of the following improvement priorities were identified following a review of the domains of quality and reported in 2012/2013 Quality Report. We also consulted with patients, governors, commissioners, LINks, Healthwatch and other external agencies in order to inform the board when determining our priorities for 2013/2014. The progress of each priority is discussed and red, amber and green (RAG) rated against performance 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 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 2013/2014.

In 2013/2014, our improvement priorities were:

- Zero tolerance to hospital acquired MRSA bloodstream infections
- Reduction in incidents that result in severe or catastrophic harm
- Pressure Ulcers – reduction
- Reduction in medication errors that are related to insulin.
- Reduction in catheter associated UTI's
- 62 day cancer access target
- SHMI – Mortality Rates
- Commissioner priorities – Commissioning for Quality and Innovation measures.

2.1.1.1 Zero tolerance to hospital acquired MRSA bloodstream infections

Healthcare associated infections (HCAIs) are infections that are acquired as a result of healthcare interventions. There are a number of factors that can increase a patient's risk of acquiring an infection, but high standards of infection control practice reduce this risk. Although hospital acquired infections are subjected to national mandatory surveillance this trust is committed to reducing the risk of harm associated with these infections and as such selected this as an improvement priority.

Within the reporting period the trust has reported 3 cases of hospital acquired MRSA bloodstream infection (against a threshold of 0) compared to 1 case in 2012/13 (against a threshold of 3). These incidents underwent in-depth investigations and key learning points were shared across the trust which included:-

- Selecting an antibiotic to provide cover for MRSA where patients are known to be colonised
- Documentation of long-term urinary catheter insertion and maintenance to ensure appropriate management
- Documentation of peripheral venous catheter site monitoring and dwell time to ensure appropriate management

2.1.1.1.1 Clostridium difficile

Within the reporting period the trust reported 31 cases of hospital acquired Clostridium difficile infections against a threshold of 19 compared to 19 cases against a threshold of 40 for 2012/2013. A variety of activities were focussed on tackling Clostridium difficile after noting an increase in cases in the early part of the year. This included, promoting isolation of symptomatic patients, enhancing environment hygiene, hand washing awareness raising and promoting prudent use of antibiotics. Antibiotics are a recognised risk factor for Clostridium difficile however they are a fundamental aspect of treating infections. To promote prudent use of antibiotics an increase in antibiotic ward rounds has taken place. The trust also participated in the European Antibiotic Awareness Day (EAAD) in November.

Although infection control will not remain as an improvement priority for 2014/15 it will continue to be monitored and reported as a quality indicator for 2014/2015.

Please see section 3.2.1 for a more detailed analysis of the management of performance in infection control at the trust.

2.1.1.2 Reduction in incidents that result in severe or catastrophic harm

It is not usually possible to eliminate all risks but this trust believes it has a critical duty to protect patients as far as 'reasonably practicable'. This means that we consistently review our practise to reduce any unnecessary risk. It is vital that we focus on the risks that really matter – those with the potential to cause harm as such we selected this measure as an improvement priority for 2013/2014.

In December 2013 the trust reported 7 incidents (*all finally approved) resulting in 4 with major harm and 3 with catastrophic harm for the period 1st April 2012 until 31st March 2013. The improvement priority threshold for 2013/2014 was therefore confirmed at 6 incidents. As at the 31st

March 2014 the trust is performing well, with 6 confirmed incidents of this severity however, there are a further 11 incidents of this severity under investigation at this time.
During this reporting period the trust is pleased to report a reduction in the level of harm to our patients in relation to pressure ulcers. **Please see section 3.2.2 & 3.2.3**.

Whilst reduction in incidents that result in severe or catastrophic harm will not continue as an improvement priority for 2014/2015, the trust has in consultation with stakeholders decided to continue with pressure ulcers and reintroduce falls as improvement priorities for 2014/2015.

***NB:** The trust has in place a process whereby incidents on datix are assigned an approval status indicating the stage that has been reached in the review process. During the review, the details of the incident are reviewed, investigated as appropriate and the severity of harm caused is identified; this may be a different severity to that initially assigned as this may not be known at the time of reporting (e.g. if a patient is awaiting an x-ray following a fall). An incident is given the status of finally approved when this process has been completed and as part of this, it is possible to assign a final severity of harm

2.1.1.3 Reduction in grade 2-4 pressure ulcers

Pressure ulcers, also sometimes known as bedsores or *pressure sores*, are a type of injury that affects areas of the skin and underlying tissue. Pressure ulcers occur in patients when the skin covering areas where pressure is concentrated may break down causing an ulcer to develop. Pressure ulcers cause misery and pain for patients and the trust has worked hard in recent years to reduce their incidence.

Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. We grade them from Grade 1 which is superficial to Grade 4 which is the most severe type of pressure ulcer. Pressure ulcers tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time. It is estimated that just under, half a million people in the UK will develop at least one pressure ulcer in any given year. This is usually people with an underlying health condition, for example, around one in 20 people who are admitted to hospital with a sudden illness will develop a pressure ulcer. People over 70 years old are particularly vulnerable to pressure ulcers as they are more likely to have mobility problems and ageing of the skin. Unfortunately, even with the highest standards of care, it is not always possible to prevent pressure ulcers in particularly vulnerable people. (NHS Choices)

During 2012/2013 we reported 18 avoidable* hospital acquired Grade 3 pressure ulcers against an improvement target of <=21 and an internal stretch target of <=19 for grade 3-4 pressure ulcers. We also reported 166 hospital acquired grade 2 pressure ulcers (avoidable and unavoidable*) against an improvement target of 232 grade 2 pressure ulcers equating to an overall 36% reduction for the year. The trust was pleased with this performance but still recognises that the continued reduction of pressure ulcers is a challenge and therefore established reduction in pressure ulcer as an improvement priority for 2013/2014 stating an improvement of a further 10% reduction across all grades namely <=149 grade 2 pressure ulcers and <=16 cases for grade 3 and 4 pressure ulcers.

As at the 31st March 2014 the trust is pleased to report the following reduction in grade 2-4 pressure ulcers as a result of the improvement work undertaken throughout the year. There has been a substantial 66.7% reduction in grade 3 pressure ulcers, with 6 confirmed grade 3 pressure ulcers. We can also report a 33% reduction in the incidence of grade 2 pressure ulcers corresponding to 112

grade 2 pressure ulcers compared to 166 grade 2 pressure ulcers in 2012/2013. Reducing the incidence of pressure ulcers remains a high priority for the trust so will continue as an improvement priority for 2014/2015.

* **Avoidable Pressure Ulcer:** "Avoidable" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."

Unavoidable Pressure Ulcer: "Unavoidable" means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non-adherence" (Department of Health)

A detailed analysis of work and performance monitoring of pressure ulcers can be found at section 3.2.2.

2.1.1.4 Reduction in medication errors related to insulin.

During 2012/2013 the trust targeted improvements in relation to the reduction of medicine errors. Nationally there is a long history of medication errors associated with the use of insulin so we established a threshold of a 10% reduction in medication errors based on data from Quarter 1 and Quarter 2 2012/2013. The trust also saw an increase in the reporting of clinical incidents involving insulin during 2012/2013 which it felt was due to both an addition of an insulin tick box within the datix incident reporting system and increased awareness of the need to report. We reported 57 insulin related incidents in 2012/2013 and established an improvement target of a further 5% reduction namely <=54 incidents for 2013/2014.

The incidents which are all reported on to the incident reporting system datix are verified and quality checked by the Deputy Chief Pharmacist. The trust has established the following inclusion criteria namely incidents that have had a clinical impact / had the potential to have a clinical impact (near miss) will be included. Incidents that are not patient related e.g. where there are safe and secure handling issues will be excluded. This patient safety indicator is included on the Quality Dashboard which is monitored on a monthly basis by the board. Our Diabetic Nurse Specialist team worked hard to support the ward teams in this reduction and the trust is pleased to report that we reduced insulin incidents by 10.5% from 57 cases to 51 cases and therefore exceeded our threshold of a 5% reduction thus achieving this improvement priority for2013/2014. This will not continue as an improvement priority for 2014/2015.

Please see section 3.2.6 for a detailed analysis of performance.

2.1.1.5 Reduction in catheter associated UTI's

The trust is committed to improving patient care by reducing the incidence of catheter-associated urinary tract infection (CAUTI) which can cause unpleasant symptoms for patients and because it can be reasonably prevented through application of accepted evidence-based prevention guidelines. As such we selected this as an improvement priority for 2013/2014.

A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and the kidneys. Urinary tract infections account for approximately 40 percent of all hospital-acquired infections annually, with approximately 80 percent of these hospital-acquired urinary tract infections attributable to indwelling urethral catheters. This is when a tube is inserted into the bladder through the urethra to drain urine. Between 15-25% of hospitalised

patients receive urinary catheters during their hospital stay and it is well established that the duration of catheterization is directly related to the risk for developing a UTI. With a catheter in place, the daily risk of developing a UTI ranges from 3 percent to 7 percent.

Considerable work has been undertaken which includes the implementation of CAUTI maintenance bundles to optimize the care of patients who require urinary catheterization during acute care, and to ensure that urinary catheters are removed as soon as clinically indicated. These two high impact interventions are based on expert advice and national infection prevention and control guidance to improve and measure the implementation of these key elements of care. The evidence base shows that the risk of infection reduces when all elements within the clinical process are performed every time and for every patient and that it increases when one or more elements of a procedure are excluded or not performed. Regular audits are undertaken within the trust in order to identify when all elements have been performed; to see where individual elements of care have not been performed and finally it enables us to focus our improvement effort on those elements which are not being consistently performed.

The trust has successfully implemented the NHS Safety Thermometer whereby it undertakes a monthly survey on one day of all appropriate patients, to collect data on four outcomes; 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. A decision was made to select CAUTI as an improvement priority going forward for 2013/2014 with agreement that the data source would be the Safety Thermometer.

We did not collect baseline data on catheter associated UTI's for last year's Quality Report but felt that it was important that we were able to produce some benchmarking data from 2012/2013 to assist analysis of performance on this important quality issue. The trust has been submitting data since May 2012 so we decided to extract the 2012/2013 data from the NHS Safety Thermometer and calculate the rolling median as our threshold for 2013/2014.

We used 3 quality indicators to monitor this improvement priority as follows:-

- Number of patients who had a catheter and a UTI as a percentage of patients with a catheter
- Number of patients with catheter and UTI
- Number of patients with catheter and UTI shown as a % of all patients surveyed.

This patient safety indicator is included on the Quality Dashboard which is monitored on a monthly basis by the board. The data shows that overall there has been a reduction in the actual number of patients with CAUTI and that the rolling median shows an overall reduction throughout the year with the exception of one month when the reported figure was slightly above the baseline. Improvements to the management of CAUTI have resulted in a reduction in infections as such this will not continue as an improvement priority for 2014/2015. However the trust determines this to be an important measure so we will continue to monitor as a quality indicator and will report performance in the Quality Report next year.

Please refer to section 3.2.4 for a more detailed analysis of performance on CAUTI.

2.1.1.6 62 day Cancer Access Target

The time from when a suspicion of cancer is raised is a particularly distressing and anxious time for both the patient and their family. The 62-day target intends to ensure that these patients are prioritised to receive the tests and procedures they need to confirm or eliminate cancer diagnosis as quickly as possible, and if cancer is diagnosed to begin treatment as soon as possible. Although this target is included in national mandatory surveillance the trust decided to select this as an improvement priority to maintain a focus on improving early diagnosis and thus improve outcomes for people with cancer.

The target is to achieve >=85% of patients diagnosed with cancer starting treatment within 62 days of urgent referral with a suspicion of cancer or referral through A&E.

In 2013-2014, Warrington and Halton Hospitals NHS Foundation Trust met its National Target and Minimum standards for patients urgently referred with a suspicion of cancer began treatment within 62 days of their referral by GP (Open Exeter Position). With regards to the reallocation position the trust is now starting to feel the negative impact of moving onto the Manchester model. Quarter 4 demonstrates that we achieved the Cancer Waiting Time Position of 85% but when we look at the percentage including reallocations we did not meet the threshold for January and February but did comply with March. This corresponds to patient deferral and patients' choice and because they are in the diagnostic phase of treatment they cannot be removed from the dataset.

62 day Cancer Wait by percentage

	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Rate
From Urgent GP Referral To Treatment - Open Exeter Position (Monitor)	>=85%	88.29%	85.96%	89.80%	89.74%	88.93%
From Urgent GP Referral To Treatment - Reallocation Position (CQC/PCT)	>=85%	85.21%	85.53%	85.33%	81.30%	85.28% (adjusted for year-end)

Going forward this will not be an improvement priority for 2014/2015 however the trust will continue to monitor this as part of the national mandatory surveillance programme and will report back in the Quality Report 2014/2015.

2.1.1.7 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 experimental 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 less than the expected numbers of deaths and a number above 100 would suggest a higher than expected number of deaths.

The trust was disappointed when, for the first time, it was named in October 2013 (for the period April 2012 – March 2013), as one of seven NHS trusts who had a higher than expected SHMI, at 112.9. We had already recognised that this was a key area for improvement. We created a number of work streams to evaluate aspects of mortality and thus identified it as a key priority for improvement in 2013/2014. Following a significant focus on mortality reduction in the trust, we are very pleased to report that since the January 2014 HSCIC publication (for the period July 2012 – June 2013) the trust has had an 'as expected' SHMI score. The latest SHMI score available (HED system) is 105 for the period February 2013 – January 2014.

The SHMI is one of two mortality measures used in the NHS, the other being HSMR (Hospital Standardised Mortality Ratio), which is 98 for the latest data period available (March 2013 – February 2014).

Mortality ratios are complex indicators and there are multiple factors that contribute to the overall score, including the quality of our documentation and coding. The Clinical Effectiveness Group has responsibility for reviewing mortality and is currently driving progress in this area; particularly focussing on six key areas of activity agreed as priorities for 2013/2014:

- Reviewing the trust's care pathways and best practice care bundles to ensure a high standard of care for every patient, every time.
- Reviewing the care of patients with respiratory conditions to ensure this is optimal at all stages of their care
- Ensuring quality and appropriate care at the end of patients' lives.
- Promoting the effective management of patients whose conditions deteriorate.
- Continue to analyse, understand, report and use mortality and morbidity data to improve outcomes.
- Ensure accurate and comprehensive documentation and coding.

Palliative Care Focus Group November 2013

Whilst the trust has not achieved the required reduction to 100 for the SHMI, it should be stressed that the positive result of work already undertaken is a SHMI score which is falling on a monthly basis and a reduction in the HSMR to below 100 in 2013/2014. Going forward this will not be an improvement priority for 2014/2015 but the trust will continue to monitor this as a quality indicator and will report back in the Quality Report 2014/2015.

Please refer to section 3.3.1 for a more detailed analysis of both SHMI and HMSR.

2.1.1.8 Commissioner priorities

The trust has also achieved compliance against a number of commissioner priorities contained within the CQUIN framework which include:

- Safety Thermometer (National)
- Family and Friends (National)
- Dementia (National)
- VTE (National)
- Advancing Quality - Acute Myocardial Infarction; Heart Failure; Hip and Knee; Pneumonia and Stroke (Local)
- Forget me Not (Local)
- Neonatal Nutrition (Local)
- High Quality Care (Local)
- Effective Discharge (Local)
- Cancer Staging Data (Local)
- Digital Technology - Minimum of 4 media options to disseminate information (Local)
- Telephone Calls - 48 hours following discharge (Local)

Further detail on the compliance against the commissioner priorities can be found in section 2.2.4 of this report.

2.1.1.9 Focus on Quality – Key issues

In addition to the agreed improvement priorities the trust board in partnership with staff and governors also agreed to focus upon a number of key issues around quality improvement as follows:-

- Achieve an improvement in the learning and analysis of complaints with themes relating to attitude, care and treatment
- To revolutionise the way that we manage complaints to provide a responsive patient focussed service
- Develop a culture within the organisation that 'everyone' will be able to recognise and help a patient with dementia
- Develop 'always events', i.e. what must we always do to ensure the quality of service.

Progress on these quality issues can be found in **Part 3** of this report.

2.1.2 Improvement Priorities and Quality Indicators for 2014 – 2015

2.1.2.1 How we identify our priorities

The priorities have been identified through receiving regular feedback and regular engagement with 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. Divisional Annual Planning 'Strategy' events have also been held to discuss and agree priorities and to discuss the quality aspects of these priorities.
The trust held a Quality Improvement Forward Planning event with all key stakeholders, approximately 25 representatives from key stakeholder organisations including Warrington Healthwatch; Halton Healthwatch; Warrington Borough Council; Governors; Assistant Director of Nursing and Quality at Cheshire, Warrington and Wirral Area Team NHS England and the external auditors for the trust *Price Waterhouse* and *Coopers (PWC) attended the event.*

Quality Improvement Forward Planning Event – February 2014

The objectives for the event were:-

- Provide an overview of the Quality Report
- Provide an update on progress with quality improvement priorities and quality indicators for 2013/2014
- Planning for improvement priorities for 2014/2015
- Planning for quality indicators for 2014/2015
- Agree a selection of quality improvement priorities and indicators to take back for discussion with the board.

Our staff, governors, members and patients are the eyes and ears of the organisation their views are constantly sought to ensure that we are focussing on the things that will make the most difference.

2.1.2.2 Improvement Priorities for 2014 – 2015
The trust board, in partnership with staff and governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2014/15 will include:

Priority 1 Complaints
Reason for prioritising: We treat and care for a significant number of people every year and the vast majority of patients have a positive experience however, when things go wrong, we are committed

to listening and reviewing practice in order to understand what happened so that we can learn lessons to ensure that meaningful improvements are made.

We continue to learn the lessons from the Francis Public Inquiry in to Mid Staffordshire NHS Foundation Trust and be responsive to the published review of the NHS Complaints system by Ann Clwydd, Member of Parliament and Professor Tricia Hart, particularly with regard to listening and learning from complaints.
Goal: – To improve the percentage of complaints responded to within timescales agreed with the patient. To provide detailed reports on themes and lessons learned as a result of complaints.
Timeframe: March 2015

Priority 2 Falls
Reason for prioritising: Whilst the reduction of falls was not an improvement priority for 2013/2014 the trust remained focussed on improvements and worked towards a challenging new threshold in relation to reducing falls resulting in moderate to catastrophic harm. We are committed to continuing the reduction of falls by increased surveillance, risk assessments and review and through the work of the Falls Prevention Group (FPG). The trust has decided select this as a key priority for 2014/15.
Goal: – Establish a 10% reduction for falls resulting in moderate - catastrophic harm.
Timeframe: March 2015

Priority 3 In-Patient Survey - improvement in low performing indicators
Reason for prioritising: Listening to patients' views is essential to providing a patient-centred health service. 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.
Goal: – Develop action plans to improve low performing areas that relate to the inpatient episode of care and where we fall below the national average and have not demonstrated improvement in past two years
Timeframe: March 2015

Priority 4 Pressure Ulcer Reduction
Reason for prioritising: Over the past two years the trust has managed a sustained reduction in grade 2-4 pressure ulcers and has not had a grade 4 pressure ulcer since March 2011. We want to build on this work and continue to evidence further improvement in the management of pressure ulcers and have therefore decided to carry this forward as an improvement priority into 2014/2015.
Goal: The trust continues to implement its planned programme of actions to further reduce pressure ulcers which includes:-

- Review of the trust policy on pressure ulcers is in progress, with particular reference to the process by which we investigate Grade 3/4 pressure ulcers.
- Root cause analysis is conducted on all Grade 3/4 pressure ulcers which develop within the trust;
- Mini investigations of all grade 2 hospital acquired pressure ulcers

Timeframe: March 2015

Priority 5 Advancing Quality (AQ) measures – Stroke and Pneumonia.
Reason for prioritising: AQ works with clinicians to provide trusts with a set of quality standards which define and measure good clinical practice. The trust has submitted data on heart attacks, heart failure, hip and knee replacement surgery and pneumonia since AQ was launched in 2008 and subsequently submitted data into the treatment of stroke patients from October 2010.

Care in hospital is always tailored to individual needs but trusts must deliver each measure to every patient to ensure they receive the highest standard of care in hospital. AQ refers to this as the Clinical Process Measures and trusts aim to achieve 100 per cent success rate.

Goal: Work streams to increase compliance with stroke and pneumonia measures to improve patient outcomes.

Timeframe: March 2015

2.1.2.3 Local Quality Indicators 2014/2015

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 2014/15 will include:

Patient Experience

- Always Events
- Complaints
- Patient Experience Indicators
- Patient Survey Indicators

Safety

- Falls
- CAUTI
- Nursing Care Indicators
- Medicines Management – development of indicators and on-going monitoring
- HCAI
- Pressure Ulcers

Clinical Effectiveness

- SHMI & HSMR
- Dementia
- PROMS
- Advancing Quality

Our success in achieving these priorities will be measured, where possible, by using nationally benchmarked information (e.g. Healthcare Evaluation Data (HED system) and National Inpatient Survey results) and using measurement tools that are clinically recognised (e.g. the pressure ulcer classification tool of the National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP)). The improvement priorities will be monitored, and recorded via the Quality Dashboard which is reported to board on a monthly basis.

2.2. Statements of Assurance from the Board

During 2013-2014 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 in 2013-2014 represents 100% of the total income generated from the provision of relevant health services by the Warrington and Halton Hospitals NHS Foundation Trust for 2013-2014.

2.2.1. Data Quality

The data is reviewed through the board's 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.

2.2.2. Participation in Clinical Audit and National Confidential Enquiries

During 2013/2014 39 national clinical audits and 4 national confidential enquiries covered relevant health services that Warrington and Halton Hospitals NHS Foundation Trust provides.

During 2013/2014 Warrington and Halton Hospitals NHS Foundation Trust participated in 37 (95%) national clinical audits and 4 (100%) of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust was eligible to participate in during 2013/2014 are as follows:-

National Clinical Audits

Adult critical care (Case Mix Programme – ICNARC CMP)
Emergency use of oxygen (British Thoracic Society)
National Audit of Seizure Management (NASH)
National Emergency Laparotomy audit (NELA)
National Joint Registry (NJR)
Paracetamol overdose (College of Emergency Medicine)
Severe sepsis & septic shock (College of Emergency Medicine)
Severe trauma
National Comparative Audit of Blood Transfusion programme Anti D Audit
Bowel cancer (NBOCAP)
Head and neck oncology (DAHNO)
Lung cancer (NLCA)
Oesophago-gastric cancer (NAOGC)
Care of dying in hospital (NCDAH)
Acute coronary syndrome or Acute myocardial infarction (MINAP)

Cardiac arrhythmia (CRM)
Heart failure (HF)
National Cardiac Arrest Audit (NCAA)
National Vascular Registry
Chronic Obstructive Pulmonary Disease
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit National Pregnancy in Diabetes
Diabetes (Paediatric) (NPDA)
Inflammatory bowel disease (IBD)
Renal replacement therapy (Renal Registry)
Falls and Fragility Fractures Audit Programme (FFFAP), includes National Hip Fracture Database (NHFD)
Sentinel Stroke National Audit Programme (SSNAP)
Elective surgery (National PROMs Programme)
National Audit of Intermediate Care
National Rheumatoid and early inflammatory arthritis
Child health programme (CHR-UK)
Epilepsy 12 audit (Childhood Epilepsy)
Maternal, infant and Newborn programme (MBRRACE-UK)
Moderate or severe asthma in children - (College of Emergency Medicine)
Neonatal intensive and special care (NNAP)
Paediatric asthma (British Thoracic Society)
National Audit of Seizure Management (NASH) – children
National Gout Audit
National NIPE Audit
Blood Cultures and long line infections on NNU - Part of NNAP Audit

National Confidential Enquiries

Subarachnoid Haemorrhage Audit
Alcohol related Liver Disease
Tracheostomy Audit
Lower limb study

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2013/2014 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 Audits 2013/2014

National Clinical Audits	Participated	Data collected	% of cases submitted 2013/2014
Adult critical care (Case Mix Programme – ICNARC CMP)	√	√	On-going data collection
Emergency use of oxygen (British Thoracic Society)	X	NA	NA
National Audit of Seizure Management (NASH)	X	NA	NA
National Emergency Laparotomy audit (NELA)	√	√	23 (100%)
National Joint Registry (NJR)	√	√	On-going data collection
Paracetamol overdose (College of Emergency Medicine)	√	√	50 (100%)

Severe sepsis & septic shock (College of Emergency Medicine)	√	√	50 (100%)
Severe trauma	√	√	On-going data collection
National Comparative Audit of Blood Transfusion programme Anti D Audit	√	√	100%
Bowel cancer (NBOCAP)	√	√	Report not finalised
Head and neck oncology (DAHNO)	√	√	On-going data collection
Lung cancer (NLCA)	√	√	On-going data collection
Oesophago-gastric cancer (NAOGC)	√	√	On-going data collection
Care of dying in hospital (NCDAH)	√	√	50 (100%)
Acute coronary syndrome or Acute myocardial infarction (MINAP)	√	√	357 cases submitted on-going data collection
Cardiac arrhythmia (CRM)	√	√	102 (100%)
Heart failure (HF)	√	√	63 cases submitted on-going data collection
National Cardiac Arrest Audit (NCAA)	√	√	88 (100%)
National Vascular Registry	√	√	161 cases submitted on-going data collection
Chronic Obstructive Pulmonary Disease	√	√	24 cases submitted on-going data collection
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit National Pregnancy in Diabetes	√	√	20 (100%)
Diabetes (Paediatric) (NPDA)	√	√	On-going data collection
Inflammatory bowel disease (IBD)	√	√	36 (90%)
Renal replacement therapy (Renal Registry)	√	√	On-going data collection
Falls and Fragility Fractures Audit Programme (FFFAP), includes National Hip Fracture Database (NHFD)	√	√	348 cases submitted on-going data collection
Sentinel Stroke National Audit Programme (SSNAP)	√	√	>90%
Elective surgery (National PROMs Programme)	√	√	On-going data collection
National Audit of Intermediate Care	√	√	85/87 (98%)
National Rheumatoid and early inflammatory arthritis	√	√	On-going data collection
Child health programme (CHR-UK)	√	√	Data collection closed April13
Epilepsy 12 audit (Childhood Epilepsy)	√	√	13 cases submitted 21 Questionnaires: On-going data collection

Maternal, infant and Newborn programme (MBRRACE-UK)	√	√	On-going data collection
Moderate or severe asthma in children - (College of Emergency Medicine)	√	√	50 (100%)
Neonatal intensive and special care (NNAP)	√	√	390 (100%)
Paediatric asthma (British Thoracic Society)	√	√	17 (100%)
National Audit of Seizure Management (NASH) - children	√	√	30 (100%)
National Gout Audit	√	√	On-going data collection
National NIPE Audit	√	√	On-going data collection
Blood Cultures and long line infections on NNU - Part of NNAP Audit	√	√	On-going data collection

National Confidential Enquiries 2013/2014

National Confidential Enquiries	Participated	Data collected 2013/2014	% Cases submitted 2013/2014
Subarachnoid Haemorrhage Audit	√	√	100%
Alcohol related Liver Disease	√	√	100%
Tracheostomy Audit	√	√	100%
Lower limb study	√	√	On-going data collection

2.2.2.1. National Clinical Audits – reviewed

The reports of 12 National Clinical Audits were reviewed by the provider in 2013 /14 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Actions for Improvement
Epilepsy 12	Develop checklist of discussion topics, to be ticked off as covered (dated and updated) and stored in the patients notes. Written information to accompany this.
	Develop guidelines to outline referral criteria for ECG, MRI, Tertiary referral and develop record sheet for the notes.
	Remind GP referrers and Dr Bedford, who filters the outpatient referrals, that all fits should be seen by Lead Consultant.
The Missing Lung Cancers	To encourage data inputting. To look at multiple surgery for history. (Especially from outside the trust e.g. Liverpool Heart & Chest Hospital (LHCH).
	To inform data inputters of potential errors inherent in Lung Cancer Audit Data Set (LUCADA) database and how to avoid them (e.g. Defaulting to null result).
	To provide overview of data and interrogate it for robustness and accuracy.

Fracture Neck of Femur - CEM Audit	To work closer with orthopaedic team.
National Audit of Dementia	Complete admission pathway and forward to ratify at appropriate committee. IT support to facilitate collecting information on re-admissions IT support to record information on delayed discharges. Clear eligibility criteria for patients with dementia going to intermediate care services. Interpreting service can meet the needs of patients with dementia.
	Presentation of repeat audit results.
	Increase the rate of cognition assessment using standard tool for appropriate patients.
	Promote best practice in screening for delirium.
National Audit of Dementia continued	Confusion Assessment Method (CAM) screening tool to be included in local dementia guideline.
	Review existing policies relating to Wandering and Restraint for compatibility with national guidelines for dementia care.
	Therapists to identify which standardised tools will be used to assess function.
	Level of cognitive impairment using standard tool recorded on discharge letter.
	Discharge letters to include any mental health issues.
	Agree criteria of emergency/urgent/routine referrals.
	Dementia champion at directorate level.
	Roll out of admission pathway which incorporates use of 'This is Me' document.
	Roll out the 'This is me document' on all adult wards admitting patients with dementia.
	Discharge policy to include the advice that dementia patients should be moved only for clinical reasons pertaining to care or treatment.
	Introduce the "forget me not" logo for all patients requiring extra time to communicate because of cognitive impairment.
	Develop local guidelines for management of dementia including Behavioural and Psychological Symptoms of Dementia (BPSD).
	Implementation of revised care planning booklet to be given to patients / relatives.
	Promote the use of dementia specific care plans within all adult wards.
	Roll out of admission pathway which incorporates:
	Identification of main carer and discuss level of input into patient's care that they would like to have whilst on the ward
	Use of the 'This is Me' document to facilitate the formulation of the care plan with patient and relatives.
	Discussion of the level of relatives/carer continued input to care on discharge and where support is needed.

BSUG National Audit of Continence & Pelvic floor dysfunction surgery	Re-Audit
BTS National Emergency Oxygen Audit 2012	Oxygen prescription policy
	Continuing training of health professionals, Nursing staff on A7: short sessions on the wards Summer 2013, Induction training for Foundation year 1 (FY1) & other Doctors from August 2013.
	Specialist respiratory nurses input/teaching on Medical wards
National Comparative Audit of Blood Transfusion: "2011 Audit of Use of Blood in Adult Medical Patients – Part 1"	Distribute finding to Foundation year 1'&2's, Speciality Training Doctors / Registrars and Consultants in the form of a "Bloody Matters" newsletter. Include in trusts "Risky Business" newsletter.
	Submit report to the: Transfusion Team Meeting (TTM), Hospital Transfusion Committee (HTC) and Clinical Governance (next meetings: TTM February 2013, HTC April 2013, CG report May 2013)
	Recommendations to be presented to the Medical Consultants at the "Grand Round" (next meeting, as part of another presentation on relevant transfusion issues).
Consultant sign off - CEM Audit	Re-audit nationally when College recommends.
	Aim to have more children in the <1year old febrile group included
	Review current IT to assess for future implementation of audit (on-going).
National Emergency Laparotomy Audit	Use of Doppler for all of these cases.
	Possum scoring of Mortality.
	Further participation in National Audit
National Paediatric Diabetes Audit (NPDA)- Quality Accounts	To Improve collection of care process. (Dietician input, chiropody, retinal screening) HbA1c Leaflet (Blood Test) To raise awareness to all staff.
Moderate / Severe asthma in Children National CEM Audit	Include systolic Blood Pressure on Asthma Pathway.
	Exclude Blood Pressure measurement on audit criteria
	Re-audit in 3 years
	Peak flow – re-educate practitioners regarding peak flow and if unable to perform document reasons why.
	Ensure if any observations are not performed to document why.
Hip Fracture Database	Discuss all the patients who failed Best Practice Tariff (BPT) and look at possible management for the avoidable patients.
	Review the last ten patient's journey to look at any possible trends that may be causing delayed discharges in order to reduce length of stay.
	Introduce the principles of enhanced recovery to the ward staff through a staff survey and education sessions.

2.2.2.2. Participation in Local Clinical Audits

The reports of 257 local clinical audits were reviewed by the provider in 2013/2014 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Local Clinical Audit – examples showing completion of the audit cycle.

Audit Title	Actions for Improvement
Acute Medicine	
Knowledge of Intranet Hub.	To remove all out of date policies.
	More focus on Hub policies at junior induction.
	Improve policy accessibility.
	Improve search engine i.e. system that will pick up document if spelling Hypomagnasaemia is incorrect.
Patient harm using global trigger tool.	Risk Acute Kidney Injury (AKI) and role medications.
	Awareness risk rehydration especially in elderly.
	AKI pathway for trust.
	Help identify AKI.
	Review and cessation nephrotoxic medication where required.
Anaesthetics.	
Perioperative care for elective joint replacement (current practice).	These findings to be discussed in Enhanced Recovery Pathway (ERP) meeting.
	Need for standardised Enhanced Recovery Pathway (ERP) for joint replacement.
	Further audit after implementing (ERP).
	Data to be presented to Orthopedicians.
30 day mortality following laparotomy.	Risk prediction scoring should be completed in all Emergency laparotomy patients.
	Active surgical and anaesthetic consultant input for all Emergency Laparotomies.
	Perioperative pathway to be put in place for the management of Emergency. Laparotomies.
	Cardiac output to be monitored intra-operatively in all Emergency Laparotomy patients.
Cardiology	
Dual antiplatelet therapy post elective PCI.	Re audit after 6 months, and include higher number of patients.
	Audit of the percentage of elective attending pre op clinic.
	Percutaneous Coronary Intervention (PCI) should be postponed if patient can't attend pre op clinic.
	Audit of time from procedure to follow up.
	Cardiac Specialist Nurses (CSNs) should aim to see all elective Percutaneous Coronary Intervention (PCI) cases within 4 weeks after the procedure.
	Cardiac Specialist Nurses should develop pathway to capture all elective Percutaneous Coronary Intervention (PCIs), so early follow up could be planned in advance.
Inpatient Coronary Angiography for	To liaise with A&E link for Cardiology regarding increasing awareness of using GRACE scoring on admission.
	Improved awareness of GRACE scoring to be highlighted to new medical staff at induction.

ACS/NSTEMI patients.	Standard Operating Procedure (SOP) to be finalised for C21 to have full control of bed flow.
	Re-audit 2014.
Child Health	
Management of the Newborn where Group B. Streptococcus. Confirmed in mother or Newborn.	Dissemination of the Maternal GBS in Pregnancy and Management of the Newborn Audit Report at the following Group Meeting: Maternity Risk Management Meeting.
	To improve compliance to the required best practice standard of 100% compliance with the completion of the Newborn postnatal observations individual staff members who do not comply with the local guideline will be identified and advised on an individual basis regarding the need for compliant documentation supported with a letter.
	Implementation of the new local guideline 'Management of the neonate at risk of early onset infection including GBS sepsis' incorporating the NICE guidance for antibiotic therapy for early onset sepsis in the neonate with red and non-red flag risk factors. Implemented into practice on the 3rd March 2014.
	New Newborn Early Warning Score (NEWS) to be implemented to replace current Newborn Postnatal Observations Chart as part of the new 'Management of the neonate at risk of early onset infection including GBS sepsis' guideline. The NEWS chart provides specific time frames for requesting a paediatric medical review for a Newborn those scores with abnormal observations.
	Implement monthly monitoring of maternal GBS in pregnancy and management of the Newborn cases and use of the NEWS chart from implementation.
	Re audit maternal GBS in pregnancy and management of the Newborn in 6 months to evaluate compliance with completion of the new NEWS chart.
	Dissemination of the results of the Maternal GBS in Pregnancy and Management of the Newborn Audit to all the relevant staff in the Maternity Unit including the Neonatal Unit through the Audit Summary via email.
TPN, Commissioning for Quality and Innovation (CQUIN).	Developing written guidelines for total parenteral nutrition (TPN) administration.
	Raising awareness of planned practice to start TPN on day 1 - 2 for this group of babies – this can be implemented immediately for babies born Sunday to Friday morning.
	Discussion re allowing peripheral TPN initially if delay in achieving central access.
	Purchasing standard TPN bags to enable easy initiation of TPN on day 1.
Support for Parents in Actual or suspected poor outcome - June 12-June 2013.	Continued inclusion of CNST Update in the Neonatal Unit Mandatory Training Programme.
	The Neonatal Unit Manager and Neonatal CNST Lead will identify individuals who are non-compliant with the local guideline and discuss documentation and practice in relation to how they can improve in these key areas with future cases.
	Monitor on an individual basis the Newborn medical records of support for parents documentation for any baby admitted to the Neonatal Unit at term with a suspected or actual poor outcome.
	Engage the Bereavement Lead Midwife in assisting with undertaking the Support for Parents in cases of actual or suspected outcome Audit.

Support for Parents in Actual or suspected poor outcome - June 12-June 2013.	Continued inclusion of 'Bereavement Support' update on the Neonatal Unit Mandatory Training Programme.
	Email all neonatal nursing staff and senior paediatric medical staff regarding compliance with the local guideline for Support for Parents in cases of Actual or Suspected Poor Outcome for the Baby in relation to the documentation of all verbal and resource support given to parents.
	Dissemination of results from this Audit to all the Neonatal Unit nursing staff through the Audit Summary Report with signature list.
	Dissemination of results to: Child Health Departmental Meeting / Senior Staff Meeting & Paediatric Audit Meeting.
Unanticipated Admissions to NNU October 13-December 13.	Continued inclusion of a Risk Management Update on the Local Neonatal Unit (LNU) Mandatory Training Programme.
	In cases of non-compliance - individuals will be approached, good practice and areas for improvement with documentation discussed and supported with a letter.
	Continue to monitor the unanticipated admissions of term new-borns to the LNU on a monthly basis and Proforma completion.
Diabetes.	
Endocrine clinic: Comparison of Thyroid management against guidelines.	Attempt to establish full diagnosis in all cases not clearly Graves' Disease.
	Document biochemistry before commencing Autoimmune Thyroid Disease (ATD) in all cases.
	Document repeats Thyrotrophin Receptor Antibiotics (TRAB) before discontinuing ATD in all cases.
	Document Smoking status and cessation advice in all cases.
Introduction of mandatory insulin teaching as part of WHH training.	To continue to provide insulin prescribing and administration courses for nursing staff.
	To teach Foundation level doctors about insulin.
	Evaluate by re-auditing effect of course/training on insulin errors.
General Surgery	
NHS breast screening.	All patients to be listed within 31 days of MDT.
	All patients to be staged with Sentinel Lymph Node Biopsy (SLNB).
	Document choice of operation.
Governance	
Urinary Tract Infections (UTI) Outliers (Dr Foster).	The Palliative Care team has been revitalised in 2012/13 and referrals to the team have increased dramatically. The implementation of the Amber care initiative is further improving end of life care for patients.
	Coding issues: Following the initial review of 20 patients, the reviewers met with the coding department manager to review processes and ensure accurate coding of UTIs. Specific cases from this extended review will be discussed, regarding UTIs and Liverpool Care Pathway (LCP).
	Patients moving between wards and specialities: New acute medicine model of care implemented including the opening of an acute older persons and liaison unit on the 3/12/12. This will allow all patients to be reviewed by a senior doctor within 12 hours of admission and for the patient to be moved once to an appropriate ward if admission is deemed necessary. Audit of hospital acquired pneumonia.
	Quality of UTI diagnosis:

	Raise awareness throughout the division of unscheduled care about making an appropriate diagnosis of a UTI. This could be at induction, audit, grand round, PC screen saver, posters or a combination of all these Repeat snapshot audit on a regular basis to ensure quality of diagnosis improves and is sustained.
	End of Care: The trust Chief Executive Officer (CEO) is the executive sponsor of a collaborative partnership. This includes the acute hospital, older adults both patients and carers, the ambulance service, clinical commissioning group, community services, social services, primary care and the voluntary sector set up this year to develop new ways of working across the whole of our local community.
	Care of specific patients.
	Level 1 investigation to be undertaken.
	Management of patients with UTI.
	Utilising the NICE guidelines, a UTI peer support decision guide can be developed and audited.
	Compliance with trust policies and procedures.
	Regarding medication omissions; quarterly trust wide audits began in Q1 2012/2013, reduction targets have been set and compliance is reported to the Board of Directors in the monthly Quality Dashboard.
	Documentation: Continue to raise awareness and audit medical record documentation. Amend clerking proforma to include comorbidity.
Consent Audit.	Discuss at the May Clinical Governance, Audit and Quality Sub Committee to delegated Consent of the present Trust doctors (Associate Specialists/Staff Grades) to see if they require to have trained delegated Consent or should this just be for new trust Grade Doctors.
	Re- Audit August 2013.
	ADG to meet with all Audit and Governance Leads to ensure the list of delegated procedures is kept up to date.
	ADG to meet with all Audit and Governance Leads to ensure the Audit is discussed at Speciality Audit meetings in conjunction with Audit Department.
	Continue monthly education and training.
Ophthalmology.	
Bacterial Keratitis Audit.	Re-audit to ensure 100% compliance with Royal College of Ophthalmologist (RCO) guidance.
Pathology.	
A Regional Re-Audit on out of hour notification to HPU and Primary Care.	All Laboratories to have a written policy on communication of important results to primary care agreed with GP out of hours. (This policy should be agreed in conjunction with relevant PCT).
	Organisms with potential of causing outbreaks should be notified to Health protection Agency (HPA) now Public Health England (PHE). A list should be agreed with the local Health protection Agency Unit (HPU).
Consent to Blood Transfusion.	Produce 'Safety Alert' on the need to obtain and document consent.
	Alert send 16/07/2013; discuss with CG to the need to re-send this alert – new alert sent 30/10/2013.
	Generate report and submit to the Transfusion Team, HTC, Clinical Governance Quality and Audit Sub Committee (CGQASC).
	Produce 'Bloody Matters' highlighting results of the audit to circulate to all clinical areas and submit for 'Risky Business'.

	Present finding at Laboratory Lunchtime Meeting + slide included into 2014 mandatory training.
Carcinoma in Prostate Chippings.	Appropriate number of blocks should be processed.
	Reports should include additional data in line with recommendations.
	Malignant prostate to be reported by 2 histopathologists.
Radiology	
Evaluate the diagnostic adequacy and safety of percutaneous image guided liver biopsy.	On the page titled "Notes", report as detailed as possible the procedure.
	Coagulation checked and ok.
	Consent obtained and signed.
	LA, dose and type of medication.
	Type of USS guidance.
	Targeted or not, right or left.
	Type of needle, gauge, coaxial, passes.
	Pain score.
	Blood pressure, beats per minute (bpm), Sa02.
Accuracy of Radioscopy lesion localisation technique.	Educate breast radiology team about advantages and efficacy of Radioscopy Lesion Localisation (ROLLS) compared to wire localisation.
	Present findings at a national meeting (to be presented at UK Radiology Congress).
	Re audit in 2 years.
	Discuss findings with Breast surgeons.
Unscheduled Care Division.	
Discharge and Transfer Policy.	To present findings to Director of Nursing and Associate (DoN's) March 2014.
	Discharge service to work with ward managers to achieve 100% compliance.
	To present findings at the Clinical Governance, Audit & Quality Sub Committee in March 2014.
	To present findings to clinical leads for Physiotherapy and Occupational Therapy.
	Re-Audit in 6 months reviewing policy checklist standard.
	To present findings to Divisional Integrated Governance Groups.
	Agreement to include Discharge and Transfer of Care on corporate induction.
Scheduled Care Division.	
World Health Organisation (WHO Checklist).	Continue to monitor the DATA from DWARF and continue to report back to the DIGG.
	Engage the clinical teams in taking ownership in the new WHO checklist. Getting support from our new divisional medical director and trust medical director.
	Continue to report back to the theatre teams on compliance and examples to learn.
	Planning to send staff to visit some other organisations which do the check list a little differently and could support the efficacy of the check list.
Vascular.	
Prevention and Management of Contrast Induced Nephropathy in vascular patients.	All patients should receive intravenous hydration pre- and post-contrast studies. All nephrotoxic medications should be withheld before the contrast studies.
	Renal functions (urea and electrolytes) should be checked before and 24-72 hours after the contrast studies.
	Topics of assessing and managing patients undergoing contrast studies should be included in the induction sessions for the junior doctors.

	Vascular unit and radiology department should set up a risk assessment protocol to stratify the contrast-related nephropathy and to manage patients undergoing contrast studies.
Women's Health.	
Examination of the Newborn Referrals Audit. Update with additional information	Dissemination of results from this Audit at the following Child Health Division Meetings at Senior Staff Meeting and Paediatric Audit Meeting.
	Implementation of oxygen saturation monitoring on all eligible new-borns as part of the full physical Newborn examination.
	In the cases of non-compliance with the local guideline documentation Individuals who are not compliant with the documentation requirements of the local guideline will be identified and advised on an individual basis regarding the need for compliant documentation.
	Development of the input of referrals to the Paediatric Murmur Clinic and Cardiac Clinic via the Meditech System.
	Development of the input of referrals to the Orthopaedic Clinic for hip follow-up via the Meditech System.
	Dissemination of results from this Audit to all the health care professionals who conduct the full physical examination of the Newborn through the Audit Summary Report via email.

KEY:

CEM	College of Emergency Medicine
NNAP	National Neonatal Audit Programme
AE	Emergency care
CG	Clinical Governance
GP	General Practitioner
PN	Practice Nurse
FY1/FY2	Foundation Year 1 & 2
ST	Speciality Training
SpR	Registrar
BSUG	British Society of Urogynaecology
ADG	Associate Director of Governance
NICE	National Institute for Health and Care Excellence
TRAb	Thyrotropin receptor autoantibodies
CNST	Clinical Negligence Scheme for Trusts (Maternity Standards for trusts)
GBS	Group B. Streptococcus.
NNAP	National Neonatal Audit Programme
NNU	Neonatal Units
NBOCAP	National bowel cancer audit programme
DAHNO	Data for Head and Neck Oncologists
DWARF	Data Warehouse
DIGG	Divisional Integrated Governance Group
NLCA	National Lung Cancer Audit
NAOGC	National Oesophago-Gastric Cancer Audit
USS	Ultrasound
ICNARC	Intensive Care National Audit & Research Centre
BTS	British Thoracic Society
NIPE	NHS Newborn and Infant Physical Examination Programme
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
PROMS	Patient Reported Outcome Measures

NPDA	National Paediatric Diabetes Audit (NPDA) | RCPCH
NDA	National Diabetes Audit
CRM	Cardiac Rhythm Management
CHR-UK	Child Health Reviews
PCI	Percutaneous Coronary Intervention
ACS	Acute Coronary Syndrome
NSTEMI	Non-ST segment elevation myocardial infarction
NCDAH	National Care of the Dying Audit
GRACE	Global Registry of Acute Cardiac Events

NB: Full details of the actions taken of all audits can be provided – please contact 01925 662736 for more details

2.2.3. 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 2013/2014 that were recruited during that period to participate in research approved by a research ethics committee was 707**.**

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 2013-2014 the trust was involved in conducting 95 clinical research studies (a 3% decrease on 2012/2013*)* in research in oncology, surgery, stroke, reproductive health, cardiology, rheumatology, gastroenterology, ophthalmology, as well as paediatric and other studies.

Research and Development at the trust is currently mainly supported through external income from the Cheshire & Merseyside Comprehensive Local Research Network (C&MCLRN) 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). We also work with the topic specific research networks and other health providers to increase NIHR clinical research activity and participation in research.

The trust has also adopted the C&MCLRN Research Management and Governance operational procedures and systems, including the NIHR Coordinated System for gaining NHS Permissions and achieved its target over the period. The trust ensures that all NIHR portfolio research activities are conducted to the highest standards and undertaken within the framework of research governance, strict legislation and recognised good clinical practice.

Most of the research carried out by the trust is funded by the NIHR. For 2013-2014 the trust received £400,700 which funds 9 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.

In 2013/2014 Warrington and Halton promoted it's Investigator Led Grant Awards Scheme and in this regard recently started partnership working with Manchester University. The aim of this is to

develop projects to take place over the next 12 months which will provide a benefit to patients whilst also developing research investigators locally.

2.2.4. 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. The locally agreed goals, which should be stretching and realistic, are discussed between trust board, commissioners and providers and included within contracts. Further details of the agreed goals for 2013/14 can be found below and details for the following 12 month period are available online on the trust website.

A proportion of Warrington and Halton Hospitals NHS Foundation Trust's income in 2013/2014 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.

The monetary total for the amount of income in 2013-2014, conditional upon achieving quality improvement and innovation goals, was £4,617m with a monetary total for the associated payment in 2013/2014 of £4,580m received. In 2012/2013 the trust received a monetary total for the associated CQUIN payment of £4.3m.

The trust achieved full compliance against all of the agreed CQUINs with the exception of the "Forget Me Not" CQUIN whereby we failed to hold a Dementia Conference within the agreed timescale and thus a payment of £36,866 was withheld. The trust had the following CQUIN goals in 2013/2014 which reflected both national priorities and Department of Health initiatives and also reflecting local needs and the views of the patients and commissioners.

CQUIN Report 2013/2014

CQUIN	TITLE	MEASURE	WEIGHTING	FINANCIAL VALUE	ACHIEVED CQUIN TARGET
National	Venous-thromboembolism (VTE) Risk Assessment - Reduce avoidable death, disability and chronic ill health from VTE.	95% of appropriate patients to be risk assessed. Number of Root Cause Analysis carried out on hospital associated thrombosis.	**5.00%**	**£230,850**	
National	Dementia	Carers survey	**5.00%**	**£230,850**	

		Dementia screening, risk assessment and referral. Named Lead for Dementia and appropriate training for staff.			
National	Family and Friends	Establish a F&F Baseline (acute in-patients & A&E combined) of 15% or more Increase in response rate that improves on Q1 and is 20% or over by quarter 4 Improved performance in Staff Survey F&F question - a better result in 2013/2014 compared with 2012/2013, or remaining in the top quartile. Delivery of Friends and Family roll-out for maternity services	**5.00%**	**£230,850**	
National	Safety Thermometer	ST Monthly data collection in relation to pressure ulcers; falls, urinary tract infection. Improvement reduction in the prevalence of pressure ulcers.	**5.00%**	**£230,850**	
Local	Advancing Quality – Application of quality requirements based on evidence and research to yield quality outcomes for:- • Pneumonia • Heart Failure • Acute Myocardial Infarction • Hip and Knee • Stroke	Performance delivery for each condition demonstration annual improvement against the targets. AMI 91.46% Heart Failure 86.85% Hip & Knee 92.23% Pneumonia 75.23% Stroke 62.57% Implementation of new quality targets.	**2.00%**	**£92,340**	
Local	Forget me Not coincide	Review the trust Dementia Strategy, introduce 'Forget me not' Introduce Dementia Champions. Nominate 2 dementia friendly wards. Assess ward environment utilising the tool kit Assess all medical wards and roll out a plan for the remaining ward areas.	**5.40%**	**£249,318**	**The trust incurred a minor penalty due to failure to hold the Dementia Conference in Q3, we subsequently agreed with commissioners that the conference would be held to coincide with launch of**

					the Dementia Ward and the penalty will be reimbursed at that point.
Local	High Quality Care	Provision of high quality care which places the patient at the centre of all care decisions is fundamental to care delivery. This CQUIN requires the trust to demonstrate this through review and implementation of quality and nursing strategies and ensure the following are delivered:- Culture of patient centred care via use of a cultural barometer Effective Leadership Workforce for safe care delivery Competent Health Care Assistants.	**22%**	**£1,014,587**	
Local	Effective Discharge	To support effective discharge and transfer of care the trust is required to implement policies and processes in line with best practice. Increase patient engagement within the discharge process. Ensure effective multi-disciplinary engagement in planning delivery and discharge thereby ensuring that all discharges are safe, patient focused and reduce risk of harm.	**24.30%**	**£1,125,396**	
Local	Cancer Staging Data	Data collection Agree baseline performance set threshold Deliver against threshold, improve by 15% or achieve 60% by end of Q3. 75% target achieved for 3 consecutive months	**2.40%**	**£109,653**	
Local	Telephone Calls 48 hours following discharge.	Establish system agree criteria and risk assessment.	**10.40%**	**£119,754**	

		Commence project and pilot to ensure correct patient cohort. Service contacting 20% of patients. Evaluate project and 45% of patients receiving calls. Evaluate how service has improved patient outcomes and reduced reliance on primary and secondary care			
Local	Neonatal Nutrition	Improve proportion of pre-term babies who start TPN by day 2. Undertake quarterly audits and action plans to improve compliance by Q4.	**2.00%**	**£92,340**	
Local	Digital Technology	Programme of work which identifies a minimum of four different options to utilise mixed media process to disseminate information to patients, carers and staff.	**11.50%**	**£530,956**	
TOTAL			**100%**	**£4,617,015**	

2.2.5. 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 2013-2014.

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.

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

2.2.5.1 CQC Unannounced Inspection 2013/2014.

The CQC made one unannounced visits to Halton Hospital on the 30th September 2013, to review systems, standards, audit and processes as part of the Regulated Activities for Quality and Safety. The inspection which was unannounced started at the Minor Injuries Unit and then continued onto the wards, pharmacy and Cheshire and Merseyside Treatment Centre (CMTC). The CQC inspected the following standards as part of a routine inspection - care and welfare of people who use services, consent to care and treatment, staffing and management of medicines. The feedback was excellent – quotes from inspectors included that it was "an enjoyable inspection" and they had "never seen such inspirational care as on B1"

The full report can be found at http://www.cqc.org.uk/directory/RWWHG

Extracts from the CQC inspection 30th September 2013 reported October 2013.

How we carried out this inspection

"We began our inspection on 30th September 2013 by visiting the Minor Injuries Unit outside of normal working hours. We returned the following day 1st October 2013 and visited the Orthopedic, Intermediate Care, Elective Surgical Services and Step down wards.. We saw that staff were well supported and had regular personal development reviews. Training was monitored and we saw evidence that staff had the opportunity to attend more specialist training courses when appropriate. There were enough staff on duty at the time of our inspection and we saw that additional staff could be accessed at short notice if required."

What the inspection revealed.

"We spoke with patients and staff of different grades on all the wards we visited. Patients spoke positively about their experience at Halton General Hospital. One said, "I much prefer this hospital to another, I have been in both for long periods of time and this hospital gives great attention to patient care, I cannot praise staff highly enough, the nurses especially night staff are just fantastic and very dedicated". Patients we spoke to felt that they had a full and clear understanding of their individual programmes of care and treatment. They commented that they felt they were given sufficient details and answers to any questions they may have, which they felt allowed them to make informed decisions. They understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment."

2.2.5.2 CQC Themed Review of Dementia Care 2013/2014

The CQC made one unannounced visits to Warrington Hospital on the 28th January 2014, to review systems, standards, audit and processes as part of the themed review of dementia care. This inspection programme reviewed three main issues namely the quality of support provided to people with dementia to enable them to maintain their physical and mental health and wellbeing; how the care provided aims to reduce admissions to hospitals from care homes and avoid unnecessary lengths of stay in hospital and how services work together when people move from one service to another. The CQC visited wards A2, A3, A8, B12 and CDU and inspected the following standards as part of this themed review

- Outcome 4 Care and Welfare of Patients
- Outcome 6 Cooperating with other providers
- Outcome 16 Assessing and monitoring the quality of service provision

The trust report, received in April 2014 showed that we had met all three standards reviewed by the CQC. The full report can be found at http://www.cqc.org.uk/node/316324

2.2.5.3 CQC Intelligence Monitoring

The Care Quality Commission has published its full risk profiles and risk bandings of all NHS trusts for the first time. It's a new system known as Intelligent Monitoring and is a publication that we fully support as a way of highlighting risk in the health service.

The intelligent monitoring is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance including detailed mortality rates, waiting time and access information, patient feedback and actual CQC inspection results.

It basically pulls together information from every available accredited source to give an informed view and raise any questions necessary on the quality and safety of each hospital's service. It helps the CQC to know where to focus their new, stringent inspection resources.

The CQC have now banded each trust into one of six categories based on the risk from these indicators that people may not be receiving safe, effective, high quality care - with band 1 being the highest risk and band 6 the lowest risk. In March 2014 Warrington and Halton Hospitals NHS Foundation Trust was placed into the Band 5 category based on these indicators of our services and care.

Whilst these are not to be seen as formal league tables, they do give an indication of the overall performance, quality and safety at a trust and is a good position to be in. We have all been working hard to build a culture of high quality, safe healthcare at Warrington and Halton Hospitals NHS Foundation Trust. Whilst there are always ways we can further improve our services, we can be proud of our achievements. This detailed analysis of performance provided by the report shows that we moving in the right direction in ensuring that we provide our patients with a service that they can trust and that we can be proud of. The full reports can be found at http://www.cqc.org.uk/directory/RWW

2.2.5.4 CQC new Inspection Regime (Keogh Framework)

As stated above the trust performance against these surveillance indicators can if the trust is placed in a high risk band trigger an inspection. The CQC will now lead significantly bigger inspection teams headed up by clinical and other experts that include trained members of the public. They will spend longer inspecting hospitals and cover every site that delivers acute services and eight key services areas: A&E; maternity, paediatrics; acute medical and surgical pathways; care for the frail elderly; end of life care; and outpatients. The inspections will be a mixture of unannounced and announced and they will include inspections in the evenings and weekends when it is recognised patients can experience poor care.

This trust invests resources in ensuring that staff, understand these processes and it has since February 2014 provided drop in sessions in order to raise awareness about the new CQC Inspection Regime.

CQC Awareness Sessions – February 2014

2.2.6. Trust Data Quality

Warrington and Halton Hospitals NHS Foundation Trust submitted records during 2013/2014 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:

- for admitted patient care – 99.5%
- for outpatient care – 99.8%
- for accident and emergency care – 98.2%

Which included the patient's valid General Practitioner Registration Code was:

- for admitted patient care – 99.2%
- for outpatient care – 99.5%
- for accident and emergency care – 98.2%

2.2.6.1. Information Governance

Warrington and Halton Hospitals NHS Foundation Trust's Information Governance Assessment overall score for 2013/2014, was 68% and was graded as "not satisfactory".

Performance will be monitored by the Information Governance and Corporate Records Group and then reported to the IM&T Steering Committee which is a sub-committee of the trust board.

Warrington and Halton Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013/2014 by the Audit Commission.

Warrington and Halton Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- We are working towards compliance at the requisite level 2 standard across all the requirements contained within the Information Governance Toolkit in 2014/2015.The Information Governance Toolkit action plan is monitored at the Information Governance and Corporate Records Group.
- A report on the IG Toolkit for 2013/14 was recently produced by MIAA and was reviewed by Audit Committee - an action plan will be taken forward.

2.3. Core Quality Indicators 2013/2014.

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.

2.3.1a. 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 Coding

DATE PERIOD	TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
October 2012 – September 2013	110.21	2	118.59	63.01	100
Jul 2012 – June 2013	112.06	2	115.63	62.59	100
April 2012 – March 2013	112.9	1	116.97	65.23	100
January 2012 – December 2012	110.69	2	119.19	70.3	100
October 2011 - September 2012	111.26	2	121	68	100
July 2011 - June 2012	109.51	2	125	71	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'

To improve this score, and so the quality of its services, Warrington and Halton Hospitals NHS Foundation Trust has:

- made significant progress in managing deteriorating patients, including the creation of a Medical Emergency Team,
- created a Clinical Effectiveness Team and Clinical Effectiveness Group which is attended by two trust board members,
- worked closely with the North West's NHS Advancing Quality Alliance; using their reducing mortality framework and data support to target our improvement efforts,
- ensured that mortality data is widely reported and understood across the organisation.

2.3.1b. 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
April 2012 – March 2013	17.2%	19.9%	44%	0.1%
January 2012 – December 2012	14.4%	19.2%	42.7%	0.1%
October 2011 - September 2012	11.6%	18.8%	43.3%	0.2%
July 2011 - June 2012	9.1%	18.2%	46.3%	0.3%

***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.

To improve this score, and so the quality of its services, Warrington and Halton Hospitals NHS Foundation Trust has employed a Palliative Care Consultant, provided specialist palliative care services to a greater number of patients, and held an event to review end of life care provision across the organisation and ensure that patients receive the best care at the end of their lives.

2.3.2. Patient reported outcome scores for (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery.

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:- http://www.hscic.gov.uk/catalogue/PUB11359

Patient Reported Outcome Scores.

		Groin hernia	Hip replacement	Knee replacement	Varicose vein
Year	**Level**	**Average health gain**	**Average health gain**	**Average health gain**	**Average health gain**
2011/2012	Trust	0.084	0.438	0.31	*
2011/2012	England	0.087	0.416	0.302	0.095
2011/2012	Highest	0.249	0.668	0.537	0.24
2011/2012	Lowest	-0.084	0.282	0.144	-0.134
2010/2011	Trust	0.055	0.382	0.299	*
2010/2011	England	0.085	0.405	0.298	0.091
2010/2011	Highest	0.156	0.503	0.407	0.155
2010/2011	Lowest	-0.020	0.264	0.176	-0.007
2009/2010	Trust	0.075	0.358	0.310	*
2009/2010	England	0.082	0.411	0.294	0.094
2009/2010	Highest	0.136	0.514	0.386	0.150
2009/2010	Lowest	0.011	0.287	0.172	-0.002

*** The trust does not undertake this procedure.**

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 has taken the following actions as described below to improve this average health gain score and so the quality of its services, by delegating responsibility for reviewing PROMs data to the Clinical Effectiveness Committee.

2.3.3. Emergency readmissions to hospital within 28 days of discharge.

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 percentage of patients aged

- 0 to 15; and
- 16 or over,

readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

Emergency readmissions to hospital within 28 days of discharge (age 16<) *

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
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 2012/13 is not available from the Information Centre**

Emergency readmissions to hospital within 28 days of discharge (age 16>) *

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
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 for 2012/13 is not available from the Information Centre**

Data relates to medium sized acute trusts.

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 rate and so the quality of its services, by making changes to the internal scrutiny and review of readmission data, redesigning the discharge service and continuing to develop readmissions software to support access to improved ward based information

The changes made have resulted in a focused analysis of readmission rates within Divisional Integrated Governance Groups to identify process issues and trend data, which are locally and organisationally acted upon to reduce readmission rates. The learning from which feeds into a whole system urgent care group as the trust continues to support a whole systems approach and work in close collaboration with key partner agencies to reduce readmissions to hospital within 30 days.

The Trust has also redesigned the Hospital Discharge Service whereby patients are risk assessed on admission and those identified with complex discharge needs are robustly tracked and supported through to discharge.

The Trust is engaged in testing a readmission management software package that will potentially support the development of risk stratification on discharge for some cohorts of patients. The focus is on the creation of a rescue plan that would be made available on discharge from hospital to better enable the patient and their carer to manage at home and reduce the need for readmission.

2.3.4. Responsiveness to inpatients' personal needs in the CQC national inpatient survey:

The following data for two reporting periods with regard to the trust's responsiveness to the personal needs of its patients during the reporting period is made available to the trust by the Health and Social Care Information Centre.

CQC national inpatient survey:– personal needs.

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
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.

Warrington and Halton Hospitals NHS Foundation Trust will take the following actions to improve this percentage and so the quality of its services, by reviewing the inpatient survey results constructing an action plan to improve year on year results. This will be supported by local surveys which focus on the above aspects of the patient experience. The trust has also selected the inpatient survey as an improvement priority for 2014/2015 and will report progress in the Quality Report next year.

2.3.5. Percentage of staff who would recommend the provider to friends or family needing care.

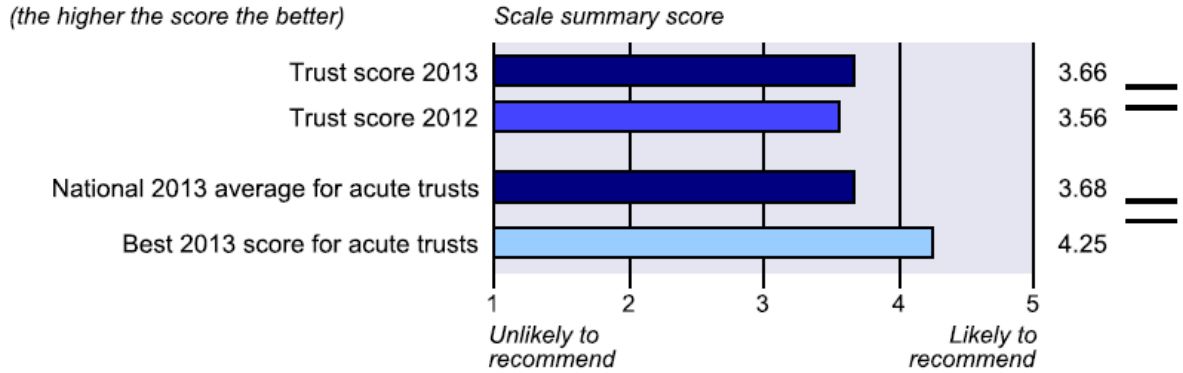
The data is made available to the trust by the Health and Social Care Information Centre via the National NHS Staff Survey Coordination Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

Staff who would recommend the provider to friends or family needing care by percentage.

DATE	TRUST	HIGHEST	LOWEST	ACUTE TRUSTS
2013	65%	93.9%	39.6%	67%
2012	58%	69%	35%	65%
2011	57%	89%	33%	65%

NB: National data for acute trusts = national score

Staff who would recommend the provider to friends or family needing care by score – Staff Survey 2013.



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 2013 national NHS staff survey conducted by the Picker Institute on behalf of the trust. The Picker Institute utilises high quality research methodology which ensures that appropriate sampling is undertaken across all staff groups resulting in a 43% response rate.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by reviewing the staff survey results constructing an action plan to improve year on year results. This is supported by local surveys using transparency audit questions which focus on quality of care.

2.3.6. 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
2013/2014	Trust	95.54%.	95.60%	96.50%	*95.76%**
	National Average	95.39%	95.69%	95.80%	**
	Highest	100%	100%	100%	**
	Lowest	78.78%	81.70%	77.70%	**
2012/2013	Trust	95.40%	95.10%	94%	93.90%
	National Average	93.40%	93.80%	94%	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%	88%	91%	93%
	Highest	***	***	100%	100%
	Lowest	***	***	32.40%	69.80%

*** *=Trust internal data only available for this reporting period.*
**** *= This data is not currently available from the Information Centre.*
***** *= This data has been archived and is unavailable.*

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that the 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 the Clinical Governance Committee and the trust board.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by revising the logic for cohort to ensure patients receive risk assessment appropriately and streamlining processes to ensure all risk assessments are logged electronically on completion.

2.3.7. 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
2012/2013	9.4	17.3
2011/2012	21	21.8
2010/2011	35.9	29.6

The Information Centre only provides average by Trust (not by highest and lowest) and 2013/14 data is not currently available.

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons in that the trust follows the national Clostridium difficile guidelines. There is a robust system for data entry and validation which ensures all cases are entered onto the data Capture system.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services:

- Surveillance of cases/monitoring for increased incidences in defined locations
- Cohort isolation facility maintained to manage cases
- Antimicrobial steering group with feedback to Clinicians on incidences of prescribing non-compliance
- Fidaxomicin introduced for treatment of patients with recurrent Clostridium difficile infection
- Text alerts to senior managers to report Clostridium difficile cases
- Increase in ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment
- Safety alerts distributed on the management of potentially infectious diarrhoea

Please see section 3.2.1 for further information on improvement actions.

2.3.8. 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 100 admissions

DATE	TRUST	TRUST NUMBER	MEDIAN	Lowest	Highest
October 2012 – March 2013	9.1	3620	7.6	1.7	16.7
April 2012 – September 2012	8.1	3257	6.7	3.11	14.44
October 2011 – March 2012	8.7	3402	6.7	2.21	10.54

NB: NRLS Report provides median rate of incidents per 100 admissions reported by all medium acute trusts

Patient Safety Incidents Severe Harm / Death - Rate

DATE	TRUST	NATIONAL %	PEER %	LOWEST	Highest
Severe Harm & Death October 2012 – March 2013	0%	0.05%	0.05%	0%	0.2%
Severe Harm April 2012 – September 2012	**0.15% (4)	*<1%	0.6%	0 0%	61 3.1%
Death April 2012 – September 2012	0.0% (1)	*<1%	0.2%	0 0%	34 1.3%
Severe Harm October 2011 – March 2012	0.2% (4)	*<1%	0.6%	1 0%	80 3%
Death	0.0% (0)	*<1%	0.2%	0	14

October 2011 – March 2012				0%	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 below.

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.

The trust has again moved up in the comparative reporting rate report to 5th best reporter (from 9th last time) having increased to 9.54 per 100 admissions (from 9.1). In addition the trust has maintained the required frequency and the median reporting speed of 5 days.

There is a discrepancy within our reported degree of harm and the degree of harm shown in the latest report. During the reporting period 1st April 2013 until 31st March 2014 the report shows 33 were categorised as severe harm (with a severity of 4 – major) and 9 have been reported with a severity of 5 as catastrophic (death) this should be 4 severe harm and 4 catastrophic harm.

The trust has queried this with NHS England and it appears part of the reason for this is that there is no longer a 2nd reporting deadline as there used to be. The impact is that everything needs to be up to date by the 1st deadline and on this occasion the trust missed this.

The trust continues to work with all the Divisions to review and finally approve their incidents. Weekly audits of all outstanding incidents are sent out. In November 2013 additional mid-week reports have been provided to ensure all incidents are updated by the required time.

Once the trust re-uploads all the data at the end of May 2014 the next NRLS report will be accurate. All of the incidents have since been re-uploaded to the NRLS and since the CQC get their data directly, our CQC profile will not be affected as they will have the most up to date.

2.3.9 Friends and Family Test – Patient.

The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2)

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.

During the reporting period 1st April 2013 until 31st March 2014 the trusts performed above average in comparison with scores for England for inpatient Friends and Family. However a comparison of Accident and Emergency data against national average reveals under performance which has a negative effect on the overall combined score for the trust.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:-

- developing Always Events as an improvement priority for 2014/2015
- ensuring lessons learned from complaints take place
- undertaking local patient survey, developing and implementing actions
- monitoring via patient experience indicators and make changes as required

This indicator is new and not a statutory requirement for 2013/2014.

Friends and Family Net Promoter 2013/2014 (NHS England)

Month	Trust - Inpatient	England - Inpatient	Trust – A&E	England – A&E	Trust - Combined	England - Combined
April	80	71	63	49	76	63
May	76	72	52	55	73	65
June	80	72	54	54	73	64
July	76	70	56	54	70	63
August	76	71	20	56	58	64
September	77	71	46	52	60	62
October	82	71	48	55	63	64
November	75	72	42	56	58	64
December	71	71	35	56	53	64
January	78	72	42	57	60	64
February	81	72	45	55	69	63
March						

NB: England data includes independent sector providers April – June 2013, from July the independent sector is excluded.

Quality Report Part 3 - Trust Overview of Quality

3.1 Introduction - Patient Safety, Clinical Effectiveness & Patient Experience

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. Our mission is to provide 'High Quality, Safe Healthcare'. To enable us to achieve this, we have four strategic objectives. They are:-

- **To ensure all patients are safe in our care**
- **To give our patients the best possible experience**
- To be the employer of choice for the health care we deliver
- To provide sustainable local health care services

The quality of patient care and the safe, effective manner in which it is provided is the core business of the NHS, and our trust strives to provide the best possible care in order to remain a sustainable health provider of choice. More recently there has been a major national policy shift to the importance attached to this. Building on the work of Lord Darzi's 'High Quality Care for All' the White paper published in 2010 'Equity and Excellence; Liberating the NHS' outlines the government's intention to establish improvement in quality and health care outcomes as the primary purpose of all NHS funded care.

More recently, the Francis Report (2013) has focussed everyone's attention nationally on the failings of the NHS. This final report of the Public Inquiry into the failings in care at another trust provided a detailed and systematic analysis of the factors contributing to those failures. It identified that warning signs existed and they could have revealed the issues earlier. Francis has provided the foundations for all health care providers to look at their existing policies and strategies in a different light, to ensure that similar failings are never repeated.

We have responded to the Francis Report and the recommendations of the Francis Report have been developed into an action plan which the trust board has monitored throughout the year. In line with these recommendations we have reviewed and aligned two of our key strategies, Quality Improvement Patient Safety Strategy and our Patient Experience Strategy to provide a single strategy "Improving Quality: Patient Safety, Experience and Clinical Effectiveness Strategy."

Francis also cautioned that "A health service that does not listen to complaints is unlikely to reflect its patients' needs" and "A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint, and undermines the public's trust in the service." This trust has invested time and resources in reconfiguring the complaints and PALS service into an integrated Patient Experience Team who are committed to providing a responsive patient focussed service. **Please refer to section 3.4.3 for information on progress in the management of complaints.**

In line with two key principles of the Francis Report namely to improve experience and reduce harm; to be open and honest with the public we decided to become a member of the 'Open and honest care: driving improvement' programme, established by NHS England. We have made a commitment to publish a set of patient outcomes; patient experience and staff experience measures so that patients and the public can see how we are performing in these areas. This includes regular publication of numbers of patients who develop pressure ulcers and patients that fall while in hospital. This combines the results from the Friends and Family Test, the NHS Safety Thermometer, patient and staff experience surveys, patient stories, staffing levels and never events all in one place, to not only build up a picture of care quality but also of an excellent and open reporting culture. The Open and Honest Reports for this trust can be found on the trust's website.

We continue to work 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.

While it is important to identify and deliver against the three separate elements patient safety, clinical effectiveness and patient experience that comprise quality, it is critical to recognise that, though different, they are all aspects of 'high quality care'. Quality is only achieved if all three of these domains are present equally and simultaneously in care and that delivering on just one or two in isolation is not enough. As such it is essential that our approach provides an equal balance and assurance on all aspects of quality within the organisation and that we can demonstrate, measure and improve quality at all levels and throughout all areas of the trust. Our revised strategy draws together the various initiatives to deliver a clear plan of how the trust will work to achieve this.

3.1.1 Data Sources

Throughout 2013/2014 we have continued to develop our quality indicators which are used to evaluate the quality of our service. These indicators are monitored and reported via a monthly 'Quality Dashboard' through the wider committees and to the trust board to provide assurance on progress and improvements made in the areas of patient safety, clinical effectiveness and patient experience. We know how important it is to patients, their families and carers that when they have to come in to hospital that they are going to receive the best possible care. We know they want

their care to be delivered in a clean and welcoming environment, where they feel safe and free from harm, so we try to ensure that these issues have been captured within our quality indicators.

The 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. Indicators allow organisations to measure and benchmark progress toward goals and the trust submits and utilises data from the Health and Social Care Information Centre (HSCIC). The HSCIC collates analyses and publishes NHS data on over a thousand indicators for everything from quality to population health and outcomes of treatments. This includes measures such as 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 following safety, risk and governance modules which enable the trust to have a comprehensive oversight of our risk management activities:

- Incident, adverse event and near miss reporting
- Patient relations
- Malpractice claims management
- Risk assessment
- Safety alerts
- Patient experience and feedback
- Accreditation self-assessment
- 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 order to improve patient care.

The trust submits data to the NHS Safety Thermometer which was developed for the NHS by the NHS as a point of care survey instrument, it provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress 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 four outcomes 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, transparency surveys and observation.
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.

Trust data systems have been reviewed and amended to more accurately reflect the description of the incident(s), therefore comparative data from local systems may only available across two reporting years and more historical data has not been included.

We are continually implementing quality improvement initiatives to enhance the safety, effectiveness and experience outcomes for our patients.

3.1.2. Data – Mersey Internal Audit Agency (MIAA) Reporting Framework Review

The Francis Report into the failings at Mid Staffordshire NHS Foundation Trust strongly reinforces that quality should be at the heart of a patient-centred NHS. Quality of care provided is a key responsibility of the boards of NHS foundation trusts. Monitor "the sector regulator for health services in England whose job it is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit" considers that maintaining and improving quality is an important indicator of the effectiveness of governance at a trust. More recently we have seen a number of documents issued providing guidance to trusts on the types of information that should be reported to trust boards.

In February 2013, Sir Bruce Keogh was asked to review the quality of care and treatment being provided by a number of hospital trusts in England that had a higher than average mortality rate over the last 2 years. The review process which was based on NHS National Quality Board guidance involved analysing and compiling data for each trust in relation to six key areas: mortality; patient experience, safety, workforce, clinical & operational effectiveness; and leadership and governance. This was the first time so much disparate data had been compiled for the purposes of assessing quality of care in the NHS. (MIAA: Reporting Framework Review, 2014).

It is vital that boards scrutinise data and importantly be confident that the data is meaningful and trustworthy. They need assurance that the processes for the governance of quality are embedded throughout the organisation. Moreover, the board should understand the organisation and that what they're being told is true, accurate, fair and backed up with sufficient evidence. This requires good data quality systems in place to deliver that data and a culture that supports ethics and candour.

To support this process the Director of Nursing and Organisational Development requested our internal auditors MIAA undertake a review of the trusts reporting framework. The overall objective was to undertake a mapping exercise to ascertain whether the information currently reported within the trust is aligned to the Keogh data set. The review also focussed upon:-

- Mapping out the information currently reported to key forums within the trust
- Undertaking a gap analysis against the Keogh data set
- Ensuring that mechanism were in place to escalate areas of concern to the board as appropriate.

The review has consisted of a series of interviews with lead officers to identify where information is reported and the process for collating the reported information. The review made three recommendations to improve data requirements and flow for effective quality governance namely:-

- The review identified a number of indicators that are not currently being reported within the trust. It acknowledged that not all information can be reported directly to the trust board. As such, the indicators should be reviewed, with an appropriate committee / sub-committee identified to review the data on a routine basis with a clear escalation process in place to ensure the board are informed should any significant concerns be highlighted by the indicators.
- All indicators should be subject to appropriate validation routines / accuracy checks and that procedure notes are developed to document the process followed
- The trust should ensure that where reported figures are manually input into performance reports / subject to filtering in excel to produce the reported figure, that figures are checked by a second officer to ensure consistency and accuracy of reporting.

3.1.3. Quality Dashboard 2013/2014

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.

		Target / threshold	A	M	J	Q1	J	A	S	Q2	O	N	D	Q3	J	F	M	Q4	YTD
Patient Safety			Figures are totals or % for the month / quarter (except where stated)																
HSMR (rolling 12 months, latest data available)		<=100	107	107	107		105	105	105		104	104	103		101				101
SHMI (rolling 12 months, latest data available)		<=100	113	113	112		110	108	108		108	108	106						106
Total deaths in hospital			117	91	99	307	76	80	93	249	72	76	76	224	101	99	89	289	1069
Regulation 28 - Prevention of future deaths report								0	0	0	0	0	1	1	0	0	0	0	1
Incidents resulting in Major or Catastrophic harm		<7 (2012/13 total)	1	1	0	2	0	2	2	4	0	0	0	0	0	0	0	0	6
Incidents of major or catastrophic harm under investigation		N/A	0	0	1	1	0	0	0	0	0	2	1	3	1	3	3	7	11
Falls (moderate, major and catastrophic harm)		<=14 per year	5	0	0	5	1	1	0	2	1	2	0	3	3	1	1	5	15
Falls (moderate, major and catastrophic harm) awaiting approval		N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure Ulcers	Grade 3 and 4 Hospital Acquired (Avoidable)	<=16 per year	0	0	1	1	1	1	0	2	0	0	0	0	1	0	1	2	5
	Grade 3 and 4 Hospital Acquired (Unavoidable)	N/A	1	0	0	1	1	0	0	1	1	0	0	1	1	0	0	1	4
	Grade 3 and 4 Hospital Acquired (Not yet determined)	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1
	Grade 2 Hospital Acquired	<=149 per year	16	6	11	33	7	7	18	32	3	5	9	17	8	6	15	29	111
	Grade 2 Hospital Acquired (under review)	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA		0 per year	1	0	0	1	0	0	1	1	0	0	0	0	1	0	0	1	3
C difficile		<=19 per year	5	4	3	12	0	1	1	2	4	2	4	10	4	1	2	7	31
Never Events		0 per year	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	1
VTE	% of patients risk assessed	>=95% of patients	95.37	95.65	95.67	95.56	95.97	95.84	95.15	96.26	96.28	96.74	95.21	96.5	95.62	96.14	95.84	96.29	96.29
	% harm free (Safety Thermometer (ST)	TBC	98	98	99		98	98	99		98	97	98		98	99	98		
Medication Errors	Omitted doses (Quarterly audit)	>=10% reduction in yr				334				371				391				399	1495
	Insulin related errors	<=54 per year	4	8	2	14	4	1	1	6	3	8	4	15	6	2	8	16	51
CA – UTI: Number of catheterised patients who developed a UTI (ST)		TBC	6	1	4	11	6	4	5	15	2	3	1	6	3	4	3	10	42
CA – UTI % of catheterised patients who developed a UTI (ST)		TBC	1.11	0.19	0.7		1.13	0.73	0.93		0.38	0.5	0.19		0.53	0.75	0.55		
Dementia Assessment (Part 1)		>=90% of patients	90.43	95.14	91.35	91.67	93.67	95.11	95.12	94.33	95.2	96.11	96.11	95.5	97.67	97.36	94.57	96.5	94.44
Dementia Assessment (Part 2)		>=90% of patients	86.77	100	100	88.78	100	100	93.3	97.4	100	96.43	96.88	98.14	100	100	100	100	99.72
Dementia Assessment (Part 3)		>=90% of patients	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Clinical Nursing Indicators		>=90% compliant				97				95	No data collected				No data collected				96

Effectiveness																			
Advancing Quality	Acute MI Threshold	>=91.46%	97.14	96.65	97.36	97.05	96.57	97.57	96.36	96.58	96.59	96.77	96.25	96.25					96.25
	Hip and knee	>=92.23%	97.47	97.56	96.77	96.77	96.08	96.46	96.98	96.08	96.30	96.41	96.21	96.21					96.21
	Heart failure	>=86.85%	85.00	90.01	93.59	85.59	93.00	90.84	90.96	90.96	87.95	89.89	88.75	88.75					88.75
	Pneumonia	>=75.23%	64.37	65.36	68.16	68.16	68.90	70.00	70.26	70.26	70.31	70.93	71.80	71.80					71.80
	Stroke	>=62.57%	59.46	55.00	53.49	53.49	55.75	58.33	57.54	57.54	57.14	56.50	56.16	56.16					56.16

3.1.4 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the trust based on performance in 2013/14 against 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 utilised indicators which are deemed to be both locally and nationally of importance to the interests and requirements of patients. The overall purpose of this information is to inform the organisation of its effectiveness and performance and to lead it in a direction of improvement by indicating specific issues/areas that need to be developed.

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 these indicators have changed from the indicators used in our 2012/2013 report, we have outlined the rationale for why these indicators have changed and where the quality indicators are the same as those used in the 2012/2013 report and refer to historical data, we have checked the data to ensure consistency with the 2012/2013 report.

It should be noted that this section includes quality indicators in support of the improvement priorities outlined in section 2. This allows the trust to provide important historical data to show if improvement work has had an impact on performance.

3.2 Patient Safety

3.2.1. Infection Control

Within the reporting period 2013/2014, the trust threshold was 0 cases of MRSA, the trust has reported 3 cases of hospital acquired MRSA bloodstream infection and 1 MRSA contaminant compared to 1 hospital acquired case in 2012/2013 (against a threshold of 3).

The trust reported 31 cases of hospital acquired Clostridium difficile infections against a threshold of 19 compared to 19 cases against a threshold of 40 for 2012/2013.

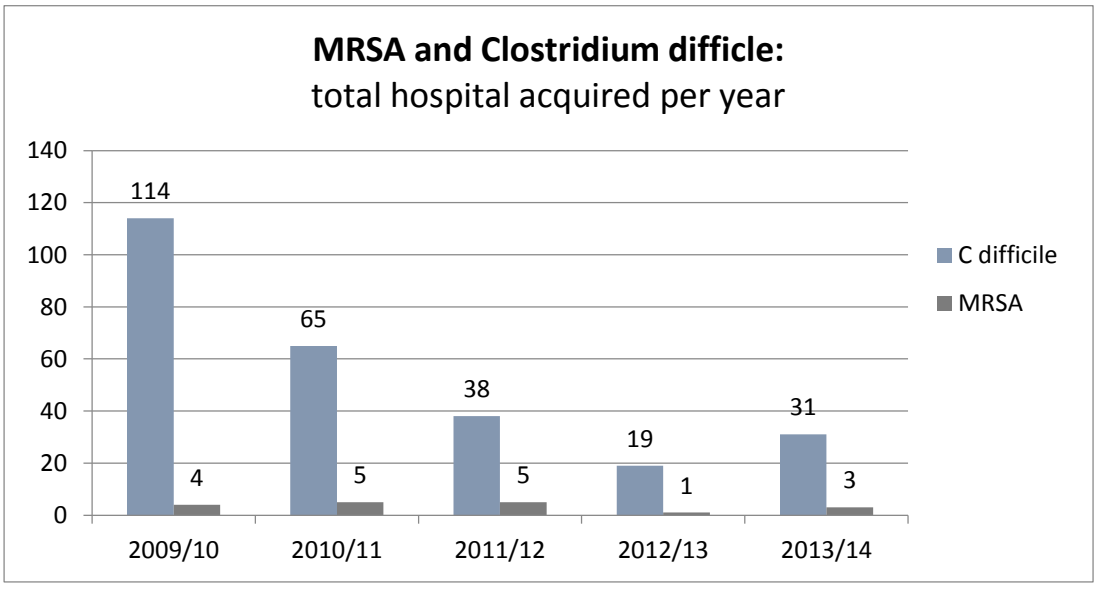
Despite the continued focus of activity, the trust was unable to achieve its threshold for Clostridium difficile. Initiatives maintained/implemented this year included but are not limited to:-

- Surveillance of cases/monitoring for increased incidences in defined locations
- Cohort isolation facility maintained to manage cases
- Antimicrobial steering group with feedback to Clinicians on incidences of prescribing non-compliance
- Fidaxomicin introduced for treatment of patients with recurrent Clostridium difficile infection
- Text alerts to senior managers to report Clostridium difficile cases
- Increase in ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment
- Safety alerts distributed on the management of potentially infectious diarrhoea

- Weekly multi-disciplinary team review of Clostridium difficile patients
- Revision to hand hygiene signage and awareness raising events
- External review of governance arrangements
- Establishment of a multi-agency Clostridium difficile action group

For the next financial year activity will be focussed on:-

- Increasing pharmacy time to support antibiotic ward rounds
- Review of IT developments to improve access to the antibiotic formulary (i.e. via an iphone app)
- Extending the use of hydrogen peroxide vapour for decontamination of side rooms vacated by Clostridium difficile patients. This requires investment in staff training and will have an operational impact as decontamination of side rooms will take slightly longer than conventional disinfection methods
- A rolling programme for decant and deep cleaning, using hydrogen peroxide vapour following ward upgrades
- Commitment to review the cleaning requirements over the 24 hour period including task team staffing levels
- Sharing learning from each Clostridium difficile case where lapses in quality of care occurred
- Review of evidence on probiotics with a view to implementing a trial in areas with a higher incidence of Clostridium difficile cases.



The data for this indicator is from a nationally prescribed data set, the indicator is monitored via the corporate performance report and the Quality Dashboard. The trust will continue to monitor HCAI as a quality indicator for 2014/2015.

3.2.2. Pressure Ulcers

As previously stated in section 2 the trust continued to focus on the management and reduction of pressure ulcers as an improvement priority for 2013/2014. The Prevention and Treatment of Pressure Ulcers (NICE Clinical Guideline 29; 2005) offers best practice advice on the care of adults

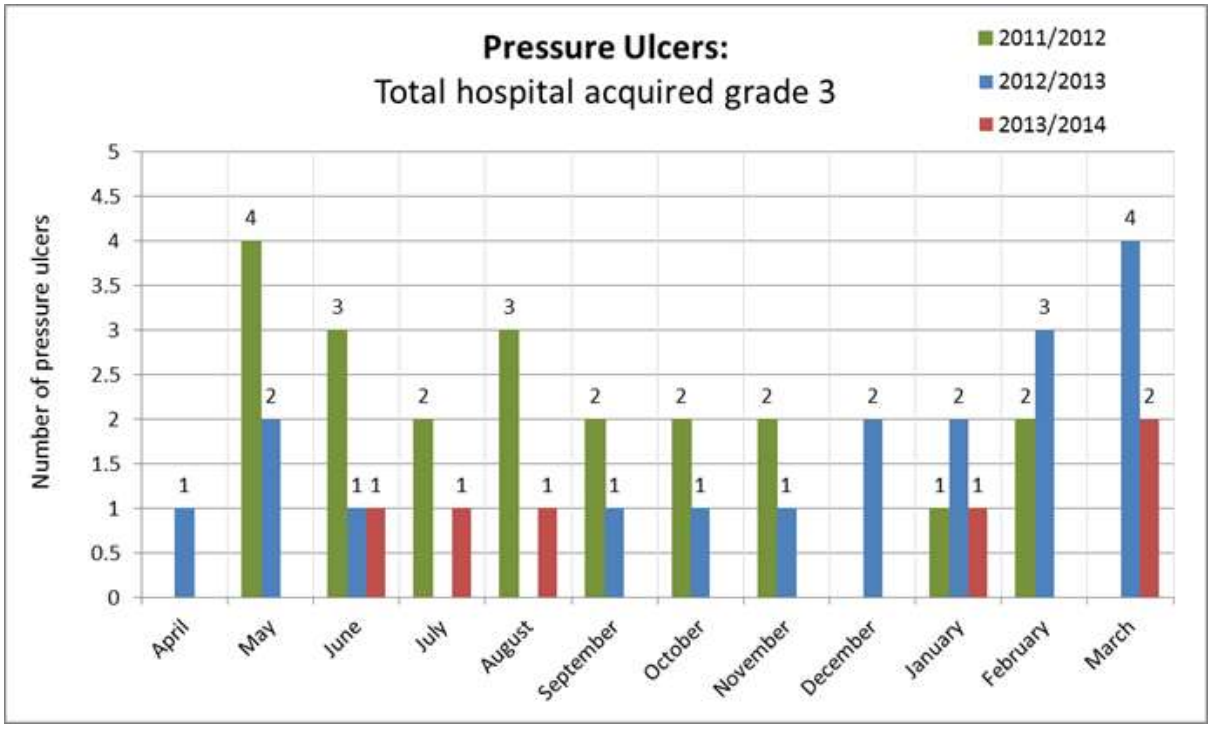
and children with pressure ulcers. This trust has ensured that our current Pressure Ulcer Management Policy is aligned to and complies with the NICE Guidance recommendations.

The trust has strengthened a number of processes and sees a strong focus on early patient assessment and the documentation of the patient's skin condition on admission as essential to good practice. This is in line with the NICE Guidance and critical to the prevention of pressure ulcers. The Waterlow risk assessment tool and management plan is used for all patients who are admitted to the hospital. The nursing documentation triggers the need to record skin condition on admission to hospital. The patient care plans promote the need to monitor and record skin condition, with additional specific plans put in place if a patient develops a pressure ulcer.

Importantly the trust has worked towards increased accuracy in reporting of all Grade 2-4 pressure ulcers to the risk management team via the electronic incident reporting system, Datix. The progressive increase in reporting pressure ulcers has provided us with the ability to know where and when pressure ulcers develop which was critical to developing our strategic improvement plan to prevent pressure ulcers. We have worked very hard in the last 18 months to ensure that pressure ulcers are recorded as those acquired in hospital and those acquired in the community so that we can accurately report and act to improve the incidence of pressure ulcers within the trust.

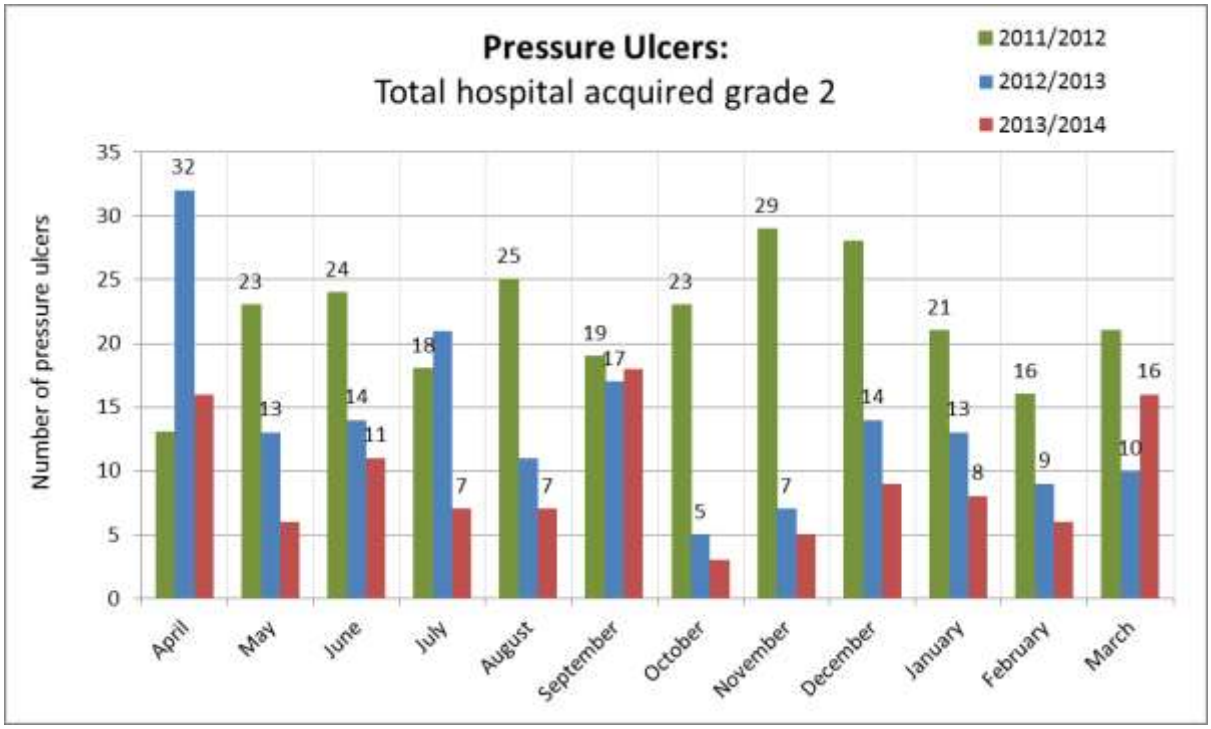
We established a target of a 10% reduction on last year for all grades as such our 10% threshold for grade 3 & 4 avoidable pressure ulcers acquired within the hospital was 16. During the reporting period we had 6 confirmed grade 3 avoidable hospital acquired pressures and no Grade 4 pressure ulcers which represented a 67% reduction on 2012/2013. The trust is pleased to report that the sustained improvement and management of pressure ulcers has resulted in a sustained reduction over a three year period as shown by the following graph.

Pressure Ulcers hospital acquired Grade 3: 2011/12 – 2013/2014



Our threshold for all grade 2 pressure ulcers acquired within the hospital was a further 10% reduction to 149 and during the reporting period we have had 111 hospital acquired Grade 2 pressure ulcers which represents a 33% reduction on 2012/2013.

Pressure Ulcers hospital acquired Grade 2: 2011/2012 – 2013/2014



Two pressure ulcer link study days have been held during 2013/2014 and the key lessons (Single Point Lessons) from the framework for "pressure ulcer prevention" have been reiterated in areas of concern with a positive effect. An example of this is in the Intensive Care Unit where the re-energising of the lessons supported effective leadership and innovative approaches to reducing device related pressure ulcers.

These lessons underpinned the "No Avoidable Pressure Ulcers Campaigns" and the Worldwide Stop Pressure Ulcer Day in November which included using screen savers stating "Pressure Ulcers? Not on our watch. We can prevent them".

The trust also ensures that the correct equipment which conforms to the NICE Guidance is purchased and this includes ensuring that all standard foam mattresses within the trust are made of a high specification pressure reducing foam. The trust hires specialist equipment to meet specific patient needs, these include the dynamic mattress replacement systems such a low air loss therapy, or occasionally air fluidised beds. The majority of beds within the Intensive Care Unit have dynamic mattresses in place, and following assessment staff can order appropriate mattresses.

The 471 electric profiling bed frames within the trust also assist in the prevention of pressure ulcers. The trust participated in a trial of Park House - Phase 111 Mattress Replacement system which is described as incorporating the latest in innovative features to help deliver the optimum in patient and pressure care for both the treatment and prevention of pressure ulcers. Importantly they are recommended for patients who are deemed at a very high risk of developing pressure ulcers. The

pilot which was supported by staff from Park House was carried out in two clinical areas namely Intensive Care Unit and A3 which is a Care of the Elderly ward. Both patients and staff provided feedback on performance, comfort, ease of installation and effect on pressure ulcer management in relation to reducing the incidence and deterioration if a pressure ulcer was already present. The product received positive feedback with A3 stating that although they had a number of very unwell patients that importantly they did not report any grade 2 pressure ulcers or deterioration of existing pressure ulcers. Patients also commented that the mattresses were very comfortable and that they slept well, staff reported that they were easy to install and lighter to use which minimised manual handling injuries. The outcome from this audit was that the trust agreed to award the contract and we are currently under negotiations to finalise arrangements. The Tissue Viability Team offers advice on specialist equipment.

Bariatric patients (patients with an increased body weight or size) are at a particular risk and require a collaborative approach to assessment of equipment needs, there is a very limited amount of equipment available to meet the needs of this patient group. The trust has identified this as an area for development in 2013/2014.

The trust has managed a sustained reduction in the number of Grade 2 and 3 pressure ulcers and we have not had a Grade 4 pressure ulcer within the trust since March 2011. We know that it is the efforts of our nursing teams, supported by the Tissue Viability Team in increasing patient care interventions which has prevented Grade 3 pressure ulcers developing into Grade 4. Similarly, our plans to reduce Grade 2's by early intervention and planning are being achieved.

Analysis of Grade 2 and 3 acquired pressure ulcers reveals the following trends:

- Acuity of illness
- Poor nutritional status
- Poor peripheral vascular supply to skin (peripheral vascular disease / inotropic drugs)
- Decrease in mobility

The trust continues to implement its planned programme of actions to further reduce pressure ulcers which includes:-

- Review of the trust policy on pressure ulcers is in progress, with particular reference to the process by which we investigate Grade 3/4 pressure ulcers.
- Root cause analysis is conducted on all Grade 3/4 pressure ulcers which develop within the trust;
- Mini investigations of all grade 2 hospital acquired pressure ulcers

This information is collected using an internationally recognised pressure ulcer grading tool devised by National Pressure Ulcer Advisory Panel (NPUAP) and European Pressure Ulcer Advisory Panel (EPUAP) and our measurement and data collection systems have been given 'significant assurance' by Merseyside Internal Audit Agency.

Pressure Ulcer Grade Definitions

1	Non blanching Erythema (reddened skin which remains reddened on fingertip pressure)
	Discolouration of the skin, warmth, oedema, hardness or pain. Bruising may indicate deep tissue injury (see below).
2	Partial thickness skin loss or blistering without slough (e.g. very superficial top layer of skin)

3	Full thickness skin loss involving subcutaneous tissue but not extending to underlying structures (may or may not have tracking)
4	Full thickness tissue loss with exposed (or directly palpable) bone, tendon or muscle / Ulcer covered with thick necrotic tissue which masks the true extent of the damage
SDTI	Suspected Deep Tissue Injury: An area of pressure related bruising may indicate deep tissue injury. Observe regularly and re-grade as appropriate. Refer to Tissue Viability Nurse Specialist.

***** Not all pressure ulcers are avoidable; there are situations that render pressure ulcer development unavoidable, including hemodynamic instability that is worsened with physical movement and inability to maintain nutrition and hydration status and the presence of an advanced directive prohibiting artificial nutrition/hydration and patient choice that inhibits full patient care. To be determined as 'unavoidable' the full circumstances of the patients care has to be contemporaneously documented within the patients care records.

Across the trust there has been an increase in reporting and importantly in the accuracy of all reporting. The trust is pleased to be in the top 5% of all organisations reporting incidents to the National Patient Safety Agency which demonstrates a real culture of wanting to be open and to learn from incidents that occur. We did see the initial expected increase in reporting of pressure ulcers however this was followed by a sustained reduction over the last three years in all grades of hospital acquired pressure ulcers.

The Trust will continue to monitor pressure ulcers as an improvement priority for 2014/2015.

3.2.2.1 Pressure Ulcer CQUIN

Achieving an improvement on the baseline within the Safety Thermometer for pressure ulcer prevalence was also established as a national CQUIN for 2013/2014. The first part of this CQUIN relates to recording the number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer on the day of each monthly survey. The second part of the CQUIN relates establishing a baseline based on the results of the first six of the year and then showing an improvement on this baseline for pressure ulcer prevalence. The trust established a baseline median of 4.95 from data gathered from the Safety Thermometer for the first six months of the year. The trust agreed this baseline figure with commissioners. We then monitored the rolling median on a monthly basis for the latter half of the 2013/2014 and the trust is pleased to report that we both achieved a reduction and remained below this figure during this period as follows:-

Pressure Ulcer Median Rate

Month	Rate	Baseline
April	5.19	
May	6.04	
June	4.71	
July	3.95	
August	3.83	
September	5.20	
Rolling median	**4.95**	Median 4.95
October	3.58	Annual RM = 4.71
November	4.13	Annual RM = 4.42
December	3.85	Annual RM = 4.13
January	4.23	Annual RM = 4.18
February	2.81	Annual RM = 4.13
March	4.62	Annual RM = 4.18

The Safety Thermometer (pressure ulcer) will continue as a national CQUIN for 2014/2015 and the trust will continue to monitor and report on this data.

3.2.3 Falls - Management and Reduction.

It is recognised that falls are one of our highest priority areas in reducing harm in the hospital setting. A number of successful initiatives have been put in place over the past two years to support falls reduction and they include firstly the falls action scheme where senior nurses and therapists attend wards and departments following a fall in the area and complete a mini-investigation of the fall. The second initiative is the "Falls Change Package" whereby a number of ward-led innovations are embedded into the way our nurses and other staff work to support individual patients who are at risk of falls. These include:

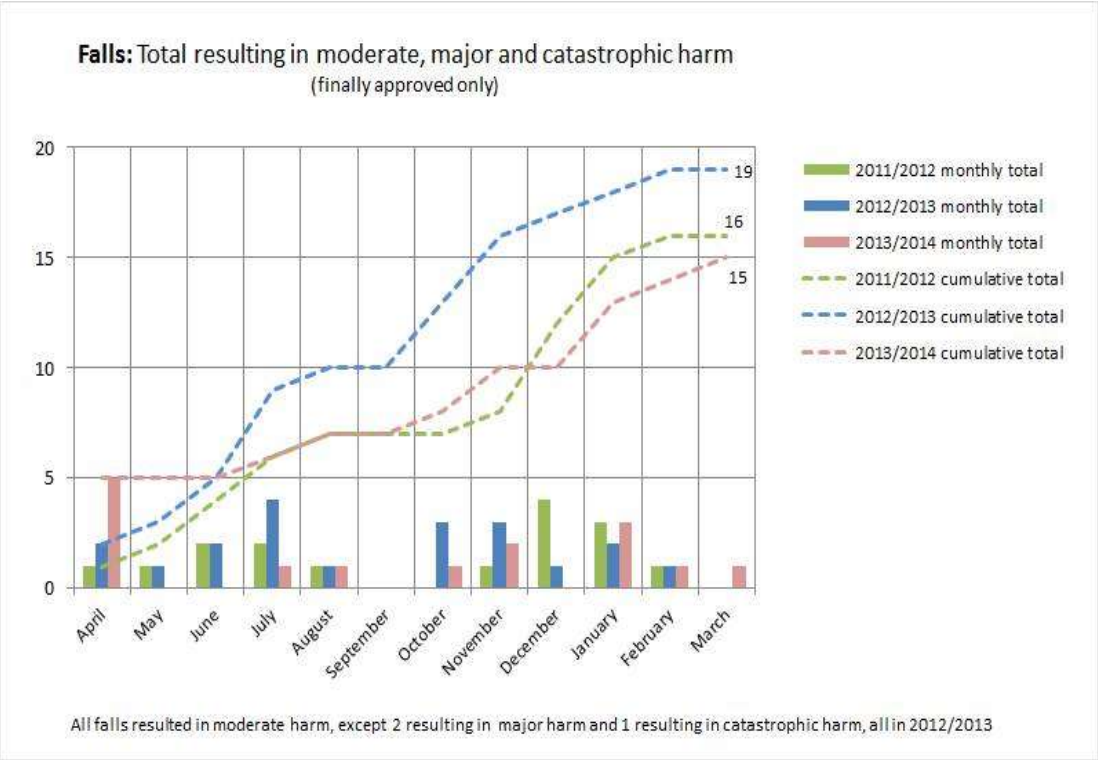
- Care and Comfort Rounds where we proactively take patients to the bathroom when they cannot easily do so themselves without assistance and when we ensure they have their belongings and beverages in reach to avoid slipping when reaching for them.
- Bay tagging where a member of staff would not leave a bay of patients unattended if a patient within that bay was considered at such high risk of falls. If they need to leave the bay, they will 'tag' a colleague who in turn cannot then leave the bay. This is highly successful, with medical staff, porters, therapists and support staff all thoroughly embracing the idea of being 'tagged' to safeguard our patients from falling.
- Toilet/commode tagging where a patient is not left unattended whilst using the commode or toilet, of course in this case it is imperative to maintain privacy and dignity whilst ensuring that a very high risk patient does not fall.
- Changes to staff base where at night during peak times for falls, nurses are based outside the entrance to, or within each individual bay
- Safety crosses where we provide real time data to staff, patients and visitors to the number of falls that have occurred on the ward

Overall we have seen a 28.28% reduction in falls since Q1 2012/13 and this trend continues to be sustained. Our aim now is to further drill down into the root causes to effect an improvement in 2014/15.

During 2012/13 our threshold for falls was 18 falls that result in moderate to catastrophic harm, and by the year end we reported 16 moderate harm falls. Whilst the reduction of falls was not an improvement priority for 2013/2014 we remained focussed on improvements and calculated that the trust's new threshold monitored via the quality dashboard should be based on a challenging 10% reduction on 2012/13 thus establishing a threshold of <=14 for this period.

Whilst the trust can report a reduction in moderate to catastrophic falls by year end we were disappointed that we did not achieve our threshold in that there have been 15 approved moderate falls incidents for 2013/2014. There have been no falls resulting in major or catastrophic harm during 2013/2014.

Falls 2011/2012 - 2013/2014



A further breakdown is provided which shows the sustained improvements in falls per quarter since the start of our renewed campaign to reduce all falls in hospital. The table below shows falls where no harm occurred as well as those with minor harm. It also includes for 2013/14 the falls which were classed as moderate (15 in total).

	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Patient Slips, Trips & Falls	251	256	246	246

Once an investigation has taken place, each fall is sub-categorised. The table below provides a breakdown of the top 5 sub-categories relating to falls.

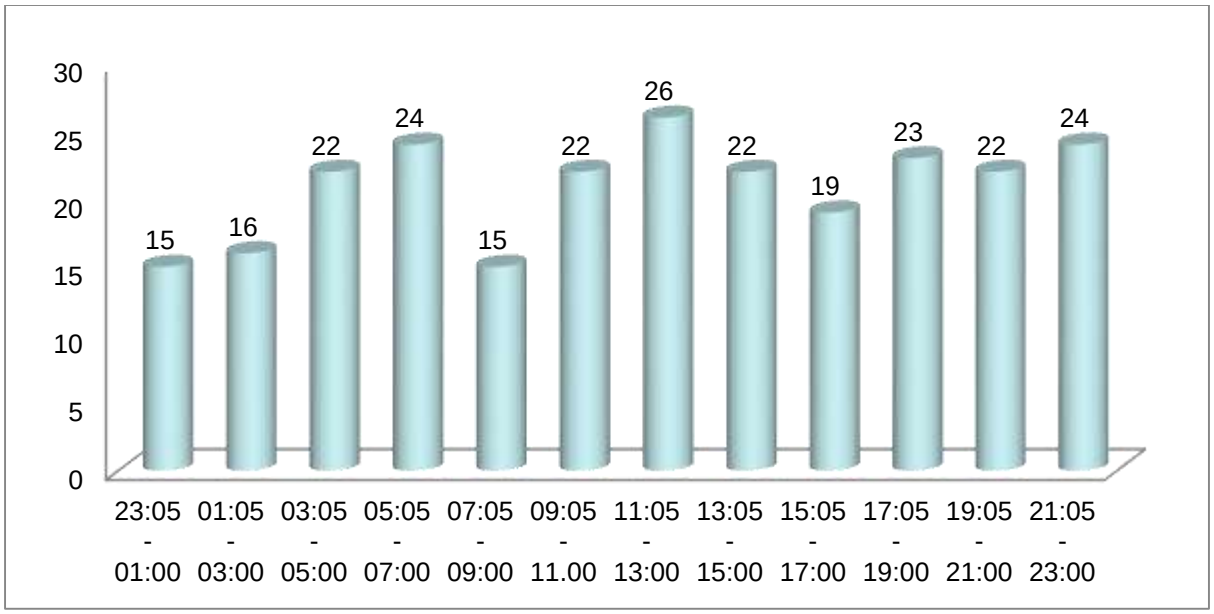
	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Found on floor	92	107	69	86
Fall from bed or trolley	40	33	29	33
Trip	23	14	32	27
Fall from Chair	23	22	18	25
Slip from Bed	17	20	36	23

In the early part of the year we focussed efforts ensuring that when a patient was 'found on the floor' a careful examination of what this meant was undertaken. For example, a patient could only be truly classed as being found on the floor if there had been no witness to the fall, and the patient was unable to explain how they had fallen. This allowed us to more appropriately apportion the fall to a 'trip' for example if the patient was able to say what had happened and/or this had been witnessed. This allow us to then focus attention in 2014/15 on the root causes of falls in a more sophisticated way. We have been fortunate to be able to fund a new post, Patient Safety and

Quality Champion and the post-holder will work very closely with the Falls Group to achieve the reduction in falls that we have set ourselves for 2014/15.

Furthermore, throughout 2013/14 our senior nurses, matrons and therapy staff have continued to support our ward based staff to ensure a safe environment for our patients, thus reducing the possibility for falls as far as possible. We have monitored falls by ward and noted the most common times that a patient may fall. This was noted to be in the early hours of the morning; therefore wards have looked again at the activities of staff at that time, as well as at the patterns of night time behaviour for individual patients who are at risk of falling. A recent Safety Walkround on one of our wards noted that in those patients who were frail and elderly there could be a link between the fall and the timings and type of the night-time beverage. We have researched this thoroughly, and are now planning a project group to try and make improvements in that area.

The table below demonstrates the times of falls across all wards in one quarter in 2013/14.



NB – This data is collected via the trust's electronic incident reporting system Datix.

- **Moderate Harm – an injury which may be a fracture, that isn't permanent but which has the ability to reduce mobility/movement**
- **Major Harm – an injury that results in either a fracture or an injury which contributes to long-term reduced movement/mobility**
- **Catastrophic Harm – an injury that causes or significantly contributes to the death of a patient or to such significant permanent injury as to be life changing.**

*The trust has in place a process whereby incidents on datix are assigned an approval status indicating the stage that has been reached in the review process. During the review, the details of the incident are reviewed, investigated as appropriate and the severity of harm caused is identified; this may be a different severity to that initially assigned as this may not be known at the time of reporting (e.g. if a patient is awaiting an x-ray following a fall). An incident is given the status of finally approved when this process has been completed and as part of this, it is possible to assign a final severity of harm. Falls data is extracted from datix and included in the Quality Dashboard and monitored on a monthly basis at board.

When patients fall (regardless of whether they experience harm or not), the incident is reported via the Datix system. This automatically informs a member of the senior nursing team who will visit the ward. A full review of processes and risk assessments required is then undertaken.

If a fall is deemed to be moderate, then in line with policy any investigation is completed within 30 days. In line with the Duty of Candour, the investigations are shared with the family within 10 days of completion and approval through the governance processes. The in-depth investigations we undertake allows us to generate lessons learned, and make recommendations through an action plan which teams work through. We offer support to our staff, families and patients throughout the investigation process as we understand how stressful this can be.

We recognise the anxiety and distress that in-patient falls cause for both the patient and their family. This can be in the form of physical harm such as broken limbs, but often there is unquantifiable psychological harm done to previously independent people whose confidence is destroyed for the rest of their lives. We believe that patients should be safe in our care and should be protected from avoidable harm wherever possible. Therefore the trust has, in consultation with stakeholders agreed to maintain falls management as a quality indicator and reintroduce it as an improvement priority for 2014/2015.

3.2.4 Catheter associated urinary tract infections.

The trust is committed to improving patient care by reducing the incidence of catheter-associated urinary tract infection (CAUTI) it therefore selected this clinical issue as an improvement priority for 2013/2014.

This was not an improvement priority in 2012/2013 so we did not collect CAUTI data on catheter associated UTI's however we felt that it was important that we were able to produce some benchmarking data from 2012/2013 to assist analysis of performance on this key quality issue.

As stated earlier the trust has been submitting data to the Safety Thermometer since May 2012 so this has allowed us to establish a performance baseline based on 2012/2013 data in order to measure any improvement made during 2013/2014. We established 3 indicators and extracted data from the Safety Thermometer in relation to the following:-

- CA – UTI: Number of catheterised patients who developed a UTI (ST)
- CA – UTI % of catheterised patients who developed a UTI (ST)
- CAUTI rolling median - local agreement to benchmark against rolling median value for last year based on 6 months from 2012/2013 against 2013/2014 median. ST Rolling Median 2012/2013 = 4.2

As stated we collected data over a two year period on both the number and percentage of catheterised patients who developed a urinary tract infection.

Month	**CA – UTI: Number of catheterised patients who developed a UTI (ST)**		**CA – UTI % of catheterised patients who developed a UTI (ST)**	
	2012/2013	**2013/2014**	**2012/2013**	**2013/2014**

April	**Data collection began in May 2012.**	6		1.11
May	9	1	1.56	0.19
June	3	4	0.47	0.7
July	5	6	0.86	1.13
August	4	4	0.73	0.73
September	6	5	1.10	0.93
October	4	2	0.72	0.38
November	5	3	0.91	0.56
December	3	1	0.52	0.19
January	3	3	0.51	0.53
February	2	4	0.34	0.75
March	1	3	0.18	0.55
	45	**36 (*excludes April)**	**0.7**	**0.6**

***NB: Data collection did not take place until May 2012 so for the purpose of comparison we have used data from May 2013 – March 2014.**

For 2013/2014 these two indicators have been reported via the Quality Dashboard to trust board. A comparison with 2012/2013 data indicates an overall improvement of 20% reduction in the actual number of catheterised patients who developed a UTI during 2013/2014. The average percentage of catheterised patients who developed a UTI reduced from 0.7% to 0.6%.

We then employed a third indicator based on on the actual number of patients with a catheter acquired infection as a percentage of all patients surveyed on that day. We measured this through the rolling median because this is deemed to be a statistically strong methodology which smooth's out short-term fluctuations and highlights longer-term trends or cycles. The rolling median which was based on six months of data from 2012/2013 was calculated at 4.2. We then monitored this CAUTI data throughout 2013/2014 to ascertain if the monthly rate remained below this figure. We are pleased to report that with the exception of September 2013 which showed a slight increase that this analysis confirmed a year on reduction in catheter acquired infection.

CAUTI – Rolling Median Data 2013/2014

MONTH	ACTUAL	ROLLING MEDIAN
APRIL	6.7*	*
MAY	1	1
JUNE	3.2	2.1
JULY	4.8	3.2
AUGUST	4.5	3.9
SEPTEMBER	5	4.5
OCTOBER	1.8	3.9
NOVEMBER	2.7	3.2
DECEMBER	1	3
JANUARY	2.9	2.9
FEBRUARY	5	3
MARCH	3.4	3.2

***NB Excluding April data**

This will not continue as an improvement priority for 2014/2015 but the trust believes this to be an important aspect of safety and will continue to monitor the CAUTI indicator rates and will report back in the Quality Report next year.

3.2.5. NPSA 'never events'.

One never event occurred during 2013/2014. The never event recorded on datix was an incident relating to Wrong Implant/Prosthesis whereby a patient for left knee replacement surgery had a right sided femoral component implanted. All actions relating to the recommendations have been completed. The investigation report shows that no harm was caused to the patient and there would be no long-term complications as a result of this incident. The trust explained everything to the patient in line with our Duty of Candour.

The contractual obligation from the 1st April 2013 means that all NHS organisations are required to tell patients if their safety has been compromised which has resulted in moderate (non-permanent harm) and or severe (permanent harm) and or death outcome as a result of something not being done. There must be an apology, appropriate investigation with recommendations to ensure that lessons are learned and thus, reduce the risk of the incident being repeated.

The trust has always embraced a non-contractual duty of openness with patients. However new rules to toughen transparency in NHS organisations and increase patient confidence has resulted in the Government creating regulations that require the NHS Commissioning Board to include a contractual duty of openness in all commissioning contracts from April 2013. This is known as Duty of Candour.

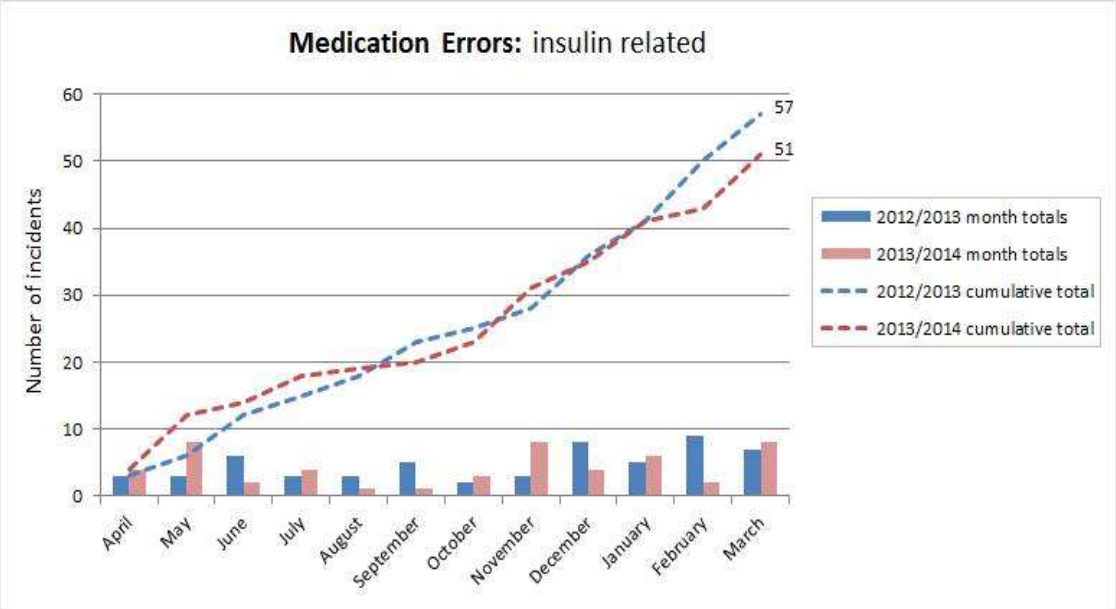
3.2.6. Reduction in medication errors that are related to insulin.

A quarterly trust wide audit of omitted medicines has been carried out since April 2012; this supports the trust in identifying areas of concern thus enabling targeted improvements to be made.

In 2012/13 a target of a 10% reduction based on data from Q1 and Q2 2012/2013 was established. There were 57 incidents related to insulin errors reported in 2012/2013 therefore the trust did not meet its internal target of 10% reduction in errors. However, during that year we did have improved reporting which corresponded to the amendment to the datix system (the addition of an insulin tick box) and the consequent increased awareness of the need to report and by a campaign to focus on allergy related incidents.

For 2013/2014 the trust improvement target was a 5% reduction in medication errors related to insulin, which translated to a reduction in real terms from 57 insulin related incidents to >=54 for 2013/2014. Insulin related medication errors are discussed at the Medicines Safety Committee and reported to board on a monthly basis via the Quality Dashboard. The chart below shows that the trust exceeded its improvement target of a 5% reduction by achieving 10.5% reduction in the number of insulin related errors reported on the trust incident management system datix.

Medication Errors: insulin related – 2012/2013 - 2013/2014.



Quality improvement initiatives to reduce errors include:-

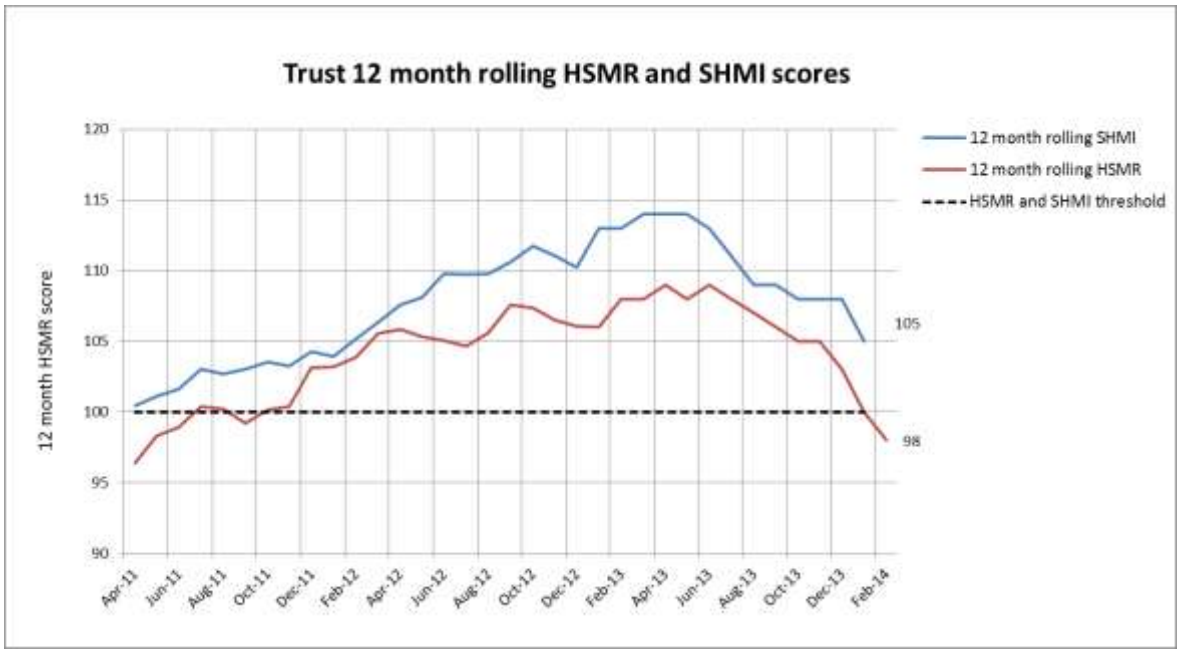
- Diabetes nurses have been delivering training sessions to groups of staff including pharmacists and junior doctors
- Mini-investigations are undertaken on all incidents.
- Increased focus on insulin incidents with immediate follow up and review with staff
- Issuing safety alerts to raise awareness of key issues for staff

Going forward this will no longer remain as an improvement priority but it will be reported as part of the quality indicator on medicines management.

3.3 Clinical Effectiveness

3.3.1. Mortality - Summary Hospital-level Mortality Indicator (SHMI) & Hospital Standardised Mortality Review (HSMR)

Both our SHMI and HSMR scores have been higher than we would have liked in 2013/2014, however, following a significant focus on mortality reduction in the trust, we are very pleased to report a fall in both scores towards the target of 100 or less. Since the January 2014 HSCIC publication (for the period July 2012 – June 2013) the trust has had an 'as expected' SHMI score and the latest SHMI score available (HED system) is 105, for the period February 2013 – January 2014.



The latest HSMR score available (HED system) is 98 for the period March 2013 – February 2014. The chart above shows these rolling 12 month figures since April 2011.

We have also improved against other North West trusts, having had the 4th highest SHMI score in 2012/2013 to now having the 9th highest out of 22 trusts, based on the latest available data.

The trust has invested in a designated Clinical Effectiveness function, a responsibility of which is to monitor and reports these figures widely across the organisation to a number of forums, and also to support staff and services to understand the detail behind them, to drive improvements.

Clinical Effectiveness Event 2013

The Clinical Effectiveness Group has responsibility for reviewing mortality and is currently driving progress in this area. In addition to on-going quality improvement activity for example clinical audit the trust has focussed on six priority areas of activity; these are shown in the table below, with examples of progress made in each area.

Priority Area	Specific activity
Reviewing the trust's care pathways and best practice care bundles to ensure a high standard of care for every patient, every time.	The development of the trust Clinical Effectiveness function affords greater capacity of support to clinical teams in the cycle of continuous improvement. Examples include supporting the revision of pathways for patients with Chronic Obstructive Pulmonary Disease (COPD) and a sepsis pathway. Enhanced Recovery Pathways have been implemented in surgery in 2013/2014 to support reduce the time patients have to spend in hospital and promote faster patient recovery. Leadership of the Advancing Quality (AQ) programme has been assumed by the Deputy Director of Nursing, and risks to its implementation and achievement of compliance against the measures have been raised at relevant forums. This new approach has raised the profile of this vital initiative and we believe this will improve our processes and in turn, patient outcomes.
Ensuring quality and appropriate care at the end of patients' lives.	The provision of Specialist Palliative Care has increased significantly in 2013/2014. See section 3.3.6 for more detail.
Reviewing the care of patients with respiratory conditions to ensure this is optimal at all stages of their care	A process mapping exercise has been carried out regarding the patient journey from admission to chest X-ray, to identify any aspects of the process which could be improved. Progress in this area is being monitored by the Clinical Effectiveness Committee. COPD (launched north west wide in April 2014) and Pneumonia are 2 of the Advancing Quality programme measures. With the additional support and senior drive behind this programme, it is anticipated that Pneumonia AQ compliance will improve and COPD AQ compliance will be achieved.
Promoting the effective management of patients whose conditions deteriorate.	The trust has made significant developments in this area with the introduction of a Medical Emergency Team, revision of the Early Warning Scoring system, standardising this across the trust and developing an "I bleep" system, using technology to greater effect in the coordination of key personnel responding to patients who deteriorate. A thorough review was undertaken into the care of patients who had a cardiac arrest; progress against identified actions is being monitored by the Clinical Effectiveness Group.
Continue to analyse, understand, report and use mortality and morbidity data to improve outcomes.	Trust staff awareness and understanding of mortality ratios has increased significantly in 2013/2014. Data is presented at a variety of forums across the organisation and an App has been developed to enable 24hour access to the information from a smart phone, tablet or PC. A detailed mortality report is presented at the monthly Clinical Effectiveness Group and quarterly at trust board. Thorough patient level reviews are carried out where the data highlights the trust as an outlier.
Ensure accurate and comprehensive	As a member of AQUA's Reducing Mortality Collaborative, the trust has used AQUA's framework for reducing mortality, which largely mirrors the

documentation and coding.	six key areas outlined here. To ensure mortality ratios are useful indicators of the quality of care, trusts must make sure that their documentation and coding is accurate as this is the data from which the scores are produced. The trust has undertaken work to ensure that we continually, accurately and comprehensively document patient's health and the care they receive so that the coding team can assign the correct codes.

We will continue to monitor and report mortality ratios in 2014/2015 and use the data as an indicator of the quality of care we provide, supporting targeted improvements.

3.3.2. Reducing harm to patients who are critically ill – high impact interventions.

Our sickest and most vulnerable patients are the ones treated within our Intensive Care Unit, and we have introduced and monitored a number of care bundles to ensure the best possible safe care is provided. The High Impact Interventions (HII) from the Department of Health 'Saving Lives' initiative are an evidence-based approach to key clinical procedures or care processes that can reduce the risk of infection if performed appropriately. They have been developed to provide a practical way of highlighting the critical elements of a particular procedure or care process (a care bundle), the key actions required and a means of demonstrating reliability. No single action will produce effective infection prevention and control practice and for any planned clinical procedure, there are a number of critical components founded on a solid evidence base that must be undertaken correctly to reduce infection risk.

Sustainable reductions in healthcare associated infections (HCAIs) require the engagement and active involvement of all staff working within the critical care environment, supported by the infection control team and clinical champions. Every clinician has the potential to significantly reduce the risk of infection to their patients by ensuring that they consistently comply with evidence based practice and guidelines when they undertake a clinical procedure.

The trust continues to use the following high impact interventions or care bundles within its Intensive Care Unit:

- Urinary Catheter: insertion
- Urinary Catheter: on-going care
- Ventilator Acquired Pneumonia
- Blood stream infections: CVC on-going care
- CVC insertion
- Peripheral cannula on-going care
- Peripheral cannula insertion

In 2011/2012 the trust achieved 97% compliance for ventilator acquired pneumonia prevention and 100% for urinary catheter infection prevention – we achieved our goals. Our plan for 2012/2013 was to maintain this high standard so the trust established an improvement target of >=90% and achieved compliance with each High Impact Intervention care bundle. The trust did not identify this audit as an improvement priority going forward for 2013/2014 but we felt it was important that we continued to audit practice because regular auditing of the care bundle actions will support cycles of review and continuous improvement in our care settings. The table shows the trust continues to

improve compliance evidenced by the following cumulative compliance rates for 2012/2014 reported in the Quality Dashboard:

High Impact Intervention	2012/2013	2013/2014
Urinary Catheter: insertion	100%	100%
Urinary Catheter: on-going care	99%	99%
Ventilator Acquired Pneumonia	94%	96%
Blood stream infections: CVC on-going care.	100%	100%
CVC insertion	100%	99%
Peripheral cannula on-going care	96%	97%
Peripheral cannula insertion	99%	99%

3.3.3. Dementia CQUIN and Forget Me Not Campaign

In 2012, a CQUIN for dementia was established to ensure that trusts identified patients with dementia and other causes of cognitive impairment alongside their other medical conditions in order to prompt appropriate referral and follow up after they leave hospital. The trust achieved the CQUIN target of over 90% of patients being assessed at each stage by Quarter 4 as per our contractual obligations reported through UNIFY the central returns dataset and the Quality Dashboard. In 2013/2014 this CQUIN remained a national contractual agreement to ensure that hospitals continued to deliver high quality care to people with dementia. Importantly for 2013/2014 this CQUIN also included additional components namely that trusts:-

- Will need to ensure they have a named lead clinician for dementia and that this role is clearly documented in the individual's job plan.
- Will provide and deliver appropriate training for staff.
- Will need to support carers by agreeing the content of a carers audit with commissioners; undertake a monthly carers audit and ensure the results are presented to the trust board, as well as implementing any actions resulting from them.

The trust has worked hard at implementing the CQUIN and is pleased to report that we achieved full compliance with this dementia CQUIN for 2013/2014.

In addition to this national CQUIN, the trust agreed a local CQUIN called the "ForgetMeNot" Campaign to ensure further improvements to services for our patients with dementia this included:-

- reviewing the trust Dementia Strategy and introducing the 'Forget me Not Campaign'
- introduce Dementia Champions across the trust
- nominating two dementia friendly wards
- assess ward environments utilising the dementia friendly tool kit

Dementia will remain as a national CQUIN and a quality indicator for 2014/2015.

3.3.3.1. Warrington and Halton Hospitals NHS Trust - Dementia Journey

Dementia was also selected as an area of focus for 2013/2014 with the specific aim of promoting the development of a culture within the organisation where everyone will be able to recognise and help patients with dementia.

At this trust the staff are dedicated to providing the best possible care for patients with dementia. The term 'dementia' describes a set of symptoms that include loss of memory, mood changes, and problems with communication and reasoning. There are many types of dementia. The most common are Alzheimer's disease and vascular dementia. Dementia is progressive, which means the symptoms will gradually get worse. (Alzheimers Society)

Our Dementia Strategy sets out the framework by which we will achieve this. Within the strategy we have identified ten key areas which are underpinned by action plans monitored by our Dementia Steering Group. An information leaflet which raises awareness around the ten areas has been developed and distributed to staff. Over the past year we have ensured that Dementia Champions are in place at board level with our Director of Nursing and Organisational Development leading the way for those patients who are amongst our most vulnerable. We have an identified both a senior medical and senior nursing lead for dementia and have in place trained dementia champions both at ward and department level; which include non-clinical and clinical staff.

The trust recognising the importance of ensuring that our environment is dementia friendly used the Kings Fund Toolkits to review how 'dementia friendly' our wards are. These results were then used to inform our successful bid to the Kings Fund in April 2013, where we were awarded £1.04M to improve the environment for patients with dementia. **Work has now been completed on our £1 million specialist ward which is now open for acute patients with dementia at Warrington Hospital.**

Why we want to be dementia friendly

- We want our patients with dementia to be warm, fed and well cared for in the right environment.
- We want their care to maintain their pride and dignity.
- We want to help eradicate the agitation and distress that often comes with dementia.

- We want to help their families and carers to feel that patients with dementia are safe in our care and to know that patients with dementia are a priority for us.
- We want our hospitals to lead the way in dementia care, and to be able to demonstrate success.
- We want our approach to mean that patients with dementia spend as little time in hospital as possible.

Forget Met Not Campaign

This campaign has successfully raised awareness of patients with dementia, and cognitive impairment. We launched the use of the Forget Me Flower symbol behind the patient's bed. The symbol reminds our staff that the patient either has a diagnosis of dementia or has cognitive impairment and that they should ensure that their approaches to the patient are appropriate. This is accompanied by information to staff, carers and families about what this means for the patient.

A programme of events, the "Forget Me Not Events", provide focussed activities within ward areas aimed at providing stimulation, diversion and helping to reduce the agitation and loneliness that so often accompanies dementia.

"Forget Me Not" muffs (twiddle muffs)

The wards have a suite of activities, including games, memory boxes, and other products aimed at keeping hands busy and stimulating the mind. This programme also includes musical events, and will be developed to include other activities such as poetry recitals. So far this year our wards have been visited by a string quartet, a choir, an a capella group and a ukulele band where patients and their relatives enjoyed a positive and stimulating social experience over tea and cakes with our staff. We have community knitting groups who make "Forget Me Not" muffs (twiddle muffs) to help keep hands busy and reduce anxiety.

Identified wards also have rummage boxes, activity boards, and games to help reduce the symptoms associated with dementia and cognitive impairment.

The trust has also promoted the use of “Forget Me Not” silicone wristbands for patients, carers, staff and families to raise awareness of dementia and cognitive impairment. We monitor the movement of patients with dementia, and put in place actions to restrict moves that are not in their best interest. We are currently auditing a sample group of patients with a diagnosis of dementia or confused state who were readmitted to our hospital within 30 days of their discharge to see what improvements we can make to ensure that they are supported to stay at home as far as possible.

A dementia training programme for staff is vital to ensuring the delivery of high quality care. The trust has purchased two courses from an external training company who work in conjunction with the Alzheimer’s Society in the development and delivery of dementia training. These workshops specifically designed to support the Dementia Champion role provide a person centred approach to dementia care offering support that reflects individual needs. We also provide a one day workshop called “Supporting the Dementia Patient Journey” which is aimed at all staff groups who come into contact with patients that have dementia. The course provides training around a number of areas including definitions of dementia; an understanding of how people with dementia communicate; a virtual dementia tour – a practical exercise exploring the effects of dementia; on line dementia café; maintaining skills – how to promote independence and supporting relationships – how to support people with dementia & their carers

Our Specialist Nurse for Older People has produced a suite of care plans for patients with dementia, delirium or cognitive impairment and we are reviewing our “Dementia Awareness Packs” for the ward and department areas. From April we will be rolling out dementia e-learning and training materials for all staff and we will hold a dementia exhibition on a regular basis to promote the ward

and a greater awareness of dementia.

We are proud of our achievements in developing a culture whereby all staff will be able to recognise and help a patient with dementia and in the summer 2014 the trust will hold a Dementia Conference to celebrate and share the innovatory work that has taken place.

3.3.4. Compliance with regional targets set for Advancing Quality – reducing variation

Advancing Quality Alliance (AQuA) is an organisation which aims to improve the quality of healthcare; they are funded by members and customers including Foundation Trusts, Mental Health Trusts and Clinical Commissioning Groups. They work with members and customers to promote and share knowledge of best practice in order to improve the quality of healthcare.

Advancing Quality (AQ) is one of AQuA's programmes which aim to improve healthcare standards provided in NHS hospitals across the North West of England and importantly reduce variation. It was launched in 2008 across all North West hospitals and originally focused on five clinical areas which affect a lot of patients in the region namely heart attacks, heart bypass surgery, heart failure, hip and knee replacement surgery and pneumonia. The programme which is independently researched and evaluated is deemed to be achieving its objectives. Following the early success of the programme, AQ expanded into the treatment of stroke patients in October 2010, followed by dementia and first episode psychosis in January 2011.

AQ works with clinicians to provide trusts with a set of quality standards which define and measure good clinical practice. Care in hospital is always tailored to individual needs but trusts must deliver each measure to every patient to ensure they receive the highest standard of care in hospital. AQ refers to this as the Clinical Process Measures and trusts aim to achieve 100 per cent success rate. For example, if a patient is admitted into hospital suffering from pneumonia, two of the key Clinical Process Measures would be to have their oxygen levels assessed when they arrive in hospital and, if antibiotics are prescribed that the patient receives them within six hours of arriving at hospital. It aims to give all patients a better experience of the NHS by ensuring that every patient admitted to a North West hospital is given the same high standard of care. The idea is, if every hospital achieves the AQ measures, it will help to:-

- Save lives.
- Reduce the number of people being re-admitted into hospital.
- Reduce complications.
- Decrease the length of time patients have to spend in hospital.

The table below provides a five year summary of the trust performance from AQuA which shows compliance with the CQUIN target for this period.

Warrington & Halton NHS Trust - Advancing Quality Data*

YEAR	Heart Attack	Heart Failure	Hip & Knee Surgery	Pneumonia	Stroke
Year 1	97.60%	73.42%	90.53%	82.11%	NRC

Year 2	99.29%	90.12%	94.09%	84.16%	NRC
Year 3	99.56%	90.66%	96.34%	86.52%	NRC
Year 4	99.55%	95.41%	98.02%	88.98%	90.60%
Year 5	99.45%	94.93%	98.48%	90.38%	88.90%
CQUIN TARGET	**91.46%**	**86.85%**	**92.23%**	**75.23%**	**62.57%**

- **NRC – No results collected**
- **** Published on the* AQuA's website**

*AQ is also a local CQUIN for the trust and we are p*erformance managed for each agreed condition Pneumonia; Heart Failure; Acute Myocardial Infarction; Hip and Knee and Stroke in order to demonstrate an annual improvement against the targets. The above table reported via the Quality Dashboard demonstrates that for 2013/2014 the trust has achieved all measures with the exception of pneumonia and stroke.

Advancing Quality Measures 2013/2014

NB Quarter 4 data will not be available until July 2014.

The Advancing Quality Group meet on a monthly basis to discuss performance and to provide assurance that all clinical areas are reviewed and ensure appropriate monitoring mechanisms are in place.

MEASURE	TARGET	APR	MAY	JUN	Q 1	JUL	AUG	SEPT	Q 2	OCT	NOV	DEC	Q3
Heart Attack	>=91.46%	97.14	98.65	97.98	97.98	98.37	97.97	98.30	98.30	98.59	98.77	98.25	98.25
Hip Knee	>=92.23%	97.47	97.56	96.77	96.77	96.08	96.46	96.98	96.98	96.30	96.41	96.21	96.21
Heart Failure	>=86.85%	85.00	90.91	93.59	93.59	93.00	90.84	90.96	90.96	87.95	89.09	88.75	88.75
Pneumonia	>=75.23%	64.37	65.36	68.16	68.16	68.90	70.00	70.26	70.26	70.31	70.93	71.80	71.80
Stroke	>=62.57%	59.46	55.00	53.49	53.49	55.75	58.33	57.54	57.54	57.14	56.50	56.16	56.16

Going forward for 2014/2015 the AQ measures described above will remain a local CQUIN and additional measures will be included in the CQUIN from April 2014, including Chronic obstructive pulmonary disease (COPD); Hip Fracture; Sepsis; Acute Kidney Injury; Diabetes and Alcoholic Liver Disease.

As previously stated during 2013/2014 the trust experienced issues in meeting all the Stroke and Pneumonia measures and has therefore decided in consultation with stakeholders to include these measures as an improvement priority for 2014/2015.

3.3.5 Reduction in readmissions.

The trust works toward reducing readmissions in accordance with contractual requirements with the commissioners.

Please refer to section 2.3.3 for further information

3.3.6. High Level Quality care at End of Life.

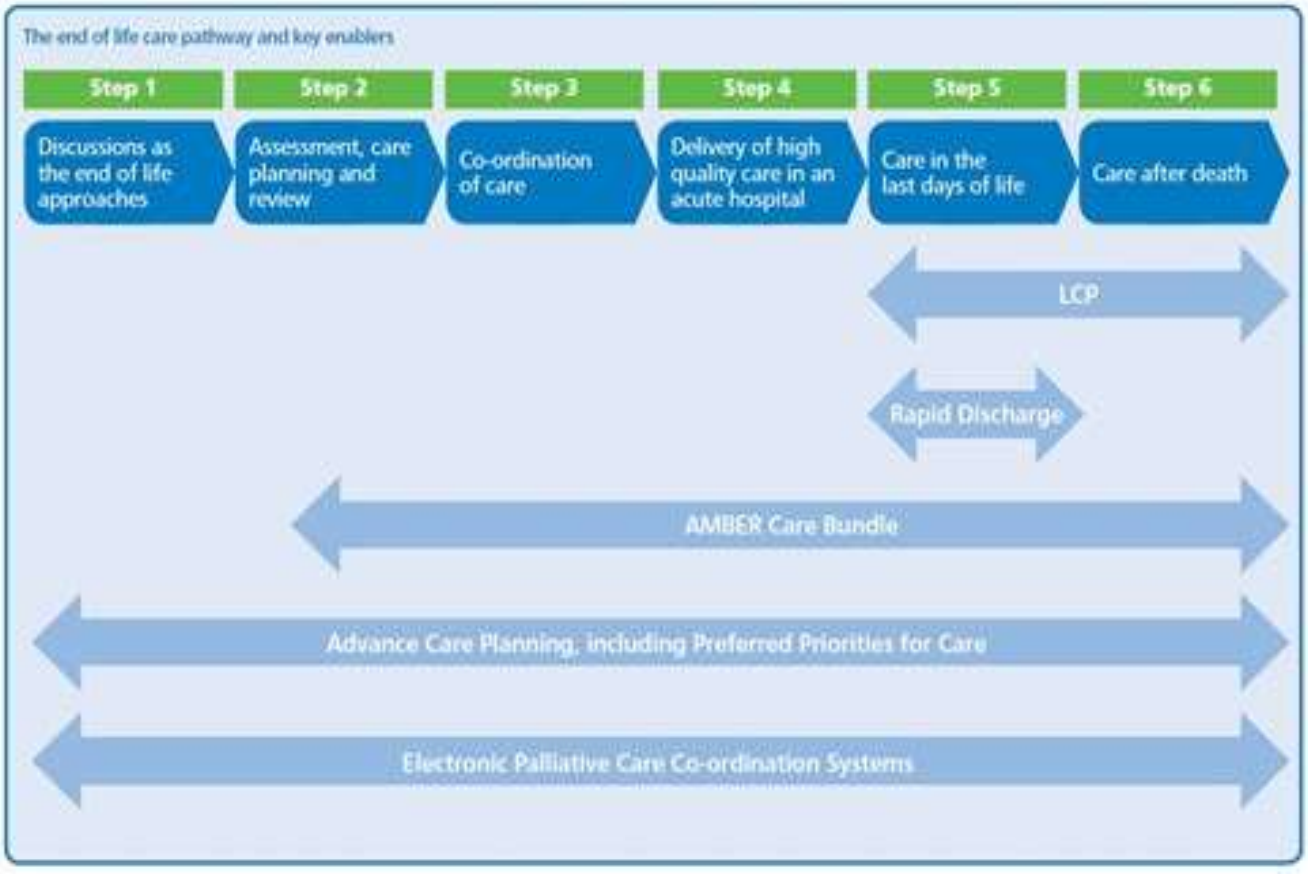
The trust has been part of the national Transform programme which aims to improve end of life care in acute trusts, enabling more people to be supported to live and die well in their preferred place. As part of the programme we have continued to use existing end of life care tools and are in particular working on the implementation of the 5 key enablers:

Key Enabler	Progress
Advance Care Planning	Education about Advance Care Planning is a key priority for the next few months as the AMBER care bundle continues to be used on more wards and will have specific relevance to the opening of the new dementia ward in the hospital. As part of the process of education regarding Advance Care Planning, road shows specifically dealing with difficult conversations are planned from June until the end of the year.

Electronic Palliative Care Coordinating Systems (EPaCCS)	EPaCCS provide a shared locality record for health and social care professionals. They allow rapid access across care boundaries, to key information about an individual approaching the end of life, including their expressed preferences for care. There is work on-going with local Palliative Care Services, local healthcare providers and the Cheshire and Merseyside Palliative and End of Life Care Network to develop an EPaCCS system which will suit the needs of the local population.
AMBER Care Bundle	The AMBER care bundle is a simple approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the worst happen. The trust is implementing the AMBER care bundle as part of the Transform national initiative, led by NHS Improving Quality (NHSIQ). The care bundle has been implemented on 10 wards across the trust, with further implementation planned on the surgical unit. A recent audit of deaths occurring in hospital found that the standard and content of the documentation including medical planning, ceiling of treatment and communication with patients/families was higher where the AMBER Care Bundle was used to support patients whose recovery was uncertain.
Rapid Discharge Home to Die Pathway	Hospital is not where most people would choose to die although we know that it is where the majority of people do die. Where people have been identified as dying and they express a preference to die at home it is sometimes possible to fulfil that wish by arranging discharges at short notice. These discharges are complex however, and there are many elements which must come together to maximise the chances of success. With this in mind the Specialist Palliative Care CNS team has drafted a supporting pathway document to try to ensure that this is done right every time. The document is ready to go out for consultation to the wider healthcare team and it is hoped that it can be implemented within the next year. New anticipatory prescribing guidance for dying patients has recently been launched in the trust along with new processes for administration sheets for these medications to go home with patients so that they can receive symptom control in a timely manner at home. This will complement the rapid discharge pathway work. A unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy was implemented across the whole of Warrington in October 2013 and this is aimed at reducing the number of unnecessary repeated conversations about CPR when patients move to different settings. It also aims to reduce the number of inappropriate CPR attempts occurring in the community. Consideration of a DNACPR decision will be necessary in planning a rapid discharge of someone who is dying.

Liverpool Care Pathway for the Dying patient (LCP).	This is a framework to guide high quality end of life care for those in the last hours and days of life. Since a national review of care of dying patients, it must be phased out in July 2014 and be replaced with individualised care plans. In line with guidance from the Leadership Alliance we in Warrington have continued to use the LCP supported by open discussions with patients and families about this as it has previously been used very appropriately here. There are plans in progress for a new individualised care plan document to be implemented in the Summer to replace the LCP and to support doctors and nurses caring for people who are dying. The trust took part in the 3rd round of National Care of the Dying Hospital Audit in November 2013, and we await the report from this audit. The report benchmarks the trust with other units across the country.

An overview of the use of the key enablers set out by the Transform Programme. Note that where the LCP is mentioned, this will be replaced by an individualised care plan for the dying patient.



The use of the key enablers from the programme has benefitted the trust by:

- Improving the quality of the individual patient experience and the quality of care
- Supporting the patient to die in the place of their choice
- Promoting the development of a skilled workforce with improved staff morale and retention
- Allowing more effective resource management by a reduction in inappropriate interventions

- Managing and reducing unplanned hospital admissions
- Reducing complaints and enhancing the reputation of the trust.

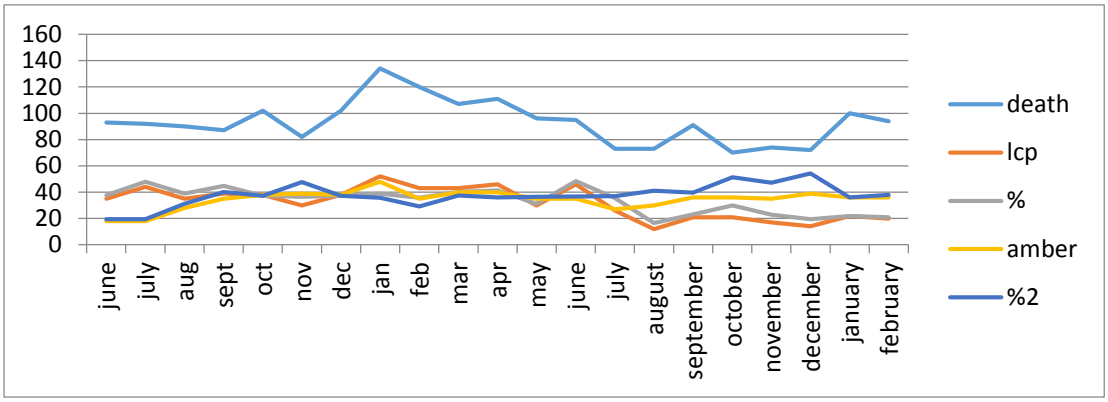
Support has been obtained from the National team in benchmarking the trust against other early implementers and this has enabled monitoring of the progress we are making.
Data from the National End of Life Care Intelligence Network shows that our trust has a lower number of bed days in the last year of life compared to the national average. The reasons for this are several including improved discharge processes, improved identification of people who are approaching the end of life and involvement of the Specialist Palliative Care Team to name but a few.
The activity of the hospital Specialist Palliative Care Team has continued to see a year on year increase with around 700 new referrals to the team in 2013/2014. We can also report an increase in the deaths coded as having input from Specialist Palliative Care. In response to the 'More Care, Less Pathway' review, referral to Specialist Palliative Care has been recommended for all patients who have been identified as dying. The aim of this is to ensure that patients are receiving the care that they need in the last hours and days of life and that families are being supported and also that the doctors and nurses looking after the patients have access to specialist support as they care for these people.

Education
Education has underpinned the improvements seen in the trust in end of life care and all members of the Specialist Palliative Care Team have delivered education to a variety of professionals in the organisation. A well-attended link nurse programme is in operation with ward nurses attending teaching at St Rocco's Hospice led by the Hospital Palliative Care Team and focussing on control of symptoms, identification of dying patients, and other issues pertinent to looking after patients at the end of their lives. Information from these days has been disseminated in the form of single point lessons so that more staff have the opportunity to benefit from this work. There have been several sessions delivered by various team members for junior doctors who have been taught on subjects such as identification and care of dying patients and safe discharges at the end of life.

The AMBER Care Bundle
The continued implementation of the AMBER care bundle owes much to the tireless efforts of Joanne Meredith who is the facilitator for this project, winning an award from the trust in 2013 in recognition of the positive difference this activity makes to patients.

A 20-30 minute training session on the use of the AMBER care bundle has been delivered to 300 medical or nursing staff, they also receive on-going support from the facilitator to enable roll out. More than 600 patients have had their care supported by an AMBER care bundle. An AMBER discharge proforma is now being developed to communicate the discussions that have taken place in hospital that care should be supported at home as per the patients wish and for re-admission to take place only if absolutely vital. A recent case note audit demonstrated that the AMBER Care Bundle used to support patients when recovery is uncertain improved the standard and content of the documentation including medical planning; ceiling of treatment and communication with patients/families.

A sample audit showed 0% rate of readmission for patients that had had care supported using the AMBER care bundle and had been discharged and had died within 100 days of discharge during September and October.



Trend analysis - tools used to support care for patients nearing end of life.

In the trust, approximately 20% of patients who die and whose deaths were expected have their care supported by the Liverpool Care pathway (LCP). There has been an expected reduction in numbers following the review of the LCP in 2013 which recommended the gradual phase out of the pathway, and to discontinue its use in by July 2014. Clinical staff and patients and families are being supported by the specialist Palliative care team and facilitators during this transition period.

3.4 Patient Experience

Following the publication of the Francis report there is heightened awareness and concern about the experience that patients have in healthcare settings. The trust supports the ideology that it needs to collect information; be open and transparent about the experience of patients within its care and that information about patient experience should be publically available. Ensuring that people have a positive experience of care is also a key objective within the NHS Outcomes Framework. This trust supports the view that patient experience is as equally important as the other elements of the quality agenda namely clinical effectiveness and patient safety, and that that it should be embedded across our work to improve quality outcomes. "There is clear evidence that where patients are engaged in their own care and have a good experience of care and treatment, clinical outcomes are better" (NHS England, 2014)

The trust is committed to improving patient experience as set out in the "Improving Quality: Patient Safety, Experience and Clinical Effectiveness Strategy." The implementation of the strategy is supported by a number of work streams and activities identified across all areas of the trust.

Priority actions for the 2013/2014 included:

- Achieve an improvement in the learning and analysis of complaints with themes relating to attitude, care and treatment
- To revolutionise the way that we manage complaints to provide a responsive patient focussed service
- Implementation of the Friends and Family CQUIN

- Develop ‘always events’, i.e. what must we always do for patients to ensure a quality experience.
- Continue to monitor mixed sex occurrences
- Develop a basket of Patient Experience Indicators
- Evidence of CQC compliance with regulations and outcomes
- Evidence of compliance with the recommendations of the Francis Report
- Improvements demonstrated in our In-patient Survey
- Successful implementation of a Patient Information Centre / Patient Experience ‘Hotline’
- Good Healthwatch reports and external reviews

The effective management of complaints and concerns is integral to ensuring a positive patient experience by addressing issues as they arise and ensuring that lessons are learnt and poor practice and systems are addressed.

Our commissioning arrangements for both national and local CQUINs for example the Friends & Family Test continue to reflect the importance of us being responsive to patient feedback to improve patient experience. The trust also participates in all relevant national surveys, and has a number of local approaches to evaluating the patient experience. Importantly, it continues to build its skills and tools to enable it to collect and analyse different sources of feedback from complaints, patient stories, PALS and local surveys in order to identify key issues that need to be addressed and then put in place improvement plans that deliver an improved experience. More recently the trust has also developed a suite of patient experience indicators which will allow us to monitor performance on a monthly basis in key areas for example collecting data on the rate of “Negative comments posted on patient opinion; NHS Choices and/or the CQC Experience Form.”

The evidence also demonstrates that “where there are high levels of co-worker support; good job satisfaction, good organisational climate, perceived organisational support, low emotional exhaustion and supervisor support, there are links to good patient-reported experience. However poor staff satisfaction is associated with worse standards of care” (NHS England, 2014) Within year the trust has undertaken a cultural barometer survey of all staff, developed an action plan and made changes as required. It has also established a project to develop and agree values and behaviours which will shape the organisation, the objective is that the new values and behaviours will drive a philosophy of improving services for the patient.

As well as encouraging staff feedback through national and local surveys we support processes to enhance staff wellbeing. The trust has dedicated web pages to promoting and supporting social and healthy living and also holds annual staff health and wellbeing events. The Staff Engagement and Wellbeing Event held in September 2013 attracted sponsorship from companies and was attended by approximately 350 members of staff. The focus of the event was to promote healthy lifestyles, with the activities such as the smoothie bike, cycling challenge and gym attendances.

The planned Friends & Family Test for staff due to start in 2014 and the staff survey results will also provide a barometer of staff experience. We also ensure that staff feedback around the quality of the patient care provided in our organisations is publicly available through for example Open and Honest, which is available at:-

http://www.warringtonandhaltonhospitals.nhs.uk/page.asp?fldArea=1&fldMenu=8&fldSubMenu=7&fldKey=1241

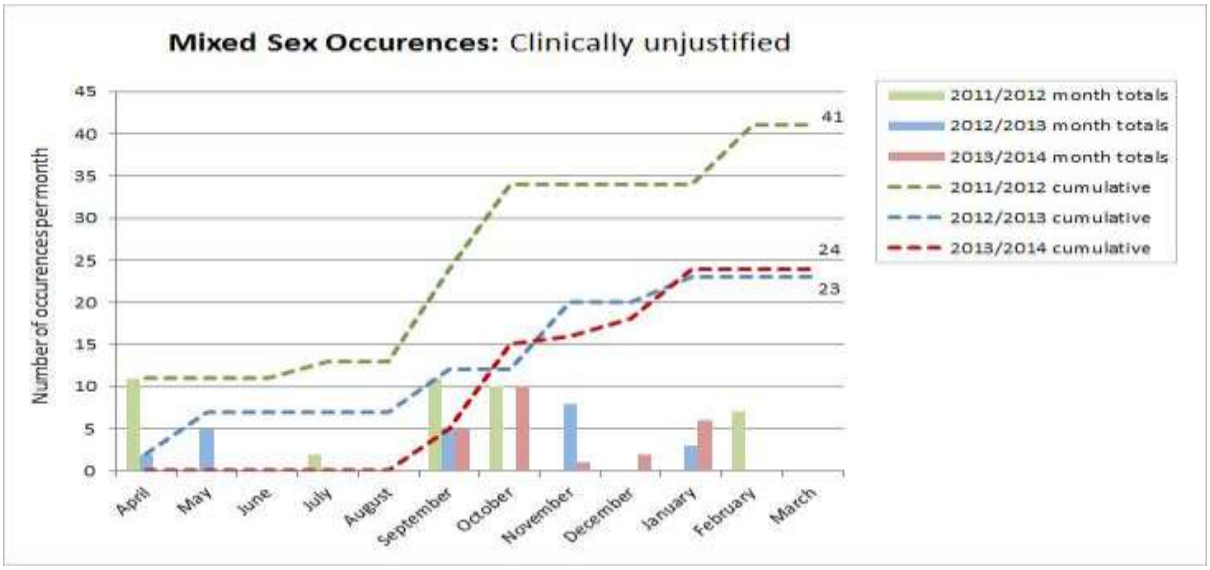
The following section provides an appraisal of progress against the patient experience key priorities.

3.4.1. Eliminating Mixed Sex Accommodation.

All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/3. The trust measures, in line with nationally prescribed guidance any occurrence of mixed sex accommodation by determining whether they are 'clinically justified' (i.e. "in the overall best interest of the patient" such as when both male and female patients are in the Intensive Care Unit) or 'non-clinically justified' (when male and female patients share either sleeping accommodation or bathrooms and toilets).

In 2012/2013 the trust threshold was for full compliance with no reported breaches however, whilst we reported 23 mixed sex occurrence breaches, this was a 44% reduction on 2011/12 when the trust had 41 breaches. For 2013/2014 the trust again established a zero tolerance threshold and it was on target to meet this objective until September 2013. Until this time the trust believed that there was a locally agreed protocol with the CCG that stated if an MSO occurred in specific areas of the trust for example the Clinical Decisions Unit and GP Assessment Unit (GPAU) then the breach will not be liable for penalty as long as it is resolved within an 8 hour time limit. However, when the trust made a request to the Department of Health (DoH) to rescind an MSO which after investigation they discovered had breached for less than 8 hours the DoH refused to grant the revision request stating that the length of time for an MSO is not relevant. The trust then instituted a review and a paper was presented to the Executive Team (ET) for the ET to agree that reporting practise would change in line with further guidance from the DoH. Unfortunately despite rigorous monitoring and changes to patient flow, the trust has continued to report breaches in these areas. However it does ensure that each breach/cluster has been reviewed using a root cause analysis and remedial action plans constructed and submitted to the CCG within fourteen days of month's end in accordance with contractual agreements.

In 2013/2014 the trust can report that following a review as described above that there were no reported breaches for February and March 2014 and a total of 24 breaches by year end. Please see graph below for a three year comparison. The trust will report progress in the Quality Report 2014/2015.



3.4.2. Always Events

In addition to the agreed improvement priorities the trust board in partnership with staff and governors also agreed to focus upon a number of key issues around quality improvement which included the development of "always events." Always events are aspects of patient care that should always happen for patients to ensure a quality experience. The trust has held a number of focus groups with patients; staff and governors to agree a small number of always events which we will monitor throughout 2014/2015. It was important to seek the ideas and suggestions of both staff and patient representatives. Focus Groups for staff and Governors provided lots of ideas about quality measures. A local healthcare event "Get Engaged" provided an opportunity to ask members of the public and representatives of patient groups and third sector organisations what were the always events they would appreciate.

It is vital that Always Events are measurable and can be implemented and monitored within current resources/budgets. Some suggestions, while they would demonstrate excellent quality of care, could not be easily introduced or monitored. A process of distillation has left us with the following Always Events. The next stage is to plan implementation and ensure that there is an audit trail inherent in the system. We will monitor the Always Events throughout 2014/2015 and report them as a quality indicator in the Quality Report next year.

The Always Events will be:-

- Every patient has a jug and glass that is within reach and has sufficient fluid.
- The name of the patients named nurse will always be displayed above the bed
- Any complaint or concern will be addressed as soon as possible and as close to the bedside as possible. Staff will bleep senior nurse to deal with complaint if needed.
- Pain relief is administered on time, every time.

3.4.3. Complaints and Compliments

The year 2013/14 was a very challenging one in terms of complaints handling in the trust. A combination of staff attrition and system problems in the central complaints handling team and

capacity and workload pressures, particularly in the Unscheduled and Scheduled Care Divisions left the trust with a considerable backlog of late complaints and relationships with complainants were sometimes affected.

A real team effort has been made to improve systems in to provide meaningful responses to those complainants where complaints were late, and in ensuring that we kept in touch as far as possible. We spent considerable time in restructuring of the team; the result is that our system is on a more even keel, though we believe there is room for even more improvement. We recognise the hard work and effort of many of our staff across all the divisions, the Patient Experience Team/corporate nursing team and at executive level to improve the handling of complaints.

In order to meet the expectations of the board, the commissioners and, most importantly, the public we must continue to improve the systems in place and ensure that the methods we employ to investigate and learn from complaints provide assurance and demonstrate a transparent and committed process and staff who want to acknowledge failures and learn from them.

The complaints process is an important source of data and feedback for the trust in its plan to improve the patient experience. The priority for the forthcoming year is to build on the progress made during 2013/14. The Patient Experience Team continues to provide support to divisional staff when dealing with complaints and there are regular divisional meetings with key members of staff to discuss the progress and handling of complaints. Having spent the last year improving the strategic systems and working practices, the teams across the trust will look to develop the skills of clinical and managerial leads in investigating complaints and strengthening the learning and assurance aspects of complaints during 2014/2015.

Specific priority actions relating to complaints for 2013/14 included:

- Achieve an improvement in the learning and analysis of complaints with themes relating to attitude, care and treatment
- To revolutionise the way that we manage complaints to provide a responsive patient focused service
- Successful implementation of a Patient Information Centre / Patient Experience ‘Hotline’

Until April 2013 this service comprised 1 WTE Patient Relations Manager, 2 WTE Patient Relations Officers, 1 WTE PALS officer, and 1 WTE Administration Assistant. The period from May until December 2013 was one of building a new team and ensuring that they, and the systems could maintain the complaint function whilst developing the service to be more effective and efficient to meet the key performance indicators mandated by the Complaints Regulations (2009) and our commissioners as well as meeting quality standards required by the Care Quality Commission (CQC).

Since May 2013 the service has developed to include all patient experience functions and is now called the Patient Experience Team. The Patient Relations Manager (now Patient Experience Matron) is responsible for leadership of the Patient Experience Team, and her remit includes complaints; PALS; Friends and Family, national surveys, growing the volunteer scheme and the development of both formal and informal feedback mechanisms, all of which help to provide a more responsive patient focused service. The Director of Nursing and Organisational Development has executive responsibility and is authorised by the trust board to oversee the trust-wide management of complaints. The Deputy Director of Nursing, Quality and Patient Experience has delegated responsibility for the strategic development of the patient experience agenda.

A remedial action plan was put in place to direct the actions to improve the complaints handling function. Many of the recommendations were predicated on the ability to comprehensively demonstrate that the investigation of complaints is thorough and open and any failings are identified with the appropriate actions put in place and completed. So for this next year, the Trust will concentrate on providing consistently effective investigation and action planning and to ensure divisions are capturing the evidence that this is happening.

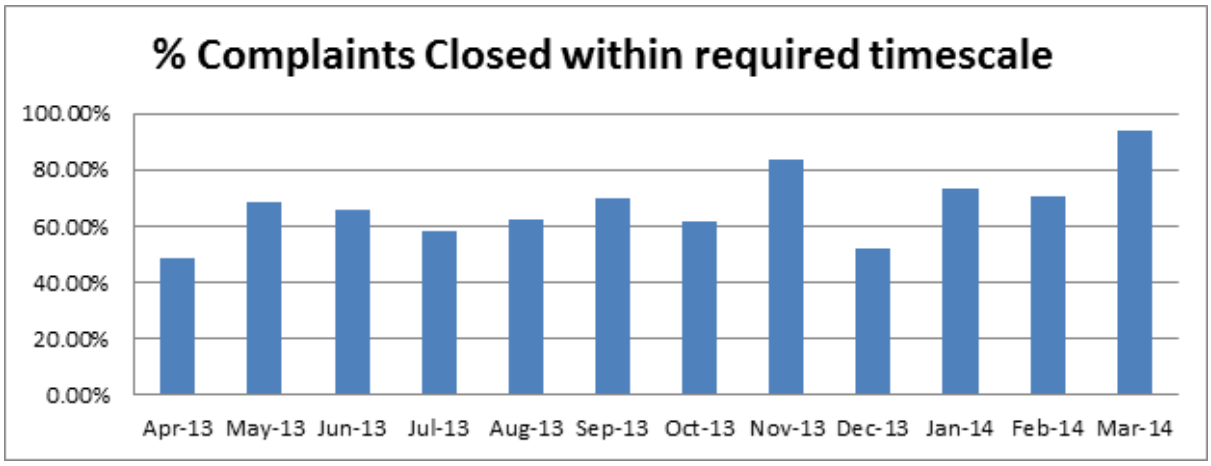
The trust deals with complaints and concerns from patients and users, their family and carers, in accordance with local complaints policies and procedures and the CQC Essential Standards of Quality and Safety. All complaints which are recorded on datix are reviewed by the Director of Nursing and OD prior to response letters being sent to the complainant from the Chief Executive Officer or Deputy Chief Executive Officer. This provides an additional level of assurance that responses are well crafted and answer the questions asked, as well as ensuring that the Director of Nursing and OD has a good grasp of practice issues, patient experience and improvements planned.

Formal Complaints received by Trust 2010/2011 – 2013/2014

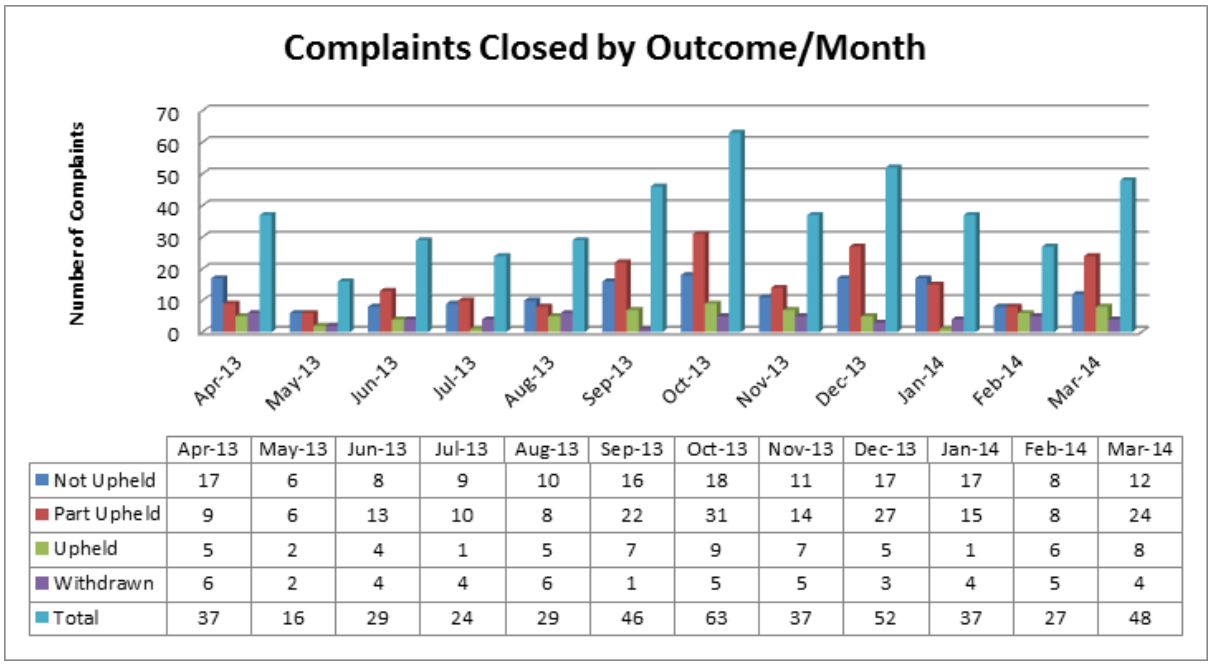
	2010/11	**2011/12**	**2012/13**	**2013/14**
Total formal complaints received	491	505	571	422

Complaints closed within timescale

As can be seen from the table below, in April 2013 the percentage of complaints closed in time was under 50%. The number of complaints already out of agreed timescales has made achieving the 94% target agreed in the local contract very difficult. The close rate for April 2014 did meet the target and recent audits show that the majority of complaints are being answered in a timely manner.



NB: Approximate timeframes - Low to moderate = 15 days; Moderate = 30 days and High to extreme = 50 days The new policy allows the divisional staff investigating a complaint to determine how long they will need to complete the investigation.



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Not Upheld	17	6	8	9	10	16	18	11	17	17	8	12
Part Upheld	9	6	13	10	8	22	31	14	27	15	8	24
Upheld	5	2	4	1	5	7	9	7	5	1	6	8
Withdrawn	6	2	4	4	6	1	5	5	3	4	5	4
Total	37	16	29	24	29	46	63	37	52	37	27	48

Top 5 Complaints Subjects

	12/13 Q3	12/13 Q4	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Care	84	67	19	21	9	14
Treatment	31	59	10	17	21	20
Waiting Times	24	41	8	14	13	25
Communication Problems	49	38	14	15	16	24
Attitude	32	28	12	12	15	23

The majority of complaints are fall into one of 5 categories in order for the trust to identify the main themes; this enables us to decide what actions we need to prioritise to help us improve the service

we provide to our patients. As described below, improvements in reporting will promote more customised reporting for teams, services and divisions, while still providing the overview of broader themes.

MIAA Review

A review of complaints in April 2013 by Mersey Internal Audit Agency (MIAA) assigned "Limited Assurance". A second review, completed in April 2014 shows "Significant Assurance" to the complaints function of the trust, and while there are still improvements and developments to make, the current systems look to be fit for purpose. We are very proud of our turnaround achievements in this year

Lessons learned

The trust is committed to providing excellent care for all our patients. This means that not only will the care we provide be safe and effective, but that the patients' experience of that care is the best it can be. It is essential that what the patients tell us is listened to and understood, whatever form the feedback takes. This feedback could be in the form of compliments and thanks, comments, concerns, complaints, or completion of satisfaction surveys. We have a duty then, once we have listened and understood, to focus on these experiences and make improvements (lessons learned) based on patients own views and concerns.

The quarterly Governance Report includes examples of lessons learned and reflects divisional reporting of local complaints.

Description of Complaint	Actions	Learning
Division: WCSS Patient received telephone call from the hospital telling her that INR was 1.8 when it was in fact 3.0. This was a transcription error that had prompted the call when the mistake was realised. (this was before drugs were prescribed)	Investigation showed: A contributory factor was an interruption that distracted the staff member's attention and broke her concentration. The anticoagulant staff members have been advised to ensure that they complete a task or get to a safe point before stopping to assist with another task. The anticoagulant staff members have also been advised to locate themselves in a quiet area when they are working on tasks requiring concentration. A copy holder has been provided. This has a ruler that allows the operator to line up the patient's name with their INR result.	Improvement needed: staff working practices needed review and reflection. Notable practice: INR recorded prompted pharmacist to ring patient to check possible cause and led to identification of error.

Description of Complaint	Actions	Learning
	Other safety measures out in place were also shared with complainant.	
Division: WCSS: Complaint about father's discharge, in particular about the physiotherapy input that left father without zimmer frame identified as needed. This was acknowledged as an oversight.	Alert was issued to remind all staff that patients must be discharged with appropriate aids. Also, if aids cannot be taken in homeward bound transport, therapy staff must be informed.	Improved discharge planning and update for, ward staff regarding the importance of ensuring MDT input is properly noted and actioned.
Division: Scheduled Care Patient unhappy as she felt that if she had received surgery on her wrist when she first attended AED she would have had a better outcome to how her wrist has healed. She had been left with residual pain and some loss of function. After receiving her response she remained unhappy.	A meeting with the consultant revealed that the patient felt that the initial conservative treatment of her fracture was influenced by her age and/or the fact that she had attended AED on a weekend. This had not been explicit in the original complaint and was not influenced by any incident during her admission, but by her belief/fear that healthcare is ageist and services are less efficient at weekends. The consultant was able to allay these concerns and review all the decisions made. Patient was reassured that treatment plan had been based on clinical issues and appropriate action was taken.	Reinforces the value of meetings with clinical professionals as a way to ensure patients can articulate their concerns and staff have an opportunity to explain care/treatment face to face. Need to offer meetings early on, not as an option at time of return.
Division Scheduled Care: Family raised their concerns around the manner and attitude of a member of nursing staff	Full investigation by Matron Staff member dealt with through trust disciplinary procedure. Letter of apology sent to family	Individual learning for nurse named in complaint. Monitoring and performance management in place.
Division: Unscheduled Care Daughter of elderly lady with Dementia had serious concerns about the infection control practices on ward, including patient information, cross infection, obtaining of samples. Felt that staff had labelled patient as incontinent of urine, when this wasn't the case. Was upset that her mother's mobility was seriously impaired while she was in hospital and that she was	Meeting arranged and senior divisional nurses were able to answer questions and acknowledge some failings. Main grievances were the decision to admit and the length of time before discharge. Some issues with GP care. Complainant felt it inappropriate for optimum care of someone with Dementia. Other issues were not resolved, e.g. eating and drinking. Complainant felt nurses should strongly encourage eating, as she does, but nurses concerned that they would	Feedback to ward staff – asked to reflect on issues raised. Learning needs re: infection control brought to attention of Infection Control Team. Meeting is often best choice of response to discuss complex issues, to build rapport/relationship with complainant and work constructively with dissatisfied service users.

Description of Complaint	Actions	Learning
unable to walk at the time of her discharge. Felt that she was not encouraged to walk and needed appropriate physiotherapy input. Also that patient's age was the reason she was not appropriately mobilised. Unhappy about essential nursing care provided to her mother, including hygiene measures and cleansing and availability of the nurse call buzzer. She felt that staff did not sufficiently encourage patient in eating and drinking. She feels that she needed more persuading and that nursing staff were unwilling to do this.	be put in position of forcing patient to eat. Complainant accepted this. Associate Director for Infection Control was able to discuss infection control issues raised and highlighted training needs for ward. Senior nurses able to discuss care of patients with dementia and recent new initiatives. Provided Health Passport to complainant and twiddle-muff for her mother. Associate Director of Nursing invited complainant to attend divisional meeting to talk about her experiences. Complainant satisfied with outcome and complaint closed.	
Unscheduled Care: Complaint about personal care provided to late mother on Assessment Ward. Complainant waited unacceptably long time after pulling nurse call to attend to mother's soiled bed linen. Was also unhappy with attitudes of nursing staff (Agency nurse and carer) regarding the incident	Assistant Matron had early meeting with complainant. She was able to reassure complainant of her intentions to address the care and attitude concerns raised with the ward and identified planned support by education department for carers on the ward. Meeting with ward team to highlight issues and discuss improving practice and communication. Ward manager addressed issues raised with Carer and Matron referred to NHSP to be addressed with agency nurse.	Reflection for, ward nursing team on respectful and personal care. Improved communication with relatives. Improved support for carers and flagging of any individual and team issues.

As already explained, it was agreed in the last Quality Report that the success of this new team will be measured via a range of outcomes as follows:

Successful implementation of a Patient Information Centre/Patient Experience Hotline

Calls to the Patient Experience Team out of hours are picked up the next working day and responded to appropriately. We trialled the Patient Experience Officers working later hours in order to ensure that if a complainant contacted us beyond 5pm then we could immediately respond. We found that there were very few calls or queries beyond that time, meaning that we looked at alternative ways of making it easier for people to contact us. A new mail inbox named "patient experience" rather

than “complaints” is being launched with the new trust website. This will encourage patient feedback that is positive, as well as queries and questions, and this will be accessed with sufficient frequency to respond in a proactive way. We will revisit some shift working for the Patient Experience Team following the review of the working practices of PALS; this will be during 2014/15.

We have some very exciting future plans for a Patient Information Centre, and these include utilisation of the current membership office as a patient experience “hub” manned by volunteers and containing the PALS office. Development of the volunteer role within the patient experience team is only just beginning, with volunteers involved in taking and logging PALS calls and administering surveys on our wards. A more responsive PALS service provides an outlet for people in need of support to air concerns and this helps to reduce the number of formal complaints received. The PALS model in place at Warrington and Halton Hospitals is increasingly rare in acute trusts, in that there is a named PALS Officer, now supported by Patient Experience Officers, who is highly visible and accessible to patients, families and the public, based in the main entrance of the main hospital site. The plans to develop and enhance this provide an excellent opportunity to strengthen the service.

Improvement in number of formal complaints
Figures for 2013/2014 have shown a 26% reduction in the number of formal complaints.
Total formal complaints handled 2012/13 - 571
Total formal complaints handled 2013/14 - 422
Total concerns handled 2013/2014 – 92

Whenever the Patient Experience Team is able to close a concern without progression to a formal complaint, the workload on divisional and particularly clinical and shop floor staff is significantly reduced. This has also helped to build the confidence of the Patient Experience Officers who are better able to support the PALS function with this experience.

Improvement in the learning and analysis of themes and trends from complaints, evidenced by reports and to be followed through action planning and monitoring.
There is a need to improve the consistency and quality of action planning and in providing assurance that learning and improvement has happened. More training for staff and support by the divisional teams to ensure those investigating complaints can meet the required standards is required. The divisions are also committed to ensure that the progress and completion of action plans is monitored on the CIRIS system.

Improvements in the Datix system will provide better reporting of themes and trends to support divisional and strategic focus for improvement. This will enable far more timely recognition of poor quality and system issues that are undermining care. For example, for the first time the Pharmacy department will have access to very specific reports about the types of medication issues that patients are complaining about. In the past medication complaints would most likely be assigned under the subject of treatment or care. This will also be the case with nutritional issues, transfer of care, referral and very specifically care associated with mental capacity, end of life care, privacy and dignity. This is all in the spirit of the Francis Report findings and reflects the type of concerns that the media report regularly and that undermine the public confidence in the NHS.

Evidence of CQC compliance with regulations and outcomes
Monitoring of these is included in the new policy and twice yearly audits will be done to monitor compliance. Monthly triangulation meetings ensure that themes and trends across complaints, claims and incidents are tracked and actioned. Quarterly reports of action plans to the Clinical Governance, Quality and Audit Sub Committee will identify good practice and outliers.

Evidence of compliance with the recommendations of the Francis Report
During 2014/15 we will be launching our new quarterly board report, beginning in July 2014. This is intended in response to Mr Francis' recommendation that the board are assured that we have listened to, heard about and learned from the things our complainants tell us. It will also include the quality of complaint responses, standards and performance against targets.

Good LINks reports and external reviews.
As stated MIAA report April 2014 has shown significant improvement in systems and performance. Complaints data and intelligence forms part of the Equality & Diversity System assessments by HealthWatch.

The trust has, in consultation with stakeholders, agreed to maintain complaints management as a quality indicator and also to introduce it as an improvement priority for 2014/2015.

3.4.4. National Surveys Results 2013

Results of the National Surveys inform comprehensive multi-disciplinary action plans focused on these specific areas. The progress of improvements to practice will be monitored throughout the year to ensure that our plan is being successfully implemented.

3.4.4.1. National Inpatient Survey 2013

Listening to patients' views is essential to providing a patient-centred health service. 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.

In 2014/2015 we have selected improvement in low performing indicators from the 2013 In Patient Survey as an improvement priority. We will develop action plans to improve areas where we fall below the national average and have not demonstrated improvement in past two years

3.4.4.2. Inpatient Surveys – National Patient Experience CQUIN

The trust is committed to ensuring a year on year improvement of patient survey responses to how hospitals "patients want to be treated by" improvement in responses to the following 5 key questions:-
(National Patient Experience CQUIN);

- Were you as involved as you wanted to be in discussions about your care?
- Did you find someone to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Were you told about medication side effects to watch out for when you went home?
- Were you told who to contact if you were worried about your condition once you left hospital?

CQUIN Inpatient Survey Questions 2011-2013

National Inpatient Survey Question	2011 Results	2012 Results	2013 Results	Other trusts
1. Were you involved as much as you wanted to be in decisions about your care?	47%	48%	57%	57%
2. Did you find a member of hospital staff to talk to about your worries or fears?	38%	31%	41%	41%
3. Were you given enough privacy when discussing your condition or treatment?	72%	70%	70%	77%
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	38%	43.%	40%	39%
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	64%	71%	76%	72%

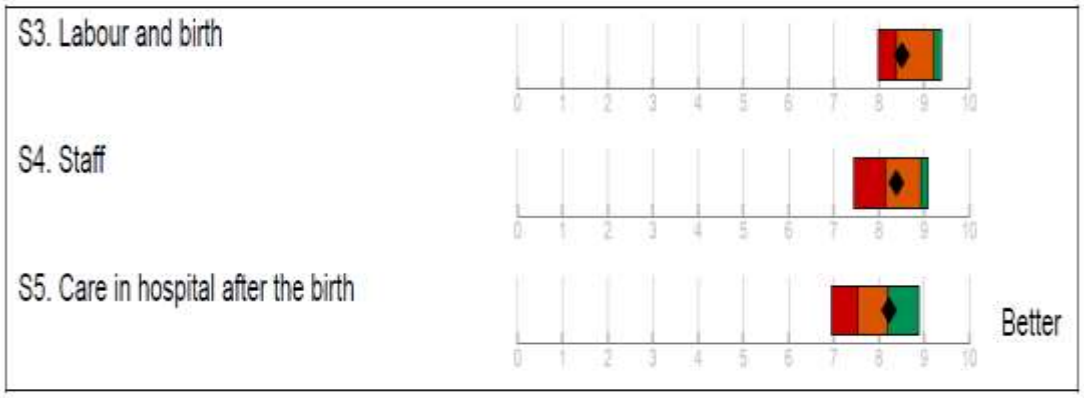
Historically the composite score for the five questions was data was provided to the trust for the CQUIN, however this measure has been suspended so the data is no longer available. Overall the questions with the exception of "Were you given enough privacy when discussing your condition or treatment?" showed that we scored above or equal to other trusts. The above table shows an improved response to three out of five questions.

3.4.4.3. National Maternity Survey 2013

Within the reporting period the trust participated in the 2013 National Maternity Survey which captures data on women's experience of maternity services. The latest publication uses data collected between May and August 2013, from women who gave birth in February 2013. Similar surveys were carried out in 2010 and 2007.

The survey provides information on experience across all three stages of the maternity pathway: before birth (antenatal), during labour and birth, and in the first few weeks after birth (postnatal). For the first time, the 2013 maternity survey provided the opportunity for women to provide free-text comments about their maternity care.

Overall the results were positive showing the trust to be the same as other trusts in managing labour and birth and the quality of staff and better than other trusts in relation to care in hospital after the birth. In relation to post natal care in hospital; breast feeding support and initiation the trust saw a significant improvement in its overall scores in comparison to the 2010 survey. The Maternity Survey report has been reviewed by the division and the department is addressing actions.



3.4.4.4. National Staff Survey 2013

We are pleased to say that the results from the 2013 NHS Staff Survey have been published and have shown an excellent improvement from the previous years in the majority of scores across the trust.

The survey is carried out independently and asks a series of questions to a random sample of 830 staff from across the trust.

In terms of the headline scores:

- We scored above the national average in terms of engaging with staff, with staff ranking the hospital(s) amongst the best 20% in the NHS for being able to contribute towards improvements at work and for staff motivation. We scored 3.80 out of 5 – against a national average of 3.74.
- We scored above the national average for developing staff, support from immediate managers and equality in terms of career progression and development
- Staff experiencing physical violence dropped from 5% in 2012 to 1% in 2013
- The trust also improved its score for staff feeling satisfied with the quality of work and patient care that they deliver.
- Perhaps most importantly, staff recommending the trust as a place to work or receive treatment has risen to be alongside the national average across the NHS.

The trust saw a slight dip in its scores for providing equality and diversity training in the year and for the percentage of staff reporting any errors witnessed in the last month. We still score below the average on health and safety training in the last year – but that's because we have a three year programme for updating health and safety training.

There's been a lot of work in the last year on engaging and communicating with staff and improving health and wellbeing across the trust and the trust is delighted to see the positive scores in the survey. People were at the centre of our QPS framework and the trust is committed to working towards further improvements in staff engagement.

3.4.5. Patient Opinion

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 Patient Opinion website or can post comments on Patient 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 the trust is currently achieving a four star rating based on 87 reviews. Users are also asked to rate aspects of the service as follows:-

Service	Number of ratings	Star rating
Cleanliness	80	
Staff Co-operation	81	
Dignity and Respect	80	
Involvement in decisions	78	
Same-sex accommodation	60	

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.

This quality indicator will support the Complaints Management improvement priority and will be reported in the Quality Report 2014/2015.

3.4.6 Friends and Family

The NHS Friends and Family Test is a new 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.

The trust sends the forms to iWantGreatCare to analyse and report on our results on a monthly basis. Patients also the option of leaving a response online at: http://warrington-halton.iwgc.net 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 two ratings

which are reported through to the board via the Quality Dashboard. The first rating is a star rating to a maximum of 5 stars and the second is the Net Promoter score up to a maximum of 100. The results for 2013/2014 are as follows:-

Friends and Family Ratings 2013/2014

Month	Star Rating	Net Promoter
April	4.7	76
May	4.7	72
June	4.7	73
July	4.7	70
August	4.5	58
September	4.5	59
October	4.6	63
November	4.6	60
December	4.5	56
January	4.6	61
February	4.66	69
March	4.61	65

NB I Want Great Care includes maternity F&F ratings from October 2013

The ratings are published on both NHS Choices and in the Open and Honest publication which is published on the NHS England trust websites.

The Friends and Family Test is also a national CQUIN aimed at increasing the combined response rate from Accident and Emergency and Inpatient wards from 15% in quarter 1 to 20% or over by the 31st March 2014. This CQUIN also required that Friends and Family was rolled out to maternity services. The trust struggled to achieve the required combined 15% response rate by the end of quarter one but following a review of systems has consistently achieved a combined response in excess of 20% since quarter two. The rollout to maternity services was successfully achieved within the required timescales. Family and Friends will remain a national CQUIN for 2014/2015 in order to roll it out to other departments; increase the overall response rate and improve the net promoter scores.

3.5. Maternity Unit

The Maternity Unit received funding of £450k from the Department of Health for an upgrade to the facilities within the Delivery Suite. The refurbished Delivery Suite opened in the Summer of 2013, the unit now has ensuite facilities in every room and has two birthing pools in its Active Birthing Suite. Ward C23 was also refurbished to include an Induction of Labour Bay. Funding was also made available to update the Bereavement Suite within the Maternity Unit.

The Maternity Unit has its own Facebook page which is very popular with women and holds regular live question and answer sessions.

Midwifery staff now provide a range of complementary therapies which include: aromatherapy; hypnobirthing and pregnancy yoga which is held at the Village Hotel in Warrington. These complementary therapies are also proving to be popular and are fully booked for months in advance.

Our Maternity Services continue to provide the best possible care to mothers and families during pregnancy and childbirth. In March 2014 we put steps in place offer extra monitoring for our women in labour, which has attracted some media attention. The monitoring offer has been in place in response to a small trend of lower birth weights and women presenting with other risks such as decreased fetal movement, which have caused higher risks for some babies in the later stages of pregnancy and labour.

We have identified an increased number of intrapartum events (i.e. issues in labour) over the last 12 months which have been investigated or are currently being investigated. In all instances we have requested external peer review from other maternity units so we can use their independent findings to improve practice. Each individual case has been reviewed very carefully to understand whether there was anything that could have been done differently at any stage in the pregnancy or labour to have prevented the tragic outcomes. These reviews have not shown any causal link between the different cases and have shown that overall we have a very safe service. However because we have seen this small cluster, we have also invited the Royal College of Obstetricians and Gynaecologists to come and carry out an overarching review for us which will take place over the coming weeks."

The Maternity Unit will be implementing GROW which is a personalised system of measuring fetal growth, in June 2014 and all midwifery staff have been trained to use the GROW charts. The department is also reviewing the risk assessment processes and policies.

3.6 Safety Conference – October 2013.

The trusts first Safety Conference a major event aimed at all staff across our hospitals was held in October 2013. The conference which was attended by over one hundred delegates provided a platform to look in detail at a serious patient safety incident, subsequent lessons learned and the work the trust has done to improve safety, comply with the latest national standards and to look at where we are, where we want to be and importantly how all staff could contribute to making improvements. The day included a mix of keynote national and local speakers; interactive workshops and marketplace events. The day included a mix of keynote national and local speakers; interactive workshops and marketplace events.

Mel Pickup (CEO) opened the conference by reflecting on her own experiences of both positive and negative aspects of healthcare. This was followed by a presentation about the serious patient safety incident at this trust where we identified our failings and described the lessons that had been learned following this failure to provide safe care. This was followed by a range of sessions including Duty of Candour; Transparency in Care; NHS Safety Culture; Organisational Approaches to Patient Safety; Reducing Mortality and Leadership for Safety. The marketplace events included stands on Busting the Myth: SHMI and HSMR; Managing the Deteriorating Patient; National Early Warning Score System and Governance Systems and Processes to Provide Assurance. Over half of the delegates completed the evaluation forms stating that the sessions were engaging; excellent and thought provoking. Overall this was an extremely successful event which will be held again in October 2014.

3.7 Speak out Safely (SOS).

Warrington & Halton NHS Trust signed up to this new Nursing Times campaign in September 2013. The trust is committed to supporting every member of staff in feeling able to raise concerns about wrongdoing or poor practice when they see it and confident that their concerns will be addressed in a constructive way. It is about our commitment to acting when staff, identify a genuine patient safety concern and our duty to patients.

The trust sees patient safety as our prime concern and that staff are often best placed to identify where care may be falling below the standard our patients deserve. In order to ensure our high standards continue to be met, we want every member of our staff to feel able to raise concerns with their line manager, or another member of the management team. We want everyone in the organisation to feel able to highlight wrongdoing or poor practice when they see it and confident that their concerns will be addressed in a constructive way.

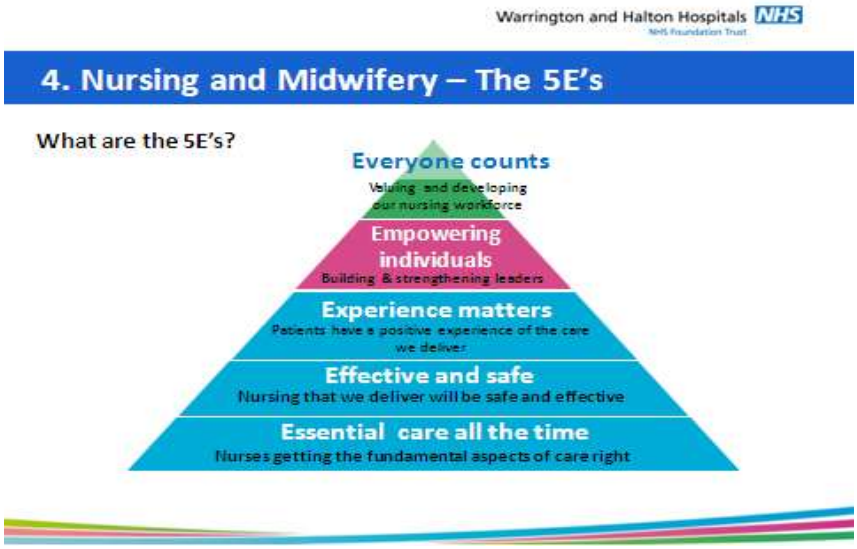
Importantly it is vital that the trust creates a culture in which staff will be supported if they speak up about genuine concerns, and patients need to know that you and the board will act on these

concerns. The trust also has a Whistleblowing Policy which provides a clear process for reporting concerns.

3.8 Nursing Strategy launch – 5 E's (3 year strategy).

During 2013/2014 the trust launched its new strategy for Nursing and Midwifery which describes how we will deliver high quality safe healthcare provided in quality environments in a timely and responsive manner and maintaining compassionate and respectful care.

It draws together the various initiatives to deliver a clear plan of how the nurses and midwives will work to achieve this. The strategy introduces the concept of the 5E's which is our vision on what nursing and midwifery means and how we want nurses and midwives to represent the trust.
The 5E's are:-



3.9 Performance against Key National Priorities (see table below)

Mar-14

Governance Risk Rating - (Monitor) 2013/14

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Level One - National Targets		Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Clostridium Difficile	Hospital Acquired (Cumulative Qtr1: 5, Qtr2: 10, Qtr3: 14, Qtr4: 19)	19	1.0 **	5	4	3	12	0	1	1	2	4	2	4	10	4	1	2	7
	Total			6	6	4	16	3	4	1	7	8	4	5	17	8	3	5	16
MRSA Bacteraemia - (Hospital Acquired Target)		0	1.0 **	1	0	0	1	0	0	1	1								
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)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.00%	99.00%	100.00%	100.00%	100.00%	100.00%
	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:62-day wait for First treatment	From Urgent GP Referral for Suspected Cancer **(Open Exeter Position)**	>85%	1.0 (Failure for either = failure against the overall target)	87.95%	88.12%	86.89%	88.29%	85.00%	86.89%	86.00%	85.96%	92.00%	85.10%	90.90%	89.80%	85.71%	89.61%	93.06%	89.74%
	From NHS Cancer Screening Service Referral	>90%		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%
Referral to treatment waiting time	Admitted patients	90%	1.0	90.93%	91.01%	91.41%	91.03%	91.19%	91.02%	90.52%	90.92%	91.70%	91.34%	93.29%	92.06%	92.44%	92.81%	93.37%	92.62%
	Non-admitted patients	95%	1.0	98.04%	97.76%	98.17%	97.99%	97.69%	97.96%	97.77%	97.80%	98.07%	97.78%	97.28%	97.72%	97.26%	98.06%	97.97%	97.65%
	Incomplete Pathways	92%	1.0	92.13%	92.11%	92.46%	92.23%	92.81%	92.41%	92.94%	92.71%	93.31%	93.45%	93.72%	93.49%	94.09%	94.40%	94.66%	94.25%

Level Two - Minimum Standards		Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	0.5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.00%	100.00%	100.00%	97.00%	98.00%	98.50%	99.00%	98.50%	98.50%	98.67%
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)	96.40%	95.60%	95.58%	95.00%	95.81%	95.20%	94.52%	95.18%	93.00%	95.40%	94.40%	94.20%	93.15%	94.02%	96.31%	94.49%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		97.70%	96.30%	95.60%	96.00%	94.62%	93.00%	93.98%	94.00%	93.85%	95.54%	97.99%	96.50%	93.55%	93.00%	93.4%	93.32%
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	93.65%	96.34%	98.03%	96.03%	95.09%	95.29%	95.64%	95.33%	95.23%	94.77%	95.61%	95.20%	94.09%	96.21%	96.96%	95.68%
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

Other Indicators	Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Risk of, or actual, failure to deliver commissioner requested services	N/A	4.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC compliance action outstanding	N/A	Special	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

Referral To Date First Seen	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%	failure against the overall target)	97.70%	96.30%	95.60%	96.00%	94.62%	93.00%	93.98%	94.00%	93.85%	95.54%	97.99%	96.50%	93.55%	93.00%	93.4%	93.32%
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	93.65%	96.34%	98.03%	96.03%	95.09%	95.29%	95.64%	95.33%	95.23%	94.77%	95.61%	95.20%	94.09%	96.21%	96.96%	95.68%
Failure to comply with requirements regarding access to healthcare for people with a learning disability		N/A	1.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

Other Indicators	Target	Weighting	Apr-13	May-13	Jun-13	QTR-1	Jul-13	Aug-13	Sep-13	QTR-2	Oct-13	Nov-13	Dec-13	QTR-3	Jan-14	Feb-14	Mar-14	QTR-4
Risk of, or actual, failure to deliver commissioner requested services	N/A	4.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC compliance action outstanding	N/A	Special	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement action within last 12 months	N/A	Special	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement notice currently in effect	N/A	4.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Moderate CQC concerns or impacts regarding the safety of healthcare provision	N/A	Special	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Major CQC concerns or impacts regarding the safety of healthcare provision	N/A	2.0	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A	Special	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Overall Governance Risk Rating **Total Points 0 - 0.9 Green, 1 - 1.9 Amber-Green, 2 - 4 Amber-Red, 4 or above Red)**			2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	2.0	1.0	1.0	2.0	1.0	1.0	1.0

Additional Notes:

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 Compliance 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 & MRSA Bacteraemia**
Monitor's annual de minimis limit for cases of MRSA reflecting a governance concern is set at 6. the de minimis for C-Diff is set at 12.
See table below for the circumstances in which we will score NHS foundation trusts for breaches of the MRSA objective.
Monitor will assess NHS foundation trusts for breaches of the C. difficile and MRSA objectives against their objectives 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 (and a red rating will be applicable)

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.

3.10. 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 with section 4.1.

3.11. Training & Appraisal

Training and Appraisal Completion

	Target	**Year End Results**
Mandatory Training Health & Safety Fire Safety Manual Handling	 85% 85% 85%	 88% 75% 75%
Additional Fire Safety and Manual Handling sessions are in place to improve these figures.		
Staff Appraisal Non-medical Medical & Dental Consultants Medical & Dental – consultants and career grades (excluding junior doctors)	 85% 100% 100%	 69% 85% 77%

Each division and professional group 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.

3.12 Quality Report request for External Assurance

Warrington and Halton NHS FT has requested the trust auditors PWC 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:

1. C. difficile; - Number of Clostridium difficile (C. difficile) infections, as defined below, for patients aged two or over on the date the specimen was taken.
Data definition - A C. difficile infection is defined as a case where the patient shows clinical symptoms of C. difficile infection, and using the local trust C. difficile infections diagnostic algorithm (in line with Department of Health guidance), is assessed as a positive case. Positive diagnosis on the same patient more than 28 days apart should be reported as separate infections, irrespective of the number of specimens taken in the intervening period, or where they were taken.
Acute provider trusts are accountable for all C. difficile infection cases for which the trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one).

2. Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers; Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.
Denominator - Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).
Numerator - Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).
3. Pressure Ulcers (local) - The indicator is the total number of grade 3 or 4 pressure ulcers that are hospital attributable. The indicator is restricted to in-patients only. Pressure ulcers that are present on patients on admission are deemed community attributable

In undertaking their tests for mandated indicators, auditors will need to document the systems used to produce the specified indicators, perform a walkthrough of the system to gain an understanding of the data collection process, and then test the indicators substantively back to supporting documentation to gain assurance over the six dimensions of data quality. The auditor will provide a report on its findings and recommendations for improvements on this indicator to the board of directors and the council of governors of the trust.

3.13. Quality Report amendments post submission for 3rd Party Commentary

Overview of the Outcomes of Governor Observation Visits to Wards July 2013 and September 2013 section (4.7.1) was removed from Quality Report on the 23rd April and replaced with a Summary of Governor Observation Visits for 2013/2014.
The Quality Report (V5) stated the trust reported two Never Events however the incident reported in February was reviewed via trust governance processes and because the patient did not suffer permanent harm this incident does not fit the criteria for a Never Event and was therefore removed.
Pressure Ulcer (3.2.2) removed community pressure ulcer data only related to quarters 1 & 2.
Participation in Research and Development (2.2.3) included 29th April 2014.
Clinical Audit and National Confidential Enquiries (2.2.2) included 29th April 2014.
Falls section (3.2.3) additional paragraph inserted.
Mortality (3.3.1) inserted.
SHMI (2.1.17) data inserted.
High Level Quality Care (3.3.6) updated.
Complaints section (3.4.3) updated with narrative and activity for 2013/2014.
Trust Data Quality (2.2.6) inserted.
Quality Dashboard inserted
Governance Risk Rating inserted
Training and Appraisal (3.10) inserted.
Advancing Quality data inserted (3.3.4)

Typographical error in the final paragraph of the Introduction - Quality People and Sustainability on page 10 of the Quality Report which originally stated deficit of 31.5m but should read £1.5m.
CQUIN Framework (2.2.4) statement inserted and table updated.
Governors Statement on QR (4.7) inserted and later modified 20th May 2014.
Trust request for External Assurance (3.11) inserted.
Maternity Unit (3.5) inserted.
Patient Safety Incidents (2.3.8) supporting narrative inserted.
Pressure Ulcer definition providing clarity between avoidable and unavoidable.
Warrington CCG statement inserted.
Cancer 62 day wait – annual data inserted.
HSMR & SHMI updated data inserted.
CQUIN table – minor amendment to table.

Quality Report Part 4 – Statements

Statements from Clinical Commissioning Groups, Healthwatch and Overview and Scrutiny Committees

Statements from the following stakeholders are presented within this document unedited by the trust and are produced verbatim.

4.1. Statement from Warrington Clinical Commissioning Group

NHS
Warrington
Clinical Commissioning Group

☎ 01925 843690
Please Ask For: John Wharton
John.wharton@warringtonccg.nhs.uk

Arpley House
110 Birchwood Boulevard
Millennium Park
Birchwood
Warrington
WA3 7QH

Tel: 01925 843690
PA: Sam Lowe

Samantha.lowe@warringtonccg.nhs.uk
www.warringtonccg.nhs.uk

21st May 2014

Karen Dawber
Director of Nursing
Warrington & Halton Hospitals Foundation Trust
Lovely Lane
Warrington
WA51QG

Dear Karen

Re: Quality Account 2013-2014

Many thanks for the submission of the Quality Account for 2013-2014, and for the presentation to local stakeholders with the Local Area Team. This letter provides the response from Warrington CCG to your Quality Account.

The account affirms the work that is being carried out by the trust and which is regularly discussed through the mechanisms which we have in place; contract monitoring, the established strong focus on quality and the rigorous SUI process are all contributory factors to ensure that both commissioner and provider are working collaboratively to improve care and agree appropriate actions and monitoring when the patient experience has not been to the standard we all aspire too. I believe that these forums have built on our relationship and cemented our united approach to delivering high standards of health care to the local population.

Warrington CCG welcomes the work delivered by the Trust in relation to improving patient care for the local population and wishes to continue the healthy relationship that we have for future planning of health care delivery. We also wish to congratulate you for the impressive work which you have carried out, particularly in the area of reducing pressure ulcers and your continued focus on improving the care of patients with dementia.

Warrington CCG welcomes the confident feedback which you received from your Care Quality Commission (CQC) unannounced visit in the latter part of last year. Our own hospital walkabouts with the trust have also proved highly advantageous to provide assurance to board members and lay representation. The inclusion of your planned Quality Priorities for 2014/15, particularly regarding the planned monitoring and reporting of Always Events and Ward Quality is also most welcome.

I conclude by informing you that we are looking forward to working with the Trust throughout 2014/15, helping to improve the quality and delivery of services for the local population and ensuring that the provider is working towards delivering the three key domains of the CCG'S quality strategy safety, effectiveness and experience remain at the heart of health care provision.

I believe that this is an accurate and honest account of your organisation and wish to congratulate you on your work.

Yours sincerely,

John Wharton
Chief Nurse & Quality Lead
Warrington Clinical Commissioning Group

4.2. 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 2014

Our Ref: QA/WHHFT/14

Karen Dawber
Director of Nursing
Warrington & Halton Hospitals Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Dear Karen

Re: Quality Account 2013-2014

Many thanks for the submission of the Quality Account for 2013-2014, and for the presentation to local stakeholders on 6th May 2014. This letter provides the response from NHS Halton CCG to the Quality Account.

Although the CCG has been a fully authorised body for just 12 months, we have, I believe had a good working relationship prior to authorisation and since. NHS Halton CCG is a member of the Contract Quality Group, which scrutinises the key quality indictors in the Quality Schedule and CQUINs in partnership with Warrington CCG, who are the co-ordinating commissioner; these are proving to be both effective and useful. The Clinical Focus Group meetings are working well and the ability to maintain links to your clinicians has been very useful.

NHS Halton CCG welcomes the work delivered by the Trust in relation to improving care for patients with Dementia, and congratulates you on your success in this area. The CCG notes the delivery against your planned improvements target, and in particular the delivery of the reduction in Pressure Ulcers and Medicines Related incidents against your internal stretch targets. NHS Halton CCG is also pleased to note the delivery against the commissioner quality priorities and would like to commend the trust on its progress in relation to visible clinical leadership.

NHS Halton CCG notes that the Trust has received very positive feedback from the Care Quality Commission in relation to the unannounced inspection during September 2013. The CCG are also pleased to see the planned Quality Priorities for 2014/2015, in particular the planned monitoring and reporting of Always Events, Ward Quality

NHS
Halton Clinical Commissioning Group

First Floor
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We look forward to working with the Trust throughout 2014/15, helping to improve the quality of services for our patients through the NHS contractual mechanisms and the review and management of Serious Incidents, applying good governance and ensuring lessons are learnt throughout the Trust

Jan Snoddon
Chief Nurse/Quality Lead
NHS Halton CCG

Email: jan.snoddon@haltonccg.nhs.uk

4.3. Statement from the Halton Health Policy Performance Board

HALTON BOROUGH COUNCIL

Ms M Pickup
Chief Executive
Warrington Hospital
Lovely Lane
Warrington
Cheshire, WA5 1QG

Our Ref EST

If you telephone please ask for Emma Sutton-Thompson

Your ref

Date 19th May 2014

E-mail address Emma.Sutton-Thompson @halton.gov.uk

Dear Ms Pickup,

Warrington and Halton Hospitals NHS Foundation Trust Quality Accounts 2014

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 6th May that your colleagues Alison Lynch and Hannah Grey 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 2013/14 the Trust identified a number of priorities to be achieved during this year. The Board noted the following:

- *Zero tolerance to hospital acquired MRSA bloodstream infections* - Trust has reported 3 cases of hospital acquired MRSA bloodstream infection, compared to 1 case in 2012/13. Although this is an increase, the Board notes the initiatives that have been implemented to work towards zero tolerance.

- *Clostridium difficile* – the Trust reported 31 cases of hospital acquired Clostridium difficile infections against a threshold of 19 compared to 19 cases against a trajectory of 40 for 2012/2013.

- *Reduction in grade 2-4 pressure ulcers* – the Trust reported a 72% reduction in grade 3 pressure ulcers and 33% reduction in the incidence of grade 2 pressure ulcers. Whilst these percentage reductions are good, the Board would still like to see the actual number of cases reduced further.

- *Reduction in medication errors related to insulin* - The Board is pleased to note that the Trust reduced insulin incidents by 10.5% from 57 cases to 51 cases and therefore exceeded your trajectory of a 5% reduction thus achieving this improvement priority for 2013/2014.

It's all happening IN HALTON
Communities Directorate
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
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HALTON
BOROUGH COUNCIL

The Board are pleased to note the following Improvement Priorities for 2014 – 2015:

- *Complaints* - To improve the percentage of complaints responded to within timescales agreed with the patient.
- *Falls* - Establish a 10% reduction for falls resulting in moderate - catastrophic harm.
- *In-Patient Survey* - improvement in low performing indicators - Develop action plans to improve low performing areas that relate to the inpatient episode of care and where we fall below the national average and have not demonstrated improvement in past two years
- *Pressure Ulcer Reduction* - The Trust continues to implement its planned programme of actions to further reduce pressure ulcers which includes:-
  - Review of the Trust Policy on pressure ulcers is in progress, with particular reference to the process by which we investigate Grade 3/4 pressure ulcers.
  - Root cause analysis is conducted on all Grade 3/4 pressure ulcers which develop within the trust;
  - Mini investigations of all grade 2 hospital acquired pressure ulcers
- *Advancing Quality (AQ) measures* – Stroke and Pneumonia - Work streams to increase compliance with stroke and pneumonia measures to improve patient outcomes.

The Board would like to thank Warrington and Halton Hospitals NHS Foundation Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

E. L. Sutton Thompson

pp **Councillor Ellen Cargill**
Chair, Health Policy and Performance Board

4.4. Statement from Warrington LINk

– Statement from Warrington LINk was requested on 17th April 2014, however a response was not available at date of publication.

4.5 Statement from Warrington Health and Well Being Overview and Scrutiny Committee – Statement from Warrington Health and Well Being Overview and Scrutiny Committee was requested on 17th April 2014, however a response was not available at date of publication.

4.6 Statement from the Halton Healthwatch

Healthwatch Halton
Sefton House
Public Hall Street
Runcorn
Cheshire WA7 1NG
Tel 01928 592405

Email: info@healthwatchhalton.co.uk
Web: www.healthwatchhalton.co.uk

Healthwatch Halton's Statement

for the Quality Account

of Warrington & Halton Hospitals NHS Foundation Trust 2013-14

"*Healthwatch Halton thanks the Trust for the opportunity to comment on the Quality Account for the year 2013-14.*

It is a well prepared report and the Trust should be complimented on this, however, for members of the public, Healthwatch Halton would appreciate a succinct executive summary with clear statements of future priorities and a 'traffic-light' system to measure the progress of last year's priorities.

Members welcomed the continued improvements in addressing the priorities set for the year. Hospital acquired infections such as MRSA and C.difficile have been reduced considerably and members are pleased to note that the Trust will continue to monitor this closely.

Through having a Healthwatch representative on the Patients' Experience Group, we have been able to keep the Healthwatch Manangement Committee up to date on issues within the Trust. Healthwatch members have also valued the opportunities to take part in the PLACE visits at the hospitals.

We welcome the governors' report on the outcomes of their unannounced observation visits.

We recognise the efforts of the Trust to engage with key stakeholders during the past year and we appreciate that feedback from a variety of sources informed the priority choices for 2014-15, however, we feel that some of the goals lack definition.

We hope that on-going meaningful dialogue with patients, carers and the wider community will help the Trust ensure their priorities are achieved."

4.7 Statement from the Trust's Council of Governors

Statement from the Trust's Council of Governors 2013/2014

Q1 Do the priorities reflect those of the population the Trust serves?

Governors think this is true. We 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. Due to the dedication, commitment and hard work of staff, our hospitals continue to enjoy an excellent reputation within our communities. Each year targets are agreed with the hospital's Governors and staff should be congratulated for continuing to achieve many of the improvement targets.

The Quality Report highlights the Trust's focus in reducing the risk of patients acquiring a pressure ulcer or experiencing a serious fall during their stay in hospital. During the last year the risk to patients of acquiring a Grade 2 pressure ulcer was reduced by 33%. The Accident and Emergency department exceeded the national target for seeing 95% or more patients within four hours. The care and treatment of patients who experience dementia is outstanding and targets for treating people who have a heart attack, heart failure, hip and knee surgery have been exceeded.

The Summary Hospital level Mortality Indicator (SHMI) and Hospital Standardised Mortality Rates (HSMR) rates continue to improve and demonstrate that the Trust is being effective in reducing the rates. These improvements show that there is an increased vigilance and drive amongst the Trust's medical and nursing staff to further improve patient care and patient safety.

The likelihood of acquiring a hospital infection has reduced significantly during the last five years. The Governors were disappointed to see a slight increase in the number of cases of MRSA and C.difficile during 2013/2014. Every effort is made to ensure these infections are not passed from one patient to another. We also appreciate this is a problem, not only for our Trust, but for most Trusts in the North West.

Many of the key performance indicators show a successful year with improvements in many areas. In a year of considerable financial pressure and having to make substantial savings through a year on year Cost Improvement Programme, it is a tribute to the management of the Trust and all the staff that these improvements have taken place.

Q2 Are there any important issues missed in the Quality Report

We believe most significant issues have been addressed. The Quality Report is very detailed and thorough and assists the Governors in holding the Board to account. They provide comprehensive information detailing patient's views of the care and treatment they have received. More data has become available during 2013/2014 to enable Governors to monitor patient and staff experiences in the Trust. The Friends and Family Test was introduced in April 2013. The CQUIN Inpatient Survey shows year on year improvements in the positive comments the Trust receives from inpatients. The percentage of staff who would recommend the Trust to friends and family needing care increased in the last year.

The Trust had prioritised complaints as an area where improvements were required and this year has recorded a reduction in them. There is further work to do and Governors are pleased to note that this area has again been included in the Trust's priorities for 2014/2015.

The Trust now participates in the NHS England initiative Open and Honest Care; Driving Improvements. This has further increased the level of accountability and public scrutiny. It is now possible to compare the performance of our Trust in areas of patient safety and patient care with other Trusts in our local area and in the region.

Once a month Governors undertake a Ward Observation Visit. These visits have been welcomed by staff, patients and their relatives. Governors are able to receive first hand assurances that the hospital wards are clean and that the correct procedures for infection control are being used and patients are provided with privacy and dignity. We ask patients for their views about the quality of the nursing and medical care they receive. The visits have provided Governors with an understanding of how hospital wards function and the high standard of medical and nursing care demanded by our patients and the hospital's inspectors the Care Quality Commission (CQC).

Q3 Has the Trust demonstrated that it has involved patients and the public in the production of the Quality Report?

Public, Partner and Staff Governors, Halton and Warrington Health Watch and local authority staff, have been fully involved in discussing the content of the Quality Report during workshops and in the bi monthly and dedicated meetings of Governor's Quality in Care Committee. Focus groups have been introduced for the first time this year and the use of online surveys have taken place to find out the views of the Trust members. Member engagement across the Trust's catchment areas has increased with Trust staff and Governors talking to members in GP practices, town centre shopping areas, outpatient clinics and at large events such as the Hospital's Open Day and Warrington Disability Day.

Governors have actively sought to engage with patients and contribute to a process of improving services. Discharge is an important part of the patient experience. Governors feel this service should be periodically reviewed to ensure patients experience a safe, timely and effective discharge. Governors have involved former inpatients in surveys and spoken to them in a focus group to find out how they think the discharge process could be improved.

Outpatient services are provided at both hospital sites and for most patients it is their first contact with the Trust. Governors have spoken to many outpatients and received suggestions about how the service could be improved. Their comments have been passed on to the Trust for consideration. Carers play a crucial role in supporting many patients during their time in hospital and after they leave. Governors have worked with unpaid carers, hospital staff and local Carers' Centres to develop a Carer Strategy for the Trust.

During the last year Governors have supported measures to improve member, patient and staff feedback and encouraged the Trust to take action on what they have to say about services and the way they are delivered.

The Quality Report shows the Trust is in the process of implementing innovations around delivery of recruitment and training. This is to be welcomed. Governors are aware that the rates for staff receiving mandatory training, in particular, fire safety and manual handling, need to increase.

The Governors were pleased to see an improvement in the number of medical and dental staff receiving an annual appraisal during the last year. We are satisfied that plans are in place to increase the number of non-medical staff receiving an annual appraisal. Governors believe the Trust's staff are its most valuable asset and without their commitment and continual personal development it would not be able to deliver safe, high quality, compassionate care to its patients.

Q4 Is the Quality Report clearly presented for patients and the public?
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. We 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 in their Quality in Care Committee have contributed their views on many aspects of the quality of services provided by our hospitals and endorsed the continued effort to improve the readability and appearance of the Quality Report. Governors encourage all Trust members and others who are interested in our hospitals and their performance to read the Quality Report.

4.7.1. Report on Governor ward observation visits - Ward Inspections 2013/2014

Background and the way we conduct each ward observation visit.

Governor led ward observation visits began in October 2011. They were initiated by the then Lead Governor in consultation with the Director of Nursing. This has led to a broadening of the role of the Governors in this trust. A small team of Governors has been established to undertake the visits and report their findings. A timetable for monthly ward observation visits has been agreed and they will continue until December 2014.

The visits are designed to provide assurance to the Trust's Governors that the best possible standard of medical and nursing care is provided to patients in our hospitals. The Governors use a checklist developed by the Care Quality Commission (CQC). This acts as a guide in assisting the Governors to assess the standard of care being provided. The team undertaking the visits usually consist of 3 to 5 Governors.

The visits usually take place between 11.30am and 2.00pm. A check is made of the display boards outside the wards. These contain important information about whether any patients on the ward have recently had a fall, experienced a pressure ulcer, whether there had been a delayed discharge and what the level of staff sickness is on the ward was . Every visit is unannounced. If a ward has not been visited in the previous 12 months it is likely to be selected.

During 2012/2013 the focus of the visits was on wards specialising in elderly care. In 2013/2014 the focus has been on all adult general medical wards at Warrington Hospital. Due to the innovative nature of the work taking place with patients who have dementia they also visited the ward that specialises in the care and treatment of patients with this condition.

At the end of a ward visit the Governors meet and compose a report detailing all aspects of the visit. A copy of the report is provided to the Director of Nursing and Organisational Development, the Associate Director of Nursing, Quality and Patient Safety, Chief Operations Officer and Deputy Chief Executive. A copy is forwarded to the Care Quality Commission. The Governor's Quality in Care Committee meeting every two months is provided with a copy of the report and has an opportunity to discuss it.

Environment

Overall the Governors found the wards to be busy and active areas. The main corridor in each ward contains the ward clerks, doctors and allied medical professionals such as occupational therapists, physiotherapists and the nursing managers and nursing staff. It contains storerooms, patient toilets and bathrooms and provides access to the bays and side rooms where the patients are located. The buzzer lights indicating a patient requires attention also are located in this area. The team have been present at shift changes and have observed handover meetings between nursing staff. Information about patients and the care they require is communicated between outgoing teams and ingoing teams.

The areas containing the nurse's station were free of clutter and are bright and well illuminated. On one ward the Governors saw the Friends and Family Test score sheet proudly displayed for patients and visitors to see. The ward that specialises in dementia care has drawings of local landmarks displayed and a Warrington Transport Bus Stop.

Staff

In 2013/2014 Governors began to talk to various members of staff on the wards about their roles. This has been very informative and has helped in the understanding of how the wards are managed and the pressures which staff may experience. For example Governors now fully appreciate the role of the housekeeper in the smooth running of the wards. They check that the ward equipment is serviceable and check and order stock in the storerooms. They ensure that the buzzers are working and have been observed serving lunch and taking patients to the toilet. During their visits Governors have met occupational therapists and physiotherapists who ensure patients are mobile and get them out of bed and help them to walk and exercise. Governors have spoken to health care assistants, ward clerks and ward managers who have described what they do to help their ward run smoothly, how their wards are staffed, how beds are allocated and how patient care is managed.

Leadership on the wards is crucial and Governors are pleased to report they have seen many examples of outstanding teamwork.

Governors pay particular attention to the interaction between the nursing, medical staff and the patients. First names are always used and they have never witnessed a member of staff using an inappropriate term when communicating with a patient. Patient name and information is displayed above their bed and this information indicates whether they are at a high risk of a fall or have dementia.

Some staff, on the wards, point out to the Governors items of equipment that may be faulty or changes which would improve patient care or the appearance of the ward. Their views are always included in the Governor's report on the ward visit. In many instances this has led to the staff suggestions being implemented and the improvements being made.

Privacy and Dignity

Governors observe whether the curtains around the patient's bed are fully drawn when a doctor or personal care is required. They listen to and observe how patients are spoken to. They record if patients are appropriately dressed and whether they have they been washed, their hair combed and the men shaved. No concerns have been reported in this area. All patients were presentable and treated with respect and their dignity maintained. For example on a visit to one ward they observed a disorientated patient removing an item of clothing which was promptly dealt with by the nursing staff.

Infection Control

Governors check that staff wash their hands and they wear gloves and aprons when in direct contact with patients. At the end of each bed there may be a hand sanitizer bottle. They check that all medical support staff, health care assistants and nurses use the hand gel when they move from patient to patient. Patients are issued with hand wipes prior to being provided with lunch.

The areas of concern the Governors have reported is occasionally they have observed some doctors wearing long sleeve garments. Patients, on some occasions, have not been asked if they wanted to go to the toilet and be offered hand wipes prior to a meal being served. On

rare occasions Governors have observed equipment, such as a blood pressure cuff and a finger oxygen monitor, has not been cleansed when used on different patients.

Medication

Usually after lunch has been served and cleared away some patients are administered with their medication. Governors will watch the administration of medicines and check that water is available and assistance is provided should it be required.

Each bay has a locked medicine cupboard and Governors observe if checks are made on the identity of the patient before certain medicines are administered.

The team have observed diabetic patients having their blood sugar levels taken and then being advised to reduce/increase their sugar levels.

Some patients have commented to Governors, during their visit, on the level of medication they have been provided with and the regularity they receive it. Their view is the frequency of administering medicine is a decision of the doctors and they will not comment on this area. Some patients have praised the hospital staff for reducing the medication provided by their GP. Governors have not observed any practices in the administration of medicine which have caused concern.

Food

Most patients were found to have been satisfied with the food provided. Occasionally the food ordered in the morning is not what some patients wanted for lunch. Every effort was made to accommodate the patient's wishes and find an alternative. Red trays were provided to indicate that a patient could not feed themselves and required assistance. On one ward, food for an Asian patient, was brought in by a member of his family.

Many patients were coaxed and encouraged to eat and drink. Health care assistants and nursing support were always on hand to offer assistance where it was required. Many staff used this interaction as an opportunity to talk to the patients, sometimes about their family situation or their hobbies. In these situations the Governors have seen considerable care, attention and compassion being provided to patients.

Cleaning

A check is always made on the cleanliness of the patient toilet areas, bathrooms and the length of the emergency cords. The team check behind lockers for dust and whether spillages and items on floors are promptly cleared up.

At no time, in the last year, have they voiced concern about the standard of cleaning. All the wards have dedicated domestic staff. They work tirelessly to maintain a high level of cleanliness. The bathrooms, toilets, floors and all patient areas have been spotlessly clean. Spillages are promptly cleaned up and the floors around patient's beds clear of trip hazards or fallen items. Many domestic staff, in addition to the health care assistants, were observed multi-tasking and assist with the serving of tea and coffee to patients (and occasionally to visiting Governors).

Patients

Patient care should be of the highest standard. The Governors always ask the patients about their views of the health care they are provided with. They ask patients about the food they

are given and the noise levels on the wards during the day and at night. They ask about the nursing and medical care they receive and whether they are satisfied with how they are being treated.
All the patients the Governors have spoken to have praised the nursing care very highly. They all comment on their level of commitment and how hard everybody works. Doctors and other health professionals were also highly praised for their attention to detail and sensitive approach to dealing with the patients in their care. Patients felt they had received information about their condition and the treatment they were being given.

Only on one occasion did we feel ward staff were working under pressure and required additional assistance. On two occasions a patient commented about the level of noise during the night. This was on an acute medical ward where some patients required treatment which disturbed others who were trying to sleep. The patient's comments were reported to the appropriate members of staff.

On a positive note Governors have heard many comments from patients who have used other hospitals. One diabetic patient said he preferred Warrington Hospital to Leighton Hospital. A resident of Liverpool, when taken ill, asked the ambulance to bring him to Warrington Hospital in preference to any Liverpool hospital.

Conclusion
The ward observation visits have become an important part of the role of a Governor. They are designed to provide the trust's Governors with an assurance that patients from Warrington and Halton are being provided with the best possible care. In publishing this report Governors are able to assure the trust's members, staff and their patients that they believe this to be the case. Their findings, during the numerous visits, have been confirmed by a recent unannounced visit by the Care Quality Commission (CQC) to some of the same wards that Governors visited during 2013/2014.

The Governor visits to the wards have helped them to understand how they are managed and the roles of various staff. It demonstrates to the many patients and staff that their trust's Governors not only attend committees but want to see and hear for themselves what it is like to be a patient in Warrington Hospital and Halton Hospital.
At the end of March 2014 23 ward observation visits will have taken place. In 2013/2014 the wards visited were A1, A2, A3, A4, A6, A7, B14, B18, B19 and the Intensive Care Unit (ICU).

Annex: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.

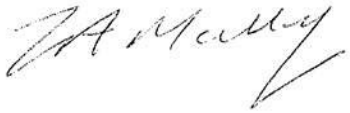
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report. In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/2014;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes for the period April 2013 to April 2014
  - Papers relating to Quality reported to the Board over the period April 2013 to April 2014;
  - Feedback from the Commissioners, Halton Clinical Commissioning Group (CCG) dated 21/05/2014 and Warrington CCG dated 21/05/2014;
  - Feedback from Governors dated 12/05/2014;
  - Feedback from local Healthwatch organisations, namely Healthwatch Halton, dated 20/05/2014;
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/05/2014;
  - Feedback from other stakeholders involved in the sign-off of the Quality Report, namely Halton Health Policy Performance Board dated 19/05/2014**;**
  - The 2013 national patient survey;
  - The 2013 national staff survey;
  - Care Quality Commission quality and risk profiles dated 31/05/2013;
  - Intelligent Monitoring Reports dated 13/03/2014 and 21/10/2013;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 30/04/2014;
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-

nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

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



Mel Pickup
Chief Executive

Allan Massey
Chairman

28th May 2013

Independent Auditor's Limited Assurance Report to the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Warrington & Halton Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Warrington & Halton Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	***Specified indicators criteria*** (exact Section where criteria can be found in the Quality Report)
Rate of Clostridium Difficile infection	Section 3.12
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Section 3.12

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "*Detailed requirements for quality reports 2013/14*" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "*Detailed requirements for quality reports 2013/14*";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2013/14 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, 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 the following documents:

- Board minutes for the period April 2013 to April 2014
- Papers relating to Quality reported to the Board over the period April 2013 to April 2014;
- Feedback from the Commissioners, Halton Clinical Commissioning Group (CCG) dated 21/05/2014 and Warrington CCG dated 21/05/2014;
- Feedback from Governors dated 12/05/2014;
- Feedback from local Healthwatch organisations, namely Healthwatch Halton, dated 20/05/2014;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/05/2014;
- Feedback from other stakeholders involved in the sign-off of the Quality Report, namely Halton Health Policy Performance Board dated 19/05/2014**;**
- The 2013 national patient survey;
- The 2013 national staff survey;
- Care Quality Commission quality and risk profiles dated 31/05/2013;
- Intelligent Monitoring Reports dated 13/03/2014 and 21/10/2013;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 30/04/2014;
- CQC Inspection reports, for inspections carried out on 28/01/2014 (Warrington) and 01/10/2013 (Halton);
- The trust's quarterly Governance Statements dated 31/07/2013 (Q1), 30/10/2013 (Q2), 29/01/2014 (Q3) and 30/04/2014 (Q4); and
- The trust's 2013/14 Annual Governance Statement.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Warrington & Halton Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Warrington & Halton Hospitals 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 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Warrington & Halton Hospitals NHS Foundation Trust for our work or this report save 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 '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:

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2013/14";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Criteria referred to above.

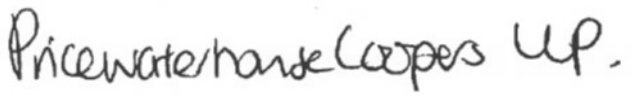
The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Warrington & Halton Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2014,

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "*Detailed requirements for quality reports 2013/14*";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the *"2013/14 Detailed guidance for external assurance on quality reports"*.



PricewaterhouseCoopers LLP
Chartered Accountants
Manchester
29/05/2014

The maintenance and integrity of the Warrington & Halton Hospitals NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Appendix

Glossary

Appraisal	method by which the job performance of an employee is evaluated
Bariatric surgery	(weight loss surgery) includes a variety of procedures performed on people who are obese.
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.
Dr Foster	is a provider of healthcare information and benchmarking solutions to enable healthcare organisations to benchmark and monitor performance against key indicators of quality and efficiency.
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?"**
Governance risk rating	MONITOR **publish two risk ratings for each NHS foundation trust, on:** Governance (rated red, amber-red, amber-green or green); and Finance (rated 1-5, where 1 represents the highest risk and 5 the lowest).
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 (HSMR)	is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.
Information governance	ensures necessary safeguards for, and appropriate use of, patient and personal information.
Making every contact count (MECC)	is about using every opportunity to talk to individuals about improving their health and well being
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
Monitor	assess NHS trusts for foundation trust status and license foundation trusts to ensure they are well-led, in terms of both quality and finances
MRSA	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
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.
National inpatient survey	collects feedback on the experiences of over 64,500 people, who were admitted to an NHS hospital in 2012.
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)	leads 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.
NNHS 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 produce and publish 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 casemix.
Riddor	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
Secondary users services (SUS)	The Secondary Uses Service is the single, comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services
Safety thermometer	is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
Subarachnoid haemorrhage (SAH)	Subarachnoid haemorrhage is a leakage of blood beneath the arachnoid membrane of the brain, from a major blood vessel. It affects a person suddenly and usually without any prior warning.
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).

Engaging with our membership and the public.

Over 13,000 local people are now members of our hospitals as part of our foundation trust membership scheme.

Over the last year we have changed our focus from recruitment of members to engaging and communicating with them. We believe our members should be ambassadors for the trust – helping us plan changes, being involved in service design and being fully aware of the plans and challenges that face us.

During 2013-2014 our governors and membership support team attended events at GP practices and community centres across the region – promoting our services and receiving feedback from the public. In February 2014 we also carried out our third annual membership strategy, seeking views on our operational plan. Results and feedback are used by our governors to look at topics they want to focus on in the year. The 250 plus public responses have led to work looking at outpatient services for the coming year, following on from a focus on discharge in 2013.

In line with recommendations from the Francis Report, we have widened our engagement work to non-members by making surveys and our membership magazine Your Hospitals accessible to everyone through our website and social media.

Over 600 foundation trust members and members of the public attended our annual family open day and members' meeting in September 2013 to learn more about our services, engage with our staff (the children's services team are pictured above) and take part in a range of fun community activities. We also took the opportunity to re-launch our trust charitable fund at the event - with a focus on fundraising in areas of key interest to our members.

6.Members

As an NHS Foundation Trust, Warrington and Halton Hospitals has a membership scheme that means that local people (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. This section gives more detail of our membership and work to involve our members and sustain our membership this year.

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 following sixteen public constituencies:

Halton

- Public 1 – Daresbury, Windmill Hill, Norton North, Castlefield
- Public 2 – Beechwood, Mersey, Heath, Grange
- Public 3 – Norton South, Halton Brook, Halton Lea
- Public 4 – Appleton, Farnworth, Hough Green, Halton View, Birchfield
- Public 5 – Broadheath, Ditton, Hale, Kingsway, Riverside

Warrington

- Public 6 – Lymm, Grappenhall, Thelwall
- Public 7 – Appleton, Stockton Heath, Hatton, Stretton and Walton
- Public 8 – Penketh and Cuerdley, Great Sankey North, Great Sankey South
- Public 9 – Culcheth, Glazebury and Croft, Poulton North
- Public 10 – Latchford East, Latchford West, Poulton South
- Public 11 - Bewsey and Whitecross, Fairfield and Howley
- Public 12 – Poplars and Hulme, Orford
- Public 13 – Birchwood, Rixton and Woolston
- Public 14 – Burtonwood and Winwick, Whittle Hall, Westbrook

Surrounding areas

- Public 15 – North Mersey
- Public 16 – South Mersey

Eligibility for membership is explained in detail on the Foundation Trust section of our website and in the trust's constitution. Membership is available to any individual aged 16 years and over who lives in the constituency areas above. The constitution states that there is a requirement for a minimum of 65 members in each of our constituencies. The trust has met this requirement since authorisation as an NHS Foundation Trust.

The North Mersey and South Mersey areas take in the geographic areas around our core catchment areas of Warrington, Runcorn and Widnes and allow for representation of patients who travel to the hospitals from these areas.

We also have out of area members who are able to join the trust but who fall outside our core areas. The majority of these members are former staff members who have moved away from the area but who wished to become affiliate members of the trust to keep in touch with developments.

The **staff constituency** is divided into 5 classes:

- Medical
- Nursing and Midwifery
- Support
- Clinical Scientist or Allied Health Professional
- Estates, Administrative and Managerial

Staff employed by Warrington and Halton Hospitals NHS Foundation Trust automatically become Staff Members unless they choose to opt-out of the membership. Since becoming an NHS Foundation Trust on 1st December 2008, a total of three staff members have opted out of membership.

Membership Size and Movements 1st April 2013 to 31st March 2014

Our total membership at 31st March 2014 was 17,443. This was in line with our predicted total membership advised in the Trust's membership strategy.

The membership size and movement in year and our predicted membership figures for 2013-2014

Membership size and movement

Total membership at 31st March 2014 = 17,443

Public constituency	Last year (2013/14)	Next year (estimated)(2014/15)
At year start (April 1)	12,948	13,056
New members	496	690
Members leaving	388	1,249 (check this figure)
At year end (March 31)	**13,056**	**12,497**
Staff constituency	**Last year (2013/14)**	**Next year (estimated)(2014/15)**
At year start (April 1)	3,923	4,045
New members	412	471
Members leaving	290	471
At year end (March 31)	**4,045**	**4,045**
Affiliate members	**Last year (2013/14)**	**Next year (estimated)(2014/15)**
At year start (April 1)	306	342
New members	36	10
Members leaving	0	45
At year end (March 31)	**342**	**307**

Analysis of current membership

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	31	4,187
17-21	469	19,787
22 +	12,201	240,322
Not stated on form	355	N/A
Ethnicity:		
White	12,708	256,624
Mixed	59	1,888
Asian or Asian British	205	4,492
Black or Black British	26	798
Other	19	494
Not stated on form	39	N/A
Socio-economic groupings:		
AB	1,750	51,451
C1	5,773	64,883
C2	4,351	36,736
DE	985	84,178
Unknown	197	27,048
Gender analysis		
Male	4,600	129,194
Female	8,456	135,102
Affiliate Members	**Number of members**	**Eligible membership**
Age (years):		
0-16	20	N/A
17-21	4	N/A
22 +	318	N/A
Not stated on form	0	N/A

Summary of membership strategy and steps and work in year to recruit and involve members

The trust recruited 496 new Public Members over the course of the year. 2013-2014 was the trust's fifth full year as an NHS Foundation Trust and our focus was on maintaining the public members figure of 12,900 with sustainable recruitment at a low cost to the Trust.

During the year the membership strategy *Active Community Engagement,* originally developed by the Communications and Membership Committee (CAMC) in 2010, was completed. A new three-year strategy called *Making Membership Work* was developed and sets out a range of activities to further develop the engagement of the membership at the hospitals and support engagement between members, their governors and the wider public.

The trust's public membership target was 12,900 (4% of the eligible public population) which was achieved in 2012. Part of the new membership strategy was to reduce overall recruitment and focus on the engagement of members and the public. However, if public membership figures fell to 12,000 the trust would re-commence recruitment activities to ensure numbers were achieved.

There was also a focus on ensuring that the membership was balanced and representative of the local population. The trust ran a range of recruitment events at local major events and at GP practices to target the under-represented areas of the membership – mainly in terms of geographic representations, but also by age and gender. Examples of this work included targeting recruitment at GP practices in constituencies with lower membership numbers. The trust also worked together with various organisations including local colleges to encourage younger people to get involved.

Changes in membership numbers over last twelve months

Alongside the recruitment of new members there were changes to the membership figures. The numbers of public members leaving the membership was as expected this year.

This was mainly due to a number of deceased members who have been removed from the membership as part of the regular audits that we have carried out to ensure our membership list is up to date and accurate during the year. This also removes any duplicate members. We have a system of double checking our data through both our database providers (Capita) and the mail house we use for mailshots to ensure as far as we possibly can that we do not mail to members who have passed away.

There were also a number of 'gone away' members who either moved from the area or who could not be located at their original address following our audits before mailings (where we run checks on the database) and returned mailings of our regular hospital newsletter.

We expect the staff membership to be reflective of the general turnover of staff.

Predicted Changes in membership numbers over the next twelve months

We expect that the public membership figures will drop slightly over the year in line with the membership strategy due to less recruitment, more engagement and a further cleanse of the data.

Key Developments in 2013-2014 included:

Recruitment

- Partnership working links with local colleges to attract more 17-21 year old members to join the trust. There will be continued focus on this during 2014-2015.

- Further recruitment and events staged with GP surgeries to help further the balance of representative membership.

- The Communications and Membership Committee (CAMC) began work on an outreach presentation programme in January 2014 whereby governors are actively contacting and visiting community and voluntary groups to promote the services at the trust, recruit members and engage in propgrammes of work. The visits would commence in spring 2014.

Communications

- Continuation of the **Your Hospitals** magazine that is sent directly to every Public Member by post or email and contains membership information, articles on key health topics from our clinical staff and general hospital news. The communications and membership committee agreed to reduce frequency of the publication from quarterly to three times a year.

- The continuation of our members **Your Health Events** - where our clinicians present topics of interest to members in the form of lectures, talks, workshops and tours. We staged five events in 2013-2014 ranging from presentations by the Ophthalmology team and Bowel Cancer team through to a tour of the Cheshire and Merseyside Treatment Centre.

- Our third hospital family **Open day** was organised for members and their families in September at Warrington Hospital to find out about what goes on at the trust, get some useful advice and attend departmental tours. The open day event will take place at Halton in 2014.

Involvement

- Our **discharge membership survey** was distributed to all members in April 2013 and focused on current issues around discharge after feedback was generated from our first focus group held the previous January. The results of the survey has helped the trust to highlight were improvements can be made with regard to our future plans and strategy and have been fed into the Annual Plan for 2014/15.

- Members were encouraged to help develop the trusts values by participating in the 'We need a word' campaign in December 2013.

- Members, the public and staff were given an opportunity to have their say on what the trust's priorities are for the forthcoming year through the **annual plan survey** in

February 2014. The information generated from the results of the survey have helped the trust assess what is most important to members with regard to our future plans and strategy.

How to contact your Governors

Governors for the trust can be contacted through our Membership Office. We have a dedicated Membership Office in the main entrance area at Warrington Hospital.

Messages are passed on directly to Governors and general enquiries from members can also be addressed to the Membership Office.

The contact details for the Membership Office are:

Warrington and Halton Hospitals NHS Foundation Trust
Membership Office
Warrington Hospital
Lovely Lane
Warrington WA5 1QG

Telephone – 01925 664222
E-Mail – foundation@whh.nhs.uk

Forget Me Not – our focus on dementia care.

A key clinical focus for the trust in 2013-2014 has been to make improvements for the care of patients using our services who have dementia. It's an area that we want to become leaders in.

In 2013 we were delighted to receive £1 million from the Department of Health to create a specialist ward at Warrington Hospital for patients with dementia that will transform care for local patients. The new ward was due to open in May 2014 and allows the hospital to focus specialist staff in one place to care for the increased needs of the patients. It will provide care for patients who come in with a range of medical conditions, but who have dementia.

The design provides a calming and relaxing environment for their care using state of the art design principles, use of colour and light. Artwork has been specially created for the ward working with a patient champion throughout the design and construction. Alongside the ward accommodation, a new garden area has been created that is especially designed for these patients to provide relaxation and stimulation.

The trust has been leading a range of work to improve care for patients with dementia. A Forget-Me-Not campaign was launched earlier in 2013-2014. It has led to a range of staff training alongside public awareness of dementia and recruitment of volunteers who can spend time with patients and even provide items that can stimulate patients. This has included 'twiddlemuff' knitting – creating a woolen band that items can be attached to, providing stimulation and something that can occupy a patient. One of the physical signs of dementia is agitation of the hands and fingers.

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7.Council of Governors

The Council of Governors holds the trust to account to the membership and the wider public communities that we serve.

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

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

From 1st April 2013 the makeup of the partner governors changed as a consequence of requirements arising from the Health and Social Care Act 2012 and following a review undertaken by the board in consultation with the council.

The board and council agreed that following the review the number of partner governors would be reduced from 9 to 6 and that the partner governor organisations who appoint them would change to reflect the trust's engagement strategy.

Public Governors

Public governors are elected by the trust's public membership. The public membership has been divided into areas based on the electoral wards for Warrington and Halton and includes two additional areas that cover areas outside the electoral wards; these include North and South Mersey. Public members within the electoral areas are able to vote during an electoral process on the person they wish to represent them as a governor of the trust. There are certain requirement that a governor is required to comply with before they can become a governor, one of which is that are only eligible to be a governor of the area they reside. This means that when a governor election is undertaken, members of an electoral area can only vote for a governor who also resides in the same electoral area. The trust has grouped together the electoral wards in Warrington, Widnes and Runcorn and outside the area.

The lead governor is Alf Clemo and is the point of contact between Monitor and the council, in circumstances only where it would be inappropriate for Monitor to contact the chair.

Full biographies and details on the tenure of office for each governor is available on the trust website www.warringtonandhaltonhospitals.nhs.uk. During the year the Public Governors of the trust were:

Halton area Public Governors

- Daresbury, Windmill Hill, Norton North, Castlefields – **Iris Keating**
- Beechwood, Mersey, Heath, Grange – **Vacant** (Desmond Keogh from 1 December 2013 until resignation on 20 March 2014; Doreen Shotton until 1st December 2013)
- Norton South, Halton Brook, Halton Lea – **David Trowbridge**

- Appleton, Farnworth, Hough Green, Halton View, Birchfield – **Roy Radley**
- Broadheath, Ditton, Hale, Kingsway, Riverside – **Dora Buff** (elected 1st December 2013)

Warrington area Public Governors

- Lymm, Grappenhall and Thelwall – **Charles Coughlan**
- Appleton, Stockton Heath, Hatton, Stretton and Walton – **Vacant** (Helen Reay until 30th November 2013)
- Culcheth, Glazebury and Croft, Poulton North – **Paul Campbell**
- Penketh and Cuerdley, Great Sankey North, Great Sankey South – **Peter Harvey**
- Latchford East, Latchford West, Poulton South – **Carole Astley**
- Bewsey and Whitecross, Fairfield and Howley – **Jean Ann Pownall**
- Poplars and Hulme, Orford – **Alfred Clemo**
- Birchwood, Rixton and Woolston – **David Ellis** (re-elected 1st December 2013)
- Burtonwood and Winwick, Whittle Hall, Westbrook – **Allan Ralston** (elected on 1st December 2013, replacing Michael Ashley who left the position on [ ] September 2013)

Surrounding area Public Governors

- North Mersey –**Vacant** (Joe Davies until 12th April 2013)
- South Mersey – **Peter Folwell** (replaced Janet Walker on 1st December 2013 following election)

Staff Governors

Staff Governors represent the trust's staff on the Council and will bring their own knowledge and skills from working in the organisation. There are five Staff governors representing the main five staff groups at the trust. Staff automatically become a member of the trust at the commencement of their employment. Staff can, if they wish, choose to opt out of being a member of the trust.

- Medical – **Dr Deb Mandal**
- Nursing and Midwifery – **Gaynor O'Brien** (elected 1st December 2013)
- Support - **Sue Bennett**
- Clinical Scientist or Allied Health Professionals – **Louise Cowell** (replaced Carol Over 27th January 2014 following election)
- Estates, Admin and Managerial – **Andree Jane Birch**

Partner Governors

The trust's partner governors are nominated by key local partnership organisations that work closely with the trust. They bring their knowledge and experience to the Council and help the trust to work in partnership with the community. During the year the partner organisations and governors were:

- Warrington Borough Council - **Cllr Pat Wright**
- Halton Borough Council – **Cllr Sue Edge**
- University of Chester – **Peter Harrop**
- Warrington Wolves Foundation – **Neil Kelly**
- Warrington Voluntary Action – **Alison Cullen**
- Halton Voluntary Sector represented by Halton & St Helens Voluntary and Community Action - V**acant**

Governor elections in year

The trust public and staff governor elections are carried out by Electoral Reform Services and the returning officer is John Box. The close of polls for the elections was 21st November 2013 and the reports from the contested elections by constituency are shown below.

- Four Public Governor seats were contested with more than one candidate standing. These areas were:
  - Beechwood, Mersey, Heath, Grange
  - Broadheath, Ditton, Hale, Kingsway, Riverside
  - Burtonwood, Winwick, Whittlehall, Westbrook
  - South Mersey
- One Public Governor seat was uncontested with one candidate standing. The area was:
  - Birchwood, Rixton, Woolston
- One Staff Governor seat was contested with more than one candidate standing. The area was:
  - Staff Class D: Clinical Scientist and Allied Health Professionals
- One Staff Governor seat was uncontested with one candidate standing. The area was:
  - Staff Class B: Nursing and Midwifery

Reports from the contested elections by constituency

Date of Election	Constituencies Involved	No of Members in Consituency	No of Seats Contested	Number of Contestants	Election Turnout %
21/11/2013	Public - Beechwood, Mersey, Heath, Grange	973	1	2	16.9%
21/11/2013	Public - Broadheath, Ditton, Hale, Kingsway, Riverside	542	1	2	13.7%
21/11/2013	Public - Burtonwood, Winwick, Whittlehall, Westbrook	650	1	3	20.8%
21/11/2013	Public - South Mersey	937	1	2	17.2%
27/01/2014	Staff Class D: Clinical Scientist and Allied Health Professional	595	1	2	14.8%

(1) The voting part of the election for Staff Class D: Clinical Scientist and Allied Health Professionals election was re run due to discrepancies found in data whilst conducting the original election.

Work is underway in the early part of 2014-2015 to run elections for the vacant two public seats of:

- Appleton, Stockton Heath, Hatton, Stretton, Walton
- North Mersey

Role of the Council of Governors

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

- holding 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.

Council of Governors' meetings and attendance

The constitution outlines the requirement that the Council would meet at least four times a year including the Annual Members Meeting. However, after reviewing the meeting structure in 2010 the Council agreed to meet six times a year (excluding the Annual Members Meeting) to better facilitate business. Agenda and minutes from the Council meetings are available on the Trust website www.warringtonandhaltonhospitals.nhs.uk

Between 1st April 2013 and 31st March 2014 the Council of Governors' met formally on six occasions. The following tables provide the attendance at each Council of Governors meeting held in public by Governor. The meetings were also attended by Executive and Non-Executive Directors.

Public Governors' attendance at Council of Governors' meeting

Name/Constituency	30th May 2013	25th July 2013	26th September 2013	28th November 2013	30th January 2014	27th March 2014
Daresbury, Windmill Hill, Norton North, Castlefields Iris Keating	●	●	●	●	-	●
Beechwood, Mersey, Heath, Grange Position Vacant (Des Keogh from 1 December 2014 until 20 March 2014, Doreen Shotton up to 30th November 2013)	●	●	●	●	-	-
Norton South, Halton Brook, Halton Lea David Trowbridge	●	●	●	●	●	●
Appleton, Farnworth, Hough Green, Halton View, Birchfield Roy Radley	●	-	●	-	●	●
Broadheath, Ditton, Hale, Kingsway, Riverside Dora Buff (Vacant up to 30th November 2013)	-	-	-	-	-	-
Lymm, Grappenhall, Thelwall Charles Coughlan	-	-	-	●	●	●
Appleton, Stockton Heath, Hatton, Stretton and Walton Position Vacant (Helen Reay up to 30th November 2013)	●	●	●	●	-	-
Culcheth, Glazebury and Croft, Poulton North Paul Campbell	●	●	●	●	●	●
Penketh and Cuerdley, Great Sankey North, Great Sankey South Peter Harvey	●	●	●	●	●	-

Latchford East, Latchford West, Poulton South Carol Astley	●	●	●	-	●	●
Bewsey and Whitecross, Fairfield and Howley Jean Pownall	●	●	●	●	●	●
Poplars and Hulme, Orford Alfred Clemo	●	●	●	●	●	-
Birchwood, Rixton and Woolston David Ellis	-	●	●	●	●	●
Burtonwood and Winwick, Whittle Hall, Westbrook Allan Ralston (Michael Ashley until [ ] September 2014, position vacant up to 30th November 2013)	-	-	-	-	-	●
North Mersey Position Vacant	-	-	-	-	-	-
South Mersey Peter Folwell (Janet Walker up to 30th November 2013)	●	●	●	●	●	●

Staff Governors' attendance at Council of Governors' meeting

Name/Constituency	30th May 2013	25th July 2013	26th September 2013	28th November 2013	30th January 2014	27th March 2014
Medical Staff Deb Mandal	-	●	●	●	-	-
Nursing and Midwifery Gaynor O'Brien	-	-	-	-	●	-
Support Staff Sue Bennett	●	-	-	●	●	-
Clinical Scientist or Allied Health Professionals Louise Cowell	●	●	-	●	●	●
Estates, Admin and Managerial Andree Jane Birch	●	●	-	-	●	-

Partner Governors' attendance at Council of Governors' meeting

Name/Constituency	30th May 2013	25th July 2013	26th September 2013	28th November 2013	30th January 2014	27th March 2014
Warrington Borough Council Cllr Pat Wright	●	●	●	●	●	●
Halton Borough Council Cllr Sue Edge	-	-	-	-	-	-
Warrington Wolves Charitable Foundation Neil Kelly	●	●	-	●	●	-
University of Chester Prof Peter Harrop	-	-	-	●	●	-
Warrington Voluntary Action Alison Cullen	●	●	●	-	-	●
Halton and St Helens Voluntary & Community Action Vacant	-	-	-	-	-	-

Board members attendance at Council of Governors' meeting

Name/Constituency	30th May 2013	25th July 2013	26th September 2013	28th November 2013	30th January 2014	27th March 2014
Chairman **Allan Massey**	●	●	●	●	●	●

Chief Executive **Mel Pickup**	-	●	●	●	●	●
Chief Operating Officer/Deputy Chief Executive **Simon Wright**	●	●	●	●	●	●
Director of Nursing & Organisational Development **Karen Dawber**	●	-	●	-	●	●
Director of Finance/Deputy Chief Executive **Jonathan Stephens** (until 31st May 2013)	●	-	-	-	-	-
Acting Director of Finance **Steve Barrow** (from 1st June 2013 until 10th September 2013)	-	●	-	-	-	-
Director of Finance and Commercial Development **Tim Barlow** (from 11th September 2013)	-	-	●	●	●	●
Interim Medical Director **Mark Halliwell** (from 13th May - 31st January 2014)	-	-	●	-	-	
Medical Director Designate **Paul Hughes** (from 1st February 2014)	-	-	-	-	-	-
Director of Information Technology **Jason DaCosta**	●	-	-	●	●	-
Non-Executive Director & Deputy Chair **Allan Mackie** (until 30th June 2013)	●	-	-	-	-	-
Non-Executive Director **Mike Lynch** (from 31st July 2013)	-	●	●	●	●	●
Non-Executive Director & Deputy Chair **Clare Briegal**	●	●	●	●	●	●
Non-Executive Director & Senior Independent Non-Executive Director **Carol Withenshaw**	●	●	●	●	●	●
Non-Executive Director **Lynne Lobley**	●	-	●	-	●	-
Non-Executive Director **Rory Adam**	-	-	●	-	●	-

Governors' Committees and work programme

The council meetings held in public are a small part of the governors' overall work in the trust. governors' have been involved in a range of work, using their experience and expertise to represent the views of members and the public and focus on issues of that impact on the quality of care to patients.

Governor committee structure

In 2013 the council agreed to change the name of the Compliance with Authorisation Committee to the Monitor Quarterly Reporting Compliance Committee as the purpose of the Committee was to assist the Council in the performance of its duties in the provision of assurance of the Trusts quarterly and year-end financial and governance reporting to the trust's regulator.

- **Communications and Membership Committee** - Recommending objectives and strategy for the trust in the development of communication and engagement with members.

- **Monitor Quarterly Reporting Compliance Committee** - Reviewing quarterly finance and corporate performance reports and receipt of the board's quarterly submission to monitor.
- **Quality In Care Committee** – Receiving and reviewing monthly quality dashboards, reviewing the annual quality report and accounts and recommending objectives and strategy for the trust in the development and improvement of the patient and workforce experience.
- **Nominations and Remuneration Committee** – The role of this committee is outlined in more detail in section 8; the remuneration report.

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.warringtonandhaltonhospitals.nhs.uk**.

Other meetings and involvement

Alongside the formal meetings and committees, a wide range 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.

Board meeting observation

In accordance with the requirements of the Health and Social Care Act 2012, board meetings have been held in public since 1st April 2013. Governors, members and the public are able to attend these meetings. A rota of attendance has been established so that governors can attend and observe the board meetings to enable them to fulfil the statutory duty to hold to the non-executive directors, individually, and collectively, to account for the performance of the board. Governors attending the board meeting are able to provide feedback to the council on any matters arising from the board. Further details on board observation can be found in section 4.

Board/Governor Workshops

During the year Governors were involved in a number of workshops to consider the priorities of the trusts annual plan 2014-2019 and consider the priorities of the Quality Report 2014-2015.

Trust Annual Plan 2014/19

In December 2013 the trust held a board to governor workshops to consider the objectives, priorities and strategy of the trusts for the development of the strategic plan 2014-2019. Following the workshop, the council undertook a survey of trust membership and the public to ascertain whether the draft objectives, priorities and strategy identified during the workshop were those that the membership and public felt was appropriate. The council received feedback from the survey that informed the development of the draft annual plan. The council received addition feedback on the development of the plan during January 2014 and March 2014 prior to its submission to Monitor on 4th April 2014.

The Governors were also involved in a workshop during February 2014 with a range of other stakeholders involved including Warrington CCG, Halton CCG, Healthwatch and Warrington and Halton local authorities. The workshop considered the improvement priorities for the trust for 2014/15. The Quality in Care Committee received feedback on the findings of the workshop and considered on behalf of the Council the improvement priorities for 2014/15 and agreed that the local indicator priority for 2014/15 would be grade 3 pressure ulcers. The committee on behalf of the council considers the Quality Report 2013/14 and provides a statement on its appropriateness that is included in the Quality Report.

Governors' ward observation visit programme

During the year the Quality in Care Committee continued the unannounced ward observation visits to observe wards within the trust. This was implemented in 2011 following the publication of the first report on the findings of the Mid Staffordshire NHS Foundation Trust Inquiry. The observation ward visits enable the Governors to observe first-hand the quality of care provided to patients of the trust. Feedback from the observation visits are provided to the Quality in Care Committee who report the findings to the trust management and the Care Quality Committee. Where areas of concern are raised by the observation team, an action plan is developed with and feedback on improvements is reported back to the Quality in Care Committee. The trust is fully supportive of the governors unannounced ward observation visits which provides valuable 'real time' information and feedback of the quality of care provided to patients.

Governors' attendance at organised and supported events

The Governors' continue to support the trust and engage with both the membership and the public across the trust's catchment areas attending events organised by the trust and the governors at GP practices, town centre shopping areas, outpatient clinics and at large events such as the Hospital's Open Day and Warrington Disability Day. Governors have actively sought to engage with patients and contribute to a process of improving services.

8. Remuneration report

The remuneration report outlines appointments and payments made to trust executive and non-executive directors in year.

The Board Nominations and Remuneration Committee

The board Nominations and Remuneration Committee (committee) meets annually, or as required to make decisions regarding the nomination, appointment, remuneration and conditions of service for executive directors including the Chief Executive. 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.

The committee 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.

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 over £50k. 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 trust does not apply performance related pay conditions linked to executive directors' remuneration and no formal policy exists in setting the remuneration of executive directors. However, in undertaking a review of executive directors' remuneration, it takes into account executive directors past performance, future objectives, market conditions and comparable remuneration information from trusts within the locality. The chief executive and executive directors participate in annual performance reviews and appraisals undertaken by the chair and chief executive respectively and individual objectives set are linked to the trust's corporate and strategic objectives.

The membership of the committee comprises of the chair, chief executive (except for matters concerning her own employment and conditions) and all the non-executive directors. During 2013-14, the committee met three times and attendance at the meetings is set out below:

	24 April 2013	16 May 2013	23 May 2013
Allan Massey (Chairman)	✓	✓	✓
Mel Pickup (Chief Executive)	✓	✓	✓
Rory Adam	✓	✓	✓
Carol Withenshaw	✓	✓	✓

Clare Briegal	✓	✓	✓
Allan Mackie (to 1 June 2013)	✓	✓	✓
Lynne Lobley	✓	✓	✓
Mike Lynch (from 31 July 2013)	-	-	-

During the year under review the committee met to discuss the size, composition and remuneration packages of the executive team. The committee approved the amalgamation of the role of Director of Finance and Director of Commercial Development and the amalgamation of the Director of Nursing with the Director of Governance and Organisational Development. The consequential effect of the amalgamations resulted in the size of the executive team reducing from eight to six.

Recalibrating the remuneration of the Director of Finance and Commercial Development to fill the vacancy resulted in a review of the executive directors remuneration in order to address any further loss of executive directors to the market, whilst at the same time extending the notice period of the executive directors from three to six months. The committee in making a decision on the remuneration of the executive directors took into account; the increased responsibility from the amalgamation of roles; market conditions; individuals past performance and affordability. As result of the amalgamation of executive director roles the employee costs for executive directors reduced from £932k in 2012/13 to £785k in 2013/14 (note 4 to the accounts).

With regard to the Chief Executives salary, a review of her salary was to have taken place in 2012, 12 months following her appointment. This did not occur and the salary position for the Chief Executive at the time of the review in May 2013 was considerably lower than counterparts in other local trusts and significantly below the benchmarked national average (information provided by the Foundation Trust Network). The Committee in approving an uplift in the Chief Executive remuneration, agreed to a request from the Chief Executive that her uplift would be implemented in two stages, the first part of the uplift of would be awarded from 1st April 2013 and the balance being awarded from 1 October 2013. The Chief Executive, in view of the trust's financial position arising in the latter part of the year, elected not to take the balance of the uplift from 1 October 2013 and agreed with the Chair that this would be implemented from 1st April 2014.

Following discussions surrounding the size and composition of the executive team and following the board evaluation process the committee agreed to review its role in developing a succession plan of executive directors during 2014-2015.

The committee did not receive any external advice or services.

The Council of Governors Nomination and Remuneration Committee

The Council of Governors Nomination and Remuneration Committee meets annually or as required to recommend to the Council of Governors the nomination of appropriate candidates to the posts of non-executive directors, including the chair and deputy chair. The committee also has responsibility for making recommendations to the Governor's Council as to the remuneration and allowances, and other terms and conditions, of office of non-executive directors and plays a role in the appraisal process of the chairman.

The committee comprises of the Chairman (or deputy chair or failing him the Senior Independent Non-Executive Director when the appointment of the chair or his/her remuneration and allowances/other terms and conditions of office are being discussed), two Public Governors (Doreen Shotton and David Trowbridge), one Staff Governor (Jane Birch) and one Partner Governor (Cllr Pat Wright).

The committee met three times during the year and considered the following:

a) the Chairman's appraisal; and
b) a proposal for the appointment of a non-executive director with clinical or medical science experience at a senior level in an acute or community/social care provider, with ability to constructively challenge current practice.

Attendance at the Committee meeting was as follows:

	24 May 2013	16 July 2013	11 March 2014
Allan Massey (Chairman)	-	✓	✓
Carol Withenshaw (Senior Non-Executive Director)*	✓	✓	-
David Trowbridge	✓	✓	✓
Doreen Shotton (to 30 November 2013)	✓	✓	-
David Ellis (from 30th January 2014)	-	-	✓
Jane Birch	✓	✓	✓
Pat Wright	✓	✓	✓

* The Senior Non-Executive Director chaired the Committee when matters relating to the trust's Chair's appraisal was discussed.

The Chairman's appraisal.

The Committee received an assessment of the Chairman's performance for 2012-2013 from the Senior Non-Executive Director. This had been undertaken during April and May 2013. The performance appraisal took the form of a questionnaire completed by directors and Governors of the trust. The Committee following the appraisal completion of the appraisal process presented the findings to the Council of Governors on the 30 May 2013.

Proposal for the appointment of a non-executive director

The Governors Nominations and Remuneration Committee at its meeting on 15th January 2013 approved an outline proposal for the recruitment and selection of a Non-Executive Director of the trust. The post arises as Allan Mackie would end his term of office on 28 February 2013 and it was agreed not to extend his term of office for a further two years. The Chairman and Chief Executive in consultation with the Board agreed that there was a requirement to complement board with a Non-Executive Director who had a clinical background and who can provide deep challenge on quality, safety and patient experience. As reported in the 2012/13 annual report, the Committee and Council recognised the huge contribution Allan Mackie had provided to the trust in his role as a non-executive director and Deputy Chairman and felt that it was important to note that the decision not to extend the contract was in no way a reflection of his performance as a non-executive and that he was held in great esteem by both Board and Governors.

The Committee noted that due to the timescales involved it may not be possible to complete an appointment process and have in place a non-Executive Director by 28th February 2013. It was therefore agreed to propose to the Council of Governors that Allan Mackie be asked to remain on the Board for a period of 4 months from 28th February 2013. The Council considered and approved the proposals at its meeting on 31st January 2013 and 30th May 2013 together with amendment to the appointment process for the appointment of a Non-Executive Director explained below.

Appointment process adopted for Non-Executive Directors

The Council of Governors approved the process for the appointment of Non-Executive Directors at its meeting on 31st January 2013 which amended the process approved on 15th January 2009.

The Council of Governors, in January 2009, agreed as part of the process the engagement of the Appointments Commission to act as the Council of Governors recruitment advisors for the appointment of Non-Executive Directors. Following the cessation of the Appointments Commission the Council of Governors at its meeting in January 2013 agreed that the role of the Appointments Commission would be performed by an independent recruitment agency and amended the process for the appointment of a Non-Executive Director of the trust. The process is explained below.

The independent recruitment agent worked closely with the Council of Governors Nominations and Remuneration Committee and attended all key stages including briefings, short listings and interviews.

The Council of Governors Nomination and Remuneration Committee agreed the basis on which candidates were assessed based on the qualities and expertise criteria set out in the advertisement and candidate information pack, the competence demonstrated at interview

and the eligibility stated in the candidate information pack and on feedback from the Board of Directors.

The pre-assessment exercise was managed by the independent recruitment agent, applications were assessed against the criteria in the candidate information pack and the advertisement and divided into 3 groups (A, B and C). Group A would consist of candidates who present the strongest evidence against the criteria with Groups B and C demonstrating less evidence of how they met the qualities and expertise required.

The Council of Governors Nomination and Remuneration Committee were provided with a list of strong applications from Group A and a final shortlist of four candidates was identified to attend a formal interview.

The Interviews were conducted by the Council of Governors Nomination and Remuneration Committee supported by the Chairman and the Director of Nursing and Organisational Development and set questions were posed to all candidates to explore the qualities, expertise and competencies outlined in the candidate information pack as requirements for the post.

The Council of Governors Nomination and Remuneration Committee assessed all candidates against the criteria and were fully discussed by the Committee at the conclusion of the interviews. Following completion of assessment documentation for all candidates The Committee made a recommendation to the Council of Governors on the preferred candidate.

The Council of Governors on recommendation from the Council of Governors Nomination and Remuneration Committee approved the appointment of Dr Mike Lynch as the preferred candidate for three years commencing 1 July 2013 at its meeting on 30th May 2013. However, following the ratification Dr Lynch was unable to take up the position until 31 July 2013 due to other commitments. Dr Lynch's appointment therefor commenced from 31 July 2013.

Contractual arrangements for non-executive directors

Name	Contract Commencement date	Contract expiry date	Notice period
Allan Massey	01/12/2004	30/11/2014	Three months
Lynne Lobley	01/12/2009	01/12/2015	Three months
Carol Withenshaw	01/07/2006	30/11/2014	Three months
Allan Mackie	01/03/2005	30/06/2013(1)	-
Rory Adam	01/12/2007	30/11/2014	Three months
Clare Briegal	01/11/2008	30/11/2015(2)	Three months
Dr Mike Lynch	31/07/2013	30/07/2016	Three months

(1) Allan Mackie left the Trust on 30 June 2013.

(2) Due to external commitments Clare Briegal agreed to stand down as a Non-Executive on 30 June 2014 and the Council agreed to extend Carol Withenshaw's appointment as a Non-Executive Director and Senior Independent Non-Executive Director to 30th November 2014.
(3) In line with Monitor's guidance, the terms of office of non-directors appointed to the antecedent NHS Trust are not considered material in the calculation of the length of office served in the Trust.

The trust's executive directors are not employed under fixed term contractual arrangements and are required to give six months' notice under the terms of their employment.

Termination payments payable to executive directors are in accordance with their contract of employment.

Both the employee and employer contribute to the NHS pension scheme and Note 1.4 of the annual accounts provides an explanation of how pension liabilities are treated in the accounts.

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Directors Remuneration - Year ended 31st March 2014 (and comparison year ended 31st March 2013 - audited)

	2013~2014						2012~2013					
	Directors' Salary and fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable benefits (to the nearest £100)	Annual Performance-related Bonuses (in bands of £5,000)	All Pension-related Benefits (bands of £5000)	**Total (bands of £5,000)**	Directors' Salary and fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable benefits (to the nearest £100)	Annual Performance-related Bonuses (in bands of £5,000)	All Pension-related benefits (bands of £5000) (4)	**Total (bands £5,000)**
	£000	£000	£000	£000	£000	**£000**	£000	£000	£000	£000	£000	**£000**
Executive Directors												
Mel Pickup Chief Executive	155-160				65-70	**220-225**	145-150				(25-30)	**115-120**
Dr Phil Cantrell Medical Director Left 13.05.2013 (2)	10-15	10-15		0-5 (1)	5-10	**25-30**	90-95	55-60		35-40 (1)	20-25	**210-215**
Dr Paul Hughes Medical Director Starter 01.02.2014	20-25				5-10	**25-30**						
Karen Dawber Director of Nursing & Organisational Development	110-115				75-80	**185-190**	95-100				(5-10)	**90-95**

Jonathan Stephens Director of Finance Left 31.05.2013	15-20				0-5	**20-25**	110-115				(25-30)	**85-90**
Tim Barlow Director of Finance & Commercial Development Starter 11.09.2013	65-70				25-30	**95-100**						
David Melia Director of Nursing Left 14.01.2013							80-85				(15-20)	**60-65**
Simon Wright Chief Operating Officer	115-120				60-65	**180-185**	105-110				(0-5)	**105-110**
Helen Bourner Director of Commercial & Corporate Development Left 31.03.2013							85-90				55-60	**140-145**
Jason DaCosta Director of Information Technology Starter 14.02.2013	70-75 (3)				145-150	**220-225**	10-15					**10-15**
Interim/acting Executive Directors												
Mr Mark Halliwell Interim Medical Director Starter 14.05.2013 Until 31.01.2014 (2)	20-25	100-105		5-10 (1)	255-260	**385-390**						
Steve Barrow Acting Director of Finance Starter 01.06.2013, Until 10.09.2013 (2)	25-30				40-45	**65-70**						

Chairman and Non-Executive Directors

Allan Massey Chairman	40-45					**40-45**	40-45					**40-45**
Allan Mackie Deputy Chairman & Non-Executive Director Left 30.06.2013	0-5					**0-5**	10-15					**10-15**
Lynne Lobley Non-Executive Director	10-15					**10-15**	10-15					**10-15**
Rory Adams Non-Executive Director	10-15					**10-15**	10-15					**10-15**
Carol Withenshaw Non-Executive Director	10-15					**10-15**	10-15					**10-15**
Clare Briegal Non-Executive Director	10-15					**10-15**	10-15					**10-15**
Dr Mike Lynch Non-Executive Director Starter 31.07.2013 (2)	10-15					**10-15**						

Notes:
(1) Refers to Clinical Excellence Award payments
(2) Refers to time in post as Director
(3) Shown net of recharge to NHS Warrington CCG
(4) Within the NHS Pension Scheme itself the CPI uplift is only applied to non-active members (i.e. deferred members, retired members and those above the contribution age). For active members no inflation uplift is applied and instead the increase in pension entitlement is driven by salary increases and additional years earned. This means that where the actual increase in an individual's pension entitlement during the year is less than the CPI percentage assumed in the calculation (5.2% for 12/13) a negative real pension increase can arise. In practice this would be limited to cases where the individual has a minimal (or nil) salary increase and/or only a few months' contributions (e.g. where they left early in the year). Such a negative real increase could in turn lead to a negative pension related benefit for the year.

Expenses paid to Directors and Governors (unaudited)

The trust is now required to report details of expenses paid to Governors and Directors.

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. The total amount of expenses reimbursed to ten Directors for 2013/14 was £ 6,775 (2012/13 £8,486).

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.

Expenses are only reimbursed on the basis of actual spend with the exception of mileage rate claims and must be supported, where possible, by original receipts. The total amount of expenses reimbursed to nine Governors for 2013/14 was £ 1,332 (2012/13 £1,222).

Pension Entitlements Year ended 31st March 2013 (audited)

Name and title	Real increase in pension at age 60 (bands of £2,500)*	Real increase in pension lump sum at age 60 (bands of £2,500)*	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2013	Real increase in Cash Equivalent Transfer Value*	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£00
Mel Pickup Chief Executive	2.5-5	10-12.5	50-55	155-160	854	755	83	
Dr Phil Cantrell Medical Director Left 13.05.13	0-2.5	0-2.5	50-55	110-115	833	750	8	
Dr Paul Hughes Medical Director Starter 01.02.2014	0-2.5	0-2.5	15-20	5-10	172	148	3	
Karen Dawber Director of Nursing & Organisational Development	2.5-5	10-12.5	25-30	80-85	390	317	66	
Jonathan Stephens Director of Finance Left 31.05.2013	0-2.5	0-2.5	45-50	135-140	772	714	7	
Tim Barlow Director of Finance & Commercial Development Starter 11.09.2013	0-2.5	N/A	10-15	N/A	132	87	24	
Simon Wright Chief Operating Officer & Deputy Chief Executive	2.5-5	10-12.5	20-25	70-75	407	334	65	

Jason DaCosta** Director of Information Technology Starter 14.02.2013	5-7.5	17.5-20	5-10	20-25	163		131	
Mr Mark Halliwell*** Interim Medical Director Starter 14.05.2013 - Until 31.01.2014	10-12.5	35-37.5	50-55	150-155	920	595	226	
Steve Barrow Acting Director of Finance Starter 01.06.2013 Until 10.09.2013	0-2.5	5-7.5	30-35	100-105	579	456	38	

Notes:
* Refers to time in post as Director
** Jason DaCosta re-joined the NHS Pension Scheme in January 2014. Comparative figures are not available as at 31 March 2013. Figures quoted as at 31 March 2014 are not wholly attributable to contributions made during the financial year under review.
*** Mr Mark Halliwell has opted to make additional voluntary contributions to the NHS Pension Scheme.

Explanation of cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

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

Explanation of real increase in cash equivalent transfer values

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

Hutton Narrative (unaudited)

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 2013/14 was £157,500 (2012/13 £187,500).

In 2013/14 the highest-paid director earned 6.9 times (7.9 times in 2012/13) the median remuneration of the workforce, which was £22,903 (£23,787 in 2012/13). The decrease is attributable to the decrease in the remuneration of the highest paid director. As disclosed above, the midpoint of their banded remuneration decreased by £30,000 (£10,000 2012/13). The highest paid director as disclosed in 2012/13 is not the same post as that disclosed for the year under review.

In 2013/14, 28 employees (6 employees in 2012/13) received remuneration in excess of the mid-point of the banded remuneration of the highest-paid director. The salary of the person listed as highest paid director in 2012/13 has been included within the number of employees receiving remuneration in excess of the highest paid director in 2013/14. Remuneration in

excess of the highest-paid director ranged from £158,352 to £235,396 (£188,060 to £249,186 in 2012/13).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and 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 2014.

There were no off-payroll engagements during the year.

Remuneration report signed by:

Mel Pickup
Chief Executive
28th May 2014

9.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 Monitor.

Under the NHS Act 2006, Monitor has directed the trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

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

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

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

Mel Pickup
Chief Executive
28th May 2014

10.Annual governance statement

1. Scope of responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going 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 2014 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Leadership and accountability

The Board of Directors provides leadership on the overall governance agenda. The Quality Governance 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 Quality Governance Committee is chaired by a Non-Executive Director with clinical background and experience and its core membership includes the Executive Directors, the Associate Director of Governance, Divisional Medical Directors, Associate Divisional Directors, Associate Directors of Nursing, he Chief Pharmacist and the Head of Allied Health Professionals. The executive lead for risk management is the Director of Nursing and Organisational Development. The supporting system for managing risk has been delegated to the Associate Director of Governance, bringing together all aspects of the risk management process and governance systems. Additional support is provided to the Trust's risk management systems through designated Governance Managers and audit and governance leads within divisions.

The Trust has kept under review and updated its Risk Management Strategy, the last revision taking place in May 2014. The Risk Management Strategy provides a framework for managing risk across the Trust in line with best practice and Department of Health guidance.

The Strategy clearly describes the process for managing risks and the roles and responsibilities of the Board of Directors, its Committees, including the Quality Governance Committee, Audit Committee, Strategic People Committee and the newly formed Finance and Sustainability Committee, and that of all staff, including the Chief Executive, Executive Directors and managers 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 Board Committees are supported in their role by their reporting committees and groups which includes quality and clinical governance, infection control, safety and risk and information governance and corporate records, all of which form part of the Trust's overall integrated Governance Structure.

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. Corporate Induction has been revised so that all new starters attend the induction before starting work within the Trust within designated wards, departments and specialties. The Corporate Induction is supported by local induction programmes which, together with the Corporate Induction, provide an indicator on the Trust's induction performance and these indicators are reported to the Strategic People Committee and Board of Directors for assurance purposes. 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.

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 Strategic People 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 aligned to root cause analysis is provided and is led by the Associate Director of Governance within the framework of the National Patient Safety Agency (NPSA). The training is underpinned by 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.

Control mechanisms including 'lessons learned'
Incidents, complaints, claims 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. Monthly meetings have been established with key post holders who work closely together, sharing best practice and learning lessons collectively rather than on an individual divisional basis. The Governance Report (incidents, complaints, PALS, Claims, Coroner inquests, external agency, Risk KPIs) is reported to; the Board of Directors; the Quality Governance Committee; the

Clinical Governance, Audit and Quality Sub Committee; the Safety and Risk Sub Committee; Divisional Integrated Governance Groups; and shared with the lead Commissioners as part of the Quality Contract. The Report has continued to receive positive comments to its qualitative and quantitative analysis in addition to Learning and Improvements. Lessons for learning are also disseminated to staff using a variety of methods including:

(i) Safety alerts and Safety Briefings

Safety alerts are circulated to raise 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 form part of Safety Briefings at Shift Handover for clinical staff.

(ii) Revision of policies and changes

The following policies have been revised as a result of the identification of common themes within the contributory factors:

- Incident and Investigation Policy (including duty of candour requirements);
- revision of the Consent to Treatment Policy underpinned by education and training linked to induction and mandatory training programmes which now includes an annual audit;
- claims handling procedure to include analysis and monitoring of claims actions;
- Duty of Candour, Supporting Staff, Analysis Learning and Improvement Patient Identification Policy; and
- Transfer and Discharge including Clinical Handover of Care
- Complaints policy

(iii) Risky Business bi monthly newsletter

The Risky Business bi-monthly Newsletter covers a wide range of topics including health and safety, security, information governance and consent to name but a few. Copies are sent to Commissioners and can be viewed by staff on the Trust's intranet portal.

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), the National Health Service Litigation Authority (NHSLA), and Health and Safety Executive (HSE).

The Trust introduced CIRIS as the integrated governance compliance and monitoring system. The system provides around the clock access to the sources of information should the Trust be subject to both internal and external review. The sources of information includes: Level Two Incident Investigations and action plans; NICE Guidance; Part 1 and 2 Risk Registers; Information Governance Standards and Toolkit; Claims Action Plans; National Confidential Enquiry into Patient Outcome and Deaths (NCEPODs) relevant to the Trust; and the Trust's responses to the recommendations of the Francis Report.

Clinical Effectiveness structures have been strengthened in 2013/2014, with a new role developed and the scope and function of the Clinical Effectiveness Group (CEG) reviewed. One of the functions of CEG, is to monitor mortality ratios and drive progress in reducing mortality. Following a period of a rising HSMR and SHMI at the end of 2012/2013, the Trust has achieved a reduction in both measures and is now within the expected range, with ratios continuing to fall each month towards our goal of 100 or less. The trust has received no mortality outlier alert correspondence from the CQC in new areas since October 2012 and

has assured the CQC that appropriate action has been taken in response to the alerts received to date. The Trust uses the Healthcare Evaluation Data (HED) system to monitor detailed mortality data and wider clinical outcome information; this data is reported to the monthly CEG, which reviews this intelligence and monitors the progress of any associate actions.

In addition, a clinical manual handler trainer post has been created and the management of stress is now a regular agenda item for the Staff and Engagement Wellbeing Group.

During the year the trust achieved level 3 NHSLA for maternity services.

4. The risk and control framework

The risk management framework is set out in the Trust's Risk Management Strategy. The key elements of the strategy include delegated roles and responsibilities in respect of the various elements of the risk management process. Risk Management requires participation, commitment and collaboration from all staff and there is strong focus on training and support given to staff to enable them to fulfil their responsibilities.

There is a robust system in place of risk identification, monitoring and reporting throughout the Trust's corporate departments, its divisions through its Integrated Governance Structure. The Trust's risk register is based upon the risks of the organisation and is populated by all services and departments through local risk registers and are monitored and maintained locally within the corporate departments and divisions. This 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.

Part 3 Risk Register (all risks with a risk score of below 12) – All risks below 12 are managed locally by each Ward/Departmental Manager. This can be managed by risk assessments and/or local risk registers. All risks must be reviewed annually and discussed/reviewed at local meetings. **Part 2 Risk Register (all risks with a risk score of 12)** – All risks of 12 are placed on CIRIS by the relevant Division/Department. Each risk has an identified Lead who will review the risk to ensure any actions are implemented. The Part 2 Risk Register is reviewed at Safety and Risk Sub Committee at least 3 times a year. **Part 1 Risk Register (risks of 15 and above) –** The Part 1 Risk Register known as the Corporate Risk Register is maintained and monitored by the Safety and Risk sub-Committee which meets monthly to assess risk with a risk score of 15 or above. Following assessment by the Safety and Risk Sub-Committee the Corporate Risk Register and Action points for the risks are submitted to the Quality Governance 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 Corporate 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.

The Trust has 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 Group. Partners and Governors 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, along with the emissary members of Warrington Overview and Scrutiny Committee has been a welcome addition in providing patient and public involvement on a range of issues.

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 essential 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, who provides additional challenge and scrutiny of the risks identified.

The Board Assurance Framework with the Corporate Risk Register provides the Board of Directors with a holistic overview of strategically significant risks relating to the Trust's operations and where gaps in control, assurance or risk management are identified, action is taken to rectify them. As part of the process of continual review and development, the existing Board Assurance Framework has been strengthened to reflect the requirements to support on-going registration with the CQC, Monitor's Risk Assessment Framework and the Trust's Provider Licence conditions.

The Trust has a rigorous system in place to monitor continued compliance against CQC essential standards, and to address any concerns against the level of compliance which are raised by the CQC and is fully compliant with the CQC registration requirements. Assurance is enhanced through regular walkabouts by members of the Board of Directors and through Ward Observation Visits undertaken by a group of Governors on behalf of the Council of Governors.

During the year the CQC made two unannounced visits to the Trust as set out below together with CQC's findings from its intelligent monitoring regime and the Trust's preparation for the CQC new inspection (Keogh Framework) regime.

CQC Unannounced Inspection 2013.
The CQC made one unannounced visits to Halton Hospital on the 30th September 2013, to review systems, standards, audit and processes as part of the Regulated Activities for Quality and Safety. The inspection which was unannounced started at the Minor Injuries Unit and then continued onto the wards, pharmacy and Cheshire and Merseyside Treatment Centre (CMTC). The CQC inspected the following standards as part of a routine inspection - care and welfare of people who use services, consent to care and treatment, staffing and management of medicines. The feedback was excellent – quotes from inspectors included that it was "an enjoyable inspection" and they had "never seen such inspirational care as on B1".

CQC Themed Review of Dementia Care 2013/2014
The CQC made one unannounced visits to Warrington Hospital on the 28th January 2014, to review systems, standards, audit and processes as part of the themed review of dementia care. This inspection programme reviewed three main issues namely the quality of support

provided to people with dementia to enable them to maintain their physical and mental health and wellbeing; how the care provided aims to reduce admissions to hospitals from care homes and avoid unnecessary lengths of stay in hospital and how services work together when people move from one service to another. The CQC visited A2, A3, A8, B12 and CDU and inspected the following standards as part of this themed review

- Outcome 4 Care and Welfare of Patients
- Outcome 6 Cooperating with other providers
- Outcome 16 Quality Monitoring of the essential standards

The full report can be found at http://www.cqc.org.uk/directory/RWW

CQC Intelligence Monitoring

The Care Quality Commission has published its full risk profiles and risk bandings of all NHS Trusts for the first time. It's a new system known as Intelligent Monitoring and is a publication that we fully support as a way of highlighting risk in the health service.

The intelligent monitoring is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance including detailed mortality rates, waiting time and access information, patient feedback and actual CQC inspection results.

It basically pulls together information from every available credited source to give an informed view and raise any questions necessary on the quality and safety of each hospital's service. It helps the CQC to know where to focus their new, stringent inspection resources. The CQC have now banded each trust into one of six categories based on the risk from these indicators that people may not be receiving safe, effective, high quality care - with band 1 being the highest risk and band 6 the lowest risk. In March 2014 Warrington and Halton Hospitals NHS Foundation Trust was placed into the Band 5 category based on these indicators of our services and care.

Whilst these are not to be seen as formal league tables, they do give an indication of the overall performance, quality and safety at a trust and is a good position to be in. We have all been working hard to build a culture of high quality, safe healthcare at Warrington and Halton Hospitals NHS Foundation Trust. Whilst there are always ways we can further improve our services, we can be proud of our achievements. This detailed analysis shows we moving in the right direction in ensuring that we provide our patients with a service that they can trust and that we can be proud of. The full reports can be found at http://www.cqc.org.uk/directory/RWW

CQC new Inspection Regime (Keogh Framework)

As stated above the Trust performance against these surveillance indicators can if the Trust is placed in a high risk band trigger an inspection. The CQC will now lead significantly bigger inspection teams headed up by clinical and other experts that include trained members of the public. They will spend longer inspecting hospitals and cover every site that delivers acute services and eight key services areas: A&E; maternity, paediatrics; acute medical and surgical pathways; care for the frail elderly; end of life care; and outpatients. The inspections will be a mixture of unannounced and announced and they will include inspections in the evenings and weekends when it is recognised patients can experience poor care. The Trust invests resources in ensuring that staff, understand these processes and provides drop in sessions in order to raise awareness about the new CQC Inspection regime.

Risks to information, including information security and data quality risks, are managed and controlled through the use of the Health and Social Care Information Centre's Information Governance Toolkit and the Trust's Risk Management Strategy. The Trust uses the Information Governance Toolkit in conjunction with the CIRIS Risk Management system to inform the work of its IM&T Steering Committee, Information Governance and Corporate Records Sub-Committee and Data Quality and Management Steering Groups respectively. The Trust's Senior Information Risk Owner (SIRO), and chair of the IM&T Steering Committee, is the Director of IT. The SIRO acts as the board level lead for information risk within NHS organisations.

Areas of weakness in relation to the management of information which are identified, or highlighted by internal audit review, are then targeted with action plans to ensure that we continue to strive to be information governance assured. The Trust received an internal audit rating of significant assurance in March 2014 after an annual Information Governance Toolkit Review.

Independent assurance is provided Payment by Results Data Assurance Framework Review by the Audit Commission which was received by the Audit Committee.

During the financial year under review there was one incident of data loss was reported to the Information Commissioner's Office during 2013/14. The incident occurred in July 2013 and involved the loss of a number of A&E Casualty Cards. The Information Commissioner concluded that no further action was necessary. Steps have been taken to prevent a recurrence of similar incidents and investigations into the root cause of the incident are ongoing.

As a Provider Licence holder, the Trust is required to apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS (Provider Licence Condition FT4 'NHS foundation trust governance arrangements'). To do this, the Trust has regard to guidance from Monitor, the sector regulator for healthcare, including the NHS Foundation Trust Code of Governance which has recently been updated. All directors and governors have signed a declaration indicating their compliance with the "fit and proper persons" test introduced through condition G4 of the provider licence. During 2013/14 the structure of the Executive was amended and roles were consolidated into a smaller Executive team. This provided a more effective organisational leadership and accountability on the quality of care provided by the Trust. The Board was also strengthened by the appointment of a Non-Executive Director with clinical experience, having previously been a Medical Director of an NHS Trust.

The Trust's integrated Governance structure has been amended to support the Trust's Quality-People-Sustainability Framework by the formation of a Finance and Sustainability Committee. The Finance and Sustainability Committee (FSC) seeks to ensure compliance with the Trust's duty to operate efficiently, economically, effectively and sustainably which includes overseeing the delivery of cost improvements on behalf of the Board. By establishing the FSC, the Board is confident that sufficient attention is now given to the key area of sustainability. The FSC membership comprises of a Non-Executive Director Chair, an additional Non-Executive Director and members of the Executive team. Associate Divisional Directors and lead clinicians are required to attend the Committee in order to account for the divisions' performance.

The integrated Governance Structure has a clear reporting structure to the Board of Directors. Minutes of the meetings of the Board Committees are presented to the Board and the Chair of each committee has the opportunity to bring any significant issues to the Board's attention.

As part of the Annual Planning process for 2013/14 the Board undertook a detailed review of compliance with its Provider Licence and has introduced a process of monitoring compliance, which is coupled with the Board Assurance Framework process.

The principal in year risks to compliance with Condition FT4 of the Trust's Provider Licence were:

- Breaches of thresholds in MRSA and C.difficle
- Non delivery of cost improvement targets
- Non delivery of financial targets and failure to achieve budget
- Implementation of new computer based systems – Symphony and E-Rostering

The principal future risks to compliance with Condition FT4 of the Trust's Provider Licence are:

- Failure to deliver cost improvements
- Non Delivery of financial targets and Continuity of Service risk rating
- Inability to generate cash to meet capital expenditure requirements
- Failures in key IT systems
- Loss of key personnel
- Breakdown in relationship with key stakeholders, such as the Trust's primary commissioner.

The trust is required under licence condition FT4(8)(b) to submit a corporate governance statement to Monitor each year as part of its Annual/Strategic Plan submission. This statement confirms the Trust's compliance with condition FT4 at the date of signature and the Trust's anticipated compliance with the condition for the coming year. The statement also outlines any risks to compliance and the actions that the Trust is intending to take to manage these risks.

The corporate governance statement takes the form of a template issued by Monitor, and the proposed responses are subject to scrutiny by, individual executive and non-executive directors and senior managers prior to approval of the statement by the Board of Directors. So that the Board had the necessary assurance that it could comply with the requirements of the Corporate Governance Statement to be submitted to Monitor, the internal auditor was asked to undertake a review of the Corporate Governance Statement and assess the trust's compliance. The findings of the review did not indicate any significant non-compliance with the statements, however recommended enhancements in processes to strengthen compliance and these enhancements would be addressed during the coming year.

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
The Trust ensures that its obligations under equality, diversity and human rights legislation are complied with via the production of its Equality Diversity Scheme and associated action plan. This is managed through the Equality and Diversity Sub Committee which reports to the Quality Improvement Board. Any risks which arise are included in the Board Assurance Framework.

The Board of Directors and members of Council of Governors, Quality in Care Committee have received Equality and Diversity training.

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

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

The Trust's financial plan submitted to Monitor, independent regulator of Foundation Trusts, was a planned surplus of £1.2m for the period 1st April 2013 to 31st March 2014. This plan was predicated on the delivery of cost savings equating to £11.0m (described in the organisation as the Cost Improvement Programme target or CIP target). For the financial year the Trust recorded a deficit of £2.8m, which included a shortfall against the CIP target of £2.1m. The 13/14 underlying deficit, including the shortfall against the CIP target has been incorporated into the 14/15 CIP target. The delivery of CIP savings is performance managed by the Innovation and Cost Improvement Committee which reports to the Finance and Sustainability Committee of the Board of Directors.

The resources of the Trust are managed within the framework set by the Standing Financial Instructions and various guidance documents that are produced within the Trust which have a particular emphasis on budgetary control. These ensure that service developments are implemented with appropriate financial controls.

The Board of Directors receives a comprehensive finance report on a monthly basis incorporating all relevant financial information including future projections to allow them to discharge their financial governance duties effectively. The formation of the new Finance and Sustainability Committee provides additional assurance to the Board on financial and corporate performance.

The Trust provides financial information to Monitor, on a monthly basis, inclusive of financial tables and a commentary.

The financial results and performance against the relevant Governance rating metrics is reported to the Council of Governors and is discussed in detail on a quarterly basis at the Governors' Monitor Reporting Compliance Committee.

The resource and financial governance arrangements are further supported by both internal and external audit to secure economic, efficient and effective use of the resources the Trust has at its disposal.

Clinical divisions and other corporate functions are accountable for the delivery of financial and other performance targets through a system of Performance Targets which are agreed as part of the annual business planning cycle and monitored through a series of bilateral meetings with the divisions led by the Chief Executive and the Executive team.

6. Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Report/Accounts for each financial year. Monitor has issued guidance to NHS boards on the form and content of annual Quality Report which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The following steps have been put in place to assure the Board of Directors that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data.

- The Trust has two specific strategic objectives focussing on quality and safety and patient experience, these being:
  i) ensure all patients are safe in our care; and
  ii) give our patients the best possible experience.
- The Board has appointed the Director of Nursing to lead, and advise it, on all matters relating to the preparation of the Trust's annual Quality Report for 2013/14.
- The Trust's Quality Governance Committee and the Clinical Governance, Audit and Quality Sub-Committee provides on going assurance and drives the delivery of the Trust's Quality Improvement Strategy and performance targets described in the annual Quality Report.
- The Trust has continued to implement programmes relating to the Safety Thermometer which is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care which has resulted in improvements to the quality and safety of care provided. The Trust has since December 2013 participated in Open and Honest Care, a key ambition for NHS England in supporting organisations to become more transparent and consistent in publishing safety, effectiveness and experience data with the overall aim of driving improvements in healthcare.
- The Trust has engaged stakeholders in the preparation of the Quality Report including the Council of Governors, Commissioners, Overview and Scrutiny Committee and Healthwatch.
- The Trust has a monthly Patient Experience Group with its membership including patient representatives, public governors, Warrington and Halton Healthwatch and Commissioner Representation as well as Trust staff. All real time and retrospective patient experience feedback is reviewed in this meeting and ensures patient experience is integral to planning and review of services and informs where improvements are targeted. The Trust also continues to work with a range of Community Groups, as well as self-help groups in specific areas.
- Preparation of the Quality Report is shared with the Council of Governors Quality in Care Committee throughout the year. This group give a valuable perspective on content, language and presentation.

The processes established to maintain and review the effectiveness of the systems of internal control in relation to the Quality Report include:

- The Trust meets monthly with the Commissioners to specifically discuss performance against quality performance measures contained within the Contract for Healthcare services. The Trust has received confirmation from the Lead Commissioner that they will provide a corroborative statement on the Quality Report.
- The annual internal audit programme agreed by the Audit Committee includes a review of elements of the systems, processes and performance metrics which are included in or support the preparation of the annual Quality Report.
- The 2013/14 plan for the Quality Report has ensured close working and involvement with the Trust's governors through the various stages.

7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers 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 a plan to address weaknesses and ensure continuous improvement of the system is in place.

Board of Directors

The Board had reviewed its assurance processes and 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 principal objectives.

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 directorates. 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.

Internal Audit

The Director of Audit's Opinion has provided significant assurance for 2013-14 and stated that there is generally sound system of internal control, designed to meet the organisations objectives and that controls are generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of particular objectives at risk. The audit programme delivered reflected effective use of Internal Audit as part of the system of internal control. There was regular dialogue with the Director of Finance and Commercial Development and the Trust's Audit Committee, which resulted in the plan being reprioritised. The overall level of assurance is provided in the context that the organisation is risk aware and has directed internal audit into a number of risk areas. Some

reviews resulted in system control weakness being identified. Action plans to address the findings and enhance key controls have been formally agreed with specified dates for implementation. The Internal Audit programme includes regular follow up against action dates agreed. Management update in terms of progress is a standing item in Audit Committee Business.

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 the NHS Litigation Authority and the Care Quality Commission.

8. Conclusion

There were no significant internal control issues or gaps in control identified in 2013-14. The Trust's internal auditor has provided an overall opinion of significant assurance, based on their work during 2013-14.

… ……..

Mel Pickup,
Chief Executive
28th May 2014

11. External auditor's statement

Independent auditors' report to the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion the financial statements, defined below:

- give a true and fair view of the state of the NHS Foundation Trust's affairs as at 31 March 2014 and of its income and expenditure and cash flows for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

This opinion is to be read in the context of what we say in the remainder of this report.

What we have audited

The financial statements, which are prepared by Warrington and Halton Hospitals NHS Foundation Trust, comprise:

- the Statement of Financial Position as at 31 March 2014;
- the Statement of Comprehensive Income for the year then ended;
- the Statement of Cash Flows for the year then ended;
- the Statement of Changes in Taxpayers' Equity for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual 2013/14 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").
In applying the financial reporting framework, the directors have made a number of subjective judgements, for example in respect of significant accounting estimates. In making such estimates, they have made assumptions and considered future events.

What an audit of financial statements involves

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)"). An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinions on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion:

- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Other matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- we have qualified, on any aspect, our opinion on the Quality Report.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the directors

As explained more fully in the Directors' Responsibilities Statement set out on page 43 the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may

come save where expressly agreed by our prior consent in writing.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Rebecca Gissing (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Manchester
29 May 2014

(a) The maintenance and integrity of the Warrington and Halton Hospitals NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

12.Financial statements

Warrington and Halton Hospitals NHS Foundation Trust

The trust accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006.

Mel Pickup
Chief Executive
28th May 2014

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31st March 2014

	NOTE	2013/14 £000	2012/13 £000
Income from activities	3	194,633	190,654
Other operating income	3	18,096	17,712
Operating income	3	**212,729**	**208,366**
Operating expenses	4	(211,534)	(205,589)
OPERATING SURPLUS		**1,195**	**2,777**
FINANCE COSTS			
Finance income - interest receivable	6	42	63
Finance expense - interest payable	7	(12)	(49)
PDC dividends payable		(4,074)	(3,900)
NET FINANCE COSTS		**(4,044)**	**(3,886)**
(DEFICIT) FOR THE FINANCIAL YEAR		**(2,849)**	**(1,109)**
Other comprehensive income			
Items that will not be reclassified to income and expenditure			
Gain from transfer by absorption from demising bodies	9	8	0
Impairment losses on property, plant and equipment	9	(808)	0
Revaluation gains on property, plant and equipment	9	3,696	6,608
Asset disposals for which there was an existing reserve	9	0	(432)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**47**	**5,067**

The notes on pages 5 to 39 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31st MARCH 2014

	NOTE	31st March 2014 £000	31st March 2013 £000
NON-CURRENT ASSETS			
Intangible assets	8	316	259
Property, plant and equipment	9	132,587	130,252
Trade and other receivables	11	1,038	1,661
Total non-current assets		**133,941**	**132,172**
CURRENT ASSETS			
Inventories	10	2,769	2,569
Trade and other receivables	11	8,041	4,854
Cash and cash equivalents	12	12,956	13,150
Total current assets		**23,766**	**20,573**
CURRENT LIABILITIES			
Trade and other payables	13	(19,094)	(16,171)
Borrowings	14	0	(450)
Other liabilities	15	(1,353)	(1,140)
Provisions	16	(415)	(317)
Total current liabilities		**(20,862)**	**(18,078)**
Total assets less current liabilities		**136,845**	**134,667**
NON-CURRENT LIABILITIES			
Provisions	16	(1,376)	(1,358)
Total non-current liabilities		**(1,376)**	**(1,358)**
TOTAL ASSETS EMPLOYED		**135,469**	**133,309**
TAXPAYERS' EQUITY			
Public dividend capital		90,063	87,950
Revaluation reserve		35,808	33,680
Income and expenditure reserve		9,598	11,679
TOTAL TAXPAYERS' EQUITY		**135,469**	**133,309**

The primary financial statements on pages 1 to 4 and the notes on pages 5 to 39 were approved by the Board of Directors on 28th May 2014 and signed on its behalf by Mel Pickup, Chief Executive.

Signed: ……..…… Date: 28th May 2014

Mel Pickup
Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Total Taxpayers' Equity £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' equity at 1st April 2013	133,309	87,950	33,680	11,679
(Deficit) for the year	(2,849)	0	0	(2,849)
Transfers between reserves	0	0	(760)	760
Impairment losses on property, plant and equipment	(808)	0	(808)	0
Revaluations (property, plant and equipment)	3,696	0	3,696	0
Other reserve movements (asset disposals)	0	0	0	0
Transfers by modified absorption	8	0	0	8
Total comprehensive income for the year	**47**	**0**	**2,128**	**(2,081)**
Public Dividend Capital received	2,113	2,113	0	0
Taxpayers' equity as at 31st March 2014	**135,469**	**90,063**	**35,808**	**9,598**

	Total Taxpayers' Equity £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' equity at 1st April 2012	116,242	75,950	28,252	12,040
(Deficit) for the year	(1,109)	0	0	(1,109)
Transfers between reserves	0	0	(748)	748
Revaluations (property, plant and equipment)	6,608	0	6,608	0
Other reserve movements (asset disposals)	(432)	0	(432)	0
Total comprehensive income for the year	**5,067**	**0**	**5,428**	**(361)**
Public Dividend Capital received	12,000	12,000	0	0
Taxpayers' equity as at 31st March 2013	**133,309**	**87,950**	**33,680**	**11,679**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31st March 2014

	NOTE	2013/14 £000	2012/13 £000
Cash flows from operating activities			
Operating surplus from continuing operations		**1,195**	**2,777**
Non-cash income and expense			
Depreciation and amortisation	4	5,858	5,590
Impairments	4	697	1,989
Reversal of impairments	3	(149)	0
Non-cash donations credited to income		0	(59)
(Increase)/decrease in trade and other receivables	11	(2,584)	2,247
(Increase)/decrease in inventories	10	(200)	(306)
Increase/(decrease) in trade and other payables	13	2,634	(599)
Increase/(decrease) in other liabilities		213	(906)
Increase/(decrease) in provisions	16	116	(51)
Other movements in operating cash flows		0	35
Net cash generated from operations		**7,780**	**10,717**
Cash flows from investing activities			
Interest received	6	62	63
Purchase of intangible assets	8	(114)	(116)
Purchase of property, plant and equipment	9	(5,526)	(15,897)
Net cash used in investing activities		**(5,578)**	**(15,950)**
Cash flows from financing activities			
Public Dividend Capital received	9	2,113	12,000
Loans repaid	14	(450)	(900)
Interest paid		(12)	(55)
PDC dividend paid		(4,047)	(3,893)
Net cash (used in)/generated from financing activities		**(2,396)**	**7,152**
(Decrease)/increase in cash and cash equivalents		(194)	1,919
Cash and cash equivalents as at 1st April		**13,150**	**11,231**
Cash and cash equivalents as at 31st March	**12**	**12,956**	**13,150**

NOTES TO THE ACCOUNTS

1. Accounting policies

Monitor has directed that the accounts of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual 2013/14 (FT ARM) which shall be agreed with HM Treasury. Consequently, the following accounts have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

The Directors have a reasonable expectation that the NHS Foundation Trust will continue in operational existence for the foreseeable future and have therefore continued to adopt the going concern basis in preparing these accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 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 critical judgements that management have made in the process of applying the entity'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.

Provisions

The pension provision relating to former employees, including directors, have 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 Litigation Authority. 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 31st March 2014. The provision includes 15.8% 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 the District Valuers of the HM Revenue & Customs Government Department. 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 (property rarely sold on the open market) and Existing Use Value for non-specialised operational property. No building indices have been applied as research into building costs implies the fair value of the buildings has not increased.

The last full asset valuation was undertaken in 2009 as at the prospective valuation date of 1st April 2010 and was applied on 31st March 2010. An interim valuation was undertaken during 2013/2014 as at the prospective valuation date of 31st March 2014 and was applied on 31st March 2014 (Note 9).

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 a sample of Trust employees based on actual point of their salary band. This is a change to the method of estimation as in previous years the Trust has used mid point of their salary band.

1.3 Income

Income 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 commissioners for the provision of healthcare services. The income from Warrington Clinical Commissioning Group (CCG) relating to patient care activity that is partially completed as at 31st March 2014 is included. Activity for all other commissioners is excluded as partially completed spells are not recognised by other commissioners and the value of partially completed activity for those commissioners is deemed immaterial.

Where income is received for a specific activity that is to be delivered in a future financial year that income is deferred.

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 e.g. 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 (15.8%).

The main source of other operating income is from Clinical Commissioning Groups, NHS England, Health Education England, NHS Trusts, NHS Foundation Trusts and Local Authorities.

1.4 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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional cost is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.5 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating 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.

1.6 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 fair value. Revaluation gains, losses and impairments are treated in the same manner as for property, plant and equipment.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 supplied 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 cost of at least £5,000; or
- a number of items which collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have 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.

Where a large asset, for example a building, includes a number of 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. Professional valuations are carried out by the District Valuers of the HM Revenue & Customs Government Department. 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. 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 International Accounting Standard (IAS) 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

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 operating expenses in the period in which it is incurred.

1.8 Depreciation, revaluations and impairments

Items of property, plant and equipment are depreciated on a straight-line basis over their estimated useful lives to a residual value. Depreciation is not provided on freehold land and assets surplus to requirements.

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 income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of other comprehensive income.

Impairments

At 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 FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (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 loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve, where at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments, such as unforeseen obsolesence, are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains and classed as other operating income.

1.9 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.

1.10 Leases

Finance leases

Leases are classified as finance leases when substantially all risks and rewards of ownership are transferred to the lessee. The Trust does not hold any finance leases.

Operating leases

Operating lease payments are recognised in operating expenses on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Operating lease income is received for the lease of buildings or land where the risks and rewards of ownership of the leased asset are retained by the Trust.

Contingent rents are recognised in operating expenses in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased buildings are assessed as to whether they are operating or finance leases.

1.11 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.

1.12 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 12).

1.13 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 rate of 2.2% in real terms, except for early retirement provision and injury benefit provisions which both use the HM Treasury's pension discount rate of 1.8% (2.35% in 2012/13) in real terms.

1.14 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution (Note 4) to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to operating expenses. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 16 but is not recognised in the Trust's accounts.

1.15 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 NHSLA 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 they become due.

1.16 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.

1.17 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 2012/13).

1.18 Foreign currencies

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 31st 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.

1.19 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. Details of third party assets are given in Note 12 to the accounts.

1.20 Public dividend capital (PDC) and PDC dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets, over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of International Accounting Standard (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 3.5%) 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), 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.

1.21 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 NHS Foundation Trusts not been bearing their 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.

1.22 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 1st January or after 1st July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Subsidiaries classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

From 1st April 2013 NHS charitable funds considered to be subsidiaries are to be consolidated within the Trust accounts in accordance with an accounting direction issued by Monitor. For 2013/14 the Trust has opted not to consolidate charitable funds with the main Trust Accounts because they are immaterial. This will be reviewed each year for appropriateness.

1.23 Financial assets & 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.

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: cash at bank and in hand, NHS receivables and part of accrued income and other receivables.

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

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

The Trust does not hold any available-for-sale financial assets.

Other financial liabilities at amortised cost

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 11).

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. Amounts are written off on a quarterly basis following approval from the Trust's Audit Committee.

1.24 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.

1.25 Accounting standards and amendments issued but not yet adopted in the FT ARM

The effective date of the following standards are disclosed after the standard's names; these amendments or new standards are not yet adopted by the European Union.

IFRS 9 Financial Instruments [new standard] (2015/16) - this new standard is likely to have a non-material impact on the Trust's accounts. This is because it is intended to eventually replace IAS 39 Financial Instruments: Recognition and Measurement, which currently sets out the requirements for the recognition and measurement of financial instruments.

IFRS 13 Fair Value Measurement [new standard] (Effective date of 2013/14 but not yet adopted by HM Treasury) - this new standard is likely to affect how the Trust measures and/or discloses the fair value of items in the Statement of Financial Position, including non-current assets and financial instruments.

IAS 32 Financial Instruments [amendments regarding offsetting financial assets and financial liabilities] (2014/15). These amendments will not have an impact on the Trust.

From 1st April 2013, NHS charitable funds considered to be subsidiaries are to be consolidated in accordance with the accounting direction issued by Monitor. For 2013/14 the Trust has opted not to consolidate charitable funds within the main Trust accounts because they are immaterial. This will be reviewed each year for appropriateness.

The following standards are likely to impact the Trust when balances are considered material enough for consolidation, only in that they may have some effect on consolidation.

IFRS 10 Consolidated Financial Statements [new standard] (Effective from 2014/15*)

IFRS 11 Joint Arrangements [new standard] (Effective from 2014/15*)

IFRS 12 Disclosure of Interests in Other Entities [new standard] (Effective from 2014/15*)

IAS 27 Separate Financial Statements [amendment] (Effective from 2014/15*)

IAS 28 Associates and Joint Ventures [amendment] (Effective from 2014/15*)

* This reflects the EU-adopted effective date rather than the effective date in the standard.

IFRS - International Financial Reporting Standards
IFRIC - International Financial Reporting Interpretations Committee
IAS - International Accounting Standard

2. Operating segments

The Trust considers the Board of Directors to be the chief operating decision maker (CODM) because it regularly reviews operating results, makes decisions about where resources are allocated as a result and assesses performance.

Income arising from the following segments is reported monthly to the Board on a distinct and separate basis and therefore they have been disclosed separately in the table below:

- Scheduled Care
- Unscheduled Care
- Women's Children's & Support Services
- Other services

The Trust provides NHS healthcare services to the general public, the majority of whom are registered with a GP Practice in England, and the above detailed segments are the key operational segments that the Trust uses to make management decisions.

Segment	2013/14 £000	2012/13 £000
Scheduled Care	71,690	72,252
Unscheduled Care	59,656	58,363
Women's, Children's & Support Services	44,253	41,685
Other services	37,130	36,066
Total operating income	**212,729**	**208,366**

Income from other services relates to patient care income not attributed to a particular segment and includes private patient income, ICR income, education and training income and other operating income received for the provision of goods and services.

The Trust has two external customers who individually generate income amounting to more than 10% of the Trust's total income. Warrington CCG generated income of £107.4m (50%) and Halton CCG generated income of £47.6m (22%). In 2012/13 there were two primary care trusts (PCTs) that individually generated income amounting to more than 10%. Warrington PCT £114.3m (55%) and Halton and St Helens PCT £62.6m (30%).

The Trust does not report expenditure, total assets or liabilities attributable to each operating segment to the Board. Consequently expenditure, total assets and liabilities attributable to each operating segment are not disclosed in this note.

3. Operating income

Income from activities

	2013/14 £000	2012/13 £000
Income from commissioner requested services		
Elective income	40,571	37,401
Non elective income	62,357	67,302
Outpatient income	32,702	32,457
A & E income	10,164	10,496
Other NHS clinical income (1)	47,377	41,197
Income from non-commissioner requested services		
Private patient income	145	132
Other non-protected clinical income (2)	1,317	1,669
Total income from activities	**194,633**	**190,654**
Other operating income		
Education and training	7,469	7,363
Non-patient care services to other bodies	1,979	2,478
Charitable and other donations	799	153
Reversal of impairments	149	0
Other (3)	7,700	7,718
Total other operating income	**18,096**	**17,712**
Total operating income	**212,729**	**208,366**

(1) Other NHS clinical income includes income received in respect of pathology, radiology, audiology, winter pressures, excluded drugs, breast screening services, neo-natal services, critical care, chemotherapy and palliative care.

(2) Other non-protected clinical income relates to ICR income received from the CRU.

(3) Other operating income of £7.7m (£7.7m in 2012/13) includes income in respect of staff recharges, clinical tests, catering, estate recharges, lease income and other miscellaneous income recharged to other NHS bodies.

Income from activities by type	2013/14 £000	2012/13 £000
Primary Care Trusts (4)	0	188,706
Clinical Commissioning Groups (4)	179,164	0
NHS England (4)	10,573	0
NHS Other (5)	1,435	147
Local Authorities (4)	1,999	0
Non NHS: private patients	145	132
ICR income	1,317	1,669
Total	**194,633**	**190,654**

(4) PCTs ceased to exist on 31st March 2013. The new successor organisations are CCGs. Some elements of activity commissioned by PCTs in 2012/13 is in 2013/14 commissioned by Local Authorities.

Private patient income

The statutory limitation on private patient income in section 44 of the National Health Service Act was repealed with effect from 1st October 2012 by the Health and Social Care Act 2012 and the financial disclosures previously included within this section of the accounts are therefore no longer required.

Operating lease income

The Trust has in place the following significant operating leases as a lessor.

Company	Lease Commencement Date	Lease Expiry Date	Lease Description
Gentian (Warrington) Limited	01/01/2001	31/12/2030	Rental of space within the main entrance at Warrington Hospital
Fresenius Medical Care Renal Services Limited	01/07/2008	30/06/2068	Rental of space for Renal Unit at Halton General Hospital
Big Bear Coffee Limited	02/12/2013	01/12/2016	Rental of catering facilities at the Cheshire & Merseyside Treatment Centre

Operating lease income	**2013/14 £000**	**2012/13 £000**
Rents recognised as income in the year	183	204
Total	**183**	**204**

Future minimum lease receipts due	**2013/14 £000**	**2012/13 £000**
- not later than one year	187	179
- later than one year and not later than five years	742	714
- later than five years	6,888	6,670
Total	**7,817**	**7,563**

4. Operating expenses	2013/14 Total £000	2012/13 Total £000
Services from other NHS bodies	104	159
Purchase of healthcare from non NHS bodies	7	713
Employee costs - executive directors	785	932
Employee costs - non-executive directors	117	117
Employee costs - staff	148,994	145,369
Employee costs - termination costs	0	100
Drug costs	12,387	10,812
Supplies and services - clinical (excluding drug costs)	18,863	18,154
Supplies and services - general	2,546	2,631
Establishment	2,280	2,100
Transport (business travel only)	287	267
Transport (other)	640	415
Premises	9,090	8,560
Rentals under operating leases	436	411
Increase in bad debt provision	141	75
Change in provisions discount rate	26	0
Depreciation on property plant and equipment	5,804	5,530
Amortisation of intangible assets	54	60
Impairments of property plant and equipment	697	1,989
Audit fees - statutory audit - Audit Commission	0	3
Audit fees - statutory audit - PricewaterhouseCoopers LLP	57	67
All other non-audit services - PricewaterhouseCoopers LLP	0	49
Clinical negligence premiums	5,453	4,466
Legal fees	147	254
Consultancy costs	622	410
Training courses and conferences	616	723
Patient travel	17	18
Commercial insurance	135	129
Losses, ex gratia & special payments	6	5
Other*	1,223	1,071
TOTAL	**211,534**	**205,589**

*Other expenditure includes early retirement costs, carbon reduction commitment allowances, personal and permanent injury benefits, the cost of annual leave accrual and patient expenses.

Expenditure previously recorded against establishment (£267k) has been re-categorised as transport (business travel only) during the current year. Transport (business travel only) is a new category for 2013/14.

The external auditors' liability is limited to £1m. The scope of work for the external auditors is to provide a statutory audit to the Trust. 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. The scope of the work is for the external auditors to be satisfied that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The external auditors are to provide their opinion on the accounts.

For 2013/14 there were no 'other non-audit services'. The costs shown for 2012/13 relate to procurement assistance provided by PricewaterhouseCoopers LLP in respect of the recruitment of medical agency staff (£43k) and training and support in respect of a Healthcare Evaluation Database (£6k).

The Late Payment of Commercial Debts (Interest) Act 1998

The total paid within 2013/14 for late payment of commercial debt was £792 (£0 in 2012/13)

Better payment practice code (BPPC)

The better payment practice code gives NHS organisations a target of paying 95% of invoices within agreed payment terms or in 30 days where there are no terms agreed.

Performance for the financial year is contained in the table below:

	2013/14 Number	2013/14 £000	2012/13 Number	2012/13 £000
Non-NHS trade invoices paid in the year	45,733	56,302	52,321	53,564
Non NHS trade invoices paid within target	29,431	37,483	45,586	43,249
Percentage of non-NHS trade invoices paid within agreed payment terms or in 30 days	**64%**	**67%**	**87%**	**81%**
NHS trade invoices paid in the year	2,084	15,811	3,003	17,586
NHS trade invoices paid within target	926	8,835	901	8,859
Percentage of NHS trade invoices paid within agreed payment terms or in 30 days	**44%**	**56%**	**30%**	**50%**

Operating lease expenditure

The Trust has in place the following significant operating leases as a lessee.

Company	Lease Start Date	Lease Expiry Date	Lease Description
Quondam Estates Limited	08/06/2000	07/06/2030	Lease for Pharmacy at Warrington Hospital
Gentian (Warrington) Limited	01/01/2001	31/12/2030	Lease for office space at Warrington Hospital
Gentian (Warrington) Limited	01/01/2001	31/12/2030	Lease for staff areas at Warrington Hospital
N Kirk & T Howard Partnership	13/08/2008	12/08/2015	Lease for parking spaces at Warrington Hospital
Singers Healthcare Finance Limited	31/05/2011	30/05/2016	Lease for mobile digital mammography equipment
Singers Healthcare Finance Limited	31/05/2011	30/05/2016	Lease for mobile breast screening trailer
DeLage Landen Leasing Limited	19/04/2013	18/04/2018	Lease for mammography system at the Bath Street Health & Wellbeing Centre

Payments recognised in expenditure

	2013/14 £000	2012/13 £000
Minimum lease payments	429	401
Contingent rents	7	10
Total	**436**	**411**

Arrangements containing an operating lease

	2013/14 £000	2012/13 £000
Future minimum lease payments due:		
- not later than one year	376	330
- later than one year and not later than five years	912	867
- later than five years	1,776	1,934
Total	**3,064**	**3,131**

5. Employee expenses	2013/14 Permanently Employed	2013/14 Other	2013/14 Total	2012/13 Total
	£000	**£000**	**£000**	**£000**
Salaries and wages	118,835	0	118,835	114,706
Social security costs	9,189	0	9,189	8,919
Pension costs (employer contributions to NHS Pensions)	12,750	0	12,750	12,326
Termination benefits*	0	0	0	100
Bank and agency staff	0	9,130	9,130	10,428
Total employee benefit expenses	**140,774**	**9,130**	**149,904**	**146,479**

Employee costs include staff costs of £125k (£78k in 2012/13) which have been capitalised as part of the Trust's capital programme. These amounts are excluded from employee expenses in Note 4.

*Termination benefits reflect the costs incurred in respect of compulsory and voluntary redundancies.

Average number of persons

	2013/14 Permanently Employed	2013/14 Other	2013/14 Total	2012/13 Total
	Number	**Number**	**Number**	**Number**
Medical and dental	383	9	392	355
Administration and estates	745	0	745	710
Healthcare assistants and other support staff	773	0	773	697
Nursing, midwifery and health visiting staff	1,005	0	1,005	1,018
Scientific, therapeutic and technical staff	522	8	530	524
Bank and agency staff	0	154	154	159
Total	**3,428**	**171**	**3,599**	**3,463**

Staff exit packages

	2013/14			2012/13
Exit package cost band	**Number of Compulsory Redundancies**	**Number of Other Agreed Departures**	**Total Number**	**Total Number**
£0 - £10,000	0	0	0	1
£10,001 - £25,000	0	0	0	0
£25,001 - £50,000	0	0	0	0
£50,001 - £100,000	0	0	0	1
Total number of exit packages by type	**0**	**0**	**0**	**2**
Total resource cost	**£0**	**£0**	**£0**	**£100,260**

Executive directors' remuneration and other benefits

	2013/14 £000	**2012/13 £000**
Highest paid director's remuneration	156	95
Other directors' remuneration	582	757
Total directors' remuneration	**738**	**852**
Employer contributions to NHS Pension Scheme for highest paid director	22	10
Employer contributions to NHS Pension Scheme for all other directors	58	89
Total employer contributions to NHS Pension Scheme	**80**	**99**
Number of directors to whom benefits are accruing under the NHS Pension Scheme during the year	10	7

The total of accrued pension and lump sum held under the NHS Pension Scheme as at 31st March 2014 for the highest paid director was £53k and £160k respectively (£50k and £180k as at 31st March 2013).

Employee benefits

An accrual in respect of the cost of annual leave entitlement carried forward at the Statement of Financial Position date of £560k has been provided for within the accounts (£623k as at 31st March 2013). No other employee benefits were incurred during the year.

Early retirements due to ill-health

Four members of staff retired early on ill health grounds during the year at an additional cost of £120k (3 members of staff at a cost of £151k for the year ending 31st March 2013). The cost of ill health retirements are borne by the NHS Business Services Authority - Pensions Division.

Pension Costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The Scheme is 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, the scheme is accounted for as a defined contribution scheme: the cost to the Trust of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting year.

In order that the defined benefit obligations recognised in the accounts do not differ materially from those that would be determined at the reporting date by 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) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31st March 2004. The national deficit of the scheme at that time was £3.3 billion. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis. A formal actuarial valuation would have been due for the year ending 31st March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

b) Accounting Valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31st March 2014 is based on detailed membership data as at 31st March 2013 updated to 31st March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS19, 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Copies can also be obtained from Her Majesty's Stationery Office (HMSO)

c) Scheme provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and the best of the last three pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1st April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum up to a maximum amount permitted under HRMC rules. This new provision is know as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30th September in the previous calendar year. From 2011/12 the Consumer Price Index (CPI) has been used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement, is payable.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

d) Future requirements

The Trust estimates its employer contributions for 2014-15 will be £21.4m. The published annual accounts of the NHS Pension Scheme in 2012/13 disclosed a liability for the whole scheme of £284bn, which is underwritten by the Exchequer. Employer contribution rates in 2014-15 will remain at 14%, but are forecast to increase from 1 April 2015 on the basis of the most recent valuation of the scheme.

6. Finance income (interest receivable)	**2013/14 £000**	**2012/13 £000**
Interest from bank accounts	42	35
Interest from cash investments (none held as at 31st March)	0	28
Total	**42**	**63**

7. Finance expense (interest payable)	**2013/14 £000**	**2012/13 £000**
Department of Health loan	11	49
Interest on Late Payment of Debt	1	0
Total	**12**	**49**

8. Intangible assets

	Software licences £000
Cost as at 1st April 2013	391
Additions - purchased	114
Impairments	(3)
Cost as at 31st March 2014	**502**
Amortisation at 1st April 2013	132
Charged during the year	54
Amortisation as at 31st March 2014	**186**

Cost as at 1st April 2012	319
Additions - purchased	116
Impairments	(44)
Cost as at 31st March 2013	**391**
Amortisation as at 1st April 2012	72
Charged during the year	60
Amortisation as at 31st March 2013	**132**

Intangible assets financing

Net book value

Owned as at 31st March 2014	316
Total as at 31st March 2014	**316**
Owned as at 31st March 2013	259
Total as at 31st March 2013	**259**

Economic life of intangible assets

	Minimum Life Years	Maximum Life Years
Software	5	8

9. Property, plant and equipment

Current Year	Total	Land	Buildings Excluding Dwellings	Dwellings	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation as at 1st April 2013	**171,516**	**19,181**	**114,292**	**1,247**	**27,929**	**43**	**8,016**	**808**
Transfers by absorption - modified*	8	0	0	0	8	0	0	0
Additions - purchased	5,788	0	3,584	0	1,320	19	815	50
Additions - donated	0	0	0	0	0	0	0	0
Impairments charge to the revaluation reserve	(805)	0	(805)	0	0	0	0	0
Reclassifications	0	0	23	72	(85)	0	(6)	(4)
Revaluation surpluses	3,696	0	3,696	0	0	0	0	0
Disposals	(2,658)	0	0	0	(621)	0	(2,021)	(16)
Cost or valuation as at 31st March 2014	**177,545**	**19,181**	**120,790**	**1,319**	**28,551**	**62**	**6,804**	**838**
Depreciation as at 1st April 2013	41,264	0	16,646	202	18,522	2	5,288	604
Charged during the year	5,804	0	3,644	45	1,503	7	571	34
Impairments recognised in operating expenses	697	0	697	0	0	0	0	0
Reversal of impairments credited to operating income	(149)	0	(149)	0	0	0	0	0
Reclassifications	0	0	(562)	0	0	0	562	0
Disposals	(2,658)	0	0	0	(621)	0	(2,021)	(16)
Depreciation as at 31st March 2014	**44,958**	**0**	**20,276**	**247**	**19,404**	**9**	**4,400**	**622**
NBV as at 31st March 2014	**132,587**	**19,181**	**100,514**	**1,072**	**9,147**	**53**	**2,404**	**216**
Prior Year								
Cost or valuation as at 1st April 2012	**149,340**	**19,181**	**95,257**	**1,247**	**24,950**	**0**	**7,906**	**799**
Additions - purchased	15,803	0	12,323	0	3,216	43	196	25
Additions - donated	153	0	104	0	49	0	0	0
Impairments charged to revaluation reserve	0	0	0	0	0	0	0	0
Revaluation surpluses	6,608	0	6,608	0	0	0	0	0
Disposals	(388)	0	0	0	(286)	0	(86)	(16)
Cost or valuation as at 31st March 2013	**171,516**	**19,181**	**114,292**	**1,247**	**27,929**	**43**	**8,016**	**808**
Depreciation as at 1st April 2012	33,745	0	13,475	158	15,004	0	4,541	567
Charged during the year	5,530	0	3,171	44	1,529	2	747	37
Impairments recognised in operating expenses	1,989	0	0	0	1,989	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0
Depreciation as at 31st March 2013	**41,264**	**0**	**16,646**	**202**	**18,522**	**2**	**5,288**	**604**
NBV as at 31st March 2013	**130,252**	**19,181**	**97,646**	**1,045**	**9,407**	**41**	**2,728**	**204**
Property, plant and equipment financing								
Net book value (NBV) as at 31st March 2014								
Owned	130,336	19,181	98,854	1,072	8,629	53	2,404	143
Government Granted	875	0	534	0	341	0	0	0
Donated	1,376	0	1,126	0	177	0	0	73
Total NBV as at 31st March 2014	**132,587**	**19,181**	**100,514**	**1,072**	**9,147**	**53**	**2,404**	**216**
Net book value (NBV) as at 31st March 2013								
Owned	128,123	19,181	96,148	1,045	8,807	41	2,728	173
Donated	2,129	0	1,498	0	600	0	0	31
Total NBV as at 31st March 2013	**130,252**	**19,181**	**97,646**	**1,045**	**9,407**	**41**	**2,728**	**204**

There is no element of land included within buildings or dwellings in the above classifications.

*The Trust received £8k of child audiology equipment from Warrington PCT, via Bridgewater Community Healthcare Trust. The transfer took place in 2013/14 as part of the legacy work due to the abolition of PCTs on 31st March 2013.

9. Property, plant and equipment (continued)

The value and remaining useful lives of land and building assets are estimated by the District Valuers of the HM Revenue & Customs Government Department. 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 Existing Use Value for non-specialised operational property. No building indices have been applied as research into building costs implies the fair value of the buildings has not increased.

The last full asset valuation was undertaken in 2009 as at the prospective valuation date of 1st April 2010 and was applied on 31st March 2010. An interim desk top valuation was undertaken, by the District Valuation Office, during 2013/2014 as at the prospective valuation date of 31st March 2014 and was applied on 31st March 2014. 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.

Land values remained the same. Building values on the whole increased, although there were some downward movements. The total downward movement was £845k (£135k impairments shown with expenditure, plus £710k shown with the revaluation reserve) and the total upward movement was £3,845k.

Any increase in valuation which reversed a previous impairment has been credited to operating expenses, to the extent of what has been charged there already relating to the asset. Any remaining balance has been credited to the revaluation reserve. Of the £3,845k upward valuation £149k related to assets that had previously been impaired. An element of the original impairment has been reversed in 2013/14 and is classed as other operating income.

Revaluations Arising from District Valuers Report on Land & Buildings	**£000**
Downward Revaluations	(845)
Upward Revaluations	3,845
	3,000
Downward Revaluations	
Taken to Revaluation Reserve	(710)
Impairment taken to I&E	(135)
	(845)
Upward Revaluations	
Taken to Revaluation Reserve	3,696
Reversal of Impairment taken to I&E	149
	3,845

The Trust has other impairments which relate to equipment. These did not form part of the District Valuers Report on land & buildings.

	£000
Impairments of Equipment	
Arising from Unforeseen Obsolescence taken to I&E*	(563)
Arising from Asset Verification Exercise taken to revaluation reserve	(98)

* This relates solely to the disposal of Picture Archiving and Communication System (PACS) which was replaced in June 2013.

9. Property, plant and equipment (continued)

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
Buildings excluding dwellings	5	172
Dwellings	8	82
Plant and machinery	5	15
Information technology	5	8
Furniture and fittings	10	10
Transport and equipment	7	7

Contractual Capital Commitments

The Trust has contractual capital commitments of £2.9m as at 31st March 2014 (£2.0m as at 31st March 2013). This includes £2.2m for a Wireless Network, £0.6m for a energy efficiency system and £0.1m for a pharmacy stock control system.

Capital Developments

Dementia Scheme
In July 2013 the Trust was successful in securing £1.1m of funding from the Department of Health to deliver a ward based dementia friendly environment. The funding has been used to create the Forget Me Not Unit which is a dedicated environment for acute patients with dementia. Providing a relaxed and familiar environment, making sure that the lighting, flooring and décor is appropriate for patients with dementia.

Energy Efficiency
In July 2013 the Trust was successful in securing £0.6m of national funding from the Department of Health for an Energy Efficiency scheme. This funding is being used to install a Combined Heating and Power (CHP) plant on both sites. This will significantly improve the efficiency of Trusts heating and power and will reduce energy costs.

Delamere Centre
During 2012/13 work commenced on a £1.1m programme to refurbish the existing oncology centre within the Delamere Centre at Halton General Hospital. This development, which has been funded by donations from Macmillan Cancer Support, has provided a private entrance for patients, a new reception area, an information centre, a landscaped garden and two complementary therapy rooms providing facilities for massage, hot stone therapy and reflexology. This scheme was completed in 2013/14.

Improving Birthing Environments
In January 2013 the Trust was successful in securing £0.4m of national funding from the Department of Health to upgrade its labour ward facilities. This additional funding has given the Trust the opportunity to provide en-suite facilities on individual labour wards, and create a birthing suite, a birthing pool and an area for birthing partners to stay overnight to offer support. The scheme started in 2012/13 and has been completed in 2013/14.

10. Inventories	2013/14 £000	2012/13 £000
Drugs, medical supplies and consumable items	2,769	2,569
Total	**2,769**	**2,569**

Inventories recognised in expenditure

The total expenditure on items classed as inventories recognised in expenditure during the year was £30.5m (£27.9m in 2012/13). The Trust incurred stock losses of £30k which is reported as drugs expenditure in the year (£36k in 2012/13). The value of inventories purchased but not used as at 31st March 2014 was £2.8m as per the table above (£2.6m in 2012/13).

11. Trade and other receivables	2013/14 £000	2012/13 £000
NHS receivables	3,052	1,164
Other receivables with related parties	290	261
Provision for impairment of receivables	(355)	(188)
Prepayments	1,727	1,016
Accrued income	884	745
Interest receivable	0	20
VAT receivable	200	345
Other receivables	2,243	1,491
Trade and other receivables - current	**8,041**	**4,854**
Provision for impairment of receivables	(195)	(239)
Other receivables	1,233	1,900
Trade and other receivables - non-current	**1,038**	**1,661**
Total	**9,079**	**6,515**

Provision for impairment of receivables	2013/14 £000	2012/13 £000
At 1st April	427	365
Increase in provision	141	75
Amounts utilised	(18)	(13)
Unused amounts reversed	0	0
At 31st March	**550**	**427**

Ageing of impaired receivables*	2013/14 £000	2012/13 £000
In three to six months	44	9
Over six months	57	39
Total	**101**	**48**
Ageing of non-impaired receivables past their due date		
Up to three months	2,500	830
In three to six months	261	(21)
Over six months	(24)	26
Total	**2,737**	**835**

*Excludes provision for impairment of receivables in respect of income due from the CRU of £449k (£379k in 2012/13).

The Trust reviews all outstanding receivables at the end of the reporting period 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 (SBS).

12. Cash and cash equivalents

	2013/14 £000	2012/13 £000
At 1st April	13,150	11,231
Net change in year	(194)	1,919
At 31st March	**12,956**	**13,150**
Made up of:		
Cash at commercial banks and in hand	19	11
Cash with the Government Banking Service	12,937	13,139
Cash and cash equivalents as at 31st March	**12,956**	**13,150**
Third party assets held by the Trust	**49**	**13**

At the end of the financial year the Trust held £49k (£13k in 2012/13) within the Trust bank accounts which related to patient monies held by the Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

13. Trade and other payables

	2013/14 £000	2012/13 £000
Current		
NHS trade payables	1,397	115
Amounts due to other related parties	2,450	1,992
Trade payables capital	1,386	1,124
Other trade payables	5,124	2,216
Other payables	24	53
Accruals	5,986	7,922
PDC payable	49	22
Social security costs (NI)	1,277	1,270
Other taxes payable (PAYE)	1,401	1,457
Total trade and other payables	**19,094**	**16,171**

14. Borrowings

	2013/14 £000	2012/13 £000
Current		
Loan from Department of Health	0	450
Total current borrowing	**0**	**450**
Non current		
Loan from Department of Health	0	0
Total non current borrowing	**0**	**0**

The loan from the Department of Health was fully repaid in September 2013.

15. Other liabilities

	2013/14 £000	2012/13 £000
Current		
Deferred income	1,353	1,140
Total other current liabilities	**1,353**	**1,140**

16. Provisions for liabilities and charges

	2013/14			
	Total £000	**Legal £000**	**Other £000**	**Pensions £000**
As at 1st April 2013	1,675	187	0	1,488
Change in the discount rate	26	0	0	26
Arising during the year	362	89	134	139
Utilised during the year	(247)	(116)	0	(131)
Reversed unused	(25)	(10)	0	(15)
As at 31st March 2014	**1,791**	**150**	**134**	**1,507**
Expected timing of cash flows:				
Within one year	415	150	134	131
Between one and five years	413	0	0	413
After five years	963	0	0	963
Total	**1,791**	**150**	**134**	**1,507**

	2012/13			
	Total £000	**Legal £000**	**Other £000**	**Pensions £000**
As at 1st April 2012	1,726	179	143	1,404
Change in the discount rate	62	0	0	62
Arising during the year	272	161	(39)	150
Utilised during the year	(349)	(117)	(104)	(128)
Reversed unused	(36)	(36)	0	0
As at 31st March 2013	**1,675**	**187**	**0**	**1,488**
Expected timing of cash flows:				
Within one year	317	187	0	130
Between one and five years	401	0	0	401
After five years	957	0	0	957
Total	**1,675**	**187**	**0**	**1,488**

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 the NHS Litigation Authority. These claims are generally expected to be settled within 1 year but may exceptionally take 2 years to settle.

Clinical negligence liabilities

£41.3m is included in the provisions of the NHS Litigation Authority as at 31st March 2014 in respect of clinical and employer's liabilities of the Trust (£37.8m as at 31st March 2013).

17. Related party disclosures

Warrington and Halton Hospitals NHS Foundation Trust is a public benefit corporation established under the NHS Act 2006. Monitor, the Regulator of NHS Foundation Trusts, does not prepare group accounts; instead, Monitor prepares NHS Foundation Trust Consolidated Accounts, for further consolidation into the Whole of Government Accounts. Monitor has powers to control NHS Foundation Trusts, but its results are not incorporated within the consolidated accounts, and it cannot be considered to be the parent undertaking for Foundation Trusts. Although there are a number of consolidation steps between the Trust's accounts and Whole of Government Accounts, the Trust's ultimate parent is HM Government.

Whole of Government Accounts bodies

All bodies within the scope of the Whole of Government Accounts (WGA) are considered to be related parties as they fall under the common control of HM Government and Parliament. The Trust's related parties therefore include other trusts, foundation trusts, clinical commissioning groups (CCGs), local authorities, central government departments, executive agencies, non departmental public bodies (NDPBs), trading funds and public corporations.

During the year, the Trust has had a number of transactions with WGA bodies. When the total transactions with a given counterparty are collectively significant, they are listed below.

Related party relationships primarily based on income from the counterparty (healthcare services)

PCTs were abolished on 31st March 2013, the new successor organisations for 2013/14 are CCGs and local authorities.

	2013/14		2012/13	
Related party	**Receivables £000**	**Payables £000**	**Receivables £000**	**Payables £000**
Ashton Leigh & Wigan PCT			0	1
Central & Eastern Cheshire PCT			11	0
Halton & St Helens PCT			333	24
Halton Borough Council	184	0	177	26
Knowsley PCT			0	179
Liverpool PCT			0	15
NHS Halton CCG	0	47		
NHS Knowsley CCG	0	0		
NHS Liverpool CCG	0	21		
NHS Salford CCG	0	49		
NHS St Helens CCG	0	37		
NHS Vale Royal CCG	114	1		
NHS Warrington CCG	450	0		
NHS West Cheshire CCG	181	1		
NHS Wigan Borough CCG	11	2		
Salford PCT			10	1
Warrington Borough Council	55	0	64	22
Warrington PCT			0	308
Western Cheshire PCT			0	77

	2013/14		2012/13	
Related party	**Income £000**	**Expenditure £000**	**Income £000**	**Expenditure £000**
Ashton Leigh & Wigan PCT			3,438	0
Central & Eastern Cheshire PCT			3,438	0
Halton & St Helens PCT			62,625	39
Halton Borough Council	3,305	436	515	25
Knowsley PCT			686	0
Liverpool PCT			691	85
NHS Halton CCG	47,612	0		
NHS Knowsley CCG	790	0		
NHS Liverpool CCG	741	0		
NHS Salford CCG	1,232	0		
NHS St Helens CCG	9,961	0		
Salford PCT			1,316	0
NHS Warrington CCG	107,402	0		
Warrington Borough Council	1,213	673	348	182
NHS Wigan Borough CCG	3,306	0		
Warrington PCT			114,356	4
Western Cheshire PCT			4,154	49
Western Cheshire CCG	4,528	0		

Other related party relationships primarily based on income from the counterparty (non healthcare services)

Related party	2013/14 Receivables £000	2013/14 Payables £000	2012/13 Receivables £000	2012/13 Payables £000
5 Boroughs Partnership NHS Foundation Trust	124	13	473	9
Bridgewater Community Healthcare NHS Trust	393	76	158	54
Clatterbridge Cancer Centre NHS Foundation Trust	46	2	1	5
Health Education England	205	26		
NHS England	883	61		
NHS North West			106	0
Royal Liverpool & Broadgreen University Hospitals NHS Trust	18	182	13	390

Related party	2013/14 Income £000	2013/14 Expenditure £000	2012/13 Income £000	2012/13 Expenditure £000
5 Boroughs Partnership NHS Foundation Trust	1,753	26	1,973	1
Bridgewater Community HealthCare NHS Trust	1,338	148	633	61
Clatterbridge Cancer Centre NHS Foundation Trust	345	0	362	1
Health Education England	6,949	0		
NHS England	0	0		
NHS North West			6,953	0
Royal Liverpool & Broadgreen	649	462	691	732

These relationships are based on the supply of staff, estates services, clinical tests, pharmacy services and education to the other party, other than NHS North West, which has provided the Trust with funding primarily for education and training purposes.

NHS Northwest was abolished on 31st March 2013, the successor bodies were NHS England and Health Education England.

Related party relationships primarily based on expenditure with the counterparty

Related party	2013/14 Receivables £000	2013/14 Payables £000	2012/13 Receivables £000	2012/13 Payables £000
Department for Communities and Local Government	0	0	0	0
HM Revenue & Customs (primarily VAT and PAYE)	200	1,401	345	1,457
National Insurance Fund (primarily Employer's NI contributions)	0	1,277	0	1,270
NHS Blood and Transplant	26	0	56	0
NHS Litigation Authority	0	2	0	1
NHS Pension Scheme	0	1,730	0	1,665
NHS Professionals	41	832	0	1,098
St Helens and Knowsley Teaching Hospitals NHS Trust	31	559	120	84

Related party	2013/14 Income £000	2013/14 Expenditure £000	2012/13 Income £000	2012/13 Expenditure £000
Department for Communities and Local Government	0	1,032	0	850
HM Revenue & Customs (primarily VAT and PAYE)	0	0	0	4
National Insurance Fund (primarily Employer's NI contributions)	0	9,199	0	8,904
NHS Blood and Transplant	0	943	5	1,109
NHS Litigation Authority	0	5,453	0	4,466
NHS Pension Scheme	0	12,750	0	12,326
NHS Professionals	0	4,005	0	4,644
St Helens and Knowsley Teaching Hospitals NHS Trust	195	2,220	277	2,178

The majority of expenditure with St Helens and Knowsley Teaching Hospitals NHS Trust comprises of drugs, staff recharges and payments for clinical supplies and services; income is mainly from the delivery of dermatology and vascular services. Payments to the Department for Communities and Local Government (DCLG) are for national non-domestic rates (business rates), which are invoiced by the two local 'billing authorities' - Warrington Borough Council and Halton Borough Council. The two billing authorities are only acting as agents between the Trust and DCLG.

The Trust made a Public Dividend Capital payment to the Department of Health totalling £4.1m (£3.9m in 2012/13) and received Public Dividend Capital of £2.1m (£12m in 2012/13) from the Department of Health.

Future commitments with related parties

2014/15 contract values with the main commissioners are listed below:

Related party	£000
Halton CCG	45,139
St Helens CCG	10,748
Vale Royal CCG	2,622
Warrington CCG	103,398
West Cheshire CCG	4,662
Wigan Borough CCG	3,302
NHS England	10,063

Charitable related parties

Warrington and Halton Hospitals NHS Foundation Trust (charitable fund with registered charity number 1051858) is a subsidiary of the Trust and therefore a related party. The Trust is the Charity's Corporate Trustee which means that the Trust's Board of Directors is charged with the governance of the Charity. The Charity's sole activity is the funding of charitable capital and revenue items for the benefit of our patients.

The Trust has received £243k in payments from the Charity within the financial year under review (£177k in 2012/13). The Charity's reserves balance as at 31st March 2014 was £664k (£657k as at 31st March 2013) with net outgoing resources of £29k for 2013/14 (£29k in 2012/13).

Other related parties

The Trust has no subsidiaries or associates, and is not involved in any joint ventures.

Key management personnel

During the financial year under review, no member of either the Board or senior management team, and no other party closely related to these individuals, has undertaken any material transactions with Warrington and Halton Hospitals NHS Foundation Trust.

18. 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 Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff Procedure cost. Monthly payments are received from commissioner based on the annual service level agreement; this arrangement reduces liquidity risk.

The Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form.

The Trust had a single Department of Health loan, which was repaid during 2013/14.

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 agreements. The credit risk associated with such customers is very low.

The Trust has minimal exposure to credit risk as all cash balances are held in within the Governments 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 11.

The movement in the provision for impaired receivables during the year is disclosed in Note 11. Of those assets which require a provision for their impairment £101k (£48k in 2012/13) are impaired financial assets.

There are no (£nil in 2012/13) 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.

19. Financial assets by category

	2013/14 Loans and receivables £000	2012/13 Loans and receivables £000
Assets as per Statement of Financial Position		
Trade and other receivables excluding non financial assets	6,278	2,400
Cash and cash equivalents at bank and in hand	12,956	13,150
Total financial assets	**19,234**	**15,550**

Financial liabilities by category

	2013/14 Financial liabilities at amortised cost £000	2012/13 Financial liabilities at amortised cost £000
Liabilities as per Statement of Financial Position		
Borrowings	0	450
Trade and other payables excluding non financial liabilities	14,803	12,919
Provisions under contract	0	0
Total financial liabilities	**14,803**	**13,369**

Fair value of financial instruments

The Trust had a loan with the Department of Health, this was repaid during 2013/14.

20. Losses and special payments

There were 84 cases of losses and special payments totalling £240k (72 cases, £170k in 2012/13) paid during the year. During the year the Trust recovered £56k from the NHS Litigation Authority in respect of Public and Employers' Liability payments made above the excess limit (£63k in 2012/13) giving net payments of £184k (£107k in 2012/13).

There were no individual cases exceeding £100k in either the current year or the prior year.