HIGH QUALITY, SAFE HEALTHCARE
QUALITY PEOPLE SUSTAINABILITY

NHS
Warrington and Halton Hospitals
NHS Foundation Trust

WARRINGTON & HALTON HOSPITALS NHS FOUNDATION TRUST
ANNUAL REPORT & ACCOUNTS 2016/17

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Welcome to Warrington and Halton Hospitals NHS Foundation Trust's Annual Report for the period 1st April 2016 to 31st March 2017

Performance Report

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

The Trust may provide goods and services for any purposes related to:-

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

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

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

Overview of Performance

It is with great pleasure that I present this annual report for 2016-17, an enormously challenging year for the 4,200 staff at Warrington and Halton Hospitals.

The national health economy faced significant sustainability challenges and pressure to achieve access standards for patients, which were inextricably linked to challenges in social care. This subsequently played out at a local level and our hospitals felt a significant impact within our own health and social care economies.

The implementation of the Five Year Forward View across 44 sustainability and transformation plans (STPs) saw this Trust become part of the Cheshire and Merseyside STP which was organised into three local delivery systems (LDS). The Alliance LDS enabled collaborative working between acute providers Southport and Ormskirk, St Helen's and Knowsley and Warrington and Halton hospitals, as well as the specialist Liverpool trusts. Together we focused on improving quality of care, reducing unwarranted variation, redesigning pathways, delivering the 7-day service agenda, working towards single teams with single leadership structures and operating models, across multiple sites.

As an alliance our mantra is 'to deliver patient care locally where possible, centrally where necessary'. This means physically or virtually clustering our skilled clinical specialists (which are in high demand), services and supporting systems to ensure that patients get the best possible care at the right time in the right place. The Alliance LDS has also looked at where we can eliminate duplication and improve efficiencies in the 'back office' again through collaboration.

Across the Cheshire and Merseyside we are tasked with closing a £900m gap and there is great distance still to travel. We are united by our commitment to ensure that our local health economies continue to deliver the best possible patient care and that we achieve sustainability of our services for future generations.

At our own hospitals we made real progress in a number of key areas, but especially in infection control and mortality rates. At 31st March 2017 we reported our 17th consecutive month MRSA-free, a C-difficile rate 30% below our target threshold and a mortality rate reducing to the 'as expected' range for the first time in a number of years. These two indicators really matter to patients and their families and I know that our staff are focussed on achieving 'best in class' in these and many other areas.

We began the year facing a devastating financial deficit of £18m, but early on NHS Improvement identified us as one of a select number of Trusts that had genuine potential to achieve with the help of sustainability funding (STF) from the Department of Health. This £8m funding had to be earned by achievement of key patient care and access standards; a financial control total deficit and cost improvement plans. I am proud to report that in the year:

- No patient waited more than six weeks for diagnostic tests.
- While more of our patients waited to be seen, treated, discharged or admitted within 4-hours during the winter quarter, we achieved the trajectory set for us by NHS Improvement of 90% for the year.
- We recorded a deficit of £8.3m but this included exceptional costs of £3.1m for impairment and restructuring costs. The deficit excluding these exceptional costs was £5.2m which was £2.9m better than the planned deficit set by NHSI of £8.1m. The recorded deficit was after the receipt of £1.1m incentive STF monies and £0.8m bonus STF monies.
- Our staff where tasked to deliver cost improvements of £10.7m and achieved £8.6m cost savings together with £2.7m of cost avoidance initiatives.

While striving to achieve national quality and access standards, we struggled, like most other Trusts, to contain medical and nursing agency spending. Recruitment to key consultant positions for certain specialties was hindered by a national shortage of these doctors. Similarly, nurse recruitment and retention was difficult given the regional over-supply of jobs and under-supply of candidates. I am relieved to note, however, that the situation really seems to be improving and we ended the year commencing a new partnership with specialist medical head hunters and launching our 'Brighter Futures' nursing campaign which saw us recruit 25 new WHH nurses on its first outing. As our reputation continues to grow as a quality, high-performing, innovative and welcoming Trust I am confident that we will be able to turn the tide on the non-contracted pay bill.

Towards the end of the year we faced our biggest challenge as the Care Quality Commission returned to carry out a full, planned inspection of our three hospitals. We know that we deliver great care because our patients and our results tell us so, but the CQC assessment remains the defining indicator upon which all care organisations are judged. In 2015 we were beyond disappointed to be assessed as 'Requiring Improvement' and our staff could not have worked harder over the intervening period to learn from shortcomings and deliver that consistency which makes good care great. We await our assessment report for 2017 with hope.

Our workforce remains our greatest asset and on 1st April 2017 we launched eight new Clinical Business Units supported by a corporate support services unit. The CBUs are led by a triumvirate of doctor, nurse/AHP and manager; are aligned around common care pathways and patients thereby putting the clinician in the driving seat to lead and develop patient care and services. The CBUs are supported by a new Medical Cabinet of senior doctors and focus on enhanced clinical leadership and quality improvement –

such as our partnership with Stanford University and enhanced patient safety work on medicines management.

The 'We Are' values of ***W**orking **T**ogether, **E**xcellence, **A**ccountable, **R**ole Model* and ***E**mbracing Change* were unveiled alongside the CBUs, the culmination of extensive involvement and engagement with staff. These refreshed values are underpinned by a set of expected behaviours which were linked to staff reward and recognition schemes. Alongside the ongoing employee and team of the month it was wonderful to host the eighth annual WHH Thank You Awards in March and recognise the amazing individuals and teams that have gone above and beyond for our patients and their colleagues. This followed the 'Long Service Awards' ceremony earlier in the year where Mayor Cllr Faisal Rashid and the lady Mayoress of Warrington recognised staff who had together served more than 2,000 years.

It really is true that you can't keep a good team down and our staff this year simply astounded us by reaching the finals of numerous renowned national awards schemes. *The Health Service Journal Awards* saw two WHH teams on the shortlist for Patient Safety and Compassionate Patient Care. *The HSJ Value and Improvement Awards* shortlisted our Paediatric Acute Response Team for community service redesign – as did the *British Medical Journal* (at time of writing we anxiously await the results!) and Midwife Katherine Conquest was 'highly commended' in the *RCM Awards* for Excellence in Maternity Care for our unique acupuncture service. Proving that all kinds of staff are focused on supporting patient care our Procurement Team were finalists in *The Guardian Public Service Awards* and the *NHS Excellence in Supply Awards*.

While every team and individual are winners in our eyes perhaps the hardest won accolade was the Royal College of Midwives' award of Midwifery Service of the Year to our amazing Maternity Services team. '*Learning from When Things Go Wrong'* told of the difficult, often emotional, journey to rebuild the service and restore the confidence of women and their families and its workforce over the past two years. *YOUR PREGNANCY, YOUR BIRTH, YOUR CHOICE* became the driver for change, using a bottom-up approach and working closely with patients and former patients to achieve a best-in-class service. The final part of the recovery journey saw the new Midwifery Led Unit open in May 2016 - a real platform for the future of midwifery and childbirth at WHH.

As we look to the future we pause to reflect on all we have faced and all we have achieved, sometimes against the odds, throughout the year. While we take a moment's pause we know that it has already started all over again in our 24/7 business and that this year will bring even bigger challenges for our staff, our hospitals, our region and our NHS nationally. We cannot continue doing what we have always done and radical change for the better is required if we are to deliver a strong sustainable health economy for the future generations of patients and staff.

Such radical change is already being seen in our region with the area of Halton Lea being selected as one of NHS England's 10 test sites for the Healthy New Town initiative. Halton General and CMTC hospitals are co-located within Halton Lea and a Health and Wellbeing Campus has become central to the development of this project. The vision of creating boundary-less, badge-less, seamless integration of mental and physical health and social wellbeing with the community is both exciting and innovative. We are working with our partners in the Borough of Halton and NHS England to fast track the journey which will place our staff and our hospital site at the forefront of reducing healthcare inequality and creating a thriving community.

At the same time I am being asked about our vision for Warrington Hospital which is landlocked, aging fast and struggling to meet current demand. As Warrington's Local Plan is to establish more than 20K new homes and establish over 350 hectares of business land in the next 20 years it is time to begin discussions about a new, fit-for-purpose hospital for the people of Warrington. The potential future 'City of Culture 2021' deserves no less!

At the HSJ national awards event in November (at which two of our teams were shortlisted), Editor Alastair McLellan noted: "When the story of this period of the NHS's history is written the authors will marvel at the resilience of its staff and conclude that it was they who pulled it through." This has never resonated more strongly and it is therefore with enormous pride and pleasure that I dedicate this 2016-17 annual report to the 4,200 amazing individuals that make up #TeamWHH.

Mel Pickup
Chief Executive

Date: 24th May 2017

3 Hospitals, 2 Sites, 1 GREAT #TEAMWHH

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

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

Warrington Hospital

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

Halton Hospital

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

Cheshire & Merseyside Treatment Centre

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

it is an extremely popular choice in the region for surgery with excellent patient feedback.

These are challenging but exciting times for the NHS nationally, and the provider sector in particular and we continued to deploy our five year strategy 'Creating Tomorrow's Healthcare Today 2014-19 – creating a sustainable organisation for the future that will deliver what our local population needs from their hospitals – within the constraints of our financial position.

Our place in the wider health economy

In delivering the Five Year Forward View we are part of the Cheshire and Merseyside Sustainability and Transformation Plan (STP) the second largest STP in the country. We are working collaboratively as part of one of three Local Delivery System within the STP in the 'Alliance LDS' where our acute trust partners are St Helen's and Knowsley NHS Trust and Southport and Ormskirk NHS Trust.

Our vital statistics

- We serve a population of 330K across both boroughs
- We saw approximately 109K A&E visits and circa 30K Urgent Care visits in year
- We deliver 500,000 individual patient appointments, procedures and stays
- We have circa 540 beds across 2 sites:
  - 431 acute care inpatient, day case and specialist beds at Warrington
  - 44 elective surgical beds and 22 intermediate care beds at Halton
  - 42 T&O beds at CMTC
- We have a bespoke Forget-Me-Not unit where we deliver acute care for patients with dementia
- We employ around 4,200 strong workforce comprising 52 nationalities
- We are proud to have been named as one of the 100 Best Places to Work in the NHS - Health Service Journal
- Our Maternity service has been awarded 'Best Maternity Service in the UK' by the RCM
- We have three key commissioners: Warrington CCG (main), Halton CCG and NHS England Specialist Commissioning
- We have an annual turnover of over £210 million
- Around 3,000 babies are born at Warrington Hospital each year
- We became an NHS Foundation Trust in December 2008

Our Mission, Vision and Values

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

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

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

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

The hospital has undergone significant development over recent years with a rebuilt accident and emergency and coronary care unit and refurbishment of most of the wards. A new critical care unit costing

£6.25 million opened in February 2009 and in late 2010 new endoscopy and eye surgery units opened in the Appleton Wing.

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

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

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

To achieve our vision we believe we need to focus on the **QUALITY** of our services, on the **PEOPLE** who deliver them and on ensuring our organisation's **SUSTAINABILITY**, within the wider health economies in which we operate. The **QPS** Aims and Objectives are: **QUALITY:** Delivering excellence for our patients **PEOPLE:** Committed to and caring for our staff **SUSTAINABILITY:** Being here for our communities, now and going forward.

Our Values 'WE ARE' Values guide everything we do

Key Organisational Risks 2016-17

The organisations has identified the following strategic risks (Red risks rated at 15 and above)

- Failure to provide adequate staffing levels in some specialities and wards caused by inability to fill vacancies, sickness which may result in pressure on ward staff , potential impact on patient care and impact on Trust access and financial targets.
- Failure to sustain financial viability, caused by internal and external factors, leading to potential impact to patient safety, staff morale and enforcement/regulatory action being taken.
- Failure to deliver national and local performance targets will impact on patient care, reputation and financial position.
- Failure to provide adequate and timely IMT system implementations & systems optimisation caused by either increasing demands and enhanced system functionality which results in pressure on staff; potential in systems being poorly used resulting in poor data quality. Impact on patient access to services, quality of care provided, potential patient harm and financial & performance targets.
- Lack of assurance regarding complaints handling within the Trust, caused by ineffective systems and processes, resulting in a poor experience for complainants, the Trust not meeting statutory and contractual complaints targets and not having effective systems in place to learn lessons from complaints
- Failure to identify and manage patients' risk of sustaining a fall; caused by inadequate risk assessment and implementation of appropriate care plans. This may cause patient harm, has a negative effect on the patient's experience, may prolong their length of stay, and give rise to complaints and claims against the trust.
- Failure to provide timely information caused by increasing internal and external demands for datasets, implementation of new systems and a lack of skilled staff with capacity to respond. This may cause financial impact, external reputation damage and poor management decision making due to lack of quality data.
- Lack of assurance regarding the Trust's safeguarding agenda being implemented across the Trust due to gaps highlighted during external review may impact on patient safety and cause the Trust to breach regulations.
- Failure to influence sufficiently within the STP and LDS may result in an inability to provide the best outcome for our patient population and organisation, potential impact on patient care, reputation and financial position.
- Failure to maintain an old estate could result in staff and patient safety issues, increased costs and unsuitable accommodation.

These risks are recorded on the Board Assurance Framework and are scrutinised quarterly by the Board, Quality Committee and the Audit Committee. In addition, any new risks, or changes to risk ratings, are provided in a monthly update to the Board

Going Concern Disclosure

The Directors are seeking additional support from the Department of Health for 2017/18 of £3,657,000 and for 2018/19 of £3,553,000. The Department of Health has not confirmed this support. These factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. However, the Directors, having made appropriate enquiries, have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

The Department of Health recommended the Trust submit a Board Resolution to enable the Chief Executive to draw down loans in 2017/18 to the value of £3,657,000. The Board Resolution was approved at the Trust Board in March 2017. Of this £1,603,000 was drawn down in April 2017 in line with the plan.

As directed by the 2016/17 Department of Health Group Accounting Manual the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

Performance Analysis

The Trust's annual plan for 2016/17 was the delivery vehicle for *Creating Tomorrow's Healthcare Today* - our five year strategic plan - underpinned by four strategic objectives which represent our core activities. Key Performance Indicators, aligned to the strategic objectives, are monitored by the Clinical Operations Board, the Executive Team and the Trust Board.

Our strategic objectives are:

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

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

Quality

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

Performance indicators

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

People

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

Sustainability

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

Activity and Performance

During 2016-17 A&E Attendances increased by 3.3 % and non-elective admissions increased by 11.0%.

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

Within this year we improved access to emergency care by opening a dedicated Ambulatory Care Unit where patients that can be treated within the same day (and do not require an overnight stay) can receive their treatment and be discharged home. Patients can be directly referred to the Unit by their GP or from the Emergency Department. Patients can be assessed, diagnosed and treated within the Unit and go home on the same day.

Activity variance

Activity	2014/15	2015/16	% change 15/16 vs 14/15	2016/17	% change 16/17 vs 15/16
Elective Inpatient Discharges	5,525	5,461	-1.2%	5,281	-3.3%
Elective Day Cases Discharges	33,015	31,429	-4.8%	31,622	0.6%
Non-Elective Discharges	39,777	38,542	-3.1%	42,773	11.0%
New Outpatient Attendances	123,321	117,912	-4.4%	108,702	-7.8%
A&E Attendances	102,625	105,450	2.8%	108,890	3.3%

Delivering the Four Hour Standard

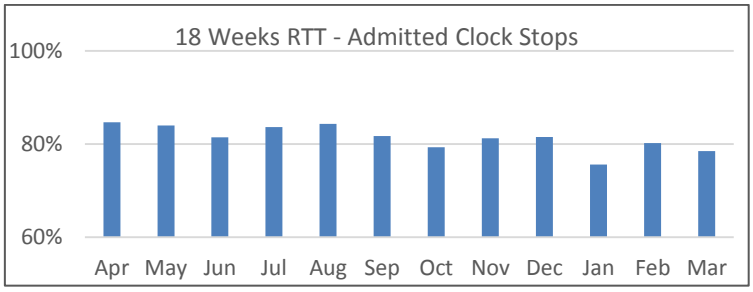
It is an expectation that all patients who attend accident and emergency are seen and treated within four hours. Nationally the target is 95% and the majority of acute trusts struggled to achieve this target in year, this trust included. The chart below illustrates our performance in seeing and treating patients within this time. While the Trust performed reasonably well in all months (except the three winter months December, January and February) it did not achieve the 95% national standard.

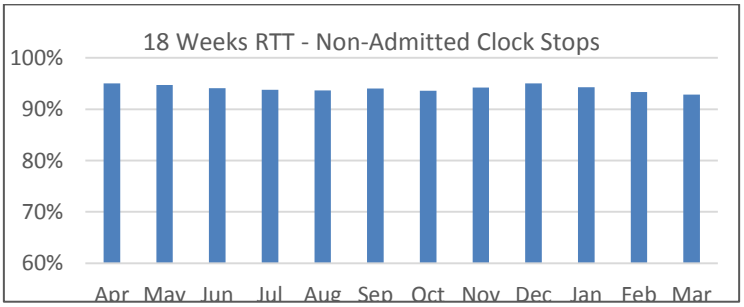
National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
A&E & MIU	% Departed <=4hrs	>=95%	90.45%	92.29%	93.52%	92.12%	92.69%	92.88%	94.75%	93.43%	92.05%	91.59%	85.13%	89.61%	85.85%	84.49%	90.74%	87.16%	90.60%
	* Number of attendances		9749	10875	10240	30864	10791	10288	10311	31390	10599	9986	10182	30767	10265	9403	10717	30385	123406
	* Number of patients breaching 4hrs		931	838	664	2433	789	733	541	2063	843	840	1514	3197	1452	1458	992	3902	11595

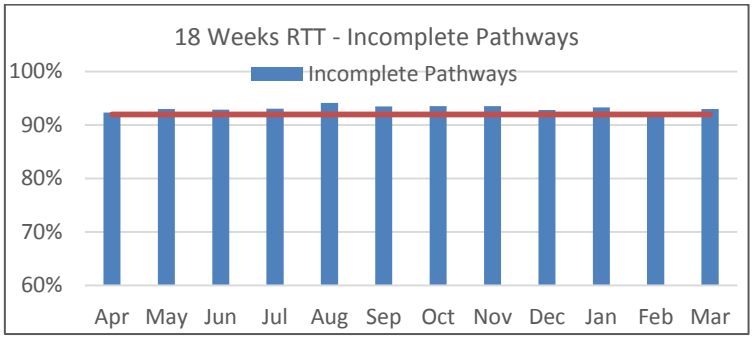
As part of our Sustainability and Transformation Funding Agreement (STF) with NHS Improvement for 2016-17 we agreed to meet an improvement trajectory for the 4-hour standard in year. We performed well against the NHSI trajectory of 90% for the year and closed with a performance of 90.60%.

Waiting Times

The Referral to Treatment (RTT) operational standards for England were met throughout the year. We moved to a centralised RTT management function which supports both validation and education and training for all staff on their roles and responsibilities when recording RTT clock starts and stops for each patient to ensure accuracy.







Delayed Transfers of Care

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

The successful discharge of frail older patients following emergency admission to hospital relies on effective joint working between NHS, social care partners and the independent sector. Early assessment and review using the most appropriate multi-disciplinary team at the point of entry to urgent and acute services was essential for frail older patients to ensure a timely and appropriate diagnosis is made, and then a plan for discharge can be implemented.

A community geriatrician continues to work closely with GPs and the extended community teams to prevent admissions and monitor those patients over 75 who have been identified at high risk of admission or readmission. The table below shows the number of delayed patients in our hospital beds on the last Thursday of every month, which is the current measure all Trusts use and report to NHS England. It also shows the number of days the patients remain delayed in a hospital bed awaiting ongoing care.

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total
Number of patients delayed on the last Thursday of each month	22	12	2	23	27	4	90
Total days lost in month	607	344	408	465	562	492	2878
Number of occupied bed days (patients aged 18+)	14547	15148	15219	14180	15293	16907	91294
Days lost as % of occupied bed days	4.17%	2.27%	2.68%	3.28%	3.67%	2.91%	3.15%
Average daily bed days lost	20	11	13	15	19	16	94
Average general and acute occupied beds (including Critical care, excluding Neonatal, Paediatrics and Daycase beds)	518	506	471	526	264	530	2815

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

ECIP System enquiry /review

The Emergency Care Improvement Program (ECIP) supported the Trust in the later part of the year and in October 2016 conducted a full system review across all parts of the local health and social care system within both Warrington and Halton. The following our main areas were identified as key priorities for the system to focus on to improve patient flow and ensure they receive the right care, in the right place, at the right time with minimal delays - therefore supporting appropriate discharges.

1. Developing system leadership
2. Assessment prior to admission
3. Doing today's work today
4. Discharge to assess

National Targets and Regulatory Requirements

Below is a summary of all the national targets and regulatory requirements that we were expected to achieve and performance against each target for the past four years.

The Trust achieved performance against the % of cancer patients waiting a maximum of 2 months from urgent GP referral to treatment for the majority of the year however failed to achieve this in quarter four achieving just under 84% against the 85% standard. Causal factors have been resolved and plans are in place to deliver the high performance we have delivered for our patients consistently in previous years.

Performance against national target and regulatory requirements 2016/17

National Targets and Minimum Standards	Target	Target 2016/17	2016/17	2015/16	2014/15	2013/14
Infection Control	Number of clostridium difficile cases 16/17 & 15/16 are the numbers due to lapses in care	<= 27	11	10	31	31
	Number of MRSA blood stream infection cases	0	0	2	3	3
Access to Cancer Services	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	97.60%	99.33%	98.67%	99.17%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (anti cancer drugs)	98%	100.00%	100.00%	99.81%	100.00%
	% of cancer patients waiting a maximum of 31 days for subsequent treatment (surgery)	94%	95.24%	99.00%	99.14%	100.00%
	% of cancer patients waiting a maximum of 2 months from urgent GP referral to treatment - Open Exeter	85%	84.04%	85.77%	88.26%	87.76%
	% of cancer patients waiting a maximum of 2 months from urgent GP referral to treatment - Reallocation	85%	83.09%	85.00%	88.38%	84.69%
	% of cancer patients waiting a maximum of 2 months from the consultant screening service referral to treatment	90%	100.00%	96.88%	99.52%	100.00%
	% of cancer patients waiting a maximum of 2 weeks from urgent GP referral to date first seen	93%	93.33%	93.88%	94.04%	94.79%
	% of symptomatic breast patients (cancer not initially suspected) waiting a maximum of 2 weeks from urgent GP referral to date first seen	93%	91.30%	93.20%	93.45%	95.00%
Access To Treatment	18 weeks Referral to Treatment - admitted		81.49%	90.70%	92.34%	91.73%
	18 weeks Referral to Treatment - non-admitted		94.03%	96.42%	97.61%	97.81%
	18 weeks Referral to Treatment - patients on incomplete pathway End of March position	92%	93.01%	92.50%	93.60%	94.66%
Access to A&E	% of patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	95%	90.60%	88.09%	89.75%	95.56%
Access for patients with a learning disability	The Trust provides self-certification that it meets the requirements to provide access to healthcare for patients with a learning disability	N/A	YES	YES		
Cancelled operations on the day for a non-clinical reason	Number of Cancellations not offered a date for readmission within 28 days	0	9	16		
	% of in-patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital	<= 2%	0.55%	1.02%	1.32%	1.36%
	% of those patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not readmitted within 28 days		11.17%	8.74%	2.81%	1.58%

National NHS Inpatient Survey 2016

The 2016 Inpatient survey was undertaken by Quality Health on behalf of the Trust and covered all aspects of patient's admission, care and treatment, operations and procedures and discharge from hospital from the inpatient specialties of General Surgery; Urology; Trauma and Orthopaedics, Cardiology, Acute Internal Medicine, Stroke and Respiratory Medicine. The initial results of the Inpatient Survey (2016) were received in March 2017. 1,193 patients were randomly selected during an inpatient stay in July 2015 and 40% responded compared to a response rate of 44% last year. 50% of respondents were over the age of 65 and 44% were male and 56% female. The following are the main headlines for 2016 benchmarked against 2015 results:

The Trust has shown improvement on the following questions:
Higher is better

	2015	2016
Waiting List or Planned Admission		
Little or no change to planned admission date	87%	90.6%
Specialist had been given all the necessary information about patient's condition	89%	90.2%
The Hospital &Ward		
Did not share a sleeping area with patients of the opposite sex at any time	93%	95.8%
Operations & Procedures		
Before the operation staff explained the risks and benefits in an understandable way	89%	89.7%
Before the operation staff explained what would be done during the operation	84%	84.4%
Before the operation staff gave understandable answers to patient questions	86%	87.6%
Before the operation the anaesthetist explained in an understandable way how patients would be put to sleep	91%	91.8%
Leaving Hospital		
Before leaving hospital patients were given written information on what they should or should not do after leaving	69%	69.2%

The Trust has deteriorated by 5% or more on the following questions:
Higher is better

	2015	2016
All types of Admissions		
Patients did not have to wait a long time to get a bed on a ward	76%	64.9%
The Hospital & Ward		
Patients got enough help from staff to eat their meals	77%	65.7%
Nurses		
Patient felt that there were enough nurses on duty	75%	68.2%
Your Care and Treatment		
Hospital staff worked well together	90%	84.8%
Hospital staff did not give contradictory information	86%	80.9%
Patients were able to find somebody to talk to about their worries and fears	58%	52.7%
Patients thought that staff did everything to control their pain	84%	78.9%
Length of time to get help after using the call button	65%	59%

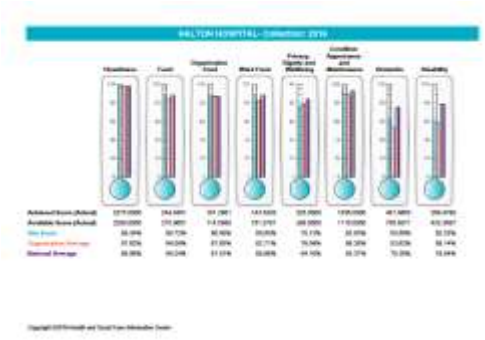
Leaving hospital		
Patients were given enough notice about their discharge	74%	67.1% ↓
Discharge not delayed due to wait for medicines/ to see a Dr/ for ambulance	66%	59.8% ↓
Discharge delayed for no longer than four hours	78%	72.9% ↓
Staff explained the purpose of medication in an understandable way	85%	78.7% ↓
Staff explained about the medication side effects to be aware of	54%	44.7% ↓
Patients were told in an understandable way how to take their medication	85%	78.9% ↓
Patients were told about what danger signals to watch for after their return	60%	54.8% ↓
Hospital staff took the home situation into account when planning discharge	75%	69.1% ↓
Patients were told who to contact if they were worried about their condition after they had left hospital	81%	72.2% ↓
Overall		
Patients received information on how to complain to the hospital about the care they received	29%	22% ↓

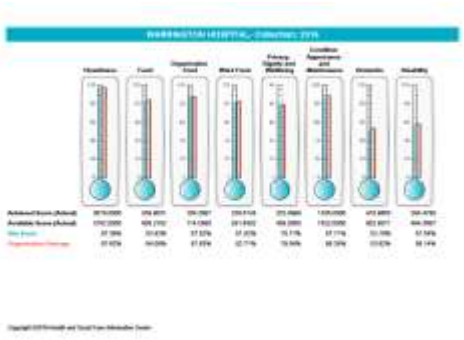
While there was improvement on 8 questions overall, and significantly better on one question the Trust deteriorated by 5% or more on 18 questions equating to 23% and is in lowest 20% national threshold for a further 32 questions or 42% of responses. The main themes for improvement are *leaving hospital and discharge* and *hospital care and treatment*. A new Patient Experience Strategy will align work streams to address the highlighted themes within the In Patient Survey and will provide a bi-annual update to the Quality Committee via the Patient Experience Sub Committee in the coming year.

Patient Care Environment

The 2016 Patient-Led Assessment of the Clinical Environment included an extensive list of changes, particularly relating to the Cleanliness, and Condition, Appearance and Maintenance sections, as well as elements of the Dementia assessment. This means making any direct Trust comparison to previous year's reviews impracticable, although a full action plan was implemented to address the issues that arose from the 2015 assessment.

The 2016 PLACE assessment, as in previous years involved Patient Assessors, who were asked to provide a non-technical view of the buildings and non-clinical services provided across the Trust. The outcome of that assessment can be seen in the following charts:





Generally the Trust scored well against cleanliness and food, with privacy and dignity, and condition, appearance and maintenance, falling slightly below the national average. The low dementia and disability scores relate directly to environmental improvements required generally across the Trust, and these are currently under review.

A full action plan was implemented following the assessment, and over 90% of the issues identified have been addressed.

Financial Performance

At the start of the year we faced an almost £18m deficit but were selected by NHS Improvement as one of a number of Trusts likely to benefit from Sustainability and Transformation Funding. This £8m STF award was linked to the achievement of performance and financial targets. We recorded a deficit of £8.3m but this included exceptional costs of £3.1m for impairment and restructuring costs. The deficit excluding these exceptional costs was £5.2m which was £2.9m better than the planned deficit set by NHSI of £8.1m. The recorded deficit was after the receipt of £1.1m incentive STF monies and £0.8m bonus STF monies.

Our staff were tasked to deliver cost improvements of £10.7m and achieved £8.6m cost savings together with £2.7m of cost avoidance initiatives.

The Use of Resources Rating score was 3.

Sustainability and climate change at the trust

One of the trust's key objectives is around sustainability and a key part of that is around carbon reduction and climate change. As the largest single organisation in the UK, the NHS is responsible for major consumption of resources emitting around 18 million tonnes of CO2 every year. It is therefore incumbent on all NHS organisations to lead, both by example and in practice, in making sustainability a strategic priority.

2016-17 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. It saw the combined heat and power units on both the Halton and Warrington sites be put into full operation, as well as the removal of local gas fired plant with plate heat exchangers, and the installation of new low energy dual-fuel boilers on the Halton site.

- **The trust has reduced its Carbon Footprint (from a 2009-10 baseline) by 24.65% based on the 2015-2016 energy consumption figures.**

It should be noted that in 2012/13 an additional building, with a footprint of 6.948m^2, was added to the estate.

The overall sustainability strategy of the trust

The aims and objectives of the trust's sustainability strategy, as encompassed by the trust's Sustainable Development Management Plan, are to:

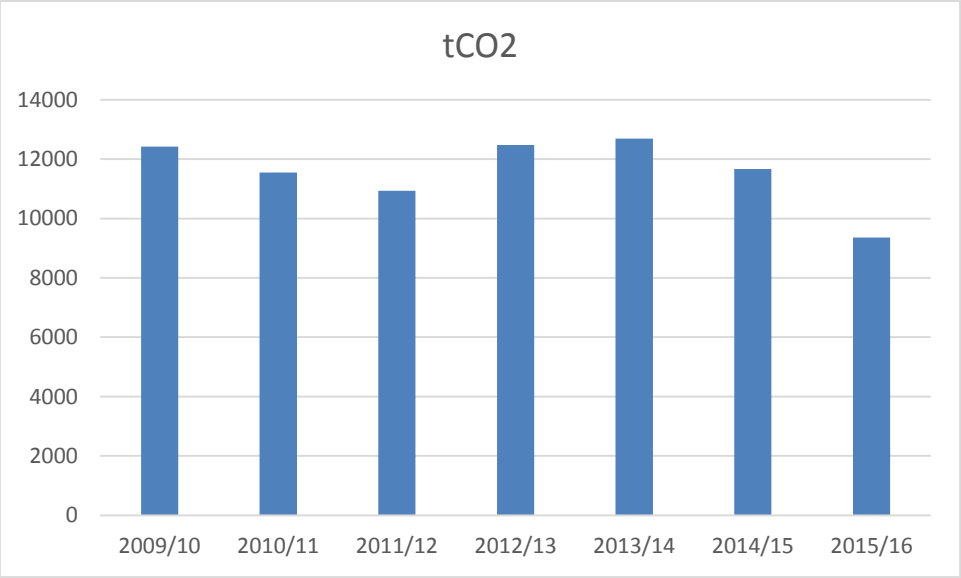
- Reduce the trust's carbon footprint in line with the trust's Carbon Management Plan.
- Ensure that all resources are used effectively and economically, thus releasing more funding to be spent directly on patient care

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

The responsibility for managing sustainability falls under the remit of the Sustainable Development Group that reports to the Estates Strategy Group. The chairman of the group will draw attention of the group to any issues that require disclosure to the full board or requiring executive action.

Sustainability performance summary

The graph and table below summarises the Trusts position with regard to its tCO^2 reduction and its current energy consumption:



	2016-17	
	Total usage	**Cost (£)**
Water	**93,381m3**	**£366,372**
Electricity	**2,693 tCO2**	**£634,940**

Gas	**9,236 tCO2**	**£985,605**

Waste Production and Control

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

Future priorities and targets around sustainability

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

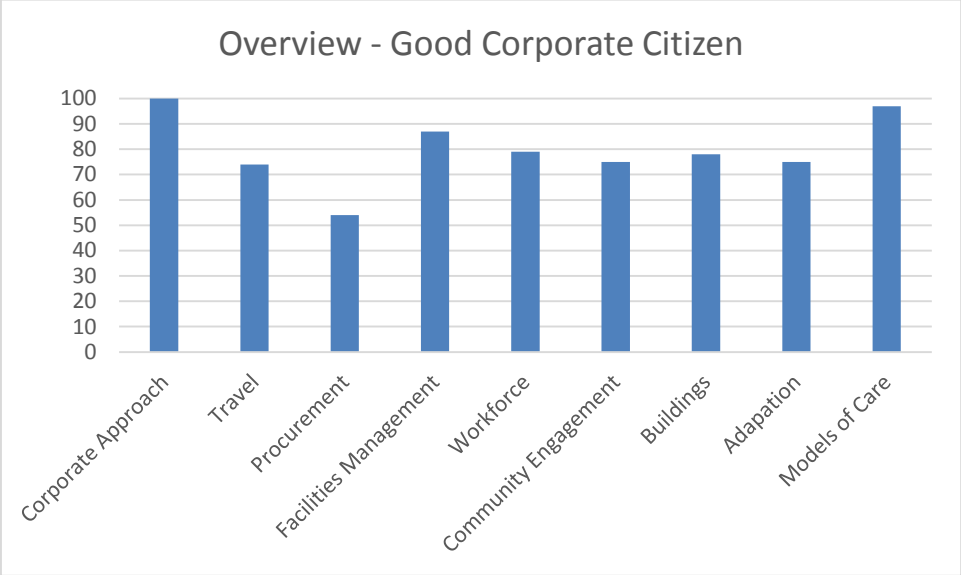
"Warrington and Halton Hospitals NHS Foundation Trust will become a leading carbon management and sustainability partner within the local community and across regional public sector carbon management / sustainability networks. The trust will work with staff, patients, suppliers and key stakeholders to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

In 2011 the Trust's Carbon Management Plan set out the following ambitious carbon reduction target:

''Warrington and Halton Hospitals NHS Foundation Trust will reduce its measured (Level 2+) baseline carbon footprint emissions (2009-2010) by a minimum of 30% by the end of March 2015.

As a consequence the trust identified, developed and reviewed the potential implementation of a large number of carbon saving schemes in order to achieve the above target.

- The Trust then successfully entered tranche 1.5 of the NHS Carbon and Energy Fund (CEF) scheme procurement process to install Combined Heating and Power (CHP) on both the Warrington and Halton hospital sites. CHP plant would provide the trust with both heat and electricity generated on site, resulting in both financial and carbon savings. This scheme is now fully operational.
- The CEF Scheme process investigated the potential installation of energy efficient lighting schemes across the trust which was also implemented.
- The trust has implemented a Sustainable Procurement Policy.
- The trust's Sustainable Development Group actively uses the NHS Good Corporate Citizenship Assessment Test and has already achieved the 2018 NHS Good Corporate Citizenship targets, and is well placed to achieve the target scores set for 2020. The Trust's current overall score is 78%, and the following graph identifies the position for each of the 9 core areas:



The Trust continues to focus on improving these scores.

- The trust is a full participant in the CRC – Energy Efficiency Scheme operated by the Environment Agency. Under the CRC Scheme arrangements, the trust has a mandatory obligation to monitor and report all relevant carbon emissions to the Environment Agency on an annual basis. The trust will also have a mandatory obligation to purchase sufficient annual Carbon Allowances to cover all relevant CRC Scheme carbon emissions each year.

- The Trust has produced a Travel Plan to minimise the impact of travel associated with the Trust, which sets out a strategy for reducing dependency on the private car while facilitating and encouraging travel by healthier and more sustainable means. The major objectives of the plan are to:

    - Objective 1 – to increase the level of cycling to and from the site
    - Objective 2 – to increase the level of walking to and from the site
    - Objective 3 – to increase the use of public transport use to and from the site
    - Objective 4 – to increase the number of people car sharing to and from the site, and in turn.
    - Objective 5 – to reduce single occupancy car travel to and from the site

Social, Community and Human Rights Issues

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

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

The trust participates with the 'Good Corporate Citizen Guide' and is proud that for its 'Workforce' it has a compliance score of 79% against the North West average of 12%.

Material changes since 31st March 2017

NHS Property Services has assumed ownership of the renal unit at Halton Hospital with effect from 1.4.17

Accountability Report

Directors' Report

Membership of the Board of Directors for the reporting period was:

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

Steve McGuirk joined us as chairman in April 2015. Steve, who lives in Warrington, joined the fire service in 1976. He retired from his role as county fire officer and chief executive of Greater Manchester Fire and Rescue Service in 2015. He was previously county fire officer and chief executive for Cheshire Fire and Rescue Service before taking on the post in Greater Manchester in 2009. He has also been a Board member and president of the Chief Fire Officers Association and has been the principal adviser on fire and rescue matters to the Local Government Association. He was awarded the long service and good conduct medal in 1996, the Queen's Fire Service Medal in 2002, and the CBE in 2005. He has also gained extensive experience in governance of public authorities.

Melany Pickup - Chief Executive

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

Executive Directors (Voting)

Prof Simon Constable - Medical Director & Deputy Chief Executive

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

Andrea Chadwick - Director of Finance & Commercial Development

Andrea was appointed director of finance & commercial development from February 2016. Andrea joined the Trust from Calderstones Partnership NHS FT where she had been seconded from Mersey Care NHS Foundation Trust as Director of Finance and Information. She is a qualified accountant (ACCA) and has worked for the NHS for over 20 years. During this time Andrea has gained experience working within acute, mental health, learning disability, community and ambulance services and has led finance, estates and information teams. Andrea is a strong supporter of staff development and has received personal and team awards for finance staff development in the North west and nationally.

Karen Dawber - Director of Nursing & Governance (to 28.08.2016)

Karen joined the Trust as director of governance and workforce in January 2012 and became director of nursing and organisational development in May 2013. Karen has extensive NHS managerial, operational and clinical experience, starting her career as a paediatric nurse at Manchester Children's Hospitals. Prior to this Karen has been a director of nursing at both The Walton Centre and Alder Hey Children's hospital. Karen has been involved in many national and regional nursing initiatives including speaking at many national conferences and universities. She is passionate about people and communications and is an avid social media user with a large following, where she speaks out on nursing and LGBT issues. She was named as one the NHS LGBT Leaders by the Health Service Journal's inaugural list. Karen left the Trust in August 2016 to take up the Chief Nurse post at Bradford Teaching Hospitals

Kimberley Salmon-Jamieson – Chief Nurse

Kimberley joined the Trust in September 2016, having previously held the position of Deputy Chief Nurse at Pennine Acute NHS Trust. With 20 years of experience working as a nurse in the NHS, she has enjoyed a variety of management and nursing roles, gaining a reputation for enthusiasm and energy. Prior to working for Pennine, she was Deputy Chief Nurse at University Hospital South Manchester NHS Foundation Trust. Her first management role was at Salford Royal NHS Foundation Trust where she had previously worked as Advanced Nurse for a long period of time. Her interests in the health sector include patient safety and experience, service development and education.

Sharon Gilligan – Chief Operating Officer

Sharon was appointed as Chief Operating Officer in December 2015 having previously held the position of Director of Operations at Wirral University Teaching Hospitals. Prior to that Sharon worked for Newcastle upon Tyne Hospitals NHS Foundation Trust in a number of key operational roles including Assistant Director of Operations and Assistant Director of Service Improvement. Sharon has also managed a number of complex services including the Regional Neurosciences Centre and Trauma and Orthopaedics. Sharon's 20 years of operational experience is supplemented by an MBA. Sharon has a strong track record of engaging with staff at all levels to ensure the delivery of high quality, cost effective care whilst achieving performance targets and enhancing patient experience.

The Board was supported by four non-voting Executive Directors with specific portfolio responsibilities:

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. Jason is married with four children and enjoys reading, walking, football management and music.

Roger Wilson - Director of Human Resources

Roger joined the trust as an interim director of human resources and organisational development in February 2015 and was appointed to the permanent post in April 2015. Prior to joining the trust, Roger had successfully managed his own consultancy business for nearly three years. Roger has eight years board level experience in the NHS in HR and OD and has over 28 years total NHS experience. He has worked across the North West of England in a range of roles and healthcare settings. He has spoken at national conferences for both the Health Service Journal and the Chartered Institute of Personnel and Development. He is passionate about supporting staff to be the very best they can be.

Pat McLaren - Director of Community Engagement and Corporate Affairs (Company Secretary Designate)

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

Lucy Gardner - Director of Transformation

Lucy joined the Trust in February 2016 from her role as a Director in Ernst & Young (EY)'s healthcare advisory practice. Her role as Director of Transformation is a new role, designed to lead transformation across the Trust and work with partner organisations to deliver change, enabling sustainable healthcare locally. Lucy started her career 12 years ago as an NHS General Management Trainee, gaining a Masters degree in health and social care leadership and management. In the 12 years she has held a number of operational management roles within the NHS and subsequently, in her role at EY, led large scale change programmes to deliver significant financial, quality and performance benefits within healthcare.

Non-Executive Directors

Lynne Lobley (to 30.11.2016)

Lynne joined the Trust Board as a non-executive director in December 2009 and is Chair of the Quality Committee. Lynne is also Deputy Chair of the Trust. She previously held 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. Lynne stepped down from the Trust in November 2016 having served the maximum permitted term.

Ian Jones

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

Terry Atherton

Terry Atherton joined the Trust Board as a non-executive director in July 2014 and was appointed Deputy Chair in March 2017, he chairs the Finance & Sustainability Committee. Terry worked for NatWest Bank for 35 years leading large teams and profit centres across the North West and North Wales. For the last 14 years he has worked with the both the public and private sector in a number of Board positions in a non-executive capacity. Terry was appointed chair of Trafford Primary Care Trust in 2009 and following the national NHS reorganisations, he became vice-chair of the cluster of ten Greater Manchester PCTs with specific responsibilities for oversight of the workforce of 2,700 and of service redesign initiatives. He was appointed in January 2013 as Independent Chair of the Morecambe Bay “Better Care Together” Programme before joining the Trust. Terry lives in Cheshire.

Anita Wainwright

Anita Wainwright joined the Trust Board as a non-executive director in January 2015. A very experienced human resources and organisational development professional Anita has worked in both the public and private sector in the North West for over 35 years, gaining experience in the nuclear and gas industries; financial services; the fire service and the Environment Agency before joining the NHS. She was appointed as Director of HR and OD at University Hospital South Manchester in 2012 and in 2014 was seconded to Tameside Hospital to support their improvement programme. Although Anita has had experience of operating at executive level, this is her first non-executive appointment. Anita is also currently undertaking an interim role at University Hospitals Central Manchester NHS Foundation Trust. Anita has lived in Warrington for over 25 years.

Dr Margaret Bamforth

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

Terms of Office (non-executive directors)

Name	Commencement date	Term of Office expiry date	Notice period
Steve McGuirk	01/04/2015	31/03/2018	Three months
Lynne Lobley	01/12/2009	01/12/2016	Term ended
Ian Jones	01/07/2014	30/06/2017	Three months
Terry Atherton	01/07/2014	30/06/2017	Three months
Anita Wainwright	01/01/2015	31/12/2017	Three months
Margaret Bamforth	01/05/2016	30/04/2019	Three months
Vacancy			

Register of interests

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

Fit and Proper Persons Declaration

In line with the requirements of the Provider Licence all directors and governors have met the 'fit and proper' person test.

How the Board Operates

The Board at Warrington & Halton Hospitals NHS FT has a collective responsibility for:

- setting the strategic direction of the Trust
- ensuring the organisation operates effectively and with openness, transparency and candour
- shaping the culture of the organisation

The Board delegates operational management and the execution of strategy to the executive team and has established an integrated governance structure to provide it with assurances that it is discharging its responsibilities.

The unitary nature of the Board means that non-executive directors and executive directors share the same liability and the responsibility and during the year under review the Board comprised of six independent non-executive directors including the chairman, five voting executive directors including the Chief Executive and four non-voting directors.

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 all voting directors together with details of the deputy chair and senior independent director can be found at the beginning of this section. Of the ten voting serving members on the Board as at 31 March 2017, six are female and four are male. During the year the structure and composition of the executive directors changed.

Our Non-Executive Directors bring a wealth of Board level experience and provide challenge and scrutiny of performance. Further details on the appointment of executive and non-executive directors can be found in the Remuneration Report. The Board considers all of its current Non-Executive Directors to be independent in character and judgment.

All directors have full and timely access to relevant information to enable them to discharge their responsibilities. The Board meets on a monthly basis 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 proceedings at all Board and committee meetings are fully recorded and allow for any director to discuss any concerns. 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 to further support them in the delivery of their duties. All directors have access to the professional advice of the company secretary who is responsible for advising the board on all governance matters, including ensuring that the organisation complies with the relevant legislation and regulations and for ensuring compliance with board probity and procedures. The appointment or removal of the company secretary is a matter for the Board as a whole.

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 team, 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.

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 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 Board believes it has a good balance of skills, experience and length of service and has worked on succession planning for Board members in the year. 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.

Committees of the Board of Directors

The Board has three statutory committees: the Charitable Funds Committee, the Audit Committee and the Nominations and Remuneration Committee. There are three additional committees: the Quality Committee; the Strategic People 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. Urgent matters are escalated by the committee chair to the Board as deemed appropriate. Each committee is chaired by an independent non-executive director.

The Work of the Audit Committee

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

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

Member	**Attendance (Actual v Max)**
Ian Jones, Non-Executive Director & Chair	5/5
Lynne Lobley, Non-Executive Director (until October 2016)	2/4
Margaret Bamforth (from May 2016) Non-Executive Director	0/3
Terry Atherton, Non-Executive Director	4/5
Anita Wainwright, Non-Executive Director	1/5

Regular attendees at the Committee Meetings were the Trust's external auditors PriceWaterhouseCooper (to December 2016) and Grant Thornton (External Auditors from January 2017), Mersey Internal Audit Agency (MIAA - Internal Audit and Counter-Fraud Services), the Director of Finance & Commercial Development and the Company Secretary.

Terms of Reference

The Committee's Terms of Reference were reviewed and agreed in January 2017 to ensure they continue to remain fit-for-purpose.

Governance & Risk Management

During the year the Trust has sought to build on the significant work undertaken in the previous year in this area to embed an integrated Governance & Risk system and approach to comply fully with Monitor's Foundation Trust Code of Governance. The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and

governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a significant assurance rating from the Head of Internal Audit (HOIA).

Internal Audit Activities

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

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

Significant Assurance

- Combined Financial Systems
- Information Governance
- Lorenzo Phase 2
- Clinical Quality Dawes
- Performance Compliance – PDR and Mandatory Training
- Payroll

Limited Assurance

- Exit Payments
- Do Not Attempt Cardiopulmonary Resuscitation
- On Call, Call Out and Overtime arrangements
- Bank and Agency
- E Rostering
- Clinical Business Unit Accountability

Two-part audits (crossing more than one financial year)

- Complaints

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

The aim of the Committee is to ensure best practice is shared within the wider Trust where high assurance levels are received. The Director of Internal Audit overall opinion for the period 1st April 2016 to 31st March 2017 was Significant Assurance.

External Audit

The three year contract for the supply for external audit services by PriceWaterhouseCooper (PWC) expired at the end of September 2016. In accordance with Monitor's guidance, the Trust undertook a full market testing exercise during the year. Following this process, the award for the supply of External Audit Service was granted to Grant Thornton who attended their first Audit Committee meeting in January 2017. PWC attended a Council of Governors meeting following the production of the Annual Report and Financial Statements to ensure Governors are assured by the process undertaken to audit the accounts. In addition, they also presented their opinion on the Quality Account to the Council of Governors and to the Annual Members Meeting.

PriceWaterhouseCooper (PWC) continued its role as Auditors to the Trust to October 2016 and during the year reported on the 2015-16 Financial Statements & Quality Accounts. No material or significant issues were raised in respect of these Statements and Accounts. Technical support has been provided on an ongoing basis to the Committee and the Trust and representatives of PWC attended each Audit Committee. During 2016-17, the Trust remained red for governance under Monitor's Risk Assessment.

Anti-Fraud Activity

The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Counter Fraud Service (CFS) working to a programme agreed with the Audit Committee. The role of CFS is to assist in creating an anti-fraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures. Pro-active work has also included induction and awareness training along with ensuring Trust policies and procedures incorporate, where applicable, anti-fraud measures including the Anti-Fraud, Bribery and Corruption Policy. The Audit Committee received regular progress reports from the CFS and also received an annual report. No significant cases or issues of Anti-Fraud took place or were identified during the year.

The Foundation Trust Code of Governance

The Trust Board has overall responsibility for the administration of sound corporate governance throughout the Trust and recognises the importance of a strong reputation. The Foundation Trust Code of Governance (the Code of Governance) was first published by Monitor, the Foundation Trust regulator in 2006 and was last updated in July 2014, taking account of more recent developments in governance practices specific to NHS Foundation Trusts. The NHS Foundation Trust Code of Governance is based on the principles of the UK Corporate Governance Code issued in 2012.

The purpose of the Code is to assist Foundation Trust Boards to ensure good governance and to improve their governance practices by bringing together the best practice of public and private sector corporate governance.

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

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The Trust strives to operate according to the highest corporate governance standards. It is

pleasing to note that work has been undertaken in 2016-17 to address previous non-compliance in the following areas:

A.5.6 *The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the new provider licence or other matters related to the overall wellbeing of the NHS foundation trust. The council of governors should input into the board's appointment of a senior independent director*

The Constitution makes reference to Resolution of Disputes with Board of Directors under clause 9 of annexe 6 and the Trust developed a policy which was approved by the Council of Governors in May 2016 for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust.

A.5.7 *The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting of advance meeting agendas and, where possible, using clear, unambiguous language*.

The Council of Governors approved an annual Cycle of Business in January 2017. A formal calendar of meetings for 2017 was published in October 2017. The Chairman Hosts monthly Q&A sessions open to all governors.

C.3.8 *The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions*.

'Speak out Safely' is reflected in the Incident and Investigations policy. The Constitution and Audit Committee terms of reference makes provision for this requirement. This Committee appoints MIAA as the internal auditor to undertake audits of services, function, processes and policies so that necessary safeguarding are in place. The Dignity at Work HR policy was refreshed in December 2016. The Raising Concerns (Whistleblowing) Policy was refreshed in January 2017.

Therefore the Trust is able to declare full compliance with provisions of the Code for 2016-17.

Attendance at Board of Director Meetings and Sub-Committees 1 April 2016-31 March 2017

Board Member	Term of Appointment	Trust Board	Audit Committee	Quality Committee	Finance & Sustainability Committee	Strategic People Committee
		Attendance (Actual/Max)				
Non-Executive Directors						
Steve McGuirk (Chairman)	01.04.15-31.03.18	12/12				
Lynne Lobley	01.12.09-30.11.16	7/8	2/4	5/6	3/7	3/3
Ian Jones	01.07.15-30.06.17	12/12	5/5	6/6		-
Terry Atherton	01.07.14-30.06.17	11/12	4/5	-	12/12	-

Anita Wainwright	01.01.15-31.12.18	9/12	1/5	-	9/12	5/5
Margaret Bamforth	01.05.16-30.04.19	10/10	1/4	11/12		1/5
Executive Directors (Voting)						
Mel Pickup	-	12/12	1/5	-	-	1/5
Prof Simon Constable	-	11/12		10/12	5/12	1/5
Karen Dawber	Until 28.08.16	5/5		5/5	-	3/3
Sharon Gilligan	From 01.12.15	10/12	1/5	2/12	9/12	2/5
Andrea Chadwick	from 01.02.16	12/12	4/5		10/12	-
Kimberley Salmon-Jamieson	From 07.09.16	6/7		7/7	3/5	2/2

Additional reporting information

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

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

Related Party Transactions

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

Appointment of External Auditors

The Trust appointed Grant Thornton as its external auditor.

Better Payment Practice Code:

The better payment practice code gives NHS organisations a target of paying 95% of invoices within agreed payment terms or in 30 days where there are no terms agreed.

Performance for 2016/17 and 2015/16 was as follows:

	2016-17 Number	2016-17 £000	2015-16 Number	2015-16 £000
Non-NHS trade invoices paid in the year	47,274	71,531	47,088	73,698
Non-NHS trade invoices paid within target	14,308	39,167	12,882	35,275
Percentage of non-NHS trade invoices paid within agreed payment terms or in 30 days	**30%**	**55%**	**27%**	**48%**
NHS trade invoices paid in the year	1,968	14,648	1,767	14,069
NHS trade invoices paid within target	315	5,953	394	7,925
Percentage of NHS trade invoices paid within agreed payment terms or in 30 days	**16%**	**41%**	**22%**	**56%**

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

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

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.

Stakeholder relations

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

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

The implementation of the Five Year Forward View across 44 sustainability and transformation plans (STPs) saw this Trust become part of the Cheshire and Merseyside STP which was organised into three local delivery systems (LDS). The Alliance LDS enabled collaborative working between acute providers Southport and Ormskirk, St Helen's and Knowsley and Warrington and Halton hospitals, as well as the specialist Liverpool trusts. Together we focused on improving quality of care, reducing unwarranted variation, redesigning pathways, delivering the 7-day service agenda, working towards single teams with single leadership structures and operating models, across multiple sites.

We agreed a Memorandum of Understanding with Alder Hey to enable greater collaboration including the provision of specialist paediatric services closer to our children's homes.

Planned engagement with stakeholder and partner organisations' participation includes an active Patient Experience Group where 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 continues to provide patient and public involvement on a range of issues.

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

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

We further entered into a relationship with Wellbeing Enterprises/Halton Voluntary Action to provide professional volunteer management services to our hospitals. Here the focus is on improving our volunteer recruitment and experience as well as working with wards and departments to successfully deploy volunteers for the benefit of our patients.

Our Foundation Trust Governors and Members

The Council of Governors

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

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

Governor Elections

A Governor election was carried out in November – December 2016 to appoint or renew governor terms in seven constituencies.

Understanding the views of the governors, members and the public

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

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

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

Members of the Board are invited to attend all Council of Governors meetings (four per year) and some Governor committees to provide input and support. Each committee of the council is supported by executive directors and senior managers from the Trust who report openly and collaboratively on the activities and performance of the Trust. In year the Council revised its work programme, reducing the number of Council meetings to quarterly from bi-monthly but increasing its Chairman's briefings to monthly. The Governors' Quality in Care committee remained unchanged and meets quarterly; the Communications and Membership committee changed to the Governors' Engagement Group which meets quarterly.

The Governors Nominations and Remuneration Committee met to appoint new non-executive directors and to conduct the Chairman's appraisal. The role of this committee is outlined in more detail in the Remuneration Report.

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

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

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

The Council has the following statutory powers and responsibilities:

- hold the non-executive directors to account individually and collectively for the performance of the Board;
- the appointment and, if appropriate, removal the chair;
- the appointment and, if appropriate, remove the other non-executive directors;
- approve the remuneration and allowances, and other terms and conditions of office, of the chair and other non-executive directors;
- approve the appointment of the Chief Executive on recommendation from the Board Nominations and Remuneration Committee;
- appoint, re-appoint and, if appropriate, remove the auditor;
- receive the annual report and accounts and any report on these provided by the auditor;
- approve any 'significant transactions' as defined within the Trust's constitution;
- approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
- decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions; and
- approve amendments to the Trust's constitution.

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

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

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

Other meetings and involvement

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

In line with the requirements of the Provider Licence all governors have met the 'fit and proper' person test.

Governors may be contacted at:

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

The Council of Governors

** In year the South Mersey constituency was renamed 'Rest of England and Wales'

Governor	Term Expires	Term (of 2)
Steve McGuirk Chairman	31.3.2018	1
Alison Kinross Daresbury, Windmill Hill, Norton North, Castlefields	30.06.2018	1
Joe Whyte Beechwood, Mersey, Heath, Grange	30.06.2018	1
Vacant Norton South, Halton Brook, Halton Lea	-	
Colin McKenzie Appleton, Farnworth, Hough Green, Halton View, Birchfield	23.12.2019	1
Kenneth Dow Broadheath, Ditton, Hale, Kingsway, Riverside	30.06.2018	1
Jeanette Scott Lymm, Grappenhall, Thelwall	30.11.2017	1
Susan Kennedy Appleton, Stockton Heath, Hatton, Stretton and Walton	20.11.2017	1
Keith Bland MBE Culcheth, Glazebury and Croft, Poulton North	23.12.2019	1
Peter Harvey Penketh and Cuerdley, Great Sankey North, Great Sankey South	30.11.2017	2
Carol Astley Latchford East, Latchford West, Poulton South	30.06.2018	2
Phil Chadwick Bewsey and Whitecross, Fairfield and Howley	30.6.2018	1
Alfred Clemo Poplars and Hulme, Orford	30.11.2017	2
Anne M Robinson **David Ellis** Birchwood, Rixton and Woolston	23.12.2019 30.11.2016	1 2
Norman Holding *(Lead Governor)* Burtonwood and Winwick, Whittle Hall, Westbrook	30.06.2018	1
James Henderson North Mersey	30.11.2017	1
Now Vacant **Peter Folwell** South Mersey**	30.11.2016	2
Dr Helen Bowers Medical Staff	23.12.2019	1
TBC Nursing and Midwifery	23.12.2019	1
Sue Bennett Support Staff	30.11.2017	2
Louise Spence (Louise Cowell to 30.11.17 Clinical Scientist or Allied Health Professionals	23.12.2019 30.11.2016	1 1
Mark Ashton Estates, Administrative & Managerial	30.11.2017	1
Warrington Borough Council **Cllr Pat Wright**	n/a	
Halton Borough Council **Cllr Peter Lloyd Jones**	n/a	
Warrington Wolves Charitable Foundation **Neil Kelly**	n/a	
University of Chester **Dr Mike Browning (Naomi Sharples to Dec 2016)**	n/a	

Membership & Attendance of the Council of Governors and Sub-Committees as at 31st March 2017

Governor	Council of Governors	Quality In Care Committee	Nominations & Remuneration Committee	Governors Engagement Group
Steve McGuirk, Chair	4/4	-	2/2	-
Alison Kinross **Daresbury, Windmill Hill, Norton North, Castlefields**	4/4	4/5	2/3	3/3
Joe Whyte **Beechwood, Mersey, Heath, Grange**	1/4	2/5	0/3	0/3
Vacant **Norton South, Halton Brook, Halton Lea**	-		-	-
Colin McKenzie **Appleton, Farnworth, Hough Green, Halton View, Birchfield**	1/1	0/1	0/2	0/1
Kenneth Dow **Broadheath, Ditton, Hale, Kingsway, Riverside**	0/3	0/5	0/2	1/3
Jeanette Scott **Lymm, Grappenhall, Thelwall**	3/4	0/5	0/2	0/3
Susan Kennedy **Appleton, Stockton Heath, Hatton, Stretton and Walton**	4/4	4/5	2/3	2/3
Peter Harvey **Penketh and Cuerdly, Great Sankey North, Great Sankey South**	3/4	4/5	1/3	0/3
Keith Bland MBE **Culcheth, Glazebury and Croft, Poulton North**	1/1	0/1	½	1/1
Carol Astley **Latchford East, Latchford West, Poulton South**	0/4	0/5	0/3	0/2
Phil Chadwick **Bewsey and Whitecross, Fairfield and Howley**	4/4	1/5	1/3	1/3
Alfred Clemo **Poplars and Hulme, Orford**	3/4	2/5	1/2	0/3
David Ellis **Birchwood, Rixton and Woolston**	2/3	4/4	1/1	2/2
Anne Robinson **Birchwood, Rixton and Woolston**	1/1	0/1	0/2	0/1
Norman Holding LEAD GOVERNOR **Burtonwood and Winwick, Whittle Hall, Westbrook**	4/4	3/5	2/3	2/3
James Henderson **North Mersey**	4/4	1/5	0/3	1/3
Peter Folwell **South Mersey**	3/3	4/4	1/1	½
Dr Helen Bowers **Medical Staff**	0/1	0/1	0/2	0/1
Gaynor O'Brien **Nursing and Midwifery**	1/3	0/4	0/1	0/2
Sue Bennett **Support Staff**	3/4	0/5	0/3	0/3
Louise Cowell **Clinical Scientist or Allied Health Professionals**	2/2	1/4	0/1	0/2
Louise Spence **Clinical Scientist or Allied Health Professionals**	1/1	0/1	0/2	0/1
Mark Ashton **Estates, Administrative & Managerial**	2/4	0/5	3/3	3/3
Warrington Borough Council **Cllr Pat Wright**	3/3	0/5	1/3	0/3
Halton Borough Council	2/4	3/5	1/3	0/3

Cllr Peter Lloyd Jones				
Warrington Wolves Charitable Foundation **Neil Kelly**	0/4	0/5	0/3	0/3
University of Chester **Naomi Sharples, to 31.12.16**		1/4	0/1	0/2
University of Chester **Dr Mike Brownsell, Appointed 01.02.17**	0/0	0/1	0/1	1/1
Vacant	-	-	-	-
Vacant	**-**	**-**	**-**	**-**

Membership

As an NHS Foundation Trust, Warrington and Halton Hospitals has a membership scheme that means that members of the public and staff can become members of the Trust.

Members play a key role in the hospitals providing input into what services they want their hospitals to provide. They do this by electing Public and Staff Governors who represent the membership's views and therefore that of the local community.

Eligibility, constituencies and boundaries for membership

There are two constituencies of membership for Warrington and Halton Hospitals NHS Foundation Trust – the public constituency and the staff constituency. The public constituency comprises of those members that live in one of the above sixteen public constituencies.

The staff constituency is divided into 5 classes:

(1) Medical
(2) Nursing and Midwifery
(3) Support
(4) Clinical Scientist or Allied Health Professional
(5) 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.

Membership size and movement

Total membership at 31st March 2017 = 15,382

Public constituency	Last year (2016/17)	Next year (estimated)(2017/18)
At year start (April 1)	11,678	10,958
New members	42	442
Members leaving	762	400
At year end (March 31)	**10,958**	**11,000**
Staff constituency	**Last year (2016/17)**	**Next year (estimated)(2017/18)**
At year start (April 1)	4,078	4,161
New members	640	500
Members leaving	557	500
At year end (March 31)	**4,161**	**4,161**
Affiliate members	**Last year (2016/17)**	**Next year (estimated)(2017/18)**
At year start (April 1)	238	263
New members	39	40
Members leaving	14	50
At year end (March 31)	**263**	**253**

Analysis of current membership

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	3	4,187
17-21	285	19,787
22 +	10,361	240,322
Not stated on form	309	N/A
Ethnicity:		
White	10,698	256,624
Mixed	49	1,888
Asian or Asian British	157	4,492
Black or Black British	19	798
Other	14	494
Not stated on form	21	N/A
Socio-economic groupings:		
AB	2,083	51,451
C1	3,057	64,883
C2	4,693	36,736
DE	1,073	84,178
Unknown	52	27,048
Gender analysis		
Male	3,759	129,194
Female	7,199	135,102
Affiliate Members	**Number of members**	**Eligible membership**
Age (years):		
0-16	0	N/A
17-21	4	N/A
22 +	252	N/A
Not stated on form	7	N/A

Remuneration report

Statement from the Chairman of the Nominations and Remuneration Committee

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

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

Remuneration

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

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

The membership of this Board committee comprises of the chair and all the non-executive directors with the attendance of the chief executive (except for matters concerning her own employment and conditions) and the Director of HR & OD and Company Secretary. During 2016-17, the committee met eight times in the year:

Member 2016-17	Attendance (Actual v Max)
Steve McGuirk, Chair	8/8
Ian Jones, Non-Executive Director	7/8
Margaret Bamforth (wef 1.5.2016) Non-Executive Director	7/7
Terry Atherton, Non-Executive Director	7/8
Anita Wainwright, Non-Executive Director	5/8
Lynne Lobley (to 30.11.2016) Non-Executive Director	2/3

Non-executive directors' appointments

The Council of Governors Nomination and Remuneration Committee (NARC) meet 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. The committee also has responsibility for making recommendations

to the Council of Governors with regard 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 chair.

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, one Staff Governor and one Partner Governor.

During 2016-17, the Council of Governors, utilising the established NARC, ensured appropriate oversight and decisions relating to the appointment of a replacement Non-Executive Director for Lynne Lobley whose term ended in November 2016.

Remuneration of non-executive directors

The council of governors did not change the amount of remuneration paid to the non-executive directors or non-executive chair during the year.

Senior Managers' Remuneration Policy

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

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

Directors of the Trust are employed on a permanent contract basis. During the year an appointment to the Board was made to cover the role of Chief Nurse. Required notice periods are six months. Where salaries of very senior managers exceed £142,500 per annum, these have been reviewed and found to be appropriate to match market rate, maintain relativities with other very senior manager posts and to match pay in the jobs from which individuals were recruited.

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

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

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

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

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

The Trust is required to report what constitutes the senior managers' remuneration policy in tabular format set out below:

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

Service Contracts obligations

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

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

Annual report on Directors Remuneration - Year ended 31 March 2017 (and comparison year ended 31 March 2016) (Audited)

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

	2016-17				2015-16			
	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All Pension-related Benefits (bands of £2500) (5)	**Total (bands of £5,000)**	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All Pension-related benefits (bands of £2500) (5)	**Total (bands £5,000)**
	£000	£	£000	**£000**	£000	£	£000	**£000**
Executive Directors								
Mel Pickup Chief Executive	160-165		5-7.5	**170-175**	160-165		22.5-25	**185-190**
Karen Dawber Director of Nursing and Organisational Development Until 19.8.2016	45-50		2.5-5	**45-50**	110-115		22.5-25	**135-140**
Prof Simon Constable Medical Director/ Deputy Chief Executive	145-150	3,700	2.5-5	**150-155**	145-150	2,100	7.5-10	**155-160**
Tim Barlow Director of Finance and Commercial Development Until 30.11.2015					80-85		25-27.5	**105-110**
Simon Wright Chief Operating Officer/Deputy Chief Executive Until 25.09.2015					55-60		62.5-65	**125-130**
Jason DaCosta (3) Director of Information Management and Technology	75-80			**75-80**	75-80			**75-80**

	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All Pension-related Benefits (bands of £2500) (5)	**Total (bands of £5,000)**	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All Pension-related benefits (bands of £2500) (5)	**Total (bands £5,000)**
	£000	£	£000	**£000**	£000	£	£000	**£000**
Lucy Gardner (1) (4) Director of Transformation From 01.02.2016	110-115		25-27.5	**135-140**	15-20			**15-20**
Roger Wilson Director of Human Resources and Organisational Development	105-110		5-7.5	**115-120**	105-110		15-17.5	**125-130**
Andrea Chadwick Director of Finance and Commercial Development From 01.02.2016	120-125		140-142.5	**260-265**	15-20		7.5-10	**25-30**
Sharon Gilligan Chief Operating Officer From 01.12.2015	115-120		27.5-30	**145-150**	35-40		10-12.5	**50-55**
Pat McLaren Director of Community Engagement and Corporate Affairs From 01.12.2015	80-85		7.5-10	**90-95**	25-30		77.5-80	**105-110**
Kimberley Salmon-Jamieson Chief Nurse From 07.09.2016	65-70		117.5-120	**180-185**				
Interim/Acting Executive Directors								
Michelle Cloney (1) Interim Director of Human Resources and Organisational Development From 06.03.2017	5-10			**5-10**				
Mark Brearley (1)(2) Interim Director of Transformation/Interim Director of Finance From 01.07.2015 - until 31.01.2016					85-90			**85-90**
Mark Partington (1) Interim Director of Transformation From 01.12.2015 - until 31.01.2016					20-25			**20-25**

	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All Pension-related Benefits (bands of £2500) (5)	**Total (bands of £5,000)**	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All Pension-related benefits (bands of £2500) (5)	**Total (bands £5,000)**
	£000	£	£000	**£000**	£000	£	£000	**£000**
Jan Ross (2) Acting Chief Operating Officer From 28.09.2015 - until 30.11.2015					10-15			**10-15**
Chairman and Non-Executive Directors								
Steve McGuirk Chairman From 01.04.2015	40-45			**40-45**	40-45			**40-45**
Lynne Lobley Non-Executive Director Until 30.11.2016	5-10			**5-10**	10-15			**10-15**
Dr Mike Lynch Non-Executive Director Until 30.11.2015					5-10			**5-10**
Ian Jones Non-Executive Director	10-15			**10-15**	10-15			**10-15**
Terry Atherton Non-Executive Director	10-15			**10-15**	10-15			**10-15**
Anita Wainwright Non-Executive Director	10-15			**10-15**	10-15			**10-15**
Dr Margaret Bamforth Non-Executive Director From 01.06.2016	10-15			**10-15**				

Notes:
(1) The individual was engaged via another entity. Payments were made to that entity rather than the individual directly.
(2) Refers to time in post as a Director.
(3) One fifth of Jason DaCosta's salary is recharged to Warrington CCG. The table above shows remuneration net of this recharge.
(4) Lucy Gardner was substantively employed by the Trust from 1st January 2017.
(5) Pension related benefits are calculated using the HMRC method derived from s229 of the Finance Act 2004. This is an annualised figure, adjusted to reflect the time in post as a Director. This may appear unusually high where an employee has been a director for part of a year or, for the first full year that they have been a director.

Pension Entitlements Year ended 31 March 2017 - Audited

Name and title	Real increase in pension at pension age (bands of £2,500)*	Real increase in pension lump sum at pension age (bands of £2,500)*	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2016	Real increase in Cash Equivalent Transfer Value*	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mel Pickup Chief Executive	0-2.5		60-65	170-175	1,000	38	1,060	
Kimberley Salmon-Jamieson Chief Nurse From 07.09.2016	5-7.5	7.5-10	30-35	85-90	340	75	480	
Karen Dawber Director of Nursing and Organisational Development Until 19.08.2016	0-2.5		30-35	85-90	455	8	487	
Prof. Simon Constable Medical Director/ Deputy Chief Executive	0-2.5		20-25	50-55	279	12	297	
Roger Wilson Director of Human Resources and Organisational Development	0-2.5		35-40	100-105	631	26	672	
Andrea Chadwick Director of Finance and Commercial Development	5-7.5	12.5-15	35-40	100-105	466	112	589	
Sharon Gilligan Chief Operating Officer	0-2.5	0-2.5	20-25	55-60	286	30	323	
Pat McLaren Director of Community Engagement and Corporate Affairs	0-2.5	2.5-5	10-15	35-40	203	23	231	
Lucy Gardner ** Director of Transformation	0-2.5	2.5-5	0-5	0-5		19	19	

Notes:
*Relates to time in post as a director.
** Lucy Gardner joined the NHS Pension Scheme in January 2017. There are no comparative figures for the previous financial year (2015/16).
As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.

Total remuneration

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

	2016-17 £000	**2015-16 £000**
Remuneration including employers national insurance contribution for Executive and Non-Executive Directors	1,206	1,111
Employers contribution to pension in relation to executive directors	121	105

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

Expenses paid to Directors and Governors (unaudited)

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

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

The table below states the total amount of expenses reimbursed to Directors and Governors for 2016/17 and comparative figures for 2015/16.

	Number in Office	Number claiming expenses during the year	**Total expenses Claimed**	Number in Office	Number claiming expenses during the year	**Total expenses Claimed**
	2016-17 Number	2016-17 Number	**2016-17 £**	2015-16 Number	2015-16 Number	**2015-16 £**
Directors	17	10	**4,100**	20	13	**8,400**
Governors	20	5	**800**	20	7	**1,400**
Total	**37**	**15**	**4,900**	**40**	**20**	**9,800**

Fair Pay Multiple (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 2016/17 was £162,500 (2015/16 £162,500). The highest-paid director in 2016/17 and 2015/16 was the Chief Executive.

In 2016/17 the highest-paid director earned 7.24 times (6.96 times in 2015/16) the median remuneration of the workforce, which was £22,458 (£23,363 in 2015/16). As disclosed above, the midpoint of their banded remuneration remained the same during the year under review.

In 2016/17, 20 employees (7 employees in 2015/16) received remuneration in excess of the mid-point of the banded remuneration of the highest-paid director. Remuneration in excess of the highest-paid director ranged from £162,664 to £291,525 (£164,235 to £251,116 in 2015/16).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions or the cash equivalent transfer value of pensions. In the case of agency staff, figures have been generated by annualising invoices for agency staff in post as at 31 March 2017.

Note: Since the production of the Remuneration Report on 31st March 2017 the Chief Operating Officer Ms Sharon Gilligan resigned on 30th April 2017 and The Director of Human Resources and Organisational Development Mr Roger Wilson resigned on 4th May 2017.

Mel Pickup
Chief Executive

Date: 24th May 2017

Staff Report

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

Under our QPS framework, people are one of the key underlying elements of our framework. The trust prides itself on its ability to attract the highest calibre of staff and aims to provide an environment that encourages staff to continuously develop and update their skills. Staff can access a range of benefits, including access to onsite health and wellbeing and counselling services and a range of training and education opportunities.

The trust works closely with trade union/professional organisation staff representatives through its Joint Negotiating and Consultative Committee. The group meets every two months as a forum for consultation and negotiation on a range of issues that are of common interest to managers and employees. Full minutes of each meeting are available through either trade union representatives or the human resources department.

Workforce Strategy

In November 2016 the Trust Board approved our first People Strategy. The strategy translates the Trust's Strategic Plan into practice, providing both direction and detail of how the people aspects of our overall strategy will be achieved and helps to further embed our organisational values and behaviours.

It recognises that steps have been made across the organisation and allows us to build upon solid foundations developing the ethos that *Our People are Central to our Success*. By engaging, empowering and recognising our workforce we will make sure they can give their best and continuously drive improvement in the delivery of services. Good management and strong leadership will lead to more engaged staff and ultimately better patient care. The People Strategy focuses on 5 interlinked principles:

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

The governance around the people agenda has been strengthened, with added clarity given to the role of Strategic People Committee, the introduction of Operational People Committee, as well as the Divisional Performance Groups. Detailed action plans and work streams are being developed in line with strategy and will be monitored at the appropriate committees.

Staffing statistics

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

	Male	Female
Directors (Executive and Non-Executive)	6	8

Senior Managers (Band 8a and above)	44	106
Other employees	709	3,217
Total of all staff	759	3,331

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

	2016/17	2016/17	2016/17	2015/16
Staff Category	Permanently Employed	Other	Total	Total
Medical and dental	369	16	385	388
Administration and estates	784	1	785	798
Healthcare assistants and other support staff	790		790	805
Nursing, midwifery and health visiting staff	939		939	973
Scientific, therapeutic and technical staff	524	10	534	554
Bank and agency staff		203	203	202
Total	**3,409**	**227**	**3,636**	**3,720**

Attendance Management

During 2016 the trust Attendance Management Policy went through a comprehensive review and after full consultation with staff and key stakeholders, was implemented in December 2016. It is too early to assess the impact of the policy changes but we will continue to monitor performance. It is important that the data provided to managers is as up to date as possible and Human Resources will continue to identify and support hotpot areas.

In addition to the updated policy, efforts have been made to enhance our 3 way approach of partnership working between Occupational Health, Human Resources and managers. Throughout 2016 as part of our Essential Mangers Courses we have introduced a full days training on Attendance Management. This session looks at both physical and mental health, giving managers information and tools to manage attendance effectively. Sickness absence has very slightly increased over the last 12 months as shown in the table below:

Period Ending	**31st March 2017**	31st March 2016
Cumulative figure	**4.66 %**	4.56%

The following table shows the number of average days lost per employee for the period 1st January to 31st December 2016; which also shows a slight increase from the previous year:

Staff sickness absence	**2016**	**2015**
Total days lost	58,675	54,479
Total staff years	3,407	3510
Average working days lost (per WTE)	**17**	**16**

Trust Policies and Procedures

During 2016/17 the Trust has reviewed and updated the following policies and procedures:

- Time Off for Trade Union Duties Policy
- Dignity at Work Policy
- Attendance Management Policy
- Grievance Procedure
- Induction Policy
- Retirement Policy
- Annual Leave Policy
- Special Leave Policy
- Management of Personal Relationships at Work Policy
- Professional Clinical Registration Policy incorporating Revalidation
- Protection of Pay Policy
- Secondment Policy
- Adoption Leave and Pay Guidance
- Disability Equality Policy
- Maternity Leave and Pay Guidance
- Scheme of Delegation for Disciplinary Sanctions
- Stress Policy: Staff Mental Wellbeing and Emotional Resilience
- Uniform and Workwear Policy

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

Equality and Diversity with emphasis on Disability

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

The Equality & Diversity Sub Committee (EDSC) is chaired by the Director of Human Resources and Organisational Development who in turn reports to the Board and advises and endorses a range of initiatives, reports and actions. The EDSC is the steering group for a specialist sub group which focuses on disability matters and improving access for disabled people. Among EDSC members are Warrington Disability Partnership and Halton Carers Centre.

The Disability Equality Group (DEG) has internal and external stakeholder membership, with active involvement from patient representatives and members of third sector bodies, these include:

- Deaf Resource Centre
- Halton Disability Partnership
- Warrington Carers (WIRED)
- Warrington Health Watch
- Warrington Disability Partnership
- Halton Health Watch
- Halton Carers Centre
- DIAL House Chester
- Elected Governors are active members of the EDSC and DEG.

In 2016/2017 the Trust liaised extensively with additional external stakeholders to increase awareness and understanding of equality issues, these include:

- Warrington Hate Crime Prevention Group
- Cheshire Police
- Forced Marriage Unit
- Cheshire Equality Leads Forum
- Warrington Homeless (YMCA)
- North West Equality and Diversity Leads Group
- City of Sanctuary
- Warrington Borough Council

The trust is aware of its obligations with regards to the Workforce Disability Equality Standard (WDES) 2018 and is committed to achieving its successful implementation. The Trust strives to support career progression and make reasonable adjustments to enable all staff to achieve their full potential regardless of disability or any other protected characteristic. The Trust has extensive disability networks that provide advice and direction in how to best support disabled staff. The Trust has also a Staff Engagement officer and Workplace Health and Wellbeing Department who support staff under the Staff Health and Wellbeing Agenda

The Trust is committed to fully supporting all persons with disabilities. The Trust runs 2 sub committees that regularly address disability issues faced by both staff and patients. Both groups have active input into concerns affecting disabled people with regards to policy, practice and patient care.

1) Applications for employment made by disabled people

The trust has successfully achieved the 'Disability Confident' standard in 2017. Our Workforce Equality Analysis Report (WEAR) published in January 2017 was able to demonstrate that the Trust supported applications from disabled staff, and found no evidence of discrimination.
In addition, the Trust is able to collect information from NHS Jobs regarding the nature of disabilities of applicants. This provides the Trust with data to see which disabilities are likely to be more commonplace among employees and enables us to determine how best to offer support.
The Trust will utilise this information going forward to support the WDES in 2018.
The Trust has also demonstrated commitment to providing work experience opportunities to disabled people through working in partnership with the Shaw Trust.

2) Continuing employment for people who have become disabled during employment.

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

- Dignity at Work Policy
- Grievance Procedure

- Flexible Working Policy
- Equal Opportunities Policy
- Disability Equality Policy

In addition, the Trust has hosted several events for staff who have become carers for disabled friends or relatives to help support their change in circumstances and provide information. These events have been run by Halton Carers Centre. Both Halton Carers Centre and WIRED attend the Trust regularly to speak to staff, patients and Carers. The internal intranet system, the extranet, now has information for staff on financial and practical support for Carers.

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

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

The Trust achieved a status of 'Excelling' for the second year running in the 2016/2017 EDS2 assessment with regards to flexible working considerations for staff. The Equality Specialist continues to attend several information sessions on the Workforce Disability Equality Scheme (WDES) due to come into force in 2018 to ensure support for the career progression of disabled staff within the NHS. During 2017 the Trust will continue to prepare for the new WDES.

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

The internal intranet system, the extranet, now has information for staff on financial and practical support for Carers. Information on Disability related issues, practical and financial support from stakeholders including Warrington Disability Partnership and Carers UK is also communicated to staff via the extranet, Team Brief, The *weekly*, information stalls and at the Trusts 'Grand Round' where a comprehensive session on understanding Hate Crime ran in 2016. All policies discussed above are freely accessible to employees via the extranet, their manager and HR.

Communication and engagement with staff

We have continued to communicate with our staff through a variety of methods always being mindful of our mantra of open and honest communication. The trust has a range of regular communications using mixed media platforms such as the monthly team brief, the emailed weekly update and daily morning bulletin communication on the trust's performance.

This year we have embraced social media with Twitter and Facebook featuring in our internal and external communication tools. We have also introduced an 'Open Mic' event where staff can ask a panel of Executive Directors questions or suggest new ways of working or ideas. Furthermore, our Executive Directors regularly 'walk the floor' to spend time with staff to listen to their concerns and this influences decision making in the trust.

Team Brief continues to be an open invite to all our staff and attendance has increased throughout the year. The structured presentation by our Chief Executive is based around our QPS framework which includes Performance Dashboards looking at our clinical, quality and people performance. Team Brief is also an opportunity to for the trust to reflect on best practice and celebrate achievement.

It is well researched that an excellent staff experience contributes to an excellent patient experience. Valuing the contribution of staff, involving them in decisions that affect them, encouraging contributions to improvements and innovation, effective, clear continuous communication at all levels throughout the

organisation, and giving all staff a voice is at the core of our People Strategy and will continue to feature as a high priority on our people agenda and threads throughout the People Strategy work streams.

The year began with a formal launch of the Trust's Values and Behaviours; WE ARE – **W**orking together, **E**xcellent, **A**ccountable, **R**ole models, **E**mbracing Change, it has been important to continue the momentum. These are the principles that determine the way we behave and what we believe in. They help bring us together giving us a common focus and are beginning to become embedded throughout the Trust. Much of our work over the last 12 months has been to foster and develop these behaviours and has included:

- Introduced a WE ARE behaviours sessions to our Trust Induction programme.
- Introduction of our behaviours badges. These pin badges recognise and acknowledge where an individual or team has demonstrated a particular behaviour and deserves recognition.
- Relaunched our Employee and Team of the Month schemes aligning the nominations to our WE ARE behaviours.
- Launch of our PROUD campaign shinning the spotlight on best practice and the demonstration of our behaviours across the organisation.
- Rebranding our Thank you Awards to link the awards with our WE ARE behaviours and introducing a separate Dedication to Service awards ceremony giving the appropriate time and recognition to staff at both events.

Throughout the year, our staff have made outstanding contributions to improving the experience of patients and staff and making a real difference to their lives and clearly demonstrating our WHH behaviours in practice. Some of these achievements were celebrated at our annual staff 'Thank You' Awards:

Excellence in Patient Care Award – Ward C20 Ward C20 were nominated, quite simply, for the amazing care that they deliver. The team are resilient, good humoured and always make sure that patient care comes first. One lady who was admitted had terminal cancer and only a few days to live. The lady's dying wish was to get married. The team worked together and fulfilled this lady's dream by creating a wedding for her on the Ward. Whilst she did not have her whole life to live, she was able to pass away as a 'Mrs'.	
Supporting Excellence in Patient Care Award (Non-Clinical) – Debbie McNamee (PACS Administrator) Debbie demonstrates supreme dedication and knowledge whilst accepting responsibility far beyond her role. She is committed to quality and is always striving for the best. She puts the patient's best interest central to everything that she does and works to ensure an excellent patient experience. With her positive and upbeat sense of humour, Debbie is a valued friend and colleague.	

The Star of the Future – Amber Unsworth (Contracts Officer) Amber takes every opportunity to further her understanding and knowledge of her role and the whole Trust. Whilst not being in a patient facing role, Amber is always looking at helping patients and going out of her way to make them feel at ease. Amber has also been really supportive of the Hospital Charity, completing a sponsored boot-camp in 2016.	
Excellence in Innovation, Improvement and Efficiency Award – Declan McClements Declan works tirelessly in providing high quality safe healthcare. He has been instrumental in key changes that have increased clinical capacity and have improved patient care, presenting work at clinical meetings and receiving recognition for the clinical body. He breaks down barriers to increase patient experience and is keen to spread change and develop a sustainable service. Declan is an inspiration to the Team.	 Unfortunately Declan was unable to attend the Award Ceremony but his award was picked up by the CBU Managers on his behalf.
Volunteer of the Year Award – Royal Voluntary Service The RVS run a gift shop at the main entrance, a tea bar in the outpatients department and provide a refreshment trolley to patients on the wards. Donations received to the RVS enable them to purchase vital equipment for our patients. The members of RVS are friendly and kind and give up their spare time to service the hospital and raise money to support the patients.	
Outstanding Contribution through Leadership Award – Mark Oakley – Ward Manager A8 Mark is an excellent communicator who leads from the front. He is dedicated to his role as Ward Manager and a role model to his team. He is approachable, well respected and extremely passionate about providing the best care possible to the patients of WHH.	

Employee of the Year Award – Lesley Howlett – ICU Sister Lesley's drive and commitment has been a shining example to the whole team. She has shown that anything can be achieved no matter how many obstacles there may be along the way. Lesley led a project that enabled a young man, who required home ventilation, to return home after 10 months in the Intensive Care Unit. She fully embraces providing high quality patient care.	
Team of the Year Award – Maternity Services The Maternity Services Team has undergone an extraordinarily challenging two year journey that has completely turned the department around. They have restored the reputation of the department whilst gaining, faith and confidence from women, their families and the wider community. The team has worked tirelessly to create and maintain a great patient experience.	
Outstanding Contribution Award – Emergency Department & Ambulatory Care Together, these two teams have made huge strides towards improving the quality of patient care and delivering it within the 4hour target. Throughout 2016, both the Emergency Department and Ambulatory Care really 'stood up to be counted' and they deserve to be recognised for all they do against seemingly impossible odds.	
Patient Choice Award – Ward A6 Ward A6 epitomise the saying of 'going the extra mile'. Recently the team arranged for a wedding to take place on the ward for a terminally ill patient and at Christmas, the team arranged for an empty bay to be made into Santa's grotto so that a patient who did not have long to live could spend Christmas with his young daughter and wife. The joy this gave the family was priceless and gave the family great memories together.	

The 'Dedication to Service' Awards took place on the 12th February 2016 where the Trust recognised the service of employees who have worked for 30, 35, 40 and 50 years at the Trust.

30 Years' Service	
35 Years' Service	

40 Years' Service	
50 Years' Service Maureen Cook & Family	

Mandatory training

The trust changed its reporting of mandatory training to the Board in June 2016. Mandatory training extends beyond health and safety, fire safety, manual handling and PDRs so two new categories were introduced. The first is 'Essential Training' which incorporates: Corporate Induction, Dementia Awareness, Fire Safety, Health and Safety and Moving and Handling. The second is 'Clinical Training' and incorporates: Infection Control, Resuscitation, Safeguarding Procedures (Adults) Level 1 & 2 and Safeguarding Procedures (Children) Level 1 & 2. The position at June 2016 and the outturn at March 2017 are shown below:

	June 2016	**March 2017**
Essential Training	*83.26%*	**89.20%**
Clinical Training	*79.3%*	**86.20%**

Health and Safety

The Trust monitors Health and Safety Compliance via the Risk Management Framework. This covers all relevant legislation and each Ward/Department is audited every 6 months. An annual report on Health and Safety Compliance is presented at the Quality Committee and the Health and Safety Sub Committee.

All areas of Health and Safety are monitored, discussed and reviewed at the Health and Safety Sub Committee. The Committee is responsible for ensuring that an effective Health and Safety Strategy is implemented throughout the Trust, to provide assurance to the Board that Health and Safety Risks are being managed appropriately. Membership includes staff side representatives, CBU/Corporate Management and Specialist Representatives.

Workforce Health and Wellbeing

Our Workplace Health and Wellbeing Team deliver our Occupational Health service and have responsibility for staff health and Wellbeing. The Department is a SEQUOSH accredited nurse led unit, with a team of fully qualified occupational health nurses. The department provides employment clearance, vaccination, flu campaigns, well-being and health support, physiotherapy and counselling.

This year has seen the launch of our 'Fit to Care' Programme. This is our programme of events and interventions for our staff with regard to their health and wellbeing.

The work can broadly be broken down into the following areas of focus:

1. **Health Awareness and promotion**
   This year saw two Health and Wellbeing days being held for staff with lots of information and stalls including financial wellbeing, smoking cessation, diet and nutrition, blood pressure and checks and challenges with over 600 staff attending.

   We have also continued our programme of monthly health awareness sessions with topics such as skin cancer, men's health and healthy hearts. January saw our 'New year, New You' campaign with a different health topic and events each week which saw smoothie masterclasses and a walking group.

2. **Musculoskeletal (MSK)**
   The Trust has improved access to physiotherapy services; the service has a fast track option for staff suffering from musculoskeletal (MSK) issues to ensure staff that are referred via GPs or by the Health and Wellbeing Department can access it in a timely manner.

3. **Nutritional Awareness**
   We have worked with all providers of food and beverages at the hospitals both internal and external to achieve a step-change in the health of the food offered on Trust, this has included:
   - removing price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS), such as pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food
   - removing the advertisements for sugary drinks and foods high in fat, sugar and salt (HFSS)
   - stop the promotion of sugary drinks and foods high in fat, sugar and salt (HFSS) at checkouts

   In line with the 2017/18 CQUIN work will continue to focus on these areas.

4. **Mental Health**

During 2016 we appointed a Senior Counsellor which allowed us to broaden our remit, allowing us to look at wider mental health issues and resilience. Alongside the provision of one to one counselling support, some of our work this year has included:

- Improving the range of training opportunities available to increase the understanding of mental health issues in the Trust.
- Introduction of Mental Health Awareness training to our Preceptorship Training programme
- Introduction of 'Heartful' meditation sessions for staff and guided relaxation to allow staff to improve resilience
- Ward manager Mental Health Awareness training sessions
- Specialist involvement in our Healthy Worker Course and Essential Manager Training.
- Awareness sessions and 'drop-ins' for all staff.

5. **Flu Campaign**

The Trust achieved the second highest flu vaccination rate in the country of 86.6% which was reported in the Nursing Times.

6. **Physical activity**

In year the Trust has worked with a number of partners to introduce fitness classes across the trust. As well as the opportunity to take part in the NHS games, the trust has introduced Bootcamps, Yoga classes, Low impact Circuits and Boxercise.

Staff Costs

During the year under review the Trust incurred the following expenditure on staff costs.

	Permanently Employed 2016-17	**Other 2016-17**	**Total 2016-17**	**Total**
	£000	**£000**	**£000**	**£000**
Salaries and wages	122,832	0	122,832	124,687
Social security costs	11,480	0	11,480	9,273
Pension costs (employer contributions to NHS Pensions)	13,389	0	13,389	13,249
Termination benefits	123	0	123	85
Bank and agency staff	0	16,609	16,609	15,721
Total staff costs	**147,824**	**16,609**	**164,433**	**163,015**
Of which: costs capitalised as part of assets	*173*	-	*173*	*381*

Expenditure on Consultancy

During the year under review the Trust incurred the following expenditure on consultancy. This expenditure is for the provision of management advice and assistance outside the "business as usual" environment and includes areas such as strategy, finance, organisation and change management and IM&T.

	2016/17	2015/16
Total expenditure (£000's)	933	355

Staff Exit Packages

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

The table below discloses the number and value of exit packages agreed in 2016/17.

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

The number and value of exit packages agreed in 2015/16 are listed in the table below for comparison.

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000	Number	£000	Number	£000	Number	£000
<£10,000			1	5	1	5	1	5
£10,00 – £25,000			2	36	2	36		
£25,001 – £50,000			1	44	1	44		
£50,001 – £100,000								
Total			4	85	4	85	1	5

Analysis of other departures

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

	2016/17 Number of Agreements	2016/17 Total Value of Agreements £000	2015/16 Number of Agreements	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs			2	36
Mutually agreed resignations contractual costs	2	77	1	44
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice	1	13		
Exit payments following Employment Tribunals or court orders				
Non-contractual payments requiring HMT approval			1	5
Total	3	90	4	85
Of which 0 non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary				

Off-Payroll Engagements

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months:

Number of existing engagements as of 31 March 2017	18
Of which...	
Number that have existed for less than one year at time of reporting.	7
Number that have existed for between one and two years at time of reporting.	7
Number that have existed for between two and three years at time of reporting.	4
Number that have existed for between three and four years at time of reporting.	0
Number that have existed for four or more years at time of reporting.	0

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

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	25
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	8
Number for whom assurance has been requested	8
Of which...	
Number for whom assurance has been received	8
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received.	0

All individuals engaged on off payroll arrangements during the year were issued with a checklist to enable the Trust to conduct a risk assessment. Assurances were sought from all 46 individuals as to their tax obligations. In some cases the assurance was requested and not received. For each of those cases the contract had already ended and the individual was no longer engaged by the Trust.

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year.	17

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

The trust would prefer to employ staff directly wherever possible. However there are some occasions where an off payroll arrangement gives the Trust the opportunity to secure the services of an experienced professional for a short period of time. The trust will conduct risk assessments and seek assurances from all individuals falling within the scope of guidance issued on 23 September 2015 by the Department of Health regarding the Tax Arrangements of Off-Payroll Staff.

The NHS Staff Survey 2016

One of the tools that we use to monitor staff engagement is the national NHS Staff Survey which is conducted each year by the Trust, the results of which are used by the Care Quality Commission, our commissioners and others to assess our performance. Improving the staff survey results is a key priority, and the survey results for 2016 show elements of progress.

An external provider must undertake the survey and Quality Health undertook the survey on behalf of the trust. Trusts are only required to survey a sample of randomly selected staff. However, this year the trust decided that all staff should have the opportunity to complete the survey. The average response rate nationally was 43%, ours was 38%, 5% higher than last year with almost 1500 members of staff taking part.

Questions within the NHS Staff Survey tested the views of staff on our patient safety culture, their confidence in reporting unsafe clinical practice and whether they would recommend the trust to friends and family as a place to receive care to treatment, or as a place to work. Staff responded to questions on quality and patient safety based on their experience of a leadership culture which allows them to raise concerns safely, without fear of blame.

Around half the responses for 2016 are better than the national average with only 2 findings in the bottom 20% of acute trusts compared to 7 in 2015. We believe that our work on staff engagement and health and wellbeing is having a positive effect on these results. The 2016 staff survey results show progress in the following areas:

- Although not in line with the national average, there was an increase in the percentage of staff who would recommend us to family and friends as a place to work or receive care or treatment
- Staff reported very low levels of discrimination and rated the trust in the top 20% of trusts for equal opportunities.
- Staff said that they were satisfied with their level of responsibility and involvement, resources and support.
- Staff felt that support from immediate mangers was above average and there was a small increase in staff reporting good communication between senior management and staff.
- Staff said that the recognition they received for managers and the organisation was better than average
- Staff felt that managers take an interest in their health and well-being and placed us in the top 20% of trusts.

The survey also highlights areas for us to work on. The key concerns being: the likelihood of staff recommending the trust as a place to work or receive treatment; staff motivation; staff agreeing that their role makes a difference and the fairness of reporting procedures. Whilst there have been improvements these have not been significant shifts and work will continue during 2017/2018 through implementing coaching and collective leadership, encouraging staff to feel more supported, and empowered to develop and change things to make a difference.

The survey results will shortly be shared with the Board and the Strategic People Committee (sub-committee of the Board), the Joint Negotiation and Consultative Committee, and CBU / Departmental Management, as well as our staff across the organisation.

This is the first data on staff satisfaction that they Trust has been able to analyse by CBU and each CBU will be given the opportunity and support to develop their own action plan based on the individual results to supplement the Trusts overarching action plan.

Staff survey report overall response rates

	2015	2016		Trust improvement/ deterioration in year
Response rate	*Trust*	**Trust**	**National Average for acute trusts**	
	33%	**38%**	**43%**	Improvement of 5 percentage points

Areas of significant improvement

There has been a significant statistical change around the quality of non-mandatory training, learning and development which ranked in our bottom 5 results and in the bottom 20% of acute trusts in 2015. This is reflective of the work the Trust has embarked upon following last year's management restructure under Project Springboard, the introduction of an Essential Manger Courses and further development of our Growing as a Leader programmes.

Although when compared to other acute trusts in England the score for effective use of patient / service user feedback is worse than average there has been a positive significant statistical improvement. Work has been ongoing throughout the organisation to publicise improvements made as a result of feedback and ensuring staff can recognise where this has been utilised and will continue under the 2016 action plan.

Although not showing statistically significant change it is notable that in the 2015 survey 7 of the trust findings were in the worst 20% of acute trusts and that this has improved to only 2 finding in the 2016 survey.

There were no areas of significant deterioration from the 2015 to 2016 surveys.

Summary of Performance

The top five ranking scores for 2016 and how they compare against the national average:

	2015	2016		Trust improvement / deterioration in year
	Trust	**Trust**	**Benchmarking against acute trusts averages**	
KF21. Percentage of staff believing that the organisation	**93%**	**91%**	**87%**	Deterioration of 2 percentage points

provides equal opportunities for career progression or promotion				
KF24. Percentage of staff / colleagues reporting most recent experience of violence	**69%**	**74%**	**67%**	Improvement of 5 percentage points
KF20. Percentage of staff experiencing discrimination at work in the last 12 months	**7%**	**8%**	**11%**	Deterioration of 1 percentage point
KF16. Percentage of staff working extra hours	**67%**	**67%**	**72%**	No change
KF10. Support from immediate managers	**3.86**	**3.81**	**3.73**	Deterioration of 0.12

The bottom five ranking scores for 2016 and how they compare against the national average:

Bottom 5 Ranking Scores				
	2015	**2016**		**Trust improvement / deterioration in year**
	Trust	**Trust**	**Benchmarking against acute trusts averages**	
KF1. Staff recommendation of the organisation as a place to work or receive treatment	**3.49**	**3.57**	**3.76**	Improvement of 0.08
KF9. Effective team working	**3.68**	**3.70**	**3.75**	Improvement of 0.02
KF30 Fairness and effectiveness of procedures for reporting errors , near misses and incidents	**3.72**	**3.65**	**3.72**	Deterioration of 0.07
KF3. Percentage of staff agreeing that	**90%**	**89%**	**90%**	Deterioration of 1

their role makes a difference to patients / service users				percentage point
KF32 Effective use of patient / service user feedback	**3.46**	**3.63**	**3.72**	Improvement of 0.17

Overall Staff Engagement Indicator:

Conclusions from the staff survey and action plans for the future

An initial summary action plan with clear responsibilities, suggested leads and timescales will be put in place. These can broadly be categorised into areas, with particular emphasis on our bottom five rankings scores and / or where our results fall into the worst 20% of acute Trusts. The Strategic People Committee will oversee the progress of the action plan with the nominated leads reporting into the Committee on a regular basis.

The results of the survey and the progress we intend to make during 2017/18 will be an integral element of our People Strategy work plan and assist us to measure our progress.

The Disclosures Set Out In the NHS Foundation Trust Code of Governance

The Trust Board has overall responsibility for the administration of sound corporate governance throughout the Trust and recognises the importance of a strong reputation.

The purpose of the Code is to assist Foundation Trust Boards to ensure good governance and to improve their governance practices by bringing together the best practice of public and private sector corporate governance.

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

Warrington & Halton Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust strives to operate according to the highest corporate governance standards.

There are NO areas of the code where the Trust is declaring noncompliance.

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

NHS Improvement's Single Oversight Framework

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

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

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

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

Segmentation

The Trust is currently assigned to segment 3 of the framework. This segmentation information is the Trust's position as at 8 May 2017. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and use of resources

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

Metric	2016-17 Quarter 3 Rating	2016-17 Quarter 4 Rating
Capital service cover	4	4
Liquidity	4	3
I&E Margin	4	4
I&E Variance from plan	1	1
Agency spend	2	2
Overall scoring	**3**	**3**

Statement of accounting officer's responsibilities

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Warrington and Halton Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Warrington and Halton Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the ***Department of Health Group Accounting Manual*** and in particular to:

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

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

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

Mel Pickup
Chief Executive

Date: 24th May 2017

Annual Governance Statement 2016-17

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2017 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and accountability
The Board of Directors provides leadership on the overall governance agenda. The Quality Committee is the committee of the Board of Directors that oversees the risk management activity of the trust and ensures that the correct strategy is adopted for managing risk; controls are present and effective; and action plans are robust for those risks that are scored 15 and above. The executive lead for risk management is the Chief Nurse. The supporting system for managing risk has been delegated to the Deputy Director of Quality and Governance. Additional support is provided to the trust's risk management systems through designated Governance Managers and audit and governance leads within divisions/clinical business units.
During the year the trust has fully refreshed its key risks and Board Assurance Framework with this refreshed format being reviewed by the Board on a quarterly basis and the Quality Committee on a monthly basis. In 2017-18 there will be further alignment of relevant elements of the Board Assurance Framework to the committees of the board.

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 and that of all staff and provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the trust. The current Risk Management strategy (2015-16) is being fully refreshed in Q1 of 2017-18 to support a culture of decentralisation, increased local autonomy and local accountability.

The Board Committees are supported in their role by their reporting committees and groups which include: patient safety and clinical effectiveness, patient experience, health and safety, infection control, medicines governance, event planning, clinical quality assurance and information governance and corporate records all of which form part of the trust's overall governance system.

- **The Quality Committee**, chaired by a Non-Executive Director, scrutinises the management of risk, delivery of the Annual Plan and compliance with Care Quality Commission Fundamental Standards. The Committee gains the necessary assurances for the compliance necessary to sign off the Annual Governance Statement; any unacceptable or high levels of risk/assurance are reported through to the Trust Board. To fulfil the responsibilities it has a number of sub-committees reporting to it including:
    - **The Patient Safety and Effectiveness Sub-Committee** which provides the Quality Committee assurance of the quality of care provided by the Trust and in particular, that adequate and appropriate quality governance structures, processes and controls are in place including the identification of risks arising from clinical care.
    - **The Health and Safety Sub-Committee** approves policies under its identified schedule of approval, reviews and monitors the management of non-clinical risk and ensures that they are implemented effectively and reviewed at appropriate intervals. It also reviews the risk register at least 3 times a year.
- **The Audit Committee**, chaired by and made up of Non-Executive Directors, provides an independent overview of the governance arrangements by giving assurance to the Trust Board on the working of all Board Committees. It scrutinises the Annual Governance statement and aligns internal audit plan to risks in the Trust.
- **Divisional Governance arrangements** are in place to ensure identification, monitoring and scrutiny of risks

Training

Training is provided to staff on risk assessment and management through a number of sources. The trust's corporate induction programme ensures all new staff (including consultant appointments) are made aware of the trust's risk management systems and processes and staff are provided with an information leaflet at the time of induction. 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. In addition to this, Governance drop-in sessions are held to further support staff. 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 within the framework of NHS England (formerly National Patient Safety Agency NPSA requirements). The training is underpinned by the required levels of investigation. For serious incidents (level two investigations) the lead investigating officers are outside of the area where the incident has occurred. No person can lead an investigation unless they have received training on the relevant principles.

The risk and control framework

Incidents, complaints, claims, Coroners' Inquests and patient feedback are routinely analysed to identify lessons for learning and improve internal control. To enhance learning and improve governance, the trust actively pursues external peer review of all serious incidents should this be necessary.
Learning and improvement from incidents, complaints, claims and coroners inquests has been a particular focus for the trust and help to improve internal control. Incidents, complaints, PALS, Claims, Coroner inquests, external agency, Risk KPIs are reported through the Quality Committee via five sub-committees, Chief of Staff bi-lateral (divisional) reports; and shared with the lead Commissioners as part of the Quality Contract. Lessons for learning are also disseminated to staff using a variety of methods including:

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

(ii) Sharing and Learning Together
This new format newsletter was introduced in the second half of the year aimed at all staff and covering a range of topics under one 'umbrella' title. Learning from investigations and Coroners' Inquests are shared and a new staff extranet platform has enabled fast and easy access to learnings, risk management systems, safety alerts and procedures, duty of candour and speak out safely information.

The trust actively encourages networking and has strong links with relevant central bodies, such as the Care Quality Commission (CQC), the National Learning and Reporting System (NRLS), and Health and Safety Executive (HSE).

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 through the trust's governance structure. The trust's risk register was fully refreshed in 2016-17 and combined into a single document with the Board Assurance Framework. Strategic risks have been reviewed and refreshed and are monitored through the Quality Committee on a monthly basis and any changes reported to Board.
Local risk registers are monitored and maintained locally within the divisions/clinical business units which enables risk management decision-making to occur as near as practicable to the risk source. For those risks that cannot be managed locally these are escalated to the appropriate manager and are included in the appropriate corporate departments or divisions risk register.

- All risks below 12 are managed locally by each Ward/Departmental Manager. This can be managed by risk assessments and/or local risk registers and should be reviewed at least annually.
- All risks of 12 are placed on CIRIS by the relevant Division/Department. Each risk has an identified Lead who will review the risk to ensure any actions are implemented and reviewed at the Patient Safety and Clinical Effectiveness sub-committee.

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

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

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.

The trust has a Board Assurance Framework in place which is reviewed by the Board of Directors, and includes: the identification of the key risks to the achievement of the strategic objectives, CQC fundamental standards and the Provider Licence and the systems in place to manage/mitigate these risks; the control systems in place to manage the key risks; the identification of sources of internal and external assurances evidencing the management of risk; and evidence of compliance with equality, diversity and human rights legislation. The Board Assurance Framework is reviewed quarterly by the Board of Directors and the Audit Committee, and monthly by the Quality Committee, who provides additional challenge and scrutiny of the risks identified.

The refreshed Board Assurance Framework was introduced in the second half of the year and sets out risks against delivery of the strategic objectives. It is outward looking as well as inward looking and the Board have discussions about level of risks we will tolerate. There is monitoring through management/committee structure of mitigations/actions and this provides evidence that our risk escalation processes are working.

The Trust has completed its NHS Foundation Trust Code of Governance (the Code) for 2016-17 under the principle of 'comply or explain'. It is pleasing to note that work has been undertaken in 2016-17 to address non-compliance in three areas (A.5.6; A.5.7 and C.3.8) and therefore the Trust is able to declare full compliance with provisions of the Code for the year.

The principle risks to compliance with the Foundation Trust license and actions identified to mitigate these are as follows:

Code (4) Non-Executive Directors

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

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

Mitigating actions: The Council of Governors approved the appointment of the SID at a meeting on 28th January 2016. The SID regularly attends meetings of the Council of Governors.

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

Mitigating actions: The Chairman has met with Non-Executive Directors without the Executives present during 2016-17. The SID leads the appraisal process for the Chair annually and reports to the CoG Nominations-Remuneration Committee on the outcome. The Committee in turn reports to the full CoG.

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

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

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

External Review and Inspections

A total of 19 external agencies (5 Boroughs Partnership, British Standards Institute, Care Quality Commission, Chartered Management Institute, Cheshire and Merseyside Trauma Network, Emergency Care Improvement Program review, Fire and rescue Service, Health Education England, Local Supervising Authority, Medicines and Healthcare Products Regulatory Agency, Mersey Deanery, Mersey Internal Audit Agency, NHS Improvement, North West Health Care Libraries Unit, Patient Led Assessments in the Care Environment, Public Health England, Quality Control North West, University of Liverpool, Warrington Borough Council) visited the trust from 1st April 2016 to 31st March 2017. This information was entered into the web-based compliance system and reported outcomes are reported through the established governance framework.

Well Led Review

All Foundation Trusts are expected to undertake a Well Led assessment every three years. Deloitte conducted the review for the Trust between Jan – Mar 2017. Well Led assessment is based on multiple observations, interviews and desk top review of a large number of documents and data sources. A comprehensive self-assessment is one of the elements and is compared against the reviewer's assessment. The Well Led Review is based upon evidence of the following key domains:

1. **Strategy and planning** – how well is the board setting direction for the organisation?

2. **Capability and culture** – is the board taking steps to ensure it has the appropriate experience and ability, now and into the future, and can it positively shape the organisation's culture to deliver care in a safe and sustainable way?
3. **Process and structures** – do reporting lines and accountabilities support the effective oversight of the organisation?
4. **Measurement** – does the board receive appropriate, robust and timely information and does this support the leadership of the trust?

The Trust was rated 'Amber-Green' in the final report presented in April 2017.

CQC Inspection
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 CQC inspected Warrington and Halton Hospitals NHS Foundation trust from 6-10th March 2017. During their visit they looked at the quality and safety of the care we provide, based on the things that matter to people. They looked at whether our service is:

- Safe
- Effective
- Caring
- Responsive
- Well-led

These key lines of enquiry were investigated using pre-visit information, the onsite inspection and local information about us – including seeking patient, staff, visitor and partner organisation views. At time of production of this report the CQC report on its visit has not been received.
The Care Quality Commission has not taken enforcement action against the Trust during 2016-2017 and the Trust has not participated in any special reviews or investigations by the CQC during the reporting period. The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

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

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

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

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

The Trust has performance management processes in place that review the economy, efficiency and effectiveness of the use of resources. The Executive Team reviews the operational performance of the Trust and leads the Trust's identification and implementation of Cost Improvement Plans (CIPs). Monthly reports to the Board provide updates on performance throughout the year, ensuring service delivery and cost improvements without jeopardising patient safety – schemes are underpinned by Quality Impact

Assessments. Part of the remit of the Finance and Sustainability Committee, which meets monthly, is to support the Trust Board in gaining assurances on the economy, efficiency and effectiveness of the use of resources.
The Trust has a policy and governance framework in place to guide staff on the appropriate use of resources through its *Standing Orders*, *Standing Financial Instructions* and *Schemes of Delegation*. In addition, the Trust has a robust system for developing and routinely reviewing policies and procedures and staff are appropriately updated and guided or trained on their application.

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

Information governance

In the 2016/17 financial year there have been no incidents of data loss which were classified as level 2 Information Governance Toolkit serious incident requiring investigation. On this basis no incidents have necessitated Information Commissioner's Office intervention. Risks to information, including information security and data quality risks, are managed and controlled through the use of the NHS Digital 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 Information Governance and Corporate Records Sub-Committee. The Information Governance and Corporate Records Sub-Committee is accountable to the Finance and Sustainability and Quality Committees which are sub-committees of the Trust board. The Trust's Caldicott Guardian (Medical Director and Deputy Chief Executive) chairs the Information Governance and Corporate Records Sub-Committee. The Director of IT is the Trust's Senior Information Risk Owner (SIRO) and this individual acts as the board level lead for information risk within Warrington and Halton Hospitals NHS Foundation Trust. Any areas of weakness in relation to the management of information risk which are identified, or highlighted by internal audit review, are then targeted with action plans to ensure that we continue to strive to be information governance assured.

In the 2016/17 financial year the Trust's Information Governance assessment score was 67% and was graded as satisfactory. The Trust was subject to an assurance review of its Information Governance self-assessment by the Mersey Internal Audit Agency in March 2017. Following review of the available evidence to support the IG Toolkit returns for 2016/17 the Trust was provided with a Significant Assurance rating.

Annual Quality Report

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

In preparing the Quality Report, directors have satisfied themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/2017 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2016 to March 2017
    - The Integrated Performance Dashboard (Quality, Operational Performance, Workforce and Finance) which is scrutinised at the Clinical Operations Board and provided for assurance monthly to Trust Board. Data quality is underpinned by a dedicated validation team and the Data Quality Policy.
    - Papers relating to Quality reported to the Board over the period April 2016 to March 2017
    - Feedback from the Trust's Commissioners, Warrington Clinical Commissioning Group and Halton Clinical Commissioning Group
    - Feedback from Governors
    - Feedback from local Healthwatch organisations, Healthwatch Halton and Healthwatch Warrington
    - Feedback from Overview and Scrutiny Committee
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - The 2016 national inpatient survey
    - The 2016 national staff survey
    - The Head of Internal Audit's annual opinion over the Trust's control environment for 2016-17

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

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 the quality committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the work of internal and external audit, the external review processes for the clinical negligence scheme along with the NHSLA and the Care Quality Commission. Improvements made in 2016-17 include:

- Addition of one Director (non-voting) to the Board
- A full review and refresh of the Board Assurance Framework and the Risk Register and a refresh of the organisation's key strategic risks
- Establishment of the Foundation Trust Office to provide greater support to the Board, committees of the Board to ensure that the Board and Governors are appropriately supported to deliver their statutory responsibilities.

Board of Directors

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

Audit Committee

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

Clinical Audit

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

Internal Audit

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

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

The Head of Internal Audit issued an overall opinion for 2016-17 of **Significant Assurance**.

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.

At time of writing the Trust remains under Enforcement from Monitor pursuant to its powers under s106 of the Health & Social Care Act 2012 for the following:

- 2014/15 financial position and 2015/16 financial forecast which resulted in a forecast Continuity of Services Risk Rating of 1
- Absence of a recovery plan to return the Trust to a Continuity of Services Risk Rating of 3 or greater and reliance upon external support to develop a turnaround plan
- Historic and current performance re: delivery of the cost savings programme

In 2016-17 the Trust has made significant progress to deliver its services on a clinically, operationally and financially sustainable basis including:

- An action plan to reduce the financial deficit and improve the 2016-17 year financial position beyond that submitted as part of the Annual Planning process.
- An action plan to minimize the 16/17 deficit and seek to move to a position of breakeven.
- The development of a longer term strategic plan to move a position of breakeven whilst remaining clinically and operationally over the longer term period.

Conclusion

There were no significant internal control issues or gaps in control identified in 2016/17 and the Trust's internal auditor has provided an overall opinion of **significant assurance** based on their work during this period.

On 12th May 2017 the functioning of the Trust was hit by a ransomware attack that affected many organisations across the world. As a result of the precautionary closedown of key IT systems, there was an impact on the Trust's operational activity. The Trust is fully cooperating with instructions from NHS Digital and other government agencies. The source of the attack and the extent to which the Trust could have prevented this are still being investigated at the date this statement was signed.

Mel Pickup
Chief Executive

Date: 24th May 2017

Voluntary disclosures

Modern Slavery Act 2015

The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, has a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles. The Trust's Statutory Statement in relation to this Act can be found on the Trust's website www.whh.nhs.uk

Equality Reporting

The trust aims to demonstrate how it is complying with the public sector duty through the Equality Diversity Assurance Report (EDAR) (published January 2017) and the Workforce Equality Analysis Report (WEAR) (2016) which was also published in January 2017. In addition to the publication of these annual reports, the trust is compliant with the publication requirements of its Workforce Race Equality Standard (WRES); WRES action plan and Equality Delivery System 2 (EDS2).

These documents outline the equality governance framework of the organisation, which underpins equality and human rights activity across all functions, policies and services within the organisation.
The trust is committed to ensuring that staff and service users are involved in shaping the equality and human rights work stream and have opportunities to influence health service planning and delivery. The Trust has invested, some years ago, in a Staff Engagement and Wellbeing lead post, in order to engage and support its workforce. There is a Staff Engagement and Wellbeing group, and an Equality and Diversity Committee made up of staff and external stakeholders, both of which strongly influence the action plan for 2017-2021.
The Equality & Diversity Sub Committee (EDSC) is chaired by the Director of Human Resources and Organisational Development who in turn reports to the Board and advises and endorses a range of initiatives, reports and actions. The EDSC is the steering group for a specialist sub group which focuses on disability matters and improving access for disabled people known as The Disability Equality Group (DEG). In order to fully engage with local community representatives both groups are made up of internal and external stakeholder membership, with active involvement from patient representatives and members of third sector bodies. The EDAR, WEAR and WRES are presented to these groups and the EDS2 is assessed by them each year.

Countering fraud

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

Regular monitoring of counter fraud activity is undertaken via the trust's audit committee on a regular basis via progress reports and an annual report of counter fraud activity. This monitoring process includes the identification of any fraudulent activity against the trust. During the year MIAA commenced investigations into two fraud issues which are still continuing.

Warrington and Halton Hospitals NHS Foundation Trust

Quality Report

2016-2017

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Glossary

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

Quality 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.

1. Statement of Quality from the Chief Executive

Mel Pickup, Chief Executive

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

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

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

Throughout 2016/2017, progress has been achieved through the hard work, commitment and dedication of every single member of staff. We have continued to see and treat an increasing number of patients, with more complex needs, on both a planned and emergency basis.

Within the reporting year the Trust has continued to work towards achieving all national targets from the operating framework. The national target for referral to treatment targets look at the waiting times for patients waiting to start treatment at the end of each month. I am pleased to say that in 2016/17 we had achieved 93.13% of patients being seen within 18 weeks but more importantly half of patients were seen within 6 weeks. In relation to the Accident & Emergency 4 hour access target of 95%, which is recognised nationally as a challenging target, we did not achieve the 95% target set. However, NHS Improvement set an individual performance target for the Trust of 90% which we exceeded for 2016/17 as the overall result was 90.60%, an increase on the year-end position of 2015/16 which was 88.09%. The Trust has achieved the majority of all quarterly cancer targets particularly in the first half of the year. Areas that we have not achieved and will strive to improve over 2017/18 were in relation to 2 months from urgent GP referral to treatment and symptomatic breast patients waiting a maximum of 2 weeks from urgent GP referral to date first seen.

With regards to health care acquired infections (HCAI) during 2014/2015, the Trust threshold was 0 cases of MRSA bacteraemia and despite the continued focus on managing HCAI, during 2015/2016 the Trust reported 2 cases of MRSA bacteraemia against a threshold of 0. I am pleased to announce that through our quality work, the Trust can report that in 2016/17 there have been no cases of MRSA bacteraemia and that the Trust has had a period of 18 months free of MRSA bacteraemia in our hospitals.

A revised, easy to follow sepsis pathway has also recently been developed and the potential for training to enable the sepsis team and critical care team to prescribe antibiotics, is currently being explored, which will save valuable time in being able to diagnose and treat patients, which is key to reduction or mortality from sepsis.

We have also made significant progress towards establishing a high quality and effective mortality review process and have achieved all our quarterly thresholds to date, with a reduction being seen

in 2016/17 in the Trust's mortality indices- which is how trust' are benchmarked nationally on mortality rates.

The Care Quality Commission (CQC), the body responsible for checking that all hospitals in England and Wales meet national standards, inspected Warrington and Halton Hospitals NHS Foundation Trust from 7th – 10th March 2017. They assessed the quality and safety of the care we provide, based on the things that matter to people. They looked at whether our service is safe; effective; caring; responsive to people's needs and well-led. At the time of writing this report we are awaiting the publication of our overall rating.

One of the most significant achievements in 2016/2017 is in relation to Warrington Hospital's Maternity Unit, who has been named the best in the Country by the Royal College of Midwives (RCM). The service won the Midwifery Service of the Year award at the RCM's Annual Midwifery Awards in March 2017. Following significant improvement work, recognised in 2014/15, the unit's staff were determined to make our service the best it could be for our patents, and through two years of sustained focus and energy, we have seen the whole team work together to rebuild the midwifery-led unit; it is great recognition for the whole team to have won such an award.

Our midwifery team developed the Your Pregnancy, Your Birth, Your Choice campaign, which became the driver for change, using a bottom-up approach and working closely with patients and former patients to achieve a best-in-class service. Our team delivers quality, safe and compassionate maternity care to women and their families who consistently highly recommend this Trust as a place to give birth and enjoy a superior patient experience.

In 2016-2017 the Trust was involved in conducting 59 clinical research studies in research in oncology, surgery, stroke, reproductive health, anaesthetics, rheumatology, gastroenterology, ophthalmology, as well as paediatric and other studies.

Most of the research carried out by the Trust is funded by the National Institute for Health Research (NIHR). For 2016-2017 the Trust received £400,000 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. We will continue to encourage and drive or research and development profile.

Looking ahead to 2017/18, we will continue to drive the Trust's quality strategy improvement priorities. These are as follows:

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

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

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

The areas we have chosen to focus on as priority areas are; to review safety culture in undertaking surgical and invasive procedures in the Trust, reduction of falls that result in harm, reduction of the impact of serious infections as a result of sepsis, supporting proactive and safe discharge, implementing the learning from deaths national policy, development of a lessons learned framework, improving our complaints processes, implementing our patient experience strategy and improving our services for patents with mental health needs, who present to A&E.

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

In conclusion, this Quality Report evidences that, whilst we have made significant progress in improving the care and services we deliver to our patients, we are committed through our priorities and quality measures for 2017/2018 to continue these improvements and show our commitment in providing high quality care to our local communities.

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

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

Mel Pickup

Chief Executive

May 2017

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

Introduction

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

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

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

Organisational Structure

Since the previous Quality Account the Trust has implemented a new organisational structure in April 2016 which allows us to be more responsive to challenges through improved clinical engagement, strong and resilient leadership at all levels, with an emphasis on responsibility and accountability to achieve transformation and innovation. The new structure was developed collaboratively with the clinical divisions and facilitates the clinical specialities to work more closely within Clinical Business Units (CBU). It embraces the concept of true leadership synergy between the 'triumvirate' which brings together lead doctors, nurses/allied health professionals and managers working seamlessly with the wider corporate teams responsible for the clinical, operational and financial functioning of their CBU. The CBUs are built around the needs of the patients and their pathways and, through innovation and collaboration with partners, the Trust aims to improve access and quality of care whilst minimising costs. Operating under the leadership and management of one of two divisions, each CBU is a vehicle for greater devolvement of accountability and responsibility and allows decision making to take place closer to the patient/professional interface.

2.1 Improvement Priorities & Quality Indicators

2.1.1 Improvement Priorities for 2016-2017 update

All of the following improvement priorities and quality indicators were identified following a review of the domains of quality and our commitment to achieving them was reported in the 2015/2016 Quality Report.

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 the board.

The Trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care. The following section includes a report on progress with our improvement priorities for 2016/2017 which were:

Priority 1 Pressure Ulcer - Reduction

Priority 2 MUST Nursing Care Indicator – compliance and outcomes maintaining body weight in patients =>75 years

Priority 3 Mortality Review – learning from reviews

Priority 4 Every patient has a voice – implementing Experience of Care Strategy

2.1.1.1 Priority 1. Pressure Ulcer - Reduction

Reason for prioritising: The Trust continued to focus on the management and reduction of pressure ulcers as a quality indicator for 2016/17. 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. Although the Trust has strengthened a number of processes, including a strong focus on early patient assessment and the documentation of the patient's skin condition on admission as essential to good practice, we believed that further work and interventions were required to ensure our patients did not develop pressure ulcers of any grade.

Lead(s): Tissue Viability Team and Matrons

Monitored: Patient Safety and Effectiveness Sub Committee; Patient Safety Sub Committee & Quality Dashboard

Goal: Achieve 5% reduction in avoidable grade 2 pressure ulcers; no incidence of grade 4 pressure ulcers and maintain grade 3 pressure ulcers at =<current rate. Achieve mini root cause analysis on 95% of grade 2 pressure ulcers.

Timeframe: March 2017

Progress: The situation at March 2017 for incidence of avoidable grade 3 and grade 4 pressure ulcers is as follows:-

Grade 2 – threshold is established as <=82. Year to date there are 36 reported Grade 2 pressure ulcers; this is a decrease on 2015/2016 when the Trust reported 102 Grade 2 pressure ulcers for the full year.

Grade 3 - threshold is established as <=3 and year to date there have been 4 approved hospital acquired avoidable grade 3 pressure ulcers; therefore we have not achieved this threshold.

Grade 4 – the zero tolerance threshold had been achieved until December 2016. Whilst significant work takes place throughout the Trust to prevent occurrences of this severity, with zero cases reported since 2013, we are disappointed to report that we are currently reviewing 1 grade 4 hospital acquired pressure ulcer.

We can further report the following progress:-

- Mini RCAs are completed on grade 2 pressure ulcers and work is currently being undertaken by Matrons to ensure this becomes embedded in practice
- Analysis of current data indicates that out of 44 reported Grade 2 Pressure Ulcers there are 9 that are deemed to be avoidable. There has been a substantial decrease of 56.8% in avoidable Pressure Ulcers across the Trust year to date. The Tissue Viability Nurse Specialist will be undertaking further work to ensure that RCA processes are being undertaken appropriately to provide assurance of the avoidable/unavoidable decision.
- A review of the tissue viability service was conducted by an External tissue viability nurse on 3rd April 2017 and we are currently awaiting their findings.

2.1.1.2 Priority 2. MUST Nursing Care Indicator – compliance and outcomes maintaining body weight in patients =>75 years

Reason for prioritising: High Quality Care was a local CQUIN for 2013/2014 and we continued the work through to 2016/17. The care indicators audit was a process which was developed, as part of a CQUIN (Commissioning for Quality and Innovation) to audit compliance with risk assessments for Falls, Waterlow (pressure ulcer) and MUST (nutritional) Risk Assessments. Whilst we have seen improvements in all these risk assessments, we continued to focus on increasing compliance with MUST risk assessments and importantly ensuring that patients maintain their body weight during their hospital stay. This was seen as particularly relevant to the elderly frail patient and patients =>75 years of age.

Lead(s): Matrons and Dietician

Monitored: Patient Safety and Effectiveness Sub Committee; Patient Safety Sub Committee & Quality Dashboard

Goal: Quarter 1 – establish systems for data collection. Monitor >=75years who have been an inpatient for >48 hours by taking weight on admission and discharge. No patient >=75 years old to lose more than 10% of body weight and if this occurs it is to be incident reported as a moderate harm.

Timeframe: March 2017

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
91%	98%	96%	*	*	97%	92%	94%	91%	91%	**	**

** Problems with Nursing Care Indicators database mean that we cannot retrieve MUST Risk Assessment data for February and March 2017.

Progress: The Trust has continued to monitor compliance with the MUST Risk Assessment via the Nursing Care Indicators process and reporting to Patient Experience Sub Committee and can report the following for 2016/2017.

*NB In July a new nursing care indicator (NCI) electronic process was established for NCI data collection which, due to lack of training on the system, resulted in poor data recording. Education and support was increased and data collection improved.

Risk assessments are now recorded in our electronic system Lorenzo, from March 2017; this will enable ward managers and matrons to electronically review the risk assessment.

The NCI process was developed to incorporate key milestones for this improvement priority as part of an on-going audit programme. The Nursing Care Indicators (NCI) now includes the following questions:-

- Is the patient aged 75 or over?
- Has the patient lost 10% or more of their original body weight since admission?
- If yes to the above has Duty of Candour been completed and documented?
- Has a datix been completed?

Going forward the process needs to be embedded within practice, it is felt that this will be supported by:-

- Lorenzo will further enhance the risk assessment process and referral to the dietician
- Lessons learned from reviews of patients will improve care of patients and reduce risk of malnutrition

2.1.1.3 Priority 3. Mortality Review – learning from reviews

Reason for prioritising: Since 1st October 2015, deaths are peer reviewed through a straightforward process, which is escalated to the Mortality Review Group (MRG) as necessary and where learning and improvement is the underlying rationale. We assessed ourselves against NHS England's Mortality Good Governance Guide (December 2015), and were confident that we had aligned to

their approach and timescales in this important area, and continued to work towards phase 2 improvement aim of reducing avoidable mortality by 20%. This remained a priority for the Trust, in order to embed mortality review and achieve 100% compliance and to increase learning from the reviews, importantly ensuring a collaborative approach with medical staff that have cases under review.

Lead(s):- Trust Lead Clinician for Mortality and Clinical Effectiveness Manager

Goal: –Improve screening compliance to 100% by March 2017. Develop an inclusive approach to learning from mortality reviews.

Monitored: Clinical Effectiveness Sub Committee and Quality Dashboard

Timeframe: March 2017

Progress: The plan in place to screen 100% of patient's deaths by Quarter 4 2017 has been affected by a number of factors. These include administrative issues and difficulty in engaging a number of Consultants with the process, resulting in a backlog of mortality reviews required for deaths that occurred in 2016. We have analysed the deaths and used a number of risk factors (age, comorbidities, patients without a DNACPR in place, mortality risk, cause of death, ICD-10 diagnosis codes and patients that trigger due to Deprivation of Liberty (DoLS), mental health or learning disabilities), to produce a list of patients whose deaths are screened as a matter of urgency.

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	FEB	MAR
MORTALITY PEER REVIEW*	50%	37%	51%	36%	23%	18%	6%	2%	0%	76%	77%	77%	100%

*NB figures change as reviews are conducted. Q1 – 70%: Q2 – 80%: Q3 – 90%: Q4 – 100%

More recently a greater number of Consultants are engaging with the process, which will ensure that we can share lessons and meet our agreed trajectory for undertaking mortality reviews. The Trust receives monthly reports from the Healthcare Evaluation Database (HED) and these provide us with areas for future investigation, where we are alerting on mortality for a particular disease area. Examples include HSMR (Hospital Standardised Mortality Ratio) alert for Pneumonia deaths, SHMI (Summary Hospital-level Mortality Indicator) & HSMR alert for UTI (Urinary Tract Infection) deaths and an HSMR alert for Cancer of the Rectum and Colon deaths. These deaths are reviewed by Consultants, with support from the Clinical Effectiveness team. Learning from these reviews are identified and disseminated through the Trust's Mortality Review Group and speciality Mortality and Morbidity meetings.

In addition to this, we are conducting further reviews into patient deaths triggered as follows:

- They are an elective patient
- They are subject to DoLS, mental health act or have a learning disability
- A screening review has indicated that a further secondary review is required
- Any deaths that are subject to a complaint or incident.

Learning Identified from Mortality Reviews

Issue	Identification method	Outcome
Medical patients admitted who have possible surgical diagnosis (bowel ischaemia/obstruction.	Focused review into Regional Enteritis and Ulcerative Colitis.	Review undertaken by the Digestive Diseases CBU Lead. Guidelines and timelines agreed for a number of diagnoses presented at the surgical and medical Governance and Audit meetings for dissemination.
Identification and recognition of patients with possible adrenal insufficiency.		Guidance to be produced into general management of patients on steroids (short and long term). Being undertaken by Dr Paula Chattington.
Patient with renal failure and high potassium waiting for dialysis and a bed at the Royal Liverpool University Hospital (RLUH).	Secondary reviews	Referral and Transfer Pathway drawn up by the RLUH visiting nephrologist to Warrington & Halton Hospitals (WHH).
Patients admitted as a day case who require stay in as an inpatient as a result of a complication of a procedure not known to out-of-hours/weekend on-call team. Gastroenterology and respiratory patients involved.		All such patients to be handed over directly to the medical registrar on-call to ensure managed as an acute admission and reviewed by the on-call team.
Poor/inadequate management of patients who have been stepped-down from ITU due to inadequate handover (medical).		Paper discharge form detailing ceilings of care provided to be available immediately in notes (there is a 2-3 day delay in transferring information to Lorenzo).
Pneumoperitoneum on chest x-ray missed by reviewing medical staff.		Case presented at the medical Audit and Governance forum to highlight the case and refresh knowledge of pneumoperitoneum on chest x-ray.
Poor/delayed recognition and treatment of sepsis.		Trust Sepsis Lead invited to Mortality Review Group to present the work now being done on sepsis, the new Sepsis Pathway and the plans for dissemination and training.
Very poor correlation between the death certificate cause of death and the cause of death identified by a consultant undertaking a secondary review. This is a recurring theme.	Identified on numerous secondary reviews and focused reviews.	Work Group set up to look at best practice guidance and bringing recommended guidance and training plans to the Medical Cabinet.
Trauma patient with fall and head injury – thoracic injuries not recognised.	Identified as part of the Trauma reviews for trauma patients.	Reinforced the importance of following the Thoracic Injury Pathway at the surgical/orthopaedic/A&E Audit meetings.

Patients under an Oncology consultant who present as an acute admission to the Trust. Teams unaware patient is receiving therapy or indeed unaware in some cases that the patient has a known malignancy. Not managed appropriately as a result.	Regional Enteritis & Ulcerative Colitis and Pneumonia focused reviews	Taken to the Patient Safety and Clinical Effectiveness Sub Committee. Also to be taken to the Lead Manager for Cancer Services and Lead Clinician for Cancer for action.
Review by HED into the Trust's high SHMI/HSMR since July 2016 suggested depth of coding issues. High number of R codes identified by AQUA Inadequate co-morbidity documentation.	Identified as part of MRG review of HMSR/SHMI even though we are aware that there is a month-on-month reduction in the levels. Also noted that all of the patients reviewed as part of the focused pneumonia deaths were patients who should have all been 'expected to die'.	We are meeting with AQUA to help us identify areas where we should target for changes.

2.1.1.4 Priority 4. Every patient has a voice – implementing Experience of Care Strategy

Reason for prioritising: The Government is committed to enabling hospitals to become better at listening, understanding and responding to the needs and wishes of patients and the public. The White Paper, Equity and Excellence: Liberating the NHS (Department of Health 2010) highlights the central aim of putting patients and the public first, to offer greater choice and control ,underpinned by the principle 'nothing about me without me.' The Health and Social Care Act (2012) underlines a commitment to put patients at the centre, by providing them with better information, more choice and a stronger voice, and the Care Quality Commission's Essential Standards outline how the NHS can provide the services and experience that patients expect.

We have developed our Experience of Care Strategy through involvement with patients, relatives, carers and the public, to ensure high quality services are delivered to our patients. The strategy demonstrates our commitment in ensuring the patient journey is a positive experience.

The strategy is structured into work streams and the Patient Experience Sub Committee will decide which work streams will be achieved by the end of the reporting year and will monitor progress until compliance is achieved. Identified work streams are:-

1. Develop a blue print for clinical business units (CBU) to meet the expectations for experience of care measurement.
2. Developing the capability and skills of staff.
3. Working together: exploring the connection between staff engagement, morale and the patients' experience of care.
4. Short term developments e.g. FFT Scorecard & template for national survey results.

Importantly the Trust through consultation with stakeholders has agreed to focus upon effective management of high risk complaints by reducing timescales and introducing 72 hour review.

Lead(s):- Complaints Manager

Goal: – Identify and agree key work streams and timescales for implementation within 2016/2017. Develop the process for 72 hour review of high risk complaints and monitor in quarter(s) 3 and 4 for 2016/2017.

Monitored: Patient Safety and Effectiveness Sub Committee and Quality Dashboard

Timeframe: March 2017

Progress: The expectations of the CBUs relating to complaints are detailed with the recently updated Complaints and Concerns Policy.

The importance of local resolution of concerns within the ward or department is being promoted. The new PALS posters have been distributed in both Warrington and Halton Hospitals.

The Staff Friends & Family and current Staff Survey will be analysed to provide evidence for exploring the connection between staff engagement, morale and the patients' experience of care. Human Resources led on the staff survey published in February 2017.

Short term developmental work is on-going in relation to FFT Scorecard; namely this is reported via the Quality Dashboard and is now included in the Trust Engagement Dashboard received by Board and also reported via Team Brief.

A system is now in place to escalate all high risk complaints to the CBUs within 72 hours. The high risk complaints, along with moderate and low risked complaints are reported to the Board of Directors on a weekly basis. All high risk complaints are discussed at the weekly Patient Experience Team meeting, and more recently an option of 72 hour review has been added into the notify box within the Datix, thus enabling reports to be generated and to record if the CBU have requested an extension to the 72 hour review.

More recently all 4 work streams have been reviewed in a Patient Experience Strategy. The attendees for the day include a wide range of clinical staff and also external representation from both Healthwatch and the CCG.

2.1.2 Local Quality Indicators 2016/2017

The Trust Board of Directors, in partnership with staff and Governors, reviewed performance data relating to quality of care and the agreed that, in addition to the improvement priorities that the quality indicators for 2016/2017 would include:

Patient Safety 2016/2017

- Nursing Care Indicators
- Medicines Management – development of indicators and on-going monitoring
- HCAI
- WHO Checklist (ORMIS)

NB: Pressure Ulcers will be an improvement priority for 2016/2017 and has therefore been removed as a quality indicator

Clinical Effectiveness 2016/2017

- Dementia
- Advancing Quality Measures - Pneumonia, COPD (Chronic Obstructive Pulmonary Disease) & Diabetes
- SHMI HMSR

Patient Experience 2016/2017

- Patient Experience Indicators
- Complaints including satisfaction survey of complaints process
- Complaints reduce number of returned complaints
- Patient Survey Indicators

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

2.1.3 Improvement Priorities and Quality Indicators for 2017/2018

2.1.3.1 Stakeholder Engagement

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

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

A paper was created and presented at various meetings with the aim to:

The aim of the presentations was to:

- Provide an overview of the Quality Report and our reporting requirements
- Provide an update on progress with quality improvement priorities and quality indicators for 2016/2017
- Planning for improvement priorities and quality indicators for 2017/2018

- Agree with the selection of quality improvement priorities and indicators to take back for discussion with the Board.

2.1.3.2 How we identify our priorities

The priorities have been identified through receiving regular feedback and regular engagement with governors, staff, patients, the public, and commissioners of NHS services, overseeing scrutiny groups and other stakeholders. Progress on the planned improvements will be reported through the Trust's assurance committees, via Quality in Care - Governors and ultimately through to Trust Board. Divisional Annual Planning 'Strategy' events have also been held to discuss and agree priorities and to discuss the quality aspects of these priorities.

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

2.1.3.3 Improvement Priorities for 2017–2018

The Trust Board, in partnership with staff and Governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2017-18 will include:

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

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

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

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

Priority 1 is supported via the Patient Safety indicators relating to Safer Surgery, Falls and Sepsis. All three patient safety indicators aim to reduce harm and focus on no avoidable deaths.

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

Priority 3 is supported via the Patient Experience indicators relating to Mental Health, PALs & Complaints and Patient Experience Strategy implementation plan roll out. All three Patient Experience indicators aim to improve outcomes based on the patient and their experience.

Full details of the Patient Safety, Clinical Effectiveness and Patient Experience indictors can be seen in section 2.1.4.4 below.

2.1.3.4 Local Quality Indicators 2017/2018

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 2017/2018 will include:

Patient Safety 2017/2018

- Safer Surgery - Evidence of avoidable harm, attitudes and practices need to change to promote safer surgery and invasive procedures
- Falls - Reduce injurious inpatient falls and increase the reporting of patient falls.
- Sepsis – Reducing the impact of serious infections (Antimicrobial resistance and Sepsis).

Clinical Effectiveness 2017/2018

- Safe Discharge – Supporting proactive and safe discharge
- Mortality – Monitor and improve mortality rates.
- Lessons Learned – Develop a lessons learned framework.

Patient Experience 2017/2018

- Mental Health – Improving services for people with mental health needs who present to A&E
- Patient Experience Strategy Roll Out
- PALs and Complaints - A full review of the Trust's complaints and PALS processes with development and investment in order to ensure these are open and transparent, and promote learning.

Patient Safety Priorities	
1. Safer Surgery - Ensure that the Trust fully embraces the culture of safer surgery in theatres and in those areas that undertake invasive procedures	
Why we chose this priority	**What success will look like**
Safety Culture and Quality Improvements in Safer Surgery will include theatres and how we have implemented the National Safer Surgery for Invasive Procedures (NatSSIPs) agenda. This was identified as a priority as a result of high profile surgery incidents.	Improvement in staff culture as measured in the Safety Culture Survey. Delivery of Quality Improvement programmes including the WHO checklist and all appropriate areas having established LocSSIPs (Local Safety Standards for Invasive Procedures). No Never Events to occur.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Undertake a Safety Culture Survey to identify baseline. Define what will be measured, and identify target trajectory. **Quarter 2** - Finalise action plan following improvement audit. Establish safety improvement champions. **Quarter 3** – Report progress of actions, highlighting areas for improvement. **Quarter 4** - Continue reporting, highlighting areas for	WHO checklists will be monitored via the IPR Dashboard that is presented to Board. A quarterly Quality Report will track milestones for the Quality Account priorities.

improvement. Report progress of actions, identify further actions as appropriate	
2. Falls – Reduction of injurious inpatient falls and increase the reporting of patient falls	
Why we chose this priority	**What success will look like**
This was identified as a priority as it was identified as a theme in the Trust's incidents and complaints received.	Establish a 10% reduction for falls resulting in moderate - catastrophic harm.
Implementation Plan	**How progress will be monitored and reported**
The Trust has employed a Falls Nurse who will commence in post in April 2017. **Quarter 1** - Complete scoping exercise across all areas; review existing policies and procedures; develop appropriate set of local standards; devise training method, and complete training needs analysis **Quarter 2** - Roll out new standards across all areas; develop an action plan to monitor compliance; **Quarter 3** – Monitor action plan; **Quarter 4** – Report on improvement.	Results in relation to the action plan following implementation will be reported through divisional governance structures and the IPR for Board. Ward dashboards will also track Falls figures. A quarterly Quality Report will track milestones for the Quality Account priorities.
3. Sepsis – Ensuring timely identification and treatment of sepsis, as per the Sepsis care bundle	
Why we chose this priority	**What success will look like**
Sepsis work continues to be a key deliverable for the Trust. Sepsis is a National CQUIN and is a local priority regarding harm reduction.	• Timely identification of sepsis in emergency departments • Timely treatment for sepsis in emergency departments and acute inpatient settings • Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours. • Reduction in antibiotic consumption per 1,000 admissions.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Review CQUIN requirements and establish Leads for the work. **Quarter 2** - Continued monitoring **Quarter 3** - Continued monitoring **Quarter 4** - Report progress	Monthly CQUIN meetings will track the progress of the work and escalate to Quality Committee. Results in relation to the CQUIN will be reported through divisional governance structures and the IPR for Board.

	A quarterly Quality Report will track milestones for the Quality Account priorities.
Clinical Effectiveness Priorities	
1. Supporting Proactive and Safe Discharge	
Why we chose this priority	**What success will look like**
This is a system wide priority to ensure reduction of delayed transfers of care and admissions avoidance. This priority is linked to a National CQUIN for 2017/18.	An increase in the number of patients who, after being admitted via a non-elective route, will be discharged to their usual place of residence within 7 days of admission.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Review CQUIN and establish Leads for the work. **Quarter 2** - Continued monitoring **Quarter 3** - Continued monitoring **Quarter 4** - Report progress	Monthly CQUIN meetings will track the progress of the work and escalate to Quality Committee. Results in relation to the CQUIN will be reported through divisional governance structures and the IPR for Board. A quarterly Quality Report will track milestones for the Quality Account priorities.
2. Mortality – implementation of the revised national mortality review processes	
Why we chose this priority	**What success will look like**
In December 2016 the Care Quality Commission reported that learning from deaths was not being given sufficient priority in some organisations and those valuable opportunities for improvements were being missed. Work has been ongoing with the Royal College of Physicians to develop a standardised tool and process for mortality reviews. Trusts must have a learning from deaths policy in place in 2017, as well as publishing preventable deaths.	A Structured Judgement Review (SJR) will be set up to meet weekly to review deaths within the Trust. Publication of preventable deaths from April 2017.
Implementation Plan	**How progress will be monitored and reported**

Q1 – Learning from Deaths policy to be drafted. Business case for the SJR will be completed and we will commence the use of SJR methodology to review patient deaths. Q2 – SJR meetings will commence. Q3 – Ensure learning from mortality reviews is linked to individual and collaborative practice, as per the Trust's learning framework. Q4 – Monitor and review	A quarterly Quality Report will track milestones for the Quality Account priorities. Results will be reported through divisional governance structures and the IPR for Board.
3. Lessons Learned – Implement a Lessons Learned Framework within the Trust	
Why we chose this priority	**What success will look like**
The aim of this priority is to ensure that we share, locally and Trust-wide, the key learning, improvements and best practice identified from all our means of review. Significant work will be completed over the next 12 months to improve governance systems and processes to promote learning.	Improvements within the Trust's 'Datix' risk management system; improvements in investigation of incidents and complaints; improved feedback from inquests and claims; improvements in clinical audit; and undertaking mortality reviews. Structured learning framework to establish how we will disseminate learning both from good practice and requirements for improvement. This will include different communication and learning methods such as round table events, newsletters, training events, and communication bulletins.
Implementation Plan	**How progress will be monitored and reported**
Q1 – Baseline assessment action and development of action plan Q2 – Deliver action plan. Q3 – Deliver action plan. Q4 – Evaluation and next steps.	Monthly reporting via Quality Committee A quarterly Quality Report will track milestones for the Quality Account priorities.
Patient Experience Priorities	
1. To improve the Trust's responsiveness to complainants and overall experience for patients/relatives/public to raise concerns	
Why we chose this priority	**What success will look like**
The Trust has an improvement plan in place regarding management of complaints, in relation to timeliness, quality of responses and learning. There will be new policies and processes and therefore in 2017-18 we are focusing on the development,	• Reduction in the number of complaints open more than 6 months – to be zero by the end of the financial year. • Increase in the numbers of staff trained in complaints handling • PHSO referrals to decrease. • Reduction of complaints between 30

implementation and effectiveness of these new processes.	days and 6 months old. • Improve the response times for complaints.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Continue work in relation to the complaints improvement action plan **Quarter 2** – Continued reporting of actions and performance improvement **Quarter 3** - Continued reporting of actions and performance improvement **Quarter 4** - Continued reporting of actions and performance improvement	Complaints will be monitored via the IPR Dashboard that is presented to Board. A quarterly Quality Report will track milestones for the Quality Account priorities.
2. Patient Experience Strategy	
Why we chose this priority	**What success will look like**
The patient experience strategy relates to the QPS framework under the focus of 'Quality' and as such supports our goals to keep the patients at the centre of everything we do, by: • Listening to our patients and carers • Learning together from their feedback • Leading change based on patient experiences • Ensuring our patients are consistently put first as we continuously improve our communication, care, environment, and processes.	Introduction of quality dashboards designed in line with the National Patient Survey results and based on 'What Matters Most' to our patients and carers. Patient experience feedback will also be shared with patients and carers, alongside actions taken, using a '...you said, we did...' approach. National survey results and FFT data will be analysed alongside patient stories to determine priorities for improvement and celebrate successes. We will build QI capability at a faster rate across the organisation and create a culture where continuous improvement, based on patient feedback, becomes an everyday activity for all staff. We will create 'always events' that support communication based on what matters most to each patient, care based on each patient's individual needs, environments that support healing and processes that are simplified.
Implementation Plan	**How progress will be monitored and reported**
Q1. Develop the programmes of work and establish sub-groups of the Patient Experience Sub Committee. Q2. Monitor the sub-groups as they will direct task and	Patient Experience Sub-committee via the relevant sub-groups.

finish groups to ensure delivery of the patient experience priorities. Q3 Continue to monitor Q4 Evaluate performance	Results will be reported through divisional governance structures and the IPR for Board.
3. Patient Experience for those patients with mental health needs who attend A&E	
Why we chose this priority	**What success will look like**
Improving services for people with Mental Health needs who present to A&E.	Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.
Implementation Plan	**How progress will be monitored and reported**
Q1 – Identify the cohort of patients. Q2 – Review and develop a co-produced care plan for each person in the cohort which includes a focus on preventing avoidable A&E attendances. Q3 – Develop and strengthen existing / new services to support this cohort of people better and offer safe and more therapeutic alternatives to A&E where appropriate. Monitor the number of attendances. Q4 – Monitor the number of attendances and improve the quality of A&E diagnostic coding for mental health needs ensuring that the coding for the final quarter of the year is complete and accurate. Conduct an internal audit of mental health diagnostic coding to provide assurance of data quality.	Monthly CQUIN meetings will track the progress of the work and escalate to Quality Committee. A quarterly Quality Report will track milestones for the Quality Account priorities. Results will be reported through divisional governance structures and the IPR for Board.

2.2. Statements of Assurance from the Board

During 2016/17 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 2016/17 represents 100 per cent of the total income generated from the provision of relevant health services by the Warrington and Halton Hospitals NHS Foundation Trust for 2016/17.

2.2.1 Data Quality

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

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

2.2.2 Participation in National Clinical Audits and National Confidential Enquiries 2016/2017

During 2016/17, 39 National Clinical Audits and 5 National Confidential Enquiries covered relevant health services that Warrington and Halton Hospitals NHS Foundation Trust provides.

During 2016/17, Warrington and Halton Hospitals NHS Foundation Trust participated in 37/39 (95%) national clinical audits and 4 (80%) national confidential enquiries of the national clinical audits and national confidential enquiries, in which it was eligible to participate.

The National Clinical Audits and National Confidential Enquiries that Warrington and Halton Hospitals NHS Foundation Trust was eligible to participate in during 2016/2017 are as follows:-

	National Clinical Audit & Enquiry Project name
1	Endocrine and Thyroid National Audit
2	Nephrectomy audit
3	Stress Urinary Incontinence Audit
4	Adult Asthma
5	Paediatric Pneumonia
6	Smoking Cessation
7	UK Cystic Fibrosis Registry
8	Elective Surgery (National PROMs Programme)

	National Clinical Audit & Enquiry Project name
9	National Diabetes Audit - Adults
10	National Joint Registry (NJR)
11	Inflammatory Bowel Disease (IBD) programme
12	Case Mix Programme (CMP)
13	National Cardiac Arrest Audit (NCAA)
14	Maternal, New born and Infant Clinical Outcome Review Programme
15	Child Health Clinical Outcome Review Programme
16	Medical and Surgical Clinical Outcome Review Programme
17	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
18	Cardiac Rhythm Management (CRM)
19	National Heart Failure Audit
20	National Comparative Audit of Blood Transfusion programme
21	Asthma (paediatric and adult) care in emergency departments
22	Severe Sepsis and Septic Shock - care in emergency departments
23	Consultant Sign Off - care in emergency departments
24	National Ophthalmology Audit
25	Diabetes (Paediatric) (NPDA)
26	Neonatal Intensive and Special Care (NNAP)
27	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
28	National Lung Cancer Audit (NLCA)
29	Sentinel Stroke National Audit programme (SSNAP)
30	Falls and Fragility Fractures Audit programme (FFFAP)
31	National Audit of Dementia
32	Bowel Cancer (NBOCAP)
33	National Prostate Cancer Audit

	National Clinical Audit & Enquiry Project name
34	Head and Neck Cancer Audit
35	National Emergency Laparotomy Audit (NELA)
36	Oesophago-gastric Cancer (NAOGC)
37	Major Trauma Audit
38	Renal Replacement Therapy (Renal Registry)
39	7 Day Service Audit – NHS England

	National Confidential Enquiries
1	Mental Health
2	Acute Pancreatitis
3	Acute Non Invasive Ventilation
4	Young People Mental Health
5	Cancer in Children, teens and Young Adults

The National Clinical Audits and National Confidential Enquiries that Warrington and Halton Hospitals NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2016/2017 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2016/2017
Endocrine and Thyroid National Audit	**No**	**NA**	**NA**
Nephrectomy audit	**√**	**√**	**Data unavailable**
Stress Urinary Incontinence Audit	**No**	**NA**	**NA**
Adult Asthma	**√**	**√**	**21/54 (39%) Data submitted**

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2016/2017
Paediatric Pneumonia	√	√	**23 cases submitted – data is still being collected**
Smoking Cessation Current smoking	√	√	**100 (100%)** **16/20 (80%) cases submitted**
UK Cystic Fibrosis Registry	√	√	**29 (100%) cases submitted**
Elective Surgery (National PROMs Programme) **Pre-operative** All procedures: Groin Hernia Hip Replacement Knee Replacement Varicose Vein **Post-operative** **All procedures:** Groin Hernia Hip Replacement Knee Replacement Varicose Vein	√ √	√ √	**307/365 (84%)** 31/44 (71%) 110/121 (91%) 159/192 (83%) 7/8 (88%) **68/148 (46%)** 14/24 (58%) 22/51 (43%) 31/70 (44%) 1/3 (33%) **Data is still being collected**
National Diabetes Audit - Adults	√	√	**14 (100%) cases Submitted**
National Joint Registry (NJR) Hips Knees Ankles Elbows Shoulders	√	√	**28** **31** **0** **2** **3** **No %'s are available as data is still being collected**

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2016/2017
Inflammatory Bowel Disease (IBD) programme	√	√	**24/29 (83%) cases submitted**
Case Mix Programme (CMP) ICNARC	√	√	**601/601 (100%)**
National Cardiac Arrest Audit (NCAA)	√	√	**72/72 (100%)** **Data is still being collected**
Maternal, New born and Infant Clinical Outcome Review Programme	√	√	**14 cases reported – data is still being collected**
Child Health Clinical Outcome Review Programme	√	√	**Data unavailable**
Medical and Surgical Clinical Outcome Review Programme	√	√	**Data unavailable**
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	√	√	**332 cases submitted – data is still being collected**
Cardiac Rhythm Management (CRM)	√	√	**Data unavailable**
National Heart Failure Audit	√	√	**155 cases submitted – data is still being collected**
National Comparative Audit of Blood Transfusion programme 2016 Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	√	√	**27 (100%) cases submitted**
Asthma - care in emergency departments	√	√	**50 (100%) cases submitted**
Severe Sepsis and Septic Shock - care in emergency departments	√	√	**50 (100%) cases submitted**

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2016/2017
Consultant Sign off - care in emergency departments	√	√	100 (100%) cases submitted
National Ophthalmology Audit	√	√	Data unavailable
Diabetes (Paediatric) (NPDA)	√	√	Data unavailable
Neonatal Intensive and Special Care (NNAP)	√	√	511 (100%) cases submitted
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	√	√	Data unavailable
National Lung Cancer Audit (NLCA)	√	√	Data unavailable – data is still being collected
Sentinel Stroke National Audit programme (SSNAP)	√	√	Data unavailable
Falls and Fragility Fractures Audit programme (FFFAP)	√	√	Data unavailable – data is still being collected
National Audit of Dementia	√	√	51 (100%) cases submitted
Bowel Cancer (NBOCAP)	√	√	Data unavailable – data is still being collected
National Prostate Cancer Audit	√	√	Data unavailable – data is still being collected
Head and Neck Cancer Audit	√	√	Data unavailable – data is still being collected
National Emergency Laparotomy Audit (NELA)	√	√	102/156 (68%) cases submitted Data is still being

National Clinical Audit & Enquiry Project name	Participated	Data collected	% of cases submitted 2016/2017
			collected
Oesophago-gastric Cancer (NAOGC)	√	√	Data unavailable – data is still being collected
Major Trauma Audit	√	√	202 cases submitted HES 286-361 Completion 56-70.5%
Renal Replacement Therapy (Renal Registry)	√	√	Data unavailable Warrington data received via Liverpool
7 Day Service Audit	√	√	192 (100%) cases submitted

National Confidential Enquiries

	Participated	Data collected 2016/2017	% Cases submitted 2016/2017
Mental Health	√	√	3/6 (50%) cases submitted
Acute Pancreatitis	√	√	3/5 (60%) cases submitted
Acute Non Invasive Ventilation	√	√	1/4 (25%) cases submitted
Young People Mental Health	√	√	Data is still being collected
Cancer in Children, teens and Young Adults	TBC	TBC	-

2.2.2.1 NATIONAL CLINICAL AUDIT

The reports of 20 National Clinical Audits were reviewed by the provider in 2016/2017 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Quality Improvement Action Plan
35796 - TARN: Major Trauma: The Trauma Audit & Research Network - Case note presentation only.	Standards Of Procedure to be put in place regards the process of The Trauma Audit and Research Network (TARN) deaths.
	Three Deaths – Secondary review at Mortality and

Audit Title	Quality Improvement Action Plan
	Morbidity meeting – to be actioned.
22967 - National Emergency Laparotomy Audit (NELA) – update.	Continue data input for NELA and audit compliance with standards proposed.
55162 - National Emergency Laparotomy Audit (NELA) – Mortality Data (December 2015 – November 2016)	Awaiting Quality Improvement Action Plan.
33958 - Neonatal Intensive and Special Care (NNAP) - 2014/2015	Annual Re-Audit to ensure standards are being met.
	Cross checking of data by data clerk for all NNAP National data.
34818 - British Thoracic Society Paediatric Asthma Audit 2015	Re-audit to monitor compliance as per BTS guidelines.
32116 - Royal College of Emergency Medicine (RCEM) - VTE Prophylaxis	Communications re-launch pathway and Emergency Department Safety brief and Governance newsletter.
	Poster to be displayed for minor's area.
	Ensure Electronic Import Delivery Order (EIDO) RCEM leaflet available. Add to Emergency Department intranet.
26998 - National Pregnancy in Diabetes (NPID) - Quality Accounts 2015 Data	Make poster that can go on TV screens to be played in General Practices (GP) across Warrington.
	Continue NPID audit and benchmark against national standards and local improvement.
	Notice for GP e-magazine re pre-conception advice and existence of clinic.
	Present NPID data to obstetric team - (finding presented on the 16/08/17).
35310 - National Lung Cancer	Better and more meaningful data interrogation.
	Improve Clinical Nurse Specialist (CNS) contact rate by increasing CNS hours.
	Improvement in stage record.
24942 - 2015 National End of Life Care Audit - Led by the RCP	Identify a Non-Executive Director with responsibility for End of Life Care, succession planning for replacement of current board members with responsibility for End of Life Care.
	Review of compliance with NICE Guideline NG31.
	Present findings at Surgical audit meeting – (findings presented 20/05/16)
26770 - Myocardial Ischaemia National Audit Project MINAP, Annual Report 2013 – 2016	Risk stratification Re-Audit has been complete and positive improvements have been made: · 88% had GRACE score calculated compared to 31%

Audit Title	Quality Improvement Action Plan
	at last audit · 60% admitted to CCU compared to 50% previously · 65% undergo coronary angiogram within 72 hours from admission, although the NICOR/MINAP figure uses a different criteria and results show 55% with 72 hours.
	Work is underway to review and update the Chest Pain Pathway.
	Annual training programs for nurses and junior doctors are scheduled: · July 2017 – ACS & Heart Failure study day · October – F1 training session
34336 - 2016 National Comparative audit of Red Cells and platelet transfusions in haematology	The guideline for the 'Use of Blood/Blood Components' be update to include recommendation 2a.
	Agree a plan for local audit by rotating doctors within Haematology.
	Disseminate audit finding to: Transfusion Team, Hospital Transfusion Committee and Patient Safety and Effectiveness Committee.
24701 - National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehab Audit - Warrington Data	Source suitable alternative to Chronic Obstructive Pulmonary Disease Assessment Test (CAT) questionnaire.
	Review resistance training assessment and delivery.
26921 - National COPD Pulmonary Rehab Audit - Halton	Improve length of time from referral to assessment; review discharge practice.
	Capacity to see discharged patients from hospitals within 1 month for Pulmonary Rehab.
	Referral pattern of consultants versus General Practices: - Education/Advertising of Pulmonary Rehab.
	Spirometry: - Evidence of predicted FEV1/other diagnostic tools. (CT Computed Tomography scans etc.)
	Practice test for 6 months. Capturing other 6 months results e.g. for AOT assessment previous Pulmonary Rehab attendance, to help compliance with National Standards.
38551 - Retinopathy of Prematurity (ROP) Screening	Re-Audit in one year time.

Audit Title	Quality Improvement Action Plan
39742 (24942) - National End of Life Care - Led by RCP	Identify Non-Executive Director with responsibility for End of Life Care, succession planning for replacement of current board members with responsibility for End of Life Care.
	Impact of this audit on education and teaching – updating information and processes.
	Review of NICE Guideline NG31.
	Lorenzo and use of IPOC.
51889 - Adherence to National Standards for Infectious Disease screening in Antenatal period	Trust is exceeding the achievable performance threshold of ≥ 99.0% for all three standards
	Performance demonstrates failsafe systems for booking bloods are effective
	Continue good practice to keep meeting achievable standard
	Offer screening to all unbooked women who present in labour and ensure follow up of results. Can be offered postnatally if unable to do so when in labour.
51892 - Compliance to standards for New-borns Bloodspot Programme	Improvement in record keeping imperative to maintain accurate figures.
	Reduction in the number of avoidable repeats – this has been achieved previously but not maintained Faster response times when repeat samples are requested from Alder Hey and also improved documentation in the community office.
	Continued auditing of new born bloodspot to achieve all standards.
	Present audit to community midwives at a community meeting to increase awareness of issues.
7 Day Service Audit – NHS England	Participate in the 3rd round of the National Audit. Awaiting Quality Improvement Action Plan
35329 - National Joint Register NJR) Audit	Re-audit annually to ensure standards are being met. Continue data collection for National Audit.
NELA National Audit	Highlight findings to Surgeons – at 16/03/17 meeting. Continue with the National Data collection.

Audit Title	Quality Improvement Action Plan

2.2.2.2 LOCAL CLINICAL AUDIT

The reports of 284 local clinical audits were reviewed by the provider in 2016/2017 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Quality Improvement Action Plans
Advancing Quality Programme	
37455 - Advancing quality in hip fracture management	Work with Emergency Department to improve pain assessment and analgesia within 60 minutes.
	Work with patient flow, ward nurses and Emergency Department team to improve four hour target to the ward.
	Work with ward nurses to improve pressure ulcer assessment within 6 hours and nutritional screen within 24 hours of admission.
	Re-audit to ensure compliance is being met.
Anaesthetic Audit Programme	
37316 - A review of pre-op investigations	Management meeting about improving efficiency in theatres by moving pre-op closer and increasing staff to allow for staggered start times.
	Implementation of Electronic based Pre-op Assessment Proforma.
	Management meeting about List Planning (start times) and increasing time for perioperative care according to GPAS guidelines.
	Education of Anaesthetic Staff on minimum criteria for pre-op assessment.
37363 - QI survey of sedation in endoscopy at Warrington Hospital	No formal action plan required.
49584 - Audit looking at the significance of the red wristbands	No formal action plan required.
27913 - Survival of patients receiving ICU care following cardiac arrest	Re-audit over period Jan-April 2016.
25154 - Audit on pre-operative anaesthetic referrals	Awaiting Quality Improvement Action Plan.

Audit Title	Quality Improvement Action Plans
47040 - Obstetric admissions to HDU over 12 months (38141)	Audit obstetric sepsis – scheduled to present in September Audit Meeting.
	Consultant involvement to be documented – shown by repeat audit.
	Expression of interest for PROMPT training.
	Training midwives questionnaire.
25152 - Audit on Anaesthetic cancellations of patients in CMTC	Awaiting Quality Improvement Action Plan.
36747 - Survey of fluid prescriptions and relationships to cannula in diagnosed AKI 3 patients	To deliver this presentation at Grand Round or medical Audit meeting.
	To have the laboratory bleep the responsible doctor for ordering tests (we have to put bleeps in for a reason; the lab should bleep the requestor and if out of hours, the on call foundation doctor).
	Educate the new foundation doctors at induction.
44517 - Re-Audit CT Head Injury Audit	Check registrar reports as soon as possible (secretaries to follow-up and remind).
	Secretaries to verify on typing CT Head reports, when clinical states head injury and it's a consultant report.
21377 - Safety of acute pain management	Improved attendance at training sessions.
46486 - Pre-op Investigations	Awaiting Quality Improvement Action Plan.
40228 - ICU Always event	Awaiting Quality Improvement Action Plan.
36157 - Patient Reported outcomes in Day case Surgery	None
41412 - Spinal Audit: Safety of Pain Management	Approve attendance at training sessions.
38548 - Times to CT for Trauma team activations Jan-Oct 2015	Meeting both Network and National CT targets.
	Rapid decision making for CT to be done in a timely manner - awareness to all staff.
	Designated scribing.
28674 - 0.3 and 0.4mg intrathecal diamorphine for LSCS	Awaiting Quality Improvement Action Plan.
42246 - Head Injuries	Awaiting Quality Improvement Action Plan.
41342 - Acute Care Team feedback	Awaiting Quality Improvement Action Plan.
38141 - Obstetric admissions to ITU over 12 months	Audit obstetric sepsis - scheduled to present in September Audit Meeting.

Audit Title	Quality Improvement Action Plans
	Training midwives questionnaire.
	Consultant involvement documented.
	Expression of interest for PROMPT training.
34399 - Merseyside anaesthetic group for improving quality - Mersey intubation checklist (MAGIQ-MIC)	Redesign of check list to include intubation details in ICU- This will ensure every intubation starts with check list and completes with intubation details
	Re audit the use of new airway form in ICU to see the compliance
	Improved training of Intensive Care Unit (ICU) staff for RSI assistant role in ICU and new DAS guidelines- Onsite training or training on attendance to WAM course
	Improved training of ODPs, recovery nurses for new DAS guidelines and use of rapid sequence induction (RSI) check list.
10652 - Anaesthetic cancellations on the day of surgery - can these be reduced by effective pre and peri-operative planning	Single pre-op pathway.
	Improve fasting information and medications.
	Timely access to pre-op clinic +/- anaesthetist.
33624 - NICE IV fluids in Emergency Patients	Present findings at Critical Care Audit meeting on the More training / education amongst juniors Senior support / review. Everyone is responsible – daily review of fluids needed including documenting a 24 hour plan. Incident reporting of fluid mismanagement so we can learn from our mistakes.
48923 - Patient information on pain relief during labour – re audit	Liaise with midwifery department further about distributing the booklets to expectant mothers. Re-audit.
53528 - Stabilisation Trolley	Audit complete – No further action.
50460 - Elective Laparoscopic Cholecystectomy	Prospective audit - to look at why: Start from pre-op – why not booked as day case. Why are drains being used? If PONV/pain delays discharge, what anaesthetic technique/post-op care is given and can this be modified?
50467 - Use of the RSI checklist and apnoeic oxygenation	Highlight abbreviated checklist as option in high risk out of theatre Rapid Sequence Induction (RSI). Checklist available in all areas. ODP empowerment and involvement important.
	Improve awareness of apnoeic oxygenation with standard nasal cannula.
	Present findings to ODP staff next audit meeting Address O2 cylinder availability.
52975 - Audit of the use of the new emergency theatre booking form	Theatre coordinators to prompt urgency category from booking team.

Audit Title	Quality Improvement Action Plans
	Adjustments to booking form in development – streamlined to essential information only, emphasising communication, availability and accessibility.
	Re-audit the use of the updated and simplified form
Children's Health Audit Programme	
35011 - Placental pathology and neonatal outcomes	No action required.
41789 - Term Admission - CQUIN	Unanticipated admissions proforma.
	MDT review to identify lessons learnt.
39174 - Maternal Transfer	Update Situation, Background, Assessment and Recommendation (SBAR) form in guidelines.
38743 - Infant deaths North West 2013-2015	Child Death Administrator Role Clearly defined.
	CARI: Care of At Risk Infants (Family history of child deaths) Clinic started.
39800 - Neonatal Cooling Therapy audit	Rectal probe for monitoring temperature.
	Recording target temperature achieved time or documenting discharge temperature in case of not achieving target temperature at the time of transfer.
26546 - Home administration of Intravenous (IV) Medications for Cystic Fibrosis (CF) Patients	Continue to input data in to the Cystic Fibrosis Registry.
	At clinic reviews look at whether the children who could use a nebuliser should be tried on Dornase alfa.
	Work with Alder Hey on the interim reviews.
31656 - Trust wide use of the DNA section of the Safeguarding Children Policy.	To review the DNA process within the safeguarding children policy.
	To complete this audit annually – to comply with section 11 self-assessment tool.
	To circulate information regarding neglect and the impact of DNAs.
	To review the audit data collection sheet.
40771 - Young people mental health study	Submit the data to National Confidential Enquiry into Patient Outcome and Death (NCEPOD) national study.
33867 - Audit of Actim Partus for threatened preterm labour.	Single point lesson produced to be disseminated to all staff via clinical leads.
53478 - Annual Meningitis Audit	All standards met. Repeat audit next year to ensure standards are maintained.
40987 - Surfactant use Re-Audit	Awaiting PowerPoint Presentation / Quality Improvement Action Plan.
45997 - Completion of Paediatric admission proforma on Lorenzo	Update the proforma.
	Re-audit to investigate if recommendations have been

Audit Title	Quality Improvement Action Plans
	implemented. Increase awareness of juniors by highlighting the importance of completing the proforma completely during all acute admission – at induction, governance and audit meetings.
56899 - Paediatric Observation	The impending arrival of the Paeds ANP will undoubtedly be a positive influence, but this does not absolve the Paediatric matron and nursing team of responsibility – these issues need actioned with some urgency.
	I have emailed this presentation to the Adult and Paeds ED senior nurses and matron, and I have asked the Paediatric team for an action plan for how they propose to implement the recommendations.
	Many similar issues were and remain prominent in the main ED. We have been focusing on, and improving standards such as BM testing. Staff can liaise with the ED nurses should advice be required.
26853 - Paediatric Head Injuries	Awaiting Quality Improvement Action Plan.
39744 - Review of standards for paediatric	Radiological report should indicate whether follow up imaging is required and what image is recommended.
imaging in Non-Accidental Injury (NAI)	Objective indicators for NAI to be included within the guidelines.
	Many radiological reports stated “signing physician” at the end of the report. However, for completeness it should state the name and grade of the radiologist.
47532 - Insulin pump in the reduction of HbA1c	Awaiting PowerPoint presentation / Quality Improvement Action Plan.
Corporate Governance Audit Programme	
40297 - Re-Audit Lorenzo - Case Note Documentation Audit	Re-audit to be carried out in 2017 to ensure compliance is being met.
Corporate Nursing Audit Programme	
20341 - Annual Infection Control Audit	Awaiting Quality Improvement Action Plan.
38667 - Deterioration Recognition Audit (NEWS)- Sep 15 - March 16	All wards to be audited to ensure 100% compliance in progress.
	Ward managers to address / forward findings to those wards that haven’t achieved targets.
36682 - ITU Falls Audit	Proforma to be updated with appropriate changes that is applicable to ITU.

Audit Title	Quality Improvement Action Plans
	Findings of this audit to be emailed to all staff on ICU for awareness.
53047 - Falls Audit	Develop a business case for a dedicated falls practitioner.
	Regular audits of compliance (Deputy Chief Nurse).
	Findings of this audit to be emailed to all CBU's for awareness and action.
30454 - Deterioration Recognition Audit (NEWS) May 2016 – July 2016	Meetings set up with ward managers and link nurses for those wards that are below nice guidelines compliance.
	All wards to be audited to ensure 100% compliance in progress.
56434 - Mental Capacity Act Audit /DoLs	MCA and DoLS Training provision should be reviewed immediately. A meeting is to be arranged with the Associate Director of Education and the Organisational Development Team to discuss training to look at the content of level three MCA and DoLS training and how this can be delivered to the nursing and medical teams.
	Support is required across the CBU's to embed and support the wards and departments with the MCA and DoLS statutory obligations and Trust policy and procedures. The group of staff responsible for this support must undergo training as soon as dates are confirmed along with other priority staff, i.e. ward managers and ward sisters.
	Repeat this audit in three months' time to assess the effectiveness of the training program and follow up with regular audits thereafter.
55925 - Deterioration Recognition Audit (NEWS) - December 2016 - January 2017.	Meet with Ward Managers and Link Nurses to highlight themes for improved compliance.
	All wards to be re-audited as per NEWS audit schedule.
Health Record Audit for Electronic Patient Record (Lorenzo) ID:52621	All fields < 75% must be addressed with nursing/clinical teams. Senior ward staff should communicate to the ward team that all fields of documentation should be compliant and that their documentation will be and is subject to audit.
	Those staff found to be non-complaint during audit should be supported to guide them to compliance; if no improvement is noted then staff are to be counselled regarding the importance of excellent standards of documentation.
	Ward managers are to keep a record of who requires support so that those who require further interventions are evident. Report to be disseminated with Ward/departmental managers, CBU Triumvirate & SMT for shared learning.

Audit Title	Quality Improvement Action Plans
Emergency Care Audit Programme	
40375 - Are patients dying without DNA CPR forms not being resuscitated	Present findings to acute care group.
	Present findings to Mortality review group.
	Review use DNA CPR - (work group WHH).
24730 - A&E Medical Documentation	Update the whole department re: coding.
	Feedback personalised audit results to all doctors, with constructive advice.
	Repeat the audit in one year in a new agreed format.
39182 – Documentation Audit	Enforce better control and registration of TAC cards.
	Inform all staff to identify them when using a TAC card. This question needs to be asked at the beginning of every shift and at daily safety brief?
	Clinical Decisions Unit (CDU) discharge document, dates not being entered. Give list of the cases to Roy, who should be able to tell us how this happened. Then educate all.
	Inform individuals
	3 ALN entries (by people other than Jim)
	1 Epilepsy Nurse
	2 Geriatrician Consultant notes
	Regarding blank templates:
	Consider removing blank templates from Lorenzo.
	Remind nursing staff of obligations re documentation standards.
	Ensure receptionist / progress chaser scans in the correct set of items. A checklist of what should be scanned in, and where, needs creating.
	Clinicians to decide which documents needs to be scanned in. This applies to both admission (transfer from ED, Emergency Department) and discharge (home or wherever) We need to work with administrative staff to create a checklist of which items are needed.
	Educate all medical staff about the importance of the ED discharge summary.
	Educate re use of the 'Transfer of Care note' – this would mainly be for those who do the CDU Ward Round.
	Create a Lorenzo document for Mental Health Team referral. It should also include a capacity and risk assessment.
	Check with Mental Health team whether we should be scanning in any of their notes.
	Provide feedback to governance team with the suggested modifications to the audit template.

Audit Title	Quality Improvement Action Plans
39184 - Renal Colic Pathway Audit	Reminder (e.g. poster) to properly and accurately document urine dipstick results - and possibly being able to upload data onto ICE for future audits.
	Re-audit with larger sample size.
32169 - Sedation in the Emergency Department	Further training in the use of the Electronic Sedation Logbook - update QRG for use of the Electronic Sedation Logbook. To ensure completion of the Electronic Sedation Logbook for all patients undergoing sedation - introduce automated email reminder systems. To improve the early recognition of patients requiring sedation - to incorporate this in the initial streaming/handover assessment. To undertake training in sedation for all professional groups - to work with the departmental medical and nursing leads and the Trust Sedation Lead to develop educational materials and opportunities.
38273 - Emergency Nurse Practitioner Halton Documentation Audit	Datix of missing documentation.
	So that IT can look into this issue of unsaved notes.
	Feedback of individual practitioners audit result so that they can reflect and adapt practice to improve documentation.
	Re audit in 1 year.
47434 - SBAR (Situation Background Assessment Recommendation Audit)	Awaiting Audit Report / Quality Improvement Action Plan.
51595 - An audit on the immediate discharge of paediatric patients with torus fractures	Introduce the new process in Urgent Care Centre [formally Minor Injuries Unit] and Emergency Department.
	Develop similar processes for other minor fractures [working with Trauma &Orthopaedic.
47737 - Warrington A&E Reception: Documentation Audit	Circulate results and raise awareness
	Re audit in 1 year
	Re-audit – Contact numbers, Next Of Kin (NOK) and schools
44083 - MET Survey Audit	Present findings at Acute Care team Meeting.
	Foundation teaching programme 2016/17.
	Present findings at Acute Care team Meeting
	Try and identify Medical Emergency Team (MET) entry clearly on Lorenzo.
44517 - Re-Audit CT Head Injury Audit	Check registrar reports as soon as possible (secretaries could chase / remind).
	Secretaries to verify on typing CT Head reports, when clinical states head injury and it's a consultant report.
38270 - Emergency Nurse Practitioner (ENP) Documentation Audit - Warrington	Disseminate findings to all Emergency Nurse Practitioners (ENPs).
	Repeat the audit in one year in a new agreed format.
51234 - Management suspect scaphoid injuries.	Present findings at Radiology Audit Meeting and with Orthopaedic Representative on the 22/02/17 – presented.

Audit Title	Quality Improvement Action Plans
38548 - Times to CT for Trauma team activations Jan-Oct 2015	Meeting both Network and National CT targets.
	Rapid decision making for CT to be done in a timely manner - awareness to all staff.
	Designated scribing.
42246 - Head Injuries	Awaiting PowerPoint presentation / Quality Improvement Action Plan.
56899 - Paediatric Observation	The impending arrival of the Paeds ANP will undoubtedly be a positive influence, but this does not absolve the Paediatric matron and nursing team of responsibility – these issues need actioned with some urgency.
	I have emailed this presentation to the Adult and Paeds ED senior nurses and matron, and I have asked the Paediatric team for an action plan for how they propose to implement the recommendations.
	Many similar issues were and remain prominent in the main ED. We have been focusing on, and improving standards such as BM testing. Staff can liaise with the ED nurses should advice be required.
26853 - Paediatric Head Injuries	Awaiting Quality Improvement Action Plan.
39744 - Review of standards for paediatric imaging in Non-Accidental Injury (NAI)	Radiological report should indicate whether follow up imaging is required and what image is recommended.
	Objective indicators for NAI to be included within the guidelines.
	Many radiological reports stated “signing physician” at the end of the report. However, for completeness it should state the name and grade of the radiologist.
47532 - Insulin pump in the reduction of HbA1c	Awaiting PowerPoint presentation / Quality Improvement Action Plan.
ENT Audit Programme	
39797 - Nasal Fracture Re-Audit	Continue to utilise the stamp and re audit in 1 year.
52999 - Re-Audit of Theatre Documentation.	Pink sheet needs adding time and elective/emergency procedure column. Redesigning of the pink sheet for better documentation.
56376 - Tongue Tie Clinic	Re Audit to ensure compliance is being maintained.
22978 - Nasal symptom improvement with turbinoplasty	No actions – it is safe to carry on with Tubinoplasty.
48988 - Audit on Ear Dressing Clinic service use.	Inform GP practices, A&E and Urgent care centre of new service – work with Communications team. To develop the service further with expansion of role, re-audit as service develops to compare results

Audit Title	Quality Improvement Action Plans
45313 - NICE Guideline in Middle Ear Effusion Management (grommet audit)	To re-audit in 1 years' time.
40707 - Coblation versus Cold Steel tonsillectomy: A Prospective study comparing Visual Analogue Scale (VAS) scoring in a Paediatric population.	Continue to collect data for study including pain scores and post op complications.
34554 - A 10 year overview of thyroglossal cyst experience - recurrence and compliance	Operative proforma / Repeat audit.
39369 - Audit on day case paediatric tonsillectomy	To consider pain management to reduce the overnight stay.
General Medicine & Elderly Care Audit Programme	
44757 - ACE - Quality Improvement Project	Awaiting Quality Improvement Action Plan.
21471 - The management of BPSD on the FMN ward	Individual care plan for BPSD to be included in discharge information to social care agencies / care facilities, for patients discharged from the FMN ward
	Cognitive Assessment Team (CAT) nurses to calculate, record and inform FMN ward of transferring patient's Pittsburgh Agitation Scale (PAS) score pre-admission
	PAS score to be recorded in case notes for those patients being discharged from FMN ward. (CAT Nurses)
	Continue to educate care practitioners in the use of non-pharmacological methods to manage the symptoms of Behavioural & Psychological Symptoms of Dementia (BPSD). (CAT Nurses)
27527 - Diabetic Nephropathy and CKD Audit	Ordering US renal if Glomerular Filtration Rate (GFR) <30 if done elsewhere
	Improve Documentation especially medication each visit.
	Re-audit in 3 years to see whether improvement in management of Chronic Kidney Disease (CKD)
	Refer to Renal team on time – look at those not referred may be end of life patients
	Making sure that patients on appropriate medications and having regular blood/urine tests based on the nice guideline.
40375 - Are patients dying without DNA CPR forms not being	Present finding acute care group.
	Present findings Mortality review group.

Audit Title	Quality Improvement Action Plans
resuscitated	Review use DNA CPR - (work group WHH).
39182 - Documentation Audit	Enforce better control and registration of TAC cards.
	Inform all staff to identify them when using a TAC card. This question needs to be asked at the beginning of every shift and at daily safety brief?
	Clinical Decisions Unit (CDU) discharge document, dates not being entered. Give list of the cases to Roy, who should be able to tell us how this happened. Then educate all.
	Inform individuals
	3 ALN entries
	1 Epilepsy Nurse
	2 Geriatrician Consultant notes
	Regarding blank templates
	Consider removing blank templates from Lorenzo.
39182 - Documentation Audit (continued)	Remind nursing staff of obligations re documentation standards.
	Ensure receptionist / progress chaser scans in the correct set of items. A checklist of what should be scanned in, and where, needs creating.
	Clinicians to decide which documents needs to be scanned in. This applies to both admission (transfer from ED, Emergency Department) and discharge (home or wherever) We need to work with administrative staff to create a checklist of which items are needed.
	Educate all medical staff about the importance of the ED discharge summary.
	Educate re use of the 'Transfer of Care note' – this would mainly be for those who do the CDU Ward Round.
	Create a Lorenzo document for Mental Health Team referral. It should also include a capacity and risk assessment.
	Check with Mental Health team whether we should be scanning in any of their notes.
	Provide feedback to governance team with the suggested modifications to the audit template.
22428 - VTE Risk assessment in AMU	New VTE forms to be introduced which will be easier to complete.
	Formal Venous Thrombo Embolism (VTE) training sessions for all junior doctors.
	VTE nurse to do random short audits to assess compliance.
40188 - Management of	Re-Audit in one year

Audit Title	Quality Improvement Action Plans
decompensated alcoholic liver disease: are we doing it right?	Increase Awareness of Alcohol Related Liver Disease (ARLD) management pathway
43330 - Audit of documentation referring to Rapid Access to Chest Pain Clinic (RACPC)	Continue to promote awareness of new version form to GP practices. ICE referral form modified to direct referrals to appropriate clinic. Re-audit in 12 months.
32818 - Audit of Accommodation of Patients at End of Life - Single Rooms or not	Share this data with ward managers.
	Continue to collect data on relatives' views on care and respond to this.
	Update Clinical Effectiveness Committee so awareness of impact of low numbers of single rooms is made more visible at hospital management level.
35936 - Impact of new medical system on call on consultants reviews CMT feedback	Consider one of Post Take Ward Round (PTWR) to be started at 8a.m.
	Re audit in 1 year.
	Making sure that CMT doctors get feedback during acute medical take.
48412 - Excess deaths coded as diabetes with complication	BG monitoring frequency added to observation SOP Bid to increase diabetes nurse inpatient support.
37435 - Risk Stratification in ACS (Re-Audit)	Review Chest Pain Pathway.
	Share these findings with A&E, Acute Medicine and Patient flow team. Revise and agree admission pathways for patients with ACS CNS to review A1 admissions from Lorenzo daily. Continue this audit alongside MINAP, report quarterly at Cardiology Speciality meeting.
48952 - Inpatient Audit (Endoscopy)	Re-audit to ensure Recommendations have been put in place.
27984 - NICE Compliance of Rapid Access to Chest Pain Clinic (RACPC)	Disseminate to GPs need to send bloods with referral form. To continue with present proforma as guidance and education programme and re-audit in 2 years.
44083 - MET Survey Audit	Present findings at Acute Care team Meeting
	Foundation teaching programme 2016/17
	Present findings at Acute Care team Meeting
	Try and identify Medical Emergency Team (MET) entry clearly on Lorenzo
48575 - Nutrition Screening	Improve weight documentation and Malnutrition Universal Screening Tool (MUST) score completion: Education of nurses/student nurses/HCS's As part of induction Reminders on wards E-Learning

Audit Title	Quality Improvement Action Plans
	Improve weight loss documentation and MUST score interpretation:
	Introduce MUST e –learning as part of junior doctors induction
	Reminders on the ward
	Lorenzo template for weight+ BMI+ MUST
	Improve monitoring of weight and completion of food charts:
	Set a specific day in week for weighing patients.
	Re-Audit in 6 months
52535 - VTE Prophylaxis May - July	Continue data collection for period August - October 2016.
33874 - Serum Blood testing for Hyperlipidaemia in ACS Re-Audit (15006)	Re-audit in 6 months (aiming to analyse ~ the same time of year).
48944 - Endoscopy in Upper GI Bleeding	Look at list location – flexible plan. Re-audit to ensure recommendations have been put in place.
48936 - 30 Day Mortality and 8 Day Readmission post endoscopy	Continue to monitor and ensure safe place, Re-audit.
48952- Diagnostic biopsies during colonoscopy for unexplained diarrhoea	Educate / share results to staff. Re-audit to ensure recommendations have been put in place.
39649 - Ongoing audit of use of single rooms at end of life	Data collection proforma – to be updated
	Communication Skills Training included in consultant mandatory training from January 2017
39710 - Orthostatic Hypotension - Lying standard BP	Educating all medical areas about consideration and importance of measuring Lying standing BP in patients with falls. Falls liaison person in each individual clinical area to be trained to help the staff as well as monitor prevention efforts. Constant re- education. Consider re audit next year.
26365 - Non pharmacological measures taken in patients rooms to prevent delirium	Discussed in audit meeting to make sure Abbreviated Mental Test (AMT) done on initial clerking/post take for elderly patient.
	Nursing staff to encourage relatives to bring familiar objects from home for elderly patients to give them more homely environment/minimize noise levels in elderly wards.
	Discuss with ward managers/bed managers to make sure elderly patient moved to appropriate wards when they are moved from A1.
39361 - Snapshot audit of confused patients who have been prescribed sedation.	Further full retrospective audit of sedation use for confused patients to be completed.

Audit Title	Quality Improvement Action Plans
36612 - Audit of discharge summaries not completed at time of discharge on A1.	Assign Junior To Be in charge of "box".
	Audit Quality of Discharge Summaries.
	Re-audit.
47673 - Outpatient management of hyperthyroidism compared to ATA guidelines	Ensure status of eyes is fully documented at all appointments- particularly in the context of Grave's Disease
	Consider repeat Audit in 3-5 years' time
	Ensure FBC and LFT are checked before Anti Thyroid Drug (ATD) treatment
27314 - Audit of management of hypothyroidism in pregnancy	WHH guidance on hypothyroidism in pregnancy.
	Present findings of audit to midwives.
	Article for CCG magazine re risks hypothyroidism in pregnancy.
	Re-audit 2018.
38722 - Audit of proportion of patients recorded as being diagnosed with Malignancy of Unknown Origin (MUO) / Cancer of Unknown Primary (CUP) that are registered with the central CUP MDT.	Awaiting presentation / Quality Improvement Action Plan.
49639 - NICE IV fluid guidelines	Present findings at Critical Care Audit meeting on the 22/02/17 – presented. More training / education amongst juniors Senior support / review. Everyone is responsible – daily review of fluids needed including documenting a 24 hour plan. Incident reporting of fluid mismanagement so we can learn from our mistakes.
52529 - VTE Prophylaxis Jan - Apr 16	Email and present findings (F1 induction, mandatory training, ward managers, meet-up with staff).
	VTE Training to be included in Trust essential training.
	To Audit between 30-50 patients on a weekly basis.
	Timely completion of Venous Thromboembolism (VTE) risk assessment prescription and administration of prophylaxis.
15089 - Insulin and oral hypoglycaemic agent prescribing and management	Using a root cause analysis pathway approach to deal with insulin errors the Diabetes specialist nurses targeted groups and individual people who have made errors. ELearning now mandatory one off course for all appropriate staff.
49327 - PTWR 14 hour - Re-Audit	The Acute Medical Unit (AMU) consultant rota to be discussed by the Acute Medical Unit (AMU) Team and the Deputy Medical Director.

Audit Title	Quality Improvement Action Plans
	Investigate why one patient not seen in 48 hours and implement change to avoid this happening again. Re-audit in 12 months' time.
52536 - VTE Prophylaxis August - October	Continue data collection (Nov - Dec 2016).
	1. Lorenzo Indicator - further investigate with IT the possibility of a highlighting "flag" in Lorenzo when VTE risk assessment is not completed.
	2. Inpatient Admission Note - spoken with the Information Team regarding the feasibility for an automatic report to be generated from Lorenzo identifying the doctor who has clerked a patient on the "Inpatient Admission Note" and not completed the VTE risk assessment. This would be to identify if there are any training issues.
	3. Daily Outcome of VTE Assessment Report - meet with the Information Team to check if a report can be available to print which highlights the outcome of VTE risk assessment.
33072 - Medicine & Elderly Care Documentation Audit 2016	Re audit in 1 year
30139 - Hydration in the Dying Patient	Use of IPOC to support dying patients
	Review of NICE Guideline NG31 and use of IPOC
	Impact of this audit on education and teaching – updating information and processes
29519 - Regional AF diagnosis and anticoagulation - A quality improvement project	All patients with AF should have: Stroke risk documented using CHA_2DS_2VASc score. Bleeding risk documented using HAS-BLED.
56676 - The Management of Hyperthyroid patient; a re-audit and guideline **comparison**	Ensure FBC and LFT are checked before ATD treatment
	Ensure status of eyes is fully documented at all appointments- particularly in the context of Grave's Disease.
	Consider repeat Audit in 3-5 years.
43972 - Epilepsy Pathway Audit – Pathway admitted with a Seizure	Re-Audit in 3 years.
41983 - Multiple MET Calls	Take summary of this audit to mortality review group or acute care group.
	Work with palliative care team re end of life care education.
	Continue to look at deaths in bereavement office and evidence end of life care planning.
ICU Audit Programme	
37350 - Think Kidney, then act	Awaiting Quality Improvement Action Plan.

Audit Title	Quality Improvement Action Plans
43477 - Ventilator Associated Pneumonia (VAP) Audit	Continue Ventilator Associated Pneumonia (VAP) audit.
	Audit of tracheal tube cuff pressure.
	Sedation level assessment- discussion regarding proposed algorithm.
	(ICU consultants responsible).
50912 - Audit of body weight of critically ill patients.	Awaiting presentation / Quality Improvement Action Plan.
47241 - Weaning in ICU	Ward round daily management sheet to be put in place – actioned.
46138 - NPSA Alert NGT Audit	Awaiting Quality Improvement Action Plan.
16312 – Tracheostomy Ward Audit	Revised audit sheet: Item not relevant at all. Item needed on ward only (not bed). ? DATIX incident logged.
1180 - Epidemiology and Outcomes of Post-Cardiac Arrest Patients admitted to ICU	Develop guidance for temperature management post cardiac arrest.
	Develop guidance for neurological prognostication following cardiac arrest.
38222 - Network Ventilator Associated Pneumonia (VAP) Audit	To continue our ongoing Ventilator Associated Pneumonia (VAP) unit audit.
	To feed back our VAP audit data to the network regularly.
Occupational Health Programme	
36621 - Reasons for needle stick follow up. Are they necessary?	No action required.
Ophthalmology Audit Programme	
34565 - Vision Screening Service Annual Audit	To liaise with Special Educational Needs (SEN) team to arrange for them to attend schools to see SEN children.
	Re-audit annually.
	Implement administrative changes.
44412 - (44415) Outcomes of Strabismus Surgery	Relaunch the prospective audit proforma / database from 1st January 2017.
	Re audit 2 years to ensure results have improved.
43319 - Cataract Surgery and Complications 2015	Future Audit using Medisoft / Ormis.
	Request patient details of complicated cases from all doctors in clinic (On-going).
33530 - Ophthalmology Documentation Audit	Annual Re-Audit (Trust requirements).
47066 - Management of AMD patients - ECLO review of AMD	To Re-audit once recommendations have been actioned.
	Miss Mandal to discuss findings with Clinical Business Unit

Audit Title	Quality Improvement Action Plans
patients	(CBU) lead.
47804 - Audit of new referrals to diabetic retinopathy clinic.	Prospective Audit to start mid-2017.
	Design Pathway and use for Prospective Audit.
33879 - Service review of the Orthoptic Stroke and Neuro service	Orthoptists to have access to the patients on the Sentinel Stroke National Audit Programme (SSNAP).
	Explore ways of identifying more of the stroke population.
42775 - Amblyopia review	Re-audit in 24 months' time including atropine occlusion.
35247 - Ophthalmic Day Surgery Cancellations Audit - Re-Audit 15421	New cancellation proforma to facilitate collection of more accurate data.
	Re-Audit in 1 year – what is the effect on cancellation rate after the introduction of Lorenzo.
	Nurse in charge on Ophthalmic Day Surgery (ODS) should ensure that the proforma is completed correctly on the day.
34646 - Audit of MIGS - micro invasive glaucoma surgery XEN gel stent and iStent trabecular micro bypass	Continuous audit - EPR
	PROM PREM as routine for surgical glaucoma patients
	Economical evaluation.
20542 - Visual symptoms following (YAG) laser peripheral iridotomies	Complete retrospective data collection and re-interview prospective patients 1+ year after their laser treatment to establish persistence of symptoms. Further data collection.
	Prospective data collection – standardised forms on 1st post-op visit. Form to develop.
	Perform Peripheral Iridotomy (PI) as per recommendation based on superior lid position. Recommendation to write.
55167 - Intravitreal injections: Process Audit	Explore option to use Lorenzo/e-Outcome to discharge patients from injection lists; list would be only for the purpose of internal organisation of patients/follow up. As patients are attending as 'day surgery'. Re-Audit.
34629 - Patient Satisfaction within the eye clinic	Re audit in 1 year.
31215 - Evaluation of Pre-operative Assessment Clinic	Re audit in 12 months the impact of these changes in our 45 minute booking slot, medisoft and pre op documentation for GA/Sedation Patients.
34662 - Audit of penetrating glaucoma surgery - Trabeculectomy, deep sclerectomy, glaucoma drainage device	Awaiting Quality Improvement Action Plan.
34623 - Additions to Clinic (Re-Audit of 1162)	Re audit 2017 looking at the inappropriate referrals received from Emergency Care and GP surgeries.
38598 - Age-related macular degeneration (AMD) Service Review	Improve medisoft data input
	Reduce waiting time for first appointment
	Maintaining New patient record
	ICG Training

Audit Title	Quality Improvement Action Plans
47273 - Diabetic eye laser documentation audit	Follow up issues to be raised with appointments and senior management. Propose instigation of E-Outcome for laser list
	Amend laser discharge letter to remove “discharged” from template. Clinicians to individualize letters and add details of follow up where possible
	Emails regarding laser patient follow up to be sent from ward email to improve audit trail
	New reception role to be made. Making follow up appointments for laser patients on the day will be incorporated into job description
56691 - School Age Pathway Audit	Update the pathways.
	To write on all patient notes who attend special school the pathways they follow.
	To Re-Audit in 12 months to assess if recommendations have been implemented.
Optometry Audit Programme	
42578 - Audit of Contact Lens Solutions	Notice in CL solution areas reminding staff to label bottles when opened
	Date Labels supplied in CL solution storage area (in case pens don’t work)
	No more ordering of large saline bottles or Oxysept 1 step
	Increase small saline holding stock
	Decrease AOSept Plus holding stock
	Re-audit CL solution stock sheet completion and dating of CL solutions.
34607 - Trends in Management of Keratoconus	Use of protocol for referral of Keratoconus (all optometrists)
	Fit contact lenses apical fit (all optometrists)
	Re audit in 2 years
45309 - Audit of Record Keeping by Optometrists in the Community Refraction Clinics	Awaiting Quality Improvement Action Plan.
Orthodontic Audit Programme	
48084 - Audit to assess the complication rates with IV sedation within the Warrington and Halton OMFS outpatient department.	Awaiting PowerPoint presentation / Quality Improvement Action Plan.
38427 - An audit on written communication with the referring general dental practitioners	Development of a series of standard template to ensure General Dental Practitioner (GDP) receives all the relevant information.
	Develop a key stage letters protocol for each unit.

Audit Title	Quality Improvement Action Plans
	Consultants should ensure that letters are generated at all crucial stages, using standard templates by the trainees or specialists.
	New specialist trainees are made aware of the protocol and the template.
Orthoptic Audit Programme	
49893 - Cycloplegic Refraction Audit	For all Orthoptists to ensure they are adhering to all standards when administering cyclopentolate or any other dilating drops. To continue to use cyclo consent labels. Re-audit in 3 years' time to ensure standards are maintained.
35204 - Orthoptic SPLD Documentation Audit	Aim to increase the use of Test of Word Reading Efficiency (TOWRE) at last visit, where time permits this.
	To test Accommodation on ALL patients.
	To test Jump Convergence on ALL patients, where necessary.
	For patients having treatment for tracking difficulties ensure Full Developmental Eye Movement (DEM) tested.
42086 - Visual Field assessments in children with Special Educational Needs (SEN)	Review literature on methodology of Visual Fields (VF) testing in Special Educational Needs (SEN) cases. Special Educational Needs (SEN team).
	Review current practice in view of this literature. Special Educational Needs (SEN team).
	Determine guidelines for assessment of Visual Fields (VF) in specific cases within Special Educational Needs schools. Special Educational Needs (SEN team).
	Re-audit in 12 months.
37869 - Orthoptic Record Keeping audit	Repeat audit annually.
	Update standards of record keeping including patient label to be placed on both sides of continuation sheet.
46141 - Parent / Guardian Satisfaction audit of the School Eye Care Service	To re-audit again in 2 years - Next audit should we get child's opinion?
52074 - Stroke Satisfaction Survey	Re-audit in 24 months' time.
46142 - The 2nd Parent / Guardian Satisfaction Audit of The Special Schools Eye Care Service	To give feedback to parents (brief written piece for the school newsletters). To give feedback to the schools (email the head teacher). Re-design the questionnaire for next audit.

Audit Title	Quality Improvement Action Plans
Pathology - General Audit Programme	
38542 - 2016 Audit on the Use of O RhD Negative Blood	Submit report to Hospital Transfusion Committee and Transfusion Team.
	Change protocol for selecting the emergency blood in the laboratory.
	Re-audit.
38683 - Review of phoning CRP results if > 200mg/l to primary care/outpatients in relation to current practice of phoning only results >300mg/l	Currently no further action required: However, implement any actions proposed by the amended Royal College document which is currently under review.
47390 - 2016 Audit of collection and labelling of transfusion samples	Produce a 'Bloody Matters' newsletter.
	Discuss findings with St Rocco's Hospice.
	Submit report to the Hospital Transfusion Committee (HTC), the Transfusion Team (TT) and to the Patient Safety and clinical Effectiveness Committee.
42400 - 2016 Audit of the Blood Collection Process	Disseminate findings to the Hospital Transfusion Committee, Transfusion Team, and Patient Safety Committee.
	Discuss with Risk Manager of Women's Health the need to collect the anti-D when the patient is in clinic.
	Discuss with Antenatal Day Unit (ANDU) and ANC to remind their staff to collect anti-D when the patient is in clinic.
	Agree recommendations for collecting albumin.
	Produce 'Bloody Matters Newsletter' to send to all the wards.
30213 - An audit of the diagnosis and management of septic arthritis	Inform the microbiology laboratory staff about this audit and to ensure consistent reporting.
	To inform infection control team.
	Re-audit in 2018.
	To inform AE matron.
35911 - An Audit of compliance with British Committee for Standards in Haematology (BCSH) guidelines on obtaining consent for systemic anti-cancer referrals	Re-Audit in 1 year due to consent form changing (3B) to see if any improvement in consenting.
	Distribute to Haematology team including nurses so aware of finding.
42850 - Re-audit: Appropriate Use of O PhD Negative Units of Blood	Submit finding to the Hospital Transfusion Committee (HTC).
34599 - Review of AKI 3 Patients	Review phoning with lab staff.
	Re-Audit 2018.

Audit Title	Quality Improvement Action Plans
35903 - Re-audit (1250) of Lenalidomide use as per NICE	Compliance, so therefore continue practice. No actions required.
37345 - Audit of haemorrhage protocol activations for 2015	Submit report to Transfusion Team, Hospital Transfusion Committee and Patient Safety Sub Committee.
	Present finding of report to Trauma Team Meeting, Obstetrics and Anaesthetics.
32600 - 2015 Administration of Blood: Audit of Bedside Practice	Present findings to the Hospital Transfusion Team, Hospital Transfusion Committee and the Patient Safety Sub Committee.
	Produce "Bloody Matters" newsletter and submit to Governance for inclusion into the "Risky Business" newsletter.
	Add one slide to the Mandatory Training Sessions for 2016 summarising main results/standards.
46600 - A re-audit on microbiology testing and antibiotic treatment for severe CAP at Warrington General Hospital	Inform the Advancing Quality Team (AQUA team), respiratory consultants and the Executive lead with Quality remit. They need to monitor the appropriate testing.
36615 - Post- Operative Red blood cell transfusion in patients with fractured neck of femur	Present at the Hospital Transfusion Committee (HTC), Transfusion Team Meeting (TTM) and Patient Safety Sub Committee (PSSC).
	Bloody Matters Newsletter.
	Present to all appropriate areas.
39634 - Regional audit of Microbiology) investigations and antibiotic guidance in adult patients admitted to hospitals with Community Acquired Pneumonia (CAP	Consider to include in Antibiotic formulary: Pneumococcal Ag for moderate severity pneumonia:
	At present we do this test for CURB-65 score of 3+ only (severe pneumonia).
	Antibiotic formulary emphasises on clinical judgement in interpreting the severity assessment. Also the compliance with urinary pneumococcal antigen testing in severe pneumonia is quite poor as reflected by a different audit. This needs to be improved before implementing this test for moderate severity pneumonia.
	Cost will be a prohibitory factor.
Pathology - Histopathology Audit Programme	
44475 - Prostate core biopsy measurement	Re-Audit in one year to ensure compliance is being met.
47688 - Re-Audit on squamous cell carcinoma	Amended reports have been issued and accurate AJCC 7th stage done.
40213 - Reporting of renal cell ca - compliance with RCPath MDS - re audit	Re-Audit in 2 years.

Audit Title	Quality Improvement Action Plans
40216 - Procedure codes in Histopathology - re-audit	Re-audit in 12 months' time.
52560 – MDT Review 2015 lung and colposcopy	Repeat audit in 1 year time.
33950 - Re-audit on urgent histopathology requests (1011)	Re-audit against the RCPath standards and local guidelines after two to three years.
37326 - A comparative assessment of endoscopic findings in lower GI pathology with Histological diagnosis	To Present findings at the Surgical Audit Meeting.
44479 - Audit of ungraded CIN	Issue Guidelines. Re-Audit.
39388 - Re-Audit of adequacy of cervical biopsies	Remind pathologists to mention Transformation Zone (TZ) in reports.
	Inform colposcopists of results.
	Re audit in 1 year.
52567 - Audit of reporting profiles in cervical biopsies	Distribute data to individual pathologists. Re-audit end of 2017.
Pharmacy Audit Programme	
1423 - Medicine Policy Audit	Awaiting completed audit report.
18625 - Management of patients once a positive diagnosis of VTE is made	Review and update current Trust Anticoagulant Guidelines.
	Present results of Audit to the Trust Thrombosis Committee.
	Review and update the current Trust Anticoagulant Prescription chart.
22788 - Medicines Reconciliation	Awaiting completed audit report.
52529 - VTE Prophylaxis Jan - Apr 16	Email and present findings (F1 induction, mandatory training, ward managers, meet-up with staff).
	VTE Training to be included in Trust essential training.
	To Audit between 30-50 patients on a weekly basis.
	Timely completion of Venous Thromboembolism (VTE) risk assessment prescription and administration of prophylaxis.
52535 - VTE Prophylaxis May - July	Continue data collection for period August - October 2016 – completed.
52536 - VTE Prophylaxis August - October	Continue data collection (Nov - Dec 2016).
	1. Lorenzo Indicator - further investigate with IT the possibility of a highlighting "flag" in Lorenzo when VTE risk assessment is not completed.

Audit Title	Quality Improvement Action Plans
	2. Inpatient Admission Note - spoken with the Information Team regarding the feasibility for an automatic report to be generated from Lorenzo identifying the doctor who has clerked a patient on the "Inpatient Admission Note" and not completed the VTE risk assessment. This would be to identify if there are any training issues.
	3. Daily Outcome of VTE Assessment Report - meet with the Information Team to check if a report can be available to print which highlights the outcome of VTE risk assessment.
56526 - Point Prevalence Audit: **Oxygen prescribing for Inpatients at** **WHH NHS FT on 16/2/2017**	Escalate to Deputy Medical Director, Divisional Chiefs of Service and Deputy Chief Nurse.
	Produce a safety alert highlighting the issues surrounding oxygen prescribing. – For all prescribers and staff who administer oxygen.
	Medical Education Pharmacist to arrange teaching to doctors regarding oxygen prescribing.
	Discuss at pharmacists meetings so they are aware of the need to review oxygen prescriptions.
	Re-audit in 6 months' time.
53311 - Pharmacist prescription intervention Audit	Awaiting completed audit report.
Radiology Audit Programme	
56189 - Timing Panscan report	Awaiting Quality Improvement Action Plan.
42896 - Audit of Radiology Alerts communication and comparison with UK standard.	Need for Result Acknowledgement System.
46764 - Accuracy of pre MRI orbit image reporting by radiographers.	Re Audit in one year.
38844 - Appropriateness of usage of computed tomography pulmonary angiography (CTPA) **investigation of suspected pulmonary embolism**	Planning to improve the ICE ordering system so it better reflect the locally-agreed protocol. If adopted, it should ask the clinician a series of questions to ensure the protocol is adhered to and the correct imaging is ordered.
	The locally-agreed protocol is available on Lorenzo but it is not interactive. A future version could enable the clinician to enter results as they become available and save a copy in the patient record.
	Will need to be agreed by IT, Radiology, AED and medical departments.
43741 - GP Plain film turnaround times	Re audit to ensure standards are being adhered too.

Audit Title	Quality Improvement Action Plans
35516 - NG Feeding tube re-audit	Report to be sent to Trust Governance Lead for action – outside remit of radiology.
40244 - Availability of emergency equipment and expertise in the Radiology Department	Introduce formal Rota for checking of resuscitation equipment and drugs.
	Hospital pharmacy to perform regular checks on drugs.
38580 - An audit of the use of MRI in lobular breast carcinoma	Re-Audit 3 years to ensure good practice.
42263 - Review of imaging for MDT meetings	No further action required.
44517 - Re-Audit CT Head Injury Audit	Check registrar reports as soon as possible (secretaries could chase / remind).
	Secretaries to verify on typing CT Head reports, when clinical states head injury and it's a consultant report.
43497 - Accuracy of Cranial CT Reporting by Advanced Practice Radiographers	Re-audit in 1 year.
38583 - Audit of chest x-ray reporting by advanced practitioner radiologist	Re-audit in 1 year.
42856 - Artefacts on paediatric chest x-ray (CXR)	Share learnings regards CXR artefacts with radiographers.
	Re audit in 2 years.
38548 - Times to CT for Trauma team activations Jan-Oct 2015	Meeting both Network and National CT targets.
	Rapid decision making for CT to be done in a timely manner - awareness to all staff.
	Designated scribing.
31360 - AED Plain film turnaround time	Re-audit with CRIS data covering all days
	Discuss in Advanced Practice Meeting and Consultant Meeting
38573 - Audit of accuracy of pre-operative MRI compared to final surgical histology in patients with Breast Cancer undergoing Neo-adjuvant Chemotherapy.	None. Re-Audit unlikely to be beneficial
42246 - Head Injuries	Awaiting presentation / Quality Improvement Action Plan.
47684 - World Health Organization (WHO) checklist use in Interventional Radiology	Scan World Health Organization (WHO) form onto Lorenzo. Ask Nurses to enforce World Health Organization (WHO) form completion. Unify the procedure form, World Health Organization (WHO) form into Local Safety Standards for Invasive Procedures (LocSSIPs), if possible.
53918 - NM Parathyroid Scan in WHH	Re-audit in 3 years.

Audit Title	Quality Improvement Action Plans
42107 - Lens Exclusion in CT Head	Define circumstances / patient subtype & radiographers that should be excluded from re-audit.
	Phased implementation – aim to achieve 70% in 2 months.
	Encourage documentation of difficult cases.
	Head or gantry tilt – training if necessary.
29576 - An audit of short term recall cases Warrington Breast Unit 2013/2014	Repeat with larger numbers and review by 2 radiologists
	Better adherence to NHS BSP and local protocols (as per QA visit July 2016)
56611 - Management of Potential Scaphoid Injuries	Consider use of MRI in patients at secondary review with suspected Scaphoid fractures, re-audit in 2018.
56852 - Audit of Warrington & Halton Hospitals Compliance with Cheshire & Merseyside (C&M) Timed Lung Cancer Pathway	Ensure all relevant staff are aware of the lung cancer pathway. Re-audit in a years' time with a larger sample size.
Rheumatology Audit Programme	
39375 - Tocilizumab Prescribing	Awaiting Quality Improvement Action Plan.
36065 - Audit initiating biologic agents in inflammatory arthritis	Re audit Nice guidelines for initiating biologics in Psoriatic Arthritis (PsA), Rheumatoid Arthritis (RA) Ankylosing Spondylitis (AS).
	Developing Disease Activity Score (DAS) and Basdai sheets for Lorenzo.
	Developing 6 months follow-up sheets in Lorenzo.
45091 - Prolia shared care	Re audit.
	Develop a template for Prolia discharge patients with enclosed information re necessary monitoring.
	Write Se Ca level and eGFR on prescription so the pharmacist who dispense the drug knows that it was checked.
Surgical Audit Programme	
46959 - Two Stage Consent	Re-audit to assess compliance and improvement.
35501 - Co-prescription of laxative with opioid prescribing.	Awaiting presentation / Quality Improvement Action Plan.
42643 - Urinary catheter discharge advice questionnaire	To devise and implement a urinary catheter passport. To implement within the Trust and across community services
	To change the Trust's catheterisation policy's to include the guidelines for the discharge process.

Audit Title	Quality Improvement Action Plans
	To re-educate the staff on the catheter discharge process to include ward visits, posters in clinical areas to support. Advertise on the extranet
42316 - Accuracy of hernia ultrasound	Present findings at surgical audit meeting
31745 - Fissurectomy combined with high dose botulinum toxin A is a safe and effective treatment for chronic anal fissure and a promising alternative to surgical spincterotomy.	We have met all the standards but we need to maintain close monitoring so that we maintain or even improve the outcomes.
20309 - Prostate Cancer	Re-Audit 1-2 years' time.
44517 - Re-Audit CT Head Injury Audit	Check registrar reports as soon as possible (secretaries could chase / remind).
	Secretaries to verify on typing CT Head reports, when clinical states head injury and it's a consultant report.
20330 - Surgical Site Infection Rates	Register with National Public Health Surveillance Programme.
20313 - Urinary Incontinence in Women	Provision of logistics for MDT?
	Inclusion in job plan.
	Improvement in diagnostics evaluation and adherence to management guidelines.
	Development of pathways.
	Findings to be presented to the Women's Health.
36472 - Management of appendicitis in children	Awaiting presentation / Quality Improvement Action Plan.
38548 - Times to CT for Trauma team activations Jan-Oct 2015	Meeting both Network and National CT targets.
	Rapid decision making for CT to be done in a timely manner - awareness to all staff.
	Designated scribing.
53905 - Delegated Consent Form Audit	Continue with larger sample size audit.
	Share with Clinical Business Unit (CBU's) via Senior Management Team (SMT).
25834 - Trust documentation / record keeping Audit	Raise awareness by discussing finings with colleagues.
	Present findings at audit meeting.
42246 - Head Injuries	Awaiting presentation / Quality Improvement Action Plan.
48958 - Enhancing the quality of discharge summaries	Re Audit in 3 months.
46194 - Management of Acute Cholecystitis	Awaiting presentation / Quality Improvement Action Plan.
40813 - Audit of Accommodation	Share this data with ward managers.

Audit Title	Quality Improvement Action Plans
of Patients at End of Life - Single Rooms or not	Update Clinical Effectiveness Committee so awareness of impact of low numbers of single rooms is made more visible at hospital management level.
	Continue to collect data on relatives' views on care and respond to this.
47063 - Utility of (Magnetic Resonance cholangiopancreatography) (MRCP)in gallstone pancreatitis	Larger study - Re-audit in 6 months.
40809 - Hydration in the Dying Patient	Impact of this audit on education and teaching – updating information and processes.
	Use of IPOC to support dying patients.
	Review of NICE Guideline NG31 and use of IPOC
50460 - Elective Laparoscopic Cholecystectomy	Prospective audit - to look at why: Start from pre-op – why not booked as day case. Why are drains being used? If PONV/pain delay discharge, what anaesthetic technique/post-op care is given and can this be modified?
50467 - Use of the RSI checklist and apnoeic oxygenation	Highlight abbreviated checklist as option in high risk out of theatre Rapid Sequence Induction (RSI). Checklist available in all areas. ODP empowerment and involvement important.
	Improve awareness of apnoeic oxygenation with standard nasal cannula.
	Present findings to ODP staff next audit meeting Address O2 cylinder availability.
52975 - Audit of the use of the new emergency theatre booking form	Theatre coordinators to prompt urgency category from booking team.
	Adjustments to booking form in development – streamlined to essential information only, emphasising communication, availability and accessibility.
	Re-audit the use of the updated and simplified form
Therapies Audit Programme	
36876 - Appropriateness of Oral Nutritional Supplements in the Community	No formal actions.
Trauma & Orthopaedic Audit Programme	
48918 - Documentation of Neurovascular status (upper & lower limb)	Explore feasibility of creating neurovascular documentation form in Exercise Pressor Reflex (EPR).
	Education regards documentation at induction, teachings etc. (posters).

Audit Title	Quality Improvement Action Plans
	Re audit 6 Months.
48571 - Improving the quality of Trauma & Orthopaedic discharge summaries	Improving the Quality of the Trauma + Orthopaedic (T+O) Discharge Summaries by using "Hash's T+O Discharge Summary Checklist".
	Discharge summary pocket cards to be given to all juniors at Induction.
	Re-Audit in 6 months to ensure recommendations are achieved.
43347 - Spinal questionnaires - Do they come back?	No action plan. Data collection has ceased due to lack of personnel to implement Spine Tango data collection.
38276 - Trauma and Orthopaedic Trust Documentation Audit	Re audit in 1 year.
47483 - Management paediatric buckle fracture of distal radius.	Awaiting Quality Improvement Action Plan.
40172 - 5th Metacarpal Fracture - Audit it's management	Guidelines for AE to refer 5th metacarpal fractures to Fracture Clinic -Information leaflet. -Direct referral to Hand Therapist. -3 X-ray views required (AP, Oblique and True lateral). Early involvement of Hand therapist. -Reduce the need for follow up in Fracture clinic. -Better outcome for patient care. Re-audit and close the loop.
41760 - Re-Audit of compliance to protocol of 1st time shoulder dislocations.	Raise awareness regarding BESS/BOA Guidelines. Early upper limb referral regarding management.
48985 - Slips, Trips and Falls - Risk assessment	Feedback to falls prevention group. Feedback to Trust – If Trust's policy is to follow NICE guidelines then need to consider updating. Individualise approach to falls risk assessment and to management of that risk, multifactorial assessment and a multifactorial intervention.
48862 - Improving the quality of Trauma + Orthopaedic discharge summaries (Re-Audit)	Improving the Quality of the Trauma + Orthopaedic Discharge Summaries by using "Hash's T+O Discharge Summary Checklist". Discharge summary pocket cards to be given to all juniors at Induction.
	Re-Audit in 6 months to ensure recommendations are achieved.
47207 - To determine if WHH are complying with the fracture clinic guidelines set by BOAST.	Re-audit in 12 months.
	Develop patient management pathways for orthopaedic injuries encountered in Emergency Department.

Audit Title	Quality Improvement Action Plans
	Develop patient information leaflets.
36615 - Post- Operative Red blood cell transfusion in patients with fractured neck of femur	Update of hospital transfusion mandatory training for doctors and nurses.
	Introduction of transfuse and check initiative.
	Present Critical Care meeting.
34000 - Impact of removal of hip precautions in hemiarthroplasties - April 2015 to March 2016	Dissemination of audit results to all staff concerned.
31501 - Accuracy of recording operative site details on theatre lists	Re-Audit after the introduction of the new scheduling system.
33760 - Initial result of SYNOVASURE test for suspected periprosthetic infection.	Further study with larger group of patients and better methodology is required. - There is NO plan to start this action until we have more evidence in literature.
38816 - Audit of fracture neck of femur with delayed surgery beyond 36 hours.	Inform anaesthetists about NHFD guidelines. Re Audit in 12 months' time.
34569 - Primary care spinal assessment and imaging to secondary care - How long does it take?	Increase the sample size audit referrals from CATS/physiotherapy via therapists that dually work in spinal clinic at Halton to orthopaedic spinal service from May 2015 – April 2016.
	Audit the outcomes of New Patients in to the spinal clinic.
49211 - Re-audit of pre-operative investigations in Trauma patients	Display the NICE guidelines clearly in the trauma room for SHOs to see.
	Highlight the extra bloods being ordered to A&E staff.
	To include guidance in junior doctor teaching.
48927 - Slips, Trips and Falls - 2 Post fall documentation	Education of haw falls ought to be documented.
	Feedback to the Falls Prevention Group.
	Consider creating a new Falls Pathway template on Lorenzo. Re-Audit in 6 months' time.
44517 - Re-Audit CT Head Injury Audit	Check registrar reports as soon as possible (secretaries could chase / remind).
	Secretaries to verify on typing CT Head reports, when clinical states head injury and it's a consultant report.
30251 - Re-Audit Unplanned transfers from CMTC to Warrington - Elective emergencies.	Awaiting presentation / Quality Improvement Action Plan.
47712 - Initial treatment of distal radius fractures (NG38)	Raise awareness and present findings regarding NICE CG at audit meeting on the 16/03/17. Regular Trauma List at CMTC. Early Senior decision regarding management.
43958 - Re-Audit: Haemoglobin	Re-audit in 3 months.

Audit Title	Quality Improvement Action Plans
checking after post-operative blood transfusion in patients with Hip fracture.	Reminder email to current orthopaedic team.
37455 - Advancing quality in hip fracture management	Work with Emergency Department to improve pain assessment and analgesia within 60 minutes.
	Work with patient flow, ward nurses and Emergency Department team to improve four hour target to the ward.
	Work with ward nurses to improve pressure ulcer assessment within 6 hours and nutritional screen within 24 hours of admission.
	Re-audit to ensure compliance is being met.
32720 - The Outcome of Lumbar disc arthroplasty at Warrington Hospital.	Awaiting Quality Improvement Action Plan.
37135 - Monitoring our practice of using drains in reverse shoulder arthroplasty and evaluating outcomes.	There is no conclusive benefit of using drains in Reverse Shoulder Arthroplasty (RSA) therefore drains should not be used routinely.
	Re audit end of 2017.
24849 - Is dry needling an effective treatment for chronic non insertional Achilles Tendinopathy	No actions required.
31639 - Patient care and outcome improvement to SCARF Osteotomy - closing the loop (Re-Audit 1344)	No actions required.
49243 - What percentage of new fracture clinic referral are seen within 72 hours of referral in last 3 months.	Standardised fracture clinic template (Follow-up / new patients). Consider trauma triage/virtual fracture clinic model.
38548 - Times to CT for Trauma team activations Jan-Oct 2015	Meeting both Network and National CT targets.
	Rapid decision making for CT to be done in a timely manner - awareness to all staff.
	Designated scribing.
40169 - Fracture neck of femur - Mobilisation strategies Post OP	Mr Sherry to carry out training to Orthopaedic Consultants on how to add operations notes on to Lorenzo.
36810 - Audit of EPIDURAL STEROID INJECTION practice at Warrington and Halton Hospitals NHS Foundation Trust	Continue to use Procedural template. Improve on Imaging archive. Improve on Discharge letter information. Consider including specific/key steps with technique/ procedure to full comply with guidelines. Re- audit to review improvement.
42246 - Head Injuries	Awaiting Presentation / Quality Improvement Action Plan.

Audit Title	Quality Improvement Action Plans
34300 - Perioperative warming in arthroscopic shoulder surgery	Continue to raise awareness of hypothermia guidelines – present findings at audit meeting 16/03/17 (Orthopaedic).
49185 - Preliminary results of Medial Patellofemoral Ligament (MPFL) reconstruction.	Continue current protocol for Medial Patellofemoral Ligament (MPFL).
	Re-Audit 3 years when larger group.
56611 - Management of Potential Scaphoid Injuries	Consider to use of MRI in patients at secondary review with suspected Scaphoid fractures, re-audit in 2018.
Women's Health Audit Programme	
43356 - Ovarian stimulation and follicular tracking	Book appropriate appointments for Fertility Clinics. Discussion to be held with appointments. Introduction of a Fertility Nurse to see new patients first. Adjust Information leaflet to 6 cycles only.
35011 - Placental pathology and neonatal outcomes	No action required.
41789 - Term Admission - CQUIN	Unanticipated admissions proforma.
	MDT review to identify lessons learnt.
43362 - Electronic fetal monitoring	Distribute findings to midwives and doctors
	Re-audit in 12 months.
33077 - Management of ectopic pregnancy 2014	To improve documentation (on Lorenzo) that trainees are performing surgery.
	If no IUP on USS HCG has to be done on the same day with a senior review and management plan and follow up until its < 20.
43157 - Hysteroscopic morcellation of uterine fibroids (Myosure)	Re-audit as per NICE criteria in 1 year.
	Modify proforma to include.
	discussion with patient pre op.
	Include review of symptoms and quality of life at 3/52 assessment.
	Improve documentation – proforma completion and referral pictures.
39174 - Maternal Transfer	Update Situation, Background, Assessment and Recommendation (SBAR) form in guidelines.
36609 - Invasive cervical cancer meeting	Further audit suggested based on breaches.
33245 - Failed Instrumental Delivery	Prospective audit of full dilatation CS
52953 - Effectiveness of acupuncture on pain conditions in pregnancy (Pelvic Girdle, Back Pain, Sciatica)	Awaiting presentation / Quality Improvement Action Plan.

Audit Title	Quality Improvement Action Plans
44404 - Test of Cure Smear Outcome after LLETZ	Improve excisional techniques to meet targets of: – Single specimen. – Minimum depth 7 mm.
	Depth of excision to be mandatory field on Compuscope database. Rationale for multiple piece Large loop excision of the transformation zone (LLETZ) specimen to be mandatory field on Compuscope.
	Re-audit 2016/17 Treatment outcomes.
38743 - Infant deaths North West 2013-2015	Child Death Administrator Role Clearly defined.
	CARI: Care of At Risk Infants (Family history of child deaths) Clinic started.
47046 - Trust documentation / record keeping	Buddy system to be implemented to improve Senior reviewing. Annual re-audit 2017.
46124 - Audit of management of hypothyroidism in pregnancy	No Actions from Women's Health Meeting.
39800 - Neonatal Cooling Therapy audit	Rectal probe for monitoring temperature.
	Recording target temperature achieved time or documenting discharge temperature in case of not achieving target temperature at the time of transfer.
47040 - Obstetric admissions to HDU over 12 months (38141)	Audit obstetric sepsis.
	Consultant involvement to be documented – shown by repeat audit.
	Expression of interest for PROMPT training.
	Training midwives questionnaire.
38710 - Timing of Elective Caesarean Section	Raise awareness of timing and validity of indications.
	Documentation of reasons if <39 weeks Use of steroids if <39 weeks.
	Review again in 12-18 months.
55030 - The Use of the Modified Early Obstetric Warning Score (MEOWS Audit	Remind staff of the need to appropriately action the triggers on the MEOWS chart, within a timely manner as per the action flow chart.
	Circulate this audit to all staff to ensure all staff are aware of the areas in which improvement is required.
	Continue MEOWS training on the mandatory study days.
	Remind staff to record observation on the partogram when in labour as this information cannot be recorded on MEOWS.
45324 - Midwifery Led Unit On-going Auditing of	Continue monthly audits to monitor compliance and feedback to midwives, share good practice and audit findings to team.

Audit Title	Quality Improvement Action Plans
Services & Outcomes (care in labour audit)	Amendments to Intrapartum risk assessment to combine fetal monitoring tool, to reduce duplication and confusion.
48066 - Consent Form Documentation Audit	Re-Audit: December 2017.
34945 - Audit referrals to Colposcopy clinic	To start one stop cervical minor procedure clinic.
33867 - Audit of Actim Partus for threatened preterm labour.	Single point lesson produced to be disseminated to all staff via clinical leads.
43012 - Maternal transfer from the "low risk" to "high risk" intrapartum pathway during labour	Monthly prospective audit of all maternal transfers and annual report. Prospective audit of all maternal transfers and annual report.
	Benchmark maternal transfer rates against birth place study.
43135 - Ultrasound guided cervical dilation for cervical stenosis.	No actions required.
49665 - Audit of outcomes for patients undergoing Urogynaecology surgery at Warrington Hospital – British Society of Urogynaecology Audit	Awaiting Quality Improvement Action Plan.
40210 - Laparoscopy vs. Laparotomy for gynaecology cases.	No actions required.
38141 - Obstetric admissions to ITU over 12 months	Audit obstetric sepsis.
	Training midwives questionnaire.
	Consultant involvement documented.
	Expression of interest for PROMPT training.
55600 - Compliance to KPI standards for Sickle Cell and Thalassaemia Programme	Awaiting Quality Improvement Action Plan.
34399 - Merseyside anaesthetic group for improving quality - Mersey intubation checklist (MAGIQ-MIC)	Redesign of check list to include intubation details in ICU- This will ensure every intubation starts with check list and completes with intubation details.
	Re audit the use of new airway form in ICU to see the compliance.
	Improved training of Intensive Care Unit (ICU) staff for RSI assistant role in ICU and new DAS guidelines- Onsite training or training on attendance to WAM course.

Audit Title	Quality Improvement Action Plans
	Improved training of ODPs, recovery nurses for new DAS guidelines and use of rapid sequence induction (RSI) check list.
21739 - Patient Questionnaire	To audit the waiting times from referral to treatment / to produce an audit more specific to the diagnostic service at WHH.
	Holistic needs assessment clinic sessions to be organised in a more formal environment.
	To ensure Cancer Nurse Specialist is present at the time of diagnosis.
55626 - Timely Assessment of Women with Hepatitis B 1st January 2016 – 31st December 2016	Awaiting Quality Improvement Action Plan.
51899 - Adherence to Regional Screening Committee Standards for The Vaccination of babies born to Hepatitis B positive women.	Continue annual audit. Continue to highlight any issues regarding programme at local and regional screening meetings.

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 2016/17 that were recruited during that period to participate in research, approved by a research approved by the a research ethics committee, was 587**.**

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 2016-2017 the Trust was involved in conducting 59 clinical research studies in research in oncology, surgery, stroke, reproductive health, anaesthetics, 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 North West Coast Local Research Network together with income obtained through grants and commercial work; the majority of this research being nationally adopted studies as part of the National Institute for Health Research (NIHR). The Trust has worked with the network and other health providers over the year to increase NIHR clinical research activity and participation in research.

The Trust has also adopted the Health Research Authority (HRA) procedures which moved the emphasis towards acceptance of HRA assessment within the framework of research governance,

strict legislation and recognised good clinical practice and local assessment of capability and capacity to run a study.

Most of the research carried out by the Trust is funded by the NIHR. For 2016-2017 the Trust received £400,000 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.

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.

A proportion of Warrington and Halton Hospitals NHS Foundation Trust's income in 2016/2017 was conditional upon achieving quality improvement and innovation goals agreed between Warrington and Halton Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at www.whh.nhs.uk.

The monetary total for the amount of income in 2016/17, conditional upon achieving quality improvement and innovation goals, was £4,476,672 with a monetary total for the associated payment in 2016/17 of £4,126,057 received. However, the associated payment received could have been £3,782,057 if a year-end deal had not been agreed with Warrington and Halton CCG. In 2015/16 the trust received a monetary total for the associated CQUINs of £4,248,324 against a target of £4,334,164.

The Trust had the following CQUIN goals in 2016/2017 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 2016/2017

No.	Description	% of contract value	Total estimated value
	NATIONAL CQUINS		
1	NHS Staff Health and Wellbeing	0.25%	£430,204
1a	Introduction of health & wellbeing initiatives Option B		
1b	Healthy food for NHS staff, visitors and patient	0.25%	£430,204
1c	Improving the uptake of flu vaccinations for front line staff within Providers	0.25%	£430,204
2	Timely identification and treatment of Sepsis		£0
2a	Timely identification and treatment for Sepsis in emergency depts.	0.125%	£215,102

No.	Description	% of contract value	Total estimated value
	Screening		
	Review		
2b	Timely identification and treatment for Sepsis in acute IP settings	0.125%	£215,102
	Screening		
	Review		
3	Antimicrobial Resistance and Antimicrobial Stewardship		
3a	Reduction in antibiotic consumption per 1,000 admissions	0.20%	£344,163
3b	Empiric review of antibiotic prescriptions	0.05%	£86,041
	TOTAL NATIONAL CQUIN VALUE	1.25%	£2,151,019
	LOCAL CQUINs		
4	AQ		
4a	AQ COPD	0.02%	£34,416
4b	AQ Diabetes	0.02%	£34,416
4c	AQ Pneumonia	0.02%	£34,416
5	Frailty	1.00%	£1,720,815
6	Dementia - John's Campaign	0.19%	£326,955
	TOTAL LOCAL CQUIN VALUE	1.25%	£2,151,019
	SPECIALIST COMMISSIONING CQUINS		
	Neo Natal Admissions		£15,300
	Innovations on transitional care in neonates		£60,099
	Nationalised standardised dose banding Adult IV systemic Anticancer Therapy		£10,010
	TOTAL SPEC COMM VALUE		£85,409
	NHSE PUBLIC HEALTH CQUINS		
	Dental		£47,775
	Cancer Screening Programme		£31,724
	TOTAL NHSE PUBLIC HEALTH VALUE		£79,499
TOTAL VALUE OF ALL CQUINS		**£4,466,946**	

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 2016-2017.

The Trust is registered to provide the following services:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury

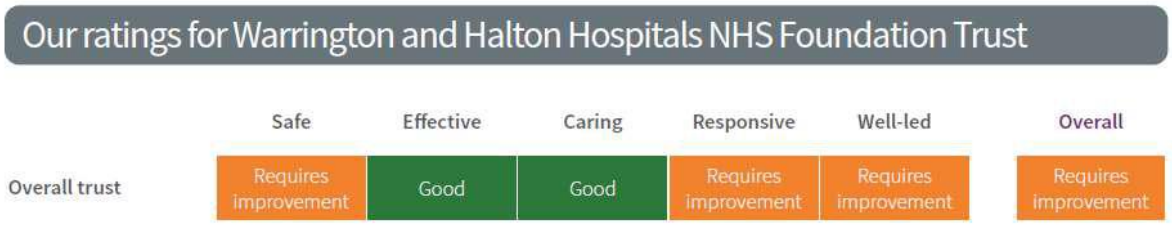
Warrington and Halton Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

2.2.5.1 CQC Inspections

The Trust was inspected by the CQC in March 2017.

At the time of writing the Trust is awaiting the CQC's detailed analysis, formal report, and ratings.

The rating below are in relation to the previous Trust inspection which was conducted in 2015; the CQC rated Halton Hospital as **good**, Bath Street Health and Wellbeing Centre (in Warrington where several clinic services are provided) as **good** and Warrington Hospital as **requires improvement**. They rated caring and effectiveness in the Trust as good across the board in all of its services.



2.2.6 Trust Data Quality

Warrington and Halton Hospitals NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS Number was:

Admitted Patient Care	99.76%
Outpatient Care	99.91%
A&E Care	99.31%

The percentage of records in the published data which included the patient's valid General Medical Practice code was:

Admitted Patient Care	99.98%
Outpatient Care	99.99%
A&E Care	98.98%

Warrington and Halton Hospitals NHS Foundation Trust will be taking the following actions to improve the data quality. The Trust's data quality team work closely with operational teams to ensure data collected Trust wide on our systems is accurate and completeness.

A detailed action plan supports improvement in key areas relating to general data quality, Trust key performance indicators, finance and contract performance. Progress against the Data Quality work plan is monitored by the Data Quality and Management Steering Group, which reports to the Finance and Sustainability Committee.

2.2.6.1 Information Governance

Warrington and Halton Hospitals NHS Foundation Trust's Information Governance Assessment overall score for 2016/2017 was 67%, and was graded as green ('satisfactory').

During the 2017/2018 financial year, progress against the Information Governance work plan and associated action plans will be monitored by the Information Governance and Corporate Records Sub-Committee which reports to both the Finance and Sustainability and Quality Committees.

The Trust was subject to an assurance review of its Information Governance self-assessment by the Trust's internal auditors (Mersey Internal Audit Agency) in March 2017. Following review of the available evidence to support the IG Toolkit returns for 2016/17 the Trust was provided with a Significant Assurance rating.

2.2.6.2 Clinical Coding/Payment by Results (PBR)

In 2016 Warrington and Halton Hospitals NHS Foundation Trust underwent a clinical coding audit by the Trust's internal auditors (Mersey Internal Audit Agency) and achieved the following results:

Primary Diagnosis	91.18%
Secondary Diagnosis	93.90%
Primary Procedure	89.66%
Secondary Procedure	91.11%

The overall accuracy of clinically coded data was categorised as very good in the May 2016 Mersey Internal Audit Agency report and meets the level 2 standard defined in requirement 14-505, contained in version 14 of the NHS Digital Information Governance Toolkit.

2.3. Core Quality Indicators 2016/2017

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

DATE PERIOD	TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
October 2015 – September 2016	108.52	2	116.02	68.91	100
July 2015 – June 2016	110.12	1	117.45	70.03	100
April 2015 – March 2016	112.44	1	118.50	68.00	100
January 2015 – December 2015	117.94	1	117.94	68.00	100
October 2014 – September 2015	114.08	1	117.74	65.16	100
July 2014 – June 2015	114.36	1	120.89	66.05	100
April 2014 – March 2015	114.45	1	120.98	66.96	100
January 2014 – December 2014	115.58	1	124.34	65.53	100
October 2013 – September 2014	111.21	2	119.82	59.66	100
July 2013 – June 2014	109.40	2	119.80	54.10	100
April 2013 – March 2014	108.20	2	119.70	53.90	100
January 2013 – December 2013	109.20	2	117.60	62.40	100
October 2012 – September 2013	110.21	2	118.59	63.01	100
July 2012 – June 2013	112.06	2	115.63	62.59	100
April 2012 – March 2013	112.90	1	116.97	65.23	100
January 2012 – December 2012	110.69	2	119.19	70.30	100

NB: This information is re based so there may be a variation from HED monthly reporting.

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset, which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data (HED) benchmarking system to facilitate further analysis. Trusts are banded 1-3 as follows:-

1. The Trust's mortality rate is 'higher than expected'
2. The Trust's mortality rate is 'as expected'
3. Where the Trust's mortality rate is 'lower than expected'

SHMI – Mortality Rates

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust-level across the NHS in England. This indicator is produced and published quarterly, as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die at the Trust, or within 30 days of being discharged, and the number that would be expected to die, on the basis of average England figures. A number below 100 indicates fewer than the expected numbers of deaths, and a number above 100 would suggest a higher than expected number of deaths.

The Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by monitoring mortality ratios on a monthly basis using the HED system and reported an 'as expected' score in the rolling 12 month periods from October 2015 to September 2016. This is a marked improvement, as our score for the period January 2015 to December 2015 was 'higher than expected' at 117.94. Our crude death rates remain comparable with local peer Trusts; however we will continue to progress with the actions in the areas outlined in section 3.3.1.

The SHMI is one of two mortality measures used in the NHS, the other being HSMR (Hospital Standardised Mortality Ratio), which is 106.58 for the latest data period available (February 2015 to January 2016). This is within the range of 'as expected'.

Mortality ratios are complex indicators and there are multiple factors that contribute to the overall score, including the quality of our documentation and coding.

2.3.1 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
October 2015 - September 2016	28.80%	27.29%	95.23%	1.04%
July 2015 - June 2016	25.38%	26.76%	94.73%	0.27%
April 2015 – March 2016	23.48%	26.05%	96.20%	0.27%
January 2015 – December 2015	25.49%	25%	99%	0.26%
October 2014 - September 2015	27.5%	23.7%	52.8%	10.1%
July 2014 - June 2015	28.2%	23.1%	47.8%	9.3%
April 2014 – March 2015	27.5%	22.5%	46.2%	7.7%
January 2014 – December 2014	27.6%	22.3%	44.6%	6.7%

October 2013 - September 2014	26.4%	21.7%	46.7%	6.1%
July 2013 - June 2014	30.5%	24.6%	49%	7.4%
April 2013 – March 2014	27.7%	23.6%	48.5%	6.4%
January 2013 – December 2013	22.8%	22%	46.9%	1.3%
October 2012 - September 2013	19.9%	20.9%	44.9%	2.7%
July 2012 - June 2013	18.9%	20.3%	44.1%	4.2%
April 2012 – March 2013	17.2%	19.9%	44%	0.1%
January 2012 – December 2012	14.4%	19.1%	42.7%	0.1%

***The palliative care indicator is a contextual indicator.**

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data benchmarking system to facilitate further analysis.

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the rate and so the quality of its services by investigating the detail behind the ratio numbers, we identified that our rate of service provision was the lowest in the North West prior to 2012/2013, and we have worked hard to now be in a position in which we compare favourably with local peers. The Trust was below the England average but has improved over the years to a steady rate, which is comparable with the England average. We now have a Head of Coding in place since May 2016 and a lot of improvement work has been conducted around correctly coding our palliative patients.

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

*PROMs also exist for varicose vein; however the Trust does not undertake this procedure

This data is made available to the Trust by the Health and Social Care Information Centre with regard to the Trust's patient reported outcome measures scores for— groin hernia surgery, varicose vein surgery, hip replacement surgery, and knee replacement surgery, during the reporting period were:-

Patient Reported Outcome Scores

		Groin hernia	Hip replacement	Knee replacement
Year	**Level**	**Average health gain**	**Average health gain**	**Average health gain**
2014/2015	Trust	0.065	0.414	0.315
2014/2015	England	0.084	0.436	0.357

2014/2015	Highest	0.123	0.523	0.357
2014/2015	Lowest	0.038	0.381	0.269
2013/2014	Trust	0.062	0.415	0.335
2013/2014	England	0.085	0.436	0.323
2013/2014	Highest	0.139	0.544	0.424
2013/2014	Lowest	0.007	0.310	0.214
2012/2013	Trust	0.062	0.428	0.357
2012/2013	England	0.085	0.438	0.318
2012/2013	Highest	0.153	0.539	0.416
2012/2013	Lowest	0.014	0.319	0.209
2011/2012	Trust	0.084	0.438	0.310
2011/2012	England	0.087	0.416	0.302
2011/2012	Highest	0.249	0.668	0.537
2011/2012	Lowest	-0.084	0.282	0.144

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

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason in that the PROMs data is a nationally agreed dataset. The data is collected, processed, analysed and reported to the Health and Social Care Information Centre by a number of organisations, including hospital Trusts which perform PROMs procedures. PROMs calculate the health gains after surgical treatment using pre and post-operative surveys. The Health and Social Care Information Centre is responsible for scoring and publishing of PROMs data as well as linking it to other data sets such as Hospital Episodes Statistics.

Warrington and Halton Hospitals NHS Foundation Trust intends to improve the rate and so the quality of its services by ensuring that PROMs data will be monitored by the Patient Experience Sub-Committee.

2.3.3 Emergency readmissions to hospital within 28 days of discharge

NB: This data is not available on HSCIC and the technical specification for the dataset is not available so the Trust cannot replicate the data using local information.

It has been acknowledged that an error was made in the drafting of the regulations and that the split of patients for this indicator should be

0 to 15; and

16 or over,

This indicator on the HSCIC Indicator Portal was last updated in December 2013 and the proposed update that was due to take place in August 2016 was postponed, therefore there is no up to date information.

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

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2014/2015	*	*	*	*
2013/2014	*	*	*	*

2012/2013	*	*	*	*
2011/2012	13.58	10.01	13.58	5.10
2010/2011	12.08	10.15	13.94	5.85
2009/2010	11.77	10.18	14.44	6.38

NB: Information Centre provides data by 16> not 15>

*** Data for 2012/15 is not available from the Information Centre**

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

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2014/2015	*	*	*	*
2013/2014	*	*	*	*
2012/2013	*	*	*	*
2011/2012	12.44	11.45	13.50	8.96
2010/2011	11.66	11.42	12.94	7.6
2009/2010	11.75	11.16	13.17	7.3

NB: Information Centre provides data by 16> not 15>. Data relates to medium sized acute Trusts.

*** Data for 2012/15 is not available from the Information Centre**

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, in that this is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from the Healthcare Evaluation Data benchmarking system to facilitate further analysis.

Warrington and Halton Hospitals NHS Foundation Trust has taken the following actions to improve this data and so the quality of its services, by reporting all data to the Trust Board and the Clinical Operational Board.

2.3.4 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
2015/2016	70.9	69.6	86.2	54.4
2014/2015	72.0	68.9	86.1	59.1
2013/2014	69.4	68.7	84.2	54.4
2012/2013	66.7	68.1	84.4	57.4

2011/2012	66.2	67.4	85	56.5
2010/2011	67.4	67.3	82.6	56.7

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, central to the Trust ethos is the view that patients deserve high-quality healthcare, and patients' views and experiences are integral to successful improvement efforts. As such it employs Quality Health to undertake a robust and comprehensive survey of patients experience on an annual basis.

Warrington and Halton Hospitals NHS Foundation Trust intends to continue work to improve this percentage and so the quality of its services.

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
2016	57%	85%	49%	70%
2015	54%	93%	38%	70%
2014	61%	89%	38%	65%
2013	65%	93.9%	39.6%	67%
2012	58%	69%	35%	65%
2011	57%	89%	33%	65%

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason, in that this report presents the findings of the 2016 national NHS staff survey conducted by Quality Health on behalf of the trust. Quality Health utilises high quality research methodology and mixed method collection resulting in a 38% response rate.

This year the Trust decided to give all staff the opportunity to respond to the staff survey rather than a statically representative sample. Therefore with a response rate of 38% almost 1500 WHH staff responded to the survey. The response rate also indicates an increase of 5% on the 2015 survey and improves the trusts performance and puts the trust in the average response rates for acute trusts for the first time. The trusts view is that the results are statistically representative.

Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve to improve this score and so the quality of its services by using the percentage of staff

recommending the trust as a place of work and treatment within the staff survey alongside the quarterly staff friends and family test results. The percentages are compared with the qualitative detail that these surveys also give and action plans are developed as appropriate. The key themes are reported to Clinical Business Units and departments to give managerial ownership of the findings. The results are also reported to the Strategic People Committee where an overall report is given on actions taken to improve the scores. The Trust is currently still working to develop the staff voice and embed the Trust 'We are' values and behaviours framework across the trust and hope that this should continue to improve a number of the factors, improving engagement levels and therefore patient 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
2016/2017	Trust	90.19%	92.50%	94.26%	**
	National Average	95.73%	95.51%	95.64%	**
	Highest	100%	100%	100%	**
	Lowest	80.61%	72.14%	76.48%	**
2015/2016	Trust	96.6%	96.1%	88.56%	88.37%
	National Average	96%	95.9%	95.5%	95.53%
	Highest	100%	100%	100%	100%
	Lowest	86.1%	75%	61.5%	48.63%
2014/2015	Trust	95.70%	95.60%	95.00%	95.93%
	National Average	96.00%	96.10%	96.00%	96.00%
	Highest	100%	100%	100%	100%
	Lowest	87.20%	86.40%	81.00%	79.23%
2013/2014	Trust	95.54%.	95.60%	96.50%	96.00%
	National Average	95.39%	95.69%	95.80%	96.00%
	Highest	100%	100%	100%	100%
	Lowest	78.78%	81.70%	77.70%	79.00%
2012/2013	Trust	95.40%	95.10%	94.00%	93.90%
	National Average	93.40%	93.80%	94.00%	94.20%
	Highest	100%	100%	100%	100%
	Lowest	80.80%	80.90%	84.60%	87.90%
2011/2012	Trust	95.60%	96.20%	95.40%	96.20%
	National	81.00%	88.00%	91.00%	93.00%

	Average				
	Highest	***	***	100%	100%
	Lowest	***	***	32.40%	69.80%

******* ***= This data is not currently available from the Information Centre.***

********* ***= This data has been archived and is unavailable.***

The Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons in that this is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency.

Warrington and Halton Hospitals NHS Foundation Trust has a well-developed system for undertaking risk assessments on admission and ensuring the data is collated corporately and incorporated into the Quality Dashboard for monthly review and monitoring by both the Quality Committee and Trust board. More recently in November 2015 the Trust introduced a new Electronic Patient Record (EPR) system (Lorenzo). Unfortunately whilst Lorenzo has provided significant benefits and opportunities for the Trust overall, since 'go live' there have been issues with accessing accurate data for quality indicators for example dementia and VTE screening.

Issues identified:

1. Medical staff do not always complete the VTE risk assessment when clerking patients in.
2. On some occasions the VTE risk assessment form is attached to the wrong encounter or a different Trust risk assessment form is used and consequently these then appear as not completed.
3. VTE risk assessments completed in ED are not picked up by the reporting system when ED have not recorded the decision to admit time (DTA)
4. The report from information does not pick up the "inpatient admission note" if it is created in ED.
5. Although a Clinical Indicator has been developed by the Information Team to highlight missing VTE risk assessments, this indicator does not pick up risk assessments that are completed in ED rather than the inpatient encounter.
6. Some patients do not require a VTE risk assessment and can be cohorted (included in the figures as 'action completed'. However since the cohorts were created a further group of patients have been identified for inclusion in the cohort group but this action has not yet taken place (requires approval

Actions that we have taken:

1. Clinical Directors have conducted education sessions with all doctors to ensure that they complete VTE risk assessments when clerking in the patients on the inpatient admission note.
2. The Emergency Department are ensuring that we monitor that the Diagnostic Test Accuracy is recorded for all patients.
3. Further assurance work is being undertaken by our IT department to ensure that all inpatients admission notes are picked up for reporting.
4. IT to investigate if it is possible to get around the current limitation in the indicator report.
5. In order to provide accurate report, IT are amending the cohort table to include the identified additional groups of patients.

When the data is corrected to include VTE risk assessments that are not captured via the information report, VTE risk assessment completion rates for November, December 2016 and January, February 2017 are exceeding the 95% risk assessment target.

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
2015/2016	17.4	14.9
2014/2015	16.9	15.1
2013/2014	16.3	14.7
2012/2013	9.4	17.3 (now 17.4)
2011/2012	21 (now 19.2)	21.8 (now 22.2)
2010/2011	35.9 (now 34)	29.6 (now 29.7)

The Information Centre only provides average by Trust (not by highest and lowest) and 2016/17 data is not currently available.

The Warrington and Halton Hospitals NHS Foundation Trust considers that the data is as described for the following reasons there is a robust system for data entry and validation which ensures all cases are entered onto the data Capture system.

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

- Action plan in place to reduce Clostridium difficile
- Increase in hours to the Antimicrobial Pharmacist role
- Participation in the national AMR CQUIN
- Participation in European Antibiotic Awareness Day
- Fidaxomicin used for treatment of patients with recurrent Clostridium difficile infection
- Antimicrobial steering group with feedback to Clinicians on incidences of antimicrobial prescribing non-compliance
- Surveillance of cases/monitoring for increased incidences in defined locations
- Improvements to methods of investigation for Clostridium difficile cases
- Cohort isolation facility maintained to manage cases
- 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 and single point lessons on Clostridium difficile and use of SIGHT mnemonic
- Environment Group re-established to monitor and direct improvements in standards of cleanliness

- Action plan in place to reduce MRSA and MSSA bacteraemia
- Participation in the national Sepsis CQUIN to promote timely blood culture sampling and IV antibiotic treatment
- Revision to post infection review template for bacteraemia cases
- Review of all MRSA positive cases and advice provided on suppression therapy and where required antibiotic treatment

2.3.8 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 1000 bed days

DATE	TRUST	TRUST NUMBER	MEDIAN	LOWEST	HIGHEST
April 2016 – September2016	37.78	3643	40.02	21.15	71.81
Oct 2015 – Mar 2016	38.62	3706	39.31	14.77	75.91
April 2015 – September 2015	39.41	3721	38.25	18.07	74.67
Oct 2014 - Mar 2015	38.6	3584	35.3	3.6	82.2
April 2014 – September 2014	36.89	3339	35.89	0.24	74.96
October 2013 – March 2014	37.1	3513	33.3	5.8	74.9

NB: NRLS Report provides median rate of incidents per 1000 bed days reported by all non-specialist acute Trusts.

Patient Safety Incidents Severe Harm / Death – Rate

DATE	TRUST	NATIONAL	LOWEST	HIGHEST
Severe Harm and Death April	0.3% (10)	0.4% (Non-specialist acutes	0% (0)	1.9% (111)

2016 – September 2016		only)		
Severe Harm and Death Oct 2015 – Mar 2016	0.1% (2)	0.4% (Non-specialist acutes only)	0% (0)	2.8% (122)
Severe Harm and Death April 2015 – September 2015	0.4% (15)	0.4 (Non-specialist acutes only)	0.03% (1)	3.6% (111)
Severe Harm & Death October 2014 - March 2015	0.1% (5)	0.5% (non-specialist acutes only)	0.05% (2)	5.19% (128)
Severe Harm & Death April 2014 – September 2014	0.1% (5)	0.5% (non-specialist acutes only)	0% (0)	1.85% (97)
Severe Harm & Death October 2013 – March 2014	0.17% (6)	Clarify scope	0.03% (1)	1.47% (72)
Severe Harm & Death April 2013 – September 2013	1.08% (42)	Clarify scope	0% (0)	3.10% (106)
Severe Harm & Death October 2012 – March 2013	0%	0.05%	0%	0.2%
Severe Harm April 2012 – September 2012	**0.15% (4)	*<1%	0 0%	61 3.1%
Death April 2012 – September 2012	0.0% (1)	*<1%	0 0%	34 1.3%
Severe Harm October 2011 – March 2012	0.2% (4)	*<1%	1 0%	80 3%
Death October 2011 – March 2012	0.0% (0)	*<1%	0 0%	14 0.6%

NB - The Trust has reported by actual number & percentage by highest/lowest rates please note these will not necessarily be the same Trusts.

NB - *National = Severe Harm and Death combined. **Please see comments.

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reasons in that it downloads all incidents via DATIX to the National Reporting and Learning System within the agreed timescales.

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

Completed investigations to the appropriate level dependant on the severity of the clinical incidents reported

Shared analysis, learning and improvement identified from clinical incidents across the Trust via the following routes:

- Quarterly Governance Reports
- Trust wide safety alerts and notifications
- Safety briefings in clinical areas
- Amendments to policy
- Weekly and Monthly meetings with Governance Managers to manage the incident process

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 primary objective is the safety of our patients.

Quality Report Part 3 - Trust Overview of Quality

3.1 Introduction - Patient Safety, Clinical Effectiveness & Patient Experience

Our aim is to be a learning organisation that consistently transforms practice by continuous learning in order to provide the best possible health care. The Trust's strategic objective is to ensure that all care is rated amongst the top quartile in the North West of England for patient safety, clinical outcomes and patient experience.

Our Quality Strategy consolidates this approach by defining the combination of structures and processes at and below Board level to lead on Trust-wide quality performance to ensure that required standards are achieved by:

- Investigating and taking action on sub-standard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care

The strategy also defines the priorities for quality improvement and sets realistic, measurable goals which include reductions in pressure ulcers; falls; mortality ratios and hospital acquired infections. It also specifies improvements in compliance with risk assessments; advancing quality measures; complaints responses and always events. It identifies the risks to quality and the steps needed to mitigate these risks; and sets out the vision for quality in a way that engages staff, patients and the local community.

The delivery of high quality services, together with the ability to demonstrate a programme of continuous service improvement, is seen as one of the most important indicators of a successful health care organisation

It is vital that we are able to provide assurance that national and local clinical and quality requirements have been identified and processes and systems are in place to implement and monitor quality within the Trust. We will ensure that we develop and integrate these tools and processes into the quality agenda to ensure a sophisticated whole systems approach. This will include and not be exclusive to an internal annual review of our systems and processes using both the Well Led Framework and the CQC Outcome framework. We will also instruct our internal auditors to undertake audits of quality in order to provide assurance that systems are in place to address national and local clinical and quality requirements to ascertain if they are fit for purpose.

We are also committed to being transparent in relation to 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 a transparency page on our internet site signposting the public to quality information and includes the monthly publication of Open and Honest Reports outlining the number of pressure ulcers and falls in addition to the results of Friends and Family Test, NHS Safety Thermometer and patient and staff experience surveys.

We continue to work collaboratively with patients and staff to provide open and honest care, and through implementing quality improvements, further reduce the harm that patients sometimes experience when they are in our care.

3.1.1 Data Sources

Intelligent information is collated from, whenever possible, sources which can be benchmarked with other organisations in order to indicate the Trust's performance in relation to others. The Trust submits and utilises data from the Health and Social Care Information Centre (HSCIC) which includes for example Patient Reported Outcome Measures (PROMs) in England whereby patients undergoing elective inpatient surgery for four common elective procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery) funded by the English NHS are asked to complete questionnaires before and after their operations to assess their perceived improvement in health.

The Trust also subscribes to datix, which is web-based patient safety software for healthcare risk management. It delivers the safety, risk and governance modules which enable the Trust to have a comprehensive oversight of our risk management activities including incident reporting and complaints, compliments, comments and concerns.

In addition to this the Trust has invested in a clinically-led benchmarking system called Healthcare Evaluation Data (HED), an online solution delivering information, which enables the Trust to drive clinical performance in order to improve patient care.

The Trust submits data to the NHS Safety Thermometer which was developed as a point of care survey instrument, providing a 'temperature check' on harm that can be used alongside other measures of harm in providing a care environment free of harm for our patients. The Trust undertakes a monthly survey on one day of all appropriate patients, to collect data on pressure ulcers, falls, urinary tract infection (UTI) in patients with catheters and VTE. The Safety Thermometer measures the percentage of patients who have experienced harm in relation to any of these issues and allows the Trust to identify weaknesses; make changes to practice and measure improvement.

Other sources of information come from Friends and Family; Inpatient, Outpatient and Staff Surveys and in-house sources including audit and transparency surveys.

3.1.2 Quality Dashboard 2016/2017

The clinical indicators in the Quality Dashboard have been reviewed in line with the revised requirements for 2016/2017 in relation to the:-

- CQUINs – National
- MONITOR KPI
- Quality Contract
- Quality Account - Improvement Priorities
- Quality Account – Quality Indicators
- Care Quality Commission
- Sign up to Safety – national patient safety topics

- Open and Honest

This is part of a wider review of quality to align reporting with the committee structure under safety; effectiveness and experience and reporting to the Quality Committee to provide assurance on progress. The information on this Quality Dashboard is also shared with our Governors and commissioners of services to demonstrate how care for patients is delivered and sustained improvements are maintained.

From April 2016 the Board has received an integrated performance dashboard which triangulates data on workforce, quality and financial information.

3.1.3 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the Trust based on performance in 2016/17 against a minimum of 3 indicators for each area of quality namely patient safety; clinical effectiveness and patient experience. These indicators were selected by the Board in consultation with stakeholders and discussions with the Quality in Care Committee of the Council of Governors. In the main, the Trust has employed indicators which are deemed to be of local and national importance to the quality of care for patients.

The report provides an explanation of the underlying reason(s) for selection and wherever possible we refer to historical data and benchmarked data if available, to enable readers to understand our progress over time and performance compared to other providers. We have also referenced the data sources for the indicators and if applicable included whether the data is governed by standard national definitions.

Where these indicators have changed from the indicators used in our 2015/2016 report, we have outlined the rationale for why these indicators have changed / removed and where the quality indicators are the same as those used in the 2015/2016 report and refer to historical data, we have checked the data to ensure consistency with the 2015/2016 report.

Where available comparative and benchmark data has been included and unless otherwise stated the indicators are not governed by standard national definitions and the source of the data is the Trust's local systems and may only be available across two reporting years as such more historical data has not been included.

The improvement priorities and quality indicators were monitored and recorded via the Quality Dashboard and the Improvement Priority Quarterly Report reported to the Quality Committee on a monthly basis.

NB The Quality Dashboard was reported to Board until August 2016 when it was replaced by the Integrated Dashboard.

The quality indicators for 2016/17 included:

Safety

- HCAI
- Nursing Care Indicators
- Medicines Management – development of indicators and on-going monitoring
- WHO Checklist (ORMIS)

NB: Pressure Ulcers is an improvement priority for 2016/2017 and has therefore been removed as a quality indicator

Clinical Effectiveness

- SHMI HMSR
- Dementia

- Advancing Quality - Pneumonia, COPD (Chronic Obstructive Pulmonary Disease) & Diabetes

Patient Experience

- Patient Experience Indicators
- Complaints
- Patient Survey (inpatient and children) Indicators

NB: Essential ward transfer has been removed as a quality indicator for 2016/2017 and will be reinstated when information systems are refined.

3.2 Patient Safety

3.2.1 HCAI - Infection Control

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 to continue as a quality indicator for 2016/2017.

During 2014/2015, the Trust threshold was 0 cases of MRSA bacteraemia and despite the continued focus on managing HCAI during 2015/2016 the Trust was reported 2 cases of MRSA bacteraemia against a threshold of 0. Year to date for 2016/2017 the Trust is pleased to report that there have been no cases of MRSA bacteraemia and that the Trust has had a period of 18 months free of MRSA bacteraemia. Work undertaken to maintain an MRSA free Trust includes:-

- Action plan in place to reduce MRSA and MSSA bacteraemia
- Participation in the national Sepsis CQUIN to promote timely blood culture sampling and IV antibiotic treatment
- Revision to post infection review template for bacteraemia cases
- Review of all MRSA positive cases and advice provided on suppression therapy and where required antibiotic treatment

During 2014/2015 the Trust reported 31 cases of hospital acquired Clostridium difficile infections against a threshold of 26 cases. However in 2015 the Trust engaged in partnership working with a CCG panel to review Cdiff cases to exclude some cases from the contractual penalties. This system investigates all hospital apportioned cases of Clostridium difficile and where no lapses in care are identified, cases are removed from those counted for the purpose of contractual sanctions. In 2016/2017 the Trust reported 24 cases of Clostridium difficile (C Diff) against a threshold of 27 cases and 13 were deemed not to be due to a lapse in care.

CDIFF Monitor Report 2015/2017

*Please note that the categorisation numbers for the 2015/16 results have changed since the last report due to the completion of the reviews into each case.

	*2015/2016	2016/2017
Due to lapses in care	17	11
Deemed not to be due to lapse in care	16	13
Under Review	0	0
Total C.Diff	33	24

Actions agreed, implemented and maintained within year included but not limited to include:

- Action plan in place to reduce Clostridium difficile
- Increase in hours to the Antimicrobial Pharmacist role
- Participation in the national AMR CQUIN
- Participation in European Antibiotic Awareness Day
- Fidaxomicin used for treatment of patients with recurrent Clostridium difficile infection
- Antimicrobial steering group with feedback to Clinicians on incidences of antimicrobial prescribing non-compliance
- Surveillance of cases/monitoring for increased incidences in defined locations
- Improvements to methods of investigation for Clostridium difficile cases
- Cohort isolation facility maintained to manage cases
- 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 and single point lessons on Clostridium difficile and use of SIGHT mnemonic
- Environment Group re-established to monitor and direct improvements in standards of cleanliness

Methicillin-sensitive Staphylococcus aureus (MSSA)

MSSA bacteraemia is caused by Staphylococcus aureus is a serious infection associated with high morbidity and mortality and often results in metastatic infections such as infective endocarditis, which have a negative impact on patient outcomes

14 MSSA bacteraemia cases have been reported YTD. All cases undergo root cause analysis investigation. 2 cases are under review, 5 have been attributed to intravascular devices, 3 sources unknown, 1 to foetal scalp electrode and 3 related to deep seated infections identified 48 hours after admission but likely community

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.

3.2.2 Nursing Care Indicators – MUST; Waterlow and Falls

The care indicators audit was developed as part of a local CQUIN to audit compliance with risk assessments for Falls, Waterlow and MUST. Reports received throughout 2013/2014; 2014/2015 to 2015/2016 showed improved compliance with Falls and Waterlow and more recently with MUST. It was agreed that the Trust should continue to monitor compliance against the established threshold >=95%. The Trust is pleased to report that results for 2016/2017 indicate further improvement to compliance with risk assessments.

Risk Assessment Compliance 2015/2016

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
FALLS	82%	92%	93%	97%	97%	93%	96%	94%	96%	92%	97%	96%
WATERLOW	77%	93%	92%	96%	95%	92%	96%	95%	97%	94%	97%	94%
MUST	78%	85%	89%	91%	80%	87%	90%	88%	93%	93%	-	-

Risk Assessment Compliance 2016/2017

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
FALLS	99%	97%	96%	*	*	100 %	100 %	99%	97%	99%	100 %	*
WATERLOW	99%	98%	98%	*	*	100 %	95%	93%	100 %	100 %	100 %	*
MUST	91%	98%	96%	*	*	97%	92%	94%	91%	91%	100 %	*

***NB: issues with training for the new electronic process resulted in poor data collection during these months. - Information not available. Data ceased to be captured in March 2017.**

During the latter part of 2016/2017 the Trust also focussed upon compliance with the interventions associated with risk assessment(s) to ensure that patients are being managed appropriately. This is managed through an enhanced Nursing Care Indicator process where nursing staff audit all aspects of care associated with the risk to ensure compliance with the pathway of care. In relation to falls the staff would ensure that a risk assessment is carried out both on admission and after a change in the patient's condition e.g. post-operative. In addition to this they would also check if the patient had received a bed rail; moving handling and incontinent assessment and if the correct footwear and walking aids were present. Substantial work has taken place to improve the process; monitoring and ensuring changes to practice if required. This work which will continue throughout 2017/2018 will be reported in the next Quality Account.

3.2.3 Medicines Management – development of indicators and on-going monitoring

The medicines management dashboard was created in response to earlier targeted work in reducing medication errors and insulin related incidents. During 2012/2013, the Trust targeted improvements on a 10% reduction in medicine errors with a specific focus on reducing insulin related incidents by 5%. By the year end even though we had reduced insulin incidents by 10.5%, it was agreed that we should include the development and monitoring of medicine indicators, including the safety thermometer, as a quality indicator and this work has continued to date. The indicators that are included in the dashboard are medicines reconciliation; discharge prescription turnaround time; outpatient prescription turnaround time; discharge prescriptions reviewed on ward; medication incidents resulting in harm; compliance with the antibiotic formulary; performance against medicines related questions in CQC surveys; medicines related complaints; prescribing audit and the pilot of the medicines safety thermometer. The dashboard is reported via the Medicines Safety Committee.

Running parallel to the development of the dashboard was the implementation of the medicines safety thermometer by the Deputy Chief Pharmacist. The Medication Safety Thermometer is a measurement tool for improvement that focuses on Medication Reconciliation, Allergy Status, Medication Omission, and Identifying harm from high risk medicines in line with Domain 5 of the NHS Outcomes Framework. It is a point of care survey which identifies the percentage harm free care occurring from medication error

Data can be used as a baseline to direct improvement efforts and then to measure improvement over time. The safety thermometer indicates a high level of safe care around medication as follows:-

% of patients free from harm (medicines safety thermometer) quarterly reporting

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB
2014/2015	P	P	P	P	P	98.3%	99.2%	97.4%	99.2%	98.6%	
2015/2016	100%	97.5%	98.1%	100%	100%						
2016/2017	100%	69.9%	NA	100%	NA	97.8%	100%	98.8%			

P – Pilot, NA – No Audit

There are still some inconsistencies in this tool for example the lower harm free percentage in November 2014 and May 2016 was because they assessed ITU who had a number of sedated patients that triggered as harm (which was the intended outcome for these patients as they were on ITU). The lead contacted Haelo and they advised that they still should be recorded as the harm trigger even though it was the intended treatment.

3.2.4 Safer Surgery – World Health Organisation (WHO) Checklist

The WHO Surgical Safety Checklist was developed after extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery. The 19-item checklist has gone on to show significant reduction in both morbidity and mortality and is now used by a majority of surgical providers around the world.

Surgical Safety Checklist

World Health Organization | Patient Safety

Before induction of anaesthesia → **Before skin incision** → **Before patient leaves operating room**

(with at least nurse and anaesthetist) | (with nurse, anaesthetist and surgeon) | (with nurse, anaesthetist and surgeon)

Has the patient confirmed his/her identity, site, procedure, and consent?
- ☐ Yes

Is the site marked?
- ☐ Yes
- ☐ Not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Is the pulse oximeter on the patient and functioning?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway or aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and two IVs/central access and fluids planned

Confirm all team members have introduced themselves by name and role.

Confirm the patient's name, procedure, and where the incision will be made.

Has antibiotic prophylaxis been given within the last 60 minutes?
- ☐ Yes
- ☐ Not applicable

Anticipated Critical Events

To Surgeon:
- ☐ What are the critical or non-routine steps?
- ☐ How long will the case take?
- ☐ What is the anticipated blood loss?

To Anaesthetist:
- ☐ Are there any patient-specific concerns?

To Nursing Team:
- ☐ Has sterility (including indicator results) been confirmed?
- ☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

Nurse Verbally Confirms:
- ☐ The name of the procedure
- ☐ Completion of instrument, sponge and needle counts
- ☐ Specimen labelling (read specimen labels aloud, including patient name)
- ☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- ☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009 | © WHO, 2009

Theatres have a daily audit tool for measuring compliance with the WHO checklist. All patient safety data has been inputted into ORMIS and gives assurance that the Safe Surgery Check list is compliant. This includes the 5 Steps to safer surgery and SBAR handovers, which are both electronically completed.

WHO compliance is checked on the ORMIS programme and any anomalies are corrected and approved by the theatre management team and the report is shared monthly at the Theatre meetings and Divisional Quality Bi- lateral Meeting for dissemination.

WHO Checklist compliance 2016/2017

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
WHO Checklist	100%	100%	100%	100%	99.8%	100%	100%	100%	100%	100%	100%	100%

Compliance with the checklist is included in the Quality Dashboard and monitored on a monthly basis via the Quality Committee. The Trust can report full compliance in 2016/2107 with the exception of August when there was one case of non-compliance, which related to a maternity procedure – emergency caesarean section. The Head of Theatres stated that this incident had been fully investigated and there have been major improvements in compliance with the WHO Checklist in the maternity theatres. To provide additional assurance the local audit on the WHO Checklist will continue and will report via a high level briefing paper to the theatre governance meetings which report into the CBU Governance meeting.

3.2.5 NPSA 'never events'

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They include incidents such as:

- wrong site surgery
- retained instrument post operation
- wrong route administration of chemotherapy

Incidents are considered to be never events if:

- there is evidence that the never event has occurred in the past and is a known source of risk (for example, through reports to the National Reporting and Learning System or other serious incident reporting system)
- there is existing national guidance or safety recommendations, which if followed, would have prevented this type of never event from occurring (for example, for 'Retained foreign object post procedure' the referenced national guidance is related to the peri-operative counting and checking processes that would be expected to occur at the time of the procedure, including suturing after a vaginal birth)
- occurrence of the never event can be easily identified, defined and measured on an ongoing basis

The threshold for never events is set at zero for contractual purposes and Trust is disappointed to report that three never events took place between April 2016 and March 2017.

The never event that occurred in April 2016 has been fully investigated and is waiting to be closed by the clinical commissioning group.

The further 2 never events occurred in March 2017 and are currently still being investigated. However, at the time of writing this report the following actions are underway;

- 72 hour review for both cases
- Retraining for all staff
- Investigation commenced led by Associate Medical Director of Quality
- Quality Account priority regarding safer surgery – safety culture/human factors /quality improvement champions

3.2.6 SEPSIS

Sepsis is defined as an infection (definite or suspected) with systemic inflammation which can deteriorate quickly into severe sepsis or septic shock. It occurs when bacteria enters the body, for example via a tissue injury.

Sepsis is common – it kills around 44,000 people each year in the UK

- Mortality rate is around 30% - 5 x more than STEMI (heart attacks) and stroke!
- Early recognition and treatment halves the death rate.
- For every hour that appropriate antibiotic administration is delayed, there is an increased risk of mortality. For example a four hour delay in administering antibiotics increases the risk of mortality from 15% to 45%!

Sepsis Six

The **Sepsis Six** is the name given to a bundle of medical therapies designed to reduce the mortality of patients with **sepsis**. The **Sepsis Six** consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis of **sepsis**.

- Give high-flow oxygen
- Take blood cultures
- Give IV antibiotics
- Start IV fluid resuscitation
- Check lactate
- Monitor hourly urine output

During the year 1st January 2016 to 31st December 2016 the Trust treated 794 patients with Sepsis recorded as the primary or secondary illness.

The challenges relating to Sepsis at WHH are;

- Sepsis being diagnosed late
- Sepsis either being diagnosed or ruled out
- Gaps in Monitoring – Observations - Urine Output - Checking blood results
- Delays in recognition and escalation of deteriorating patients

The Trust has made major improvements namely funding for two sepsis nurses, one of who is newly appointed and in post, the other due to commence in post shortly. In addition, a new ELearning module has been developed, which is to become part of mandatory training for all clinical staff.

Sepsis six boxes, containing special sepsis bags with all the equipment required in cases of suspected sepsis are currently being rolled out to all clinical areas, which will free up the nursing staff to obtain the required IV antibiotics.

A revised, easy to follow sepsis pathway has also recently been developed and the potential for training to enable the sepsis team and critical care team to prescribe, is currently being explored, which will save valuable time.

Performance has improved significantly following the promotion of sepsis awareness by the Emergency Department (ED) Consultant and Sepsis Lead. Sepsis screening for ED has risen from 32% in quarter 1 to 81% in quarter 3 and for inpatients from 9% to 76%.

3.2.7 Falls - Management and Reduction

The Trust cares for many vulnerable patients, who may have a history of falls and who are therefore at risk of further falls when admitted to the Trust. A specialist falls prevention nurse is being recruited and as an interim measure the Lead Nurse for Airway breathing and Circulation (ABC) CBU, is leading a new 'Falls Programme' to help understand how we can help reduce the number of falls across the Trust.

As part of the programme, a pilot scheme has commenced on Wards A7 and A8, to trial new coloured slipper socks, yellow for 'high risk' falls and red for patients who don't have footwear. In addition, a new initiative 'SWARM' has been introduced, whereby in the event of a fall, a SWARM is initiated as soon as possible after an adverse incident or undesirable event occurs. Like bees, staff swarm to discuss the incident with an RCA being completed at the time of the incident.

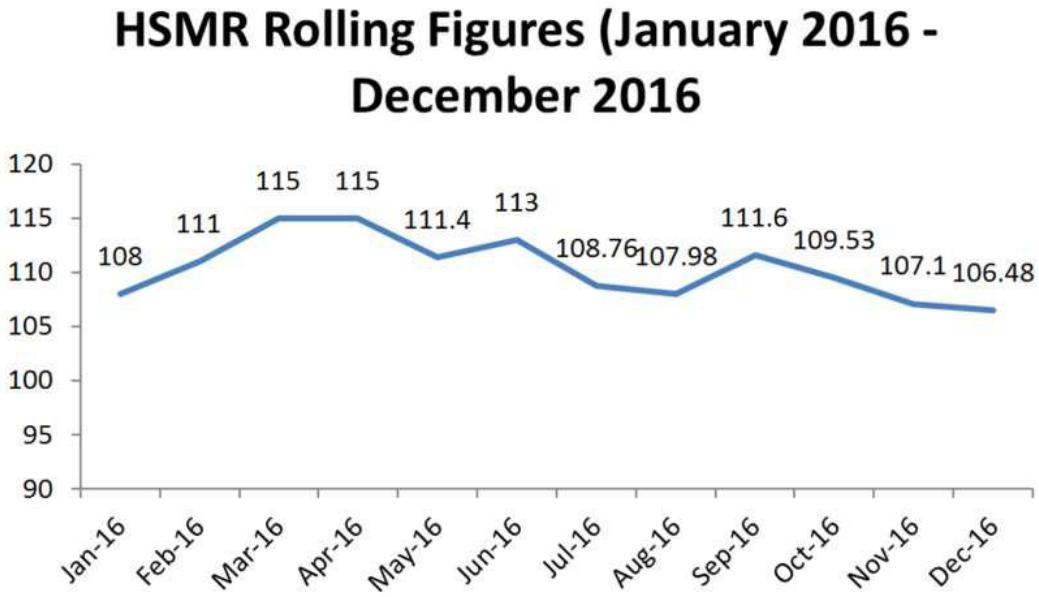
Other measures introduced include:

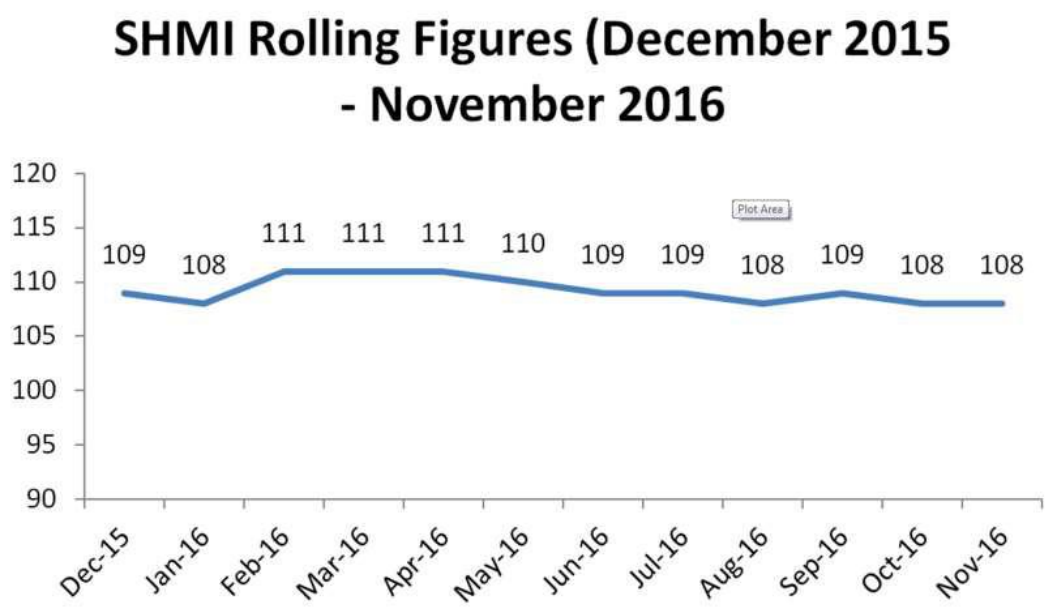
- The Trust's 'moving and handling' therapist is currently trialling and evaluating falls equipment.
- Special 'falls' blankets have been introduced to help identify patients at high risk of falls
- The Matron for older people's services is currently undertaking an enhanced specialised monitoring project based on people at risk of falls
- A 'Falls Steering Group' has also been re-established, to explore ways of preventing and managing falls within the Trust

3.3 Clinical Effectiveness

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

We agreed to continue to monitor and report mortality ratios in 2016/2017 and use the data as an indicator of the quality of care we provide, supporting targeted improvements. The latest available figures for HSMR is 106.48 for the period January 2016 to December 2016 and SHMI 108.12 for the period December 2015 to November 2016 (HED system). The chart below shows these rolling 12 month figures since January 2016. The SHMI was in the range of 'higher than expected' until November 2015, however this is now 'as expected' for the period January 2015 – December 2015. The HSMR is 'as expected' throughout this period. Our crude death rates compare favourably with local peer Trusts and across the North West.





The Trust has continued its commitment to reducing avoidable mortality. Key developments include:

- We have introduced a process over the last twelve months were all of our patients who have died are having a case note review by a Consultant other than the Consultant in charge of the patient to assess for areas of improvement or areas which would require further investigation. In the event of either of these being identified, the case is then being reviewed in detail and presented to the Trust Mortality Review Group by a member of that group. Where we identify areas for improvement this is cascaded across the Trust. The screening of deaths is a work in progress. Our aim was to have every death screened, however due to unforeseen difficulties in ensuring the process has been fully adhered to, as it requires the Consultant to complete the form. The process has been strengthened as a result we aim to have 100% of deaths screened for 2017. We have noted a steady decrease in SHMI over the last twelve months. Other areas where we are aware affects the SHMI are correct diagnosis by doctors and good documentation of the patients' comorbidities which allows our coders to accurately code the patients. This is an ongoing improvement project and we expect to see continuing improvements in these areas.
- A number of focused reviews that have been conducted have found that care is generally good for those patients.
- A review into Regional Enteritis patients highlighted a delay in obtaining surgical consultation, requiring an improvement in the interface between medicine and surgery. These two cases were presented at Patient Safety & Clinical Effectiveness Sub-Committee and Clinical Business Unit meetings to ensure the learning is disseminated across relevant areas of the organisation. A pathway was introduced to ensure referrals to surgery are made in a timely and appropriate manner.
- A review into pneumonia deaths we are currently completing found:
    - Death certification process review needed. We have started a quality improvement project with foundation year trainees to look at improving the accuracy of death certification recording.
    - End of life care could have been started earlier and earlier DNACPR. This will require a general review of care pathways for end of life, palliative and DNACPR patients which will take place once this review has been completed.

- Accuracy of coding could have been improved in cases. The Coding Department have looked at 50% of the cohort to allow us to identify specific improvements to documentation and coding.
- Lack of senior review by a Consultant within 12 hours in 6 cases. This review was from a cohort of patient from January 2016 and since then senior review of patients within 12 hours has been put in place. This is monitored via the screening review process and where senior review is more than 12 hours, assessment is required to ascertain whether this was detrimental to the patient's care.
- Two of the patients could have remained in the community to die in peace. Work with Warrington CCG is due to be started to improve the setting for these patients.
- Need a clear pathway or process for ensuring patients with a known cancer or being investigated for a suspected cancer is picked up at every admission and acute oncology informed. Continuing to develop the relationship between medics and coders, so that they can jointly better understand the impact of how they document and then code this information

We will continue to monitor and report mortality ratios in 2017/2018 and use the data as an indicator of the quality of care we provide, supporting targeted improvements.

3.3.2 Dementia CQUIN

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. In the last two years the Trust achieved all three elements of Find; Assess and Refer of the CQUIN target of over 90% of patients being assessed at each stage by Quarter 4. It was agreed to continue to report on this as a quality indicator for 2016/2017. This will also be supporting the local CQUIN Johns Campaign where the Trust will be monitoring information being given to family and carers on open visiting times.

The Trust with stakeholders agreed that we should continue to include dementia CQUIN as a quality indicator for the 2015/2016 Quality Report. As the table reveals our compliance has been somewhat varied from November 2015 which was as a result of data management issues relating to the introduction of Lorenzo. The Trust had discussions with our CCGs who accepted that we are experiencing issues with validating data from the new PAS and agreed not to invoke any penalties for under performance on either Part for November and December. Importantly, they accepted our assurances that patients were still being reviewed and assessed as per guidance and that the issue related to data extraction problems. As the table indicates these issues were resolved by January 2016 when the Trust was able to evidence compliance as per guidance. Compliance has continued throughout 2016/2017.

Dementia Assessments FAIR 2013 - 2017

Dementia	A	M	J	J	A	S	O	N	D	J	F	M
Part 1 2013/2014 FIND	90.43	93.14	91.3	92.87	95.12	95.12	95.2	95.13	96.1	97.76	97.36	94.57
Part 1 2014/2015 FIND	94.55	95.69	95.43	94.26	96.59	92.45	92.7	96.61	96.29	96.93	94.81	N/A
Part 1 2015/20	96.85	97.62	95.53	96.80	94.86	94.36	92.18	81.30	26.9	90.3	92.78	90.42

16 FIND												
Part 1 2016/2017 FIND	92.21	93.29	91.02	94.72	94.41	93.26	98.74	95.53	94.32	92.13	93.97	
Part 2 2013/2014 INVESTIGATE	96.77	100	100	100	100	93.3	100	96.43	96.88	100	100	100
Part 2 2014/2015 INVESTIGATE	100	100	100	100	100	91.89	100	100	97.22	96.77	100	N/A
Part 2 2015/2016 INVESTIGATE	100	100	100	100	100	100	85.71	73	88.9	96.7	97.56	93.85
Part 2 2016/2017 INVESTIGATE	98.78	93.75	100	95.08	98.75	93.33	100	97.73	98.99	100	98.75	
Part 3 2013/2014 REFER	100	100	100	100	100	100	100	100	100	100	100	100
Part 3 2014/2015 REFER	100	100	100	100	100	100	100	100	100	100	100	N/A
Part 3 2015/2016 REFER	100	100	100	100	100	100	100	100	100	100	100	100
Part 3 2016/2017 REFER	100	100	100	100	100	100	100	100	100	100	100	100

Dementia Training

To determine that appropriate Dementia training is available to staff through locally determined training programme.

We provide the Commissioners with quarterly reports to provide assurance that:

- Numbers of staff who have completed the training are improving each quarter;
- We regularly review overall percentage of staff training.

Dementia Awareness training is now a requirement for all staff and the training can be completed via e-learning by accessing the e-Dementia: Introduction to Dementia (Learning Certification). This course is a nationally agreed e-learning tool which provides an introduction to dementia and guidance on supporting those living with dementia, along with their carers. The training enables staff to:-

- Describe dementia, its effect on the brain, and its common signs and symptoms

- Identify some of the complex difficulties experienced by people with dementia
- Challenge some of the common myths and negative attitudes about dementia
- Identify ways of communicating effectively with someone with dementia
- Describe the importance of living well with dementia and how the HCP can facilitate this
- Discuss other sources of support for those with dementia and their carers
- Outline the elements of best quality practice in caring for the individual with dementia, to include end-of-life care

Current results demonstrate >85% compliance with dementia awareness training.

Patient Experience

We have introduced a 'carer's card' to the Trust which is offered to all main carers of patients with memory problems to facilitate unrestricted visiting and if appropriate, to support in the delivery of care as recommended in our dementia guidance. This and other 'carer aware' initiatives have established the Trusts involvement with a national campaign called 'Johns List' which is a campaign for the right of people with dementia to be supported by their carers in hospital.

The Observer newspaper supports John's Campaign and has established a dedicated page on the Guardian website which will lists all the hospitals in the UK where carers are welcome, WHHFT is included in the first 100 Trusts on this list and has selected John's Campaign as a local CQUIN for 2016/2107 – we are currently compliant with this CQUIN.

3.3.3 Compliance with regional targets set for Advancing Quality – reducing variation

AQUA monitor the quality of services delivered at hospitals through a programme called Advancing Quality (AQ). It aims to make sure every patient admitted to hospital is given the same high standard of care no matter which hospital they attend. Each hospital is measured against how many of their patients get the appropriate care they need for the best outcome from their surgery

The AQ programme was established in the North West in 2008, in order to measure that hospitals carry out the right steps with patients, at the right time, during their care. It is currently being used in two large areas of secondary care in the North West and South East coast of England. The participation in the programme was voluntary and this Trust joined the programme at the start in 2008.

Initially it focused on five clinical conditions that were deemed to be most critical for patients in the North West.:-

- Heart Failure
- Acute Myocardial Infarction
- Hip and Knee Replacements
- Heart bypass surgery
- Pneumonia

Subsequently the following clinical focus areas were added:-

- Stroke
- Hip Fracture
- Alcohol Related Liver Disease (ARLD)
- Diabetes
- COPD
- Sepsis
- AKI

NB: Presently, AMI and Stroke have been retired from AQ. Heart Failure will retire from September 2016 discharges. In 2015, WHH decided not to participate in Sepsis and AKI, as the two conditions were part of the national CQUIN requirements. AKI is not a CQUIN in 2016/17.

The objective of the AQ Programme is to provide hospitals with a list of key evidence based measures, which should be delivered to every single patient, to ensure they receive the highest standard of care. After the first year of the launch of the programme in 2008, it was transferred to local CQUIN requirement.

Each condition has an associated performance target set by the AQ Reference Board. The targets are specified in terms of Appropriate Care Score (ACS). ACS measures the proportion of patients that received all of the **relevant** interventions for each individual patient, and is therefore a measure of 'perfect care' for each patient.

Currently the AQ conditions, under local CQUIN for 2016/17, (January 2016 to December 2016 discharges) are:

- COPD ACS 50% target
- Diabetes ACS 50% target
- Pneumonia ACS 78% target

ADVANCING QUALITY (2016/2017 cumulative targets and figures)

		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV
***COPD**	50%	44.19%	42.19%	45.51%	47.12%	47.35%	47.84%	48.35%	48.61%
DIABETES	50%	13.64%	12.24%	16.92%	17.39%	18.58%	18.38%	18.18%	20.23%
PNEUMONIA	78%	73.38%	73.62%	73.63%	73.14%	73.68%	73.59%	73.60%	72.85%

*** CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

It should be noted that collecting AQ data is resource intensive and the thresholds are inflexible; nevertheless the Trust is disappointed that, despite enormous effort and changes to practice, we did not achieve the AQ thresholds. The following changes have been taken place:-

- New blood glucose monitors – Wi-Fi connectivity
- DKA Policy
- Electronic foot assessment on Lorenzo
- Working with smoking cessation team to simplify process of referral
- COPD Care bundle under development

The Trust continues to measure non CQUIN AQ conditions for which data is collected and reported namely ARLD Hip Fractures and Hip & Knee Replacement as follows :-

Heart Failure - Data collected from January 2016 – September 2016 discharge population prior to transition of programme to National Heart Failure Audit data.

WHH achieved an Appropriate Care Score (ACS) of 57.3% and was second top provider of care out of the 8 participating regional Trusts. Areas for improvement include heart failure specialist review within 72 hours of documentation of heart failure diagnosis and the issue of heart failure information on discharge from hospital.

Hip & Knee Replacement Surgery - Elective hip and knee replacement measures were revised and released in April 2016. WHH has provided 94.2% of patients with appropriate care over the 12 months of monitoring. WHH are the top provider for delivery of care in the region for an NHS organisation.

Hip Fracture - WHH have participated in the hip fracture measure set in 2016. Improvement plans and improvement opportunities have been identified to ensure that patients admitted to hospital with hip fractures have appropriate care.

Alcohol Related Liver Disease - WHH have participated in the ARLD AQ measures for the last 12 months. As part of the programme they have introduced an ARLD care bundle to ensure patient delivery of care meets required standards. 87.7% of patients of non-elective admissions with ARLD are now commenced on a care bundle support delivery of care.

3.4 Patient Experience

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. Importantly it will place equal emphasis on responding to the qualitative feedback from stories, as on the quantitative evidence from numbers

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). In addition to the development of a Patient Experience Strategy and work streams which are an improvement priority for this year the Trust is committed to improving patient experience through implementing and monitoring patient experience indicators as set out in the Quality Report for 2015/2016.

Patient experience indicators for 2016/2017 include:

- Complaints
- Friends and Family Test – inpatients; accident and emergency and maternity services.
- Develop and monitor 'always events', i.e. what we must always do for patients to ensure a quality experience.
- Continue to monitor mixed sex occurrences
- Review our In-patient Survey

The Trust participates in all relevant national surveys. The planned Friends & Family Test which began in 2014 (section 3.4.6) and the staff survey results (section 3.4.4) 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.whh.nhs.uk/page.asp?fldArea=1&fldMenu=5&fldSubMenu=2&fldKey=178

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

3.4.1. Eliminating Mixed Sex Accommodation

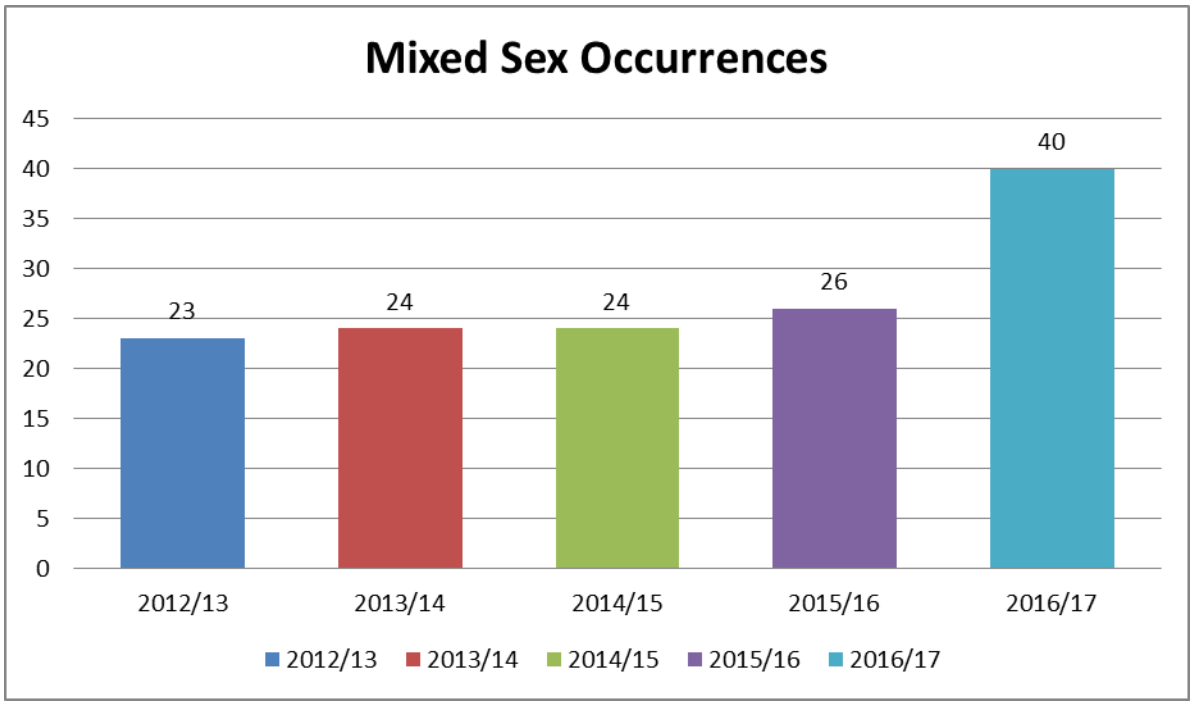
All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/3. The Trust measures, in line with nationally prescribed guidance any occurrence 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 2011/2012 when the Trust had 41 breaches. However in subsequent years the Trust has been unable to achieve the threshold set at zero. To date there have been 40 mixed sex occurrence breaches in 2016/2017.

A review has been conducted by Corporate Nursing to address the rising number of mixed sex occurrences. Improvements have been made to the escalation process once a mixed sex occurrence

has been identified, so that it is escalated to the relevant management team, in order to prevent a breach from occurring. Further work is also being conducted to reduce the number of delayed discharges which also impact on the number of mixed sex occurrences and we aim to see a reduction in the number of breaches at the end of 2017/18.

Please see graph below for the five year comparison.



3.4.2. Always Events

In addition to the agreed improvement priorities, the Trust Board of Directors, 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 held a number of focus groups, including a local healthcare event "Get Engaged" with patients; staff and governors, to agree a small number of always events, which we developed, piloted and monitored throughout 2014/2015.

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. We then used the first six months of 2014/2015 to plan implementation and ensure that there was an audit trail inherent in the system. We began monitoring the Always Events in October 2014 via the Dawes Ward Assessment process and reported them as a quality indicator in the Quality Dashboard through to board.

The Always Events are:

- **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.**

The pilot results were very positive and the Trust continued to monitor the always events as a quality indicator for 2016/2017 as follows:-

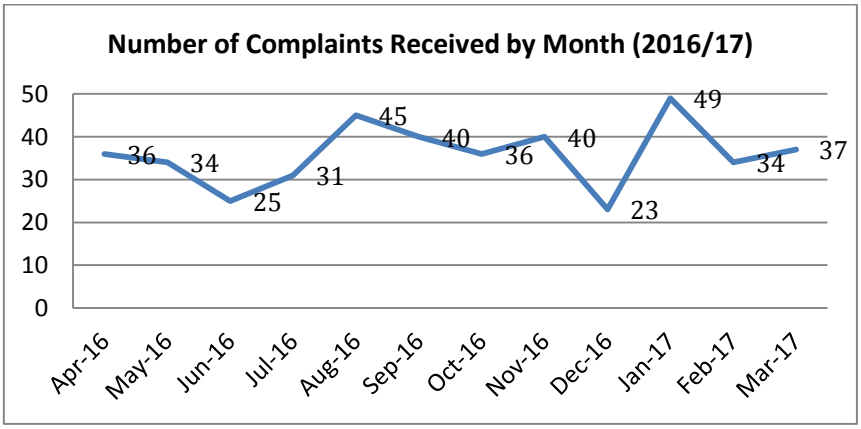
	A	M	J	J	A	S	O	N	D	J	F	M
2015/2016	89%	90%	92%	96%	96%	88%	94%	96%	96%	97%	87%	97%
2016/2107	97%	95%	97%	N/A	N/A	95%	97.35%	93%	94%	98%		

3.4.3 Complaints

In accordance with the *NHS Complaints Regulations* (2009), the Complaints Report(s) annual and quarterly set out a detailed analysis of the nature and number of formal complaints. Following the organisational restructuring of the Trust, the expectations of the CBUs relating to complaints are detailed with the recently updated Complaints and Concerns Policy.

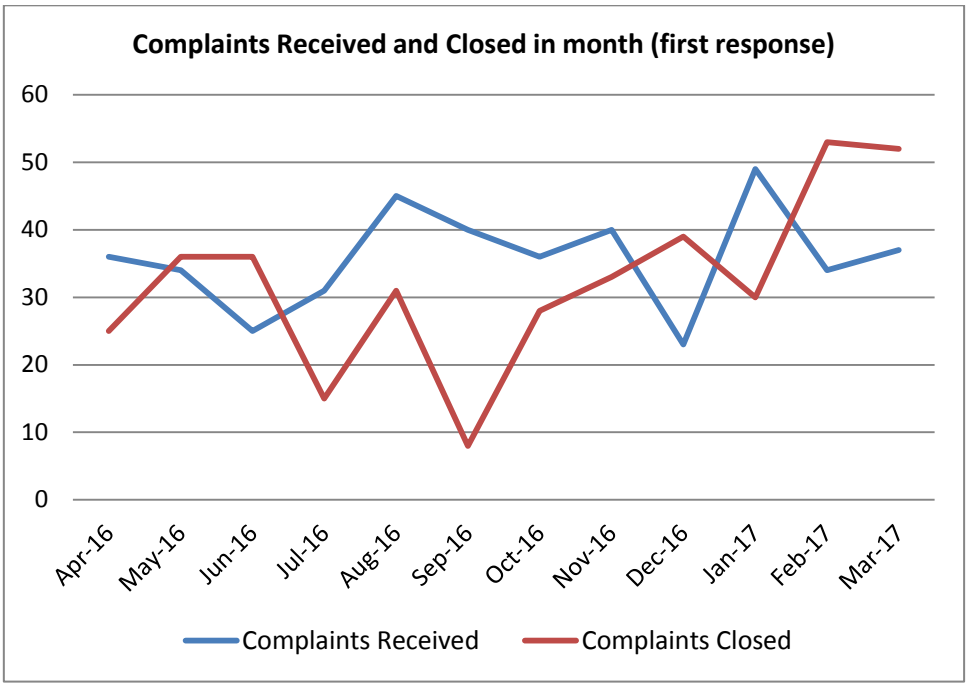
The Trust sees complaints as an opportunity to reflect on the experience of our patients and learn from their experience, making amendments to services as appropriate to ensure we improve patient care and the quality of the services the Trust provides.

The Trust received a total of 430 formal complaints from 1 April 2016 – 31 March 2017. This represents an increase of 6.7**%** compared to the previous year when 403 formal complaints were received. Of the 430 complaints received they were triaged as follows; Low Harm 155, Moderate Harm 240 and High Harm 35.



In the last financial year, from the total of 239 closed complaints, a total of 22 complainants were unhappy at the outcome of the investigation. That represents a figure of 9.3%, a decrease of 0.6% in comparison to the figures from 2015/16.

Of the 430 complaints received between 1 April 2016 and 31 March 2017 we closed 386 complaints during the same time period. The table below highlights the number of complaints received and closed by month.



3.4.3.1 Lessons Learned

Below are examples of closed complaints and actions taken by the divisions who are responsible for implementing and monitoring lessons learned. Each division has specific systems in place to feedback learning from complaints, firstly during/after the investigations and then through divisional groups, e.g. Divisional Integrated Governance Groups (DIGG, senior nurse/ward manager meetings.

- Access to BSL interpreters - as soon as it is identified that a patient may require a BSL interpreter this is recorded on Lorenzo and therefore when an outpatient appointment is booked this triggers a request to book an appropriate interpreter. This also highlights, should a patient attend A&E, and allows for interpreter services to be accessed quickly.
- Long admission process from A&E - comfort rounds in A&E have been introduced and the Lead Nurse, Clinical Director and CBU Manager are working with Trust Transformation Team to ensure a more efficient admission process for patients.
- Template Letters – the Endoscopy team are reviewing all template letters following concerns raised into lack of information about cancellation and re-scheduled procedures.
- Patient Transfers – the Ward has implemented a transfer book which documents where patients have been transferred to and whether next of kin have been informed to ensure that families are kept fully informed of a patient's location.
- As required medication – the Ward no longer locks inhalers in the patient's locker. These are left within easy reach of the patient.

3.4.3.2 Parliamentary and Health Service Ombudsman (PHSO)

The PHSO is a free and independent service, set up by Parliament. Their role is to investigate complaints were individuals feel they have been unfairly treated or have received poor service from government departments; other public organisations and the NHS in England. The PHSO make the final decisions on complaints about these public services for individuals.

Complainants dissatisfied with the Trust's response have the right to ask the Parliamentary Health Service Ombudsman (PHSO) to consider their complaint. However, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

The PHSO will consider the complaint file, medical records and any other relevant information as necessary. The PHSO may decide not to investigate further and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and / or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

The table below details the PHSO and Hospital and Community Health Services Complaints Collection (KO41a) data for local Trusts for the year 2015/16 (published September 2016). An appropriate comparison is the rate of conversion for complaints to PHSO enquiries which runs at 12.4%. This is in line with other local trusts except Countess of Chester, which currently runs at a conversion of 8.9%.

Trust	Complaints Received by the PHSO 2015/16	Complaints Accepted for investigation by the PHSO 2015/16	Fully or Partially Upheld 2015/16	Not upheld 2016/16	Total Complaints Reported (KO41) 2015/16	% of complaints converting to PHSO Enquiries
Warrington & Halton Hospital NHS Foundation Trust	56	16	7	6	421	12.4%
St Helens and Knowsley Teaching Hospitals NHS Trust	34	7	5	5	276	12.3%
Wirral University Teaching Hospital	53	10	5	11	416	12.7%
Wrighton, Wigan and Leigh NHS Foundation Trust	40	14	5	5	365	10.9%
Countess of Chester Hospital NHS Foundation Trust	22	10	3	6	245	8.9%

*https://www.ombudsman.org.uk/organisations-we-investigate/what-our-data-tells-us/quarterly-reports-complaints-about-nhs-organisations & http://content.digital.nhs.uk/catalogue/PUB21533

The formal information relating to cases from 2016/17 is due to be published in September 2017. The table below details the progress of cases over the year within the Trust.

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
PHSO cases received	3	3	3	1	1	1	0	1	2	1	0	0
PHSO cases closed	0	1	0	2	2	1	4	3	2	4	1	1
Ongoing PHSO Cases	15	17	20	19	18	18	14	12	12	9	8	7

Of the 21 cases closed by the PHSO in 2016/17 the outcomes were as follows;

10 cases were partially upheld

9 cases were not upheld

2 cases were upheld

3.4.4 National Survey Results 2016

3.4.4.1 National Inpatient Survey 2016 (published but under embargo until 8th June)

Listening to patients' views is essential to providing a patient-centred health service. The annual National Inpatient Survey is a Care Quality Commission (CQC) requirement with the aim of obtaining feedback to improve local services for the benefit of the patients and the public. Survey results are reported to the CQC, who use the information as part of the Hospital Intelligent Monitoring. Patients are eligible for the survey if they are aged over 16 years or older, and have spent at least one night in hospital, and were not admitted to maternity or psychiatric units.

The 2016 Inpatient survey was undertaken by Quality Health, on behalf of the Trust and covers all aspects of patient's admission, care and treatment, operations and procedures and discharge from hospital from the inpatient specialties of General Surgery; Urology; Trauma and Orthopaedics, Cardiology, Acute Internal Medicine, Stroke and Respiratory Medicine. The initial results of the Inpatient Survey (2016) were received in March 2017. 1193 patients were randomly selected during an inpatient stay in July 2015 and 40% responded compared to a response rate of 44% last year. 50% of respondents were over the age of 65 and 44% were male and 56% female.

The NHS in patient survey provides the Trust with intelligence around the overall patient experience and it is vital that we review and act upon this information to address poor performance.

The Picker Institute coordinates all the national results on behalf of the CQC, who publish reports which include benchmarks against best and worst performance. Seventy-six questions are asked and categorized into twelve domains as follows:

- Admission to hospital
- A&E Department
- Waiting List and Planned Admission
- All types of Admission
- The Hospital and Ward
- Doctors
- Nurses
- Your Care and Treatment
- Operations and Procedures
- Leaving Hospital
- Overall views on care and Services
- About you

The following are the main headlines for 2016 benchmarked against 2015 results:

The Trust has deteriorated by 5% or more on the following questions: Higher is better		
	2015	**2016**
All types of Admissions		
Patients did not have to wait a long time to get a bed on a ward	76%	64.9% ↓
The Hospital & Ward		
Patients got enough help from staff to eat their meals	77%	65.7% ↓
Nurses		
Patient felt that there were enough nurses on duty	75%	68.2% ↓
Your Care and Treatment		
Hospital staff worked well together	90%	84.8% ↓
Hospital staff did not give contradictory information	86%	80.9% ↓
Patients were able to find somebody to talk to about their worries and fears	58%	52.7% ↓
Patients thought that staff did everything to control their pain	84%	78.9% ↓
Length of time to get help after using the call button	65%	59% ↓
Leaving hospital		
Patients were given enough notice about their discharge	74%	67.1% ↓
Discharge not delayed due to wait for medicines/ to see a Dr/ for ambulance	66%	59.8% ↓
Discharge delayed for no longer than four hours	78%	72.9% ↓
Staff explained the purpose of medication in an understandable way	85%	78.7% ↓
Staff explained about the medication side effects to be aware of	54%	44.7% ↓
Patients were told in an understandable way how to take their medication	85%	78.9% ↓

Patients were told about what danger signals to watch for after their return	60%	54.8% ↓
Hospital staff took the home situation into account when planning discharge	75%	69.1% ↓
Patients were told who to contact if they were worried about their condition after they had left hospital	81%	72.2% ↓
Overall		
Patients received information on how to complain to the hospital about the care they received	29%	22% ↓

The Trust performed significantly better than the national average in the top 20% of Trusts in relation to "Before leaving hospital patients were given written information on what they should or should not do after leaving". The Trust's performance on a further thirty-two questions are within the lowest 20% nationally, equating to 42% of responses. These results require focus and attention to surpass the current average scores. Issues around care and treatment and matters relating to leaving hospital and discharge appear to be highlighted.

The Trust showed some improvement on 5 questions. The Trust has deteriorated by 5% or more on 18 questions equating to 23% and is in lowest 20% national threshold for a further 32 questions or 42% of responses

The main themes to focus on are leaving "hospital and discharge" and "hospital care and treatment".

The new WHH Patient Experience Strategy will align work streams to address the highlighted themes within the In Patient Survey and will provide a biannual update to the Quality Committee via the Patient Experience Sub Committee.

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 for 2016/2017 the Trust was rated 3 stars by 19 respondents.

A review of Patient Opinion indicates that 15 people would recommend this service and 11 people would not recommend this service.

Cleanliness		**19 ratings**
Environment		**24 ratings**
Information		**23 ratings**
Involved		**42 ratings**
Listening		**24 ratings**
Medical		**19 ratings**
Nursing		**17 ratings**
Parking		**19 ratings**
Respect		**42 ratings**
Timeliness		**42 ratings**

The Trust is committed to acknowledging all comments and if the service user expresses concerns we will try to address them in our response or encourage the reviewer to contact the PALS Team for further discussions.

3.4.6 Friends and Family

The NHS Friends and Family Test is an opportunity for patients to leave feedback on their care and treatment they received at Warrington and Halton NHS Foundation Trust. The feedback will be used to review our services from the patient perspective and enable us to celebrate success and drive improvements in care.

When patients visit our Accident and Emergency (A&E) Department for treatment, or are admitted to hospital, they are asked to complete a short postcard questionnaire when they are discharged. They basically tell us how likely they are to recommend the ward/ A&E department to friends and family if they needed similar care or treatment. The patient's response is anonymous and they will be able to post the card into the confidential box on their way out of the ward or A&E. The boxes are emptied regularly to process the information and provide reports to the ward manager and matron.

If a patient is unable to answer the question, a friend or family member is welcome to respond on their behalf. Users are also asked to rate their responses and this is translated into 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 up to July 2014 is the Net Promoter score up to a maximum of 100. The Trust is currently procuring a new FFT contract in order to improve the process and increase the response rate e.g. text services and we are in the process of meeting with meeting several companies who provide this service.

The results for 2014/2017 are as follows:

Friends and Family scores 2013/16

	Star Rating 2014/15	Star Rating 2015/16	Star Rating 2016/17	Inpatient 2014/15	Inpatient 2015/16	Inpatient 2016/17	A&E 2014/15	A&E 2015/16	A&E 2016/17
Apr	4.54	4.61	4.73	76	97	96	42	83	90
May	4.5	4.66	4.77	74	98	95	35	86	90
Jun	4.58	4.70	4.75	81	98	96	41	88	92
Jul	4.53	4.66	4.78	76	98	98	40	87	96
Aug	4.6	4.65	4.73	77	96	94	80	90	92
Sept	4.59	4.72	4.79	94	97	96	82	85	93
Oct	4.6	4.71	4.78	95	96	95	85	86	93
Nov	4.6	4.70	4.76	97	96	94	87	85	94
Dec	4.59	4.73	4.77	96	96	93	84	82	96
Jan	4.59	4.72	4.81	96	94	95	87	76	94
Feb	4.55	4.67		97	95	94	84	81	94
Mar	4.61	4.69		96	96	*	83	84	*

***Awaiting publication on NHS England website and requested from STC**

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

3.4.6.1 Friends and Family – Maternity Services

This CQUIN also required that Friends and Family was rolled out to maternity services. The rollout to maternity services was successfully achieved within the required timescales. It was agreed to maintain this as a patient experience indicator for 2016/2017.

F&F question is asked at four stages along the maternity pathway and the following table indicates the Trust performs well in relation to the national average:-

	TRUST ANTENATAL CARE	ENGLAND ANTENATAL CARE	TRUST BIRTH	ENGLAND BIRTH	TRUST POSTNATAL	ENGLAND POSTNATAL	TRUST POSTNATAL COMMUNITY	ENGLAND POSTNATAL COMMUNITY
MARCH 2017								
FEBRUARY 2017								
JANUARY 2017	93	96	100	97	83	94	NA	98
DECEMBER 2016	82	96	98	96	93	94	NA	98
NOVEMBER 2016	98	96	97	97	94	94	100	97
OCTOBER 2016	95	95	94	96	94	94	100	98
SEPTEMBER 2016	100	96	90	96	98	94	100	98
AUGUST 2016	100	95	98	96	91	93	100	97
JULY2016	96	95	98	97	100	93	100	98
JUNE 2016	98	95	94	97	94	94	100	98
MAY 2016	97	96	91	97	98	94	100	98
APRIL 2016	95	96	98	96	94	94	NA	97
MARCH 2016	NA	95	94	96	100	94	NA	98

FEBRUARY 2016	94	95	90	96	95	94	NA	98
JANUARY 2016	NA	96	87	97	95	94	NA	98
DECEMBER 2015	100	95	NA	97	NA	94	100	98
NOVEMBER 2015	91	96	88	96	96	94	NA	98
OCTOBER 2015	97	95	78	96	94	94	100	98
SEPTEMBER 2015	97	95	95	97	95	93	100	98
AUGUST 2015	96	95	95	97	100	94	100	98
JULY 2015	98	94.6	98	96.8	93	94.2	100	97.5
JUNE 2015	96	95.9	98	96.9	98	93.4	100	97.7
MAY 2015	98	95.9	96	97	100	93.3	100	97.8
APRIL 2015	98	95.3	100	97.2	98	93.7	100	97.7

3.5 Royal College of Midwives National Award – Midwifery Service of the Year

Warrington and Halton Hospitals NHS FT was named 'Midwifery Service of the Year' in the Royal College of Midwives' national awards held in London in March 2017. There was firm competition from Barking, Havering and Redbridge University Hospitals, Lancashire Teaching Hospitals and NHS Highland in this category, which was sponsored by Kellogg's All-Bran. Earlier in the year the service reached the finals of the national HSJ Awards in the Patient Safety category.

'Learning from When Things Go Wrong' told of the difficult, often emotional, journey to rebuild the service and restore the confidence of women and their families as well as its workforce over the past two years. The team developed the ***YOUR PREGNANCY, YOUR BIRTH, YOUR CHOICE*** campaign which became the driver for change, using a bottom-up approach and working closely with patients and former patients to achieve a best-in-class service. The final part of the recovery journey saw the new Midwifery Led Unit open in May 2016 - a real platform for the future of midwifery and childbirth at the Trust.

3.6 Duty of Candour

Last year the Trust reported that the Investigating Panel, as part of each Serious Incident investigation, check that Duty of Candour has been followed. The Trust also developed staff and patient information leaflets, located on the Trust internet, to inform people about the process. Duty of Candour also formed part of Medical Mandatory Training in 2013 to 2015. In the previous Quality Account, we reported that the Trust has not at the time of this report ever had any issues brought to its attention where Duty of Candour has not been undertaken as required. However in February 2017, an audit of Duty of Candour was undertaken, and the Trust could not demonstrate a central monitoring system for Duty of Candour and that the Trust was routinely complying with the requirement of notification by letter within 10 days of becoming aware that a patient had been moderately or severely harmed.

The clinical governance team have undertaken a substantial review of Duty of Candour and actions and processes have now been applied to ensure the Trust complies with Duty of Candour requirements and evidences this appropriately going forward, including now having a central mechanism for monitoring via the Datix system.

The role of Family Liaison Officer is being developed in the Trust, to have highly trained individuals supporting patients and/or families when a Serious Incident occurs.

3.7 Sign up to Safety

Sign up to Safety is a national patient safety campaign that was announced in March 2014 by the Secretary of State for Health. It launched on 24 June 2014 with the mission to strengthen patient safety in the NHS, and make it the safest healthcare system in the world.
The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. This is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.
We agreed to 3 central commitments when we signed up to safety namely:-

- To describe the actions we will undertake in response to the five Sign up to Safety pledges and agree to publish this on our website for staff, patients and the public to see.
- Turn our proposed actions into a Safety Improvement Plan which will show how the Trust intends to save lives and reduce harm for patients over the next 3 years.
- Identify within our Safety Improvement Plan the safety improvement areas that we will focus on.

Our Trust agreed to focus upon three key areas namely;

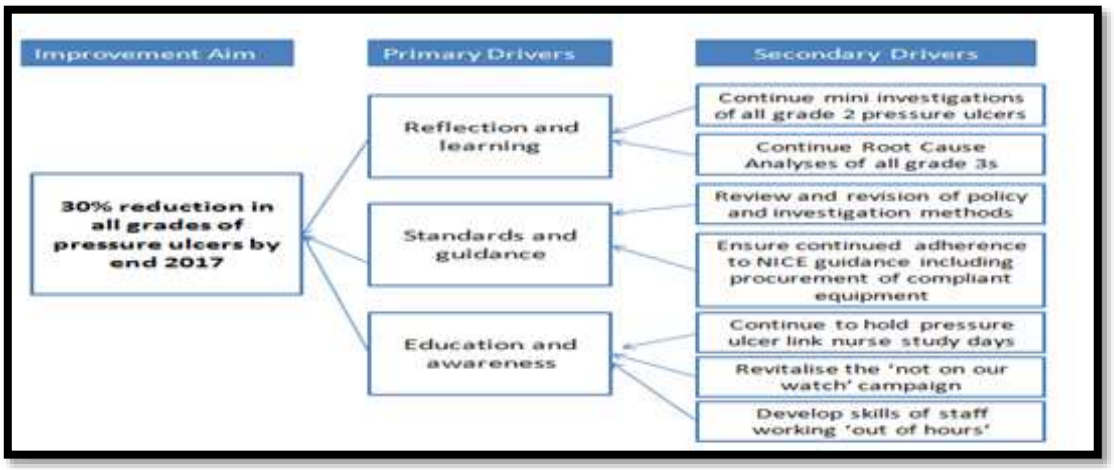
- Reducing avoidable mortality
- 30% reduction in moderate falls
- 30% reduction in all grades of pressure ulcers by 2017.

3.7.1 Sign up to Safety – Pressure Ulcer reduction

Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. Sign up

to Safety's three year objective is to reduce avoidable harm by 50% and save 6,000 lives across the NHS.

The driver document articulates the Trust's strategy for a 30% reduction in all grades of pressure ulcers by 2017. The Trust is pleased to report that it has met this sign up to safety objective for pressure ulcers by the end of year one with a 39.83% reduction in all pressure ulcers.



3.7.2 Sign up to Safety – reducing mortality

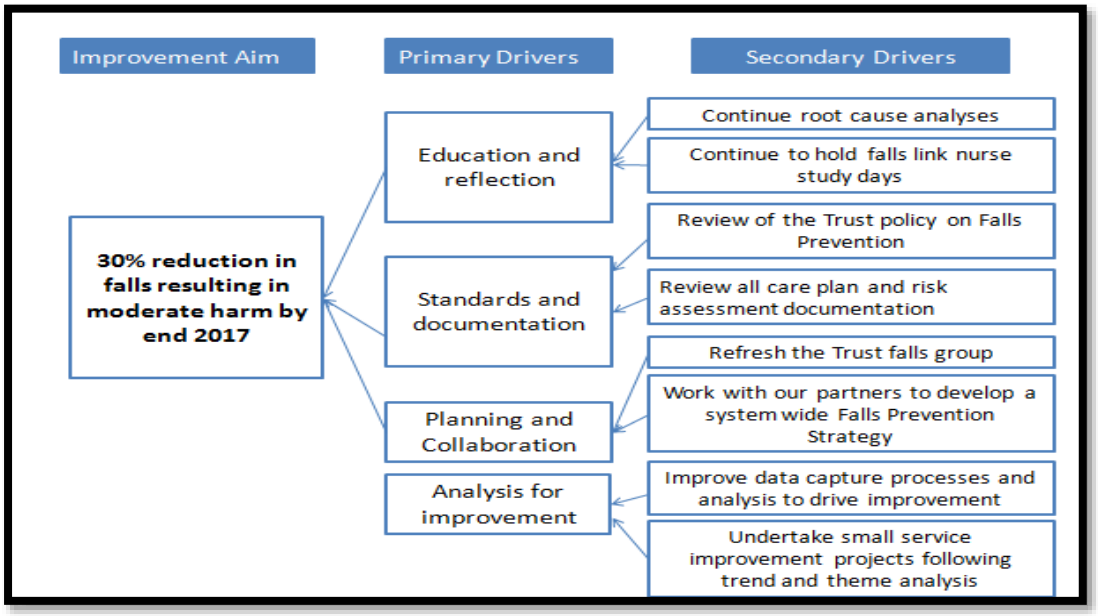
Reducing avoidable mortality (Mortality Review) was identified as a 'Sign up to Safety' (SU2S) priority when the Trust signed up to this three year initiative in 2014/15. Our aim for phase 1 (end of quarter 1 2015/16) was to identify areas for improvement. Whilst we were conducting mortality review at that time and identifying minor aspects of care which could be improved, we were not in a position, by quarter 1 2015/16 to use the findings to drive large improvement projects. Since SU2S was launched, the Trust has undergone significant change, some of which has inadvertently delayed our achievement of this aim, but all of which has underpinned the implementation of a robust system of mortality review. Key developments include:

- A new Medical Director with a change in focus, to consultants peer reviewing all deaths
- The implementation of a new electronic patient record, Lorenzo, which required a change in approach, but then enabled streamlining of the process
- The Mortality Review Group has increased medic, nursing and CCG involvement
- Valuable collaboration with our CCG partners; in the Mortality Review Group (MRG) and in reviewing patients' whole pathways of care
- New Associate Medical Director roles, in Governance (MRG chair) and Service Improvement have lent weight to the successful implementation, for example with the engagement of medics
- Development of an IT system to support mortality review, now into phase two of development
- Integration of corporate and specialty mortality review systems

Further information in relation to reducing mortality can be seen in section 2.3.1 of this report.

3.7.3 Sign up to Safety – reduction of moderate falls

During 2014/2015 the Trust has also identified falls as a Sign up to Safety goal. The driver document articulates the Trust's strategy for a 30% reduction in moderate falls by 2017.



The Trust did agree a 10% reduction in falls where moderate harm occurs by March 2015 for stage one of Sign up to Safety but as with the improvement priority we have failed to reach this threshold. As such we concentrated efforts to reduce moderate falls during 2015/2016 and set a reduction threshold of an additional 10% moderate falls of <=12 by March 2016 (overall 20% reduction for 2014/2016). For this year we can report that there have been 9 moderate falls approved compared to 15 moderate falls in 2013/2014 which constitutes a 40% reduction and as such the Trust has achieved this sign up to safety indicator of a 30% reduction by 2017.

3.8 Staff Survey Indicators

The most recent NHS Staff Survey results for indicators KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that Trust provides equal opportunities for career progression or promotion) are as follows;

In relation to the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (KF26) the Trust score was 23% a slight but not statistically significant deterioration and is still better than the acute Trust average. The indicator for the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (KF21) was 91% above the national average for acute Trusts and puts the Trust's results were in the top 20% of all acute Trusts.

3.9 Speak out Safely

Warrington and Halton Hospitals NHS Foundation Trust supports the national Speak Out Safely campaign. This means we encourage any staff member who has a genuine patient safety concern to raise this within the organisation at the earliest opportunity.

Patient safety is our prime concern and our 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.

We promise that where staff identify a genuine patient safety concern, we shall not treat them with prejudice and they will not suffer any detriment to their career. Instead, we will support them, fully investigate and, if appropriate, act on their concern. We will also give them feedback about how we have responded to the issue they have raised, as soon as possible.

We are passionate about creating an open and listening culture where patient and staff views contribute to the running of the organisation. We now have a Freedom to Speak up Guardian, Jane Hurst, who will help support the Trust to become a more open, transparent place to work by listening to staff and supporting them to raise concerns.

3.10 Performance against key national priorities

(Please see table below)

Performance against the relevant indicators and performance thresholds set out in Appendix A of Monitor's risk assessment framework'. Where any of these indicators have already been reported on in Part 2 of the quality report, in accordance with the Quality Accounts Regulations, they do not need to be repeated here.

Mar-17

Monitor Access Targets & Outcomes - 2016/17

Warrington and Halton Hospitals NHS
NHS Foundation Trust

All targets are QUARTERLY

Target or Indicator		Threshold	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Referral to treatment waiting time	Admitted patients	90%	N/A	84.65%	83.99%	81.46%		83.61%	84.29%	81.74%		79.32%	81.26%	81.48%		75.57%	80.22%	78.51%	
	Non-admitted patients	95%	N/A	95.00%	94.68%	94.11%		93.78%	93.68%	94.02%		93.59%	94.24%	95.00%		94.29%	93.35%	92.82%	
	Incomplete Pathways	92%	1.0	92.37%	93.00%	92.90%		93.04%	94.16%	93.50%		93.56%	93.54%	92.82%		93.30%	92.34%	93.01%	
A&E Clinical Quality	A&E Maximum waiting time of 4 hrs from arrival to admission/transfer/discharge	>=95%	1.0	90.45%	92.29%	93.52%	92.12%	92.69%	92.88%	94.75%	93.43%	92.05%	91.59%	85.13%	89.61%	85.85%	84.49%	90.74%	87.16%
All Cancers:62-day wait for First treatment	From urgent GP referral - **post** local breach re-allocation (CCG)	85%	1.0 (Failure for either = failure against the overall target)	85.88%	85.54%	90.70%	87.40%	85.92%	86.08%	85.71%	85.91%	86.15%	90.32%	79.10%	85.05%	85.19%	62.96%	76.67%	73.78%
	From NHS Cancer Screening Service referral - **post** local breach re-allocation	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%
	From urgent GP referral - **pre** local breach re-allocation (Open Exeter - Monitor)	85%		86.42%	87.34%	92.86%	88.93%	86.11%	85.33%	85.71%	85.71%	86.15%	90.32%	79.10%	85.05%	81.67%	75.29%	74.44%	76.60%
	From NHS Cancer Screening Service referral - **pre** local breach re-allocation	90%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
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%			87.50%	87.50%	100.00%	100.00%	92.31%	96.15%
	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%
	Radiotherapy (not performed at this Trust)	>94%																	

All Cancers: 31-Day Wait From Diagnosis To First Treatment		>96%	1.0	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.30%	93.18%	95.79%	96.23%	95.24%	97.14%	96.24%
Cancer: Two Week Wait From Referral To Date First Seen	Urgent Referrals (Cancer Suspected)	>93%	1.0 (Failure for either = failure against the overall target)	93.46%	93.11%	94.78%	93.79%	93.20%	93.96%	93.49%	93.57%	93.24%	93.73%	93.58%	93.52%	87.91%	93.50%	95.25%	92.52%
	Symptomatic Breast Patients (Cancer Not Initially Suspected)	>93%		93.64%	93.33%	93.83%	93.63%	93.10%	93.55%	93.33%	93.33%	94.57%	93.90%	91.49%	93.28%	80.00%	93.26%	79.10%	84.55%
Clostridium Difficile - Hospital acquired **(CUMULATIVE)**	Due to lapses in care	27 (for the Yr)	1.0 **	1	1	1	1	2	2	2	2	2	2	5	5	7	8	11	11
	Not due to lapses in care	Cumulative Qtr1: 7 Qtr2: 14 Qtr3: 21 Qtr4: 27		0	2	3	3	5	6	6	6	6	7	8	8	10	11	13	13
	Total (including: due to lapses in care, not due to lapses in care, and cases under review)			1	3	4	4	7	8	8	8	8	9	13	13	17	19	24	24
	Under Review			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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

Target or Indicator	Target	Weighting	Apr	May	Jun	QTR-1	Jul	Aug	Sep	QTR-2	Oct	Nov	Dec	QTR-3	Jan	Feb	Mar	QTR-4
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Date of last CQC inspection	N/A		March 2017- report not received (last inspection March 2015)															
CQC compliance action outstanding (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement action within last 12 months (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		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 (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		March 2015 Inspection Report - Requires Improvement															
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission) Breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 regarding the safety of healthcare provision	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Overall rating from CQC inspection (as at time of submission)	N/A		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		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		No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A																	

Service Performance Score	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	5.0	3.0	2.0	3.0	4.0	3.0

NHS foundation trusts failing to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters, will trigger a governance concern, potentially leading to investigation and enforcement action

18 Weeks Referral to Treatment

Performance is measured on an aggregate (rather than specialty) basis and NHS foundation trusts are required to meet the threshold on a monthly basis.

Consequently, any failure in one month is considered to be a quarterly failure for the purposes of the Risk Assessment Framework.

Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process.

Failure against any threshold will score 1.0, but the overall impact will be capped at 2.0

**** Clostridium Difficile**

Monitor's annual de minimis limit for cases of C-Diff is set at 12. However, Monitor may consider scoring cases of <12 if Public Health England indicates multiple outbreaks

Monitor will assess NHS foundation trusts for breaches of the C. difficile objective against their objective at each quarter using a cumulative year-to-date trajectory.

Criteria	Will a score be applied
Where the number of cases is less than or equal to the de minimis limit	No
If a trust exceeds the de minimis limit, but remains within the in-year trajectory# for the national objective	No
If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective	Yes
If a trust exceeds its national objective above the de minimis limit	Yes

Assessed at: 25% of the annual centrally-set objective at quarter 1; 50% at quarter 2; 75% at quarter 3; and 100% at quarter 4 (all rounded to the nearest whole number, with any ending in 0.5 rounded up).

Monitor will not accept a trust's own internal phasing of their annual objective or that agreed with their commissioners.

In relation to the above A&E data, it is important to note that May 2016 and October 2016 data was incorrectly submitted for the national statistics. The percentages obtained above are locally sourced percentages. The published data for May 2016 is 92.18% and for October 2016 is 92.06%.

The above Referral to Treatment targets include non NHS commissioned pathways. The nationally published Referral to Treatment figures show that as a Trust we achieved a year end average of 93.13%. Monthly data is as follows;

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
92.38%	93.02%	92.91%	93.05%	94.17%	93.5%	93.57%	93.55%	92.81%	93.3%	92.35%	93%

3.11 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 4.7

3.12 Training & Appraisal

Training and Appraisal Completion

	Target	**Year End Results**
Mandatory Training Health & Safety Fire Safety Manual Handling	 85% 85% 85%	 94.91% 87.77% 89.90%
Additional Fire Safety and Manual Handling sessions are in place to improve these figures.		
Staff Appraisal Non-medical Medical & Dental staff Medical & Dental (excluding consultants) Consultants	 85% in last 12 months 85% 85% 85%	 86.08% 70.35% 63.29% 74.15%

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.

3.13 Quality Report request for External Assurance

Warrington and Halton NHS FT has requested the Trust auditors Grant Thornton UK LLP to undertake substantive sample testing of two mandated indicators and one local indicator (as selected by the governors) included in the quality report as follows;

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

Safer Surgery.

Annex 1 Quality Report Statements

Statements from Clinical Commissioning Groups, Healthwatch and Overview and Scrutiny Committees 2015/2016

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 843636

Please Ask For: John Wharton

E-mail: john.wharton@warringtonccg.nhs.uk

Arpley House
110 Birchwood Boulevard
Arpley House
Birchwood
Warrington
WA3 7QH

www.warringtonccg.nhs.uk

Date: 22nd May 2017

Kimberley Salmon Jamieson
Chief Nurse
Warrington & Halton Hospitals NHS Trust
Executive Offices
Kendrick Wing
Warrington Hospital
Warrington
WA5 1QG

Dear Kimberley

In accordance with the national guidance around provider Quality Accounts and on behalf of NHS Warrington Clinical Commissioning Group I hereby supply the organisation's official response.

Many thanks for submitting your quality account to us and its presentation by Hayley Mannin, Quality Assurance Lead for the organisation. Whilst the CCG is aware that you are still awaiting the outcome of a recent Care Quality Commission (CQC) review of the organisation, the group unanimously agreed that the account was focused and informative. This was viewed as an improvement over those that have previously received. The group acknowledged the cultural change in the organisation has impacted on the account providing a stronger assurance with regards to the main determinants of quality; safety, effectiveness and patient experience.

Invited representation from NHS England, local Patient Participation Groups (PPGs) and Warrington Healthwatch, along with GP Commissioners from the organisation, used the opportunity to request further assurance and detail to ensure that concerns that they had identified in the account were raised. Questions about the account included; how the organisation will assure themselves and the commissioners about their priorities for 2016/17 that were RAG rated Amber but were not included in the priorities for 2017/18? Why were these priorities not rolled forward into this year? In terms of the patient experience there were concerns raised that whilst there have been significant pieces of work to embed the patient experience, Staff Strategy Development sessions were not attended by senior clinical staff. Further observations suggested that the lack of senior staff representation appears to be having an adverse effect on staff morale. Other questions were raised regarding the management of patients with mental health problems in the Accident & Emergency (A&E) Department and the ongoing work to improve liaison psychiatry in the department was also discussed.

There are obvious areas of improvement in the account and the way it is presented and there are aspects of the account which could be further improved by the addition of more detailed information. One area that we would have welcomed greater detail is the organisation's future plans for their workforce and how the staff's Personal Development Reviews (PDRs) are being used as a basis for future planning. Are these plans linked to investment for a strong and competent workforce able to deliver high standards of care and meet the future challenges of health and social care? Whilst Hayley offered her own personal account of how she has been treated since joining the organisation, the account didn't offer a positive narrative of how the organisation is planning for the workforce needs of the future. The group also commented on the lack of information in the organisation's account regarding the roll out of plans for seven day working and the impact of this change on quality.

Finally, the group concluded that the account offers a solid foundation on which the Trust will build, particularly the work to improve processes and systems in the area of complaints and concerns, from both patients and staff. The group were also impressed with the improved relationships with the CCG. Areas highlighted were the reporting of serious incidents and the established mortality reviews. This was seen as assurance that the organisation is eager to learn from incidents and acknowledge when care has failed to meet the standards commissioned.

In conclusion, I believe that this account highlights the organisation's intent to move forward and work with partner organisations and commissioners to ensure that they deliver high standards of care for the local population but equally learn lessons when this has not been achieved. I believe that this is a true and honest account of a health care organisation on the precipice of delivering significant change.

Yours sincerely

John Wharton
Chief Nurse & Quality Lead
Warrington Clinical Commissioning Group

c.c. Hayley Mannin, Quality Assurance Lead

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

12th May 2017

Ms M Pickup
Chief Executive
Warrington and Halton Hospitals NHS
Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Dear Mel,

Quality Accounts 2016 - 2017

I am writing to express my thanks for the submission of Warrington and Halton Hospitals NHS Foundation Trust Quality Report for 2016 2017 and for the presentation given by Ursula Martin to local stakeholders on 25th April 2017. This letter provides the response from NHS Halton Clinical Commissioning Group to the Quality Report 2016-2017

NHS Halton CCG understands the pressures and challenges for the Trust and the local health economy in the last year and would like to congratulate and thank the Trust for the level of partnership working and support in this year.

NHS Halton CCG noted the Priorities and progress made in 2016 – 2017:

1. Reduction in **Pressure Ulcers** with the Trust goal to achieve
   - 5% reduction in avoidable grade 2 pressure ulcers – The Trust achieved this in reporting 36 with a threshold of 82.
   - Maintain grade 3 pressure ulcers at 2015/16 rate – The Trust marginally missed this target reporting 4 against a threshold of 3.
   - Zero incidences of grade 4 pressure ulcers - the Trust reported 1.

   It was noted that overall there has been substantial decrease of 56.6% in avoidable Pressure Ulcers across the Trust in 2016/17.

2. Compliance with the **MUST Nursing Care Indicator** in patients over the age of 75 years of age. The Trust achieved 91% against a target of 100% and further improvements will include:
   - Risk assessments are now recorded in your electronic system Lorenzo, from March 2017.
   - Changes to on-going audit to include new questions as a result from learning.

3. Learning from **Mortality Reviews** by improving screening to 100% by March 2017. The screening target was achieved. Learning from these reviews are identified and disseminated through the Trust's Mortality Review Group and speciality Mortality and Morbidity meetings. The latest reported figures for HSMR is 106.48 for the period January 2016 to December 2016 and SHMI 108.12 for the period December 2015 to November 2016 (HED system). The SHMI was in the range of 'higher than expected' until November 2015, however this is now 'as expected' for the period January 2015 – December 2015. The HSMR is 'as expected' throughout this period.

4. Implementing **Experience of Care Strategy** with a focus on developing the process for 72 hour review of high risk complaints and monitor in quarter(s) 3 and 4 for 2016/2017 and ensuring every patient has a voice. NHS Halton CCG acknowledge that the Trust have undertaken a significant amount of work in

Q4 with regard to complaints management and a system is now in place to escalate all high risk complaints to the Clinical Business Units within 72 hours.

- The high risk complaints, along with moderate and low risked complaints are reported to the Board of Directors on a weekly basis.
- All high risk complaints are discussed at the weekly Patient Experience Team meeting and more recently an option of 72 hour review has been added into the notify box within the Datix system.

In terms of patient experience one area stakeholders highlighted was with regard to the National Survey 2016 and the Trust's performance, in that thirty-two questions are within the lowest 20% nationally, equating to 42% of responses. Issues around care and treatment and matters relating to leaving hospital and discharge appear to be highlighted. The Trust has deteriorated by 5% or more on 18 questions equating to 23% and is in lowest 20% national threshold for a further 32 questions or 42% of responses. The main themes are "leaving hospital and discharge" and "hospital care and treatment". It was noted that supporting safe and proactive discharge is a priority for 2017/2018.

5. **Patient Safety and Effectiveness** Indicators:
   - Medicines Management - 97% of patients were free from medicine related harm.
   - Health Care Acquired Infections (HCAI) - 2016/2017 the Trust reported zero cases of MRSA bacteraemia and that the Trust should be commended in having a period of 17 months free of MRSA bacteraemia. To date in 2016/2017 there have been 19 cases of Clostridium Difficile against a threshold of 27 and 8 cases are deemed not to be due to a lapse in care.
   - WHO Checklist (ORMIS) the Trust reported full compliance in 2016/2017 with the exception of August when there was one case of non-compliance, which related to a maternity procedure. Audit has shown improvements in compliance with the WHO Checklist in the maternity theatres and is reported via the theatre governance meetings which report into the CBU Governance meeting

NHS Halton CCG noted the Trusts Improvement Priorities for 2017 – 2018:

Priority 1 – The Trust will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks. Focussing on Safer surgery, Falls and Sepsis management.
Priority 2 – The Trust will improve outcomes based on evidence and deliver care in the right place, first time, every time. Focussing on supporting proactive and safe discharge, Mortality and Lessons learned.
Priority 3 – The Trust will focus on the patient and their experience adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for. Focussing on patient experience, mental health and A&E.

NHS Halton CCG recognises the challenges for providers in the coming year but we look forward to working with the Trust during 2017-2018 to deliver continued improvement in service quality, safety and patient experience and also on the partnership work as we move forward with our One Halton model of service delivery

NHS Halton CCG would like to congratulate the trust on the hard work of its staff and their commitment to the care of the people of Halton thanking local staff and managers for their on-going commitment locally and for the opportunity to comment on the draft Quality Account for 2016/2017.

Yours sincerely,

Michelle Creed

Michelle Creed
Chief Nurse

2

4.3 Statement from the Halton Health Policy Performance Board

HALTON BOROUGH COUNCIL

Ms M Pickup
Chief Executive
Warrington and Halton Hospitals NHS
Foundation Trust
Lovely Lane
Warrington
WA5 1QG

Our Ref	EST
If you telephone please ask for	Emma Sutton-Thompson
Your ref	
Date	12th May 2017
E-mail address	Emma.Sutton-Thompson @halton.gov.uk

Dear Ms Pickup

Quality Accounts 2016 - 2017

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held on 26th April that your colleague Ursula Martin attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

During the year 2016/17 the Board were pleased to note that the Trust made progress against the following priorities;

- Pressure Ulcer Reduction - to achieve 5% reduction in avoidable grade 2 ulcers no increase of grade 3 pressure ulcers and no incidence of grade 4 pressure ulcers. The Board were pleased to note the Trust had achieved the target of reducing grade 2 ulcers by 2% and were interested to hear about the measures being put in place regarding the difficulties in meeting targets regarding grade 3 and 4 pressure ulcers.
- MUST Nursing Care Indicator – to establish systems for data collection and monitor inpatients ≥75 years to ensure no more than 10% weight loss. The Board noted that there had been problems in collecting data and increasing nutritional assessments to which a plan was underway to embed into practice and collect information electronically via Lorenzo.
- Mortality Review – to improve screening compliance to 100% by March 2017. The Board were pleased to note the Trust achieved this priority.
- Patient Experience – a system is now in place to escalate all high risk complaints within 72 hours. The Board noted that the Trust would continue into 2017/18 with a focus on the backlog of complaints and resolving complaints where possible at the bedside.

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Communities Directorate
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 907 8300
www.halton.gov.uk

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HALTON BOROUGH COUNCIL

In terms of Safety Indicators the Board were pleased to note that results for 2016/17 indicated improvement to compliance with risk assessments, medicines management and that the Trust had been free from MRSA infections for 17 months.

Regarding Clinical Effectiveness, the Board were pleased to note the work the Trust has been progressing around Dementia, including supporting Carers through John's Campaign. Whilst COPD was not within target, the Board noted the indicators are improving over time.

The Board are pleased to note the following Improvement Priorities for 2017 – 2018:

- Safer Surgery – The Trust have had two never events in the last two months which has prompted a review in observation audits and procedures. Progress will be monitored via a dashboard which is presented to the Executive Board at WHHFT.
- Falls – The Trust has employed a Falls Nurse and is aiming to reduce falls resulting in moderate/catastrophic harm by 10%.
- Sepsis – In line with the National CQUIN, the Trust will work to achieve timely assessment, identification and treatment of Sepsis within emergency departments and acute inpatient settings.
- Supporting Proactive and Safe Discharge – Linked to a National CQUIN to ensure reduction of delayed transfers of care and admission avoidance.
- Mortality – Following on from a report by CQC which highlighted that opportunities for improvement should be prioritised regarding preventable deaths.
- Lessons Learnt – To ensure that best practice, key learnings and improvements is shared locally and Trust-wide via a wide variety of communication methods.
- Patient Experience for those patients with MH needs attending A&E – The Board were very interested to hear about the Trust's plans to reduce the number of people with MH needs attending A&E. The Trust are developing and strengthening existing and new services to offer safe and more therapeutic alternatives to A&E.

The Board would like to thank Warrington and Halton Hospitals NHS Foundation Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Councillor Joan Lowe
Chair, Health Policy and Performance Board

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4.4 Statement from Warrington Healthwatch

healthwatch Warrington

Healthwatch Warrington
The Gateway
89 Sankey Street
Warrington
WA1 1SR
Tel 01925 246892

contact@healthwatchwarrington.co.uk
www.healthwatchwarrington.co.uk

17th May 2017

Dear Hayley,

Re: Healthwatch Watch Warrington's Response to Warrington and Halton Hospitals NHS Foundation Trust (WHHFT) Draft Quality Account Document 2016 - 2017 (May 2017)

Healthwatch Warrington is pleased to have the opportunity to review WHHFT's 2016 - 2017 Quality Account and reflect on the information given within the document.

As a consumer champion for health and social care, we recognise the fundamental impact that values and a person-centred approach have in shaping the quality and safety of service delivery, as well as patient experience. Though the WHHFT QA comprises a vast array of medical data and evidence, the document and narrative feel very clinical. It is unfortunate that the WHHFT QA does not centre from the beginning on a person-centred focus e.g. using the Trust's values/mission statements. We often find that this values-based approach sets a tone for a QA, and indeed a services approach, and is well received by the public.

As Healthwatch Warrington, it must be said that most of the feedback that we receive through our online public feedback centre (www.healthwatchwarrington.co.uk) is largely positive. Our feedback centre allows reviewers to rate health and social care services accessed by Warrington residents out of 5 stars (1 being the lowest, 5 being the highest rating). The feedback centre also allows comments and responses by providers, to have their say and respond directly to reviewers (who can choose to leave feedback anonymously).

Overall, the Hospital Trust is rated positively, with a rating of 4/5 stars from 136 reviews over the 2016/17 period. Quality of care, in particular treatment explanation and staff attitude are positive aspects of patient experience, with a rating of 4.5/5 stars each. Waiting times and quality of food are, however, less well rated with just 3.5/5 stars. These ratings indicate that though there are positive areas experienced in care at the Trust, there are aspects of patient access and services received to improve upon. Capacity of staff continues to be an access issue for the Trust, within our feedback. Overall feedback, as captured by our feedback centre, indicates that quality of care is very high at WHHFT, with 91% positive feedback. Staff attitude is also rated very highly, with over 90% positive experiences recounted to Healthwatch. Access to services, however, is weighted equally - 46% reviewing waiting times refer to them as negative, while 46% rate them as positive.

Healthwatch Warrington
Charitable Incorporated Organisation
Registered Charity Number 1172704

The report clearly states the four key priorities of the Trust during 15/16; Pressure ulcer reductions, must Nursing Indicator, Mortality Review and Patient Voice. Given that the QA reports a 56.8% reduction in Grade 2 Pressure Ulcers, it is still concerning that around 21% of Grade 2 Pressure Ulcers reported were avoidable - the role of a Tissue Viability Nurse Specialist is to be commended, as there is evidently further work to be done around this. The QA reports a 5% reduction in Grade 2 Pressure Ulcers, which is a positive step - the development of Grade 3 and Grade 4 pressure sores however, is concerning. As the QAs across the region have shown, pressure ulcers continue to be an area for improvement for most acute trusts - perhaps there is learning to be done from those Trusts who are actively succeeding in addressing this.

Again, given the ever growing pressure of an ageing population and rising complex needs, the Trust's work to mitigate risk of falls and harm by addressing and monitoring body weight for those patients 75yrs plus using the MUST Nursing Care Indicator is a step in the right direction. The Trust's work on the Mortality Review and the achievements measured so far show a commitment to improve learning from patient deaths. Progressing screening of 100% of patient deaths from 2% in Q2 to 77% in Q4 shows an aim to address and learn from incidents. The Trust's work to review the Death certification processes and improve accuracy of Death certification recording is important for the Trust itself, as well as families and carers, given that delays in this process or inaccuracies can cause significant distress and anxiety as seen during some of our advocacy work. An aim to learn and improve the quality of the process as a result of this work is needed.

End of Life Care, DNACPRs and documentation is noted as requiring review, to explore where palliative care could have been started earlier - as a Healthwatch, we are aware of this need through our Advocacy support work. We are also aware that there is a need for clearer End of Life pathways within the Trust, as well as a review for process, information and communication about patient's/families' preference of setting e.g. moves to transfer patients home or to other care settings (hospice) at palliative stage. This need has also been highlighted by the local Hospice (St Rocco's) - work is being undertaken to develop better links and communication with GPs and other services so those in need are better able to access palliative care support as early as possible.

The Experience of Care Strategy focussing on shared decision making ('nothing about me, without me') is admirable - to be successful, this approach must be embraced, lived and supported by all levels of the Trust, from all frontline staff, senior members and executives, to clinical staff in all departments e.g. Consultants and Specialists. Shared decision making is also a key project for Healthwatch Warrington, working in partnership with AQuA and Bridgewater Community Healthcare Trust and others, where we are working on developing and delivering training to help patients have better and more effective care conversations with professionals (the Expert in Me project).

We are pleased to see recruitment of a new Chief Nurse and Deputy Chief Nurse - we hope this is a way forward for the Trust to develop, and will establish a continuous commitment and drive to include staff and clinicians in delivery of quality care.

The QA also states that "the importance of local resolution of concerns within the ward or department is being promoted". Again, this immediate aim to localise resolutions as soon as they occur could best serve patient need and help minimise patient/family/carer distress and

concerns. These issues however, should still be recorded and monitored to identify and address trends or issues.

Healthwatch Warrington's advocacy support work for patients/families/carers with experience of the Trust has shown us that there are some consistent issues within the Trust - lack of timely intervention in care, limited consistency in policies and procedures and late cancellations of procedures. Other issues arising include follow up appointments being missed/not occurring where patients are unsure of whose responsibility it is for booking appointments in Outpatients. Patients, families and carers also shared that communications can be limited/disjointed, especially during staff changes to the rota, and that information is sometimes not always clearly communicated with GPs or other professionals, and feedback to patients is limited/late.

The Trusts' future priorities for 2017/18 are clear and concise; to reduce harm e.g. sepsis, safer surgery and falls and focus on no avoidable deaths, to focus on safe discharge, learning from incidents, to improve outcomes "care in the right place, first time, every time", and to focus on patients and their experiences 'no decision about me, without me'.

A Falls Nurse is now in post (from April 2017), which can help to direct activity and preventative work around falls. Falls prevention is a key area for most trusts and the local authority, use of schemes like coloured socks (yellow for those who are deemed high risk, red for those with no footwear) will hopefully help staff at a glance to understand patient needs while on wards. Use of falls equipment, falls blankets and greater monitoring of those at risk could help address needs as well. Learning from other good practice within acute trusts could also help inform this work e.g. falls prevention work with infrared technology sited in bathrooms/toilets at The Walton Centre, awareness raising poster campaigns on keeping patients mobile ("Let's Keep Moving") at James Paget University Trust.

The QA states that there is an aim to "increase the number of patients who, after being admitted via a non-elective route, will be discharged to their usual place of residence within 7 days of admission". Though this will lead to less extended stays in hospital and the ability for patients to recuperate at home, there is a need for supportive services e.g. home adaptations, sensory services, to have a 7 day turnaround to enable safe discharge of these patients. There will also be a need for an effective MDT approach to ensure staff, families, carers and support services are able to work together within those 7 days.

The Trust states that there is a comprehensive need to improve responsiveness to complaints, experiences and concerns. Our advocacy support work reflects this, highlighting that contact/follow up from the Trust PALS/Patient Engagement Team is limited and that resolution and complaints handling can be a drawn-out affair. We welcome the Trust's work on new policies and processes to be put in place in the forthcoming year to address this. The Trust aims to reduce complaints which are open for 6 months plus, and has set a key aspiration to reduce this to 0 by the end of the financial year. The Trust also aims to reduce those complaints with a duration between 30 days to 6 months. In terms of complaints handling/feedback, the Trust could also be more proactive at responding to feedback on the online Healthwatch Warrington Feedback Centre, which acts as a rich source of qualitative feedback from those using WHFT.

Increasing the number of staff trained in complaints handling will again help to address complaints more readily, and the Trust aims to decrease PHSO referrals. Parts of the narrative

of complaints handling/patient experience in the QA feel centrally driven - the commentary in the document at times feels NHS England-led rather than Trust driven, which lends a certain distance to those areas. These parts of the QA could be enhanced by leading with the Trust's wishes and aims to address patient needs within complaints/feedback and using NHS England's framework/evidence to underpin this.

The Patient Experience Strategy aims to focus on 4 key areas; listen, learn, lead change and put patients first. Though these aims are statistically measurable, there could be benefits to be gained by gathering and learning from qualitative data. Other Trust approaches can be built on for this benefit e.g. Clatterbridge Cancer Centre.

The Trust shows a willingness to learn and change, by developing areas in need of focus e.g. the Sepsis Six, Mortality Review process etc. The Sepsis Six pathway is particularly transferrable throughout the hospital and will ensure a clear and consistent approach to identifying and monitoring sepsis/early diagnosis. Screening in the Emergency Department has increased significantly - from 32% in Q1 to 81% in Q3. Inpatients sepsis screening has also increased significantly, from 9% to 76% in Q3. Though there is evidence of a learning culture throughout the report, there could be more done within the Trust to be patient-led in its learning and developing of services, rather than reacting to areas of concern.

As a Healthwatch, we are aware that cultivating positive staff attitudes and taking on board their ideas are essential ingredients for good care outcomes. This QA document unfortunately evidences rather low levels of staff satisfaction at the Trust. With 38% of staff returning feedback, the evidence gathered on is statistically relevant. Staff who would recommend the provider to friends or family needing care is rated at 57% (in 2016), while the average rating in an acute Trust is 70%. Again, there could be learning gleaned from those organisations with high staff satisfaction rates e.g. The Walton Centre, St Rocco's Hospice, Clatterbridge Cancer Centre.

In our experience, the presence and support offered by WIRED Carer's Centre and Halton Carer's Centre is a significant support for patients, families and carers accessing the Trust, and should be praised. With John's Campaign to be further established and built upon, even more support will be available to carers. Likewise, provision of a carer's card to help support unrestricted visiting and parking is commendable.

Dementia E-training available throughout WHHFT offers to build staff awareness to describe, identify, challenge, discuss and utilise best practice in Dementia care - with a greater than 85% uptake this approach has the potential for staff to really lead the way in Dementia awareness and treatment. Alongside this, work around Always Events will hopefully lead to further equity of care and a more positive experience for patients, families and carers throughout the Trust.

Regrettably the CQC National Inpatient Survey (2015/16) data within the QA outlines poor experiences for patients in a variety of areas, including; waiting time, enough staff on duty, staff working together, contradictory info, pain control, ability to talk about concerns/issues, delays for discharge, medications and support, medications explanations. Again, this is a reflection of the feedback received by Healthwatch Warrington.

Though improvement and quality indicators have previously been measured statistically will be measured the same way in the future, there is a limitation of qualitative data to

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accompany this. Overall, the QA is medically driven which though quantifiab.e does not lend itse.f to being easily read or interpreted intc identifiable experiences for readers/members of the public.

In thc year ahead, we look forward to supporting WHHFT's engagement strategy by encouraging wider public participation in events and sub groups and strengthening the voice of patients in other ways.

We look forward to hearing from you and being involved in future developments.

Kind regards,

Lydia Thompson
Chief Executive Officer
Healthwatch Warrington

4.5 Statement from Warrington Health and Well Being Overview and Scrutiny Committee

THIS WAS REQUESTED BUT NOT RECEIVED

4.6 Statement from the Halton Healthwatch

healthwatch Halton

Commentary on Warrington & Halton Hospitals NHS FT Quality Account 2016-17

We welcome the opportunity to provide this commentary on Warrington & Halton Hospitals NHS Foundation Trust Quality Account for 2016/17.

The Trust is to be congratulated on what is very comprehensive report which gives a good overview of the work carried out by the Trust to improve the quality of its services.

In responding to this year's Quality Account we have tried to answer the following questions:

1. Does the draft Quality Account reflect people's real experiences as told to local Healthwatch by service users and their families and carers over the past year?
2. From what people have told Healthwatch Halton, is there evidence that any of the basic things are not being done well by the provider?
3. Is it clear from the draft Quality Account that there is a learning culture within the Trust that allows people's real experiences to be captured and used to enable the provider to get better at what it does year on year?
4. Are the priorities for improvement as set out in the draft Quality Account challenging enough to drive improvement and it is clear how improvement has been measured in the past and how it will be measured in the future?

From the comments we are receiving on the Trust, and the experiences we are hearing about while we are out in the community, we would state that overall the Quality Account report reflects people's real experiences of using the service.

It appears that the Trust gets the basics right the majority of the time. Local people are telling us that they value the services provided by the Trust, with Halton Hospital coming in for particular praise.

It is clear though, as shown from the deterioration by 5% or more on some of the results from the National Inpatient Survey, that there is a need for some improvements around the care, treatment and discharge of patients. We do worry that as the Trust gets busier patient care may suffer.

Also, while understanding that it is recognised nationally as a challenging target, we are disappointed to see that the 95% A&E 4 hour access target is consistently being missed.

healthwatch
Halton

We note that Trust plan to focus on these issues in the next year and we look forward to seeing improvements. We would welcome the Trust working with both Healthwatch Halton and Healthwatch Warrington on ways to improve patient care and particularly for improvements around patient discharge.

We are pleased to note the improvements in infection control with Clostridium difficile cases dropping to 19 compared to 33 for the previous year. We note the actions put in place to reduce MRSA, MSSA and C Diff over the coming year and we look forward to further improvements next year.

We also welcome the reduction in falls and the re-establishment of the Falls Steering Group. Initiatives such as the trial of coloured socks for patients at higher risk of falls and SWARM are to be applauded.

The Trust's focus on reducing the number of deaths from Sepsis is a positive move. We hope that the funding of two sepsis nurses and the introduction of a revised sepsis pathway will help the Trust meet its target of reducing the number of deaths from sepsis.

The achievements of Warrington Hospital's Maternity Unit, named best in the Country by the Royal College of Midwives, are to be congratulated and highlight how an organisation can learn, improve and raise the level of service provided to patients.

The three improvement priorities for 2017-18 of Patient Safety, Clinical Effectiveness and Patient Experience are welcomed. It is difficult for us to say whether all the priorities are challenging enough for the Trust but we believe they all offer the opportunity to drive improvement. We would suggest that the Trust involve both local Healthwatch in its work on improving patient experience during the next year.

From the information supplied in the Quality Account, and our close work with the Trust over the past 4 years, we can say that it is clear how improvements have been measured in the past and how they will be measured for these priorities.

During the next 12 months we will continue to offer challenge to the Trust on key priorities and work with it to help improve the experience of patients who use both local hospitals.

Kind regards

Brian Miller & Dave Wilson
Healthwatch Halton Quality Account Leads

15th May 2017

4.7 Statement from the Trust's Council of Governors 2016/2017

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Account for 2016/17.

The Quality Report is very detailed and thorough and assists the Governors in holding the Non-Executive Directors to account for the performance of the Board of Directors.

As Governors one of our prime roles, is too particularly to focus on quality. As part of the Council's governance structure it meets regularly at its Governor Quality in Care Group. At the Governor Quality in Care Group, the Governors receive the latest performance information and have the chance to analyse it and raise questions.

The formal public governor's council meeting programme is a small part of the governors' work in the trust. The Governors have a number of committees which they lead on, which allows them to bring information and views to the main council meeting. Other agenda items include updates from those committees and other topics of interest.

The Governors strongly support the emphasis on patient safety, patient experience and clinical effectiveness documented throughout the Quality Report. Patients, their relatives, carers and the hospital's key stakeholders have all identified these as three areas of paramount importance.

For the coming year, the Governors agree with the priorities established. The Patient Safety Priority relating to Safer Surgery will help the Trust to achieve its objective in relation to Never Events which is to have zero Never Events within the year and to improve patient safety. The Patient Experience Strategy will provide a wider range of better quality information from which to drive improvement and the Governors look forward to receiving the quality dashboards that will be designed in line with the National Patient Survey results and based on 'What Matters Most' to our patients and carers. There is further work to do in the complaints area, and Governors are pleased to note that there is a specific Patient Experience Priority dedicated to improving the Trust's responsiveness to complaints and the overall experience for patients, relatives, public to raise concerns. Finally, Governors see the improvement of care for Mental Health patients in A&E as an important initiative that the Trust is establishing to improve the experience for those patients, as well as strengthening working relationships with our Community and Mental Health partners.

Governors find the format and section headings helpful. The Quality Report contains considerable detail commensurate with the complex and diverse range of services provided by an Acute Hospital Trust. The Governors believe the Quality Report to be accurate. The graphs and accompanying explanations help the public and members to understand clearly the progress made in many areas of patient safety and patient care.

The Governors are aware that the 2017/18 Quality Report is to be amended by the Chief Nurse to provide data that is more meaningful, understandable and clearer to all, the report will show indicating trends, and comparisons with the previous year statistics.

Governors encourage all Trust members and others who are interested in our hospitals and their performance to read the Quality Report.

Annex 2: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/2017 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2016 to date of signing this statement
    - Papers relating to Quality reported to the Board over the period April 2016 to date of signing this statement
    - Feedback from the Commissioners, Warrington Clinical Commissioning Group dated 22nd May 2017 and Halton Clinical Commissioning Group dated 12th May 2017
    - Feedback from Governors dated 27th April 2017
    - Feedback from local Healthwatch organisations, Healthwatch Halton dated 15th May 2017 and Healthwatch Warrington dated 17th May 2017
    - Feedback from Overview and Scrutiny Committee – statement requested but not received
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2nd May 2017
    - The 2016 national inpatient survey published March 2017 but under embargo until 8th June 2017
    - The 2016 national staff survey published February 2017
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 24th April 2017
    - CQC inspection report dated 10th July 2015

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

25 May 2017 **Date**…… Steve McGuirk **Chairman**

25 May 2017 **Date**…… Mel Pickup **Chief Executive**

[NB: sign and date in any colour ink except black]

Independent Auditor's Limited Assurance Report to the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust on the Annual Quality Report.

Appendix

Glossary

Appraisal	method by which the job performance of an employee is evaluated
Care quality commission (CQC)	Independent regulator of all health and social care services in England. They inspect these services to make sure that care provided by them meets national standards of quality and safety.
Clinical audit	Is a process that has been defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Clinical commissioning group (CCCG)	Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Clostridium difficile (C diff)	A Clostridium difficile infection (CDI) is a type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital. (CMCLRN) Cheshire and Merseyside Comprehensive Local Research Network
Commissioning for Quality and Innovation (CQUIN)	This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
Friends and Family test (FFT)	Since April 2013, the following FFT question has been asked in all NHS Inpatient and A&E departments across England and, from October 2013, all providers of NHS funded maternity services have also been asking women the same question at different points throughout their care : "How likely are you to recommend our [ward/A&E department/maternity service] to friends and family if they needed similar care or treatment?"
Governors	Governors form an integral part of the governance structure that exists in all NHS foundation trusts; they are the direct representatives of local community interests in foundation trusts
Healthwatch	Healthwatch is a body that enables the collective views of the people who use NHS and social care services to influence policy.
Healthcare evaluation data (HED)	Clinical benchmarking system to support clinical experts in more effective management of clinical performance.
Hospital episode statistics (HES)	Is a database containing information about patients treated at NHS providers in England.
Hospital Standardised Mortality Review (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.

Mandatory training	The Organisation has an obligation to meet its statutory and mandatory requirements to comply with requirements of external bodies e.g. Health & Safety Executive (HSE), training is provided to ensure that staff are competent in statutory and mandatory
MRSA	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
MSSA	Methicillin-sensitive *Staphylococcus aureus* (MSSA) is a bacteraemia caused by Staphylococcus aureus which is a serious infection associated with high morbidity and mortality and often results in metastatic infections such as infective endocarditis, which have a negative impact on patient outcomes
National confidential enquiries (NCEPOD)	The purpose of NCEPOD is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by: reviewing the management of patients; undertaking confidential surveys and research; by maintaining and improving the quality of patient care; and by publishing and generally making available the results of such activities.
NHS Improvement	NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
National inpatient survey	Collects feedback on the experiences of over 64,500 people who were admitted to an NHS hospital in 2016.
National institute for health and clinical excellence (NICE)	Is responsible for developing a series of national clinical guidelines to secure consistent, high quality, evidence based care for patients using the National Health Service.
National institute of health research (NIHR)	Organisation supporting the NHS.
National patient safety agency (NPSA)	Lead and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.
National reporting and learning system (NRLS)	Is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.
Never Events	Are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHS outcomes framework	Reflects the vision set out in the White Paper and contains a number of indicators selected to provide a balanced coverage of NHS activity. To act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.
Open and Honest	North of England Trusts produces and publishes monthly reports on key areas of healthcare quality.

Palliative care	Focuses on the relief of pain and other symptoms and problems experienced in serious illness. The goal of palliative care is to improve quality of life, by increasing comfort, promoting dignity and providing a support system to the person who is ill and those close to them.
Patient Reported Outcome Measures (PROMs)	Provide a means of gaining an insight into the way patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life.
Payment by results (PBR)	Provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for case mix.
Safety thermometer	Is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
Summary hospital-level indicator (SHMI)	reports mortality at trust level across the NHS in England using standard and transparent methodology.
Urinary tract infection (UTI)	is an infection that affects part of the urinary tract
Venous thromboembolism (VTE)	A venous thrombosis or phlebothrombosis is a blood clot (thrombus) that forms within a vein. A classical venous thrombosis is deep vein thrombosis (DVT), which can break off (embolize), and become a life-threatening pulmonary embolism (PE).

Independent Practitioner's Limited Assurance Report to the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust to perform an independent limited assurance engagement in respect of Warrington and Halton Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and additional supporting guidance in the 'Detailed requirements for quality reports for foundation trusts 2016/17' (the 'Criteria').

Scope and subject matter
The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (see section 3.10);
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge (see section 3.10).

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

Respective responsibilities of the directors and Practitioner
The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period 1 April 2016 to 24 May 2017;
- papers relating to quality reported to the Board over the period 1 April 2016 to 24 May 2017;
- feedback from Commissioners
- feedback from Governors
- feedback from local Healthwatch organisations
- feedback from Overview and Scrutiny Committee
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2 May 2017
- the national patient survey;
- the local patient survey
- the national staff survey
- the local staff survey
- the Head of Internal Audit's annual opinion over the Trust's control environment dated March 2017; and
- any other information obtained during our limited assurance engagement.

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.

The firm applies International Standard on Quality Control 1 and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Warrington and 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 2017, 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 and Halton Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;

- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower 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 affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Warrington and Halton Hospitals NHS Foundation Trust.

Our audit work on the financial statements of Warrington and Halton Hospitals NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Warrington and Halton Hospitals NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Warrington and Halton Hospitals NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Warrington and Halton Hospitals NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Warrington and Halton Hospitals NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Warrington and Halton Hospitals NHS Foundation Trust and Warrington and Halton Hospitals NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion
The indicator reporting "the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period", did not meet the six dimensions of data quality in all respects:

- Accuracy – our testing identified 10 cases out of the 25 cases tested where the indicator numerator and denominator contained errors due to the clock-stop date being recorded incorrectly,

- Validity – our testing identified 1 case out of the 25 cases tested where the clock had been incorrectly started and the case should not have been included within the scope of this indicator.
- Timeliness - our testing identified 10 cases out of the 25 cases tested where errors in the indicator data were not identified in a timely manner.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
4 Hardman Square
Spinningfields
Manchester M3 3EB

26th May 2017

Trust name:	Warrington and Halton Hospitals NHS Foundation Trust
This year:	2016/17
This year ended:	31 March 2017
This year beginning:	1 April 2016

Foreword to the accounts for the year 1 April 2016 to 31 March 2017

Warrington and Halton Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2017, have been prepared by Warrington & Halton Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Mel Pickup
Chief Executive
24-May-17

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2017

	NOTE	2016/17 £000	2015/16 £000
Income from activities	3	202,832	196,856
Other operating income	3	30,490	21,507
Operating income	3	**233,322**	**218,363**
Operating expenses	4	(237,930)	(232,548)
OPERATING DEFICIT		**(4,608)**	**(14,185)**
FINANCE INCOME / (EXPENSE)			
Finance income - interest receivable	7	20	25
Finance expense - interest payable	8	(461)	(88)
PDC dividends payable		(3,010)	(3,925)
NET FINANCE COSTS		**(3,451)**	**(3,988)**
Net losses on disposal of assets	9	(201)	(102)
DEFICIT FOR THE FINANCIAL YEAR		**(8,260)**	**(18,275)**
Other comprehensive expense			
Items that will not be reclassified to income and expenditure			
Net impairment losses on property, plant and equipment	10	(11,791)	(10,210)
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(20,051)**	**(28,485)**
Allocation of losses for the period			
(a) Deficit for the period attributable to:			
(i) non-controlling interest, and		0	0
(ii) owners of the parent.		(8,260)	(18,275)
TOTAL		**(8,260)**	**(18,275)**
(b) Total comprehensive expense for the period attributable to:			
(i) non-controlling interest, and		0	0
(ii) owners of the parent.		(20,051)	(28,485)
TOTAL		**(20,051)**	**(28,485)**

* Comparatives for 2015/16 have been restated to net off reversal of impairments of property, plant and equipment against impairments in operating expenses. This is line line with the accounting direction set out in the Department of Health General Accounting Manual (DH GAM).

The notes on pages 5 to 39 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2017

	NOTE	31 March 2017 £000	31 March 2016 £000
NON-CURRENT ASSETS			
Intangible assets	11	2,308	2,319
Property, plant and equipment	12	117,890	133,041
Trade and other receivables	15	991	994
Total non-current assets		**121,189**	**136,354**
CURRENT ASSETS			
Inventories	14	3,437	3,435
Trade and other receivables	15	13,163	9,167
Cash and cash equivalents	17	1,201	2,583
Total current assets		**17,801**	**15,185**
CURRENT LIABILITIES			
Trade and other payables	18	(19,338)	(22,314)
Borrowings	19	(454)	(430)
Provisions	21	(279)	(364)
Other liabilities	20	(1,137)	(2,092)
Total current liabilities		**(21,208)**	**(25,200)**
Total assets less current liabilities		**117,782**	**126,339**
NON-CURRENT LIABILITIES			
Borrowings	19	(28,152)	(16,701)
Provisions	21	(1,377)	(1,334)
Total non-current liabilities		**(29,529)**	**(18,035)**
TOTAL ASSETS EMPLOYED		**88,253**	**108,304**
TAXPAYERS' EQUITY			
Public dividend capital		87,742	87,742
Revaluation reserve		22,478	34,269
Income and expenditure reserve		(21,967)	(13,707)
TOTAL TAXPAYERS' EQUITY		**88,253**	**108,304**

The primary accounts on pages 1 to 4 and the notes on pages 5 to 39 were approved by the Board of Directors on 24 May 2017 and signed on its behalf by Mel Pickup, Chief Executive.

Signed:  Date: 24 May 2017

Mel Pickup
Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2017

	Total Taxpayers' Equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity as at 1 April 2016	108,304	87,742	34,269	(13,707)
Deficit for the year	(8,260)	0	0	(8,260)
Transfers between reserves	0	0	0	0
Net impairment losses on property, plant and equipment	(11,791)	0	(11,791)	0
Public Dividend Capital received	0	0	0	0
Public Dividend Capital repaid	0	0	0	0
Taxpayers' equity as at 31 March 2017	**88,253**	**87,742**	**22,478**	**(21,967)**

	Total Taxpayers' Equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity as at 1 April 2015	139,289	90,242	45,077	3,970
Deficit for the year	(18,275)	0	0	(18,275)
Transfers between reserves	0	0	(598)	598
Net impairment losses on property, plant and equipment	(10,210)	0	(10,210)	0
Public Dividend Capital received	0	0	0	0
Public Dividend Capital repaid	(2,500)	(2,500)	0	0
Taxpayers' equity as at 31 March 2016	**108,304**	**87,742**	**34,269**	**(13,707)**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2017

	NOTE	2016/17 £000	2015/16 £000
Cash flows from operating activities			
Operating deficit from continuing operations		**(4,608)**	**(14,185)**
Non-cash income and expense			
Depreciation and amortisation	4	5,102	4,848
Impairments	4	3,007	965
Income recognised in respect of capital donations	3	(114)	(39)
(Increase) / decrease in trade and other receivables	15	(4,122)	2,243
(Increase) / decrease in inventories	14	(2)	(123)
Increase / (decrease) in trade and other payables	18	(3,414)	2,975
Increase / (decrease) in other liabilities	20	(955)	1,118
Increase / (decrease) in provisions	21	(42)	(32)
Other movements in operating cash flows		23	(4)
Net cash used in operations		**(5,125)**	**(2,234)**
Cash flows from investing activities			
Interest received	7	20	25
Purchase of intangible assets	11	(558)	(1,312)
Purchase of property, plant and equipment	12	(4,017)	(7,089)
Sales of property, plant and equipment		74	91
Receipt of cash donations to purchase capital assets	3	114	4
Net cash used in investing activities		**(4,367)**	**(8,281)**
Cash flows from financing activities			
Public Dividend Capital repaid		0	(2,500)
Loans received from Department of Health	19	21,236	15,800
Loans repaid to the Department of Health	19	(9,425)	0
Capital element of finance lease	19	(337)	(291)
Interest paid	8	(446)	(1)
Interest element of finance lease	8	(37)	(41)
Public Dividend Capital dividend paid		(2,881)	(4,380)
Net cash used in financing activities		**8,110**	**8,587**
Decrease in cash and cash equivalents		(1,382)	(1,928)
Cash and cash equivalents as at 1 April		2,583	4,511
Cash and cash equivalents as at 31 March	17	**1,201**	**2,583**

NOTES TO THE ACCOUNTS

1. Accounting policies and other information

Basis of preparation

NHS Improvement (NHSI), in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. 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.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

Going concern

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

The Board approved the 2017/18 Annual Plan for submission to NHS Improvement (NHSI) which covered both 2017/18 and 2018/19 on 21 December 2016, with planned deficits of £3.8m in 2017/18 and £3.7m in 2018/19.

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

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

- 2016/17 forecast outturn
- Changes in demography and demand
- National Payment by Results rules and regulations
- Changes to national tariff structure and prices
- Commissioning Intentions
- Receipt of Sustainability and Transformation funding

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

The main financial headlines resulting from application of the above factors and assumptions, submitted to NHSI as part of the planning processs, in financial year 2017/18 are as follows:

- A planned deficit of £3.8 million
- Acceptance of the planned control total of £3.7 million set by NHSI
- Receipt of Sustainability and Transformation funding totalling £7.0 million
- Cost savings target totalling £10.5m (equivalent to 4.5% of turnover)
- A working capital loan requirement of £3.7million
- Capital expenditure totalling £5.6 million
- Planned closing cash balance of £1.6 million

The Trust believes that it has been realistic in its assessment of efficiency targets over the two year period and therefore believes that the two year plan submitted to NHSI provides a realistic assessment of the Trust’s position in 2017/18 and 2018/19.

1 Going concern (continued)

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

Notwithstanding the 2017/18 planned deficit referred to above, the Trust does not have any evidence indicating that the going concern basis is not appropriate as the Trust has not been informed by NHS Improvement that there is any prospect of intervention or dissolution within the next 12 months.

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

The Directors are seeking additional support from the Department of Health for 2017/18 of £3,657,000 and for 2018/19 of £3,553,000. The Department of Health has not confirmed this support. These factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. However, the Directors, having made appropriate enquiries, have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

The Department of Health recommended the Trust submit a Board Resolution to enable the Chief Executive to draw down loans in 2017/18 to the value of £3,657,000. The Board Resolution was approved at the Trust Board in March 2017. Of this £1,603,000 was drawn down in April 2017 in line with the plan.

As directed by the 2016/17 Department of Health Group Accounting Manual the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

1.1 Key sources of judgement and estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the judgements that management have made in the process of applying the 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 Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

The pension provision relating to former employees, including directors, has been calculated using the life expectancy estimates from the Government's actuarial tables.

The legal claims provision relates to employer and public liability claims and expected costs are advised by the NHS Litigation Authority. The Trust accepts financial liability for the value of each claim up to the excess defined within the policy.

1.1 Key sources of judgement and estimation uncertainty (continued)

Provision for impairment of receivables

A provision for impairment of receivables has been made for amounts which are uncertain to be received and non-NHS organisations as at 31 March 2017. The provision includes 22.94% (21.90% for 2015/16) Injury Cost Recovery (ICR) income to reflect the average value of claims withdrawn as advised by the Dep Health's Compensation Recovery Unit (CRU).

Asset valuations and lives

The value and remaining useful lives of land and building assets are estimated by Cushman & Wakefield w professional valuation services. The valuations are carried out in accordance with the Royal Institute of Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed re of the Department of Health and HM Treasury. Valuations are carried out primarily on the basis of D Replacement Cost based on modern equivalent for specialised operational property (property rarely sold o market) and Current Value in Existing Use for non-specialised operational property.

The Trust commissioned Cushman & Wakefield to provide a 'desk top' revaluation for land and buildings ar of asset lives for buildings as at 1 April 2016 and 31 March 2017, on the basis that a reprovision of service provided from a single site. The decision to revalue on the basis that any reprovision of services would be site follows approval by the Trust's Finance and Sustainability Committee after considering guidance issu NHSI.

The changes following revaluation have been reflected with the 2016/17 annual accounts. A full asset v undertaken every five years with an annual 'desk top' valuation being undertaken in the intervening years. Ma was used in arriving at fair value for the assets subject to the assumption that the property is sold as continuing enterprise in occupation.

The lives of equipment assets are estimated on historical experience of similar equipment lives with re national guidance and consideration of the pace of technological change. Operational equipment is carried less any accumulated depreciation and any impairment losses. Where assets are of low value and / or 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 co 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 sa Trust employees based on actual point of their salary band (Note 5.1).

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable.

The main source of income for the Trust is from NHS commissioners, mainly Clinical Commissioning Groups (CCG), for the provision of healthcare services. This income is recognised either on discharge of patient or value of partially completed activity as at 31 March 2017 for all NHS commissioners.

Where income is received for a specific activity that is to be delivered in a future financial year that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

The Trust receives income under the Injury Cost Recovery (ICR) Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for example by an insurer. The Trust recognises the income when it receives notification from the Department of Health's CRU that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision to reflect the average value of claims withdrawn.

The main sources of other operating income are from the Department of Health, Health Education England, NHS Trusts, NHS Foundation Trusts and Local Authorities.

1.3 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the accounts to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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 operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that 'the period between formal valuations shall be four years, with approximate assessments in intervening years'. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

1.4 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as an intangible asset or an item of property, plant and equipment.

1.5 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset, if it meets the above conditions.

Measurement

Intangible assets are initially recognised at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
  - collectively, a number of items which have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
  - items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

1.6 Property, plant and equipment (continued)

The whole of a site is designated as the property asset with the land, the separate buildings upon it and the external works being the main components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment is initially measured at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and where it would meet the location requirements of the service being provided an alternative site valuation can be used. The Trust commissioned Cushman & Wakefield to undertake a 'desk top' valuation and review of assets lives as at 1 April 2016 and further review of values as at 31 March 2017, on the basis that a reprovision of services would be provided from a single site. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of Financial Position date. Fair values are determined as follows:

- Land and non specialised buildings - market value for existing use.
- Specialised buildings - depreciated replacement cost.
- Equipment - depreciated historical cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by International Accounting Standard (IAS) 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

1.6 Property, plant and equipment (continued)

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenses.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income / expenses'.

Impairments

At the end of the financial year the Trust reviews whether there is any indication that any of its assets have suffered an impairment loss. If there is an indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

In accordance with the DH GAM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses, and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve, where at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments, such as unforeseen obsolescence, are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains and classed as 'other operating income'.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met:

The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales and the sale must be highly probable i.e. management are committed to a plan to sell the asset, an active programme has begun to find a buyer and complete the sale, the asset is being actively marketed at a reasonable price, the sale is expected to be completed within 12 months of the date of classification as ‘held for sale’ and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.6 Property, plant and equipment (continued)

Donated, government grant and other grant funded assets

Donated, government grant and other grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation / grant is credited in full to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation / grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Contingent rents are recognised in operating expenses in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula, which is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.9 Cash and cash equivalents

Cash is defined as cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value. Interest earned on bank accounts is recorded as interest receivable in the periods to which it relates. Balances exclude monies held in bank accounts belonging to patients (Note 17).

1.10 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount, for which it is probable that there will be a future outflow of cash or other resources, and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk adjusted cash flows are discounted using HM Treasury's discount rates. Early retirement provisions and injury benefit provisions have both been discounted using the HM Treasury's pension discount rate of 0.24% (1.37% in 2015/16) in real terms.

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 not recognised in the Trust's accounts (Note 21).

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to 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 the liability arises.

1.11 Value added tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.12 Corporation tax

Warrington and Halton Hospitals NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is temporarily exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA). Accordingly, the Trust will become within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare and where the profits exceed £50,000 per annum. However, there is no tax liability in respect of the current financial year (£nil in 2015/16).

1.13 Foreign exchange

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

1.13 Foreign exchange (continued)

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expenditure in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.14 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with requirements of HM Treasury's FReM (Note 17).

1.15 Public dividend capital (PDC) and PDC dividend

PDC is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of 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 3.50%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (ii) average daily cleared cash balances held with Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the unaudited version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.16 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in operating expenses on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its' own risks (with insurance premiums then being included as normal revenue expenditure).

However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.17 Consolidation

The Trust is the corporate Trustee to Warrington & Halton Hospitals NHS FT Charitable Fund. The Trust has assessed its' relationship to the charitable fund and determined it to be subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its' involvement with the charitable fund and has the ability to effect those returns and other benefits through its' power over the fund.

1.17 Consolidation (continued)

The Charitable Fund's statutory accounts are prepared to 31 March in accordance with the UK Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Stand 102.

The Trust has opted not to consolidate charitable funds with the main Trust Accounts in 2016/1 they are immaterial. This will be reviewed each year for appropriateness.

1.18 Other subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominan so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and r subsidiaries are consolidated in full into the appropriate financial statement lines. The capital an attributable to minority interests are included as a separate item in the Statement of Financial Positi

The amounts consolidated are drawn from the published accounts of the subsidiaries for the ye where a subsidiary's financial year end is before 1 January or after 1 July in which case the actua for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where t under UK FRS 102) then amounts are adjusted during consolidation where the differences are mat entity balances, transactions and gains / losses are eliminated in full on consolidation.

Subsidiaries classified as held for sale are measured at the lower of their carrying amount and fair costs to sell.

1.19 Interests in other entities

Associates

Associate entities are those over which the Trust has the power to exercise a significant influence and are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trusts share of the entities profit or loss or other gains and losses (e.g. revaluation gains on the entities property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g. share dividends are received by the Trust from the associate.

Associates which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its' financial statement its share of the assets, liabilities, income and expenses.

1.20 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities that arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases (Note 1.7).

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

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

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

Classification and measurement

Financial assets are categorised as fair value through income and expenditure, loans and receivables or available-for-sale financial assets.

Financial liabilities are classified as fair value through income and expenditure or as other financial liabilities.

Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. The Trust does not hold any financial assets or financial liabilities at fair value through income and expenditure.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market and are included in current assets.

The Trust's loans and receivables comprise: a working capital loan and capital loan from the Department of Health, cash at bank and in hand, NHS receivables and part of accrued income and other receivables.

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

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

The Trust does not hold any available-for-sale financial assets.

1.20 Financial instruments and financial liabilities (continued)

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to the Statement of Comprehensive Income.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of the impaired receivables provision account (Note 15).

At each period end the Trust reviews trade receivables for recoverability and makes a provision for those debts which it believes recovery of the amount outstanding is doubtful. Receivables deemed irrecoverable are written off on a quarterly basis and notified to the Trust's Audit Committee.

1.21 Reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. Additional PDC may also be issued to NHS Foundation Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are also recognised in operating expenses. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

1.22 Segmental reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The Trust's chief operating decision maker, responsible for providing strategic direction and decisions, allocating resources and assessing performance of the operating segments, is the Board of Directors.

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

1.24 Accounting standards and interpretations issued but not yet adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 and IFRIC 22 is still subject to HM Treasury consideration.

IFRS 9 (Financial Instruments) - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 15 (Revenue from Contracts with Customers) - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 (Leases) - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 22 (Foreign Currency Transactions and Advance Consideration) - Application required for accounting periods beginning on or after 1 January 2018.

IFRS - International Financial Reporting Standard
IFRIC - International Financial Reporting Interpretations Committee

2. Operating segments

The Trust has considered segmental reporting and the Chief Executive and the Board receive sufficient and appropriate high level information to enable the business to be managed effectively and to monitor and manage the strategic aims of the Trust. Sufficiently detailed information is used by middle and lower management to ensure effective management at an operational level. Neither of these are sufficiently discrete to profile operating segments,as defined by IFRS8, that would enable a user of these financial statements to evaluate the nature and financial effects of the business activities that this Trust undertakes. Therefore, the Trust has decided that it has one operating segment for healthcare.

3. Operating income

3.1 Operating income : by nature	**2016/17 £000**	**2015/16 £000**
Income from activities		
Elective income	36,566	36,709
Non elective income	59,260	55,615
Outpatient income	35,082	33,080
A & E income	11,698	11,125
Other NHS clinical income	58,934	56,641
Additional income for the delivery of healthcare services	0	2,500
Income for non-commissioner requested services		
Private patient income	98	102
Other non-protected clinical income	1,194	1,084
Total income from activities	**202,832**	**196,856**
Other operating income	30,490	21,507
Total operating income	**233,322**	**218,363**

* Comparatives for 2015/16 have been restated to net off reversal of impairments of property, plant and equipment against impairments in operating expenses. This is line line with the accounting direction set out in the Department of Health General Accounting Manual (DH GAM).

3.2 Operating lease income	**2016/17 £000**	**2015/16 £000**
Rents recognised as income in the year	231	255
Total	**231**	**255**

Future minimum lease receipts due	**2016/17 £000**	**2015/16 £000**
- not later than one year	213	212
- later than one year and not later than five years	775	846
- later than five years	6,695	6,610
Total	**7,683**	**7,668**

3. Operating income (continued)

3.3 Operating income : by source	2016/17 £000	2015/16 £000
Income from activities		
NHS Other	1,003	832
NHS Clinical Commissioning Groups	186,172	179,149
NHS England	12,118	12,158
Local Authorities	1,996	1,928
Non NHS: private and overseas patients	98	102
NHS Injury Scheme	1,194	1,084
Non NHS Other	251	(897)
Department of Health	0	2,500
Total income from activities	**202,832**	**196,856**
Other operating income		
Education and training	8,636	8,061
Donation of assets	0	35
Cash donations / grants for the purchase of assets	114	155
Non-patient care services to other bodies	827	867
Sustainability and transformation fund	9,891	0
Other *	8,251	9,137
Rental revenue from operating leases	231	255
Income in respect of staff costs where accounted on gross basis	2,540	2,997
Total other operating income	**30,490**	**21,507**
Total operating income	**233,322**	**218,363**
*** Analysis of other operating income 'other'**		
Car parking	1,808	1,474
Estates recharges	910	804
Information Technology recharges	190	131
Pharmacy sales	673	674
Staff accommodation rentals	120	93
Clinical tests	1,764	2,141
Catering	178	136
Other	2,608	3,684
Total other operating income 'other'	**8,251**	**9,137**

* Comparatives for 2015/16 have been restated to net off reversal of impairments of property, plant and equipment against impairments in operating expenses. This is line line with the accounting direction set out in the Department of Health General Accounting Manual (DH GAM).

3.4 Overseas visitors (relating to patients charged directly by the Trust)

	2016/17 £000	2015/16 £000
Income recognised this year	44	33
Cash payments received in-year	32	31
Amounts added to provision for impairment of receivables	6	6
Amounts written off in-year	10	2

4. Operating expenses	**2016/17 £000**	**2015/16 £000**
Services from NHS Trusts	335	342
Purchase of healthcare from non NHS bodies	417	0
Employee expenses (executive directors)	1,415	1,216
Remuneration (non-executive directors)	110	111
Employee expenses (staff)	162,722	161,333
Supplies and services (clinical; excluding drug costs)	19,349	19,182
Supplies and services (general)	2,497	2,874
Establishment	1,970	1,865
Transport (business travel only)	281	269
Transport (other)	565	749
Premises (business rates)	983	910
Premises (other)	7,676	8,019
Increase in bad debt provision	60	101
Change in provisions discount rate	100	(7)
Drug costs	15,999	15,831
Rentals under operating leases (minimum lease payments)	1,976	1,251
Rentals under operating leases (contingent rent)	26	42
Depreciation on property, plant and equipment	4,550	4,606
Amortisation on intangible assets	552	242
Net impairments of property, plant and equipment *	3,007	965
Audit services (statutory audit)	62	70
Other auditor remuneration (external auditor only) - analysis in note 6.5	7	8
Clinical negligence premiums	10,557	9,605
Legal fees	200	243
Consultancy costs	933	355
Internal audit costs	95	77
Training courses and conferences	919	785
Patient travel	16	20
Redundancy	123	85
Commercial insurance	98	95
Losses, ex gratia & special payments	19	16
Other expenditure	311	1,288
Total operating expenses	**237,930**	**232,548**

* Comparatives for 2015/16 have been restated to net off reversal of impairments of property, plant and equipment against impairments in operating expenses. This is line line with the accounting direction set out in the Department of Health General Accounting Manual (DH GAM).

5. Staff

5.1 Employee expenses

	2016/17 Total £000	2015/16 Total £000
Salaries and wages	122,832	124,687
Social security costs	11,480	9,273
Pension costs (employer contributions to NHS Pensions)	13,389	13,249
Termination benefits	123	85
Bank and agency staff	16,609	15,721
Total employee benefit expenses	**164,433**	**163,015**
Less costs capitalised as part of assets	(173)	(381)
Total per employee expenses in Note 4.	**164,260**	**162,634**

Employee costs include staff costs of £173k (£381k in 2015/16) which have been capitalised as part of the Trust's capital programme. These amounts are excluded from employee expenses (Note 4). The employee expenses table above is for executive directors, staff costs and redundancy payments only. It excludes non-executive directors.

An accrual in respect of the cost of annual leave entitlement carried forward at the Statement of Financial Position date of £360k has been provided for within the accounts (£592k as at 31 March 2016).

5.2 Early retirements due to ill-health

Two members of staff retired early on ill-health grounds during the year at an additional cost of £191k (three members of staff at a cost of £117k for the year ending 31 March 2016). The cost of ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

6. Other operating expenditure

6.1 Analysis of operating lease expenditure

2016/17	Land £000	Buildings £000	Plant & Machinery £000	Other £000	Total £000
Minimum lease payments	64	177	1,735	0	1,976
Contingent rents	0	0	26	0	26
Total	**64**	**177**	**1,761**	**0**	**2,002**

2015/16	Land £000	Buildings £000	Plant & Machinery £000	Other £000	Total £000
Minimum lease payments	54	226	917	54	1,251
Contingent rents	0	0	42	0	42
Total	**54**	**226**	**959**	**54**	**1,293**

6.2 Arrangements containing an operating lease

Future minimum lease payments due	2016/17 £000	2015/16 £000
On land leases:		
Not later than one year	94	54
Later than one year and not later than five years	288	189
Later than five years	10	0
Total	**392**	**243**
On building leases:		
Not later than one year	171	167
Later than one year and not later than five years	684	657
Later than five years	1,411	1,481
Total	**2,266**	**2,305**
On plant and machinery leases:		
Not later than one year	1,638	928
Later than one year and not later than five years	4,563	2,186
Later than five years	5,544	194
Total	**11,745**	**3,308**
On other leases:		
Not later than one year	0	40
Later than one year and not later than five years	0	0
Later than five years	0	0
Total	**0**	**40**
On all leases:		
Not later than one year	1,903	1,189
Later than one year and not later than five years	5,535	3,032
Later than five years	6,965	1,675
Total	**14,403**	**5,896**

6. Other operating expenditure (continued)

6.3 Limitation on auditor's liability

The external auditors' liability is limited to £1m. The scope of work for the external auditors is to provide a statutory audit of annual accounts and report and provide opinion on them to the Trust and the Trust's Council of Governors. This will be conducted in accordance with the Audit Code for NHS Foundation Trusts (the Audit Code) issued by Monitor in accordance with paragraph 24 of schedule 7 of the National Health Service Act 2006 schedule 10 of the National Health Service Act 2006 with due regard to the Comptroller and Auditor General's Code of Audit Practice (the Code) issued by the National Audit Office (NAO) in April 2015.

6.4 The Late Payment of Commercial Debts (Interest) Act 1998

The total paid within 2016/17 for late payment of commercial debt was £3,293 (£564 in 2015/16).

6.5 Other audit remuneration

The total paid to the Trust's external auditors for other remuneration amounted to £7k (2015/16 £8k).

7. Finance income - interest receivable

	2016/17 £000	2015/16 £000
Interest on bank accounts	20	25
Total	**20**	**25**

8. Finance expense - interest payable

	2016/17 £000	2015/16 £000
Capital Loans with the Department of Health	27	6
Working Capital Loans with the Department of Health	395	40
Interest on Finance Leases	36	41
Interest on Late Payment of Debt	3	1
Total	**461**	**88**

9. Gains / (losses) on disposal / de-recognition of assets

	2016/17 £000	2015/16 £000
Gains on disposal of other property, plant and equipment	45	44
Losses on disposal of other property, plant and equipment	(246)	(146)
Total net losses on disposal of assets	**(201)**	**(102)**

10. Impairment of assets

	2016/17		
Impairments due to change in market price:	**Net Impairments £000**	**Impairments £000**	**Reversals of Impairments £000**
Impairments charged to operating expenses	3,007	3,023	(16)
Impairments charged to the revaluation reserve	11,791	14,605	(2,814)
Total impairments due to change in market price	**14,798**	**17,628**	**(2,830)**

	2015/16		
Impairments due to change in market price:	**Net Impairments £000**	**Impairments £000**	**Reversals of Impairments £000**
Impairments charged to operating expenses	965	1,596	(631)
Impairments charged to the revaluation reserve	10,210	16,475	(6,265)
Total impairments due to change in market price	**11,175**	**18,071**	**(6,896)**

The value and remaining useful lives of land and building assets are estimated by Cushman and Wakefield. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. Valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Current Value in Existing Use for non-specialised operational property.

The Trust instructed Cushman & Wakefield to provide a full revaluation of land and buildings as at 1 April 2016. The changes have been reflected with the 2016/17 annual accounts. A further 'desk top' revaluation exercise, including an assessment of asset lives in respect of buildings, was completed by Cushman & Wakefield with a prospective date of 31 March 2017, which was applied to the accounts on 31 March 2017. Both these valuations were carried out on the basis that the Trust's services could be reprovided for on a single site.

A full asset valuation is undertaken every five years with an annual 'desk top' valuation being undertaken in the intervening years. Any increase in valuation which reverses a previous impairment has been credited to other operating income, to the extent of what has been charged there already relating to the asset. Any remaining balance has been credited to the revaluation reserve.

11. Intangible assets

	Software licences
	£000
Cost as at 1 April 2016	**3,161**
Additions - purchased	558
Additions - donated	0
Reclassifications	0
Disposals	(17)
Cost as at 31 March 2017	**3,702**
Accumulated amortisation as at 1 April 2016	**842**
Provided during the year	552
Reclassifications	0
Disposals	0
Accumulated amortisation as at 31 March 2017	**1,394**
Cost as at 1 April 2015	**802**
Additions - purchased	1,312
Additions - donated	25
Reclassifications	1,022
Disposals	0
Cost as at 31 March 2016	**3,161**
Accumulated amortisation as at 1 April 2015	**235**
Provided during the year	242
Reclassifications	365
Disposals	0
Accumulated amortisation as at 31 March 2016	**842**
Net book value as at 31 March 2017	**2,308**
Net book value as at 31 March 2016	**2,319**

All intangible assets are owned assets.

	Minimum Life Years	Maximum Life Years
Software licences	1	10

12. Property, plant and equipment

12.1 Property, plant and equipment 2016/17	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation as at 1 April 2016	**160,738**	**12,475**	**117,357**	**1,512**	**1,253**	**17,541**	**101**	**9,670**	**829**
Additions - purchased	4,341	0	1,418	5	0	1,534	0	1,384	0
Additions - leased	0	0	0	0	0	0	0	0	0
Additions - donation of physical assets (non-cash)	0	0	0	0	0	0	0	0	0
Additions - assets purchased from cash donations	114	0	76	0	0	38	0	0	0
Impairments charged to revaluation reserve	(14,605)	(2,705)	(11,893)	(7)	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	2,814	730	2,056	28	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Disposals	(1,030)	0	0	0	0	(1,025)	0	(5)	0
Cost or valuation as at 31 March 2017	**152,372**	**10,500**	**109,014**	**1,538**	**1,253**	**18,088**	**101**	**11,049**	**829**
Accumulated depreciation as at 1 April 2016	**27,697**	**0**	**13,198**	**301**	**0**	**9,983**	**30**	**3,888**	**297**
Provided during the year	4,550	0	1,886	32	0	1,283	13	1,253	83
Impairments charged to operating expenses	3,023	0	3,023	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	(16)	0	(16)	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Disposals	(772)	0	0	0	0	(770)	0	(2)	0
Accumulated depreciation as at 31 March 2017	**34,482**	**0**	**18,091**	**333**	**0**	**10,496**	**43**	**5,139**	**380**
Net book value as at 31 March 2017	**117,890**	**10,500**	**90,923**	**1,205**	**1,253**	**7,592**	**58**	**5,910**	**449**

12.2 Property, plant and equipment 2015/16	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation as at 1 April 2015	**166,191**	**20,181**	**118,850**	**1,322**	**614**	**17,387**	**72**	**7,326**	**439**
Additions - purchased	5,612	0	684	517	639	681	29	2,672	390
Additions - leased	692	0	0	0	0	0	0	692	0
Additions - donation of physical assets (non-cash)	10	0	0	0	0	10	0	0	0
Additions - assets purchased from cash donations	4	0	0	0	0	2	0	2	0
Impairments charged to revaluation reserve	(16,475)	0	(16,475)	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	6,265	0	6,265	0	0	0	0	0	0
Reclassifications	(1,022)	(7,706)	8,033	(327)	0	0	0	(1,022)	0
Disposals	(539)	0	0	0	0	(539)	0	0	0
Cost or valuation as at 31 March 2016	**160,738**	**12,475**	**117,357**	**1,512**	**1,253**	**17,541**	**101**	**9,670**	**829**
Accumulated depreciation as at 1 April 2015	**22,837**	**0**	**10,388**	**131**	**0**	**8,902**	**18**	**3,165**	**233**
Provided during the year	4,606	0	1,985	30	0	1,427	12	1,088	64
Impairments charged to operating expenses	1,596	0	1,596	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	(631)	0	(631)	0	0	0	0	0	0
Reclassifications	(365)	0	0	0	0	0	0	(365)	0
Revaluations	0	0	(140)	140	0	0	0	0	0
Disposals	(346)	0	0	0	0	(346)	0	0	0
Accumulated depreciation as at 31 March 2016	**27,697**	**0**	**13,198**	**301**	**0**	**9,983**	**30**	**3,888**	**297**
Net book value as at 31 March 2016	**133,041**	**12,475**	**104,159**	**1,211**	**1,253**	**7,558**	**71**	**5,782**	**532**

12.3 Property, plant and equipment financing	Total £000	Land £000	Buildings excluding Dwellings £000	Dwellings £000	Assets Under Construction £000	Plant & Machinery £000	Transport & Equipment £000	Information Technology £000	Furniture & Fittings £000
Net book value as at 31 March 2017									
Owned	115,054	10,500	89,055	1,205	1,253	7,127	58	5,460	396
Finance Leased	450	0	0	0	0	0	0	450	0
Government Granted	736	0	546	0	0	190	0	0	0
Donated	1,650	0	1,322	0	0	275	0	0	53
Total net book value as at 31 March 2017	**117,890**	**10,500**	**90,923**	**1,205**	**1,253**	**7,592**	**58**	**5,910**	**449**
Net book value as at 31 March 2016									
Owned	130,036	12,475	102,324	1,211	1,253	7,038	71	5,194	470
Finance Leased	588	0	0	0	0	0	0	588	0
Government Granted	802	0	562	0	0	240	0	0	0
Donated	1,615	0	1,273	0	0	280	0	0	62
Total net book value as at 31 March 2016	**133,041**	**12,475**	**104,159**	**1,211**	**1,253**	**7,558**	**71**	**5,782**	**532**

13. Economic lives of non-current assets

The lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at its cost less any accumulated depreciation and any impairment losses. Where assets are of low value and / or have short useful economic lives, these are carried at depreciated historical cost as a proxy for current value.

The following table discloses the range of economic lives of various assets.

	Minimum Life Years	Maximum Life Years
Intangible assets (software)	1	10
Land	250	250
Buildings excluding dwellings	1	82
Dwellings	10	40
Plant and machinery	1	15
Transport and equipment	4	10
Information technology	1	14
Furniture and fittings	1	10

14. Inventories

14.1 Inventory movements 2016/17

	Total £000	Drugs £000	Consumables £000
Carrying value at 1 April 2016	3,435	1,162	2,273
Additions	33,336	13,316	20,020
Inventories consumed (recognised in expenses)	(33,334)	(13,398)	(19,936)
Total as at 31 March 2017	**3,437**	**1,080**	**2,357**

14.2 Inventory movements 2015/16

	Total £000	Drugs £000	Consumables £000
Carrying value at 1 April 2015	3,312	1,057	2,255
Additions	35,570	14,066	21,504
Inventories consumed (recognised in expenses)	(35,447)	(13,961)	(21,486)
Total as at 31 March 2016	**3,435**	**1,162**	**2,273**

15. Trade and other receivables

Current	2016/17 £000	2015/16 £000
NHS receivables	1,485	1,717
Provision for impairment of receivables	(431)	(385)
Prepayments	1,834	1,261
Accrued income	6,923	3,142
PDC receivable	250	379
VAT receivable	696	426
Other receivables	2,406	2,627
Total current trade and other receivables	**13,163**	**9,167**
Non current		
Provision for impairment of receivables	(295)	(281)
Other receivables	1,286	1,275
Total non current trade and other receivables	**991**	**994**
Total trade and other receivables	**14,154**	**10,161**

Provision for impairment of receivables	2016/17 £000	2015/16 £000
As at 1 April	666	574
Increase in provision	60	101
Amounts utilised	0	(9)
As at 31 March	**726**	**666**

16. Analysis of financial assets past due date or impaired

Analysis of impaired financial assets	2016/17 Trade & other receivables* £000	2015/16 Trade & other receivables* £000
0 - 30 days	1	0
30 - 60 days	3	0
60 - 90 days	0	0
90 - 180 days	7	0
Over 180 days	715	666
Total	**726**	**666**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	1,821	793
30 - 60 days	125	199
60 - 90 days	283	84
90 - 180 days	783	113
Over 180 days	156	234
Total	**3,168**	**1,423**

*Includes provision for impairment of receivables in respect of income due from the Compensation Recovery Unit (CRU) of £664k (£600k in 2015/16).

those debts where it believes recovery of the outstanding amount is unlikely. Decisions are made after taking into consideration previous experience of the debtor, the age of the debt, the risk associated with that particular class of debtor and discussions with the debt management team of the Trust's shared business services provider.

17. Cash and cash equivalents

	2016/17 £000	2015/16 £000
As at 1 April	2,583	4,511
Net change in year	(1,382)	(1,928)
As at 31 March	**1,201**	**2,583**
Breakdown of cash and cash equivalents		
Cash at commercial banks and in hand	26	17
Cash with the Government Banking Service	1,175	2,566
Cash and cash equivalents as at 31 March	**1,201**	**2,583**
Third party assets held by the Trust	**15**	**39**

As at the 31 March 2017 the Trust held £15k (£39k as at 31 March 2016) within the Trust bank accounts which related to patient monies held by the Trust on behalf of patients and staff lottery. This has been excluded from the cash at bank and in hand figure above.

18. Trade and other payables

Current	2016/17 £000	2015/16 £000
NHS trade payables	3,653	3,979
Amounts due to other related parties	1,834	2,646
Trade payables capital	564	126
Other trade payables	4,663	6,057
Social security costs	1,559	1,319
Other taxes payable	1,374	1,399
Other payables	218	126
Accruals	5,473	6,662
Total trade and other payables	**19,338**	**22,314**

19. Borrowings

Current	2016/17 £000	2015/16 £000
Capital loans from the Department of Health	106	107
Working capital loans from the Department of Health	0	0
Obligations under finance leases	348	323
Total current borrowing	**454**	**430**
Non current		
Capital loans from the Department of Health	1,386	1,493
Working capital loans from the Department of Health	26,119	14,200
Obligations under finance leases	647	1,008
Total non current borrowing	**28,152**	**16,701**

During 2016/17 the Trust obtained further working capital loans from the Department of Health totalling £11.9m, at an interest rate of 1.50%. This new loan funding is repayable in full in 2020/21.

20. Other liabilities

	2016/17 £000	2015/16 £000
Current		
Deferred income	1,137	2,092
Total other liabilities	**1,137**	**2,092**

21. Provisions

	2016/17			
	Total	Legal	Other	Pensions
	£000	£000	£000	£000
As at 1 April 2016	1,698	246	0	1,452
Change in the discount rate	100	0	0	100
Arising during the year	264	124	81	59
Utilised during the year	(231)	(114)	0	(117)
Reversed unused	(175)	(175)	0	0
As at 31 March 2017	**1,656**	**81**	**81**	**1,494**
Expected timing of cash flows:				
Within one year	279	81	81	117
Between one and five years	467	0	0	467
After five years	910	0	0	910
Total	**1,656**	**81**	**81**	**1,494**

	2015/16			
	Total	Legal	Other	Pensions
	£000	£000	£000	£000
As at 1 April 2015	1,730	122	84	1,524
Change in the discount rate	(7)	0	0	(7)
Arising during the year	261	205	0	56
Utilised during the year	(242)	(37)	(84)	(121)
Reversed unused	(44)	(44)	0	0
As at 31 March 2016	**1,698**	**246**	**0**	**1,452**
Expected timing of cash flows:				
Within one year	364	246	0	118
Between one and five years	453	0	0	453
After five years	881	0	0	881
Total	**1,698**	**246**	**0**	**1,452**

The pensions provision relates to early retirement costs in line with the NHS Business Service Authority - Pensions Division. Legal claims relates to third party legal claims advised by the NHS Litigation Authority. These claims are generally expected to be settled within one year but may exceptionally take two years to settle.

Clinical negligence and employee liabilities

£99.2m is included in the provisions of the NHS Litigation Authority as at 31 March 2017 in respect of clinical negligence and employer's liabilities of the Trust (£93.2m as at 31 March 2016).

22. Contingent laibilities

	31 March 2017	31 March 2016
Value of contingent liabilities	**£000**	**£000**
NHS Litigation Authority legal claims	(39)	(86)
Gross value of contingent liabilities	**(39)**	**(86)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(39)**	**(86)**

23. Related party disclosures

23.1 Related party transactions

Value of transactions with other related parties in 2016/17	Revenue £000	Expenditure £000
Department of Health	0	0
Other Department of Health Group bodies	223,698	17,063
Charitable funds	32	0
Other	0	419
Total value of transactions with other related parties in 2016/17	**223,730**	**17,482**

Value of transactions with other related parties in 2015/16	Revenue £000	Expenditure £000
Department of Health	5,029	0
Other Department of Health Group bodies	205,052	15,314
Charitable funds	32	0
Other	0	413
Total value of transactions with other related parties in 2015/16	**210,113**	**15,727**

23.2 Related party balances

Value of balances with other related parties as at 31 March 2017	Revenue £000	Expenditure £000
Department of Health	250	106
Other Department of Health Group bodies	7,432	3,536
Charitable funds	40	0
Other	10	0
Total value of balances with other related parties as at 31 March 2017	**7,732**	**3,642**

Value of balances with other related parties as at 31 March 2016	Revenue £000	Expenditure £000
Department of Health	379	46
Other Department of Health Group bodies	4,706	5,503
Charitable funds	(6)	0
Other	0	0
Total value of balances with other related parties as at 31 March 2016	**5,079**	**5,549**

Whole of Government Accounts bodies

All bodies within the scope of the Whole of Government Accounts (WGA) are considered to be related parties as they are part of the DH group of bodies such that the Department of Health is the parent department, and they fall under the common control of HM Government and Parliament. The 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.

23. Related party disclosures (continued)

During the year, the Trust has had a number of transactions with WGA bodies. Where total transactions for either income or expenditure is significant (greater than £500k), they are listed below.

Related party relationships primarily based on income from the counterparty

5 Boroughs Partnership NHS Foundation Trust
Bridgewater Community Healthcare NHS Foundation Trust
Halton Borough Council
Health Education England
NHS England
NHS Halton CCG
NHS Liverpool CCG
NHS Salford CCG
NHS St Helens CCG
NHS Vale Royal CCG
NHS Warrington CCG
NHS West Cheshire CCG
NHS Wigan Borough CCG
Royal Liverpool and Broadgreeen University Hospitals NHS Trust

Related party relationships primarily based on expenditure with the counterparty

HM Revenue and Customs
NHS Litigation Authority
NHS Pension Scheme
NHS Professionals
St Helens and Knowsley Teaching Hospitals NHS Trust

24. Contractual Capital Commitments

The Trust has contractual capital commitments of £1.2m as at 31 March 2017 (£1.8m as at 31 March 2016). This includes, £0.3m for estates work, £0.1m for installation of new IT systems and £0.8m for new equipment.

25. Finance Leases

	2016/17 £000	2015/16 £000
Gross lease liabilities		
of which liabilities are due:		
- not later than one year;	373	372
- later than one year and not later than five years;	664	1,037
- later than five years.	0	0
Finance charges allocated to future periods	(42)	(78)
Total gross lease liabilities	**995**	**1,331**
Net lease liabilities		
of which payable:		
- not later than one year;	348	323
- later than one year and not later than five years;	647	1,008
- later than five years.	0	0
Total net lease liabilities	**995**	**1,331**

26. Events after the reporting period

Following the completion of the financial statements to 31 March 2017 a significant operating lease contract has been novated from Fresenius Medical Care Renal Services Ltd to NHS Property Services Ltd. The lease relates to the rental of premises at Halton General Hospital until 30 June 2068 with future minimum lease income due for the duration of the contract of £6,831k.

27. Financial instruments

Liquidity risk

The Trust's net operating costs are incurred under annual service level agreements / contracts with commissioners which are financed from resources voted annually by Parliament. The Trust receives such income in accordance with national tariff payment system, which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff Procedure cost. Monthly payments are received from Commissioners based on the annual contract values; this arrangement reduces liquidity risk.

The Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form.

Interest rate risk

All of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest and the Trust is not therefore exposed to significant interest rate risk.

Credit risk

The main source of income for the Trust is from Clinical Commissioning Groups in respect of healthcare services provided under agreements. The credit risk associated with such customers is negligible.

The Trust has minimal exposure to credit risk as all cash balances are held within the Government Banking Services (GBS) account which generates additional cash through an applied interest rate. The Trust does not hold cash in any other investment institution on a short or long term basis.

Before entering into new contracts with non NHS customers, checks are made regarding creditworthiness. The Trust also regularly reviews debtor balances and has a comprehensive system in place for pursuing past due debt. Non NHS customers represent a small proportion of income and the Trust is not exposed to significant credit risk in this regard. There are no amounts held as collateral against these balances.

An analysis of aged and impaired receivables is disclosed in Note 16.

The movement in the provision for impaired receivables during the year is disclosed in Note 15. Of those assets which require a provision for their impairment £2k (£66k in 2015/16) are impaired financial assets.

There are no (nil in 2015/16) 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.

27. Financial instruments (continued)

27.1 Financial assets by category

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total
	£000	£000	£000	£000	£000
Assets included in Statement of Financial Position as at 31 March 2017					
Trade and other receivables excluding non financial assets	9,101	0	0	0	9,101
Cash and cash equivalents at bank and in hand	1,201	0	0	0	1,201
Total as at 31 March 2017	**10,302**	**0**	**0**	**0**	**10,302**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total
	£000	£000	£000	£000	£000
Assets included in Statement of Financial Position as at 31 March 2016					
Trade and other receivables excluding non financial assets	5,319	0	0	0	5,319
Cash and cash equivalents at bank and in hand	2,583	0	0	0	2,583
Total as at 31 March 2016	**7,902**	**0**	**0**	**0**	**7,902**

27.2 Financial liabilities by category

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities included in Statement of Financial Position as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	27,611	0	27,611
Obligations under finance leases	995	0	995
Trade and other payables excluding non financial liabilities	14,571	0	14,571
Provisions under contract	162	0	162
Total as at 31 March 2017	**43,339**	**0**	**43,339**

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities included in Statement of Financial Position as at 31 March 2016			
Borrowings excluding finance lease and PFI liabilities	15,800	0	15,800
Obligations under finance leases	1,331	0	1,331
Trade and other payables excluding non financial liabilities	20,247	0	20,247
Provisions under contract	1,698	0	1,698
Total as at 31 March 2016	**39,076**	**0**	**39,076**

27.3 Maturity of financial liabilities

	2016/17 £000	2015/16 £000
In one year or less	15,186	22,375
In more than one year but not more than two years	14,654	453
In more than two years but not more than five years	12,539	16,248
In more than five years	960	0
Total	**43,339**	**39,076**

27.4 Fair values of financial assets and liabilities

All non current financial assets and liabilities are held at fair value.

28. Losses and special payments

	2016/17		2015/16	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	16	5	8	6
Fruitless payments	13	7	5	0
Bad debts and claims abandoned	8	12	6	3
Stores losses and damage to property	10	(3)	12	40
Total losses	**47**	**21**	**31**	**49**
Special payments				
Ex-gratia payments	42	139	32	70
Special severance payments	0	0	1	5
Total special payments	**42**	**139**	**33**	**75**
Total losses and special payments	**89**	**160**	**64**	**124**
Compensation payments received		**22**		**27**

There were no individual cases exceeding £300k in either 2016/17 or 2015/16.

INDEPENDENT AUDITOR'S STATEMENT TO THE DIRECTORS OF WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST ON THE NHS FOUNDATION TRUST CONSOLIDATION SCHEDULES

We have examined the consolidation schedules designated FTC1 to FTC38 (excluding FTC8a and FTC8b) of Warrington and Halton Hospitals NHS Foundation Trust for the year ended 31 March 2017, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This statement is made solely to the Board of Directors of Warrington and Halton Hospitals NHS Foundation Trust, as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and paragraph 4.2 of the Code of Audit Practice. Our work has been undertaken so that we might state to the Board of Directors those matters we are required to state to them in a consistency statement and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Board of Directors as a body, for our audit work, for this statement, or for the opinions we have formed.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the consolidation schedules extends only to those figures within the consolidation schedules which are also published in the audited financial statements. Auditors are required to report on any differences over £250,000 between the audited financial statements and the consolidation schedules.

In our opinion the figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.

Our auditor's report on the audited financial statements included an emphasis of matter paragraph. In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1 to the financial statements concerning the Trust's ability to continue as a going concern. The Trust incurred a deficit of £8,260,000 during the year ended 31 March 2017. The Directors are seeking additional support from the Department of Health for 2017/18 of £3,657,000 and for 2018/19 of £3,553,000. As disclosed in note 1 to the financial statements, the Department of Health has not, at the date of our report, confirmed this support. These conditions, along with the other matters explained in note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Grant Thornton UK LLP

Grant Thornton UK LLP
4 Hardman Square, Spinningfields
Manchester, M3 3EB

26th May 2017

Our opinion on the financial statements is unmodified

In our opinion:

- the financial statements give a true and fair view of the financial position of the Warrington and Halton Hospitals NHS Foundation Trust (the Trust) as at 31 March 2017 and of its expenditure and income for the year then ended; and
- the financial statements have been prepared properly in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2016/2017 and the requirements of the National Health Service Act 2006.

Emphasis of matter – Going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1 to the financial statements concerning the Trust's ability to continue as a going concern. The Trust incurred a deficit of £8,260,000 during the year ended 31 March 2017. The Directors are seeking additional support from the Department of Health for 2017/18 of £3,657,000 and for 2018/19 of £3,553,000. As disclosed in note 1 to the financial statements, the Department of Health has not, at the date of our report, confirmed this support. These conditions, along with the other matters explained in note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

What we have audited

We have audited the financial statements of Warrington and Halton Hospitals NHS Foundation Trust for the year ended 31 March 2017 which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers' equity, the statement of cash flows and the related notes.

The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2016/17.

Overview of our audit approach

- Overall materiality: £4,164,000 which represents 1.75% of the Trust's gross operating expenses;
- We performed a full-scope audit of Warrington and Halton Hospitals NHS Foundation Trust;
- Key audit risks were identified as:
    - Occurrence of income from patient care activities and the existence of associated receivables
    - Occurrence of other operating income and existence of associated receivables – including Sustainability and Transformation Fund
    - Going Concern material uncertainty disclosures
    - Valuation of property, plant and equipment.

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that, in our judgement, had the greatest effect on our audit and how we tailored our procedures to address these risks in order to provide an opinion on the financial statements as a whole. This is not a complete list of all the risks we identified:

Audit risk	How we responded to the risk
Occurrence of income from patient care activities and the existence of associated receivables The Trust receives 87% of the Trust's income from patient care activities from contracts with NHS commissioners, of which 85% is derived from contracts with the Trust's three main commissioners. The Trust recognises patient care activity income during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in the contracts with NHS commissioners, are subject to verification and agreement by the NHS commissioners. As such, there is the risk that income is recognised for these additional services that is not subsequently agreed to by the NHS commissioners. We, therefore, identified the occurrence of income from patient care activities and the existence of associated receivables as a significant risk requiring special audit consideration.	Our audit work included, but was not restricted to: • gaining an understanding of the Trust's system for accounting for income from patient care activities and evaluating the design of the associated controls; • evaluating the Trust's accounting policy for recognition of income from patient care activities for appropriateness; • on a sample basis agreeing amounts recognised as income from the three main commissioners in the financial statements to signed contracts, contract variations and invoices or other supporting documentation; • for the remainder of income from patient care activities other than that from the three main commissioners agreeing, on a sample basis, the amounts to signed contacts, contract variations and invoices or other supporting documentation; • on a sample basis agreeing associated receivables at year-end to subsequent cash receipts; • obtaining an exception report from the national agreement of balances exercise undertaken by the Department of Health (DoH) that details differences in reported income and expenditure; and receivables and payables between NHS bodies; agreeing the figures in the exception report to the Trust's financial records; and for all differences calculated by the DoH as being in excess of £250,000, obtaining corroborating evidence to support the amount recorded in the financial statements by the Trust.

Audit risk	How we responded to the risk
	The Trust's accounting policy on recognition of income from patient care activities is shown in note 1.2 to the financial statements and related disclosures are included in note 3.1.
Occurrence of other operating income and existence of associated receivables – including Sustainability and Transformation Fund 13% of the Trust's income is from other operating income sources, including £9,891,000 (32%) relating to funding from the national Sustainability and Transformation Fund (STF). Eligibility for income from the Fund is determined based on the Trust meeting quarterly financial targets agreed with NHS England. Income is paid quarterly in arrears, when the Government bodies (including the Department of Health, HM Treasury, NHS Improvement and NHS England) verify the Trust's achievement of these financial targets. At the year-end income from the Fund for the final quarter is accrued before the achievement of the financial target has been verified. As such, there is the risk that income recognised in the final quarter of the year may be misstated. We identified the occurrence of other operating income and the existence of associated receivables as a significant risk requiring special audit consideration.	Our audit work included, but was not restricted to: • gaining an understanding of the Trust's system of accounting for other operating income and evaluating the design of the associated controls; • evaluating the Trust's accounting policy for recognition of other operating income for appropriateness; • agreeing income for the first three quarters of the year from the Fund recognised in the financial statements to cash receipts; • assessing the validity of the income and the associated receivables relating to the fourth quarter; • agreeing the total income from the Fund (including any finance incentive, bonus payments and additional income from the final distribution) to communications from NHS England; • agreeing for the remaining population of other operating income, on a sample basis, amounts recognised in income in the financial statements to contracts and invoices; • on a sample basis agreeing associated receivables at year-end to subsequent cash receipts. The Trust's accounting policy on income recognition is shown in note 1.2 to the financial statements and related disclosures are included in note 3.3
Going Concern material uncertainty disclosures The Trust has received financial revenue support totalling £11,919,000 during the 2016/17 financial year. The Trust incurred a £8,260,000 financial deficit in 2016/17 and management anticipates that it may take some time before the Trust income equals or exceeds its expenditure. The Trust will therefore require further working capital loans to pay its expenses in 2017/18 and 2018/19. The source and value of this support/loans has yet to be confirmed.	Our audit work included, but was not restricted to: • determining whether the procedures performed by management for identifying material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern were appropriate; • assessing the appropriateness of the assumptions and judgements underpinning the cash-flow forecasts used by management to assess the existence of material uncertainties relating to going concern; • verifying that the disclosures within the financial statements explaining the material uncertainty that casts significant doubt on the Trust's ability to continue as a going concern are appropriate and accurately explain the events and conditions that gave rise to the uncertainty and the assumptions and judgements made by management in its assessment; and

Audit risk	How we responded to the risk
In the prior year the foundation trust annual reporting manual 2015/16 did not explicitly require disclosure in the financial statements of material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern. In the current year, the Department of Health Group Accounting Manual 2016/17 explicitly requires these disclosures. Given the sensitive nature and the updated requirements specifically requiring these disclosures in the financial statements, we have identified this as an area of focus in our audit. We therefore identified the adequacy of disclosures relating to material uncertainties that may cast doubt on the Trust's ability to continue as a going concern in the financial statements as a significant risk requiring special audit consideration.	• verifying that the disclosures within the financial statements comply with the reporting requirements detailed in the Department of Health Group Accounting Manual 2016/17. The Trust's accounting policy in respect of the going concern basis of preparation is shown in note 1 to the financial statements.
Valuation of property, plant and equipment The Trust's land, buildings and dwellings within property, plant and equipment is valued at £117,890,000 and involves estimates that require judgements in relation to useful lives and asset valuation basis. Specifically, the land and buildings asset valuation estimates have decreased by £15,460,000 primarily due to the adoption of the single site modern equivalent asset valuation basis. As such, there is an increased risk that these assets are incorrectly valued. We therefore identified the valuation of property, plant and equipment as a significant risk requiring special audit consideration.	Our audit work included, but was not restricted to: • obtaining management's assessment of the valuation of property, plant and equipment and understanding the valuation process, including key controls and assumptions used by management; • assessing the competence, objectivity and expertise of management's valuer, including the work of an auditor's expert to assess whether we could place reliance on their work; • assessing the appropriateness of the instructions issued to the valuer and the scope of their work, including the completeness of the data provided to the valuer; • for a sample of assets revalued in the year, agreeing the valuation included in the valuer's report to the asset register and the financial statements; • challenging and obtaining evidence for the assumptions made by management in relation to the full valuation of land and buildings including the appropriateness of the adoption of an alternative site valuation methodology where applied. The Trust's accounting policy on property, plant and equipment is shown in note 1.6 to the financial statements and related disclosures are included in note 12.

Our application of materiality and an overview of the scope of our audit

Materiality

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

This is the first year of our appointment as auditor for the Trust. We determined materiality for the audit of the Trust's financial statements as a whole to be £4,164,000, which is 1.75% of the Trust's gross operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding.

We also determined a lower level of specific materiality for certain areas such as related party transactions and disclosures of senior manager remuneration in the Remuneration Report.

We determined the threshold at which we will communicate misstatements to the Audit Committee to be £208,000. In addition we will communicate misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Chief Executive as Accounting Officer; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements 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.

We conducted our audit in accordance with International Standards on Auditing (ISAs) (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of financial statements of public sector bodies in the United Kingdom'. Our responsibilities under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code) and those standards are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

We are independent of the Trust in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based, and in particular included an interim visit, evaluation of the Trust's internal control relevant to the audit including relevant IT systems and controls over key financial systems.

Overview of the scope of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code. Based on our risk assessment, we undertook such work as we considered necessary.

Other reporting required by regulations

Our opinion on other matters required by the Code is unmodified

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2016/17 and the requirements of the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the audited financial statements.

Matters on which we are required to report by exception

Under the ISAs (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to report to you if:

- we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the annual report is fair, balanced and understandable; or
- the annual report does not appropriately disclose those matters that we communicated to the Audit Committee which we consider should have been disclosed.

Under the Code we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2016/17 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls; or
- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in respect of the above matters.

Responsibilities for the financial statements and the audit

What the Chief Executive, as Accounting Officer, is responsible for:

As explained more fully in the Statement of Accounting Officer's responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2016/17 and for being satisfied that they give a true and fair view. The Accounting Officer is also responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

What we are responsible for:

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

We are required under Section 1 of Schedule 10 of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the financial statements of Warrington and Halton Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code.

Mark Heap

Mark Heap
Director
for and on behalf of Grant Thornton UK LLP

Grant Thornton UK LLP
4 Hardman Square
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Manchester
M3 3EB

26th May 2017

The Audit Findings for Warrington and Halton Hospitals NHS Foundation Trust

Year ended 31 March 2017

May 2017

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23rd May 2017

Dear Members of the Audit Committee

Audit Findings Report for Warrington and Halton Hospitals NHS Foundation Trust for the year ending 31 March 2017

This Audit Findings report presents the observations arising from the audit that are significant to the responsibility of those charged with governance to oversee the financial reporting process, as required by International Standard on Auditing (UK & Ireland) 260, the Local Audit and Accountability Act 2014 and the National Audit Office Code of Audit Practice. Its contents have been discussed with management.

As auditor we are responsible for performing the audit, in accordance with International Standards on Auditing (UK & Ireland) ('ISA (UK&I)'), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance. The audit of the financial statements does not relieve management or those charged with governance of their responsibilities for the preparation of the financial statements.

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed for the purpose of expressing our opinion on the financial statements. Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify control weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all defalcations or other irregularities, or to include all possible improvements in internal control that a more extensive special examination might identify. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

We would like to take this opportunity to record our appreciation for the kind assistance provided by the finance team and other staff during our audit.

Yours sincerely

Mark Heap

Engagement lead

Chartered Accountants
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Section 1: Executive summary

01. Executive summary
02. Audit findings
03. Value for Money
04. Other statutory powers and duties
05. Fees, non audit services and independence
06. Communication of audit matters

Purpose of this report

This report highlights the key issues affecting the results of Warrington and Halton Hospitals NHS Foundation Trust ('the Trust') and the preparation of the Trust's financial statements for the year ended 31 March 2017. It is also used to report our audit findings to management and those charged with governance in accordance with the requirements of ISA (UK and Ireland) 260, and the Local Audit and Accountability Act 2014 ('the Act').

Under the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to report whether, in our opinion, the Trust's financial statements give a true and fair view of the financial position of the Trust and its income and expenditure. We are also required to give an opinion on some elements of the Remuneration and Staff report. We are required to consider other information published together with the audited financial statements, whether it is consistent with the financial statements, apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or otherwise misleading and in line with required guidance.

We are required to carry out sufficient work to satisfy ourselves on whether the Trust has made proper arrangements to secure economy, efficiency and effectiveness in its use of resources ('the value for money (VFM) conclusion'). Auditor Guidance Note 7 (AGN07) clarifies our reporting requirements in the Code and the Act so that if we are not satisfied then we are required to report by exception.

The Act also details the following additional powers and duties for Trust auditors, which we are required to report to you if applied:

- a referral to Secretary of State if we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency (section 30 of the Act);
- a public interest report if we identify any matter that comes to our attention in the course of the audit that in our opinion should be considered by the Trust or brought to the public's attention (section 24 of the Act); and
- written recommendations which should to be considered by the Trust and responded to publicly (section 24 of the Act).

In addition to our responsibilities under the Code we are also required to carry out a limited assurance engagement on the Trust's Quality Report in accordance with the requirements of the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17' issued by NHS Improvement.

Introduction

In the conduct of our audit we have not had to alter or change our audit approach, which we communicated to you in our Audit Plan dated 24th March 2017.

Our audit is substantially complete although we are finalising our procedures in the following areas:

- completing our final testing on journals, property, plant and equipment, income, operating expenses and the Remuneration and Annual Report
- complete our review of the outcome of the agreement of balances exercise
- review of the final version of the financial statements
- obtaining and reviewing the management letter of representation
- review of the accounts consolidation schedules
- updating our post balance sheet events review, to the date of signing the opinion.

We received draft financial statements at the commencement of our work, in accordance with the national deadline.

Key audit and financial reporting issues

Financial statements opinion

We have not identified the need to make any adjustments arising from our audit affecting the Trust's deficit position for the year. The Trust did, however receive notification of some further Sustainability and Transformation Funding in May, after the draft accounts had been submitted. The Trust has decided to adjust for this additional income in 2016/17, the resultant impact being that the deficit for the year will reduce further by £0.044m to £8.260m.

The Trust continues to rely on has increased levels of Department of Health (DH) working capital loan support to ease its liquidity situation. Cash support for the control total of £7.919m deficit was initially received and a further £4m obtained due to the delays in receiving Sustainability and Transformation Funding for quarters 3 and 4. The Trust also plans to request future DH loan support in 2017/18 and 2018/19 to meet its forecasted control total deficits (£3.7m in 2017/18 and £3.6m in 2018/19), as well as anticipating the possibility of a further £14.2m loan in 2018/19 to fund the repayment of its 2015/16 £14.2m Department of Health loan.

The level of loans required by the Trust to ensure liquidity continues to increase and will only start to reduce once the Trust achieves a year end surplus position, which is not forecasted in the foreseeable future. Given the increased reliance on DH support with little prospect of this reducing going forward an emphasis of matter around going concern is proposed.

Our anticipated audit opinion will be unqualified in respect of the financial statements, but will include reference to an emphasis of matter paragraph around going concern.

Other financial statement responsibilities

As well as an opinion on the financial statements, we are required to consider the consistency of other information published with the financial statements, including the Annual Report and Annual Governance Statement (AGS). We are also required to carry out work to satisfy ourselves that disclosures made in your AGS are in line with guidance issued and consistent with our knowledge of the Trust.

Based on our review of the AGS and our on-going work reviewing the Annual Report we are satisfied that they are consistent with the audited financial statements. The AGS meets the requirements set out in the Department of Health Group Accounting Manual 2016/17 and associated guidance.

Controls

Roles and responsibilities

The Trust's management is responsible for the identification, assessment, management and monitoring of risk, and for developing, operating and monitoring the system of internal control.

Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify any control weaknesses, we report these to the Trust.

Findings

Our work has not identified any significant control weaknesses which we wish to highlight for your attention. We have made an observation around the process for declaring interests, which is covered in more detail in section 2.

Value for Money

Based on our review, we are satisfied that, in all significant respects, the Trust had proper arrangements in place to secure economy, efficiency and effectiveness in its use of resources.

Further detail of our work on Value for Money are set out in section three of this report.

Other statutory powers and duties

We have not identified any issues that have required us to apply our statutory powers and duties under the Act.

Quality Report

We have completed our limited assurance procedures on the Trust's Quality Report, based on the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17.' We have provided a separate report to the Trust's Board of Governors setting out our results and conclusions and planned limited assurance opinion.

Acknowledgement

We would like to take this opportunity to record our appreciation for the assistance provided by the finance team and other staff during our audit.

Grant Thornton UK LLP
May 2017

Section 2: Audit findings

01. Executive summary

02. Audit findings

03. Value for Money

04. Other statutory powers and duties

05. Fees, non audit services and independence

06. Communication of audit matters

Materiality

In performing our audit, we apply the concept of materiality, following the requirements of ISA (UK&I) 320: Materiality in planning and performing an audit. The standard states that 'misstatements, including omissions, are considered to be material if they, individually or in the aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements'.

As we reported in our audit plan, we determined overall materiality to be £4,034,000 ,being 1.75% of forecasted gross revenue expenditure, (gross operating expenses). We have considered whether this level remained appropriate during the course of the audit and have made increased the overall materiality to £4,164,000, based on 1.75% of the actual gross revenue expenditure from the financial statements, (gross operating expenses), as a result of higher than forecasted gross revenue expenditure.

We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 75% of financial statement materiality for the audit of the financial statements. We also determined a lower level of specific materiality for certain areas such as related party transactions and disclosures of senior manager remuneration in the Remuneration Report

We also set an amount below which misstatements would be clearly trivial and would not need to be accumulated or reported to those charged with governance because we would not expect that the accumulated effect of such amounts would have a material impact on the financial statements. We have now redefined the amount below which misstatements would be clearly trivial to be £0.208m . This is a change from the figure reported in our audit plan, as a result of the change in materiality.

As we reported in our audit plan, we identified the following items where we decided that separate materiality levels were appropriate. These remain the same as reported in our audit plan.

Balance/transaction/disclosure	Explanation	
Disclosures of senior manager salaries and allowances in the remuneration report	Due to public interest in these disclosures and the statutory requirement for them to be made.	£20,000
Related party transactions	Due to public interest in these disclosures and the statutory requirement for them to be made.	£20,000. Individual misstatements will also be evaluated with reference to how material they are to the other party.

Misstatements, including omissions, are considered to be material if they, individually or in the aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements; Judgments about materiality are made in light of surrounding circumstances, and are affected by the size or nature of a misstatement, or a combination of both; and Judgments about matters that are material to users of the financial statements are based on a consideration of the common financial information needs of users as a group. The possible effect of misstatements on specific individual users, whose needs may vary widely, is not considered. (ISA (UK and Ireland) 320)

Audit findings against significant risks

In this section we detail our response to the significant risks of material misstatement which we identified in the Audit Plan. As we noted in our plan, there are two presumed significant risks which are applicable to all audits under auditing standards.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
1.	**The revenue cycles include fraudulent transactions** Under ISA (UK and Ireland) 240 there is a presumed risk that revenue may be misstated due to the improper recognition of revenue. The Trust receives 87% of the Trust's income from patient care activities is derived from contracts with NHS commissioners, of which 85% is derived from contracts with the Trust's three main commissioners. The Trust recognises patient care activity income during the year based on the completion of these activities. Patient care activities provided that are additional to those incorporated in the contracts with NHS commissioners, are subject to verification and agreement by the NHS commissioners. As such, there is the risk that income is recognised for these additional services that is not subsequently agreed to by the NHS commissioners.	As part of our audit work we have: • documented our understanding of management's controls over revenue recognition and performed walkthrough testing to confirm the controls identified have been implemented • reviewed revenue recognition policies for compliance with relevant accounting standards and guidance • agreed revenue recognised to signed contracts held by the Trust • reviewed the output from the national agreement of balances exercise to compare revenue and receivables balances recognised by the Trust with expenditure and creditors balances disclosed by counterparties and obtained explanations for differences considered to be significant • agreed Sustainability and Transformation Fund income to supporting documentation • sample testing of debtor balances and income recognised outside of the Trust's main contracts to obtain assurance that revenue has been recognised on an appropriate basis.	Our audit work to date has not identified any issues in respect of revenue recognition.

Audit findings against significant risks

In this section we detail our response to the significant risks of material misstatement which we identified in the Audit Plan. As we noted in our plan, there are two presumed significant risks which are applicable to all audits under auditing standards.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
1.	**The revenue cycles include fraudulent transactions (cont)** 13% of the Trust's income is from other operating income sources, including £9,891,000 (32%) relating to funding from the national Sustainability and Transformation Fund (STF). We identified the occurrence of income from patient care activities and the existence of associated receivables as a significant risk requiring special audit consideration. We have concluded that the greatest risk of material misstatement relates the occurrence of income and the existence of associated receivables for both healthcare and non-healthcare income.	As part of our audit work we have: • documented our understanding of management's controls over revenue recognition and performed walkthrough testing to confirm the controls identified have been implemented • reviewed revenue recognition policies for compliance with relevant accounting standards and guidance • agreed revenue recognised to signed contracts held by the Trust • reviewed the output from the national agreement of balances exercise to compare revenue and receivables balances recognised by the Trust with expenditure and creditors balances disclosed by counterparties and obtained explanations for differences considered to be significant • agreed Sustainability and Transformation Fund income to supporting documentation • sample testing of debtor balances and income recognised outside of the Trust's main contracts to obtain assurance that revenue has been recognised on an appropriate basis.	Our audit work to date has not identified any issues in respect of revenue recognition.
2.	**Management override of controls** Under ISA (UK and Ireland) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities.	As part of our audit work we have: • identified accounting estimates, judgments and decisions made by management relevant to the risk of management override • confirmed our understanding of the arrangements for inputting and authorising journals • reviewed journal entries considered to be large or unusual given our knowledge and understanding of the Trust to understand why such journals have been posted and that such journals are supported by relevant documentation • reviewed significant unusual transactions.	Our audit work to date has not identified any evidence of management over-ride of controls. In particular the findings of our review of journal controls and testing of journal entries has not identified any significant issues.

Audit findings against significant risks continued

We have also identified the following significant risks of material misstatement from our understanding of the entity. We set out below the work we have completed to address these risks.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
3.	**The expenditure cycle includes fraudulent transactions** Practice Note 10 suggests that the risk of material misstatement due to fraudulent financial reporting that may arise from the manipulation of expenditure recognition needs to be considered, especially where the body is required to meet targets.	As part of our audit work we have: • reviewed accounting estimates, judgments and decisions made by management • documented the processes and controls around the accounting for operating expenses • reviewed journal entry processes and controls and significant journals processed at year end • performed cut off testing.	Our audit work to date has not identified any significant issues in relation to expenditure recognition.
4.	**Going Concern material uncertainty disclosures** In light of the Trust's recent financial performance, reliance on external cash support and forecast deficit financial outturn for 2016/17, there are uncertainties about the appropriateness of the going concern assumption for the Trust's financial statements. .	As part of our review as to whether the Trust is a going concern we have: • reviewed management's assessment that the going concern basis is appropriate for the 2016/17 financial statements • obtained details of the future £7.0m Sustainability and Transformation funding expected to be received by the Trust in 2017/18 • reviewed the level of loan support required • reviewed the Trust's cash flow forecasts up to 31/3/2019.	This year the Trust has increased the level of its Department of Health working capital loan support from £14.2m to £26.2m, £4m of which was required due to the delays in receiving Sustainability and Transformation Funding for quarters 3 and 4.The Trust also plans to request future Department of Health working capital loans in 2017/18 and 2018/19 to meet its forecasted control total deficits (£3.7m in 2017/18 and £3.6m in 2018/19). Furthermore the Trust anticipates that it may require an additional £14.2m loan in 2018/19 to fund the repayment of its 2015/16 £14.2m Department of Health loan, although it is also considering a number of other options for repayment. The level of loans required by the Trust to ensure liquidity continues to increase and will only start to reduce once the Trust achieves a year end surplus position, which is not forecasted in the foreseeable future.

Audit findings against significant risks continued

We have also identified the following significant risks of material misstatement from our understanding of the entity. We set out below the work we have completed to address these risks.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
4.	**Going Concern** In light of the Trust's recent financial performance, reliance on external cash support and forecast deficit financial outturn for 2016/17, there are uncertainties about the appropriateness of the going concern assumption for the Trust's financial statements. The Trust has received financial revenue support totalling £11,919,000 during the 2016/17 financial year. The Trust incurred a £8.260,000 financial deficit in 2016/17 and management anticipates that it may take some time before the Trust income equals or exceeds its expenditure. The Trust will therefore require further working capital loans to pay its expenses in 2017/18 and 2018/19. The source and value of this support/loans has yet to be confirmed. In the prior year the foundation trust annual reporting manual 2015/16 did not explicitly require disclosure in the financial statements of material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern. In the current year, the Department of Health Group Accounting Manual 2016/17 explicitly requires these disclosures. Given the sensitive nature and the updated requirements specifically requiring these disclosures in the financial statements, we have identified this as an area of focus in our audit. We therefore identified the adequacy of disclosures relating to material uncertainties that may cast doubt on the Trust's ability to continue as a going concern in the financial statements as a significant risk requiring special audit consideration.	As part of our review as to whether the Trust is a going concern we have: • reviewed management's assessment that the going concern basis is appropriate for the 2016/17 financial statements • obtained details of the future £7.0m Sustainability and Transformation funding expected to be received by the Trust in 2017/18 • reviewed the level of loan support required • reviewed the Trust's cash flow forecasts up to 31/3/2019.	Discussions with the Trust indicate that whilst its 2017/18 and 2018/19 financial plans, which include its intended future Department of Health borrowing profile have not been challenged, it has not, along with many other Trust's nationally, received support letters regarding the availability of future levels of loan support. This is not necessarily unusual and past history suggests funding levels request will be supported, but it does add a further degree of uncertainty. Given the increased reliance on Department of Health support with little prospect of this reducing going forward an emphasis of matter around going concern is proposed. We do not have any concerns about the going concern assumption as the basis for preparing the accounts, however, our concern is around the likelihood of future material uncertainties.

Audit findings against significant risks continued

We have also identified the following significant risks of material misstatement from our understanding of the entity. We set out below the work we have completed to address these risks.

	Risks identified in our audit plan	Work completed	Assurance gained and issues arising
5.	**Valuation of property, plant and equipment** The Trust revalues its land and buildings on an annual basis to ensure that carrying value is not materially different from fair value. This represents a significant estimate in the financial statements The Trust's land, buildings and dwellings within property, plant and equipment is valued at £117.890,000 and involves estimates that require judgements in relation to useful lives and asset valuation basis. Specifically, the land and buildings asset valuation estimates have decreased by £15.460,000 primarily due to the adoption of the single site modern equivalent asset valuation basis. As such, there is an increased risk that these assets are incorrectly valued. We therefore identified the valuation of property, plant and equipment as a significant risk requiring special audit consideration.	As part of our audit work we have: • obtained management's assessment of the valuation of property, plant and equipment and understanding the valuation process used by management to value assets, including their key controls, use of experts and significant assumptions • considering the appropriateness and reliability of information provided to management's expert • for a sample of revalued assets, we have agreed the valuation from the valuer's report to the accounts via the asset register • for assets not formally revalued in the year, we have reviewed and challenged how management have obtained sufficient assurance that the value in the Statement of Financial Position is fairly stated.	During 2016/17 the Trust changed the way that it valued all of its land and building assets, and valued these on the basis that a re-provision of services would be provided from a alternative single site. Good practice is that the judgements and assumptions made by a Trust, including the benefits of any alternative site used as the basis for the valuation, should be approved by TCWG and disclosed in the accounts. There was discussion by the Finance and Sustainability Committee in February but the level of detail was limited. We recommend that where similar decisions are taken in the future there is a more robust rationale around the assumptions and judgements being made by management. We have identified that there is an inconsistency in the way some assets are identified and logged at the Trust. The asset register and IT asset system does not have the same asset ID number making it difficult to locate individual assets for inspection. We have made a recommendation around the need for a common ID asset number. Other than the issues raised above our audit work has not identified any significant issues in relation to the risk identified.

Audit findings against other risks continued

In this section we detail our response to the other risks of material misstatement which we identified in the Audit Plan.

Transaction cycle	Description of risk	Work completed	Assurance gained & issues arising
Employee remuneration	Employee remuneration accruals understated (Remuneration expenses not correct)	• Gained an understanding of the systems used to recognise expenditure on pay and year-end accruals, and evaluated the design of the associated controls. • Obtaining a copy of the year-end pay reconciliation, ensuring that the pay costs included in the accounts included both Trust payroll costs and bank agency payments and reconciled to the financial ledger and through to payroll and other pay interface reports. • Analysed payroll data to provide assurance on the completeness of pay costs, ensuring that month-on-month variations in gross pay and on-costs were in line with expectations, that payroll transactions had been recorded in the correct financial year and that all payroll systems interfaces were included in the financial ledger. • Testing of a sample of payroll payments made to staff as part of our overall testing of payroll costs.	Our audit work to date has not identified any significant issues in relation to the risk identified.
Operating expenses	Creditors understated or not recorded in the correct period (Operating expenses understated)	• Gained an understanding of the systems used to recognise non-pay expenditure and year-end accruals, and evaluating the design of the associated controls. • Tested a sample of post year-end payments to confirm the completeness of accruals.	Our audit work to date has not identified any significant issues in relation to the risk identified.

"In respect of some risks, the auditor may judge that it is not possible or practicable to obtain sufficient appropriate audit evidence only from substantive procedures. Such risks may relate to the inaccurate or incomplete recording of routine and significant classes of transactions or account balances, the characteristics of which often permit highly automated processing with little or no manual intervention. In such cases, the entity's controls over such risks are relevant to the audit and the auditor shall obtain an understanding of them." (ISA (UK&I) 315)

Accounting policies, estimates and judgements

In this section we report on our consideration of accounting policies, in particular revenue recognition policies, and key estimates and judgements made and included within the Trust's financial statements.

Accounting area	Summary of policy	Comments	Assessment
Revenue recognition	Accounting Policy 1.2 states that the Trust recognises revenue in respect of services when and to the extent that performance occurs and is measured at the fair value of the consideration received. The main source of income for the Trust is from NHS commissioners for the provision of healthcare services. This income is recognised either on discharge of patient or value of partially completed activity as at 31 March 2017 for all NHS commissioners.	The recognition of revenue by the Trust is in line with recognised accounting guidance and in line with the Group Accounting Manual recommended approach.	
Judgements and estimates	Key estimates and judgements include: – useful life of property, plant and equipment – revaluations – impairments – provisions – accruals.	Our audit work to date has found no issues to report regarding the: • appropriateness of policy under relevant accounting framework • extent of judgement involved • potential financial statement impact of different assumptions • adequacy of disclosure of accounting policies, other than the amendment made to include a policy regarding critical accounting judgements and key sources of estimation uncertainty.	
Other accounting policies	The Trust has adopted the standard accounting policies for the NHS as set out in the DH Group Accounting Manual.	We have reviewed the Trust's policies against the requirements of the Group Accounting Manual. Other than the disclosure issues reported on pages 19-22, the Trust has appropriately tailored the standard accounting policies to its individual circumstances.	

Assessment

● Marginal accounting policy which could potentially attract attention from regulators
● Accounting policy appropriate but scope for improved disclosure
● Accounting policy appropriate and disclosures sufficient

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Other communication requirements

We set out below details of other matters which we, as auditors, are required by auditing standards and the Code to communicate to those charged with governance.

	Issue	Commentary
1.	**Matters in relation to fraud**	• We have discussed the risk of fraud with the Audit Committee on the 24/4/2017. We have not been made aware of any other incidents in the period and no other issues have been identified during the course of our audit procedures.
2.	**Matters in relation to related parties**	• From the work we carried out, we have not identified any related party transactions which have not been disclosed, other than the issues reported on pages 17 and 20.
3.	**Matters in relation to laws and regulations**	• You have not made us aware of any significant incidences of non-compliance with relevant laws and regulations and we have not identified any incidences from our audit work.
4.	**Written representations**	• A letter of representation has been requested from the Trust which is included as part of the Audit Committee papers for the 23rd May 2017 meeting. Specific representation has been requested regarding the going concern of the Trust.
5.	**Disclosures**	• Our review identified a small number of typographical and presentational errors which have been amended. Other changes made to disclosure notes and accounting policies are summarised on pages 19-22.
6.	**Auditable elements of Remuneration and Staff Report**	• We are required to give an opinion on whether the part of the Remuneration and Staff Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury. • We have audited the elements of the Remuneration and Staff report, as required by the Code. We found no issues to report to date. • We propose to issue an unqualified opinion.
7.	**Matters on which we report by exception**	• We are required to report on a number of matters by exception in a number of areas. In particular: • if the Annual Governance Statement does not meet the disclosure requirements set out in the DH Group Accounting Manual or is misleading or inconsistent with the information of which we are aware from our audit. • the information in the Annual Report is materially inconsistent with the information in the audited financial statements or apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit, or otherwise misleading. • We have not identified any issues we would be required to report by exception to date.

Internal controls

The purpose of an audit is to express an opinion on the financial statements.

Our audit included consideration of internal controls relevant to the preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control. The matters reported here are limited to those deficiencies that we have identified during the course of our audit and that we have concluded are of sufficient importance to merit being reported to you in accordance with auditing standards.

Our work has not identified any significant control weaknesses which we wish to highlight for your attention, however, the following observation was noted.

	Assessment	Issue and risk	Recommendations
1.		**Declaration of Interests** In line with recommended practice the Trust has a register of interest where any pecuniary interests are recorded. It is recommended that guidance accompanying the register and he arrangements for recording such interests is revisited as it is not always clear as to the circumstances which may warrant a disclosure. Our audit also identified a recently recruited director who had not completed a declaration of interest form. There is a need to ensure that all new starters in position of influence are aware of the need to complete a declaration recording any interests.	• Update register of interest guidance to make sure it is clear when disclosure is required. • Ensure arrangements are put in place when new starters, who are in a position of potential influence, complete a declaration of interest form.

Assessment
- Significant deficiency – risk of significant misstatement
- Deficiency – risk of inconsequential misstatement

"The purpose of an audit is for the auditor to express an opinion on the financial statements.
Our audit included consideration of internal control relevant to the preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of internal control.
The matters being reported are limited to those deficiencies that the auditor has identified during the audit and that the auditor has concluded are of sufficient importance to merit being reported to those charged with governance." (ISA UK and Ireland 265)

Misclassifications and disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

	Adjustment type	Value £'000	Account balance	Impact on the financial statements
1	Disclosure	n/a	Property Plant and Equipment (Note 12.1)	The Group Accounting Manual states that upon a formal revaluation, cumulative depreciation should be "zeroed" as an in year movement, with a corresponding adjustment made to the "cost" line ensuring that the "zeroing" arrangement does not itself distort net book values. The Trust has not shown this level of detail within its property, plant and equipment disclosure note. We found that brought forward balances for cost and accumulated depreciation in PPE Note 12 did not agree to the asset register although they agree at net level. This is because all revaluations are recorded against cost in asset register but are split differently over cost and depreciation in Note 12. The figures for the asset register and the Note agree at net level. Subsequent testing of asset movements including revaluations has shown that these have been correctly accounted for, so this is a presentational issue only and does not impact on PPE balances or charges to SOCI or Revaluation Reserve. Going forward the Trust should correctly disclose the impact on any revaluations on depreciation and cost and ensure that the asset register agrees to the note at all disclosure levels.
2	Disclosure	6,265	Property Pant and Equipment (Note 12.2)	The 2015/16 comparative figures for property, plant and equipment was missing the disclosure of reversal of impairments credited to the revaluation reserve of £6.265m.

Misclassifications and disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

	Adjustment type	Value £'000	Account balance	Impact on the financial statements
3	Classification	n/a	Employee expenses (Note 5.1)	The note has been amended to show the correct classification of salaries and wages and bank and agency costs within the note.
4	Disclosure	n/a	Accounting policies and notes	The following amendments have been made to disclosure notes or accounting policies: • Accounting Policy Consolidation (Note 1.17) has been updated to make it clear that the Trust has opted not to consolidate its charitable funds within the Trust's financial statement. • Going concern – the accounting policy (Note 1) have been updated to reflect the assumption that the Trust remains a going concern and that the accounts have been prepared on this basis. • Operating segments (Note 2) has been amended to highlight that the Trust only has one material operating segment, which is healthcare. • Key sources of judgements and estimation and uncertainty (Note 1.1) has been expanded to detail the basis of management's assumption of the benefits of any alternative single site used as the basis for the valuation, and to updated the note that assets that are held for their service potential and are in use, should be measured at current value in existing use not of fair value (a similar change has been made to Note 10). • Accounting policy Note 1.2.1 has now been updated to provide information on reserves. • Notes 5.2 (Average number of employees) and notes 5.4, 5.5, 5.6 (Exit packages) have been removed from the annual accounts and included within the Annual Report in line with the new disclosure requirements this year.

Misclassifications and disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

	Adjustment type	Value £'000	Account balance	Impact on the financial statements
6	Disclosure	n/a	Accounting policies and notes (Cont)	• Note 1.10 on provisions has been updated to reflect the Trust's position on provisions.
7	Disclosure	n/a	Financial Instruments (Notes 27.2 and 27.3)	The note has been amended to remove provisions relating to pension benefits, which should be excluded from the note. As a result of this change – there is also a change to the analysis in Note 5.3 relating to maturity of financial liabilities.
8	Disclosure	n/a	Related Party Transactions (Note 23)	The note had disclosed that the Trust had a related party transaction with Warrington Borough Council and St Helens and Knowsley Teaching Hospitals NHS Trust as it received income from both the Council and the Trust in excess of £500,000. Income actually received from the Council as per the FTC's which support the financial statements, was £117,000 and from St Helens and Knowsley £250,00 and therefore both have now been excluded from the note on the basis that there is not a significant related party relationship based on income. Additionally the Trust does have expenditure with St Helens and Knowsley of £3.2m and this should have been disclosed in the section of the note which highlights that a related party relationship exists based on expenditure. The note has also been amended to disclose the Department of Health as the parent department

Misclassifications and disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

	Adjustment type	Value £'000	Account balance	Impact on the financial statements
9	Disclosure	n/a	Annual Governance Statement	The Annual Governance Statement has been updated to reflect the response taken by the Trust to the ransomware attack on the 12th May 2017 that affected many organisations across the world.

Section 3: Value for Money

01. Executive summary
02. Audit findings
03. Value for Money
04. Other statutory powers and duties
05. Fees, non-audit services and independence
06. Communication of audit matters

Background

We are required by section 21 of the Local Audit and Accountability Act 2014 ('the Act') and the NAO Code of Audit Practice ('the Code') to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This is known as the Value for Money (VFM) conclusion.

The Act and the Code require us only to report by exception where we are not satisfied that NHS bodies have proper arrangements in place to secure value for money. However, we are required to carry out sufficient work to satisfy ourselves that proper arrangements are in place at the Trust.

In carrying out this work, we are required to follow the NAO's Auditor Guidance Note 3 (AGN 03) issued in November 2016. AGN 03 identifies one single criterion for auditors to evaluate:

> *In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people.*

AGN03 provides examples of proper arrangements against three sub-criteria but specifically states that these are not separate criteria for assessment purposes and that auditors are not required to reach a distinct judgement against each of these.

Risk assessment

We carried out an initial risk assessment in and identified two significant risks in respect of specific areas of proper arrangements using the guidance contained in AGN03. We communicated this risk to you in our Audit Plan dated 24th March 2017.

We have continued our review of relevant documents up to the date of giving our report, and have not identified any further significant risks where we need to perform further work.

We carried out further work only in respect of the significant risks we identified from our initial and ongoing risk assessment. Where our consideration of the significant risks determined that arrangements were not operating effectively, we have used the examples of proper arrangements from AGN 03 to explain the gaps in proper arrangements that we have reported in our VFM conclusion.

Significant qualitative aspects

AGN 03 requires us to disclose our views on significant qualitative aspects of the Trust's arrangements for delivering economy, efficiency and effectiveness. We have focused our work on the significant risk that we identified in the Trust's arrangements.

We have set out more detail on the risks we identified, the results of the work we performed and the conclusions we drew from this work on pages 25-26.

Overall conclusion

Based on the work we performed to address the significant risks, we concluded that:

- the Trust had proper arrangements in all significant respects to ensure it delivered value for money in its use of resources.

We only report by exception in our auditors' report where we give a qualified conclusion. The text of our report, which confirms this under the 'matters on which we report by exception' section, can be found at Appendix B.

Key findings

We set out below our key findings against the significant risk we identified through our initial risk assessment.

Significant risk	Work to address	Findings and conclusions
Financial outturn The Trust forecasted that it will incur a deficit in 2016/17 of £8.1 million. Whilst this is the budgeted position it would only be achieved with Sustainability and Transformation Funding (STF) monies of approximately £8m which required the achievement of financial and performance targets. In 2015 Monitor announced that it believed there were grounds to suspect that the Trust had breached its licence after recording a higher than expected deficit.	We reviewed the Trust's arrangements for monitoring and managing the delivery of its budget and savings plans for 2016/17, including the impact on service delivery. We assessed the progress that the Trust has made with regards to the breach of its licence.	We found that the Trust has appropriate arrangements in place to monitor and manage the delivery of its budget and savings. These arrangements have helped the Trust improve its overall financial performance. Key aspects of the arrangements include: • the Trust producing clear meaningful financial reports promptly each month • monthly Finance and Sustainability Committee meetings, which consider financial issues in detail; and • the development of the integrated performance dashboard which includes both finance and performance issues for the Board. The monitoring and managing of savings has also developed during the year and continues to evolve further in 2017/18. The CIP tracker has developed and ensures that all savings ideas, from many different sources, are recorded. The tracker records those savings ideas that are still being considered, rejected, and those that are in development. Financial values are put against each scheme where possible and the Trust are able to monitor whether savings are on track. Service impact is considered through impact assessments and will be considered during the scheme if there are any concerns. In relation to the breach of the licence, we understand that the Trust has written to NHSI to seek the lifting of the breach given the improving financial performance.

Key findings

We set out below our key findings against the significant risk we identified through our initial risk assessment.

Significant risk	Work to address	Findings and conclusions
Financial sustainability The Trust has identified a significant cost improvement programme (CIP) target for 2017/18 of £10.5m to achieve the control total deficit of £3.8m, which is a significant reduction in the deficit compared to previous year. There is a risk that if the Trust does not have robust savings plans then the control total will not be achieved.	We reviewed the Trust's arrangements for updating, agreeing and monitoring its savings and budget plans, and for communicating key findings to the Governing Body.	The Trust has appropriate arrangements for updating, agreeing and monitoring its savings and budget plans. The Trust has a documented approach to setting the overall budget. Part of that process is getting the balance right between investment in services and setting a realistic CIP target. One important part of the budget setting process relates to investment decisions. Clinical Business Units identify service developments through their Annual Business Plans and complete a short template to request funding. These are reviewed by the Divisions and then challenged by the Executive team. Where there is a decision to progress with the investment the Head of Management Accounts summaries the impact this would have on the CIP required and further review takes place until the budget is agreed. This process will ensure that there is an appropriate balance to investment and savings targets. The budget is then monitored during the year and regular reports produced for the Finance and Sustainability Committee (FSC). The Committee considers both financial assurance and planning issues. The monthly finance report presented at the Committee sets out in detail the key financial issues at the Trust and allows members of the Committee a thorough understanding of such issues. Another development is the CIP report produced for the FSC allowing a clear understanding of the position and actions required. The Board are updated on financial issues through the integrated performance dashboard and also an update by the FSC. The integrated report is also presented to the Council of Governors to ensure they are fully sighted of performance and finance issues at the Trust.

Significant difficulties in undertaking our work

We did not identify any significant difficulties in undertaking our work on your arrangements which we wish to draw to your attention.

Significant matters discussed with management

There were no matters where no other evidence was available or matters of such significance to our conclusion or that we required written representation from management or those charged with governance.

Any other matters

There were no other matters from our work which were significant to our consideration of your arrangements to secure value for money in your use of resources.

Section 4: Other statutory powers and duties

01. Executive summary
02. Audit findings
03. Value for Money
04. Other statutory powers and duties
05. Fees, non audit services and independence
06. Communication of audit matters

We set out below details of other matters which we, as auditors, are required by the Act and the Code to communicate to those charged with governance.

	Issue	Commentary
1.	**Referral to the Secretary of State**	• We have not identified any issues which we need to refer to the Secretary of State.
2.	**Public interest report**	• We have not identified any matters that would require a public interest report to be issued.
3.	**Written recommendations**	• We have not made any written recommendations that the Trust is required to respond to publicly.

Section 5: Fees, non-audit services and independence

01. Executive summary
02. Audit findings
03. Value for Money
04. Other statutory powers and duties
05. Fees, non audit services and independence
06. Communication of audit matters

We confirm below our final fees charged for the audit and provision of non-audit.

Fees

	£
Foundation Trust audit (including Quality Report)	52,200
Total audit fees (excluding VAT)	**52,200**

Fees for other services

Service	Fees £
Audit related services	nil

Independence and ethics:

- We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention. We have complied with the Auditing Practices Board's Ethical Standards and confirm that we are independent and are able to express an objective opinion on the financial statements
- We confirm that we have implemented policies and procedures to meet the requirement of the Auditing Practices Board's Ethical Standards

Non- audit services

- For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust. The table above summarises all non-audit services which were identified
- The above non-audit services are consistent with the Trust's policy on the allotment of non-audit work to your auditor.
- We have considered whether non-audit services might be perceived as a threat to our independence as the Trust's auditor and have ensured that appropriate safeguards are put in place.

Section 6: Communication of audit matters

01. Executive summary
02. Audit findings
03. Value for Money
04. Other statutory powers and duties
05. Fees, non audit services and independence
06. Communication of audit matters

Communication of audit matters with those charged with governance

Our communication plan	Audit Plan	Audit Findings
Respective responsibilities of auditor and management/those charged with governance	✓	
Overview of the planned scope and timing of the audit. Form, timing and expected general content of communications	✓	
Views about the qualitative aspects of the entity's accounting and financial reporting practices, significant matters and issues arising during the audit and written representations that have been sought		✓
Confirmation of independence and objectivity	✓	✓
A statement that we have complied with relevant ethical requirements regarding independence, relationships and other matters which might be thought to bear on independence. Details of non-audit work performed by Grant Thornton UK LLP and network firms, together with fees charged. Details of safeguards applied to threats to independence	✓	✓
Material weaknesses in internal control identified during the audit		✓
Identification or suspicion of fraud involving management and/or others which results in material misstatement of the financial statements		✓
Non compliance with laws and regulations		✓
Expected modifications to the auditor's report, or emphasis of matter		✓
Unadjusted misstatements and material disclosure omissions		✓
Significant matters arising in connection with related parties		✓
Significant matters in relation to going concern	✓	✓

ISA (UK and Ireland) 260, as well as other ISAs, prescribe matters which we are required to communicate with those charged with governance, and which we set out in the table here.

This document, The Audit Findings, outlines those key issues and other matters arising from the audit, which we consider should be communicated in writing rather than orally, together with an explanation as to how these have been resolved.

Respective responsibilities

The Audit Findings Report has been prepared in the context of the Statement of Responsibilities of Auditors and Audited Bodies issued by Public Sector Audit Appointments Limited (http://www.psaa.co.uk/appointing-auditors/terms-of-appointment/)

We have been appointed as the Trust's independent external auditors by the Audit Commission, the body responsible for appointing external auditors to local public bodies in England at the time of our appointment. As external auditors, we have a broad remit covering finance and governance matters.

Our annual work programme is set in accordance with the Code of Audit Practice ('the Code') issued by the NAO (https://www.nao.org.uk/code-audit-practice/about-code/). Our work considers the Trust's key risks when reaching our conclusions under the Code.

It is the responsibility of the Trust to ensure that proper arrangements are in place for the conduct of its business, and that public money is safeguarded and properly accounted for. We have considered how the Trust is fulfilling these responsibilities.

Appendices

A. Action Plan

A. Action plan

Priority

Rec no.	Recommendation	Priority	Management response	Implementation date and responsibility
	Declaration of Interest • Update register of interest guidance to make sure it is clear when disclosure is required. • Ensure arrangements are put in place when new starters, who are in a position of potential influence, complete a declaration of interest form.	Medium		
	Property Plant and Equipment (PPE) assets • Ensure that a robust rationale exists including details about the assumptions and judgements being made by management to support future decisions which are likely to have a material impact on the PPE balance, such as the adoption of the single site alternative valuation basis this year. • Consider adopting a common ID asset number for those assets who have different ID numbers on both the asset register and the IT asset system.	Medium		

Controls
- High – Significant effect on control system
- Medium – Effect on control system
- Low – Best practice

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