WARRINGTON & HALTON HOSPITALS NHS FOUNDATION TRUST
ANNUAL REPORT & ACCOUNTS 2018/19

Warrington and Halton Hospitals NHS Foundation Trust Annual Report and Accounts 2018/19

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ANNUAL REPORT 2018-19 - Version 1.9

Warrington and Halton Hospitals NHS Foundation Trust's Annual Report for the period 1st April 2018 to 31st March 2019

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CHAPTER 1

Performance Report

Overview

It is with enormous pride that I present this annual report 2018-19 which I do on behalf of the 4,482 staff and 500+ WHH Volunteers that have shown the most amazing determination and commitment during the year in embracing and deploying our new Trust Strategy of becoming an OUTSTANDING organisation for our patients, our communities and each other.

This has been a year of quality and performance, where we set out to ensure that our patients were seen, diagnosed and treated within all set national standards and where we strived to make every touch point to the highest quality, the safest possible and the best possible experience.

We determined that our Trust would not just aim high, but highest, and set out to correct our failings in the CQC inspection of 2017 which left us 'requiring improvement'. We did this by starting with a fundamental driver – the Trust's Strategy - which, in collaboration with our patients, their families and carers; our staff and membership, visitors and general public, our partners and other stakeholders, set out our ambitions to become an outstanding organisation. To do this meant 'getting to good' first and at time of writing we wait with anticipation the outcome of our very recent inspection.

We were inspected during March and April 2019 and experienced the regulator's new inspection regime. In addition to the traditional core service inspection this now has a separate programme for the 'Well Led' line of enquiry and a new 'Use of Resources' domain. Following the conclusion of an intense, seven-week inspection period I know that our staff have their heads held high and are already working on what it takes to be 'outstanding' for our patients, our communities and each other.

Throughout our journey we are driven by our vision which is 'To be the change we want to see in the world of health and social care' and to be this change means being supremely innovative, adaptable and of course fleet of foot. The vehicle for this is our WHH Quality Academy which we launched in June 2018 to 'Enable cutting edge research and innovation, embedding excellence in care through continuous quality improvement; working with our staff, our patients, our partners and our public.'

We know we can't be the change alone and have embraced the opportunities emerging from our place-based integrated care partnerships where health, social care, other public services and third sector partners come together on a borough level. As our Trust spans two boroughs we are active in both One Halton and Warrington Together and this integrated working has produced some tangible benefits for patients in these boroughs including a new Frailty unit and pathway in Warrington and the continued working towards a new hospital and wellbeing campus in Halton. With third-sector partners we have now recruited more than 500 WHH Volunteers through a managed service contract with Halton & St Helen's VCA/Wellbeing Enterprises and created an Independent Living Centre at our Warrington orthopaedic out-patients in partnership with Warrington Disability Partnership.

The NHS 10 year plan published in January 2019 set out the ambition to achieve 'place based care' through the breaking down of barriers between primary, community and acute care through models of integration and collaboration. We are working closely, and will continue to do so, with GP federations, our community and mental healthcare partners, other acute and specialist Trusts and local government services - especially social care - to break down those barriers and allow our patients to move seamlessly on their treatment, recovery and rehabilitation journeys.

Achieving innovative change relies on our staff's willingness and ability to seize and run with opportunities. To enable this we embarked on a 'Listening into Action' journey which empowered staff to bring their ideas forward with an overarching objective of improving the quality and safety of care we provide to our patients. As well as exceeding LIA's best ever response rate to the initial pulse survey with 73% I was proud to attend the first 'Pass It On' event where the 11 pioneering teams shared the amazing changes they had made in just 20 weeks. This work has a valuable by-

product in significantly enhancing staff engagement.

Investment and achievement in innovation continued across the Trust and across our systems throughout the year and safety/quality/experience-related technologies were a major enabler. In medications safety we commenced deployment of the electronic medicines prescribing module of our electronic patient record system Lorenzo and at close of year ePMA been safely implemented at both Halton General and CMTC hospitals, with Warrington underway throughout 2019. In collaboration with NHS England and the North West Academic Health Science Network we also introduced PharmOutcomes, enabling hospital pharmacy to inform community pharmacy when a patient has been admitted to hospital and send medication updates at the point of discharge.

Our work with Lorenzo reaped rewards when we became one of only four Trust's in the country to join the Lorenzo Digital Exemplars Programme and we proceed to move towards Digital Exemplar status. As well as securing digital innovation funding we have plans to improve quality of care, maximise efficiencies and become a reference site for other Trusts with established blueprints. Our digital journey continues…

Improving the experience as well as care of our patients we introduced a new two-way appointment text reminder service. This service reminds patients of their appointment as well as enabling patients to confirm, re-book or cancel their appointment by responding to the text. On completion of the appointment the same system sends a further text to seek feedback on their care and experience. Did not attends (DNAs) have reduced from an average of 13% to the national average of 8% in year as well as a corresponding increase in responses and recommendations to the Friends and Family question.

Investment takes money as well as time and it is well documented that the Trust carries a sizeable financial deficit and a number of loans. We are on the journey back to financial sustainability thanks to the support of our regulator NHS Improvement and the continued efficiencies brought forward by our staff. In year we improved on our target control total of £16.9m deficit by nearly £2m achieving £15m deficit enabling us to benefit from Provider Sustainability incentive. Our staff delivered a significant £5.6m in savings and we continued to invest in medical equipment, technology and our estate to the tune of £7.2m.

In year we spent £9m on quality initiatives encompassing everything from significantly increasing the number of medics, nurses, health carers, therapists and pharmacists we employ; a new acute cardiac care unit, a new discharge suite, a new bereavement suite, multiple equipment acquisitions including £1m on endoscopy and MRI scanner. IM&T required further investment in security and equipment and we deployed significant monies to maintain and upgrade our aging estate. We will continue to invest in the right way for the safety and comfort of our patients until we are able to deliver fit-for-purpose modern hospitals for the people of Halton, Warrington and beyond.

There were also huge innovations that required little or no financial investment but drew on the talent, enthusiasm and commitment of our staff. We became the first Trust in the country to launch NEWS2 – the national early warning system that helps quickly identify deteriorating patients and introduced a Ward Accreditation scheme that now sees all wards meeting or exceeding standards. Led by our deputy medical director and associate chief nurse for patient safety, we launched the UK's first daily Trust-wide Safety Huddle in an acute environment which, one year on, has produced significant improvement in the safety culture of the organisation reflected in the 2018 NHS Staff Survey where we exceeded the national average and are nudging towards 'best in country'. We welcomed our first cohort of overseas doctors in our collaboration with Wrightington, Wigan and Leigh NHSFT and the King Edward Memorial Hospital in India and where six qualified doctors joined us for two years on the MCh/MMed programme on a 'Learn, Earn and Return' scheme. We have signed a MoU with our local higher education provider Warrington Collegiate with the intention of creating a career pipeline and quality educational and learning experiences for students seeking healthcare work experience.

In fact our unsinkable TeamWHH rose time and again to any number of challenges that we threw at them. They didn't just step forward to be 'Flu Fighters' they picked up the gauntlet and became one of the top five Trusts in the country for frontline staff vaccinations. They didn't just welcome our new staff Mental Health support

programme, more than 80 (at the last count) stepped forward to train as mental health first aiders to support their colleagues in the workplace. And as if we hadn't already challenged enough, we asked for a strong response to the whole census NHS Staff Survey and they turned in our best ever response with 51% against the national average of 44% and an improvement in 9 out of the 10 key themes.

Whilst we really felt that together we were changing, improving and innovating – at pace, as a Trust we also faced some real difficulties during the year.

As we closed the books this time last year the embers were still smoking in the oldest part of our Warrington estate at Kendrick Wing having sustained a large fire on 29th March 2018. This meant the immediate relocation of our very busy Ophthalmology service and the displacement of large numbers of staff including our Finance and Clinical Coding teams at a critical time in their year. It is thanks once again to our amazing staff that Ophthalmology was relocated and up and running within 48hrs with just one day's clinic appointments cancelled and all patients re-booked within the fortnight. We hope to have fully restored Kendrick wing by summer 2019 and are grateful to our insurers for working closely with us throughout this time.

The voluntary suspension of our spinal services continued throughout the year while we worked to investigate all incidents in the service going back three previous years and to work with independent experts. Our thoughts are with the patients and their families whose serious incidents prompted the suspension of the service and the commissioning of the Royal College of Surgeons' Invited Review. While nothing can change the outcome, we would once again like to unreservedly apologise for failing these patients. We further apologise to the many patients who have been inconvenienced as a result of the continued suspension and their transfer to alternative providers - we do not underestimate the frustration that this caused. We are now part of discussions taking place across Cheshire and Merseyside about the future provision of spinal services and we are committed to supporting this in any way we can.

Like many other acute Trusts we continued to face challenges in achieving the national 4-hour standard for A&E and winter seemed to go on until early summer in 2018. Again work with our partners in community and social care is reaping rewards and a whole system review of bed requirements and capacity; together with our investment in assessment facilities such as GPAU/Ambulatory Care Unit. These are significant steps in seeing, treating and admitting or discharging our patients within the prescribed standard.

As we move into 2019-20 we do so a very different organisation to this time last year.

We will continue to push forward with our ambitions to create new care and treatment environments for our patients in Halton and Warrington. New estate will enable us to bring our partners together on the same site, in the same wards and departments and in the same teams -breaking down those barriers for the benefit of our patients and their families.

With the ambitious Local Plan for the borough of Warrington describing unprecedented growth in residential and business properties, it has been recognised that new hospital estate is a fundamental requirement to support this population expansion. We are grateful that a new hospital for Warrington is included in the Local Plan and to our system partners for their wholly supportive approach from the outset.

At Halton we are exploring alternative funding sources having been unsuccessful in the Government's capital funding rounds over the past two years. A new hospital and wellbeing campus underpins the 'One Halton' new way of working that will join up all the services that deliver care and wellbeing to the people of Halton ensuring that they have the right support, at the right time, in the right away to provide the best possible outcomes. Simultaneously, we continue to bid to host the planned 'Eastern Sector Cancer Hub' at our already excellent facility at the Cantreat Clatterbridge Cancer Centre supported by the Macmillan Delamere cancer support centre at Halton General.

Financially we have accepted a very challenging control total from NHS Improvement which we anticipate will return us to balance for the first time in a number of years. We are ready for this challenge having held our financial position in context of national deterioration, we have strong, supported financial plans and financial governance and a workforce that is ready to deliver on yet

another challenge. Returning to financial balance is, for TeamWHH, a game-changer.

It will be a pleasure to finally open our longed-for Outdoor Play Area on our Children's Unit thanks to unswerving support from our corporate partners, fundraisers and staff who have worked (and abseiled!) tirelessly for WHH Charity's Making Waves campaign. We will also celebrate the fifth birthday of our much-loved Forget me Not Dementia unit with the opening of the second and final phase of our remembrance garden. On behalf of all the patients, young and old, who will enjoy pleasure and comfort from these facilities, I thank all who gave their time, energy, supplies, workforce and money to help us get this far.

This has been a truly memorable year for Warrington and Halton Hospitals and one which I believe has been a real turning point for the organisation, our patients, their families, our staff and our communities. We are absolutely committed to being the best we can be and I could not be more proud to lead our amazing TeamWHH, confident that together we are really 'moving to outstanding'.

Mel Pickup, Chief Executive

Statement of the purpose and activities of the Trust

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

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

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

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

A brief history of the Trust and its statutory background.

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

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

Warrington Hospital

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

Halton Hospital

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

Cheshire & Merseyside Treatment Centre

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

Our place in the wider health economy

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

We are also working within our integrated care systems – the 'place-based' systems that work together within the Warrington (Warrington Together) and Halton (One Halton) boroughs.

Our Vital Statistics

- We serve a population of 330K across both boroughs
- We saw approximately 114K A&E visits and 135K total visits to A&E, Runcorn Urgent Care Centre and Widnes Walk in Centre
- We deliver 500,000 individual patient appointments, procedures and stays
- We have circa 680 beds/assessment beds and trollies across all sites:
  - 567 acute care inpatient, day case, assessment and specialist beds at Warrington
  - 71 elective surgical and 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 living with dementia
- We employ around 4,200 strong workforce comprising 52 nationalities
- We are proud to have been named as one of the 100 Best Places to Work in the NHS - Health Service Journal
- Our Maternity service was awarded 'Best Maternity Service in the UK' by the RCM
- We have three key commissioners: Warrington CCG (main), Halton CCG and NHS England Specialist Commissioning
- We have an annual turnover of over £210 million
- Around 3,000 babies are born at Warrington Hospital each year

About the Trust

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

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

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

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

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

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

In 2006 a reconfiguration of services saw the Trust's emergency and acute medical care work centralised at Warrington Hospital and planned

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

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

Our Mission: To be OUTSTANDING for our patients, our communities and each other

Our Strategic Objectives

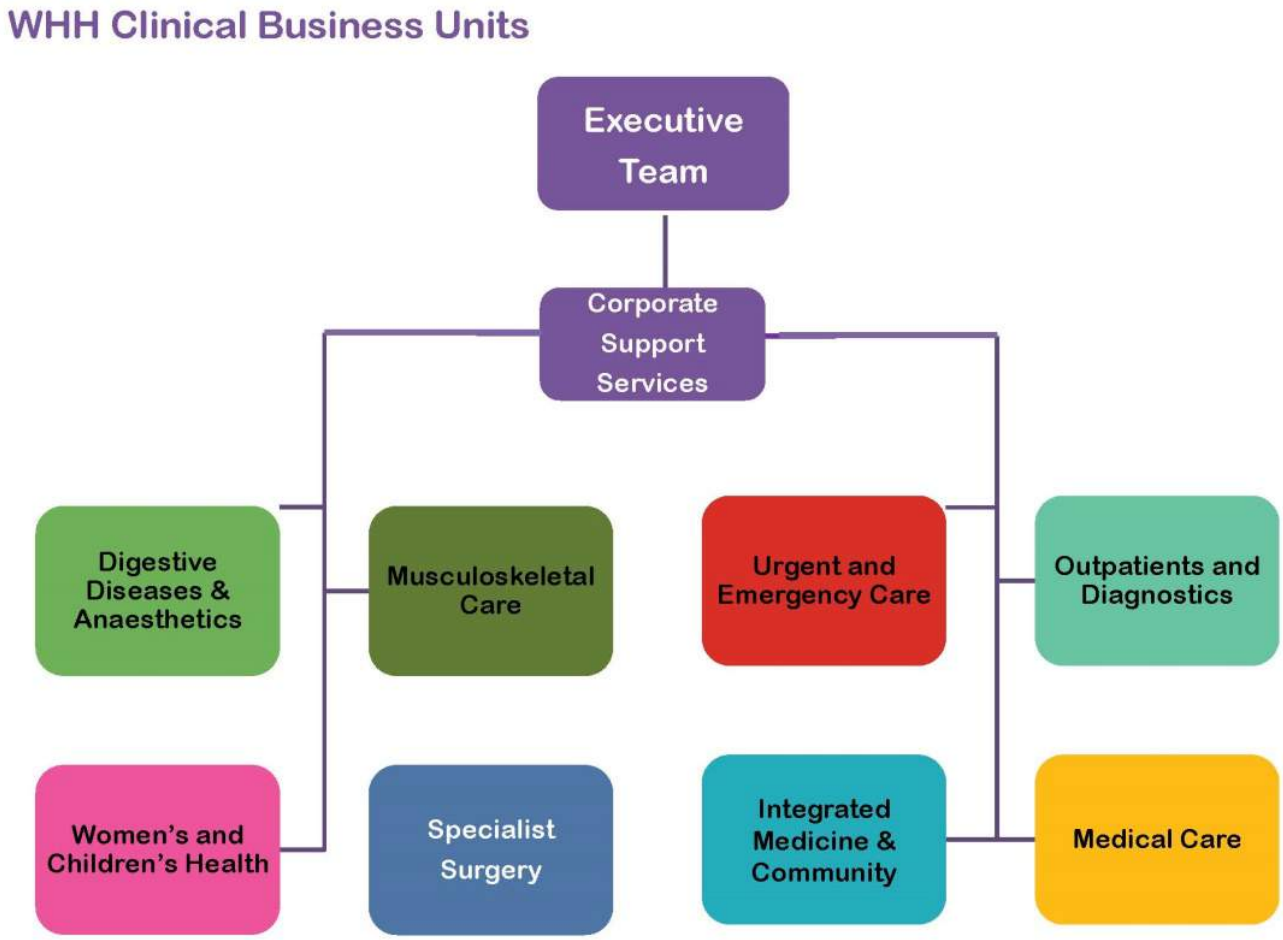
1. Quality: We will always put our patients first though high quality, safe healthcare and an excellent patient experience
2. People: We will be the best place to work with a diverse, engaged workforce that is fit for the future
3. We will work in partnership to design and provide high quality, financially sustainable services.

Our Vision: To be the change we want to see in the world of health and social care

Our Values: **WE ARE**

Working Together, **E**xcellent, **A**ccountable, **R**ole Models, **E**mbracing **C**hange

How we are organised



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

The key issues and risks that could affect the Trust in delivering its objectives are as below. These risks are recorded on the Board Assurance Framework and are scrutinised quarterly by the Board, Quality Assurance Committee and the Audit Committee. In addition, any new risks, or changes to risk ratings, are provided in updates to the Trust Board at every meeting through associated committees**.** These risks vary on an ongoing basis and are downgraded or upgraded as a result of changing circumstances and the implementation of mitigations. These risks are valid at time of producing this report, April 2019. The organisation has identified the following strategic risks (Red risks rated at 15 and above)

Red Risks (ie scored at 15 and above)

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

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

3. Failure to 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.

4. Failure to successfully counter the regulatory and contractual consequences, caused by the suspension of spinal services in September 2017, resulting in significant reputational damage.

5. 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. Resulted in a financial impact, external reputation damage and poor management decision making due to lack of quality data.

6. Failure to meet the emergency access standard caused by system demands and pressures. Resulting in potential risk to the quality of care and patient safety, risk to trust reputation, financial impact and below expected Patient experience.

7. Failure to maintain an old estate caused by restriction, reduction or unavailability of resources resulting in staff and patient safety issues, increased estates costs and unsuitable accommodation.

8. Failure to provide continuity of services caused by the scheduled March 2019 Brexit resulting in difficulties in procurement of goods and services, workforce and the associated risk of the increase in cost of supplies.

9. Influence within Cheshire & Merseyside
   a) Failure to deliver our strategic vision, including two new hospitals and vertical & horizontal collaboration, and influence sufficiently within the Cheshire & Merseyside Healthcare Partnership and beyond, may result in an inability to provide high quality sustainable services 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.

   b) Failure to fund two new hospitals 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.

Going Concern Disclosure

These accounts have been prepared on a going concern basis.

International Accounting Standard (IAS) 1 requires the management of all entities to assess, as part of the accounts preparation process, the bodies' ability to continue as a going concern. This is further enforced by Department of Health requirements to review the trust's going concern basis on an annual basis, the going concern principle being the assumption that an entity will remain in business for the foreseeable future.

This is to facilitate the accounting basis to be used in the preparation of the Trust's annual accounts. Should an assessment be made that an entity is not a going concern then the year end balance sheet should be prepared on a 'disposals' basis i.e. items valued at their likely sale value. In many cases this would propose significantly lower values than the usual valuations based on ongoing trading (e.g. stocks) and require the inclusion of other 'winding up costs' (e.g. redundancies).

The Trust's accounts for 2018/19 have recorded a deficit of £16.0 million and the cumulative deficit position on retained earnings amounts to £52.6 million. The Statement of Financial Position shows negative net current assets and liabilities of £26.7 million.

In line with national guidance the annual plan (2019/20) has been submitted and assumes revenue support to support a planned deficit of £0.2 million. This results in a breakeven control total that has been agreed with NHS Improvement.

The Trust is due to repay loan principal of £22.1 million to the Department of Health and Social Care during 2019/20. It is anticipated that the repayment terms of these loans will be extended and that these payments will not be required during 2019/20. This has not yet been confirmed with the Department of Health and Social Care.

In accordance with IAS 1, management has made an assessment of the Trust's ability to continue as a going concern considering the significant challenges described above. Although these factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts and the financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern

The main financial headlines resulting from application of these factors that form the basis of the final 2019/20 Annual Plan are as follows:

- A £0.2m planned operating deficit and a breakeven control total.
- External support of £17.9m comprising of £4.9m Provider Sustainability Funding, £12.0m Financial Recovery Funding and £1.0m Marginal Rate Emergency Tariff Funding.
- Cost savings target totalling £7.0m (equivalent to 2.7% of turnover).
- No increase to working capital loans of £56.6m (this is comprised of a £14.2m loan in 2015/16, a £7.9m loan in 2016/17, a £17.6m loan in 2017/18 and a £16.9m loan in 2018/19 to support planned and actual deficits together with a £2.3m loan in 2017/18 to support aged creditors). The 2015/16 loan was due for repayment in November 2018 and has been extended until November 2019. The 2016/17 loan is due for payment in January 2020. In order to repay these loans on the due date replacement loans will be required.
- Capital expenditure totalling £11.7m (this includes £3.5m relating to the estimated capital costs associated with the restructure works following the Kendrick Wing Fire in March 2018).
- Planned closing cash balance of £1.2m (in line with the terms and conditions of the working capital loan).

The Trust believes that it has been realistic in its assessment of efficiency targets and therefore believes that this forward plan provides a realistic assessment of the Trust's position in 2019/20.

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

Based on the acceptance of the control total, the external support and the fact that the Trust has not been informed by NHS Improvement that there is any prospect of intervention or dissolution within the next 12 months, the Trust does not have any evidence indicating that the going concern basis is not appropriate.

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 and there is no planned requirement for a further

working capital loan following acceptance of the 2019/20 breakeven control total.

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

Performance Report

The Trust's annual plan for 2018-19 is underpinned by the Quality, People and Sustainability (QPS) strategy which represent the Trusts core activities. Key Performance Indicators, aligned to the strategic objectives, are monitored by the Trust Operations Board, the Executive Team and the Trust Board.

Strategic Objectives:

Quality

1. Patient Safety – we are committed to developing and enhancing our patients safety through a learning culture where quality and safety is everyone's responsibility
2. Patient experience – by Focusing on patient experience we want to place the quality of patient experience at the heart of all we do where 'seeing the person in the patient' is the norm
3. Clinical Effectiveness – Ensuring practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients.

People

1. Attract and retain a diverse workforce aligned to our culture and values to ensure that we have the staff with the skills, attitude and behaviours to meet the needs of our population providing excellent and safe care
2. Create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience.
3. Develop a collaborative and inclusive leadership at all levels and organisations learning

Sustainability

1. Play a central role in our healthcare economies to support integrated p-lace based care
2. Work with other acute trusts care providers to ensure that those services which need to be provided in an acute environment are the best they can be and are clinically and financially stable
3. Provide our services in an estate that is fir for purpose, supported by technology and aligned to the needs of our developing populations.

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.

Activity and Performance

During 2018-19 A&E Attendances increased by 0.4% and non-elective admissions decreased by 5.11%.

The age and morbidity of the patients we saw and treated continued to increase, reflecting the demographics of the population we serve. Whilst we continue to plan for this, it remains a challenge to our resources, specifically bed capacity, and the local health economy's ability to discharge patients. We continue to work very closely with our health and social care partners to transform patient pathways, to increase care closer to home or in the community whilst minimising hospital attendances and admissions.

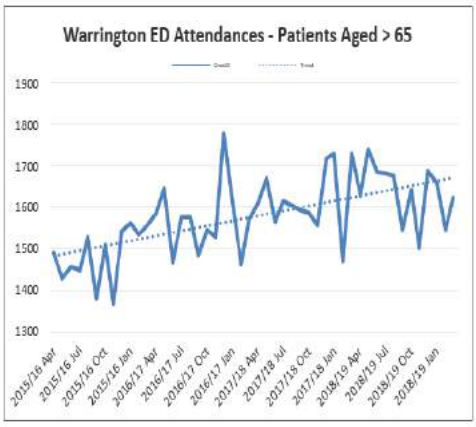
Activity Variance

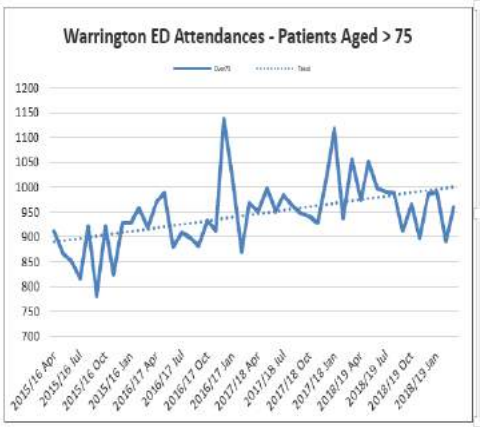
Activity	2015/16	% change 15/16 vs 14/15	2016/17	% change 16/17 vs 15/16	2017/18	% change 17/18 vs 16/17	2018/19	% change 18/19 vs 17/18
Elective Inpatient Discharges	5,461	-1.2%	5288	-3.2%	4919	-7.0%	4634	-5.8%
Elective Day Cases Discharges	31,429	-4.8%	31633	0.6%	28937	-8.5%	27267	-5.8%
Non-Elective Discharges	38,542	-3.1%	42760	10.9%	39636	-7.3%	37729	-4.8%
New Outpatient Attendances	117,912	-4.4%	109309	-7.3%	103584	-5.2%	99629	-3.8%
A&E Attendances	105,450	2.8%	108889	3.3%	112925	3.7%	113398	0.4%

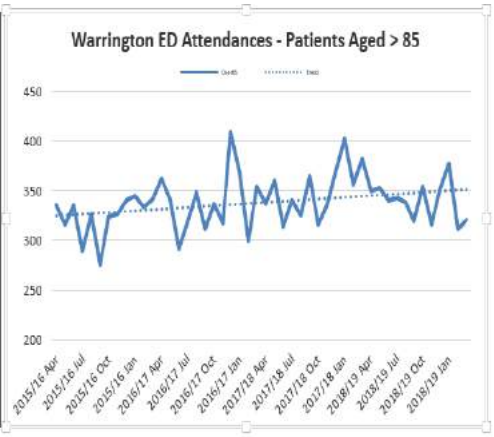
Delivering the Four Hour Standard

It is an expectation that all patients who attend accident and emergency are seen and treated within four hours. Nationally the target is 95% and the majority of acute Trusts have struggled to achieve this target in year. The chart below illustrates our performance in seeing and treating patients within this time. While the Trust performed well compared to peers it did not achieve the 95% national standard and closed with a performance of 85.11% for the year.

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
A&E & MIU (Including Widnes Walk-in)	% Departed <=4hrs	>=95%	86.73%	90.91%	90.98%	89.60%	90.46%	87.55%	84.85%	87.73%	84.71%	83.22%	80.06%	82.72%	78.22%	79.45%	82.37%	80.03%	85.11%
	* Number of attendances		11224	12096	11857	35177	12028	11004	10759	33791	11436	10869	10679	32984	11248	10383	11359	32990	134942
	* Number of patients breaching 4hrs		1489	1100	1070	3659	1147	1370	1630	4147	1748	1824	2129	5701	2450	2134	2003	6587	20094



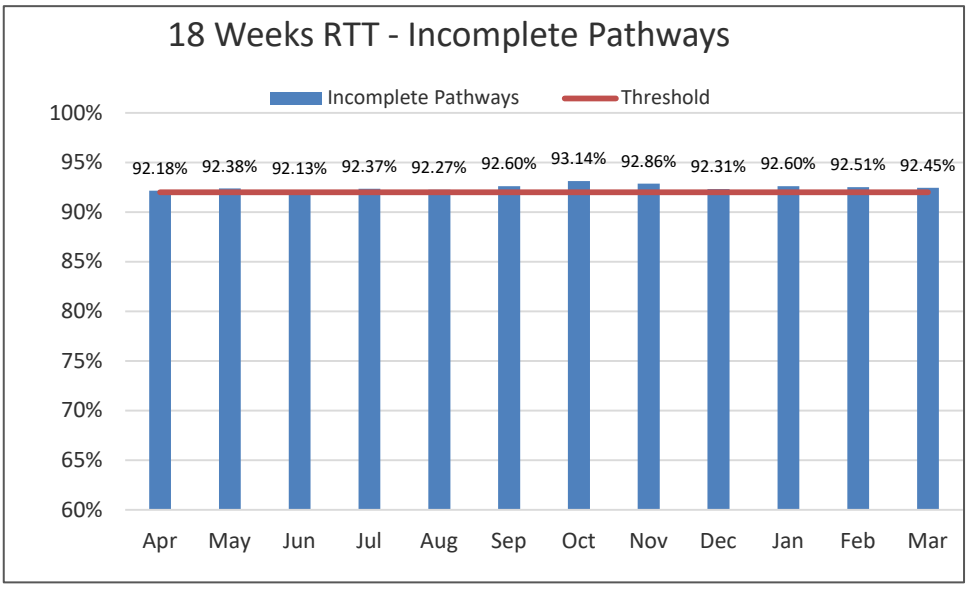




Referral to Treatment (RTT) waiting times

The Referral to Treatment operational standard for England focused on the number of incomplete pathways less than 18 weeks. The Trust achieved the 18 week referral to treatment target consistently throughout 2018-19, against a target of 92%; this is difficult and challenging but supports care being delivered in a timely manner.

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
RTT - 18 Weeks	Incomplete Pathways % <18 Weeks	>=90%	92.18%	92.38%	92.13%		92.37%	92.27%	92.60%		93.14%	92.86%	92.31%		92.60%	92.51%	92.45%		
	* Number of incomplete pathways		18384	18325	17883		18942	19110	18992		18853	18923	18702		18276	19022	18965		
	* Number of patients waiting 18+ weeks		1437	1397	1407		1445	1478	1406		1293	1351	1438		1352	1424	1432		
	* Number of patients waiting 52+ weeks	0	0	0	0		0	0	0		0	0	0		0	0	0		



Delayed Transfers of Care

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

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

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

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
Number of patients delayed on the last Thursday of each month	25	30	11	8	17	33	124
Total days lost in month	850	840	525	400	430	726	3771
Number of occupied bed days (patients aged 18+)	15413	13887	13534	15761	13164	14889	86648
Days lost as % of occupied bed days	5.51%	6.05%	3.88%	2.54%	3.27%	4.88%	4.35%
Average daily bed days lost	27	28	17	13	15	23	124
Average general and acute occupied beds (including Critical care, excluding Neonatal, Paediatrics and Day case beds)	478	480	472	505	494	497	2926

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

Diagnostics waiting times

Through 2018-19 the Trust has successfully improved performance against the target of less than 1% of patients waiting more than 6 weeks for a diagnostic test. From quarter 2, 2018-19, the Trust has continued to meet the performance standard every month.

Cancer waiting time 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. Throughout 2018-19 the Trust improved monthly performance for Cancer waiting times and achieved the performance standard of 85% against the percentage of cancer patients waiting a maximum of 2 months (62 days) from urgent GP referral to treatment for all four quarters.

Performance against national Cancer waiting times 2018-19

National Indicators		Target	Apr	May	Jun	Qtr1	Jul	Aug	Sep	Qtr2	Oct	Nov	Dec	Qtr3	Jan	Feb	Mar	Qtr4	YTD Position
Cancer	2 Week Wait	>=93%	93.88%	93.51%	92.02%	93.14%	93.03%	94.20%	94.44%	93.84%	93.11%	96.05%	94.03%	94.35%	93.23%	94.38%	94.17%	93.94%	93.82%
	* Numerator		767	936	796	2499	907	844	764	2515	933	850	803	2586	799	840	921	2560	10160
	* Denominator		817	1001	865	2683	975	896	809	2680	1002	885	854	2741	857	890	978	2725	10829
	Breast Symptom 2 Week Wait	>=93%	88.71%	84.75%	92.21%	88.89%	88.57%	90.00%	98.36%	92.15%	97.62%	93.24%	93.65%	95.02%	98.75%	96.15%	91.11%	95.16%	93.01%
	* Numerator		55	50	71	176	62	54	60	176	82	69	59	210	79	75	82	236	798
	* Denominator		62	59	77	198	70	60	61	191	84	74	63	221	80	78	90	248	858
	31 Day First Treatment	>=96%	97.53%	97.73%	97.53%	97.60%	98.51%	100.00%	100.00%	99.48%	97.22%	100.00%	100.00%	98.96%	100.00%	100.00%	98.67%	99.59%	98.86%
	* Numerator		79	86	79	244	66	67	58	191	70	58	62	190	95	71	74	240	865
	* Denominator		81	88	81	250	67	67	58	192	72	58	62	192	95	71	75	241	875
	31 Day Subsequent Treatment : Surgery	>=94%	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%	100.00%
	* Numerator		11	12	7	30	10	6	1	17	11	4	4	19	5	7	6	18	84
	* Denominator		11	12	7	30	10	6	1	17	11	4	4	19	5	7	6	18	84
	31 Day Subsequent Treatment : Drugs	>=98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%
	* Numerator		2	6	2	10	6	3	6	15	9	9	4	22	2	4	0	6	53
	* Denominator		2	6	2	10	6	3	6	15	9	9	4	22	2	4	0	6	53
	62 Day First Treat - Urgent GP - Open Exeter	>=85%	90.43%	85.58%	88.30%		86.05%	85.71%	88.31%	86.64%	86.84%	85.71%	86.49%	86.34%	87.27%	85.25%	85.23%	86.10%	86.83%
	* Numerator		42.5	44.5	41.5	128.5	37.0	36.0	34.0	107.0	33.0	33.0	32.0	98.0	48.0	26.0	37.5	111.5	445.0
	* Denominator		47.0	52.0	47.0		43.0	42.0	38.5	123.5	38.0	38.5	37.0	113.5	55.0	30.5	44.0	129.5	512.5
	62 Day First Treat - Urgent GP - Reallocation	>=85%	90.43%	81.65%	87.23%	86.20%	86.05%	82.56%	89.33%	85.83%	90.14%	84.21%	84.93%	86.36%	87.25%	85.48%	86.90%	86.69%	86.26%
	* Numerator		42.5	44.5	41.0	128.0	37.0	35.5	33.5	106.0	32.0	32.0	31.0	95.0	44.5	26.5	36.5	107.5	436.5
	* Denominator		47.0	54.5	47.0	148.5	43.0	43.0	37.5	123.5	35.5	38.0	36.5	110.0	51.0	31.0	42.0	124.0	506.0
	62 Day First Treatment - Screening (Pre-Reallocation)	>=90%	100.00%	100.00%	100.00%	100.00%	90.00%	100.00%	100.00%	98.31%	100.00%	87.50%	100.00%	96.83%	94.87%	100.00%	92.31%	95.45%	97.45%
	* Numerator		6.5	7.5	9.5	23.5	4.5	14.0	10.5	29.0	12.5	7.0	11.0	30.5	18.5	7.0	6.0	31.5	114.5
	* Denominator		6.5	7.5	9.5	23.5	5.0	14.0	10.5	29.5	12.5	8.0	11.0	31.5	19.5	7.0	6.5	33.0	117.5
	CRS 62 Day Consultant Upgrade		100.00%	75.00%	100.00%	92.31%	100.00%	100.00%	100.00%	100.00%	88.89%	100.00%	100.00%	92.31%	60.00%	100.00%	100.00%	90.00%	93.33%
	* Numerator		1.0	1.5	3.5	6.0	2.0	3.0	2.0	7.0	4.0	1.0	1.0	6.0	1.5	1.5	6.0	9.0	28.0
	* Denominator		1.0	2.0	3.5	6.5	2.0	3.0	2.0	7.0	4.5	1.0	1.0	6.5	2.5	1.5	6.0	10.0	30.0

Financial Performance

The Trust recorded a £16.0m deficit for the year, which included £6.8m Sustainability and Transformation Funding and net impairment costs of £1.1m. This deficit was £1.0m below plan the planned deficit of £17.0m. The control total set by NHSI was £16.9m and after the exclusion of impairments and other technical adjustments the Trust recorded an actual control total of £15.0m, £1.8m below the planned control total.

The Trust secured £3.5m for the finance element of the core Provider Sustainability Fund (PSF) monies but failure to achieve the A&E 4 hour target meant that the £1.5m for the A&E element of core PSF monies was not realised. The Trust secured an additional £3.3m for incentive PSF monies.

There was an under recover against the clinical income target of £4.5m (excluding £3.0m funding for the unfunded costs of the Agenda for Change pay award), a £1.4m shortfall against the £7.0m CIP target and agency costs of £11.4m but these were offset by an over recovery of other operating income and an underspend on non-pay costs

The planned deficit meant that the Trust required a £16.9m working capital loan and the full value of the loan was drawn down in the year.

The annual capital programme (including external funding) was £10.5m and the actual spend for the year was £7.2m, an underspend of £3.3m

The cash balance was £1.3m which was £0.1m above the balance required under the terms and conditions of the working capital loan agreement.

Sustainability and climate change at the Trust

One of the trust's key objectives is around sustainability and a key part of that is around carbon reduction and climate change. As the largest single organisation in the UK, the NHS is responsible for major consumption of resources emitting around 22.8 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.

2018-19 has seen the Trust develop and introduce measures and initiatives that have enabled the organisation to continue to make progress on the sustainability and carbon management agenda. The combined heat and power units on both the Halton and Warrington sites are in full operation, producing electricity, for consumption on the sites and hot water which is utilised within its heating and hot water systems. The CHP also allows the Trust to feed any excess electricity generated and not used by the Trust back into the National Grid.

The Trust has reduced its Carbon Footprint (from the baseline year 2009/10) by 16% based on the 2018-2019 energy consumption figures

The overall sustainability strategy of the Trust

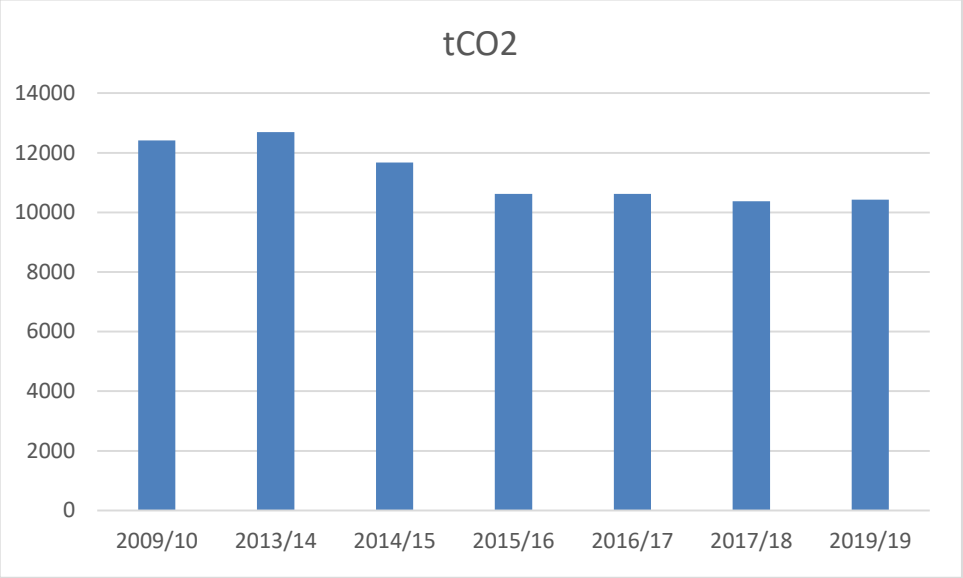
The aims and objectives of the Trust's sustainability strategy, as encompassed by the Trust's Sustainable Development Management Plan, are to:

- 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 reduction commitment

Sustainability performance summary

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



	2018-19	
	Total usage	**Cost (£)**
Water	**84,694 m3**	**£439,032**
Electricity	**2,666 tCO2**	**£733,051**
Gas	**7,891 tCO2**	**£925,519**

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 and procedures around waste management. The Trust has completed a full procurement process in collaboration with other Trusts for external waste contractors, who will 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 the domestic waste, cardboard waste, and confidential/clean office waste it produces.

Future priorities and targets around sustainability

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

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

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

- The Trust then successfully entered tranche 1.5 of the NHS Carbon and Energy Fund (CEF) scheme procurement process to install Combined Heating and Power (CHP) on both the Warrington and Halton hospital sites. CHP plant provides the trust with both heat and electricity generated on site, resulting in both financial and carbon savings. This scheme is now fully operational and efficiency figures for the CHP units are showing both achieving above 98% availability.
- The CEF Scheme process investigated the potential installation of energy efficient lighting across large parts of the trust which was implemented and not only enhanced the patient experience, it saved energy and carbon.
- The Trust are now working in partnership with Veolia (formerly Cynergin), then invested in further energy efficient lighting on its external Car Parks.
- In 18/19 the Trust applied for National Energy Efficiency Funding for LED lighting across Warrington and Halton sites; however they were unsuccessful with their bid. Further funding may be made available centrally in the next financial year, however, the Trust have engaged with Veolia to look at the funding of this scheme through other funding streams so that the savings can be realised.
- The Trust are working with Veolia through the CEF contract to look at other potential energy saving initiatives around the Trusts engineering assets to reduce its overall energy use and carbon emissions.

Social, Community, Anti-Bribery and Human Rights Issues

The Trust takes very seriously its position in the local community as a major employer. Various relationships have already been established with local schools and colleges as the Trust recognises that its future workforce will largely be provided from the local community. A variety of placements across the Trusts are offered arranged which allows our local populations to see first-hand the type of roles available and whether there are career opportunities that meet their expectations.

We aim to we aim to be a leading organisation, which is recognised locally, regionally and nationally, for promoting Equality, Diversity and Inclusion. Applications are welcomed and encouraged from those with any or all protected characteristics to ensure that we benefit from an increasingly diverse workforce. 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. The Trust's commitment to protecting and promoting human rights is enshrined in our Statement on Modern Slavery which is published on the Trust website.

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 2018/19 MIAA commenced investigations into two potential fraud issues, both of which are still continuing.

Compliance with the Modern Slavery Act 2015

The Modern Slavery Bill was introduced into Parliament on 10th June 2014 and passed into UK law on 26th March 2015. The Modern Slavery Act is an Act to make provision about slavery, servitude and forced or compulsory labour and about human trafficking, including the provision for the protection of victims.

A person commits an offence if

- The person holds another person in slavery or servitude and the circumstances are such that the person knows or ought to know that the other person is held in slavery or servitude
- The person requires another person to perform forced or compulsory labour and the circumstance are such that the person knows or ought to know that the other person is being required to perform forced or compulsory labour

Organisational Structure

Warrington and Halton Hospitals NHS Foundation Trust comprises Warrington Hospital and Halton General Hospital in the North West of England.

The two hospitals work together to provide high quality, safe health care services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas.

The Trust also provides orthopaedic services at the Cheshire and Merseyside Treatment Centre building on the Halton General campus.

Each hospital has a range of 'General Hospital' services, with a full Accident and Emergency Department at Warrington Hospital. Both combined provide a range of planned care, including outpatients, diagnostics, therapies, and day case and inpatient surgery.

The Trust has an overall budget of around £246 million each year, over 4,200 members of staff and provides access to care for over 500,000 patients.

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 has a non-pay budget of £74m of which over £34m per annum is spent on goods and services. Over 90% of the £34m is spent with the Trusts top 250 suppliers.

Our Supply Chain

It is important to ensure that suppliers to the Trust have in place robust systems to ensure that their own staff, and organisations within their own supply chain are fully compliant with the requirements of the Modern Slavery Act 2015.

In compliance with the consolidation of offences relating to trafficking and slavery within the Modern Slavery Act 2015, the Trust has an ongoing process of reviewing its supply chains with a view to confirming that such behaviour is not taking place.

By the end of April 2016, the Trust's Procurement Team made contact with each of its top 250 suppliers to request confirmation that they are compliant with the Act. As part of this communication we also issued the Supplier Code of Conduct to all suppliers used across the organisation inclusive of pharmaceutical suppliers.

As part of this communication, suppliers have been advised that as part of the Trusts commitment to ensuring that we do not trade with organisations who do not meet the requirements of the Act, they will be required to provide a copy of their annual Modern Slavery Action Statutory Statement detailing actions undertaken to ensure they meet and enforce the requirements of the Act.

This will only apply to suppliers defined as a "commercial organisation" in accordance with the Act:

- Supplies goods and services
- Has a turnover of not less than £36m

The Trust's Procurement team is committed to raising awareness with all suppliers by ensuring that all suppliers the Trust trades with are aware of our commitment to ensure compliance with the Act.

As part of the Trust's ongoing review, when trading with new suppliers, and prior to establishing the supplier on Trust systems, the supplier will be requested to confirm in writing that they are compliant with the Act.

All potential new suppliers will be issued with the Supplier Code prior to setting them up on our systems.

The Act is referred to in all tendering activity undertaken by the Trust's Procurement Team. All tendering for goods and services is managed centrally by the procurement team. A copy of the Act will be sent to all organisations involved in the tendering process along with a short statement from the trust reminding bidders of their obligations under the Act. All suppliers will be requested to issue a statement as part of their tender response regarding their compliance with the Act.

Our Trust

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

All staff are appointed subject to meeting the NHS Standards on Employment Checks which includes references, health Checks, DBS checks, immigration checks and Identity checks. In addition the Trust has developed a number of values and behaviours which are fully embedded into the organization. The Trust expects its existing staff to comply with these standards and all future appointments will be expected to demonstrate these attributes as part of the appointment process. This ensures that the Trust can be confident, before staff commence with the Trust, that we know some background about our staff and that they have a legal right to work for the Trust.

By adopting the national pay, terms and conditions of service, the Trust has the assurance that all staff will be treated fairly and will comply with the various legislation. This includes the assurance that staff receive at least, the National Living Wage.

The Trust has various employment policies and procedures in place designed to provide guidance and advice to staff and managers but to also comply with employment legislation. Every policy is impact assessed from an Equality and Diversity perspective.

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

The Trust has an extensive training and development programme which is based on a minimum requirement to complete all statutory and mandatory training and other ad-hoc training which staff are required to undertake for their various roles. Training needs are identified through Individual Performance Development Reviews and a Personal Development Plan produced.

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

Important events since year end

There have been no important events since the year end.

ACCOUNTABILITY REPORT

Directors' Report

At 31st March 2019 the Trust Board declares that it has a full complement of Non-Executive and Executive directors, with all voting and non-voting positions substantively filled. The Board is assured about its balance in terms of gender, with eight female and eight male Directors in total, of which voting members comprise 5 females and 6 males. In addition, the Directors have complementary skill sets and many have considerable prior Board-level experience across both public and private sectors. The Trust Board believes it is therefore appropriately comprised and satisfies the requirements to lead the NHS Foundation Trust.

The Board evaluates its performance, its Committees and its Directors, including the chairperson, on an ongoing basis. At regular Board Meetings an anonymous meeting effectiveness review takes place, the results of which are discussed at the following meeting and 'rolling tracker' of performance maintained. Annual reports are received from each of the committees to the Board.

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

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

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

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

The Board of Directors for the reporting period:

1. Non-Executive Directors

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

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

Terry Atherton – Deputy Chair

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

Ian Jones – Senior Independent Director

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

Anita Wainwright

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

Dr Margaret Bamforth

Margaret Bamforth joined the Trust Board as Non-Executive Director in May 2016 and is Chair of the Quality Assurance Committee. Margaret qualified from Liverpool Medical School and completed her training as a Child and Adolescent Psychiatrist in Manchester. She practiced as a Consultant Child and Adolescent Psychiatrist in Halton for 22 years, before retiring from clinical practice. She has always had a strong interest in Medical Education and continued to work as an Associate Postgraduate Dean for Mersey Deanery and subsequently HENW, following her retirement. She has an interest in leadership and mentoring and has previously been 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. Margaret's Term of Office was extended for a second

term in February 2019, for a further three years to April 2022.

Professor Jean-Noel Ezingeard

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

Executive Directors – Voting

Melany Pickup - Chief Executive

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

Professor Simon Constable – Executive Medical Director & Deputy Chief Executive

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

Andrea McGee - 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.

Kimberley Salmon-Jamieson – Chief Nurse

Kimberley joined our Trust in September 2016, having previously held the position of Deputy Chief Nurse at Pennine Acute NHS Trust. With 20 years of experience working as a nurse in the NHS, she has enjoyed a variety of management and nursing roles, gaining a reputation for enthusiasm and energy. Prior to working for Pennine, she was Deputy Chief Nurse at University Hospital South Manchester NHS Foundation

Trust. Her first management role was at Salford Royal NHS Foundation Trust where she had previously worked as Advanced Nurse for a long period of time. Her interests in the health sector include patient safety and experience, service development and education.

Chris Evans – Chief Operating Officer

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

Additional Executive Directors (non-voting)

Jason DaCosta, Director of Information Management and Technology (To June 2018). Jason left the Trust to pursue a role with Deloitte.

Phill James, Chief Information Officer

Phill joined us in December 2018 as Chief Information Officer – a shared post between WHH and the accountable care systems of Warrington Together and One Halton. Phill has over two decades of experience in IT engineering roles within both public and private sectors across health, manufacturing, systems and support services.

During this time he worked with Salford Royal NHS Foundation Trust, the North West Ambulance Service, Lancashire Ambulance Service, Datel Technology, Amey Datel and British Aerospace Military Aircraft Division. His most recent post was with Pennine Acute Hospitals NHS Trust where he was employed by Salford Royal NHSFT within the Northern Care Alliance NHS Group and his areas of expertise include transformational change through a range of technical architectures, aligning technology to business requirements and programme management. Phill's role across the partnership is to develop and deliver the Information Management and Technology Digital strategy.

He will direct digital transformational change through collaboration within the local health and social care economies in commissioning and delivering safe, effective and affordable patient care through technology.

Michelle Cloney, Director of Human Resources and Organisational Development

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

Pat McLaren - Director of Community Engagement & Fundraising

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

Lucy Gardner - Director of Transformation

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

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

The focus of Lucy's role altered in 2018, which led to a change in Job title to Director of Strategy. The change in title reflects Lucy's revised portfolio, which now includes leading the programme to deliver two new hospitals, as well as lead for development and delivery of the Trust's overall strategy. Lucy continues to work with partner organisations, both in terms of horizontal and vertical collaboration, to deliver change and enable sustainable healthcare locally.

Dr Alex Crowe – Deputy Medical Director, Director of Medical Education & Chief Clinical Information Officer

Dr Alex Crowe is a consultant nephrologist who was appointed as Deputy Medical Director for WHH in December 2016 and Medical Director in October 2017. Alex is also the Trust's Clinical Chief Information Officer and current medical appraiser for NHS England and supports the Royal College of Physicians for a number of courses such as Physicians as Educators, Mentoring, Appraisal and Revalidation and Leadership.

He joined the Trust in 2016 from Arrowe Park Hospital and Countess of Chester Hospitals where he was Consultant Nephrologist. He was also the renal Lead for Cheshire and Merseyside networks. He has also worked as a Secondary Care Doctor in Manchester, involved in promoting Healthcare Devolution in Manchester. He trained at St Thomas' Hospital, London.

Register of interests

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

DISCLOSURE REPORT

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

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

2. Disclosure relating to member and public engagement

The Council has engaged with the Trust's membership through the *Your Hospitals* member publication which was received by post to each registered household. In addition, it deployed the Patient and Public Participation and Involvement Strategy which it co-created and drew in members as well as patients and public. It hosted a number of Conversation Cafes under the brand 'What Matters to Me?' It further hosted the Annual General Members Meeting in September 2018.

The Council will continue to oversee the deployment of the PPP&I Strategy during 2019-20 through the annual work plan as well as co-hosting a number of events relating to the Trust's new 'Moving to Outstanding' Strategy launched mid 2018 describing the Trust's ambition to become an Outstanding organisation. Notably, one of the Trust's Quality Objectives for the year is focused on this PPP&I work.

3. Disclosure relating to Quality Governance

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

4. **Statement of Disclosure to Auditors**

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

- so far as each of the Trust directors is aware, there is no relevant audit information of which the Trust's auditor is unaware; and
- each director has taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

For the purposes of this declaration:

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

Additional reporting information

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

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

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

Appointment of External Auditors

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

Better Payment Practice Code:

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

Performance for 2018/19 and 2017/18 was as follows:

	2018-19 Number	**2018-19 £000**	**2017-18 Number**	**2017-18 £000**
Non-NHS trade invoices paid in the year	48,285	84,366	45,312	73,205
Non-NHS trade invoices paid within target	24,665	58,300	13,787	32,703
Percentage of non-NHS trade invoices paid within agreed payment terms or in 30 days	**51%**	**69%**	**30%**	**45%**
NHS trade invoices paid in the year	2,397	21,689	1,891	15,560
NHS trade invoices paid within target	1,262	16,081	313	7,624
Percentage of NHS trade invoices paid within agreed payment terms or in 30 days	**53%**	**74%**	**17%**	**49%**

The total paid within 2018/19 for late payment of commercial debt was £5k (£72k in 2017/18).

Disclosures relating to NHS Improvement's Well Led Framework

As part of a commitment to simplifying regulatory approaches, NHS Improvement worked closely with the Care Quality Commission (CQC) to bring together their respective approaches to the Well-Led key line of enquiry (KLOE). This resulted in a new, wholly joint Well-Led Framework structured around eight key lines of enquiry introduced in 2017/18.

The Trust began implementing updated systems and processes in line with the new guidance at the start of the financial year. This work builds on work already undertaken under the previous regulatory framework. In April 2017 the Trust received its external Well Led assessment which concurred with its own assessment as 'Amber-Green'. An action plan to address 31 recommendations was developed and progressed by Executive Director leads, reporting to Trust Board.

Work on a further self- and external assessment to incorporate the four additional domains of the Well Led framework was completed in year and has provided further assurance that the Trust is well led through:

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

Further information on these assurances can be found in the Annual Governance Statement and the Quality Report. At the time of writing, the Trust has been advised by the Care Quality Commission that it will receive a Well-led review towards the end of April and into early May, 2019.

Signed

Mel Pickup, Chief Executive
Date 23/05/2019

Directors' Report

Board Member Terms

Board Member (Voting)	Term of Office
Steve McGuirk (Chairman)	01.04.15-31.03.18 Extension 01.04.2018-31.03.2021
Ian Jones	01.07.15-30.06.17 Extension 01.07.2017-30.06.2020
Terry Atherton	01.07.14-30.06.17 Extension 01.07.2017-30.06.2020
Anita Wainwright	01.01.15-31.12.17 Extension 01.01.2018- 30.12.2020
Dr Margaret Bamforth	01.05.16-03.04.19 Extension 21.04.2019 - 20.04.2022
Jean-Noel Ezingeard	26.04.17-25.04.20
Mel Pickup (CEO) *	From 15.02.11
Prof Simon Constable	From 02.02.15
Kimberley Salmon-Jamieson	From 07.09.16
Andrea McGee	From 01.02.16
Chris Evans	From 1.3.18
Non-Voting Directors	
Jason DaCosta	From 04.02.13 to 30.06.2018
Phill James	From 01.12.2018
Pat McLaren	From 01.12.15
Lucy Gardner	From 01.02.16
Michelle Cloney	Interim from 01.03.17 Substantive 1.11.17
Dr Alex Crowe	From 1.10.17

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

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

**Following her appointment as Senior Responsible Officer of the Cheshire & Merseyside Health and Care Partnership on 18 September 2017, Mel Pickup, Chief Executive continued in this role throughout 2018/19. She shares her working week between CEO of Warrington & Halton Hospitals NHS Foundation Trust (the Trust) and SRO of the Health and Care Partnership for Cheshire and Merseyside and the Trust is reimbursed for her time and associated costs, including backfill. The taxable benefit and performance related bonus shown for Mel Pickup are wholly attributable to the role of SRO.*

Attendance at Board of Director Meetings and Sub-Committees 1 April 2018-31 March 2019

Attendance (actual/maximum possible)

Board Member	Term of Appointment	Trust Board 6 meetings	Audit Committee 5 meetings	Quality Assurance Committee 6 meetings	Finance & Sustainability Committee 12 meetings	Strategic People Committee (from 09/2018) 4 meetings
		Attendance (Actual/Max)				
Non-Executive Directors						
Steve McGuirk (Chairman)	01.04.15-31.03.18	4/6				
Jean-Noel Ezingeard	26.04.17-25.04.20	3/6	3/5	5/6	-	-
Ian Jones	01.07.17-30.06.20	6/6	5/5	1/1	-	4/4
Terry Atherton	01.07.17-30.06.20	6/6	5/5	1/1	12/12	-
Anita Wainwright	01.01.18-30.12.20	6/6	5/5	-	11/12	4/4
Margaret Bamforth	21.04.19-20.04.22	6/6	5/5	5/6	-	-
Executive Directors (Voting)						
Mel Pickup	From 15.02.2011	4/6	1/1	-	-	-
Prof Simon Constable	From 02.02.2015	6/6	1/1	5/6	8/12	1/1
Andrea McGee	From 01.02.2016	6/6	5/5	(wef Jan 2019) 2/2	10/12	4/4
Kimberley Salmon-Jamieson	From 07.09.2016	6/6	-	6/6	6/12	2/4
Chris Evans	From 01.03.2018	5/6	-	5/6	10/12	0/4

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

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

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

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

The Work of the Audit Committee

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

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

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

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

Substantial Assurance was provided in the following:

Data Quality, Combined Financial Systems and Care and Comfort Round Review.

Moderate Assurance was provided in the following: Data Protection & Security Toolkit, Mental Capacity Act/Deprivation of Liberty, Safeguarding, 5 Steps to Safer Surgery and Medical Locums.

Limited Assurance was provided in the following: Review of Servers, Temporary Staffing – Non-Clinical and Overtime Payments.

There were no areas reported as providing no assurance.

In addition, the Committee continued to have concerns about the Trust's pay bill and requested that quarterly reports continue to be submitted relating to recruitment of senior posts at Band 8C and above and appointment and term of contract for all interim posts.

Governance and Risk Management

During the Year the Trust continued to develop and enhance its governance and risk management systems and processes. It also fully appraised its key strategic risks and refreshed its Board Assurance Framework which is fully reviewed by the Board at each of its meetings and the Quality Assurance Committee on a bi-monthly basis. In year, there was further alignment of the relevant elements of the Board Assurance Framework to the Committees of the Board.

The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a **Moderate Assurance** rating from the Head of Internal Audit (HOIA).

System of Internal Control

The Trust's Governance Structure aligns the Trust's various governance groups to the Trust Board committees. The Board Assurance Framework provides an overview of the internal control environment and evidence of the effectiveness of the controls that manage the risks to the Trust in achieving its strategic objectives as identified in the annual plan,

The Audit Committee is charged by the Board in reviewing and evaluating the system of internal control through the delivery of the internal audit plan. The Chair of the Audit Committee provides an annual report of the work of the Committee to the Board as well as periodic escalation reports following each meeting.

Internal Audit Activities

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

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

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

Substantial Assurance	**Moderate Assurance**	**Limited Assurance**	**Advisory Support and Guidance Provided to:**
• Data Quality • Combined Financial Systems • Care and Comfort Round	• Data Protection & Security Toolkit • Mental Capacity Act/Deprivation of Liberty • Safeguarding • 5 Steps to Safer Surgery • Medical Locums	• Review of Servers • Temporary Staffing – Non-Clinical • Overtime Payments.	• Continued to support the Trust's own internal tracker for Internal Audit recommendations. • CQC Action Plan • Cyber Security • GDPR Regulations • Bank and Agency (Medical Locums)

An Assurance Framework opinion test against NHS best practice was undertaken and it was confirmed that it is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.

External Audit

Grant Thornton commenced its 3-year term as Auditors to the Trust in January 2017 following a competitive procurement exercise and review and recommendation by the Council of Governors. During the year the Auditors reported on the 2017-18 Financial Statements and Quality Accounts. No material or significant issues were raised in respect of these Statements and Accounts. Technical support has been provided on an ongoing basis to the Committee and the Trust and representatives of Grant Thornton attended each Audit Committee.

Grant Thornton have since audited these 2018-19 Financial Statements and Quality Accounts and their report and opinion is enclosed herein

Anti-Fraud Activity

The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Anti-Fraud Service (AFS) working to a programme agreed with the Audit Committee. The role of AFS 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 AFS and also received an annual report. No significant cases or issues of Anti-Fraud took place or were identified during the year.

REMUNERATION REPORT

Statement from the Chairman of the Nominations and Remuneration Committee

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

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

Nominations

In year the Committee considered and approved the following:

- Appointment of substantive Chief Information Officer – competitive process
- Amendments to the operational priorities and day to day responsibilities of the Deputy Medical Director.
- Appointment of Interim Company Secretary

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 Head of Corporate Affairs

During 2017-18, the committee met as below:

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

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

Hill Dickinson LLP - Independent, professional legal organisation	Attendance requested by the Committee at various points throughout the period – to provide advice relating to Employment Law.

SENIOR MANAGER REMUNERATION POLICY

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

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

During the year under review the Chief Executive Officer received a performance related bonus which was wholly attributable to her role as Senior Responsible Officer of the Cheshire & Merseyside Healthcare Partnership. Full details of the award are contained within the remuneration report. In addition the Director of Human Resources & Organisational Development received a performance related bonus which was wholly attributable to her role as Director of Workforce & Organisational Development at Bridgewater Healthcare NHS Foundation Trust. Full details of the award are contained within the remuneration report.

Directors of the Trust are employed on a permanent contract basis. During the year appointments to the Board were made to the role of the Chief Information Officer (non-voting) and the Director of Medical Education and CCIO (non-voting). Required notice periods are six months. Where salaries of very senior managers exceed £150,000 (£142,500 in 2017/18) per annum, these have been reviewed and found to be appropriate to match market rate, maintain relativities with other very senior manager posts and to match pay in the jobs from which individuals were recruited.

Performance Appraisal

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

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

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

Provisions for Termination of Contract

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

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

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

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

Annual report on Directors Remuneration - Year ended 31 March 2019 (and comparison year ended 31 March 2018) (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.

	2018-19						2017-18			
	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All performance related bonuses (bands of £5,000)	All Pension-related Benefits (bands of £2,500) (6)	**Total (bands of £5,000)**	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	All performance related bonuses (bands of £5,000)	All Pension-related benefits (bands of £2500) (6)	**Total (bands £5,000)**
	£000	£	£000	£000	**£000**	£000	£	£000	£000	**£000**
Executive Directors										
Mel Pickup (1) Chief Executive	180-185	19,400	20-25	-	**220-225**	165-170	8,600	5-10	32.5-35	**220-225**
Prof Simon Constable (2) Executive Medical Director/ Deputy Chief Executive	165-170	1,300		60-62.5	**225-230**	170-175	4,200		-	**170-175**
Dr Alex Crowe (3) Deputy Medical Director until 31.01.19 Director of Education and CCIO from 01.02.19	140-145			12.5-15	**155-160**	80-85			17.5-20	**100-105**
Jason DaCosta (4) Director of Information Technology until 20.07.18	15-20			-	**15-20**	80-85				**80-85**
Lucy Gardner Director of Strategy	120-125			32.5-35	**155-160**	120-125			37.5-40	**155-160**
Roger Wilson Director of Human Resources and Organisational Development Until 04.05.17						10-15			-	**10-15**
Michelle Cloney (5)(7) Director of Human Resources and Organisational Development	105-110			150-152.5	**260-265**	95-100			17.5-20	**112.5-115**
Andrea McGee Director of Finance and Commercial Development	130-135			37.5-40	**170-175**	125-130			50-52.5	**175-180**
Sharon Gilligan Chief Operating Officer Until 28.04.17						70-75			-	**70-75**

	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)	erformance related bonuses ands of £5,000)	All Pension-related Benefits (bands of £2500) (6)	**Total (bands of £5,000)**	Directors' Salary and fees (bands of £5,000)	Taxable benefits (to the nearest £100)		All Pension-related benefits (bands of £2500) (5)	**Total (bands £5,000)**
	£000	£	£000	£000	**£000**	£000	£		£000	**£000**
Chris Evans (7) Chief Operating Officer from 01.03.18	120-125			75-77.5	**195-200**	5-10			2.5-5	**10-15**
Pat McLaren Director of Community Engagement and Corporate Affairs	85-90			2.5-5	**90-95**	85-90			7.5-10	**95-100**
Phillip James Chief Information Officer from 08.12.18	35-40			10-12.5	**45-50**					
Kimberley Salmon-Jamieson Chief Nurse	120-125			5-7.5	**125-130**	115-120			-	**115-120**
Acting Executive Directors										
Jan Ross (3) Acting Chief Operating Officer From 01.05.17 - Until 07.01.18						65-70			67.5-70	**135-140**
Chairman and Non-Executive Directors										
Steve McGuirk Chairman	40-45				**40-45**	40-45				**40-45**
Prof Jean-Noel Ezingeard Non-Executive Director From 26.04.17	10-15				**10-15**	10-15				**10-15**
Ian Jones Non-Executive Director	10-15				**10-15**	10-15				**10-15**
Terry Atherton Non-Executive Director	10-15				**10-15**	10-15				**10-15**
Anita Wainwright Non-Executive Director Reappointed 01.01.18	10-15				**10-15**	10-15				**10-15**
Dr Margaret Bamforth Non-Executive Director	10-15				**10-15**	10-15				**10-15**

Notes:

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

(2) The total banded remuneration for the Deputy Chief Executive/Executive Medical Director during the year under review was 160-165 (165-170 in 2017/18). The table above for 2017/18 includes a single arrears payment of £5,000 Clinical Excellence Award made in 2015 and arrears payment relating to the £6,000 per annum pay award upon appointment to Deputy CEO effective 1.04.16. (This uplift required HM Treasury approval which was received in November 2017)

(3) Refers to time in post as a Director.
(4) One fifth of Jason DaCosta's salary was recharged to Warrington CCG. The table above shows remuneration net of this recharge.
(5) Michelle Cloney was substantively employed by the Trust from 01.11.17. Prior to this she was engaged via another entity. Director's salary and fees include salary and payments made to the other entity rather than to the individual directly. From 01.01.19 two fifths of Michelle Cloney's salary was recharged to Bridgewater Community Healthcare NHS Foundation Trust. The table above shows remuneration net of this recharge.
(6) Pension related benefits are calculated using the HMRC method derived from s229 of the Finance Act 2004. This is an annualised figure, adjusted to reflect the time in post as a Director. This may appear unusually high where an employee has been a director for part of a year or, for the first full year that they have been a director. Where the pension related benefit in year is a loss the figure is reported as zero. Pension related benefits are not received by the employee during the year but reflect the combined increase in accrued pension and lump sum (due to the employer's contributions to the NHS Pension Scheme) payable upon retirement to the individual.
(7) Michelle Cloney and Chris Evans were employed by the Trust for part of 2017/18; the increases in the accrued pension and lump sum for 2018/19 (forming part of the above calculation) have been compared to proportionate figures for the previous year, the increase in 2018/19 appears high as a result.

Pension Entitlements Year ended 31 March 2019 (Audited)

Name and title	Real increase in pension at pension age (bands of £2,500)(1)	Real increase in pension lump sum at pension age (bands of £2,500)(1)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018	Real increase in Cash Equivalent Transfer Value (1)	Cash Equivalent Transfer Value at 31 March 2019	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mel Pickup Chief Executive	0-2.5	-	70-75	180-185	1,184	168	1,374	-
Prof Simon Constable Executive Medical Director/ Deputy Chief Executive	2.5-5	5-7.5	20.25	40-45	294	101	401	-
Dr Alex Crowe Director of Education and CCIO	0-2.5	-	45-50	120-125	845	133	994	-
Lucy Gardner Director of Strategy	2.5-5	0-2.5	0-5	0-5	41	29	70	-
Michelle Cloney Director of Human Resources and Organisational Development	7.5-10	20-25	35-40	85-90	622	234	868	-
Andrea McGee Director of Finance and Commercial Development	2.5-5	0-2.5	40-45	110-115	684	143	839	-
Chris Evans Chief Operating Officer	2.5-5	5-7.5	20-25	45-50	234	103	341	-
Pat McLaren Director of Community Engagement and Corporate Affairs	0-2.5	2.5-5	10-15	40-45	268	46	320	-
Kimberley Salmon-Jamieson Chief Nurse	0-2.5	-	35-40	90-95	531	97	638	-

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

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.

	2018-19 £000	2017-18 £000
Remuneration including employers national insurance contribution for Executive and Non-Executive Directors	1,560	1,531
Employers contribution to pension in relation to executive directors	162	135

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 2018/19 and comparative figures for 2017/18.

	Number in Office	Number claiming expenses during the year	**Total expenses Claimed**	Number in Office	Number claiming expenses during the year	**Total expenses Claimed**
	2018-19 Number	2018-19 Number	**2018/19 £**	2017-18 Number	2017-18 Number	**2017/18 £**
Directors	17	12	**4,421**	19	11	**6,776**
Governors	26	3	**1**	27	5	**583**
Total	**43**	**15**	**4,422**	**46**	**16**	**7,359**

Fair Pay Multiple (Audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The mid-point of the banded remuneration of the highest-paid director in Warrington & Halton Hospitals NHS Foundation Trust in the financial year 2018/19 was £222,500 (2017/18 £187,500). The highest-paid director in 2018/19 and 2017/18 was the Chief Executive Officer.

In 2018/19 the highest-paid director earned 8.64 times (9.44 times in 2017/18) the median remuneration of the workforce, which was £25,755 (£19,852 in 2017/18). The increase in the midpoint of the banded remuneration of the highest director was due to taxable benefits and performance related bonus paid on behalf of the Cheshire and Merseyside Healthcare Partnership.

In 2018/19, 6 employees (8 employees in 2017/18) 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 £223,524 to £251,935 (£191,750 to £285,516 in 2017/18).

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 2019.

Signed

Mel Pickup, Chief Executive

Date: 23/05/2019

The Council of Governors

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

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

Governor Elections
A Governor election was carried out in May-June 2018 to appoint or renew governor terms in five constituencies.

Understanding the views of the governors, members and the public

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

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

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

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

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

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

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

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

The Council has the following statutory powers and responsibilities:

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

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

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

- Contribute to the business planning process and the development of forward plans for the Trust in co-operation with the Board of Directors;
- Represent the interests of the communities served by the Trust and ensure they are appropriately represented;
- Consult with members and reflects the view of the membership; and
- Develop and maintain the Trust's membership and engagement strategy – now encompassed in the Patient and Public Participation and Involvement 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 made 'Fit and Proper Person Test' declarations.

The Council of Governors between 1st April 2018 and 31st March 2019 comprised:

Constituency	Governor	Term	Term Ends
Daresbury, Windmill Hill, Norton North, Castlefields	Alison Kinross	2	30/11/2021
Beechwood, Mersey, Heath, Grange	Joe Whyte	1	30/06/2018
Beechwood, Mersey, Heath, Grange	Linda Mills	1	30/11/2021
Norton South, Halton Brook, Halton Lea **(Vacant since Feb 2017)**			
Appleton, Farnworth, Hough Green, Halton View, Birchfield	Colin McKenzie	1	23/12/2019
Broadheath, Ditton, Hale, Kingsway, Riverside **(Vacant since June 2018)**			
Lymm, Grappenhall, Thelwall	Ryan Newman	1	30/11/2020
Lymm, Grappenhall, Thelwall **(Vacant since February 2019)**			
Appleton, Stockton Heath, Hatton, Stretton and Walton	Nick Stafford	1	30/11/2020
Penketh and Cuerdley, Great Sankey North, Great Sankey South	Paul Bradshaw	1	30/11/2020
Culcheth, Glazebury and Croft, Poulton North	Keith Bland MBE	1	23/12/2019
Latchford East, Latchford West, Poulton South	Carol Astley	2	30/06/2018
Latchford East, Latchford West, Poulton South	Erin Dawber	1	30/11/2021
Bewsey and Whitecross, Fairfield and Howley **(Vacant since January 2018)**			
Poplars and Hulme, Orford	Colin Jenkins	1	30/11/2020
Birchwood, Rixton and Woolston	Anne M Robinson	1	23/12/2019
Burtonwood and Winwick, Whittle Hall, Westbrook	Norman Holding **(Lead Governor)**	2	30/11/2021
Rest of England and Wales	Jim Henderson	2	30/11/2020
Rest of England and Wales	Dalton Boot	1	30/11/2020
Rest of England and Wales **(Vacant since March 2019)**			
Medical and Dental	Dr Helen Bowers	1	23/12/2019
Nursing and Midwifery	TBC	1	23/12/2019
Staff - Support	Peter Beesley	1	30/11/2020
Clinical Scientist or Allied Health Professionals	Louise Spence	1	23/12/2019
Estates, Administration, Managerial	Mark Ashton	2	30/11/2020
Halton Borough Council	Cllr P Lloyd Jones	2014	n/a
Warrington Borough Council	Cllr Pat Wright	2011	n/a
Wolves Foundation	Neil Kelly	2013	n/a
University of Chester	Mike Brownsell	2017	Resigned 2018
University of Chester	Prof John Hughes	2018	n/a
Widnes Vikings	John Hughes	2017	n/a
Warrington & Vale Royal College	Victoria Harte	2019	n/a

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

Governor	Council of Governors	Quality In Care Committee	Nominations & Remuneration	Governors Engagement Group
Steve McGuirk, Chair	4/4	-	1/2	-
Ian Jones, Senior Independent Director	4/4	-	1/1	-
Alison Kinross **Daresbury, Windmill Hill, Norton North, Castlefields**	3/4	2/3	1/2	4/4
Linda Mills *(elected June 2018)* **Beechwood, Mersey, Heath, Grange**	3/3	0/2	0/2	0/3
Joe Whyte *(to June 2018)* **Beechwood, Mersey, Heath, Grange**	0/1	0/1	-	0/1
Vacant since February 2017 **Norton South, Halton Brook, Halton Lea**	-	-	-	-
Colin McKenzie **Appleton, Farnworth, Hough Green, Halton View, Birchfield**	4/4	0/3	0/2	0/4
Kenneth Dow (*to June 2018)* **Broadheath, Ditton, Hale, Kingsway, Riverside**	0/1	0/1	-	0/1
Ryan Newman *(to 11.02.2019)* **Lymm, Grappenhall, Thelwall**	2/3	0/2	0/2	1/3
Nick Stafford **Appleton, Stockton Heath, Hatton, Stretton and Walton**	3/4	1/3	0/2	3/4
Paul Bradshaw **Penketh + Cuerdley, Great Sankey North, Great Sankey South**	3/4	0/3	1/2	0/4
Keith Bland MBE **Culcheth, Glazebury and Croft, Poulton North**	3/4	0/3	0/2	1/4
Carol Astley *(to June 2018)* **Latchford East, Latchford West, Poulton South**	0/1	0/1	-	0/1
Erin Dawber *(elected June 2018)* **Latchford East, Latchford West, Poulton South**	2/3	0/2	0/2	1/3
Vacant Since January 2018 **Bewsey and Whitecross, Fairfield and Howley**	-	-	-	-
Colin Jenkins **Poplars and Hulme, Orford**	1/4	3/3	2/2	2/4
Anne Robinson **Birchwood, Rixton and Woolston**	3/4	0/3	1/2	1/4
Norman Holding LEAD GOVERNOR **Burtonwood and Winwick, Whittle Hall, Westbrook**	3/4	2/3	1/2	4/4
Dalton Boot *(elected June 2018, resigned March 2019)* **Rest of England and Wales (formerly South Mersey)**	1/3	0/2	0/2	1/3
Jim Henderson *(elected June 2018)* **Rest of England and Wales (formerly South Mersey)**	0/3	0/2	0/2	0/4
Dr Helen Bowers **Medical Staff**	0/4	0/3	0/2	0/4
TBC **Nursing and Midwifery**	-	-	-	-
Peter Beesley **Support Staff**	0/4	0/3	0/2	0/4
Louise Spence **Clinical Scientist or Allied Health Professionals**	3/4	1/3	0/2	1/4
Mark Ashton, Estates **Administrative & Managerial**	3/4	0/3	1/2	1/4
Warrington Borough Council **Cllr Pat Wright**	3/4	0/3	0/2	0/4
Halton Borough Council **Cllr Peter Lloyd Jones**	3/4	2/3	2/2	3/4
Warrington Wolves Charitable Foundation	0/4	0/3	0/2	0/4

Neil Kelly				
University of Chester *(to August 2018)* **Dr Mike Brownsell, Appointed 01.02.17**	1/2	0/2	0/1	0/2
University of Chester(from October 2018) **Professor John Williams**	0/2	0/1	0/1	0/2
Widnes Vikings **John Hughes, Appointed December 2017**	0/4	0/3	0/2	0/4
Warrington + Vale Royal College *(from January 2019)* **Victoria Harte**	1/1	0/1	0/1	0/1

Changes to the Foundation Trust Constitution in Year

The Council of Governors engaged in resolving a number of initiatives to enhance our member and public engagement which have necessitated amendments to our Constitution. As per Article 45 'Amendment to the Constitution' the Trust may make amendments to its constitution if more than half of the members of the Board of Directors of the Trust voting approve the request. Following the support of the Council of Governors on 14th February 2019, the Trust Board unanimously agreed on 27th March 2019, that the following amendments should be made to the Trust's Constitution:

1. Extend the number of terms a Governor can serve from two to three (maximum 9 years)
2. Extend the tenure of Non-Executive Directors beyond the current two terms of office. (maximum 9 years)
3. Strengthening of eligibility criteria to be a Governor and strengthening of requirements for Governor attendance at meetings.
4. Replacement of references to *S/he, his/her* with *they & their* as appropriate to ensure the document is gender neutral

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

Governors may be contacted at:

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

The Foundation Trust Membership

As an NHS Foundation Trust, Warrington and Halton Hospitals has a membership scheme that means that members of the public (aged 16 and over) and staff can become members of the Trust. Members play a key role in the hospitals, providing input into what services they want their hospitals to provide. They do this by electing Public and Staff Governors who represent the membership's views and therefore that of the local community.

Eligibility, constituencies and boundaries for membership

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

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

Membership breakdown – total staff and public members 15,439

Public Constituency	**2018-19**
At year start 1st April 2018	**11,172**
At year end 31st March 2019	**10,957**
Daresbury Windmill Hill Norton North Castlefields	750
Beechwood, Mersey, Heath, Grange	829
Norton South, Halton Brook, Halton Lea	875
Appleton, Farnworth, Hough Green, Halton View, Birchfield	525
Broadheath, Ditton, Hale, Kingsway, Riverside	471
Lymm Grappenhall Thelwall	595
Appleton, Stockton Heath, Hatton, Stretton, Walton	571
Penketh and Ceurdley, Great Sankey North and South	711
Culcheth, Glazebury and Croft, Poulton North	589
Latchford East, Latchford West, Poulton South	644
Bewsey and Whitecross, Fairfield and Howley	767
Poplars Hulme Orford	610
Birchwood Rixton Woolston	677
Burtonwood and Winwick, Whittle Hall Westbrook	550
Rest of England and Wales	1793
Staff Constituency	
At year end 31st March 2019	**4,482**

Membership Demographics

In year we worked with our FT Governors to co-create a holistic patient and public participation and involvement strategy, which included our membership, with the aim of '*Making a formal commitment to creating opportunities for the participation and involvement of all groups (patients, families, carers, staff, members, communities, advocates, partners and other stakeholder groups), ensuring that ways and means to engage are accessible to all and that all voices are heard and views considered and incorporated wherever possible in service delivery, design and transformation through the championing of co-production.*' In developing this aim we drew upon the NHS

Constitution where: **Everyone counts. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind.** In deploying our work plan we are focusing on those areas where we are under-represented to ensure that everyone has the opportunity and is supported to join our Trust.

Member* demographic profile vs borough profile %

	WHH FT Membership N = 9118**	**Warrington (n = 205100)**	**Halton (n = 125746)**
Asian/Asian British	**1.8**	**2.4**	**0.2**
Black/African/Caribbean/Black British	**0.3**	**0.4**	
Mixed Multiple Ethnic Groups	**0.5**	**1.1**	
Other ethnic group	**0.2**	**0.3**	**1.5**
White	**96.8**	**95**	**98**
Prefer not to say	**0.4**	**-**	**0.3**
Source:		***Borough Profile 2015***	***CENSUS 2011***

Public constituencies only
****To note for purposes of accurate comparison the Rest of England constituency has been excluded from this data***

Gender (*source NOMIS 2017*) %	**WHH FT**	**Warrington**	**Halton**
- Female	65.7	50.4	48.8
- Male	34.3	49.6	51.2

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

Staff Report

At Warrington and Halton Hospitals NHS Foundation Trust we recognise that our workforce is central to us achieving our ambition of '*getting to good, moving to outstanding*.' We believe that by harnessing the talents of our workforce and creating the conditions for staff to provide excellent care we will be recognised as an outstanding organisation – somewhere where people want to be cared for and somewhere where people want to work.

The Trust People Strategy, which is built on the foundations of our Quality, People and Sustainability Framework (QPS), was ratified in September 2018. It sets out how we will achieve our strategic People aim to be the best place to work with a diverse, engaged workforce that is fit for the future. We are committed to the wellbeing, experience and development of our staff. We want to attract and retain a diverse, values-driven and highly skilled workforce, and support them to develop their careers here at WHH.

Analysis of Staff Costs

	2018/19 Total £000s		2017/18 Total £000s
Salaries and wages	**130,878**		**128,145**
Social security costs	**12,607**		**11,922**
Apprenticeship levy	**619**		**586**
Pension costs (employer contributions to NHS Pensions)	**14,900**		**14,201**
Pension costs (other)	**76**		**16**
Termination benefits	**72**		**138**
Bank and agency staff	**23,341**		**18,906**
Total employee benefit expenses	**182,493**		**173,914**
Less costs capitalised as part of assets	(159)		(158)
Total per employee expenses	**182,334**		**173,756**

Employee costs include staff costs of £159k (£158k in 2017/18) which have been capitalised as part of the Trust's capital programme. These amounts are excluded from employee expenses (Note 5.1). The employee expenses table above is for executive directors, staff costs and redundancy payments only. It excludes non-executive directors.

Average Staff Numbers

Below is a breakdown of the number of male and female directors and senior managers:-

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

Senior Managers (Band 8a and above)	**53**	**160**
Other Employees	**813**	**3440**

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.

	2018/19			2017/18
Staff Category	**Permanently Employed**	**Other**	**Total**	**Total**
Medical and dental	395	32	**427**	415
Administration and estates	880	4	**884**	866
Healthcare assistants and other support staff	807	106	**913**	899
Nursing, midwifery and health visiting staff	954	127	**1,081**	1,062
Scientific, therapeutic and technical staff	576	27	**603**	590
Total	**3,612**	**296**	**3,908**	3,832

Attendance Management

The Trust approach to tackling sickness absence is twofold; strategic initiatives to support the health and wellbeing of our workforce and robust operational management of absence. The Trust has a clear and robust framework within which managers are able to address the issues of attendance and sickness absence with a consistent, supportive and fair approach. Sickness absence will continue to be a key area of focus in 2019/20, with plans in place to learn from best practice and work collaboratively to improve attendance.

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

Staff sickness absence	2018	2017
Total days lost	39,635	35,703
Total staff years	3,471	3,444
Average working days lost (per WTE)	**11.42**	**10.4**

Staff Policies and Actions Applied in Year

The following workforce policies were applied in the financial year:

- Special Leave
- Secondment Policy
- Annual Leave Policy
- Disability Equality Policy (to be replaced with Equality In Employment Policy)
- Study and Professional Leave Policy For Non-Training Grade Medical Staff
- Clinical Excellence Awards Policy
- IV Drug Administration Policy
- Time off for Recognised Representatives and members of Trade Unions/Staff Organisations policy
- Grievance Procedure
- Dignity at Work
- Attendance Management
- Stress Policy - Staff Mental Wellbeing and Emotional Resilience
- Organisational Change Policy
- Exit Payments Policy
- Multi-professional Clinical Supervision Policy
- Preceptorship Policy
- Whistleblowing - Freedom to Speak Up Policy
- Recruitment and Selection
- Remediation Policy for Medical and Dental Staff
- Maintaining High Professional Standards
- Temporary Staffing Policy: Medical Staff, Professions Allied to Medicine and Admin and Clerical Staff
- The Strengthened Medical Appraisal to Support Revalidation Policy
- Retirement and Long Service Policy
- Overtime Policy
- Work Experience Policy
- Unified Do not attempt Resuscitation Policy
- Policy for the Payment of Travel and Expenses
- Management of Needle stick, Sharps and Innoculation Injury, including Sharps Safety Policy
- Workplace Alcohol, Drug and Substance Misuse Policy
- Providing Employment References
- Apprenticeship Policy
- Training and Development Policy
- Job Planning Policy for Consultant Medical Staff (Agreed at WC but JLNC claim approval not given)
- Resuscitation Policy
- Annual Leave Policy for Consultant Medical and Dental Staff
- Career Break
- Medical Illustration Policy
- Performance Improvement Policy
- Shared parental leave policy
- On Call Policy
- Professional Clinical Registration
- Non-Medical Staff Study Leave / Funding Policy
- Disciplinary Policy
- Protection of Pay
- Management of Personal Relationships at Work
- Immunisation Of Healthcare Workers And Health Clearance - Occupational Health Standards
- Appraisal Policy
- Pay Progression Policy
- Induction Policy

- Job Planning Policy for SAS Doctors

Equality, Diversity and Inclusion

The Trust is committed to equality, diversity and inclusion across our workforce. We aim to be a leading organisation, which is recognised locally, regionally and nationally, for promoting Equality, Diversity and Inclusion. To support us to achieve this aim, the Trust Board approved our new Equality, Diversity and Inclusion Strategy in March 2019, following engagement with our patients, our workforce and our communities. Our Strategy sets out how we will create a positive culture where all our patients will experience outstanding care which meets their specific needs, with a workforce where no-one will feel compelled to conceal or play down elements of their identity for fear of stigma, where people can be authentic and their unique perspective, experiences and skills seen as a valuable asset to the Trust.

The Trust has met all of its statutory reporting requirements throughout 2018/29 and all reports are published on the Trust website (available here: https://whh.nhs.uk/about-us/corporate-publications-and-statutory-information/equality-diversity-and-human-rights). The outputs of these publications have been used to direct our engagement with our patients, our workforce and our communities, and have fed into our Strategy.

Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees:

We have continued to communicate with our staff through a variety of methods. We make use of a variety of media platforms such as the monthly team brief, the emailed weekly update and daily safety briefing arising from the daily safety huddle.
We have further developed out use of social media with Twitter, Facebook and Instagram featuring in our internal and external communication tools. 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. It continues to be presented by our Chief Executive, based around our Quality, People and Sustainability framework.
We have continued the momentum around our Trust Behaviours; WE ARE WHH– Working together, Excellent, Accountable, Role models, Embracing Change. These are the principles that determine the way we behave and our culture. Our behaviours badges, which are awarded when an individual or a team has demonstrated a particular behaviour and deserve recognition, are well received and have helped to embed these values. We continue to hold Employee and Team of the Month awards which complement the behaviours badges.

Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests:

There is a strong culture of partnership working with Staff Side colleagues and the Trust works closely with trade union/professional organisation partners 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.

Information on health and safety performance and occupational health:

Our Workplace Health and Wellbeing Team deliver our Occupational Health service and have responsibility for supporting 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.
The team consists of nurses, physiotherapists, counsellor, administrators and external doctor provisions offering a robust integrated OH service, supporting Commissioning for Quality Innovation (CQUIN) targets and our People Strategy. Key highlights of the year include:-

Health Awareness and promotion

The 'Fit to Care' Programme continues to evolve and this year we have focused on three elements, these being mental health, muscular skeletal and health promotion and wellbeing.

Health promotion and wellbeing events
Over the last 12 months we have undertaken events such as, back awareness, mental health and suicidal, New Year / New You, health eating, diet clubs. The events where attended by several hundreds of staff and feedback was positive.

Flu Campaign

The department commenced the influenza vaccination campaign on the 1st October 18 and completed it on the 5th March 19. The trust achieved the vaccination rate of 89.6% in frontline staff.

Musculoskeletal (MSK)

The Physiotherapists have increased their profile following the New Year / New You event and have a constantly full clinic. Back Club drop in sessions were launched this year to give employees the opportunity to seek specialist advice for spinal issues. Links have been publicised on the extranet to offer employees the advice / exercise for commonly experienced MSK conditions prior to referring for physiotherapy support if required.

Mental Health

The Lead Counsellor continued to evolve her role to support the employees in the Trust. This has included resilience training and Mental Health First Aid Training. The types of therapy available to employees have become more bespoke to the individual needs, continuing to offer a maximum of six session and offering personal centred one to one counselling, relaxation therapy and hypnosis therapy.

Staff Survey Results

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, across our entire workforce. Improving the staff survey results is a key priority, and our survey results for 2018 show significant progress. Although only required to survey a relatively small sample of randomly selected staff, the Trust decided, for the second year running, that all staff should have the opportunity to take part in the exercise. We therefore believe that our results truly reflect the opinions of our whole workforce.

Staff Engagement:

Our overall engagement score increased from 6.8 in 2017 to 7.0 in the 2018 survey. This is based on the new scale for recording staff engagement which was introduced this year. This was equal to the average engagement score for Acute Trusts in 2018.
Staff survey report overall response rates:
Our response rate was 7 percentage points higher than the national average at 51%, with almost 2000 members of staff opting to respond. This represented an increase of 5 percentage points over our last year's response rate of 46%.

The improvement in our response rate was achieved by driving participation locally through our clinical business unit structure and we will continue with this approach into the future. Our response rates for the last 3 years are as follows:-

year	% response rate
2016	38%
2017	46%
2018	51%
2018 average for Acute Trusts	44%

For our staff survey results see Annexe 2

Trade Union Facilities Time

The Trust's statistics relating to our Trade Union facility time for the period ending 31 March 2018 (published in July 2018) are as follows:-

no employees who were relevant union officials	full time equivalent employee number
33	**31.95**

Percentage time spent on TU activity/facility time	no of individuals
0%	**4**
1 – 50%	**27**
51 – 99 %	**1**
100 %	**1**

Cost of TU activity/facility time	£
total cost of facility time	**£ 70,755**
total pay bill (2017 – 18)	**£ 145,624,534**
% age of total pay bill spent on facility time	**.05%**

	%age
paid TU activity time as a percentage of paid facility time	**5.66 %**

Expenditure on Consultancy

The Trust has incurred the following expenditure on consultancy services:-

	2018/19	2017/18
Total expenditure (£000's)	1,708	1,000

Expenditure of £438k (£300k in 2017/18) was for the provision of Trust management advice and assistance outside the "business as usual" environment and covers strategy, financial, organisation and change management and IM&T services. Expenditure of £1,163k (£700k in 2017/18) was for the provision of consultancy services on behalf of the Cheshire and Merseyside Sustainability and Transformation Programme which has been hosted by the Trust since 18th September 2017. Expenditure of £107k related to project management in relation the Kendrick Wing fire (£0 in 2017/18)

Disclosures set out in the NHS Foundation Trust Code of Governance

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

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

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

In the 2017/18 Annual Report, the Trust declared that it was partially compliant with Code of Governance Reference B.5.6 - Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.

During 2018/19, the Council of Governors co-created the Patient, Public, Participation and Involvement (PPP&I Strategy and deployed it through the Annual Plan. This was achieved by hosting conversation cafes at all three sites, the raising of awareness at the Annual Members Meeting, conducting Carers Cafes and supporting raising awareness of the new strategy at a variety of market places and delivery of a number of 'what matters to me' events in Outpatients and the Urgent and Emergency department.

Warrington and Halton Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. It declares that there are no items for which the Trust is not fully compliant; and disclosures are made throughout the 2018/19 Annual Report on a comply or explain basis.

Annex 1

Staff exit packages

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

The table below discloses the number and value of exit packages agreed in 2018/19.

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			19	55	19	55		
£10,00 – £25,000	1	17			1	17		
£25,001 – £50,000								
£50,001 – £100,000								
Total	**1**	**17**	**19**	**55**	**20**	**72**		

*please note that this table includes payments in lieu of notice.

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

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	**£000**	**Number**	**£000**	**Number**	**£000**	**Number**	**£000**
<£10,000	1	8	14	39	15	47		
£10,00 – £25,000	2	31			2	31		
£25,001 – £50,000								
£50,001 – £100,000			1	60	1	60		

Total	**3**	**39**	**15**	**99**	**18**	**138**		

Analysis of other departures

During 2018/19 there were no non-compulsory departures which attracted an exit package in the year. There were none for 2017/18 to list for comparison.

Annex 2 NHS Staff Survey 2018

Our results are equal to or better than the national average in 9 out of the 10 themes.

Some key highlights of our survey results are as follows:-

- More staff said they looked forward to coming to work;
- More staff said they were enthusiastic about their job;
- There was an improvement in staff telling us they would recommend our Trust as a place to work;
- There was an improvement in staff telling us they would be happy with the standard of care provided for a friend or relative;
- There was a significant improvement in all questions relating to safety.

The survey also highlights areas for us to work on. Our planned actions are as follows:-

- Further analysis of results for staff with protected characteristics;
- Mapping of results to key Trust strategies to inform our work programmes going forward;
- Review of our appraisal process to enhance the quality of discussions;
- Sharing of feedback at a local level to identify quick wins and long term actions.

The survey results were shared with our 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. Our results for 2018, along with the benchmarking of indicators for 2018 and the previous 2 years, are shown below:-

	2016	2017	2018

Indicator/Theme	us	average	us	average	us	average
Equality, Diversity & Inclusion	9.4	9.2	9.4	9.1	9.3	9.1
Health & Wellbeing	6.3	6.1	6.2	6.0	6.2	5.9
Immediate Managers	6.9	6.7	6.9	6.7	7.0	6.7
Morale	n/a	n/a	n/a	n/a	6.2	6.1
Quality of Appraisals	5.1	5.3	5.2	5.3	5.3	5.4
Quality of Care	7.5	7.6	7.5	7.5	7.5	7.4
Safe Environment (B & H)	8.1	8.0	8.3	8.0	8.4	7.9
Safe Environment (Violence)	9.4	9.4	9.4	9.4	9.5	9.4
Safety Culture	6.4	6.6	6.5	6.6	6.7	6.6
Staff Engagement	6.8	7.0	6.8	7.0	7.0	7.0

The results of the survey will inform our People Strategy work plan going forward and will be used to measure our progress against key performance indicators.

Annex 3 – NHS Improvement's Single Oversight Framework

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

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

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

Segmentation

The Trust is currently assigned to segment 2 of the framework. This segmentation information is the Trust's position as at 18 April 2018. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and use of resources

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

This segmentation information is the Trust's position as at 31st March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Area	**Metric**	**2018/19 scores**				**2017/18 scores**			
		Q4	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**	**Q2**	**Q1**
Financial sustainability	Capital service cover	4	4	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4	4	4
Financial efficiency	I&E margin	4	4	4	4	4	4	4	4
Financial controls	Distance from financial plan	1	2	2	1	4	4	1	4
	Agency spend	3	3	2	2	2	2	2	2
Overall scoring		**3**	**3**	**3**	**3**	**4**	**4**	**3**	**4**

Annex 4 Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Warrington and Halton Hospitals NHS Foundation Trust.

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Warrington & 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.

Signed

Mel Pickup, Chief Executive

Date: 23/05/2019

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Warrington and Halton Hospitals 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 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Accounting Officer, supported by the Board Members, I have responsibility for the overall direction of the risk management systems and processes within the Trust. I have delegated the Executive Lead for risk management to the Chief Nurse who in turn is supported by the Director of Integrated Governance and Quality who manages the risk team.

The Quality Committee is the delegated committee of the Board of Directors to oversee the strategic risk register. Strategic risks are discussed at each meeting. It approves amendments to the strategic risk register / board assurance framework for ratification by the Board of Directors.

The Finance and Sustainability Committee oversees financial risk and risks arising through transformation on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register.

The Strategic People Committee oversees workforce risk on behalf of the Trust and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register

The Risk Review Group reports to Trust Quality Assurance Committee and oversees CBU risk registers on a rolling programme and make recommendations to Quality Assurance Committee regarding new strategic risks, review of existing strategic risks and assurance review of the CBU risk register

The Trust Operations Board oversees the Trust's operations and any risks associated with delivery of this and report on any additional risk/controls/assurances which will be recorded on the appropriate risk register.

The Audit Committee oversees the entire risk management system. It commissions an annual audit of the board assurance framework and strategic risk register, as part of the internal audit plan, to satisfy itself that the system of internal control is effective. It examines the assurances on the effectiveness of controls for all strategic risks received from the Chair of the Quality Committee, and from internal and external auditors.

Risk Training

Staff are trained and equipped to manage risk in a way appropriate to their authority and duties. All new staff receive an overview of the Trust's risk management processes as part of the corporate induction programme, supplemented by local induction organised by line managers. Further education is provided with cyclical mandatory training undertaken by both clinical and non-clinical staff; the content for this programme is continually reviewed in light of any changes. There is a robust appraisal process which facilitates the identification of individual staff training needs. These are reviewed as part of the member of staff's annual performance and development appraisal. All relevant risk policies are available to staff via the Trust's document management system including:

- Risk Management Strategy and Policy
- Incident Reporting & Investigation Policy (Including Serious Incident Framework & Duty of Candour)
- Complaints & Concerns Policy

The Trust is committed to quality improvement and recognise the benefits gained from shared learning which helps to minimise future risk and to improve the care that the Trust provides. To achieve this, the Trust uses a range of mechanisms including clinical supervision, reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit and the application of evidence based practice. The revalidation process that a number of health professionals now undertake further supports learning and development.

Lessons learned and good practice is shared throughout the Trust, for example via the Trust-wide Safety Huddle, daily Safety Briefings, Quality Assurance Committee, Patient Safety & Clinical Effectiveness Sub Committee, Complaints Quality Assurance Group and the Clinical Claims Group. Furthermore, the Trust publishes the Learning to Improve Newsletters quarterly. The CBUs also have a robust governance process for feedback.

The risk and control framework

During the year the Trust continued to develop and enhance its governance and risk management systems and processes. It also fully appraised its key strategic risks and refreshed its Board Assurance Framework which is reviewed by the Board at each of its meetings and the Quality Assurance Committee on a bi-monthly basis. In year, there was further alignment of the relevant elements of the Board Assurance Framework to the committees of the board.

The Risk Management Strategy provides a framework for managing risk across the Trust. The Strategy describes the process for managing risks and the roles and responsibilities of the Board of Directors, its Committees and that of all staff and provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the Trust.

Local risk registers are monitored and maintained locally within the Clinical Business Units (CBU) 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 CBU risk register.

Risks should be scored by the competent person undertaking the risk assessment and validated by a manager according to the residual risk score:

- 6 or below (low, and very low) are verified by the ward or department manager.
- 8-10 (moderate) are verified by CBU Managers, Corporate Heads of Service, Lead Nurse, Matron
- 12 (high) are verified by the Clinical Directors, Associate Directors

- ≥15 (significant) are verified at Executive level. They are reviewed at the

Risk Review Group by the Chief Nurse, Director of Integrated Governance and Quality, Chief Operating Officer, Deputy Medical Director, Head of Safety and Risk and the Divisional Governance Managers. This group will review the risk for inclusion onto the Board Assurance Framework. The recommendation will then be reviewed and ratified by the Trust Quality Assurance Committee.

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

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

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

The Trust has a Board Assurance Framework in place which is reviewed by the Board of Directors, and includes: the identification of the key risks to the achievement of the strategic objectives, CQC fundamental standards; 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 by the Board of Directors at each of their meetings and the Audit Committee, and bi-monthly by the Quality Assurance Committee, which provides additional challenge and scrutiny of the risks identified.

The NHS Digital Data Security and Protection Toolkit, an online tool that enables organisations to measure compliance against data security and information governance requirements, was introduced in June 2018.

Following a series of audits and reviews of the Data Security Protection Toolkit and associated information/cyber security requirements a gap analysis was undertaken and a number of risks have been identified, some of which appear on the Trust's Board Assurance Framework.

The Trust receives assurance from the National Reporting and Learning System (NRLS) on reporting performance. This data forms part of the CQC Insight Report which incorporates data indicators that align to key lines of enquiry, brings together information from users of the Trust's services, knowledge from inspections of the Trust and data from our partners. Furthermore, the report indicates where the greatest risk to quality of care lies, points to services where the quality may be improving and monitors change over time for each measure.

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

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

Supporting the learning are monthly meetings such and the Complaint Quality Assurance Group and Clinical Claims Group.

Furthermore, each quarter a Learning from Experience Report is compiled and submitted to the Quality Assurance Committee and the Trust Board and includes aggregated analysis of Incidents, Complaints, Claims, Health & Safety incidents and Inquests. The report contains trend data and through qualitative and quantitative data analysis, provides assurance of lessons learned from past harms together with the changes to clinical practice that have subsequently been put in place.

CQC Registration and Assessment

The Trust is required to register with the Care Quality Commission. The Foundation Trust is fully compliant with the registration requirements of the

Care Quality Commission.

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

At the time of writing, the CQC have commenced a new inspection of the core services of the Trust, with a planned Well-Led inspection and NHSI Use of Resources review in April 2019.

The Trust remains fully compliant with the registration requirements of the Care Quality Commission.

The Foundation Trust Code of Governance

The Trust has completed its NHS Foundation Trust Code of Governance (the Code) for 2018-19 under the principle of 'comply or explain'.

The Foundation Trust governance structure ensures that the Board has an overarching responsibility through its leadership and oversight, to ensure and be assured that the organisation operates with openness, transparency and candour particularly in relation to its patients, the wider community and its staff. The Board holds itself to account including with a wide range of stakeholders.

The Governors play a significant role in holding the Board, and in particular the Non-Executive Directors, to account in a challenging but constructive way within a unitary board. The Council of Governors meets quarterly as well as a quarterly Governor Engagement Group and regular Governor Working Party meetings. The Board has developed a culture across the organisation which supports open dialogue and includes Non-Executive Directors and Executive Directors regularly visiting Wards and Departments to personally listen to feedback from staff, patients, their carers and relatives.

The Board of Directors have throughout the year regularly reviewed the relationship and responsibilities of the Board committees and sub-committees to ensure appropriate delegation of authority and that the appropriate assurance and oversight is maintained on behalf of the Trust Board. As a result of this ongoing review, the Strategic People Committee was re-introduced. All the committees; which comprise of the Quality Assurance Committee, the Finance and Sustainability Committee and the Strategic People Committee, have Non-Executive Director (NED) membership and Chairs. The Complaints Quality Assurance Group is also chaired by the Chair of the Trust. The Audit Committee is a significant statutory committee of the Board that is chaired by the Senior Independent Director.

The Board receives Chair's Key Issue Reports from each of the committees which provide timely and accurate information. This facilitates an overarching and durable framework that allows the Board to make sense of the effective use of the information and data to gain further assurance of good practice in governance provide confidence that the organisation provides patient centred care or provide alerts to where further investigation and monitoring may be required. To further support the Board, each of the committees receive regular updates and High Level Briefings from the operational groups which are chaired by the Executive Directors. There is an opportunity at each meeting for the relevant operational group minutes to be questioned and where needed, further details requested and clarified.

The Board and its committees demonstrate leadership and the rigour of oversight of the Trust's performance by having formulated an effective strategy for the organisation, ensuring accountability by robustly challenging the control systems in place and where appropriate seeking further intelligence on the current trend analysis with the Trust's performance indicators to further understand the wider community's health needs.

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.

People & Organisational Development

The Trust has a 3 year 'People Strategy' in place, which was launched in 2018. The People Strategy is built around our Strategic People aim to be the best place to work with a diverse, engaged workforce that is fit for the future. The strategy incorporates our Trust values, which help us to create the right organisational culture to achieve our Trust mission. The Trust also has an annual Workforce Plan in place. Operational delivery of both the Strategy and Workforce Plan is overseen by the Operational People Committee, chaired by the Director of HR and OD. Strategic People Committee, which is a Committee of the Board, Chaired by a Non-Executive Director, has strategic oversight of the Strategy and Plan, and provides assurance to Board. Both the Strategy and the Workforce Plan set out the Trust's approach to developing our substantive workforce, including the introduction of new and emerging roles. The Trust takes a structured approach to workforce change and this is driven through our Workforce Redesign Group. Staffing processes have been benchmarked against the NQB recommendations for each of the in-patient areas and all the recommended actions are in place.

The Trust's 2018 Staff Survey scores demonstrate an improvement in our safety culture to above national average. All Trust staff are supported by the Freedom to Speak Up Guardian, Champions and Policy. The introduction of Daily Safety Huddles has ensured that staff are able to raise any safety concerns and all issues are communicated clearly and consistently across the Trust. Executive presence within the Trust induction process for all new starters and regular Executive 'walk-arounds' are all important elements of keeping our teams informed, at the same time providing opportunity for feedback. These mechanisms support the mainstreaming of regular two-way communication with our workforce, embedding our culture of openness and transparency.

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

The foundation trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS guidance.

NHS Pension Scheme

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

Equality, Diversity and Human Rights

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

Carbon Reduction

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its 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 been assessed as being in 'Segment 2' by the regulator NHS Improvement, meaning the Trust is offered targeted support. This position improved in December 2017 from segment 3 where the Trust had been receiving mandated support.

The Trust has performance management processes in place that review the economy, efficiency and effectiveness of the use of resources. The Director of Finance & Commercial Development chairs the monthly Finance Resource Group which receives updates on financial performance from all CBUs and Corporate Areas. The Executive Team reviews the operational performance of the Trust and monitors this through the Trust Operational Board, and leads the Trust's identification and implementation of Cost Improvement Plans (CIPs). The Trust has a Use of Resources group, which is led by the Director of Finance & Commercial Development. Use of Resources is a work stream of the Trust's programme of Getting to Good, Moving to Outstanding. Progress is reported quarterly to the Trust Board via a combined Lord Carter/Use of Resources report. 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 produced a document which provides supporting information around performance and progress for each Use of Resources Key Lines of Enquiry.

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

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

Financial Governance

The Trust recorded a £16.0m deficit for the year, which included £6.8m Sustainability and Transformation Funding and net impairment costs of £1.1m. This deficit was £1.0m below plan the planned deficit of £17.0m. The control total set by NHSI was £16.9m and after the exclusion of impairments and other technical adjustments the Trust recorded an actual control total of £15.0m, £1.8m below the planned control total.

The Trust secured £3.5m for the finance element of the core Provider Sustainability Fund (PSF) monies but failure to achieve the A&E 4 hour target meant that the £1.5m for the A&E element of core PSF monies was not realised. The Trust secured an additional £3.3m for incentive PSF monies.

There was an under recover against the clinical income target of £4.5m (excluding £3.0m funding for the unfunded costs of the Agenda for Change pay award), a £1.4m shortfall against the £7.0m CIP target and

agency costs of £11.4m but these were offset by an over recovery of other operating income and an underspend on non-pay costs

The planned deficit meant that the Trust required a £16.9m working capital loan and the full value of the loan was drawn down in the year.

The annual capital programme (including external funding) was £10.5m and the actual spend for the year was £7.2m, an underspend of £3.3m

The cash balance was £1.3m which was £0.1m above the balance required under the terms and conditions of the working capital loan agreement.

I am satisfied that there were no failures in financial governance. The Financial Resources Group and the Finance and Sustainability Committee review and scrutinise the financial position and performance of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report. Furthermore, the Board reviewed position and challenged forecast outturns and mitigations on a monthly basis.

The Trust has quarterly review meetings with NHSI and the financial position, forecast and associated mitigations were rigorously tested as part of these review meetings.

Information governance

Organisations that have access to NHS patient information must provide assurances that best practice data security and protection mechanisms are in place. The Trust is contractually obliged to undertake assessments against the NHS Digital Data Security and Protection Toolkit on an annual basis.

The Trust's 2018/19 Data Security and Protection Toolkit assessment was reviewed by Mersey Internal Audit Agency in March 2019 as part of the Trust's annual audit programme. The Governance assurance statement provided in the published review stated that "the Trust has demonstrated that it has implemented an adequate Information Governance framework which is active". The overall assurance level awarded for the Trust's 2018/19 Data Security and Protection Toolkit submission is moderate assurance.

In the 2018/19 financial year the Trust has recorded no data loss incidents of the severity which would require the intervention of the Information Commissioner's Office (ICO).

Under the Network and Information Systems (NIS) Regulations 2018 the Trust is required to have adequate data and cyber security measures in place to protect against the increasing cyber threat. As an operator of essential services we are required to report network and information systems incidents which have significantly affected the continuity of services. The Trust has recorded no such incidents in the 2018/19 financial year.

As required by the Data Protection Act 2018 the Trust carries out Data Protection Impact Assessments (DPIAs) on projects that involve new types of data processing. Ten Data Protection Impact Assessments on new IT system implementations in 2018/19 have been completed. A summary of these assessments will be made publically available on the Trust's website.

The Trust uses the Data Security and Protection Toolkit in conjunction with the Datix Risk Management system to inform the work of its Information Governance and Corporate Records Sub-Committee. The Information Governance and Corporate Records Sub-Committee is accountable to the Quality Assurance Committee which is a sub-committee of the Trust board.

The Trust's Senior Information Risk Owner (SIRO) chairs the Information Governance and Corporate Records Sub-Committee which is also attended by the Trust's Caldecott Guardian. The SIRO (Chief Information Officer) acts as the Board level lead for information risk within the Trust. Any areas of weakness in relation to the management of information risk which are identified, or are highlighted by internal audit review, are targeted with action plans to ensure that we continue to strive to be information governance assured.

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 2018-19 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 2018 to March 2019

    - The Integrated Performance Dashboard (Quality, Operational Performance, Workforce and Finance) 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 2018 to March 2019

    - Feedback from the Trust's Commissioners, Warrington Clinical Commissioning Group and Halton Clinical Commissioning Group

    - Feedback from Governors

    - Feedback from local Health watch organisations, Health watch Halton and Health watch 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 2018 national staff survey

    - The Head of Internal Audit's annual opinion over the Trust's control environment for 2018-19

- 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 risk/ clinical governance/ quality committee, if appropriate] and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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 discussed 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 regularly to the Committee by Internal Audit 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 2018-19 of **Moderate Assurance** noting that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk. The HOIA confirmed continued compliance with the definition of internal audit (as set out in the Trust's Internal Audit Charter), code of ethics and professional standards. The HOIA also confirmed organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

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

Conclusion

In preparing this statement I have considered the corporate, quality and clinical governance infrastructure, functionality and effectiveness in place at the Trust. This was strengthened in year through the introduction of the Strategic People Committee which reports directly to the Trust Board.

The Board of Directors remain committed to continuous improvements and enhancement of the systems of internal control. In line with the guidance on the definition of the significant control issues I have no significant internal controls to declare within this year's statement. My review confirms that Warrington and Halton Hospitals NHS Foundation Trust has a generally good sound system of governance and stewardship that supports the achievement of its policies, aims and objectives.

Signed.....

Chief Executive Date: 23 May 2019

Annex 6 Off-payroll arrangements disclosure requirements

Off Payroll Arrangements

For all off-payroll engagements as of 31 March 2019 for more than £245 per day and that last for longer than six months	
Number of existing engagements as of 31 March 2019	4
Of which...	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	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 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months :	
Number of new engagements, or those that reached six months in duration between 1 April 2018 and 31 March 2019	7
Of which...	
Number assessed as within the scope of IR35	1
Number assessed as NOT within the scope of IR35	5
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	1
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019	
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:

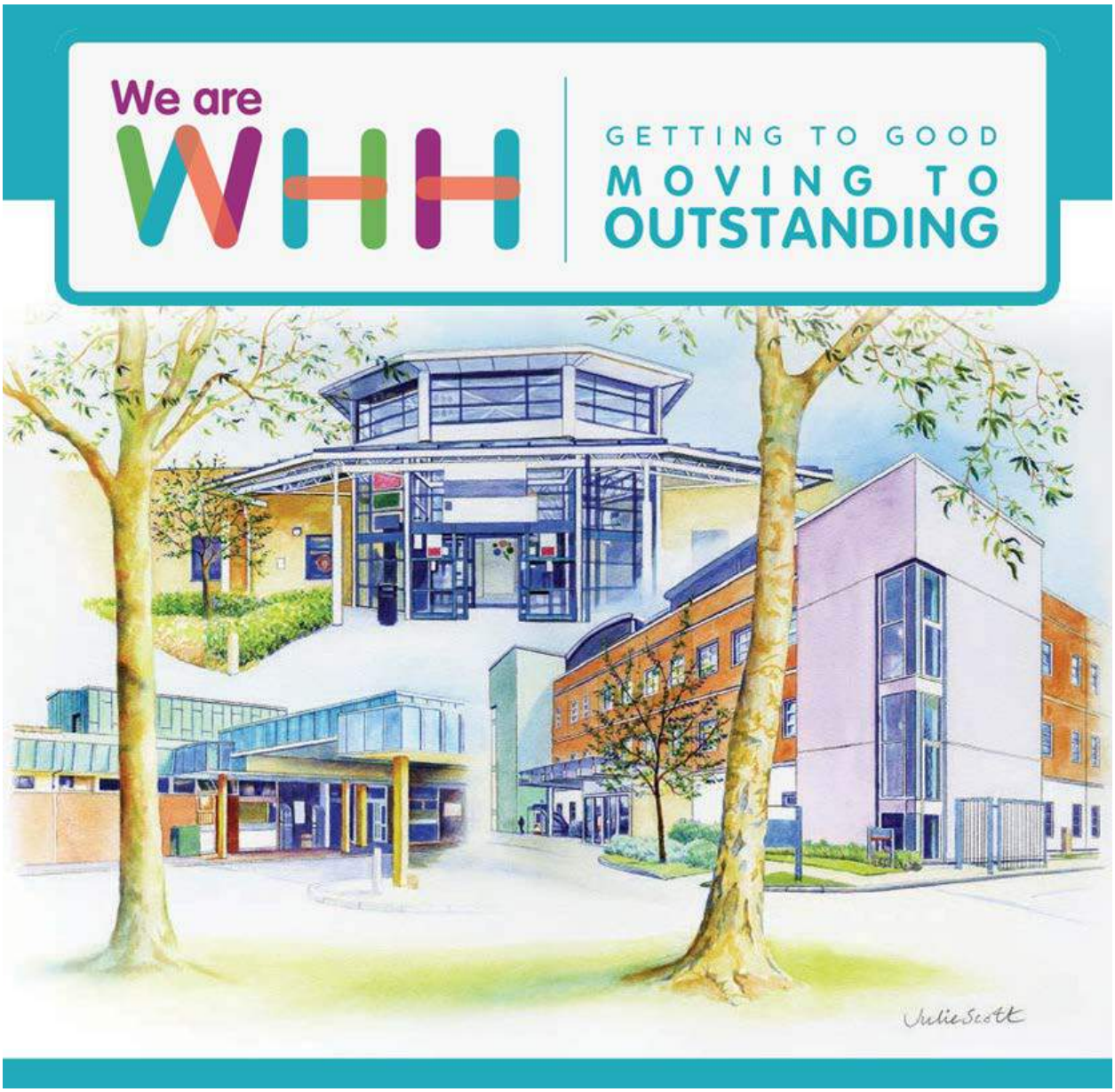
The Trust has a temporary staffing policy which clearly details the process for obtaining approval to appoint temporary staff. Managers are required to ensure, where possible, staff are directly employed. Where this is not the case, managers are required to comply with the IR35 legislation introduced in April 2017. In exceptional circumstances, where staff are engaged externally who fall outside of the IR35 legislation, the Trust has used the HMRC tool to make this assessment to ensure any risk is minimised.

We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Quality Account

2018/19



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We are WHH

Warrington and Halton Hospitals NHS
NHS Foundation Trust

Quality Account

Quality is our number one priority.

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

1. Statement of Quality from the Chief Executive, Mel Pickup

Warrington and Halton Hospitals NHS Foundation Trust is dedicated to the provision of high quality care and clinical excellence. Recognising that our patients and staff deserve nothing less than OUTSTANDING, we have embarked on an organisation- wide journey called 'Getting to Good, Moving to Outstanding'.

We have updated our strategy to reflect our 'Outstanding' ambitions and our mission is: **We will be OUTSTANDING for our patients, our communities and each other.**

We are benchmarking ourselves against the best and putting improvements in place, where appropriate, for example improvements to our ageing estate to ensure it is an optimal environment to treat patients.

We have also launched our Quality Academy, so that we are embedding the highest quality and safety of care at every level and throughout every staff group – and everyone is empowered and knows how to put quality improvement initiatives in place, in order to make a difference for our patients – every time.

I believe this is the single most important thing we can do for our patients and I have every confidence in #TeamWHH to embrace the culture of continuous improvement so that together we can take the Trust to where it deserves to be – Moving to Outstanding.

The patient is at the heart of everything we do, and we are very committed to ensuring that our staff are supported to provide the best care they can.

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 2018/19, 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 standards from the national operating framework that all Trusts must adhere to.

In relation to the Emergency Department, nationally the standard is 95% against the 4 hour standard. The majority of acute Trusts have struggled to achieve this standard in year. While the Trust performed well compared to peers it did not achieve the 95% national standard and closed with a performance of 85.11% (Inc. Widnes Walk-in-Centre). The Trust continues to monitor and seek assurance relating to the actions that have supported performance; these have included investment and development of a Discharge Lounge, GP Assessment Unit, ED Ambulatory Unit and successful funding via the Health & Care Partnership to develop a Frailty Hub in association with a Frailty

Assessment Unit (FAU) on site. All these development have supported the increase of assessment capacity and reduction of direct admissions from our Emergency Department.

The Referral to Treatment (RTT) operational standard for England focused on the number of incomplete pathways less than 18 weeks. The Trust achieved the 18 week referral to treatment standard consistently throughout 2018-19, against a standard of 92%; this is difficult and challenging but supports care being delivered in a timely manner. Once again, the Trust regularly monitors and sought assurance against this performance standard. In addition, the Trust maintained the waiting list size throughout 18/19 without growth and continued to not have any patients wait over 52 weeks for elective treatment.

With regards to health care acquired infections (HCAI) during 2018/19, the Trust threshold was 0 cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and despite the continued focus on managing HCAI; the Trust reported 2 cases of MRSA bacteraemia. In relation to Clostridium difficile the Trust reported 27 hospital onset cases against the annual threshold of 26 cases. The CCG review panel consider the cases and have deemed that 18 of the 22 cases between Q1 and Q3 were not due to lapses in care. Cases from Q4 will be reviewed in May.

The Trust also carefully monitors Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia and E. coli bacteraemia. The Trust reported 15 hospital onset cases of MSSA bacteraemia during the financial year. This is a decrease of 2 cases compared to the previous financial year. These cases are under review to identify any areas for care improvement. The Trust reported 46 hospital onset cases of E. coli bacteraemia. Partnership working is in place across the health economy and the Trust is working with community partners to progress the action plans. Work streams related to the reduction of healthcare acquired infections continue with oversight at Patient Safety Sub Committee and Quality Assurance Committee.

We reported 1 Grade 4 pressure ulcer in 2018/19 and 5 grade 3 pressure ulcers. We have an increased focus on staff training in high incidence areas including face to face and e-learning teaching packages. The Trust Quality Academy collaborative will also provide support on initiatives for the prevention of pressure ulcers. Monthly panel meetings are in place to ratify RCAs identifying whether the pressure ulcer was deemed to be avoidable or unavoidable and hospital or community acquired. Learning from these panels is disseminated via the lesson learned framework and master classes A.

Our quality priorities for 2019/20 in relation to Patient Safety focus on a reduction on Hospital Acquired Pressure Ulcers and Gram Negative Bloodstream Infections (GNBSI), full details of which can be found in section 2.5 of this report.

The Patient Safety team continued to train staff to screen and treat patients in relation to sepsis and through this we have seen screening rates increase to 100% in ED and 100% for inpatients by the end of Q4 from 100% and 98% in 2017/18 respectively, which saves valuable time in being able to diagnose and treat patients, which is key to reduction of mortality from sepsis.

The Care Quality Commission (CQC), the regulator 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 services are safe; effective; caring; responsive to people's needs and well-led. The Trust was given an overall rating of 'requires improvement' by the CQC, following a series of announced and unannounced inspections. The CQC noted that there had been progress since the previous inspection with improvements noted in urgent and emergency care, maternity, outpatients and diagnostics and critical care. The Trust committed to implementing a robust action plan, following the inspection in 2017. At the time of writing this report we are looking forward to welcoming back the CQC in April 2019, to inspect the Trust, so that we can showcase the improvements we have made for our patients.

In 2018-2019 the Trust was involved in conducting 84 clinical research studies in surgery, oncology, reproductive health, anaesthetics, emergency medicine, rheumatology, gastroenterology and cardiology 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.

Most of the research carried out by the Trust is funded by the NIHR. For 2018-2019 the Trust received £371,000 which funds staff including eight 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.

During the year work has been undertaken to develop the role of Clinical Leads with regard to research, in order to promote and engage Trust clinical staff to become actively involved in research within the Quality Academy, to maximise commercial research activity and to develop and foster partnerships. The major aim will be to widen the portfolio of research projects the Trust is involved both commercially and non-commercially. The Trust has also continued to work within the Health Research Authority (HRA) procedures which moved the emphasis towards acceptance of HRA assessment within the framework of research governance, strict legislation and recognised good clinical practice and local assessment of capability and capacity to run a study.

Looking ahead to 2018/19, we will continue to drive the Trust's quality strategy 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; Hospital Acquired Pressure Ulcers, Gram Negative Bloodstream Infections (GNBI), Serious Harm Falls, Time to first consultant review, National Quality Improvement Collaborative, Work with the Innovation Agency, Patient and Public Involvement Strategy, Improving timeliness of Complaints and the Midwifery Led Unit.

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 2019/20 to continue these improvements and show our commitment in providing the best 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 myself 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.

SIGNATURE

Mel Pickup

Chief Executive

May 2019

1.1 Introduction from the Executive Medical Director, Simon Constable and Chief Nurse, Kimberley Salmon-Jamieson

In 2018/19 we launched the new Quality Strategy for the Trust which is an integral part of our Quality, People and Sustainability Framework (QPS). The Quality Strategy sets out our firm commitment to improving the quality of care for our patients and how we will make this a reality, in terms of equipping our staff with the right, skills, training, policies and processes and environment to deliver quality patient care, every day.

It is important to recognise that we have made many improvements to the safety and quality of patient care and we are committed to ensuring we continuously improve, to ensure we are providing the best care that we can to our patients and their families.

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

In order to enable delivery of this Quality Strategy, the Trust has also launched a Quality Academy.

Quality Academy
Warrington and Halton Hospitals
NHS Foundation Trust

Quality Improvement
Warrington and Halton Hospitals
NHS Foundation Trust

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

- Developing a reputation for enabling excellence in clinical research, linking into national and international opportunities.
- We will be at the forefront of benchmarking ourselves against evidence-based best practice standards and ensuring staff use quality improvement as the basis for making and measuring change
- Creating a culture and environment where all Trust staff can develop and test new and creative methods
- Be the provider of choice for knowledge management and library services within the Cheshire & Mersey

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

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

We look forward to continuing working with staff to support the implementation of this strategy. Together we will report measurable success in our Annual Quality Account and commit to celebrating our achievements year on year.

SIGNATURE

Professor Simon Constable
Deputy Chief Executive
And Executive Medical Director
May 2019

Kimberley Salmon-Jamieson
Chief Nurse
May 2019

2. Improvement Priorities & Statement of Assurance from Board

Warrington and Halton Hospitals NHS Foundation Trust provides services at Warrington Hospital, Halton General Hospital and the Cheshire and Merseyside Treatment Centre, located in the North West of England. The Trust has a budget of nearly £210 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 Quality, People and Sustainability Framework (QPS). We work to a number of nationally and locally set standard 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:

- **Quality - Patient Experience** - By focussing on patient experience we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.
- **People - Employee Wellbeing & Engagement** - Create the conditions to promote wellbeing and enable an engaged workforce to improve patient and staff experience.
- **Sustainability - Work with other acute care providers** to ensure that those services which need to be provided in an acute environment are the best they can be and are clinically and financially sustainable

2.1 Organisational Structure

Our organisational structure allows us to be more responsive to challenges through improved clinical engagement, strong and resilient leadership at all levels, with an emphasis on responsibility and accountability, to achieve the best for our patients and continuous improvement, transformation and innovation. The structure was developed collaboratively and facilitates clinical specialities to within a Clinical Business Unit (CBU). There are eight Clinical Business Units within the Trust, who report into the Executive Directors. The Trust's organisational structure embraces the concept of true leadership synergy between the 'triumvirates' 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 being as cost efficient as we can be. Each CBU is a vehicle for greater devolvement of accountability and responsibility and allows decision making to take place closer to the patient/professional interface.

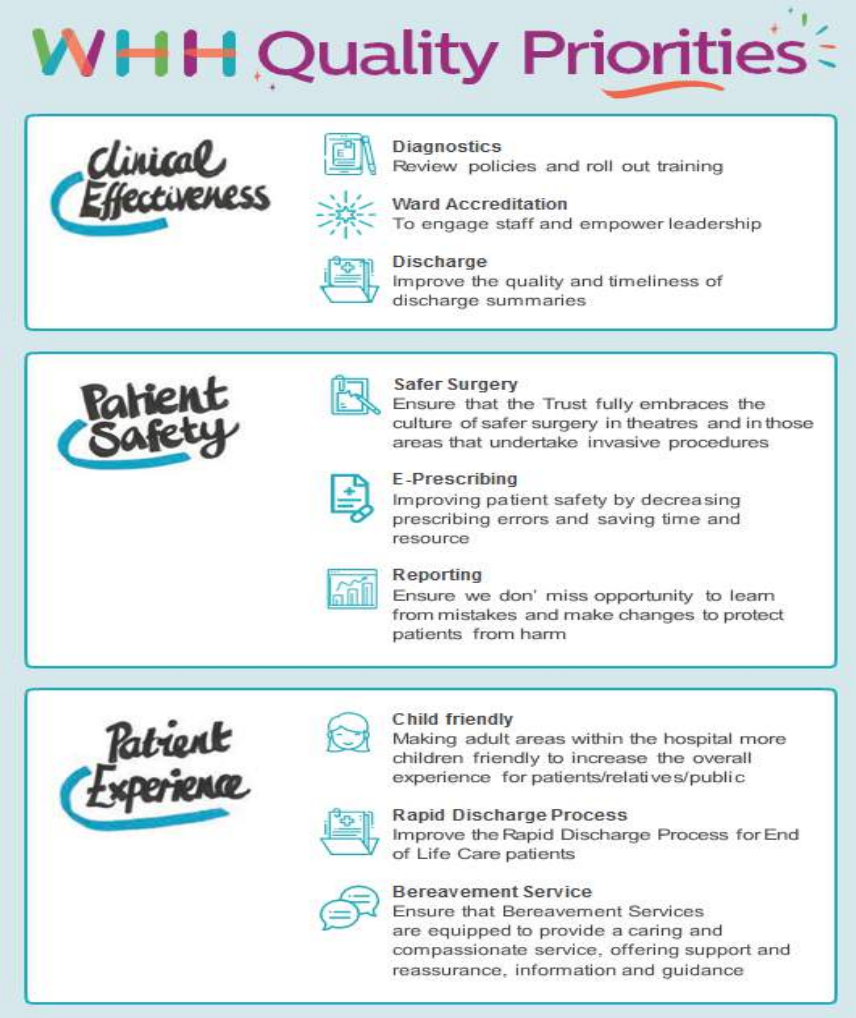
2.2 Priorities for improvement - Improvement Priorities for 2018-19 update

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 2017/18 Quality Report.

The progress of each priority is reported on a quarterly basis to the Trust's Quality Assurance Committee. 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 of Directors.

The Trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care. The 3 quality priorities; Patient Safety, Clinical Effectiveness and Patient Experience are all supported by a separate group of indicators which are detailed below;

The following section includes a report on progress with our improvement priorities for 2018/19 which were:



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

- **Safer Surgery - Ensure that the Trust fully embraces the culture of safer surgery in theatres and in those areas that undertake invasive procedures**

Safer Surgery - Background:

Safety Culture and Quality Improvements in Safer Surgery will include theatres and how we have implemented the National Safer Surgery for Invasive Procedures (NatSSIPs) agenda.
This was identified as a priority as a result of high profile incidents and near misses.

Safer Surgery - How progress will be monitored, measured and reported:

- Training being rolled out in LocSSIPs across the Trust.
- Full assurance that LocSSIPs are being implemented consistently and that safety culture in theatre and in non-theatre settings is in place.
- No Never Events.
- 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.
- Quarter 1 – The Trust Policy is approved regarding NatSSIPs within the Trust, all appropriate areas have LoCSSIPs, and a training programme for NatSSIPs/LocSSIPs is in place, with a risk assessment being conducted to influence training roll out plan.
- Quarter 2 - 25% of high risk areas have been trained.
- Quarter 3 – 50% of areas have been trained and audits have commenced in those high risk areas, to ensure processes and safety culture is in place.
- Quarter 4 – 100% of areas have been trained and an audit plan is in place to audit all areas.

Safer Surgery - Performance:

The progress made in relation to the above actions during quarters 1 - 3 is as follows;

- A policy has been developed within the Trust setting out revised expectations and standards for NatSSIPs and LocSSIPs.
- A training needs analysis for NatSSIPs/LocSSIPs within the Trust was completed.
- A LocSSIP gap analysis was completed in Q1 and 2 to assess where we needed to ensure LocSSIPs were developed. As LocSSIP and Human Factor training for 'Trainers' progressed, current LocSSIPs were reviewed and new LocSSIPs developed.
- A LocSSIP Train the Trainer programme was created and training commenced. This programme identified clinical leads and practice educators for specific areas to have LocSSIP and Human Factor training and the relevance to the prevention of 'Never Events'. The 'Trainers' lead the development and implementation of LocSSIPs to their areas.
- High risk areas within the Trust were identified and targeted to ensure LocSSIPs were in place. Endoscopy, Interventional Radiology, A&E and Radiology had 'Train the Trainer' training in Q3.
- Awareness training information was disseminated via the Trust wide Safety Huddle and LocSSIPs 'Train the Trainer Programme' were presented at the Medical Cabinet.
- An observational audit tool and audit programme for LocSSIPs was developed. This was included in the NATSSIPs/LocSSIPs policy and aligned to the Quality Accounts.

During Quarter 4 the following progress was made;

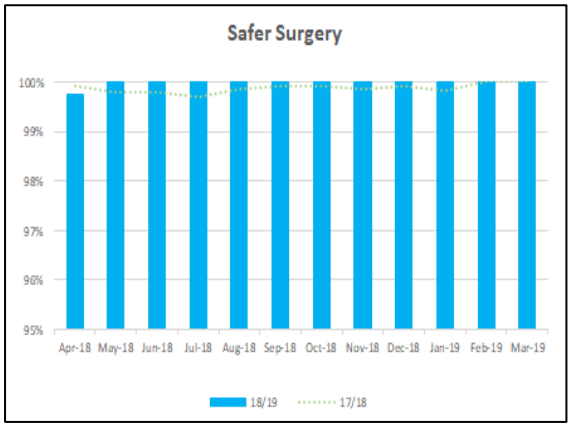
- All speciality areas have been trained and LocSSIPs produced.
- Additional training for ward areas has been initiated.
- High risk areas (Interventional Radiology, Endoscopy, Maternity, Critical Care and Catheter Laboratory) have completed LocSSIPs.
- Interventional Radiology, Endoscopy and Maternity have had observational audits with good outcomes.
- Critical Care and Catheter Lab have completed and implemented LocSSIPs. Observational audits are being planned.
- The NatSSIPs policy identifies the audit plan requirements once observational audits of areas have been completed.

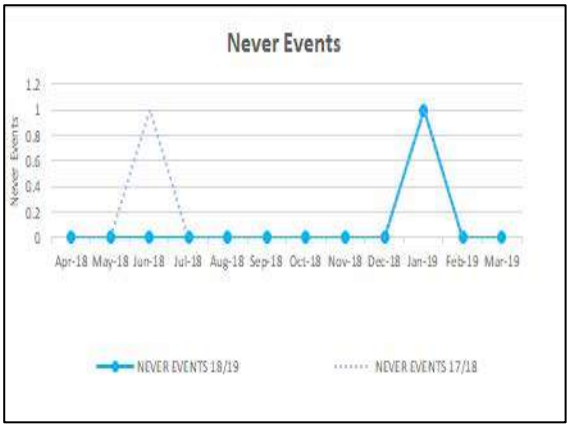
There has been active collaboration in the development and implementation of LocSSIPs in many areas. Some areas are receiving continued input until implementation and observational audits have been completed. The Task and Finish group will continue to oversee the implementation until transfer to the speciality and CBU governance and audit process.

LocSSIPs processes were introduced to specific procedural areas in 2017; however a gap analysis confirmed that these were not consistently implemented in all areas. A LocSSIP Task and Finish Group was set up to develop and implement a robust process and align these to the Quality Account priorities for 2018 – 2019. The group was chaired by the Director of Governance and Quality and included the Associate Medical Directors and Chief Nurses for Patient Safety and Clinical Effectiveness, Head of Education, Theatre manager and co-opted individuals from specialities.

Experience of implementing the NATSSIP principles in the past confirmed that a cultural understanding of 'Never Events', Human Factors and the role of LocSSIP checklists was essential in ensuring that procedural teams led the development of the process. A 'Train the Trainer' programme was adopted and implemented. Ensuring all areas and specialities were represented in the programme has been the biggest challenge. Q4 all specialities have been represented and observational audits have confirmed full implementation in two 'high risk' areas.

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





- **Medicines Optimisation - improving patient safety by decreasing prescribing errors and saving time and resource**

Medicines Optimisation – Background:

This was identified as a priority as part of the Trust Pharmacy Transformation and Informatics Programmes. The Board agreed investment to implement an e-prescribing system to enable the Trust to transform its medicines processes.

Medicines Optimisation – How progress will be monitored, measured and reported:

- A decrease in the number of medication errors and incidents of the type seen with prescribing / administering medication on paper charts.
- Implementation of medicines process changes that improve the patient experience and support patient flow from an operational management perspective.
- Access to information that supports quality and safety activities.
- Dashboards will also track medication incidents.
- A quarterly Quality Report will track milestones for the Quality Account priorities.
- Quarter 1 - Development of a Programme approach regarding e- prescribing.
- Quarter 2 - Identify areas to pilot and development of a roll out plan.
- Quarter 3 – Implementation and monitoring of plan.
- Quarter 4 – Report on improvement.

Medicines Optimisation – Performance:

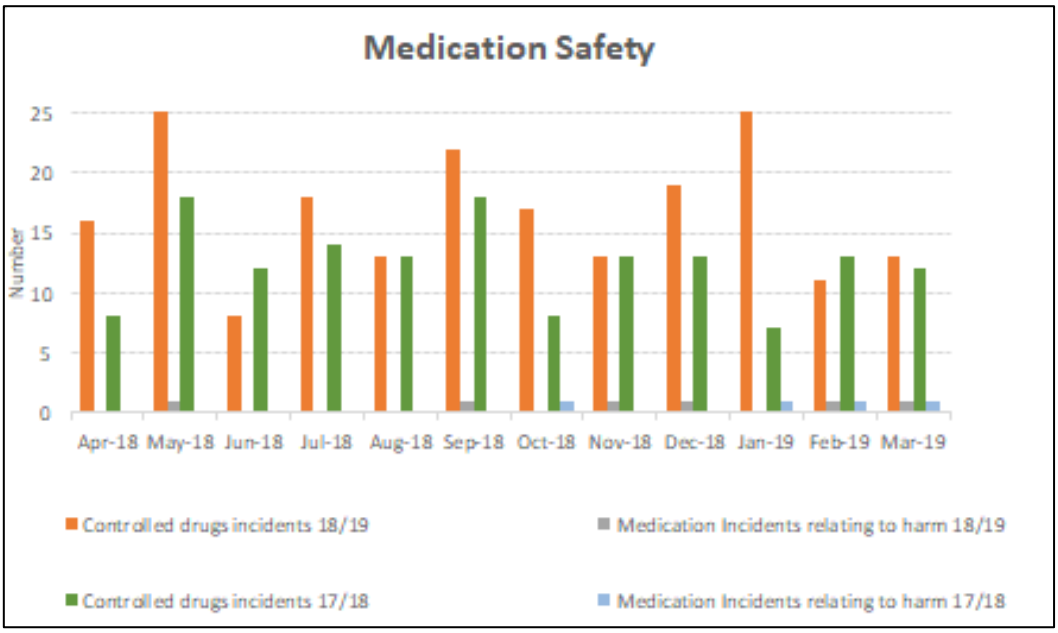
In Quarter 1 a programme approach regarding e- prescribing was developed. The programme took into account the fact that Warrington cannot go live with e-prescribing until quarter 1 of 2019/20 as we were awaiting an upgrade of Lorenzo to be installed that provided critical functionality. With the necessary delay in commencing EPMA implementation at Warrington it was agreed to focus work at the Halton site for 2018/19 as this site did not require the same critical functionality. The Halton EPMA programme included initial staff engagement, equipment approval and Estates work and staff training. Immediately prior to launch, existing patients' prescriptions were pre-loaded onto the system so that the ward doctors did not have to take on this task. Intensive staff support was provided through go-live and 2 to 3 weeks after.

EPMA is currently live on B1, B4 and CMTC Wards and in Halton and CMTC Theatres. Clinical staff within these areas have shown a pleasing level of acceptance of the training, support and are using the EPMA system successfully.

The learning from these pilot implementations has been used to develop the roll out plan for Warrington. A rapid roll out has been proposed for Warrington. Subject to approval, this plan could achieve implementation of EPMA in surgical, gynaecological, Main Theatres and medical wards before August 2019 with remaining areas (Maternity, Maternity Theatres and Paediatric Wards) following from September.

Medication order sets have been developed with anaesthetics and are in use for elective surgical and orthopaedic patients at Halton. These provide a more standardised approach to prescribing for the post-operative period. Oxygen and fluids are also being prescribed electronically. To date there is evidence of improved documentation of medication administration with far fewer instances of omitted medicines where a reason for omission has not been given. Since implementing EPMA on CMTC Ward, medicines reconciliation improvements have been seen with % completed increasing by 14%.

The table below shows the total number of medication incidents per month since April 2018.



- **Increase Incident Reporting – Ensure that we continue to encourage staff to report incidents, to promote a learning culture, and to ensure we don't miss opportunities to learn from mistakes and make changes to protect patients from harm**

Increase Incident Reporting – Background:

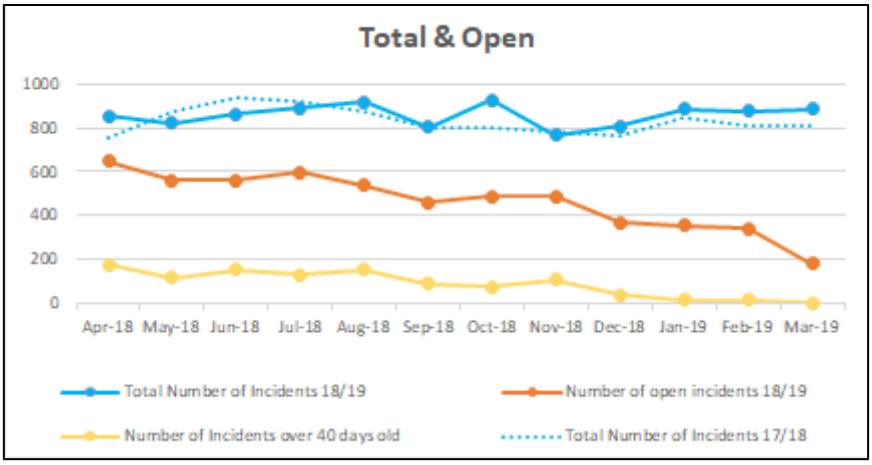
This was identified as a priority to ensure that we are aware where any patient could have been harmed or has suffered any level of harm following an incident. This was also identified in the Trust Staff Survey as an area that requires improvement.

Increase Incident Reporting – How progress will be monitored, measured and reported:

- Increase in the number of incidents being reported which will be monitored via the IPR Dashboard that is presented to Board.
- Weekly incident meetings will track the progress of the work and escalate to Quality Committee.
- Incidents data will be reported through divisional governance structures and the IPR for Board.
- A quarterly Quality Report will track milestones for the Quality Account priorities.
- Staff Survey action plan report will report to Workforce Sub Committee and Operational Board.
- Quarter 1 – Identify a baseline in accordance with 2017/18 incidents data. Work with clinical staff and managerial staff in the Clinical Business Units and CBUs and Corporate services to identify what are the issues with regard to incident reporting in the Trust and how we can improve it.
- Quarter 2-3 – Develop an improvement plan and implement.
- Quarter 4 – Report progress and again consult with staff as to what further improvements can be made.

Increase Incident Reporting – Performance:

The following graph shows the number of incidents reported in the Trust as evident the Trust reports an average of 2576 incidents per quarter and 10304 per year.



All incidents that are reported within the Trust are uploaded and reported externally to the National Reporting and Learning System (NRLS). The NRLS benchmarks Trust data with all similar size Trusts. The last NRLS report which was published in March 2018 the Trust to be a middle reporter of incidents and therefore shows the need for an improvement.

In Quarter 2 the Trust launched its Report to Improve Campaign during the Safety Summit. The aim of this campaign is to encourage staff to report incidents and to educate managers on how to appropriately give feedback to the staff when incidents are reported. To support the implementation of this campaign significant work has been undertaken to simplify the incident reporting system and also a significant amount of time invested in training clinical and managerial staff in the new revised Datix systems.

In Quarters 3 and 4 the campaign was rolled out further with additional training and communication to staff.

Incident Reporting results are monitored via the Board and Quality Committee Dashboards.

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

- **Diagnostics - Review the Trust Diagnostics Policy, to ensure consistent processes are in place across the Trust, supported by technology and ensure staff are trained in those processes and procedures.**

Diagnostics - Background:

This was identified following a cluster analysis of incidents and complaints, where it showed that whilst we had policies and processes in place for following up diagnostic tests, theses needed to be consistently applied, with the requirement for more robust technology, training, monitoring and reporting to be in place.

Diagnostics - How progress will be monitored, measured and reported:

- Having a Trust wide Policy for Diagnostics in place, a training programme, technology to support this and ultimately a having no incidents where a contributory factor or root cause of the incident occurring is related to diagnostic systems and processes.
- A report on diagnostic testing will be developed to ensure Consultants, clinical staff and service leadership are able to monitor these standards.
- Quarter 1 - Development of a Task & Finish Group to review Trust Policy and processes regarding Diagnostic Tests.
- Quarter 2 - Development of a staff communication, education and training programme for the revised policy standards.
- Quarter 3 – Ensure the new policy standards are embedded.
- Quarter 4 – Audit implementation of the revised policy.
- A quarterly Quality Report will track milestones for the Quality Account priorities.

Diagnostics - Performance:

During Quarter 1 a Diagnostic Policy Task and Finish group was established, chaired by Dr Alex Crowe, Trust Medical Director, reporting to Trust Patient Safety and Effectiveness Committee. The purpose of the Task and Finish group was to review current systems in place for following up and reporting of diagnostic tests and to assess whether the current policies and processes in place were robust. A review of the policy has been undertaken and new policy developed which sets out minimum standards for the requesting, follow up and reporting of diagnostic tests. As part of the review of this policy the Trust has invested in Sunquest ICE system to ensure the electronic reporting of results, this has been implemented across the Trust.

In Quarter 2 work has commenced on development of an education and training package for clinical staff, including being targeted at trainees and junior doctors. A foundation year 1 doctor is supporting the medical director on this quality improvement project. Process mapping and updating of the policy has also commenced.

In quarters 3 and 4 the following work was undertaken;

- Diagnostic Testing Policy developed and in place;
- Task and Finish group for Diagnostic Testing Policy has finished this work stream and summary report to be submitted to PSCESC;
- Development of e-learning programme for staff in progress, being developed in liaison with trainees;
- Audit of results reviewed by clinician over 24 hours on ICE completed; discussions within department of IM&T to progress with a Request and Results work stream within Electronic Patient Record Lorenzo.

- **Discharge – Improve the quality and timeliness of discharge summaries, to ensure seamless communication and care with primary care**

Discharge – Background:
The aim of this priority is to improve the quality and timeliness of discharge summaries.

Discharge – How progress will be monitored, measured and reported:

- An improvement of quality and timeliness of discharge summaries following an audit and baseline position being established.
- Timely and quality discharges in place for all of our patients.
- A quarterly Quality Report will track milestones for the Quality Account priorities.
- Quarter 1 – Development of a Task and Finish Group with clinical staff from the Trust and GP representation; review incident and complaints data regarding discharge and undertake an audit of quality of discharge summaries to set a baseline and inform an action plan for improvement.
- Quarter 2-3 –Implementation of action plan.
- Quarter 4 – Undertake a follow up audit and show improvement of timeliness and quality, based on targets sets following the development of the baseline position.

Discharge – Performance:
A Discharge Summary Task and Finish group has been established, jointly led by the Trust Associate Medical Director for Patient Safety and a GP governing body lead. Work that has been undertaken to date has involved a workshop being scheduled in May with attendance from a wide range of multi-disciplinary staff. This resulted in the development of an issues log which helped prioritise actions. Some of these actions have been as follows;

- A spot check audit being undertaken of discharge summaries being sent out from the hospitals;
- Development of training and education programme for our junior doctors regarding timeliness and quality of discharge summaries;
- IT solutions being explored regarding connecting ICE and Lorenzo to ensure timely electronic discharge summaries;
- Encouraging GP's to report any incidents relating to discharge via their incident reporting system so that the Trust can investigate and learn.

Work has continued on education and training about quality of discharge letters. A letter has been developed. However this currently cannot be sent electronically but when the pilot work for electronic clinic letters has been complete, it is likely that this communication will also be able to be sent electronically i.e. separate from the discharge letter , if the patient remains in hospital.

A pilot has started using a standard ward round template which populates the electronic discharge letter in a consistent fashion. This part of the project is being led by the Chief Registrar; it is also forms part of the ward round accreditation scheme.

Work continues into 2019/20 as there are multiple interface incidents regarding duplicate discharge letters/ other issues with quality of discharge letters. There is a deep dive currently underway looking at the themes from these incidents surrounding discharge letters and there is a plan to produce a learning document for the education of staff and our external colleagues.

- **Ward Accreditation – Develop a Ward Accreditation Scheme within the Trust, to engage staff and empower leadership to ensure we deliver the highest standards of healthcare for our patients**

Ward Accreditation – Background:

Ward accreditation has been selected as a priority to increase the quality of care on our wards.

Ward Accreditation – How progress will be monitored, measured and reported:

- All wards will be measured against a set of quality standards agreed by the Nursing and Midwifery Committee.
- Each ward team will be supported to develop and implement an improvement action plan to further enhance the quality of care and patient experience before their next ward inspection.
- A quarterly Quality Report will track milestones for the Quality Account priorities.
- Quarter 1 – Finalise the new ward accreditation process and commence with a pilot within the Trust.
- Quarter 2 – 3 - Commence the accreditation process and monitor compliance. Quarter 2 25% of all wards will be have gone through the accreditation process, Quarter 3- 50%
- Quarter 4 –100% of all wards will have gone through the accreditation process and report on overall results.

Ward Accreditation – Performance:

The ward assessments are led by the Chief Nurse, Deputy Chief Nurse and Associate Chief Nurses, supported by the senior nursing teams. All assessments are unannounced (except to the assessment team) and include a review of care records and documentation, real time observations of care given, discussions with patients, carers and staff members. In addition, review of the ward quality metrics, staff training data, complaints, incidents and safety thermometer data is included to ensure the assessment process is not just 'a moment in time'.

Implementation

The programme commenced in May 2018, with a formal launch workshop with the ward managers and senior nursing teams to ensure understanding and expectations of the programme. A commitment has been given that all wards will be accredited this year.

Ratings

The Ward Accreditation Programme is focused on celebrating achievements, and results completed for the 30 assessment standards which are combined to make an overall 'awarded status' based on the level of success achieved.

Award Status and Definition

Progress year to date

Since the introduction of the programme in May 2018 a total of 29 wards have been accredited. The ratings achieved for each of the wards are detailed below;

Silver Award	
Ward	***Speciality***
A5	Surgery
B19	Medicine
B12	Dementia Ward
B1	Step Down Care - Halton
ED	Emergency
B4	Elective Surgery – Halton
CCU	Acute Cardiology
UCC	Medical Assessment
A6	Surgery Colorectal
A4	Gastroenterology
ITU	Critical Care
C20	Gynaecology
C22	Step Down Care - Warrington
B14	Medical – Stroke
Birth Suite	Maternity
NNU	Children's

Bronze Award	
Ward	***Speciality***
AMU	Acute Medical Admissions
CMTC	Elective Orthopaedic - Halton
A9	Trauma and Orthopaedic
B10/11	Paediatrics
C21	Cardiology
B18	Medical Cohort
C23	Maternity – Antenatal and Post Natal
A8	Acute Medical
Amb Care	Medical Assessment
A7	Medical Respiratory
A2	Acute medical
B3	Medically Fit Escalation Ward – Halton
PIU	Planned Investigation Unit

Staff feedback

Senior Nurse - *"It has raised the standards with ownership of the environment and improvements in patient safety and patient care."*

Senior Nurse - *"Unity between the ward managers, learning and supporting each other through the process"*

Housekeeper - "*My ward is 100% better now, every day – thankyou"*

Housekeeper - *"It's positive, it's been really good"*

Challenges and next steps

The Ward Accreditation Programme has set an ambitious commitment to have all wards assessed by December 2018. The assessments have been led by the Chief Nurse and senior nursing team, which have placed a significant demand on the very senior team due to the number of assessments to be undertaken (on occasions 2 per week). As we move to extend the programme in 2019, to include non-ward based areas, consideration will need to be given to the sustainability and investment in the programme going forward. The Chief Nurse was very keen to move forward with the Ward Accreditation Programme and as such moved the programme forward without formal resource. The programme is currently being reviewed in order to extend the assessments to outpatients and theatres in 2019.

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

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

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

This was identified as a priority following our last CQC Inspection. Also this links in to the patient experience strategy and as such supports our goals to keep the patients at the centre of everything we do, by:

- Listening to our patients and carers
- Learning together from their feedback
- Leading change based on patient experiences

Making adult areas within the hospital more child friendly to increase the overall experience for patients/relatives/public - How progress will be monitored, measured and reported:

- ❖ Feedback from children and their families who use the service is positive on the changes we have made.
- ❖ CQC follow up inspection confirms that we have/are in the process of implementing this.
- ❖ Via the Trust Patient Experience Sub Committee.
- ❖ A quarterly Quality Report will track milestones for the Quality Account priorities.
- ❖ Quarter 1 – Undertake a gap analysis of all adult areas and what is required regarding ensuring they are child friendly.
- ❖ Quarter 2- Development of a Children's Group within the Trust to help develop a plan regarding taking forward actions to ensure adult areas where children are seen are child friendly.
- ❖ Quarter 3 – Implement actions identified and development of business cases where further resource may be required.
- ❖ Quarter 4 – ensure the plan is fully implemented and feedback is sought from children and their families regarding the improvements made.

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

Year to date the Head of Patient Experience as led on the following work to achieve this priority;

Quarter 1 – Undertaken a gap analysis of all adult areas to establish what is required regarding ensuring they are child friendly.

Quarter 2- Developed a Children's Group within the Trust to help develop a plan regarding taking forward actions to ensure adult areas where children are seen are child friendly.

There is a newly created children's ambassador in the Trust as part of the evolving Children's & Young Person's Strategy (C&YPS) that is supporting this patient experience priority, by providing feedback to ensure that WHH is listening, learning and leading the changes.

In Q2, the *Patients Voice* has been heard through feedback from parents, children and a walk round with the children's ambassador. There has been excellent engagement, with ideas that would enhance a child's experience in an adult area. The range of discussions has addressed the wishes of younger children, adolescents and children who have autism and visual impairment.

Ongoing work will be undertaken to review ALL children's areas, to ensure they are assessed as being "child- friendly". This priority will continue to be progressed and monitored at the monthly Patient Experience Sub Committee meetings and high level briefing papers to the Quality Assurance Committee (QAC).

In Q3, visits to both Warrington and Halton hospitals were undertaken to discuss specific resource requirements for adult areas where children were seen. A task & finish group was convened and in collaboration with the appropriate departments, clinic staff and the 2 play specialists in the Trust, a review was conducted of items suitable for children to either play with or decoration for those areas where they were seen.

Part of the review looked at installation requirements and costs. However, we have secured investment internally and from League of Friends to progress with the purchasing of children's toys, furniture and for decorating areas that were identified as needing further work. Areas that are undergoing decoration at present are;

- Fracture Clinic
- Ultrasound
- Outpatient areas (both Warrington & Halton)

Work within Ophthalmology has been completed and the positive improvement can be seen in the images below;

During quarter 4 the plan was fully implemented and areas where gaps were identified have been furnished to make child friendly.

In the Halton Outpatient department, the phlebotomy room was relocated and this room was transformed into a children's play area and there are plans for additional age appropriate books and toys to be procured.

Feedback from children and families have been extremely positive, expressing pleasure at the areas where there had previously been very little to occupy children on visits to the hospital.

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

Improve the Rapid Discharge Process for End of Life Care patients, so that if patients chose to die out of hospital, we can facilitate this in a dignified and timely manner - Background:
This was identified as a priority following our last CQC Inspection. Also this links in to our End of Life strategy as we are committed to support patients to die in a dignified manner, supported to make choices as to where they wish this to be, and ensuring that we can respond to those wishes.

Improve the Rapid Discharge Process for End of Life Care patients, so that if patients chose to die out of hospital, we can facilitate this in a dignified and timely manner - How progress will be monitored, measured and reported:

- This is a system wide piece of work, so success is working in partnership to ensure there is a system wide policy and that processes in place can respond to facilitate rapid discharge from hospital to allow people to die in their place of choice.
- Via the Trust Patient Experience Sub Committee and Trust End of Life Steering Group.
- A quarterly Quality Report will track milestones for the Quality Account priorities.
- Quarter 1 /Quarter 2 – Work with our partners (commissioners, Local Authority, Hospices etc.) to review our policies and procedures in place to ensure rapid discharge from hospital to support End of Life Choices for patients.
- Quarter 3 – Implementation and communication and training of the policy and processes agreed.
- Quarter 4 – review effectiveness of the system for rapid discharge for those End of Life patients who express a wish to not die in hospital, by auditing and engaging with families who this has affected.

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

The finding from the CQC Warrington and Halton Hospitals NHS Foundation (WHH) Trust Quality report found that as a Trust we needed to *"Improve the Rapid Discharge Process for End of Life Care patients, so that if patients chose to die out of hospital, we can facilitate this in a dignified and timely manner"*

This priority also this links in to the patient experience strategy and as such supports our goals to keep the patients at the centre of everything we do, by:

- Supporting patients to die in a dignified manner
- Ensuring patients are supported to make choices as to where they wish to be and to ensure that we can respond to those wishes

Year to date the Head of Patient Experience as led on the following work to achieve this priority;

Quarter 1 / Quarter 2 - Work was undertaken with key stakeholders to produce the Rapid Discharge Home To Die (RDHTD) policy which is being reviewed and discussed at Oct 2018 PSESC and ratified at Nov 18 Quality Assurance Committee (QAC).

Quarter 3 - The new policy 'Rapid discharge home to die for adult patients' has now been implemented to support the discharge process for patients in the last days/hrs of their lives. Either they or their loved ones have identified that their preferred place of death is their usual residence. The process of rapid discharge home starts with excellent communication, not only with the patient and their loved ones but with the wider MDT both within the trust and our community partners. It also requires each service to recognise this as important and urgent in order to make it happen quickly and seamlessly for each patient and family. The policy raises the awareness of all professionals involved to be aware of the necessity for delivering their own element within a specified time, measured in a very small number of hours. The impact of this implementation is a patient being cared for in their preferred place of care/death at the right time. The Specialist Palliative Care Team have been involved in this process on several occasions including over the Christmas period, we have received feedback from the community teams with positive comments from the family of their appreciation that there loved one was able to die in his own home.

Quarter 4 – There has been an ongoing process of implementation which has received positive feedback from community partners. The Specialist Palliative Care Team has facilitated patient discharge to usual residence on several occasions. Evidence of positive feedback has been received via the Communications team and Bereavement questionnaires continue to be provided and the information returned is fed back to the wards and relevant individual staff. Learning is collated and presented at the End of Life Steering Group Meeting

- **Ensure that the Trust has processes and services in place to support families and loved ones following bereavement, offering appropriate support and reassurance, information and guidance**

Ensure that the Trust has processes and services in place to support families and loved ones following bereavement, offering appropriate support and reassurance, information and guidance -

Background:

This has been identified following discussions with families through the complaints, incidents and inquest processes.

It is a natural action following on from the Trust's development of a Learning from Deaths Process, which was part of the 17/18 Quality Priorities. This priority aims to ensure that whilst we are investigating and learning from deaths, we ensure we engage and support families that are bereaved in a coordinated way**.**

Ensure that the Trust has processes and services in place to support families and loved ones following bereavement, offering appropriate support and reassurance, information and guidance - How progress will be monitored, measured and reported:

- Families and loved ones feel supported following bereavement. Any questions that they may have following the death of their loved one, can be addressed. IF there is an investigation or inquest process, families are supported and we ensure that the bereavement team in the Trust and the governance team work in a joined up way, to ensure the best support and communication we can provide.
- Via seeking feedback from those who have been bereaved to assess what improvements are required and how effective any changes have been.
- A quarterly Quality Report will track milestones for the Quality Account priorities.
- Quarter 1- Ensure the Bereavement Service within the Trust moves under the management of the Patient Experience Manager. Review processes within the Trust of how we support families through the bereavement process and any subsequent investigation.
- Quarter 2- Develop a task and finish group to review current Trust processes and what we could do better. Seek feedback from people who have been bereaved and what support from the Trust felt like for them. Development of an action plan.
- Quarter 3 – Implementation of the actions.
- Quarter 4 – Report on improvements and again seek feedback from people who have been bereaved to assess effectiveness of change.

Ensure that the Trust has processes and services in place to support families and loved ones following bereavement, offering appropriate support and reassurance, information and guidance - Performance:

In Q1, the bereavement service within the Trust moved under the management of the Head of Patient Experience.

Recommendations from the recent "Learning from deaths: Guidance for NHS Trusts working with bereaved families and carers" is supporting the work streams. An audit was undertaken by the bereavement team in July 2018, seeking feedback from bereaved relatives and carers about cubicle v's bay positioning of patients on EoL care, the results and themes shared.

Z beds have been procured and are being used in areas of the Trust to support relatives/carers who wish to stay overnight. During Q2, the bereavement office was being re-located to Cheshire House, which will support the staff to be equipped to provide a caring and compassionate service, offering *support* and reassurance, information and guidance.

In Q2, a Task & Finish group was developed and Trust processes have been reviewed, some gaps have been identified and additional opportunities also, and these will be developed as part of an action plan.

In Q3, a review of the Bereavement Booklet was undertaken in line with new national guidance which consolidated existing guidance and provided perspectives from family members who had experienced bereavement within the NHS. It detailed how trusts should support and engage families after a loved one's death in their organisation's care.

During Q2, the bereavement office re-located to Cheshire House and work continued in Q3 to ensure that the environment supported staff to be equipped to provide a caring and compassionate service, offering support and reassurance, information and guidance. The proximity of the new office, to the beautiful trees and shrubbery that have been spectacular in the autumn sunlight, serves to promote a serene ambience. Please see photos below of the furniture that was provided by League of Friends monies. There is also an *In Memoriam* tree that the bereavement office staff created, with small butterflies for relatives/carers to write on in memory of their loved one.

Comments that have been received from relatives "This is beautiful in here, it is so peaceful and calm" and "How gorgeous to walk into this room, it is relaxing".

During Quarter 4 an updated Bereavement booklet was produced and circulated to all the wards. The Trust now also has a Bereavement section on the external Trust website for families and carers to be able to access Bereavement information at all times.

2.3 Improvement Priorities and Quality Indicators for 2019/20 - How we identify our priorities – stakeholder engagement

The Trust has a duty to fully engage with stakeholders and members to ensure that we are listening to their views on quality and quality priorities moving forward. The priorities have been identified through receiving feedback and regular engagement with governors, staff, patients, the public, and commissioners of NHS services, overseeing scrutiny groups and other stakeholders. Progress on the planned improvements will be reported through the Trust's Quality Assurance Committee and ultimately through to Trust Board.

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

Family Test and from those results we capture the views of the staff and wider public in relation to the range of priorities.

2.4 Improvement Priorities for 2019/20

The Trust Board, in partnership with staff and Governors, has reviewed data relating to quality of care and agreed that our improvement priorities for 2019/20 will continue to be:

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

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

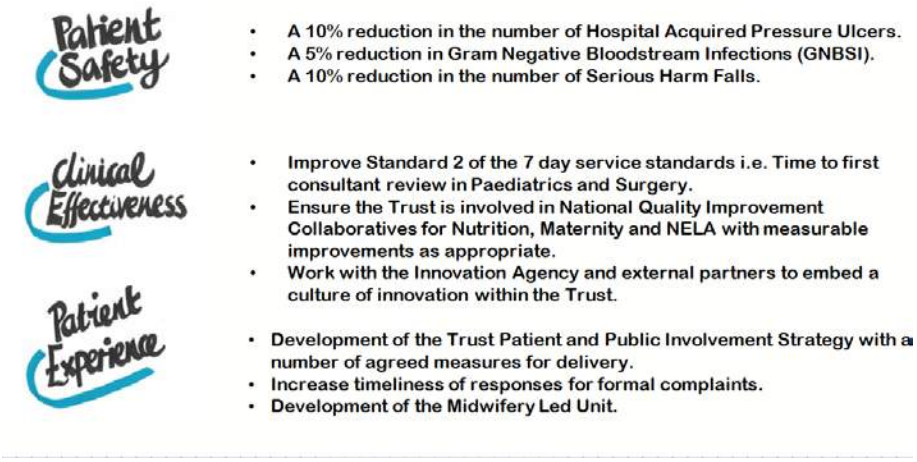
We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, and well cared for.

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

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

2.5 Local Quality Indicators 2019/20

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 2019/20 will include:



Patient Safety Priorities	
A 10% reduction in the number of Hospital Acquired Pressure Ulcers.	
Why we chose this priority	**What success will look like**
We have seen an increase in the number of category 3 pressure ulcers in our Quality Dashboard. There are adverse health outcomes associated with pressure ulcers. Pressure ulcers affect a patient's quality of life, morbidity, and mortality. Once a pressure ulcer develops, complications such as infection with the potential for sepsis may occur. This priority links in with our Quality Strategy as we committed to developing and enhancing our patients' safety.	A 10% reduction in the number of Hospital Acquired Pressure Ulcers.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Establish the Pressure Ulcer collaborative Quarter 2 – Implement tests of change & monitor Quarter 3 – Implement tests of change & monitor Quarter 4 – Reporting overall results.	Tissue Viability Meeting. Patient Safety & Clinical Effectiveness Sub-committee. A quarterly Quality Report will track milestones for the Quality Account priorities.

A 5% reduction in Gram Negative Bloodstream Infections (GNBSI).	
Why we chose this priority	**What success will look like**
We have seen an increase in the number of GNBSIs in our Quality Dashboard. There is a national ambition to reduce healthcare associated Gram-negative blood stream infections (healthcare associated GNBSIs) by 50% by March 2021. This priority links in with our Quality Strategy as we committed to developing and enhancing our patients' safety.	A 5% reduction in Gram Negative Bloodstream Infections (GNBSI).
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Focus of infection Urinary tract/ Catheter associated urinary tract and Hospital Acquired Pneumonia. Quarter 2 – Will focus on Patient and staff education. Quarter 3 – Partnership working/ Learning from incidents. Quarter 4 – Review and report on overall results.	Infection Prevention and Control Sub Committee. Patient Safety & Clinical Effectiveness Sub-committee. A quarterly Quality Report will track milestones for the Quality Account priorities.
A 10% reduction in the overall number of Serious Harm Falls.	
Why we chose this priority	**What success will look like**
The human cost of falling in hospital can be devastating and may lead to pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. Falling also has an impact on quality of life. This priority links in with our Quality Strategy as we committed to a 20% reduction in Serious Harm Falls by 2020.	A 10% reduction in the overall number of Serious Harm Falls.
Implementation Plan	**How progress will be monitored and reported**

Quarter 1- Relaunch updated multifactorial documentation and commence QI programme. Quarter 2- Audit use of multifactorial documentation. Quarter 3- complete QI programme with measurement of progress. Quarter 4- Spread the changes implemented through QI across Trust. Complete Enhanced Care Process Audit.	Falls Steering group. Patient Safety & Clinical Effectiveness Sub-committee. A quarterly Quality Report will track milestones for the Quality Account priorities.
Clinical Effectiveness Priorities	
Improve Standard 2 of the 7 day service standards i.e. Time to first consultant review in Paediatrics and Surgery.	
Why we chose this priority	**What success will look like**
A recent 7 day services audit has flagged we need to deliver an improvement in Standard 2 of the 7 day service standard which is *time to first consultant review in Paediatrics and Surgery*.	Improvement in the time to first consultant review in Paediatrics and Surgery.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Meeting with key stakeholders to analyse their data and understand what are the barriers to Consultant Review within 14 hours. Quarter 2 - 7 Day Service audit is to be conducted again as the basis for this year's national data submission. Quarter 3 – Implementation of small tests of change to test whether the suggested actions are improving time to review. Quarter 4 – Monitor the progress of time to review ensuring both specialties are maintaining their measure improvements.	Externally with the CCGs. Patient Safety & Clinical Effectiveness Sub-committee. A quarterly Quality Report will track milestones for the Quality Account priorities.
Ensure the Trust is involved in National Quality Improvement Collaboratives for Nutrition, Maternity and NELA with measurable improvements as appropriate.	
Why we chose this priority	**What success will look like**

NHSI and the Innovation agency are hosting a number of improvement collaboratives and the Trust is keen to participate.	Participation, engagement, clear milestones for improvement.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Identify leads in collaboration with the different agencies. Quarter 2 – Ensure high level plans are in place and being delivered. Quarter 3 – Monitoring tests of change via collaborative working. Quarter 4 – Reporting improvements.	Quality Academy Board. Patient Safety & Clinical Effectiveness Sub-committee. A quarterly Quality Report will track milestones for the Quality Account priorities.
Work with the Innovation Agency and external partners to embed a culture of innovation within the Trust.	
Why we chose this priority	**What success will look like**
Through working with the Innovation agency we are hoping to improve health and care, generate economic growth. This is a key aspect of both the Quality and Quality Academy Strategies. We will be able to connect with regional networks of NHS and academic organisations, local authorities, the third sector and industry - responding to the diverse needs of our patients and populations through partnership and collaboration. We hope this work will engage our current staff but also increase our reputation in order to attract new staff.	Improvement in culture for innovation.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Recruit to Innovation Lead within the Trust and development of innovation pathway. Quarter 2 – Scope out a feasibility study for an innovation hub for WHH. Host QA and Innovation summit. Quarter 3 – Align with Quality Academy plan. Implement following on from Summit and taking key	Quality Academy Board. Patient Safety & Clinical Effectiveness Sub-committee. A quarterly Quality Report will track milestones for the Quality Account priorities.

innovations forwards. Working towards launching hub. Quarter 4 – Launch hub.	
Patient Experience Priorities	
Development of the Trust Patient and Public Involvement Strategy with a number of agreed measures for delivery.	
Why we chose this priority	**What success will look like**
We wanted to make a formal commitment to creating opportunities for the participation and involvement of all groups (patients, families, carers, staff, communities, advocates, partners and other stakeholder groups). We want to ensure that ways and means to engage are accessible to all and that all voices are heard and views considered and incorporated wherever possible in service delivery, design and transformation through the championing of co-production.	Successful deployment of our work plan as described: Achieved/representation. Engagement by services – recorded and reported, evidenced in outcome reporting. Increased engagement with and participation and involvement of our wider public and advocacy partners – measured through recruitment in numbers and representation. Attendance at training/coaching events. Delivery of celebration event(s). Reported evidence of patient and public involvement and participation and their views in all service change programmes. Monitoring of involvement of hard to reach individuals and groups and those with protected characteristics.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 - Develop and deploy a work plan for 2019 building upon the PHE annual health promotion calendar, key events requested by our FT Governors, service changes and developments; collaborations, milestone surveys etc. and celebrations. Quarter 2 - Promote the PPP&I Strategy to clinical business units and services including the new Standard Operating Procedure. Secure agreement by services for registration of programmes **in advance** according to	Patient Safety & Clinical Effectiveness Sub-committee. A quarterly Quality Report will track milestones for the Quality Account priorities.

SOP and linked to completion of Quality Impact Assessment. Quarter 3 - Seek appropriate training opportunities, working with established groups (such as National Association for Patient Participation, Patient Voices, Patients Association, AQUA, etc.) and drawing on our own Quality Improvement and Quality Academy resources. Quarter 4 - Celebrate Successes and milestones – recognise contributions, reward participants through training and recognition scheme.	
Increase timeliness of responses for formal complaints.	
Why we chose this priority	**What success will look like**
Trust has been working on improving complaints management over 2 years which has resulted in improvements in processes, training, clearing backlogs, demonstrating improvements and learning from complaints. We now want to focus on increasing the timeliness of responses to be in-line with national standards.	All complaints responded to within timeframes.
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Baseline assessment, trajectories set. Quarter 2 – Work with CBUs to review Trust complaints pathway and what improvements can be made. Quarter 3 – Work with CBUs and report improvements. Quarter 4 – Report improvements.	Complaints Quality Assurance Group. Patient Safety & Clinical Effectiveness Sub-committee. Patient Experience Sub-committee. A quarterly Quality Report will track milestones for the Quality Account priorities.
Development of the Midwifery Led Unit (MLU).	
Why we chose this priority	**What success will look like**
Evidence suggests that women actively seek to give birth in maternity units that offer services which value privacy, dignity, choice, and personalised care. Therefore it is essential that we meet these basic standards.	An established Midwifery Led Unit which will provide women with private rooms for induction of labour and ensure privacy and dignity.

The decision was made to support the relocation of the MLU to enable to Induction of Labour (IOL) bay to be located within the Birth Suite, without affecting the total number of intrapartum beds.	
Implementation Plan	**How progress will be monitored and reported**
Quarter 1 – Planning stage Quarter 2 – Relocation of the MLU to Ward C22. Quarter 3 – Implementation stage - During this stage we will work towards achieving 20% of total unit births on the MLU; ensuring all women receive appropriate care in the right place, at the right time, given by the appropriate professional. We will also monitor staffing and escalation processes to ensure that safe staffing levels are maintained in all areas; flexing the staff to meet capacity and demand at times of high acuity. Quarter 4 – Growth, development and expansion of Maternity Services	Patient Safety & Clinical Effectiveness Sub-committee. A quarterly Quality Report will track milestones for the Quality Account priorities.

2.6 Statements of Assurance from the Board

During 2018/19, 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 NHS services reviewed in 2018/19 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 2018/19.

2.7 Data Quality

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

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

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

During 2018/19, 37 national clinical audits and 3 national confidential enquiries covered relevant health services Warrington and Halton Hospitals NHS Foundation Trust provides. During that period Warrington and Halton Hospitals NHS Foundation Trust participated in 97% national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Warrington and Halton Hospital NHS Foundation Trust was eligible to participate in during 2018/19 are as follows;

	National Clinical Audit Project
1.	Cardiac Rhythm Management
2.	Myocardial Ischaemia National Audit Project (MINAP)
3.	Case Mix Programme (CMP ICU)
4.	National Audit of Emergency Laparotomy (NELA)
5.	National Audit of Breast cancer in Older People (NABCOP)
6.	National Audit of Care at the End of Life (NACEL)
7.	Trauma Audit and Research Network (TARN)
8.	National Early Inflammatory Arthritis Audit (NEIAA)
9.	National Audit of Dementia
10.	National Ophthalmology Database Audit (NOD)
11.	British Association of Urological Surgeons (BAUS) Nephrectomy
12.	Epilepsy 12 Audit: Seizures Epilepsies Child/Young People
13.	National Bowel Cancer Audit (NBoCA)
14.	RCEM: Feverish Children (Care in Emergency Department)
15.	RCEM: Vital Signs in Adults (Care in Emergency Department)
16.	RCEM: VTE Risk in Lower Immobilisation (Care in Emergency Department)
17.	Mandatory Surveillance of bloodstream infections and C- Difficile Infection
18.	Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK)
19.	National Prostate Cancer Audit (NPCA)
20.	National Comparative Audit of Blood Transfusion Programme

21.	Serious Hazards of Transfusion (SHOTS)
22.	National Neonatal Audit Programme (NNAP)
23.	National Paediatric Diabetes Audit (NPDA)
24.	National Heart Failure Audit
25.	National Audit of Cardiac Rehabilitation (NACR)
26.	National Maternity & Perinatal Audit (NMPA)
27.	National Intermediate Care Audit
28.	Sentinel Stroke (SSNAP)
29.	National Pregnancy in Diabetes (NPID)
30.	National Joint Registry (NJR)
31.	Falls and Fragility Fractures Audit programme (FFAP)
32.	National Cardiac Arrest Audit (NCAA)
33.	National Oesophago-gastric Cancer (NAOGC)
34.	National Adult NIV Audit
35.	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)
36.	National Diabetes Audit-Adults

The national clinical audits and national confidential enquiries that Warrington and Halton Hospitals NHS Foundation Trust participated in, and from which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit	Participated	Data collected	% of cases submitted 2018/19
Cardiac Rhythm Management	Yes	Yes	Awaiting Data Validation
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	100%
Case Mix Programme (CMP ICU)	Yes	Yes	100%
National Audit of Emergency Laparotomy (NELA)	Yes	Yes	100%

National Audit of Breast cancer in Older People (NABCOP)	Yes	Yes	Existing sources of patient data is collected by national organisations
National Audit of Care at the End of Life (NACEL)	Yes	Yes	100%
Trauma Audit and Research Network (TARN)	Yes	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Ongoing Data Collection
National Audit of Dementia	Yes	Yes	100%
National Ophthalmology Database Audit (NOD)	Yes	Yes	100%
British Association of Urological Surgeons (BAUS) Nephrectomy	Yes	Yes	Ongoing Data Collection
Epilepsy 12 Audit: Seizures Epilepsies Child/Young People	Yes	Yes	Ongoing Data Collection
National Bowel Cancer Audit (NBoCA)	Yes	Yes	Awaiting Data Validation
RCEM: Feverish Children (Care in Emergency Department)	Yes	Yes	100%
RCEM: Vital Signs in Adults (Care in Emergency Department)	Yes	Yes	100%
RCEM: VTE Risk in Lower Immobilisation (Care in Emergency Department)	Yes	Yes	100%
Mandatory Surveillance of bloodstream infections and C- Difficile Infection	Yes	Yes	Ongoing Data Collection
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes	Ongoing Data Collection
National Prostate Cancer Audit (NPCA)	Yes	Yes	97%
National Comparative Audit of Blood Transfusion Programme	Yes	Yes	100%
Serious Hazards of Transfusion (SHOTS)	Yes	Yes	8 Incidents
National Neonatal Audit Programme	Yes	Yes	100%

(NNAP)			
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
National Heart Failure Audit	Yes	Yes	82%
National Audit of Cardiac Rehabilitation (NACR)	Yes	Yes	Ongoing Data Collection
National Maternity & Perinatal Audit (NMPA)	Yes	Yes	Ongoing Data Collection
National Intermediate Care Audit	Yes	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	100%
National Pregnancy in Diabetes (NPID)	Yes	Yes	100%
National Joint Registry (NJR)	Yes	Yes	100%
Falls and Fragility Fractures Audit programme (FFAP)	Yes	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
National Oesophago-gastric Cancer (NAOGC)	Yes	Yes	79%
National Adult NIV Audit	Yes	Yes	Ongoing Data Collection
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes	Yes	Ongoing Data Collection
National Diabetes Audit-Adults	Yes	Yes	Unavailable

National Confidential Enquiries

During 2018/2019 there were 5 NCEPOD studies, of which WHH were eligible to participate in the following 3;

	National Confidential Enquiries
1	Perioperative Diabetes
2	Pulmonary Embolism
3	Acute Bowel Obstruction

2.8.1 National Clinical Audit

The reports of 17 national clinical audits were reviewed by the provider in 2018/19 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided, as listed in the Quality Improvement Action Plan column below.

National Audit Title	Quality Improvement Action Plan
National Audit of Emergency Laparotomy (NELA)	Expansion and formalisation of NELA QIP Group with developed Terms of Reference – membership to include A&E, Radiology & ITU consultant colleagues, and to include monitoring of QI projects and link with Mortality Review Group
	Roll out of emergency laparotomy pathway to ED and SAU
National Audit of Breast Cancer in Older Patients (NABCOP)	Audit locally World Health organisation (WHO) performance status
National Bowel Cancer Audit (NBoCA)	Secure Pharmacy and Endoscopy representation regarding provision of bowel preparation- to enable patients to go Straight to Test
	Review of Enhanced Recovery Pathway in consideration of bed pressures, review possibility of a dedicated Enhanced Recovery Bay and Nurse
National Oesophago-gastric Cancer (NAOGC)	Undertake local audit of initial CT staging scans to understand position
Sentinel Stroke National Audit Programme (SSNAP)	Meet with Therapies to discuss Speech and Language provision
	Implement a visual prompt for MUST and swallow checks
	Provision of training on Stroke Audit Pathway to Stroke Team
	Provision of training on Stroke Audit Pathway to A&E Team highlighting requirement for prompt referral
	Investigate potential for provision of shared data while partnership working
National Diabetes Insulin Pump Audit	Head of Clinical Audit to liaise with Transformation Team about potential support regarding diabetes audit data collection
	Develop increased capacity within DSN service with an expertise in insulin pumps
Case Mix Programme (ICNARC)	Make the data available within Unit and wider Trust on a quarterly basis
	Utilise detailed data to review specific patient groups: •Early readmissions which may represent premature discharges •High risk admissions from the ward which may represent failed

	opportunities for early intervention •Ad hoc review of diagnostic groups e.g. patients with sepsis
	Utilise data to inform local audit projects e.g. recent audit of outcomes following admission after cardiac arrest
National Audit of Diabetes Inpatients (NADIA)	Inpatient consultant sessions
	Quality Improvement project for inpatient care
	Introduction of inpatient support workers
	Audit the number of inpatients seen in MDT foot clinic within 24 hours
National Lung Cancer Audit (NLCA)	Case note review of the 20 stage I/II patients to ensure the treatment decision was reasonable Warrington will identify the surgical cases to enable CCC to amalgamate all radical patients
	The number of referred cases of SCLC is very small- CCC to complete case note review of SCLC
	It may be reasonable to look at time from referral to first appointment with oncology/ date first treatment commenced to exclude the possibility that delay is a factor (awaiting formal data for waiting times from Cancer Data Team
National Hip Fracture Database (NHFD)	Re-establishment of NOF Group
	Recruitment of a second Orthopaedic Trauma Co-ordinator
	Undertake local audit of NOF Pathway
	Discussion of risk regarding Orthopaedic bed base and documentation time
National Prostate Cancer Audit (NPCA)	Review design of Prostate Cancer MDT sheet particularly PSA and Gleason and revise accordingly
Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2016 (MBRRACE-UK)	National report reviewed- no actions required
Saving Lives, Improving Mothers Care December 2017 (MBRRACE-UK)	Pre-conceptual advice is to be made available on the Trust's social media sites
	Staffing reviews are ongoing as part of CNST safety actions
	Neurological examination including assessment for neck stiffness and

	fundoscopy is mandatory for all women with new onset headaches or headaches with atypical features, particularly focal symptoms
	Women identified as experiencing postpartum psychosis are placed under the care of a Consultant Obstetrician with a special interest in perinatal mental health and the Clinic has links with a Mental Health Liaison Nurse and Psychiatry Services
Perinatal Mortality Report: 2015 births (MBRRACE-UK)	Reporter to issue cause of death as 'unknown' if reason is not known
National Maternity and Perinatal Audit (NMPA)	Improve recording of smoking status at birth
	Review reason for lack of data on episiotomy
	Review reason for lack of data on breast milk at discharge
National Pregnancy in Diabetes Audit (NPID)	Pre-conception (P-C) advice to all women with diabetes
	Review number babies large for gestation age based on individual grow charts
	Review mode and gestation at delivery for all patients 2016 with pre-gestational diabetes
	Pre-conception care projects for patients with pre-gestational diabetes in the community and assessing the impact of the current initiatives
National Audit of Dementia (NAD)	Develop pathway including delirium evidence based recommendations
	Review dementia training to include delirium as component of mandatory Trust training
	Conduct audit of personal information (This is Me form)
	Introduction of patient/carer survey to understand food preferences and create more options for patients
	Implement dementia friendly hot snack boxes
	Review catering options with a Specialist Dietician
	Nurse Specialist for Older People role reviewed and replaced by a Nurse Consultant for Dementia
	Review of Level 2 Dementia training content
	Nurse Consultant to cascade Level 2 training to all Nurses on the Forget Me Not Unit and Dementia Champions within the Trust
	Safeguarding to lead on mental capacity assessment and deprivation of liberties training

	Ward to complete Mental Capacity Assessment and audited by Safeguarding
	MUST scoring and appropriate actions taken which includes dietician referral, accurate food chart and fluid balance documentation with regular audit to ensure compliance
	Monitoring quality of discharge summaries
	Dementia patients assessed and listed for the Forget Me Not unit from admission reducing bed moves for the patient
	Reinstate audit of patient moves for patients with dementia

2.8.2 Local Clinical Audit

The reports of 78 local clinical audits were reviewed by the provider in 2018/19 and Warrington and Halton Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided as detailed in the tables below;

Digestive Diseases	
Gastroenterology	
Audit	**Action**
Discharge summaries	• Regular education about good discharge summary • Simplify discharge summary • Members of the team should communicate about what relevant clinical information to mention in discharge summary. • Re audit with simplify pro-forma
Surgery	
Analysis of post-operative management of complicated appendicitis in paediatrics	• Re audit to assess uptake of laparoscopy in children
Rib fractures admitted under general surgical team	• Consider introducing new pathway to ensure necessary referrals are made and management initiated on admission • Calculate rib fracture score on admission to guide analgesia prescribing • Discuss with pain team regarding use of PCAs in moderate risk patients (RFS>6) • Have a wider discussion around the current pathway regarding joint rehabilitation and respiratory care • Re-audit
Surveillance of Barretts oesophagus	• A panel graded each of the recommendations on the basis of the strength of gathered evidence, taking into consideration limitations of the studies and weighing the difference between the estimated benefits and risks of the intervention
Surgical documentation	• Staff should receive comprehensive IT training. • TAC users should automatically be identified by name and role. • Approved abbreviation list should be made easily accessible.

	• Paper notes to be scanned onto Lorenzo
Appendicitis diagnosis and post-operative length of stay	• Prospective audit of CT use in RIF pain and role to exclude operative intervention, alongside Alvarado scoring
Audit of Compliance of Consent Form in General Surgery	• More encouragement for patients to take at least one yellow consent form. Understanding that many factors impact on whether consent is documented before or on operation date.
Operation Notes for Surgical Emergencies	• Re-audit when new pro-forma implemented
Review of returning patients on Surgical Assessment Unit	• Instigate new management strategy including Pas on SAU.
Two stage consent audit	• Re-audit in two years.
Diagnostics	
Radiology	
Hot Reporting for Fractures (NICE Guidelines)	• Re-audit once changes have been implemented
Audit of breast sonographer needle sampling accuracy	• Re-audit 12 months as per WHH guidance for radiographer advanced practice
Audit of axillary USS accuracy in breast service	• Re-audit 18-24 months – concentrate on node positive cases.
Patient satisfaction survey - Re audit	• Repeat survey in 1 year with larger cohort
Holder's forms audit	• Share results with staff (newsletter, huddles, presentation). • Provide a training session.
Neonatal hip ultrasound	• Audit in 6 months
Operation Notes for Surgical Emergencies	• Re-audit when new pro-forma implemented
Missed lung cancers on plain chest x ray	• Re-audit in 5 years
Review of practice against RCR standards for NAI imaging	• Re audit 2 years as per WHH guidelines
Pathology	
Epidemiology of hospital apportioned E coli bacteraemia at Warrington Hospital	• A repeat audit should be done in 1 year time
Colorectal MDT cases	• Issue amended reports for all cases with a discrepancy. Discuss the audit findings with the surgeons and seek suggestions for further improvement. • Comply with the MDT SOP and review all histology cases prior to MDT discussion.

Integrated Medicine and Community	
Elderly Care	
Risk of stroke in patients over 65 with AF	• Re-audit one year. Small session to be introduced in induction for proper documentation. Posters on each ward as a reminder
Medical Care	
Critical Care	
ITU Consultant Reviews	• Re-audit march 2019
MUST	• Availability of appropriate patient weighing scales to enable objective MUST score. • Single Point Lesson for all ICU staff on importance of accurate MUST scores to be developed and delivered • Re-audit September 2018
Delirium	• Delirium checklist introduced in January 2019. • Re-audit
Medicines	• Presented to all staff on IV update training
Critical Care Records	• Present audit May 2019
ICU drug fridge temperature recording compliance	• Re-audit 96% compliance. • Team leader daily checks
Infection prevention dashboard	• Monthly dashboard updated and displayed
PCT on the ICU	• Continue to use PCT in ICU
Use of qSOFA/SOFA in the AED Sepsis pathway	• qSOFA score now replaced by new NEWS2 so no longer required
ICU patient satisfaction survey	• To be presented at march ICU audit 2019
Diabetes and Endocrinology	
Insulin prescribing and medication errors	• Evaluate effect Ward Educator to help staff care inpatients. • Continue mandatory training on insulin safety. • GIFT Review.
Respiratory Medicine	
NIV audit 2017	• Improve capture of acute NIV patients correctly. Distinguish between NIV and CPAP. • NIV prescription sheet to be added onto Lorenzo. • Include in hospital induction. • Amend prescription sheet. • Standardised agreed functional assessment tool • Target saturations. • Improve nursing handover and documentation of time to transfer. • Improve time to start NIV. • NIV SOP to be put in place to avoid delay in initiation. • More robust standardised training of A&E staff. • Combined ward round with physio and medical staff for NIV patients to optimise weaning plans (weekdays)Weekend plans for

	NIV patients on Fridays – handed over at Friday 1600 handover. • Effective follow up plans to be put in place. Consider advanced care planning. • Regular annual competency training for staff. • Review of the local NIV policy. • Update equipment. • Ensure respiratory clinic follow up for all patients who have received acute NIV in hospital. • Consider advanced care planning discussions to be initiated during acute episode and carried forward in OPD setting post discharge. • Consider utilising general palliative care/ respiratory palliative care resources for patients considered to be nearing end – of –life.
Musculoskeletal Care	
Trauma and Orthopaedics	
Audit of compliance with surgical site marking forms	• Ward staff and surgical team to take responsibility for prompting documentation of confirmed surgical site marking at each stage. • Mention in Team Brief prior to starting the list to ensure correct documentation.
Audit of Revision Total Hip/Knee Replacements done under a single surgeon - Lessons learnt.	• Additional scanner (already provided at UCC)
Audit of Blood Transfusion in Elective THR and TKR surgery at CMTC	• Education of CMTC ward staff on “Transfuse and check” protocol • Further education on induction for new trust/departmental staff on correct transfusion practices within the trust • Use of Haemocue for point-of-care checking of Hb
Hip fracture analgesia	• Take audit to Fracture Neck of Femur Focus Group to improve Ward targets. • Take audit to ED to improve ED targets. • Re-audit in 2019
Use of x-ray for hallux valgus	• Re-audit
Management of stable ankle fractures	• Ensure dose badges are available for all rooms & mobiles and remind staff to take badges on portables.
Perioperative fasting in adults undergoing Orthopaedic surgery at WHH	• Audit has been discussed with Ward manager and mentioned to nursing staff at safety briefing • There is a ward champion for hydration and nutrition • Presentation of audit at meeting • Email to all T&O about the audit and to SHO’s in particular about fasting times • Posters to improve education amongst MDT • Education with T&O juniors • Discussion at the trauma meeting about who can drink and until when, FY1s to take charge of updating nursing staff about when patients can drink until
Management of wrist fractures	• Discussion for introducing virtual fracture clinic to try and improve time to assessment and surgery • Introduce clerking pro-forma for ED to improve compliance with the guidelines with emphasis on documentation • Introduce an algorithm for orthopaedic doctors to allow for easier decision making
Surgical site marking	• Ward staff and surgical team to take responsibility for prompting documentation of confirmed surgical site marking at each stage.

	• Mention in Team Brief prior to starting the list to ensure correct documentation.
Weight bearing in ankle fractures	• Local protocol agreed upon by Orthopaedic and A&E departments for immobilisation in non-operative and operative ankle fractures. • Consider early weight bearing in post-operative ankle fractures if considered appropriate.
Nerve Conduction Study on Carpal Study Release	• Implement One-stop clinic for carpal Tunnel syndrome • Re-audit waiting time against RTT after implementation of clinic
Re-audit: Pre-operative Fasting Practises of Patients on Trauma List	• We need to reduce our pre-operatively starvation times particularly for fluids • Starvation times before surgery- patients do not need to be kept NBM of fluids until 7am NBM of food from 2am • Early restoration of oral hydration post operatively
Specialist Surgery	
ENT	
Ear dressing clinic service use	• Re- audit 2019
Ophthalmology	
Warrington Emergency Eye Care Provision Audit	• ED Training staff. • System for follow ups post on-call into cons clinic • Self-referrals- Streamline this pathway • Optom/GP- Triage. • If longer wait than 3-4 days -> PCC/ Cons clinic • Protocols- for discharge • FU- Cons clinics only. • Alternatively, Nurse/Optom clinics. • Safety net/telephone FU.
Record keeping	• Identify who is the senior professional – «under the care of + Consultant name» in discharge entry/TTO. • Start writing designations in discharge summaries/TTO's. • Document pre-op assessments electronically on Lorenzo • Re audit 1 year
Diabetic screening and treatment	• Named staff only to give appointments for referrals from doctors (<2/52 for r3, <13/52 for r2/m1). • Continue to improve failsafe procedures to reduce DNA rates for clinic & laser appointments • Prospective audit of all (new & review) patients undergoing laser review for doctor. • Continue to obtain feedback from patients about doctor service • Audit patients undergoing vitrectomy for doctor to identify preventable causes • Continue to audit patients registered SI/SSI due to doctor • Re-audit in 12 months
Glaucoma new patient compliance with NICE guidance	• Glaucoma specific new patient clinics should continue to be provided at WHH • Further audit of compliance in 24 months should be carried out • Further training should be given to appointments staff to ensure that all glaucoma referrals are appropriately directed to glaucoma primary care clinics.
Nurse-led glaucoma clinic	• To ensure management plan is in place • To use Medisoft as patients are able to be seen efficiently even if no notes available

	• Ensure time scale for follow up is documented so that e-outcomes can be completed same day • Looking to the future IOP check using Goldmann's application tonometer - clinic permitting to ensure a more accurate reading
Outcome of Amblyopia Treatment	• Audit in 12 months that will review documentation of patching and atropine being offered as a first-line treatment. Repeat final VA outcomes audit in 24 months
Urgent and Emergency Care	
Emergency Medicine	
Record keeping and discharge summaries	• Re-audit in 1 year - 30.06.19
Missed fractures in ED	• Include brief section on common missed XR abnormalities (e.g. effusions, ACJ disruption) in junior doctor induction week
Women's and Children's Health	
Obstetrics and Gynaecology	
One to One Pathways	• Policy to be updated regarding telephone numbers. Generic email address for the delivery suite.
A review of uterine fibroid embolisation standard operating procedure	• BSIR leaflet to be made available. Amend SOP to reflect change to Radiology follow up protocol regarding removal of catheter
Quality of consent process and documentation	• Re audit December 2018. Adding a separate check box for information leaflets, making sure information leaflets are available, and provided to the patients in time prior to the procedure.
Term SROM with GBS - Audit of Mum's and Babies	• Re audit with Paediatric Team to be presented May / June 2019.
Safeguarding maternity notes	• Meet with the senior midwives to discuss the concerns identified. • Review the current safeguarding paperwork and update. • Disseminate information in relation to domestic abuse. • Promote Domestic Abuse training. • Re-audit in 12 months.
Review of BSUG database, prolapse and incontinence surgery	• Continue maintaining database
Laparoscopic hysterectomy outcomes	• Re audit
Care in labour and transfer from home audit	• Raise awareness of place of birth options. • Antenatal risk assessment place of birth. Intrapartum risk assessment for place of birth and women on the appropriate intrapartum pathway. • Appropriate use of foetal monitoring. Number of admissions to the midwifery led unit. Number of home births. Maternal transfers from midwife led pathway to complex care (home and AMU). Increase use of aromatherapy (post-dates and in labour)
LOCSSIPs	• Re-audit 12 months. Should be observational audit
Patient satisfaction in Colposcopy	• Review appointments access for patients – SOP requested. • Estates to improve lighting for waiting room; improve signage for

	facilities in waiting area. Seating area on risk register. • Option appraisal completed. • Annual colposcopy patient satisfaction survey as part of cervical screening pathway audit • 2018/19 Service Specification standard.
Assessment of newly opened Gynaecological Assessment Unit	• To review and ensure Lorenzo is used to access the information we need for audit. • To audit HCG reviews and outcomes to ensure best practice / guidelines are being followed – look at M5 logistical regression model. • To audit early pregnancy problems in GAU specifically and the outcomes.
Domestic abuse screening in Maternity	• Discuss issues with individual midwives audited. Findings of audit discussed with head of midwifery. • Domestic abuse awareness week. Recirculate safety alert for support at home. • Promote domestic abuse training for all staff grades. • Explore other methods to promote screening. Spot checks across the unit. • Posters/support details in all areas of the trust.
Enhanced recovery pathway for women undergoing Elective C Section	• Person cannulating to complete the VIP chart. Ward Manager to discuss with team around observations being recorded in a timely fashion. Documentation around cannula three times in 24 hours. • Remind the Obstetricians to complete post-natal VTE on Lorenzo following their delivery notes. Ensure that all women are taught Clexane administration at the pre op appointment. • Look forward to Enhanced Recovery Pathway.
Perinatal mental health service	• Re-audit with a goal for 100% documentation of screening questions in the paper booking notes (recorded in Lorenzo) • Re-audit the numbers of women referred to clinic and those referred to another service. Document in the care plan if a safeguarding referral has been sent.
Paediatrics and Neonatology	
Management of Croup	• Improve awareness of the pathway amongst doctors and nurses on PAU/B11 and train staff on how to generate the pathway on a patient's account.
Audit of babies requiring therapeutic cooling	• Rectal probe for monitoring temperature
Possible deflection of patients from PAU to PART	• Disseminate findings to Transformation team. Disseminate findings to CCG following approval from Management team. • Disseminate findings to Paediatric Network
Unplanned neonatal readmissions to hospital within 28 days of birth	• Implementing the use of Bilirubin meters in the community. • Raise awareness of feeding issues by community midwives
Associations of Pneumothoraces with High Flow Oxygen Therapy in Neonates	• Raising awareness of nursing and medical staff on increased incidence and the potential relation between the incidence of pneumothorax • Initiation of Vapotherm in near term or term babies with significant respiratory distress. Use of nasogastric tubes (as it inadvertently creates increased delivery pressure through Vapotherm). • Consider joint paeds and obs and gynae audit on the use of steroids in preterm babies born between >34 but less than 37 weeks of gestation.

Management of Sepsis in Children	• Share audit results to all medical staff during induction and to all nursing staff during safety briefing.
Outcome of babies born to GBS +ve mothers	• Disseminate results among midwives, paediatric and obstetric staff. • Ensure new doctors are informed about local guidelines for prevention and management of EOGBS infection in neonates.
Rapid Access Clinic Audit	• Inappropriate referrals, Inappropriate triaging of patients into clinics, Appropriate continuity of care
Review of Paediatric Advice and Guidance requests	• Disseminate findings to Transformation team. • Disseminate findings to CCG following approval from Management team. • Disseminate findings to Paediatric Network.

2.9 Participation in Clinical Research and Development

The number of patients receiving NHS services provided or sub- contracted by Warrington and Halton Hospitals NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 646. 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 2018-2019 the Trust was involved in conducting 84 clinical research studies in surgery, oncology, reproductive health, anaesthetics, emergency medicine, rheumatology, gastroenterology and cardiology 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.

Most of the research carried out by the Trust is funded by the NIHR. For 2018-2019 the Trust received £371,000 which funds staff including eight 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.

During the year work has been undertaken to develop the role of Clinical Leads with regard to research, in order to promote and engage Trust clinical staff to become actively involved in research within the Quality Academy, to maximise commercial research activity and to develop and foster partnerships. The major aim will be to widen the portfolio of research projects the Trust is involved both commercially and non-commercially. The Trust has also continued to work within the Health Research Authority (HRA) procedures which moved the emphasis towards acceptance of HRA assessment within the framework of research governance, strict legislation and recognised good clinical practice and local assessment of capability and capacity to run a study.

2.10 The CQUIN Framework

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

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

A proportion of Warrington and Halton Hospitals NHS Foundation Trust's income in 2018/19 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 2018/19 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/

The monetary total for the amount of income in 2018/19, conditional upon achieving quality improvement and innovation goals, meeting the 17/18 control total and engaging in the STP was £4,518,994 with a monetary total for the associated payment in 2017/18 of £4,294,737 received. In 2018/19, the trust received a monetary total for the CQUINs of £4,658,317 against a target of £4,658,317.

The Trust had the following CQUIN goals in 2018/19 which reflected national priorities and Department of Health initiatives.

CQUIN Report 2018/19

No.	Name	% of contract value	Total estimated final value
	NATIONAL CQUINS		
1	**NHS Staff Health and Wellbeing**	0.25%	447,396
1a	Improvement of health and wellbeing of NHS staff		
1b	Healthy food for NHS staff, visitors and patient		
1c	Improving the uptake of flu vaccinations for front line staff within Providers		
2	**Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)**	0.25%	447,398
2a	Timely identification of patients with sepsis in emergency departments and acute inpatient settings		

2b	Timely treatment of patients with sepsis in emergency departments and acute inpatient settings		
2c	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72hrs		
2d	Reduction in antibiotic consumption per 1,000 admissions		
4	**Improving services for people with mental health needs who present to A&E**	0.25%	447,398
5	**Offering advice and guidance (A&G)**	0.25%	447,398
6	**Preventing ill health by risky behaviours - alcohol and tobacco**	0.25%	447,398
6a	Tobacco Screening. Percentage of unique adult patients who are screened for smoking status AND whose results are recorded		
6b	Tobacco Brief Advice. Percentage of unique patients who smoke AND are given very brief advice		
6c	Tobacco referral and medication offer. Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication		
6d	Alcohol Screening. Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems		
6e	Alcohol Brief Advice or referral. Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral		
7	Engagement and commitment to STP process	1.25%	2,236,990
	NHS ENGLAND CQUINS		
8	**Breast Screening Programme Clerical Staff Development (Health Promotion Role)**		41,114

9	**Dental**		54,162
9a	Referral Management		
9b	Managed Clinical Networks (MCNS)		
	SPECIALLY COMMISSIONED CQUINS		
10	**Hospital Pharmacy Transformation and Medicines Optimisation**	1.20%	53,438
11	**Nationally standardised dose banding for adult intravenous**	0.80%	35,625

2.11 Care Quality Commission (CQC) Registration

Warrington and Halton Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Warrington and Halton Hospitals NHS Foundation Trust during 2018/19.

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 participated in a special review by the Care Quality Commission relating to the following areas during 2018/19; Warrington Hospital Emergency Department. Following publication of their findings Warrington and Halton Hospitals NHS Foundation Trust intends take the following action to address the conclusions or requirements reported by the CQC; an action plan will be created in line with the recommendations which will be overseen by Trust Board and also reported to the Quality Committee to ensure timely completion of the actions.

2.12 CQC Inspections

The Trust was inspected by the CQC in March 2017. During their visit they looked at the quality and safety of the care we provide, based on the things that matter to people. They looked at whether our service is:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

The key lines of enquiry were investigated using pre-visit information, the onsite inspection and local information about us – including seeking patient, staff and visitor views. In November 2017 the CQC published our report which included a rating by specialty; location and an overall rating for the trust from the inspection.

Our ratings for Warrington and Halton Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Warrington Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Halton General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Requires improvement	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

The trust can report that the CQC rated Halton Hospital as **Good** and Warrington Hospital as **Requires Improvement**. They rated the domain of Caring in the Trust as Good across the board in all of its services.

The trust was given an overall rating of **'Requires Improvement'** by the CQC. At the time of the inspection, the Trust implemented a lot of improvements. An action plan is in place within the Trust following receipt of the CQC action plan with actions at service and Trust level. This has formed our Getting to Good, Moving to Outstanding vision and priorities within the Trust. This is monitored by a monthly meeting, which has been convened to oversee the action plan implementation. At the time of writing this report we are looking forward to welcoming back the CQC in April 2019, to inspect the Trust, so that we can showcase the improvements we have made for our patients.

2.13 Trust Data Quality

Warrington and Halton Hospitals NHS Foundation Trust submitted records during April – December 2018/19* 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	99.80%
Outpatient Care	99.90%
A&E Care	99.10%

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

Admitted Patient Care	100%
Outpatient Care	99.10%
A&E Care	100%

* provided from SUS - Data up to Q3 18/19

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

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

2.14 Information Governance

The Trust uses the Data Security and Protection Toolkit in conjunction with the Datix Risk Management system to inform the work of its Information Governance and Corporate Records Sub-Committee. The Information Governance and Corporate Records Sub-Committee are accountable to the Quality Assurance Committee which is a sub-committee of the Trust board. The Trust's Senior Information Risk Owner (SIRO) chairs the Information Governance and Corporate Records Sub-Committee which is also attended by the Trust's Caldicott Guardian. The SIRO (Chief Information Officer) acts as the Board level lead for information risk within the Trust. Any areas of weakness in relation to the management of information risk which are identified, or are highlighted by internal audit review, are targeted with action plans to ensure that we continue to strive to be information governance assured.

The Trust's 2018/19 Data Security and Protection Toolkit assessment was reviewed by Mersey Internal Audit Agency in March 2019 as part of the Trust's annual audit programme. The Governance assurance statement provided in the published review stated that "the Trust has demonstrated that

it has implemented an adequate Information Governance framework which is active". The overall assurance level awarded for the Trust's 2018/19 Data Security and Protection Toolkit submission is moderate assurance.

2.15 Clinical Coding/Payment by Results (PBR)

Warrington and Halton Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19.

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

- Continuous engagement with clinicians to improve documentation and clinically coded data.
- Working with clinicians to migrate from handwritten to digital operation notes.
- On-going programme of internal clinical coding staff audits.
- Supporting the mortality review group with documentation and clinical coding reviews.
- Continuous training and updating of skills for clinical coders.
- Targeted specialty documentation and clinical coding audits.
- Collaboration with Informatics to enhance the usability of Lorenzo to improve the coding process.
- Highlight data quality issues for resolution to the Application Support Team.

2.16 Learning from deaths

In March 2017, The National Quality Board issued "National Guidance on Learning from Deaths: a framework for NHS trusts and NHS foundation trusts on identifying, reporting, investigating and learning from deaths in care". This guidance included the requirements that trusts must publish a Learning from Deaths policy, and that from December 2018 Trusts must collect and publish on a quarterly basis specified information on deaths, through a paper and an agenda item to a public Board meeting. This data should include the total number of the Trust's inpatient deaths and those deaths that the Trust has subjected to case record review. Of those deaths subjected to review, trusts must estimate how many deaths were judged more likely than not to have been due to problems in care.

Reducing mortality is a priority for the Trust which is now focused through the Mortality Review Group (MRG). The Mortality Review Group performs in-depth investigations using the Structured Judgement Review methodology into groups of patients conforming to agreed criteria as defined within the Trust Learning from Deaths policy.

The Trust has currently trained 11 clinicians in the Royal College of Physicians Structured Judgment Review (SJR) method for recording deaths, mortality reviews and their outcomes. The Trust has invested in the DATIX ICloud (electronic risk management system) which has an additional functionality to log SJRs electronically.

Mortality meetings focus on process and system change, with the aim of developing recommendations to prevent a similar adverse outcome in the future. Any actions and improvements that have been made by the Mortality Review Group reported to the Patient Safety & Clinical Effectiveness Sub-Committee.

During 1st April 2018 to 31st March 2019, 1065 of WHH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 296 in the first quarter;
- 237 in the second quarter;
- 245 in the third quarter;
- 287 in the fourth quarter

By 31st March 2019, 202 care record reviews (SJR) and 21 investigations (Serious Incidents) have been carried out in relation to 1,065 of the deaths included above.

In 12 cases a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was as follows:

- 4 in the first quarter;
- 4 in the second quarter;
- 2 in the third quarter;
- 2 in the fourth quarter

5* representing 0.46% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. It should be noted that 2 investigations are still in progress and are awaiting conclusion, these will be reported on in the 2019/20. The 5 cases are SIs that were reported to, and reviewed by, the Trust Board and deemed as preventable harm.

In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 1 representing 0.09% for the second quarter;
- 4 representing 0.37% for the third quarter;
- 0 representing 0% for the fourth quarter with 2 cases still under investigation

In order to support our learning and help improve the treatment of our patients, we disseminate learning from both the case record reviews and serious incident investigations. This provides valuable feedback on all aspects of care and helps us to understand what we may need to improve and equally what has been effective and meaningful for our patients. Here are some of the things that we have learnt;

Appropriateness of Care / End of Life Care
Appropriateness of Care, especially in relation to transition from active to end of life care was a recurrent theme throughout 2018/19.
Action: There is a new Rapid Discharge Home to Die Policy now on the Hub which provides staff with further guidance in relation to this topic.
Action: Staff are being referred to the Amber Care Bundle on the Hub for further guidance.

Intestinal Infections
Intestinal Infections triggered as an outlier for being statistically significantly high for SHMI within this group, over a 12 month rolling period; Jan 17 to Dec 17.

An overview of the 22 cases was conducted in November 2018 and a full report with actions was presented at the Mortality Review Group in March 2019.

Learning: This review showed that this group are patients who are admitted with a diagnosis of an Intestinal Infection, either due to a specific pathogen e.g. E- Coli (bacterial) or virus or NEC (Necrotising Enterocolitis) secondary to a pathogen. There is clearly quite a crossover between infective and Ischaemic colitis in this group of patients and in some cases the inability to make a definitive diagnosis of Ischaemic Colitis has resulted in the default diagnosis of 'infective' colitis.

Transfers between departments
A theme from some of the SJR's undertaken in year was in relation to transfers of patients between departments. The following learning was identified and disseminated;

- **Learning:**
  I. Joint radiology and surgical teaching session on the specific incident for learning.
  II. Unwell patient with abdominal pain should not be referred to another specialty until the management is discussed with the consultant.
  III. Ensure that you are completing an SBAR or formal handover when transferring a patient.

Any actions and improvements that have been made by the Mortality Review Group are being reviewed during 2019/20 to see whether they have had the desired impact. These actions will be reported to the Patient Safety & Clinical Effectiveness Sub-Committee.

1 case record reviews and 8 investigations completed after 1st April 2018 which related to deaths which took place before the start of the reporting period.

1 representing 0.09% of the patient deaths before the reporting period are judged to more likely than not to have been due to problems in the care provided to the patient.

5 representing 0.49% of the patient deaths during 1st April 2018 to 31st March 2019 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Communicating with patients, families and carers was, and continues to be, a Patient Experience priority during 2018/19 with the development of the Bereavement Service. The Trust website now provides information on mortality and bereavement to the general public, in line with guidance from the 2017 National Quality Board's National Guidance on Learning from Deaths.

The web site has links to the latest public Board reports containing mortality data along with an explanation of the way that mortality rates are measured. The page also provides a link to the Trust's dedicated bereavement webpage.

Processes are in place to keep families and carers informed (in line with Duty of Candour requirements) throughout: the screening of a death, the SJR process and / or a serious incident review. Advice is given to families and carers by means of a booklet, that they can raise concerns and that these will be considered when deciding whether or not to further investigate a death.

2.17 Core Quality Indicators 2018/2019

The 2012 Quality Account Amendment Regulations (10) state that Trusts are required to report against a core set of quality indicators using the following standardised statement set out as follows:

Where the necessary data is made available to the Trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) are included for each of those listed with:-

- The national average for the data.
- The NHS Trusts and NHS foundation Trusts with the highest and lowest of the same, for the reporting period.
- Present, in a table format, the percentage/proportion/score/rate/number for at least the last two reporting periods.

Trusts are only required to include indicators that are relevant to the services they provide.

2.18 Summary Hospital-Level Mortality Indicator (SHMI)

The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period was:

DATE PERIOD	TRUST	BANDING	HIGHEST	LOWEST	NATIONAL
October 2017 – September 2018	109.92	3	126.81	69.17	100
July 2016 – June 2017	112.32	2	122.77	72.61	100

NB: This information is re-based so there may be a variation from HED monthly reporting.
(There is no 18/19 national comparative data available at present)

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'

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 of 109.92 in the rolling 12 month periods from October 2017 – September 2018.

The SHMI is one of two mortality measures used in the NHS, the other being HSMR (Hospital Standardised Mortality Ratio), which is 109.18 for the latest data period available (December 2018). This is within the range of 'as expected'.

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

In an aim to improve our SHMI and HSMR we conduct focused reviews where the HED system indicates we are an outlier in a particular diagnosis group, for example Pneumonia.

Where we are above our expected number of deaths in a diagnosis group for over three months we will work alongside specialists within the appropriate specialty to perform case note reviews of the patients' stay.

This deep dive provides us with valuable learning as to what is needed to be implemented to ensure we have no further triggers within diagnosis groups. Some aspects of learning are applicable to reduce the likelihood of triggering in the future, such as improved documentation and coding, whereas others are specifically of relevance to that treatment, such as using a dip stick before diagnosing a patient as having a urinary tract infection.

We share learning from the Mortality Review group using the Mortality and Morbidity (M&M) meetings which are an opportunity for peer review, collective learning and quality improvement which are held across all CBU's on their allocated audit days.

Mortality and morbidity meetings are blame-free and are a professionally accountable forum based on sound educational principles and encourages openness, honesty and transparency from participants; they focus on learning and improvement of systems and processes of care and not on individual performance.

2.19 Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
October 2017 – September 2018	34.3%	33.4%	59.5%	14.3%
July 2016 – June 2017	41.7%	31.1%	58.6%	11.2%

*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 has improved over the years to a steady rate, which is comparable with the England average. However, we continue to prioritise the coding of patient deaths to ensure that they are coded correctly as palliative care.

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

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

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

		Groin hernia	Hip replacement	Knee replacement
Year	Level	Average health gain	Average health gain	Average health gain
2017/2018	Trust	0.019	0.341	0.312
2017/2018	England	0.089	0.488	0.345
2016/2017	Trust	0.036	0.455	0.370
2016/2017	England	0.086	0.444	0.324
2015/2016	Trust	0.081	0.429	0.345
2015/2016	England	0.088	0.439	0.321

http://digital.nhs.uk (2018/19 data is not available at the time of writing this report)

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

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

2.21 Emergency readmissions to hospital within 28 days of discharge

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

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

0 to 15; and

16 or over,

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

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

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2018/19	*	*	*	*

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

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

DATE PERIOD	TRUST	ENGLAND	HIGHEST	LOWEST
2018/19	*	*	*	*

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

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

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

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

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

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

DATE	TRUST	ACUTE TRUSTS
2018	60.8%	71.3%
2017	60%	71%

Warrington and Halton Hospitals NHS Foundation Trust considers that this data is as described for the following reason, in that this report presents the findings of the 2017 national NHS staff survey

conducted by Quality Health on behalf of the trust. Quality Health utilises high quality research methodology and mixed method collection resulting in a 51% response rate compared to the Acute Trust Average of 44%. This represents 1,990 staff responding to this survey.

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 Trust is continuing to adopt a strategic OD approach to improving culture and leadership within the organisation. Listening into Action has been implemented throughout 2018/19 resulting in a number of key service improvements. The Trust is currently developing a leadership framework and has embarked a team development programme. In addition to the above, the Trust has launched the Quality Academy which will be a further support mechanism for staff to implement change.

2.23 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	Q1	Q2	Q3	Q4
2018/2019	95.76%	95.02%	95.03%	95.58%
2017/2018	95.18%	95.88%	95.24%	95.62%

Warrington and Halton Hospitals NHS Foundation Trust considers that this percentage 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 taken the following actions to improve this percentage, and so the quality of its services by updated the Lorenzo system to further support the established process for undertaking risk assessments, and the Trust consistently achieves over the 95% recommended standard for risk assessment completion, the data is collated corporately and incorporated into the Quality Dashboard for monthly review and monitoring by both the Quality Committee and Trust board. Trust policy has been updated to reflect changes to NICE guidance with associated amendments to patient information. Early identification of patient risk of VTE remains a high priority for the Trust.

2.24 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
2017/2018	30.2	38.3
2016/2017	33.9	36.7

https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

(There is no 18/19 national comparative data but the Trust's 18/19 performance is shown in Section 3.15)

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

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

- Action plan in place to reduce Clostridium difficile
- Participation in the national AMR CQUIN
- Participation in European Antibiotic Awareness Day
- Fidaxomicin used for treatment of patients with recurrent Clostridium difficile infection
- Antimicrobial steering group with feedback to Clinicians on incidences of antimicrobial prescribing non-compliance
- DIPC challenge for antibiotic prescribing non-compliant with Trust Formulary
- Surveillance of cases/monitoring for increased incidences in defined locations
- Improvements to methods of investigation for Clostridium difficile cases
- Cohort isolation facility maintained to manage cases
- Increase in ward based training for management of infectious diarrhoea, viral gastroenteritis outbreaks and use of personal protective equipment and single point lessons on Clostridium difficile and use of SIGHT mnemonic
- An Infection Control Operational Group has been set up to monitor and direct improvements in standards of cleanliness
- Action plan in place to reduce MRSA and MSSA bacteraemia cases
- Participation in the national Sepsis CQUIN to promote timely blood culture sampling and IV antibiotic treatment
- Revision to post infection review template for bacteraemia cases
- Review of all MRSA positive cases and advice provided on suppression therapy and where required antibiotic treatment
- Gram Negative Bloodstream Infection (GNBSI) reduction Group has been set up and there is an action plan in place with a focus on reducing use of urinary catheters, patient hydration and patient hand hygiene

2.25 Patient Safety Incidents

The data is made available to the Trust by the National Reporting and Learning System with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Patient Safety Incidents – Rate of incidents per 1000 bed days

DATE	TRUST	TRUST NUMBER	MEDIAN	LOWEST	HIGHEST
Oct 2017 – Mar 2018	38.78	3764	42.55	24.19	124
April 2017 – September 2017	41.07	3619	42.84	23.47	111.69

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

Patient Safety Incidents Severe Harm / Death – Rate

DATE	TRUST	NATIONAL	LOWEST	HIGHEST
Severe Harm and Death Oct 2017 – Mar 2018	0.37% (14)	0.3% (Non-specialist acutes only)	0% (0)	1.55% (99)
Severe Harm and Death April 2017 – September 2017	0.64% (23)	0.4% (Non-specialist acutes only)	0% (0)	1.98% (121)

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 by:

- Launched the *'Reporting to Improve'* campaign which actively encourages incident reporting by any member of staff at any time and to promote an open and honest culture.
- Completed investigations to the appropriate level dependant on the severity of the clinical incidents reported.
- Trained staff to use the Trust online reporting system, Datix.
- Supported senior staff with Risk training to assist them when reviewing incidents for their area.
- Monitor the actions from incidents to ensure that they are completed in time in order to improve care for our patients and staff.

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
- Quarterly Learning to Improve newsletter
- Annual Safety Summits
- Daily Safety Huddles
- Trust wide Safety brief

2.26 Freedom to Speak Up (FTSU)

"We consider FTSU in everything we do, all staff will know how to speak up and feel safe doing it. We will become outstanding by listening and learning from our staff."

The Trust has a named Executive Lead, Non-Executive Lead and a Freedom to Speak up Guardian. In addition, several champions have been appointed to support the work and spread the word across the Organisation.

The Trust policy is on the Intranet and there are posters with the details of how to contact the team across the Trust. The Trust has a policy which is in line with the national guidance and is reviewed annually. Freedom to Speak up links to the QPS aims and objectives of the Trust.

Staff can raise issues through FTSU via the website, email, telephone, in writing or face to face. Cases have been raised through all these ways. The FTSU Team work closely with the Communication Team, Human Resources Team and Governance Team to ensure that FTSU is on as many agendas across the Trust as possible. The FTSU Team wear the green FTSU lanyard to highlight to all staff that they are FTSU Champions.

Once an issue has been raised a next steps plan is made together and the individual is signposted to the relevant expert in the organisation to resolve the issue. The FTSU team member keeps in touch to see how everything is going and that a resolution has been found.

The activities of the FTSU Team are reported twice a year to the Board and Quarterly to the Quality Committee and Strategic People Committee. The number disclosures are benchmarked against similar Trusts and national guidance is reviewed and implemented. The Trust undertakes the toolkits provided by the national office.

2.27 Seven Day Hospital Services (7DS)

The 7DS audit that was conducted in 2017 demonstrated that for Clinical Standard 2, General Surgery, Paediatrics and Acute medicine did not meet the standard. Although Acute medicine had the better compliance percentage (84%) of the three areas, it also had the greatest numbers. Consequently plans were put in place for all three areas. The 7 DS Audit results were presented to the Trust in February 2019. The clinical effectiveness team has met with the three main areas to progress plans.

Following the 2018 7 Day Services audit we are currently compliant with the following standards:

CS5: Access to diagnostic tests	94%
CS6: Access to consultant-directed interventions	100%
CS8: Ongoing review by consultant twice daily if high dependency patients, daily for others	100%

1. General Surgery in 2017 achieved 33% of patients reviewed by a Consultant within 14 hours. Discussion with the Clinical Director and analysis of data confirmed that it was patients presenting late in the day that were primarily affected. Triangulation with incidents and mortality reviews also recommended greater Consultant presence at the start of the patient journey. Over the last year, feedback from incidents has resulted in increased direct Consultant oversight of cases and has been quantified for example in the improved National Emergency Laparotomy Audit (NELA) standards. Operating an 'on call' system from 1800 hours was felt to be a factor limiting compliance. Discussion with Medical Director and CBU Clinical Director confirmed the need to increase Consultant surgeon direct review of patients. The CBU have presented options to the Executive team. The final agreement has been to provide increased Consultant Surgeon presence in the Trust up to 2200hrs and particularly supporting the Surgical Assessment Unit. This new rota commenced in January 2019. Consequently, the last audit showed improvement in QS 2 at 57%. The effect of the new Surgeon rota will be seen at the next audit.
2. Acute Medicine. Although percentage compliance in 2017 was greater than 80%, a number of medical patients were not seen within 14 hours by a Consultant Physician. The Trust continued Consultant recruitment to the acute rota, timetabled Consultant review to 'medical outliers' and prioritised "sick and quick" patients for review, in order to prioritise clinical need. As the acute Consultant Physician was resident until 10pm, the rota was not changed. 2018 data has demonstrated an improvement, however not compliant with the standard. The Clinical effectiveness team have met with the Clinical Director for Acute care and analysed the data in more depth. Certain cohorts of patients are primarily responsible for greater than 14 hour review. There is an improvement plan currently in place, which has been developed with the Clinical Director, which has actions up to July 2019. Part of the action plan is to complete an audit which should demonstrate adherence with the standards.
3. Paediatrics. In 2017 reviewed 63% of patients within 14 hours. Paediatric physicians were resident until 10pm and felt they had sufficient provision to meet this standard. 2018 data has demonstrated however a reduction in % patients seen by a Consultant. The Associate Medical Director for Effectiveness has met with Child Health & Women's CBU Clinical Director to look at the data. Consultant Paediatricians when on call coordinate the care of patients with their team, prioritising acute patients to themselves and other patients to other members of the team. It is felt they have sufficient on call provision however are planning to develop non-consultant pathways as suggested by NHS Improvement, which means that patients with conditions that do not require senior review clinically will be triaged onto these.

In terms of Clinical Standard 5, prior to the 2017 audit, utilisation data confirmed the need for echocardiograms (ECHO) predominantly on weekdays. Consequently the service moved to that model. At weekends if an ECHO is required this is reviewed by a Registrar and checked by a

Consultant on Monday. There is increased ECHO provision during winter months supported with Locum Consultants.

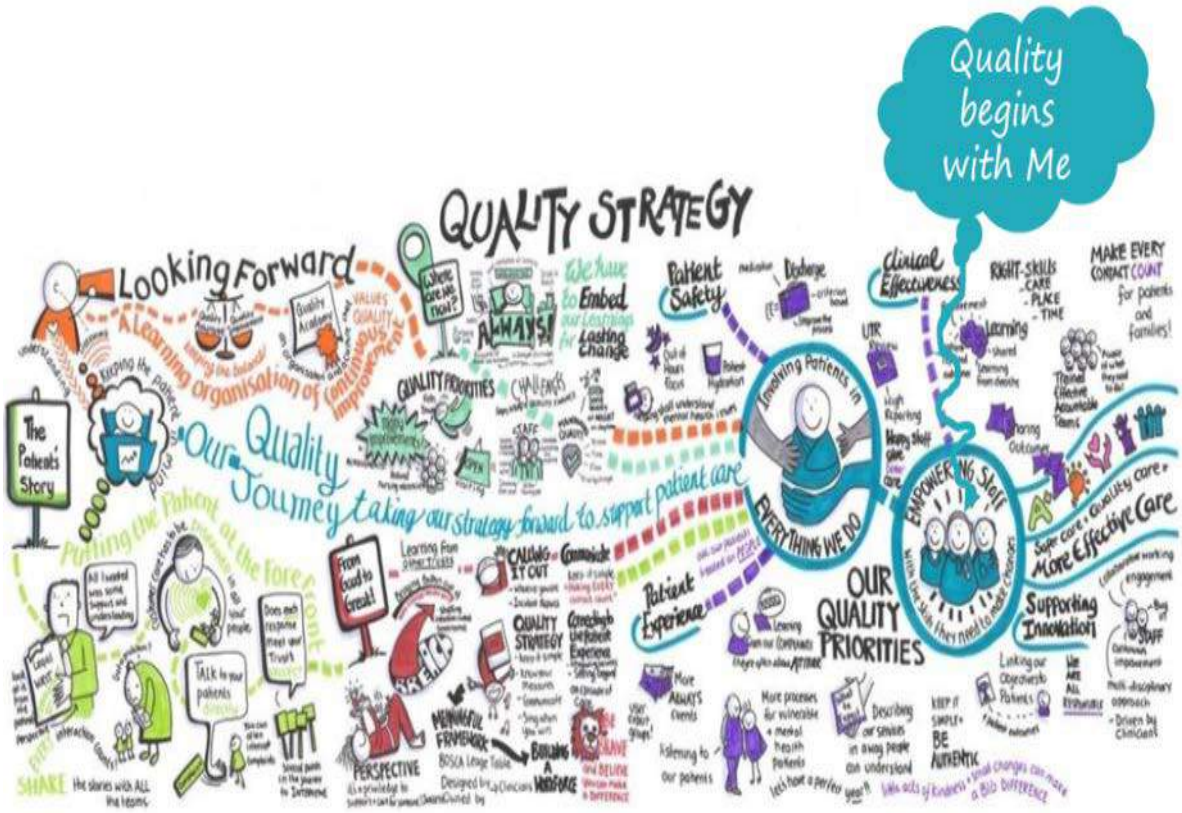
2018 audit results demonstrating 94% ECHO compliance. We await confirmation from the Integrated Medicine Clinical Business Unit Manager regarding further plans for weekend cover for ECHO.

The 2017 audit for Clinical Standard 6 shown that all but interventional Radiology was provided seven days per week. Following this, an SLA was put in place with the Countess of Chester to provide Interventional Radiology out of hours and during the weekend. This action was evaluated in the 2018 audit and took the Trust to full compliance.

We currently meet the standard for Clinical Standard 8. In 2017, acute care has a significant reliance on Locum Consultants. Efforts have been made to recruit Locums with appropriate sub-speciality training and experience and to recruit substantive consultants. Winter plans include rostered Consultant ward rounds for 'medical outliers' and prioritisation of acute patients and patients for discharge to maintain flow.

Quality Report Part 3 - Trust Overview of Quality

Patients are at the centre of everything we do and providing high quality service for every one of our patients is at the heart of our organisation.



Pictured above is an illustration of our Quality Strategy for 2018/21.

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 vision is that we will be the change we want to see in the world of health and social care.

To support our overall aim we have developed a Quality Strategy to ensure that all staff who work in our hospitals strive for excellence in all that they do and believe that the focus of the organisation is on providing safe care, which is responsive, caring and effective in terms of providing good outcomes for our patients.

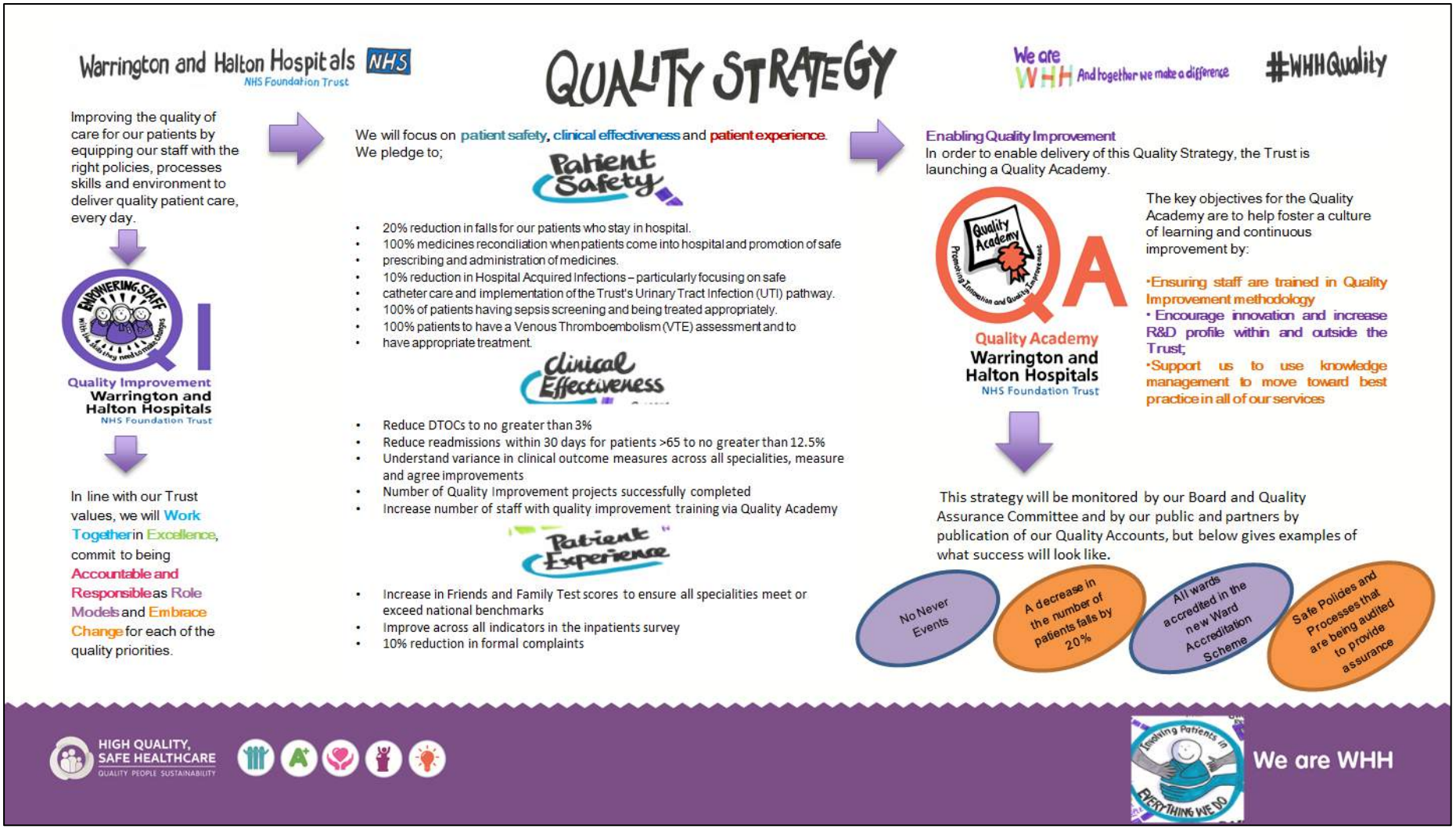
The Quality strategy has been developed based first and foremost to ensure patients are safe in our care; secondly, to provide patients with the best possible clinical outcomes for their individual circumstances; and thirdly, to deliver an experience of hospital care which is as good as it possibly can be. With the above care model in mind we use the following three priority domains:


Patient
Safety


Clinical
Effectiveness


Patient
Experience

3.2 Quality Strategy on a page



3.3 Data Sources

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

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

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

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

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

3.4 Quality Dashboard 2018/19

The clinical indicators in the Quality Dashboard have been reviewed in line with the revised requirements for 2018/19 in relation to the:-

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

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

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

3.5 Quality Indicators – rationale for inclusion

The following section provides an overview of the quality of care offered by the Trust based on performance in 2018/19 against a minimum of 3 indicators for each area of quality namely patient safety; clinical effectiveness and patient experience. These indicators were selected by the Board in consultation with stakeholders and discussions with the Quality in Care Committee of the Council of Governors. In the main, the Trust has employed indicators which are deemed to be of local and national importance to the quality of care for patients.

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

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

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

The quality indicators for 2018/19 included:

Patient Safety

- Safer Surgery
- E-prescribing
- Increase Incident Reporting

Clinical Effectiveness

- Diagnostics
- Ward Accreditation
- Discharge

Patient Experience

- Child Friendly
- Rapid Discharge Process
- Bereavement Services

The above indicators have been reported in section 2 of this report.

3.6 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 progress of cases over the year within the Trust.

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
PHSO cases received	0	0	1	0	0	0	0	0	0	0	0	0
PHSO cases closed	0	1	1	2	1	1	0	0	0	0	0	0
Ongoing PHSO Cases at the end of 2018/19 = 7												

3.7 National Survey Results 2018 - National Inpatient Survey 2018 (published but under embargo, date to be confirmed)

Listening to patients' views is essential to providing a patient-centred health service. The annual National Inpatient Survey is a Care Quality Commission (CQC) requirement with the aim of obtaining feedback to improve local services for the benefit of the patients and the public. Survey results are reported to the CQC, who use the information as part of the Hospital Intelligent Monitoring. Patients are eligible for the survey if they are aged over 16 years or older, and have spent at least one night in hospital, and were not admitted to maternity or psychiatric units.

The 2018 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 (2018) were received in March 2019. 1250 patients were randomly selected during an inpatient stay in July 2018 and 41% responded compared to a response rate of 35% last year.

The NHS in patient survey provides the Trust with intelligence around the overall patient experience and it is vital that we review and act upon this information to address poor performance.

The Picker Institute coordinates all the national results on behalf of the CQC, who publish reports which include benchmarks against best and worst performance. Seventy-six questions are asked and categorized into twelve domains as follows:

- Admission to hospital
- A&E Department
- Waiting List and Planned Admission
- All types of Admission
- The Hospital and Ward
- Doctors
- Nurses
- Your Care and Treatment
- Operations and Procedures
- Leaving Hospital
- Overall views on care and Services
- About you

The following are examples of improvement for 2018 benchmarked against 2017 results using the suppressed standardised data provided by Quality Health:

The Trust has improved by 5% or more on the following questions: Results- *Higher is better*		
	2017	**2018**
Were you ever bothered by noise at night from other patients?	**59.4%**	**64.8%** 
On the day you left hospital, was your discharge delayed for any reason?	**56.7%**	**63.2%** 

What was the MAIN reason for the delay?	**59.6%**	**68.4%** 
How long was the delay?	**70.1%**	**77.0%** 

A high majority of scores for Warrington and Halton Hospitals NHS Foundation Trust are in the intermediate 60% range of Trusts surveyed by Quality Health. 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.

Areas of focus for improvement have been recommended as the hospital ward, where the highest concentrations of the scores in the bottom 20% were found. The Ward Accreditation Scheme within the Trust will help to improve this rating as the aim is to engage staff and empower leadership to ensure we deliver the highest standards of healthcare for our patients.

The National Inpatient Survey key themes had been reviewed in full and have been scrutinised. There has been significant work undertaken by the CBUs, with the implementation of the five work streams of the Patient Experience strategy, led by Lead Nurses and Allied Health Professionals, who provide monthly updates to the Patient Experience Sub Committee. Warrington and Halton Hospitals NHS Foundation Trust have taken the following actions in response to the personal needs of our patients;

- #EndPJParalysis is a global social movement embraced by nurses, therapists and medical colleagues, to get patients up, dressed and moving. Having patients in their day clothes while in hospital, rather than in pyjamas (PJs) or gowns, enhances dignity, autonomy and, in many instances, shortens their length of stay.
- Morning Movers is an exercise class on ACCU to achieve increased patient activity to help improve patient mood, promote healthy lifestyle behaviours and improve patient outcomes. The exercise classes are 15 minutes, low intensity with an adapted tai chi approach.
- Always Events Pilot in conjunction with NHS England, using Quality Improvement and Patient Experience Methodology. WHH are part of the advisory group and we have provisionally agreed an Always Event®, in the patient voice " *I will always know about my discharge plans"*
- Bedside Booklet - This booklet was designed after consulting our patients and staff, to provide patients with general information about our hospitals and services.
- The Welcome to the Ward Board is an efficient tool that improves patients and visitors experience within hospital wards.

- Lack of sleep due to noise on wards is a common problem in hospitals world-wide. Warrington and Halton Hospitals are reducing noise at night through their "*Have a good night*" scheme.
- Developed an alert system for patients living with a Learning Disability/Dementia accessing outpatient services to ensure we are providing adequate support at appointments.
- A Customer Care Strategy has been developed within the Trust.
- Finger foods for patients living with dementia are now provided by our catering services.
- Maternity acupuncture has been offered at Warrington for the last 3 years. The Clinic runs every Saturday in the Antenatal Clinic (ANC). The most common conditions treated:
    - Lower back & pelvic pain
    - Sciatica
    - Headaches & migraines
    - Nausea & vomiting
    - Low level anxiety & insomnia
    - Hay fever & sinusitis
    - Preparation for birth

3.9 Friends and Family

The NHS Friends and Family Test is an opportunity for patients to leave feedback on their care and treatment they received at Warrington and Halton NHS Foundation Trust. The feedback will be used to review our services from the patient perspective and enable us to celebrate success and drive improvements in care.

When patients visit our Accident and Emergency (A&E) Department for treatment, or are admitted to hospital, they are asked to complete a short postcard questionnaire when they are discharged. They basically tell us how likely they are to recommend the ward/ A&E department to friends and family if they needed similar care or treatment. The patient's response is anonymous and they will be able to post the card into the confidential box on their way out of the ward or A&E. The boxes are emptied regularly to process the information and provide reports to the ward manager and matron.

If a patient is unable to answer the question, a friend or family member is welcome to respond on their behalf. Users are also asked to rate their responses and this is translated into a rating which is reported through to the board via the Quality Dashboard.

The Trust has in place an FFT contract in order to improve the process and increase the response rate e.g. text services.

The results for 2017/2018 and 2018/19 are as follows:

Friends and Family scores 2017/2018 and 2018/2019

	Inpatient	Inpatient	A&E	A&E

	2017/18	2018/19	2017/18	2018/19
Apr	97%	94%	97%	85%
May	97%	94%	93%	86%
Jun	97%	95%	97%	83%
Jul	95%	95%	85%	84%
Aug	95%	97%	86%	86%
Sept	94%	96%	84%	81%
Oct	95%	94%	79%	81%
Nov	94%	94%	82%	78%
Dec	95%	96%	82%	81%
Jan	90%	94%	85%	76%
Feb	95%	94%	82%	77%
Mar	94%	96%	81%	80%

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

3.10 Duty of Candour

During 2018/19, the Clinical Governance team have further developed processes to ensure that monitoring is in place by utilising and reporting through the Trust incident system, Datix. To support this process, weekly monitoring reports continue to be provided for the Executive and operational teams and compliance is monitored by the Clinical Governance team at their weekly investigation meeting. Compliance with Duty of Candour is also now reviewed at the weekly Executive Meeting of Harm chaired by the Chief Nurse and continues to be reported monthly to the Patient Safety & Clinical Effectiveness Sub-Committee.

The Director Integrated Governance & Quality conducted an audit of duty of candour in 2018. Whilst the process for monitoring via Datix was in place it was agreed as an action, that a quality assurance check of all related duty of candour correspondence was to be undertaken by the Clinical Governance Managers prior to any letter being sent from the Trust and this has helped support further improvements in the process.

In order to ensure that staff are aware and understand the importance of Duty of Candour, the staff guidance leaflet continues to be sent out as part of the induction pack for each new member of staff. During April 2018/19 and is also discussed at the Corporate Trust induction.

For each new serious incident (SI) investigation, a patient or family liaison officer continues to be appointed to provide support and advice. A 2 day programme of training for senior clinical staff commenced in October 2018 related to investigation and includes a bespoke session on the role of the patient/ family liaison officer role. The Trust has also developed an on-line training package for duty of candour that will be launched shortly and all staff will be requested to complete this in line with the Clinical Governance and Trust TNA that has been developed for duty of candour.

3.11 Staff Survey Indicators

The most 2018 NHS Staff Opinion Survey results for the themes of Equality, Diversity and Inclusion and Safety Environment – Bullying and harassment are as follows:-

Equality, Diversity and Inclusion

The Trust scored 9.3 for this theme overall, comparing to the Acute Trust average of 9.1.

For question 14- Does your organisation act fairly with regards to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age the Trust scored 89.1% compared to the Acute Trust average of 83.9%. This was a slight reduction since 2017 where the Trust scored 89.3% but this is not considered significant and demonstrates a consistent response to this question.

Safety Environment – Bullying and Harassment

The Trust scored 8.4 for this theme overall, compared to the Acute Trust average of 7.9.

For question 13b – In the past 12 months how many times have you personally experienced bullying, harassment or abuse at work from managers? The Trust scored 10.1% which is an improvement on the 2017 score of 10.3% and lower than the Acute Trust average of 13.7%.

For question 13c – In the past 12 months how many times have you personally experienced bullying, harassment or abuse at work from other colleagues? The Trust scored 14.5% which is an improvement on the 2017 score of 16.9% and lower than the Acute Trust average of 20.0%.

3.12 Quality Academy

In order to enable delivery of the Quality Strategy the Trust has launched a Quality Academy.

Objectives

Key priorities for the Quality Academy are:

- **Part of an enabling arm to deliver the Clinical and Quality Strategies.**
- **Help you to implement innovative ideas.**

- **Training in QI Methodology.**
- **Ensuring QI work is linked in with our quality priorities for the service/Trust to stop duplication and silo-working.**
- **Encourage innovation and increase R&D profile within and outside the Trust – maximising opportunities for patients to take part in research.**
- **Support to move toward best practice – benchmarking ourselves against best in class – therefore using knowledge management.**

Quality Improvement & Training

We are using Quality Improvement Methodology to deliver Quality Improvement within the Trust.

There will also be a training programme developed within the Trust based on the model shown, whereby there will be differing levels of Quality Improvement training given to individuals within the Trust. All staff will receive Foundation Level training, as part of induction.

Pictured above are the first recipients of the QI Foundation Training certificate.

Engagement

Key to ensuring that we are addressing the right issues with regard to the service we provide is to actively seek, listen and act on feedback received from our patients, the public, our staff and groups such as Governors, HealthWatch and Health Scrutiny Committees.

The Quality Academy therefore will link to work being undertaken with the Patient Experience and patient involvement agenda to ensure that the patient voice is integral to Quality Improvement.

Also the Quality Academy will work with Workforce & Organisational Development, to ensure that staff can engage in the agenda and are given the empowerment and support to make improvements in their work.

Update on work to date

Quality Academy Strategic Aim 1:

Develop a reputation for enabling excellence in clinical research, linking into national and international opportunities.

NHS Warrington and Halton Hospitals NHS Foundation Trust

Working with industry, Clinical Research Network and academic partners to maximise external R&D opportunities

- Dr Salih has been recruited to Clinical Lead for R D & I Partnerships and due to start in April 2019.
- Terms of Reference for Trust R&D Forum reviewed and includes horizon scanning for new research opportunities.

Quality Academy Strategic Aim 1:

Develop a reputation for enabling excellence in clinical research, linking into national and international opportunities.

NHS Warrington and Halton Hospitals NHS Foundation Trust

Raise the profile of R&D internally and externally with a strong communications strategy, branding and marketing, utilising current social media platforms.

- Clinical Directors membership of the Trust R&D Forum from March 2019 onwards.
- 21st June – Quality Academy Open Day – promoting research to Trust staff alongside the other functions.
- Staff research repository created.

Quality Academy Strategic Aim 2:

We will be at the forefront of benchmarking ourselves against evidence-based best practice standards and ensuring staff use quality improvement as the basis for making and measuring change

NHS Warrington and Halton Hospitals NHS Foundation Trust

Offering and enabling Trust staff to develop the skills and capabilities for quality improvement, through a suite of training

- Foundation QI now on Trust Induction for new staff.
- Foundation QI e Learning available for current Trust staff from April 2019 in partnership with the Innovation Agency.
- Practitioner QI training monthly session available from April 2019.
- Advanced QI training available September 2019

Quality Academy Strategic Aim 3:

Create a culture and environment were all Trust staff can develop and test new and creative methods

NHS Warrington and Halton Hospitals NHS Foundation Trust

- Dr Farag appointed to Clinical Lead for RD & Innovation post.
- 21st June – Quality Academy Open Day – working with the Innovation Agency to bring SMEs to WHH to provide potential solutions to Clinicians.
- Intellectual Property policy and Innovation Pathway in development.

INNOVATION AGENCY

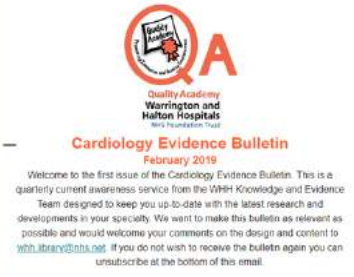
Quality Academy Strategic Aim 4:

Be the provider of choice for knowledge management and library services within the Cheshire & Mersey

NHS Warrington and Halton Hospitals NHS Foundation Trust

Proactive knowledge management to ensure that Trust staff are able to respond to the ever-changing needs of healthcare, so that we can ensure that our patients receive the most up to date, clinically effective treatments

- We maintained our Libraries Quality Assurance Framework rating of 100% in December 2018.
- Range of knowledge bulletins created per Specialty – latest practice-changing evidence on the desktop



QA

Quality Academy
Warrington and Halton Hospitals
NHS Foundation Trust

Cardiology Evidence Bulletin

February 2019

Welcome to the first issue of the Cardiology Evidence Bulletin. This is a quarterly current awareness service from the WHH Knowledge and Evidence Team designed to keep you up-to-date with the latest research and developments in your specialty. We want to make this bulletin as relevant as possible and would welcome your comments on the design and content to whh.library@nhs.net. If you do not wish to receive the bulletin again you can unsubscribe at the bottom of this email.

3.13 Local Quality Initiatives

Trust Safety Huddle and Morning Safety Brief

Launched in May 2018, a daily 15 minute huddle brings representatives from all wards and departments together supported by Corporate Support Services to look at: Safety issues, Hot Topic of the week, Bright Spots and any HALT moments (where a service is stopped due to Patient Safety concerns). Issues are resolved swiftly and a global email brief is sent within the hour.

Conversation Cafes – What Matters to Me?

Supported by our elected (public) governors we use 'conversation cafes' to offer a pop up opportunity to engage patients, visitors and staff.

In year we have engaged large numbers at both hospitals on topics such as 'our strategy', what matters to you in OPD, what matters to you in ED and 'A new hospital for Halton'. The concept has now established with two monthly Carers Cafes at both sites.

Electronic transfer of care to community pharmacy

In collaboration with NHS England and the North West Academic Health Science Network, the Trust went live with PharmOutcomes in May 2018.

This system enables the hospital pharmacy to inform the community pharmacy when a patient has been admitted to hospital, and send medication updates at the point of discharge.

Learn, Earn and Return Scheme

We welcomed our first cohort of overseas doctors in collaboration with WWL and King Edward Memorial Hospital in India. Four qualified doctors are here for two years on the MCh/MMed Wrightington Learn/Earn and Return scheme.

Integrated Care - Frailty Assessment Unit

The Frailty Assessment Unit (FAU) opened as part of a pilot scheme in 2018 and is now open 7-days per week. It works on a "Home First" philosophy providing rapid access to a specialist multi-disciplinary team for people identified as living with frailty. During the FAU pilot we successfully discharged 86.1% of the patients, with appropriate support, back home – avoiding inevitable admission and an average LOS of 10 days for this cohort.

Design of Contemporary Ward – the WREN Unit

We engaged our patients and clinicians to develop a modern clinical setting by taking action through collaboration and empowering our patients through enablement. Action, Collaboration, Enablement! We redesigned the model of care for a clinical setting that accepts patients no longer in need of acute care but still not yet ready to return home.

Always Events

Our Radiology team led the way in adopting the national 'Always Events' programme at WHH. Using this framework they established a multidisciplinary team to challenge assumptions; learn from patients about both what was wrong AND what 'good' looks like. Genuine co-design has brought people together, published in Synergy (Radiography Journal, July 18) and poster at UKRC. The service now offers volunteer-supported meet and greet, enjoys closer teamwork between different modalities, has a process to continually hear the patient voice and really positive patient feedback.

3D Ear Mould Scanner

We are the first NHS provider in the country to currently offer ear mould scanning. The service benefits children and patients living with dementia who regularly lose their aids, as the image is scanned on to the system they do not have to return to hospital to have another scan to replace their hearing aids.

First in UK to Launch the NEWS2

We were the first in the UK to launch the revised National Early Warning Score (NEWS2).

Key improvements include:

- Better identification of patients likely to have sepsis
- Improved scoring for patients with hypercapnic respiratory failure
- Recognising the importance of new-onset delirium or confusion

End to End Text Reminder and Feedback Service

The Trust launched a new appointment text reminder service in June 2018 followed by the feedback module enabling real time collection of data and feedback from our patients. DNAs were 57K in 2016 – 2017 (circa 12%) and have reduced to the national average of 8%.

Fully accessible website for all

The Trust launched a fully accessible, mobile- enabled website in November 2018 supporting access for those for whom English is not their first language and for those with visual impairments.

E-Outpatient scheduling system – BookWise

In June 2018 the Trust launched the electronic Outpatient Clinic Scheduling System, BookWise. This reduces the administration time to book and cancel Outpatient Clinics and the real-time ability of the system ensures notifications are instant, resulting in the efficient use of Clinic time and resources.

3.14 Patient Stories - In their own words….our patients share their experiences of our Trust

A&E Warrington

"After a fall backwards in my wheelchair I found it necessary to visit A&E at Warrington Hospital last Monday afternoon.

The welcome I received from the receptionist was professional and I was referred to Minors where I was seen by a Nurse Practitioner, who treated me as a person, not just looking at my damaged shoulder, she also took into account my ongoing long-term health condition, which as you know is tetraplegia after a spinal injury. She was both caring and compassionate.

I was referred for an x-ray; once again the staff were caring and considerate. Finally I was seen by an A&E Doctor who also considered my ongoing difficulties, my lifestyle, work and home life, not just my shoulder.

The good news was that I hadn't broken anything, but it is a badly torn muscle which requires physiotherapy.

I hope you don't mind me sending you this email, but in times when A&E Departments are at full stretch and the NHS staff and services are under constant public scrutiny, I thought it would be nice to say Thank You.

What made the real difference was not just the care and compassion, but more so, the fact was that staff looked at me the person, not just a patient with a damaged shoulder. This was the attitude and behaviour I encouraged during my 20 years in the NHS and continue to today through lecturing at universities and colleges."

Radiology Warrington

"I attended Radiology as a day case. Outstanding care for the entire day. Made sure I was calm and kept well informed of the medical procedure throughout the day. Extremely professional and caring"

Anti-coagulant service Warrington

"All the nursing staff are excellent in both renal and anticoagulant services and the department that I attend on a regular basis are a polite, friendly and helpful team, they deserve recognition"

Ward A6 Warrington

"They are very efficiently organised and take the time to explain what is happening. My stay on this ward was a really good experience due to the dedication and commitment of the staff."

Endoscopy Halton

"Everyone was kind and considerate. Lovely ward and lovely staff. Treated with total dignity and respect."

Neonates Warrington

"There was absolutely nothing the staff on neonatal could have done more, they were always extremely professional, friendly, informative and caring"

Cheshire and Merseyside Treatment Centre

"Such a high standard of care in all areas; from the consultant and anaesthetist, to all nursing staff. You are treated with professionalism, care and empathy. The practical advice given is excellent too and on discharge, I feel confident that I have received the appropriate information and care."

Frailty Assessment Unit

"Such lovely people, very attentive. Good explanations, just a lovely atmosphere."

Diabetes Clinic Warrington

"Excellent service, quick book in, seen promptly, treated excellently."

Ward B12 Warrington

"The staff on this ward are fabulous they are caring and dedicated to the patients. Mum has been in hospital for 7 weeks and have thrived and blossomed into the Mum we love and know and it's all down to the care she has received on this ward."

3.15 Performance against key national priorities

Performance against the relevant indicators and performance thresholds. 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.

Figures in red are not finalised

National Targets and Minimum Standards	Indicator	2018/19 Threshold	2018/19 Position	2018/19 Reporting period	2017/18 Position
Infection Control	Number of clostridium difficile cases due to lapses in care	<= 27	4	Apr-Mar	3
	Number of MRSA blood stream infection cases	0	2	Apr-Mar	1
Cancer: 31 day wait from diagnosis to treatment	% of cancer patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	98.86%	Apr-Mar	98.17%
Cancer: 31 day wait for second or susequent treatment	Anti cancer drugs	98%	100.00%	Apr-Mar	100.00%
	Surgery	94%	100.00%	Apr-Mar	98.20%
Cancer: 62 day wait for first treatment	From urgent GP referral (pre-allocation position)	85%	86.75%	Apr-Mar	82.81%
	From the consultant screening service	90%	97.46%	Apr-Mar	97.35%
Cancer: 2 week wait from referral to date first seen	Urgent GP referral suspected cancer referrals	93%	93.82%	Apr-Mar	91.51%
	Symptomatic breast patients (cancer not initially suspected)	93%	93.01%	Apr-Mar	91.51%
Referral to Treatment within 18 weeks	Admitted patients with a clock stop		80.01%	Apr-Mar	78.52%
	Non-admitted patients with a clock stop		90.83%	Apr-Mar	92.46%
	Patients on an Incomplete pathway End of March position	92%	92.45%	Apr-Mar	92.35%
Access to A&E	Patients waiting a maximum of 4 hours in A&E from arrival to admission, transfer or discharge	95%	85.11%	Apr-Mar	88.67%
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	Apr-Mar	YES
Cancelled operations on the day for a non-clinical reason	Number of Cancellations not offered a date for readmission within 28 days	0	10	Apr-Mar	10
	Patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital	<= 2%	0.60%	Apr-Mar	0.86%
	Patients whose operations were cancelled by the hospital for non-clinical reasons on day of or after admission to hospital, and were not readmitted within 28 days		8.17%	Apr-Mar	8.08%

NB: 62 day pre-allocation indicator is based on information for the period from April 2018 - September 2018 which is based on national data, and from October 2018 - March 2019 this is based on the latest local information as at the 10th May 2019

3.16 Training & Appraisal

Training and Appraisal Completion

	Target	Year End Results
Mandatory Training		
Health & Safety	85%	95.85%
Fire Safety	85%	88.98%
Manual Handling	85%	90.22%
Additional Fire Safety and Manual Handling sessions are in place to improve these figures.		
Staff Appraisal		
Non-medical		
Medical & Dental staff	85%	86.34 %
Medical & Dental (excluding consultants)		
Consultants		

3.17 Rota Gaps

The following is how the Trust identifies and then covers a medical rota gap:

For wards

- The assistant CBU managers for each three CBUs with the medical utilisation manager (MUM) and an administrator meet every Thursday to discuss ward cover prospectively for three weeks
- Gaps in medical cover on the wards are identified; this could be due to study leave, annual leave, or on-call commitments
- Between the three CBUs the locum medical staffing is shared to cover the wards to at least the minimum established staffing levels. The rota is then updated. Junior doctors on training posts from HEE are not moved unless deemed absolutely necessary on the day. Every effort is made to find locum cover; this includes advertising the gap through agencies and to doctors on the Trust bank
- WhatsApp messages are sent to all doctors as well to explore if any on AL would be interested in covering the gap

For on-call

- Most rota gaps are known about well in advance. The only unpredictable gaps arise due to sickness on the day. When this occurs, the MUM and administrator review the ward cover and see if any medical doctors can be released to support the on-call rota. Every effort is made not to disrupt the formal CMT/FY2/FY1 training sessions.
- All doctors on AL would also be emailed and called to explore whether any would like to cover the gap on the day
- The post is also advertised via the Trust Bank and agencies
- WhatsApp messages are also sent to all doctors as well to explore if any on AL would be interested in covering the gap

3.18 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 patients with a maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

SMHI (Summary hospital-level indicator).

Annex 1: Quality Report Statements

Statements from Clinical Commissioning Groups, Healthwatch and Overview and Scrutiny Committees 2018/19

Statements from the following stakeholders are presented within this document unedited by the Trust and are produced verbatim.

Statement from Warrington and Halton Clinical Commissioning Groups

NHS
Warrington
Clinical Commissioning Group

NHS
Halton Clinical Commissioning Group

Ms M Pickup
Chief Executive
Warrington and Halton
Hospitals NHS Foundation
Trust
Lovely Lane
Warrington

Second Floor
Arpley House
110 Birchwood Boulevard
Birchwood
Warrington
WA3 7QH

01925 843636

24th May 2019

Dear Mel,

Re: Quality Accounts 2018 - 2019

I am writing on behalf of partners to express our thanks for the submission of Warrington and Halton Hospitals NHS Foundation Trust Quality Report for 2018-2019 and for the presentation given by Kimberley Salmon-Jamieson, Chief Nurse and Ursula Martin, Director of Governance to local stakeholders on 10th May 2019. This letter provides the response from both NHS Halton and NHS Warrington Clinical Commissioning Groups to the Quality Account Report 2018-2019.

NHS Halton and NHS Warrington CCGs understand 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 & NHS Warrington CCGs noted the Priorities and progress made in 2018 – 2019:

- CQC all Must Do and Should do Action completed.

Patient Safety

- Progress in Sepsis recognition and care
- NEWS2 Implementation – first in country
- £9m investment in Quality
- Development of a Quality Academy
- Daily Trust-wide Safety Huddle
- Ward Accreditation

Clinical Effectiveness

- Mental Health improvement work
- Dementia and Frailty care improvement
- How our clinicians have embraced Use of Resources framework (SLR, Carter, Model Hospital, GIRFT)
- Partnership working and collaborative e.g. Stroke, Frailty
- Development of new WHH Strategy

1

NHS Warrington Clinical Commissioning Group

NHS Halton Clinical Commissioning Group

- Integration system working - One Halton, Warrington Together
- Alliance with Bridgewater Community Healthcare
- Use of technology including e-rostering and ePMA
- Became a Lorenzo Digital Exemplar Trust – one of four in UK
- Opening GPAU, new Ambulatory Care, Discharge Suite
  - 493 more admissions to Assessment Units
  - 193 less admissions to Inpatient wards
  - 418 more patients discharged home with zero LOS

Patient and Staff Experience

- Improvement in patient and staff satisfaction scores
- Our People Strategy
- Patient & Public Participation and Involvement with Carers, Children & Young People, and Maternity Voices 'Whose Shoes?' Complaints Focus Group
- NHS Staff Survey results improved
- Staff engagement – LiA
- Engagement in Clinical Strategy

Workforce

- Significant Workforce investment and Innovation
- Learning Framework developed and implemented
- New and embedded quality governance framework
- Training and appraisal improvement
- Recruitment to Nursing and AHP workforce.

Stakeholders acknowledged the open, honest and transparent presentation to partners given by the Chief Nurse and Director of Governance on the journey taken to date by the Trust, which acknowledge areas of concern, areas for improvement and highlighted good practice. The short video presented was well received and allowed for questions to be posed and answered. The Getting to Good, Moving to Outstanding Programme was welcomed and seen as an area of good practise.

NHS Halton & NHS Warrington CCGs noted the Trusts Improvement Priorities for 2019 – 2020:

- **Priority 1** – Patient Safety
  We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.
  - 10% reduction in the number of Hospital Acquired Pressure Ulcers
  - 5% reduction in Gram Negative Bloodstream Infections (GNBSI)
  - 10% reduction in the number of Serious Harm Falls
- **Priority 2** – Clinical Effectiveness
  We will improve outcomes, based on evidence and deliver care in the right place, first time, and every time.
  - Improve standard 2 of the 7 day service standard – Time to first contact review in Paediatrics and Surgery.
  - Ensure the Trust is involved in National Quality Improvement Collaborative for Nutrition, Maternity and NELA with measurable improvements.

NHS Warrington Clinical Commissioning Group

NHS Halton Clinical Commissioning Group

- Work with the Innovation Agency and external partners to embed a culture of innovation with the Trust.

- **Priority 3** – Patient Experience
  We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, clean, well fed and well cared for.
  - Development of the Trust Patient and Public Involvement Strategy with agreed measures for delivery.
  - Increase timeliness of responses to formal complaints.
  - Development of a Midwifery Led Unit.

NHS Halton & Warrington CCGs recognise the challenges for providers in the coming year and we look forward to working with the Trust during 2019-2020 to deliver continued improvement in service quality, safety and patient experience and also on strengthening integrated partnership working to deliver the greatest and fastest possible improvement in people's health and wellbeing by creating a strong, safe and sustainable health and care system that is fit for the future.

NHS Halton & Warrington CCGs would like to congratulate the trust on the hard work of its staff and their commitment to the care of the people of Halton and Warrington, thanking local staff and managers for their on-going commitment locally and for the opportunity to comment on the draft Quality Account for 2018/2019.

Yours sincerely,

Michelle Creed.

Michelle Creed
Chief Nurse

Cc
Kimberley Salmon-Jamieson
Dr Andrew Davies

β

Statement from the Halton Health Policy Performance Board

HALTON BOROUGH COUNCIL

Mel Pickup
Chief Executive
Warrington and Halton Hospitals NHS
Foundation Trust
Lovely Lane
Warrington
Cheshire
WA5 1QG

Our Ref EST/WHH

If you telephone 0151 511 7398
please ask for: Emma Sutton-Thompson

Date 16th May 2019

E-mail address Emma.Sutton-Thompson@halton.gov.uk

Dear Mel,

Quality Accounts 2018 - 2019

Further the Joint Quality Accounts event held on 10th May 2019 that your colleagues Kimberley Salmon-Jamieson and Ursula Martin attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

During the year 2018/19 the Board were pleased to note that Warrington and Halton Hospitals NHS Foundation Trust (WHH) made progress against the following areas:

- The Launch of the WHH Quality Academy empowering staff to make changes to improve the quality of care;
- The Bereavement Service changes including the re-location of the office to Cheshire House and the purchase of z-beds to enable family members to stay overnight if they wish;
- E-prescribing went live at Ward B4 and Halton Theatres which included staff engagement, staff training and intensive staff support.

The Board were very pleased to view WHH video and thought it really captured some of the improvements that have taken place at the Trust over the last two years. It would be a useful tool to use in Halton to help promote WHH to residents.

It's all happening IN HALTON

People Directorate
Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 511 6941

North West

HALTON
BOROUGH COUNCIL

The Board are pleased to note the following Improvement Priorities for 2019 – 2020 and look forward to hearing about progress on these next year:

- **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; and
- **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 Board would like to thank WHH for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Joan Lowe

Councillor Joan Lowe
Chair, Health Policy and Performance Board

It's all happening IN HALTON

People Directorate
Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0151 511 6941

North West

Statement from Warrington Healthwatch

Healthwatch Warrington is pleased to be asked to review Warrington and Halton Hospitals' 2018-19 Quality Account (QA) and think about the current and future priorities in the document. As Warrington's consumer champion for health and social care, we recognise the impact that patient experiences have in shaping the quality and safety of services.

We look at the trust's performance in relation to four key questions:

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?

Whilst Healthwatch Warrington receives much positive feedback from service users, areas highlighted for further improvement include quality of care across different specialties, diagnosis and communication, and end of life care.

The report states a 41% inpatient survey response rate (512/1250 surveyed), increased from 35% last year, with improved results for 13/18 questions, and a focus on leaving hospital and discharge as areas to try and improve. It would be useful to include details of what had improved, and what still needed work.

Family and friend scores have reduced slightly this year in A&E compared to last year (although data is incomplete); mean score 2017-18 inpatient 95% A&E 86%; mean score 2018-19 inpatient 95% A&E 82%. We know from taking part in the Trust patient experience subcommittee meetings that this reflects increased demand in A&E and the Trust are working to improve people's experience of this service.

The Trust has 7 ongoing cased referred to Parliamentary Health ombudsman; this is very similar to last year. The report no longer gives comparative data so it is not clear if there were more complaints received but not upheld, or benchmarking data compared to other Trusts. This data could help readers understand the seriousness of complaints made to the Trust, and how the Trust compares to other similar hospitals.

The Trust is building on its aims from previous years to continue to improve standards and quality of care. The report shows the trust is aware of areas that still need improvement, such as discharge process, response to complaints, and communication.

From what people have told local Healthwatch, is there evidence that any of the basic things are not being done well by the provider?

Healthwatch Warrington does not have evidence of system-wide failure to provide health care within the Trust.

Is it clear from the draft Quality Account that there is a learning culture within the provider organisation 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?

The culture of quality improvement is clear throughout the report. The Trust has developed a Quality strategy and a Quality Academy to drive learning.

Reporting on last year's priorities highlights progress in key areas:

Increase Incident Reporting. Staff have been encouraged to report incidents, to promote a learning culture, and make changes to protect patients from harm. The Quality Account states that 10304 incidents were reported this year, from the graph this appears to be similar to those reported last year.

Review the Trust Diagnostics Policy. New policy standards have been drawn up, put into practice and audited, although results of the audit were not given.

Discharge – Improve the quality and timeliness of discharge summaries. Training and a spot audit have been performed but no results reported.

Ward accreditation. A set of quality standards to has been developed based on national standards, and rolled out across all the wards, creating an incentive to improve and maintain quality care.

Improve the Rapid Discharge Process for End of Life Care patients. A new policy was drawn up and put into practice with positive feedback, although we have received some negative feedback around communication in end of life care, and will continue to monitor this.

Ensure that the Trust has processes and services in place to support families and loved ones following bereavement. New folding beds have been purchase, a leaflet updated and the bereavement room relocated with positive feedback.

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?

The Trust's priorities for improvement are: hospital acquired pressure ulcers, Gram negative bloodstream infections, serious harm falls, assessment of patients for the risk of venous thromboembolism, medicines reconciliation, time to first consultant review, patient and public involvement strategy, improving timeliness of complaints and development of the Midwifery Led Unit.

Healthwatch Warrington expects that work in all of these areas should drive improvement across a range of services provided by the Trust. We are pleased that the Trust has set an ambitious aim to increase how quickly they respond to formal complaints. At the presentation day, the Trust explained that it aims to respond to 90% of complaints within 30 days. The current response rate was given as 60%; we hope the Trust can achieve this new ambitious target. We will continue to work with the Trust through patient experience subgroup to monitor this. The Trust continues to encourage incident reporting; both of these work streams should improve quality, and response to complaints is key to improving communication and how happy people are with services. It is disappointing that no details on how the Trust Patient and Public Involvement Strategy will be developed, driven or measured. As patient experience is key to improving quality, we would like this detail when it is available, and to work with the Trust to ensure the patient voice is heard. We congratulate the trust on public involvement ideas such as the children's ambassador role and involving young people their families and carers into plans to make adult areas of the hospitals more comfortable for them. These show the commitment of the trust to include the voice of patients, carers and their families in the work of the hospitals.

We appreciate that the Quality Account needs to report certain data in a particular way. However, Healthwatch Warrington is concerned that the use of medical terms without simple explanation, incomplete data and implementation plans, affect the readability of this document. We would like to see next year's Quality Account to be more accessible to service users, their carers and families, so that they are aware of the high quality care provided by the Trust, and the plans to improve this.

Statement from Warrington Health and Well Being Overview and Scrutiny Committee

A formal letter of response wasn't received from the committee but the following email was received;

From: Kellock, Adam [mailto:akellock@warrington.gov.uk]
Sent: 28 May 2019 17:11
To: MCCAFFREY, Hayley (WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST)
Subject: RE: FAO - WARRINGTON HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE - Consultation on Warrington and Halton NHS Trust DRAFT Quality Report (Account) 2018-19 [<AX65139>]

Hi Hayley,

I can confirm that the Health Scrutiny Committee have no comments on the draft quality report.

Kind Regards
Adam Kellock
Senior Democratic Services Officer
Warirngton Borough Council
Tel: 01925 442144
Email: akellock@warrington.gov.uk

Statement from the Halton Healthwatch

healthwatch Halton

Mel Pickup
Chief Executive
Warrington & Halton Hospitals NHS FT
Lovely Lane
Warrington
Cheshire
WA5 1QG

Healthwatch Halton
Suite 5, Foundry House
Widnes Business Park,
Waterside Lane
Widnes
WA8 8GT

Tel 0300 777 6543

28th May 2019

Dear Mel,

Re: Quality Account 2018-2019

We welcome the opportunity to provide a commentary on Warrington & Halton Hospitals NHS Foundation Trust Quality Account for 2018-2019.

The Trust is to be congratulated on a clear and comprehensive report which gives an excellent overview of the work carried out during the past year to improve the quality of services.

In responding to the Quality Account we have based our response on guidance from Healthwatch England:

- 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?
- From what people have told Healthwatch Halton, is there evidence that any of the basic things are not being done well by the provider?
- 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?
- 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?

We are pleased to see the progress made by the Trust on the priorities for 2018-2019.

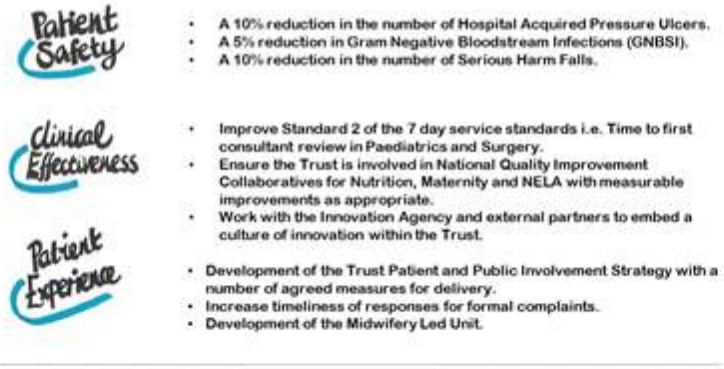
From public feedback we've received, during our outreach work in the local community and at both hospital sites, we believe the Quality Account reflects people's real experiences of using the service. Our recent report, following visits to wards at both Halton Hospital and Warrington Hospital, included a great deal of positive feedback from patients.

healthwatch Halton

We welcome the launch of the Trust's new Quality Strategy and the introduction of the Quality Academy. We can see throughout the Quality Account that the Trust is showing a firm commitment to improve the quality of care for patients.
During the past year we have had regular experience of working with, and offering challenge to the Trust. We have noted, during this time, a willingness to learn and improve from the experiences of patients. We feel the Quality Account correctly highlights this learning culture within the Trust.

On 10th May 2019 we attended a joint Quality Accounts event in Halton where the Trust's Chief Nurse and Director of Governance presented a summary of the Quality Accounts. The presentation was both open and transparent in highlighting the progress made and the journey yet to be covered. The short video was excellent and gave a real flavour of some of the recent improvements at the Trust.

We are pleased to note the 3 quality priorities for 2019-2020; Patient Safety, Clinical Effectiveness and Patient Experience.



We look forward to seeing progress on all 3 priorities during the next year. In particular, with regards to Patient Experience, we would welcome the opportunity to work closely with the Trust on this priority area.

Kind regards

Dave Wilson
Manager - Healthwatch Halton

Statement from the Trust's Council of Governors

Statement from the Trust's Council of Governors 2018/2019

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Account for 2018/19.

The Quality Report is very detailed and thorough and assists the Governors in holding the Non-Executive Directors to account for the performance of the Board of Directors.

As Governors one of our prime roles, is to focus on quality. As part of the Council's governance structure it meets regularly at its Governor Quality in Care Group. At the Governor Quality in Care Group, the Governors receive the latest performance information and have the chance to analyse it and raise questions. The Governors have a observer at the Trusts Quality committee who reports to the CoG on the effectiveness of the NED in the role of Chair of the Trusts Quality committee.

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 Reducing harm and focus on no avoidable deaths. The Patient Experience Priority. Focus on patients "No discussion about me without me". Finally, Governors see the Clinical Effectiveness Priority regarding, the focus on improves outcomes, right place, first time, every time as a key area for delivery of a better all-round patient path through the hospital.

The Governors are happy that the 2018/19 Quality Report provides data that is more meaningful, understandable and clearer to all, the report shows indicating trends, and comparisons with the previous year statistics. For the coming year the Governors will review the Quality Report quarterly at our Quality in Care Group thus being up to date through out the year.

Governors find the format and section headings helpful. The Quality Report contains considerable detail commensurate with the complex and diverse range of services provided by an Acute Hospital Trust. The Governors believe the Quality Report to be accurate. The graphs and accompanying explanations help the public and members to understand clearly the progress made in many areas of patient safety and patient care.

Governors encourage all Trust members and others who are interested in our hospitals and their performance to read the Quality Report.

Annex 2: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 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 2018 to date of signing this statement
    - Papers relating to Quality reported to the Board over the period April 2018 to date of signing this statement
    - Feedback from the Commissioners, Warrington Clinical Commissioning Group and Halton Clinical Commissioning Group dated May 2019
    - Feedback from Governors dated May 2019
    - Feedback from local Healthwatch organisations, Healthwatch Halton dated xxx and Healthwatch Warrington dated May 2019
    - Feedback from Overview and Scrutiny Committee dated May 2019
    - Feedback from Halton Borough Council dated May2019
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 7th May 2019
    - The 2018 national inpatient survey under embargo until June
    - The 2018 national staff survey published 2019
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2019
    - CQC inspection report dated November 2017

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate

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

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

By order of the Board

Xxx Date…… Steve McGuirk **Chairman**

xxx **Date**…… Mel Pickup **Chief Executive**

[NB: sign and date in any colour ink except black]

Independent Auditor's 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

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 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer to discharge
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers We refer to these national priority indicators collectively as "the indicators".

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 2018/19' 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 2018/19' 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 2018/19'; 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' 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 2018 to 28 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 28 May 2019;
- feedback from commissioners dated 24 May 2019;
- feedback from governors;
- feedback from Halton Borough Council dated 16 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 7 May 2019;
- the national in-patient survey dated June 2018;
- the 2018 national staff survey dated 26 February 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2019;
- 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 these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Warrington and Halton 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 2019, 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 against supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' 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 that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' 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.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 2018/19' 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 2018/19'; and
- the indicators in the Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP

Chartered Accountants

The Colmore Building
20 Colmore Circus
Birmingham
B4 6AT

28 May 2019

Trust name:	Warrington and Halton Hospitals NHS Foundation Trust
This year:	2018/19
This year ended:	31 March 2019
This year beginning:	1 April 2018

Foreword to the accounts for the year 1 April 2018 to 31 March 2019

Warrington and Halton Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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
23 May 2019

We are
WHH

NHS
Warrington and
Halton Hospitals
NHS Foundation Trust

23 May 2019

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester

Dear Sirs

Warrington and Halton Hospitals NHS Foundation Trust
Financial Statements for the year ended 31 March 2019

This representation letter is provided in connection with the audit of the financial statements of Warrington and Halton Hospitals NHS Foundation Trust for the year ended 31 March 2019 for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2018-19.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i. As Trust Board members, we have fulfilled our responsibilities under the National Health Services Act 2006 for the preparation of the financial statements in accordance with International Financial Reporting Standards and the Department of Health and Social Care Group Accounting Manual 2018-19 (GAM); in particular the financial statements are fairly presented in accordance therewith.

ii. We have complied with the requirements of all statutory directions affecting the Trust and these matters have been appropriately reflected and disclosed in the financial statements.

iii. The Trust has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of the Care Quality Commission or other regulatory authorities that could have a material effect on the financial statements in the event of noncompliance.

iv. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

v. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

vi. In calculating the amount of income to be recognised in the financial statements from other NHS organisations we have applied judgement, where appropriate, to reflect the appropriate amount of income expected to be derived by the Trust in accordance with the International Financial Reporting Standards and the GAM. We are satisfied that the material judgements used in the preparation of the financial statements are soundly based, in accordance with International Financial Reporting Standards and the GAM, and adequately disclosed in the financial statements. There are no other material judgements that need to be disclosed.

vii. We acknowledge our responsibility to participate in the Department of Health and Social Care's agreement of balances exercise and have followed the requisite guidance and directions to do so. We are satisfied that the balances calculated for the Trust ensure the financial statements and consolidation schedules are free from material misstatement, including the impact of any disagreements.

viii. Except as disclosed in the financial statements:

a. there are no unrecorded liabilities, actual or contingent
b. none of the assets of the Trust has been assigned, pledged or mortgaged
c. there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

ix. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards and the GAM.

x. All events subsequent to the date of the financial statements and for which International Financial Reporting Standards and the GAM require adjustment or disclosure have been adjusted or disclosed.

xi. We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your Audit Findings Report. The financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

xii. Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of International Financial Reporting Standards.

xiii. We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

Information Provided

xiv. We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
b. additional information that you have requested from us for the purpose of your audit; and
c. unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

xv. We have communicated to you all deficiencies in internal control of which management is aware.

xvi. All transactions have been recorded in the accounting records and are reflected in the financial statements.

xvii. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

xviii. We have disclosed to you all information in relation to fraud or suspected fraud that we are aware of and that affects the Trust and involves:

a. management;
b. employees who have significant roles in internal control; or
c. others where the fraud could have a material effect on the financial statements.

xix. We have disclosed to you all information in relation to allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

xx. We have disclosed to you all known instances of noncompliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxi. We have disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which we are aware.

xxii. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

xxiii. The Trust has reported a deficit of £16 million during the year ended 31 March 2019 and, as of that date, the Trust's current liabilities exceeded its current assets by £26.7 million. The Trust is expecting to extend repayment terms for £22.1m of loan liabilities scheduled to be repaid during 2019-20. Agreement to this has not yet been confirmed with the Department of Health and Social Care. These events or conditions, along with other matters as set forth within note 1.2 to the financial statements, indicate that a material uncertainty exists that may cast significant doubt on the Trust's ability to continue as a going concern.

Although these factors represent a material uncertainty that may cast significant doubt over the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the GAM, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future.

Annual Report

xxiv. The disclosures within the Annual Report fairly reflect our understanding of the Trust's financial and operating performance over the period covered by the financial statements.

Annual Governance Statement

xxv. We are satisfied that the Governance Statement fairly reflects the Trust's risk assurance framework and we confirm that we are not aware of any significant risks that are not disclosed within the Governance Statement.

Approval

The approval of this letter of representation was minuted by the Trust's Audit Committee at its meeting on 21 May 2019

Yours faithfully

Name: Mel Pickup

Position: Chief Executive

Date: 23rd May 2019

Name: Andrea McGee

Position: Director of Finance

Date: 23rd May 2019

Signed on behalf of the Governing Body

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2019

	NOTE	2018/19 £000	2017/18 £000
Income from activities	3	210,888	209,235
Other operating income	3	32,349	25,496
Operating income	3	**243,237**	**234,731**
Operating expenses	4	(256,387)	(246,412)
OPERATING DEFICIT		**(13,150)**	**(11,681)**
FINANCE INCOME / (EXPENSE)			
Finance income - interest receivable	7	85	30
Finance expense - interest payable	8	(784)	(536)
PDC dividends payable		(2,002)	(2,465)
NET FINANCE COSTS		**(2,701)**	**(2,971)**
Net losses on disposal of assets	9	(168)	(4)
DEFICIT FOR THE FINANCIAL YEAR		**(16,019)**	**(14,656)**
Other comprehensive expense			
Items that will not be reclassified to income and expenditure			
Net impairment losses on property, plant and equipment	10	4	8,229
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(16,015)**	**(6,427)**
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		(16,019)	(14,656)
TOTAL		**(16,019)**	**(14,656)**
(b) Total comprehensive expense for the period attributable to:			
(i) non-controlling interest, and		0	0
(ii) owners of the parent		(16,015)	(6,427)
TOTAL		**(16,015)**	**(6,427)**

The notes on pages 5 to 37 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019

	NOTE	31 March 2019 £000	31 March 2018 £000
NON-CURRENT ASSETS			
Intangible assets	11	2,049	2,461
Property, plant and equipment	12	127,023	126,634
Trade and other receivables	15	827	907
Total non-current assets		**129,899**	**130,002**
CURRENT ASSETS			
Inventories	14	3,484	3,264
Trade and other receivables	15	15,287	11,969
Cash and cash equivalents	17	2,124	2,209
Total current assets		**20,895**	**17,442**
CURRENT LIABILITIES			
Trade and other payables	18	(21,693)	(23,209)
Borrowings	20	(24,304)	(14,665)
Provisions	22	(353)	(420)
Other liabilities	19	(1,267)	(2,361)
Total current liabilities		**(47,617)**	**(40,655)**
Total assets less current liabilities		**103,177**	**106,789**
NON-CURRENT LIABILITIES			
Borrowings	20	(34,621)	(22,238)
Provisions	22	(1,242)	(1,315)
Total non-current liabilities		**(35,863)**	**(23,553)**
TOTAL ASSETS EMPLOYED		**67,314**	**83,236**
TAXPAYERS' EQUITY			
Public dividend capital		89,245	89,152
Revaluation reserve		30,711	30,707
Income and expenditure reserve		(52,642)	(36,623)
TOTAL TAXPAYERS' EQUITY		**67,314**	**83,236**

The primary accounts on pages 1 to 4 and the notes on pages 5 to 37 were approved by the Audit Committee on 21 May 2019 on behalf of the Trust Board using the powers delegated to the Committee and signed on its behalf by Mel Pickup, Chief Executive.

Signed: ..... Date: 23 May 2019

Mel Pickup
Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2019

	Total Taxpayers' Equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity as at 1 April 2018	83,236	89,152	30,707	(36,623)
Deficit for the year	(16,019)	0	0	(16,019)
Transfers between reserves	0	0	0	0
Net impairments on property, plant and equipment	4	0	4	0
Revaluation gains on property, plant and equipment	0	0	0	0
Public Dividend Capital received	93	93	0	0
Public Dividend Capital repaid	0	0	0	0
Taxpayers' equity as at 31 March 2019	**67,314**	**89,245**	**30,711**	**(52,642)**

	Total Taxpayers' Equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity as at 1 April 2017	88,253	87,742	22,478	(21,967)
Deficit for the year	(14,656)	0	0	(14,656)
Transfers between reserves	0	0	0	0
Net impairments on property, plant and equipment	8,229	0	8,229	0
Revaluation gains on property, plant and equipment	0	0	0	0
Public Dividend Capital received	1,410	1,410	0	0
Public Dividend Capital repaid	0	0	0	0
Taxpayers' equity as at 31 March 2018	**83,236**	**89,152**	**30,707**	**(36,623)**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2019

	NOTE	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating deficit from continuing operations		**(13,150)**	**(11,681)**
Non-cash income and expense			
Depreciation and amortisation	4	5,967	5,583
Impairments and reversals	4	1,100	(449)
Income recognised in respect of capital donations	3	(245)	(59)
(Increase) / decrease in trade and other receivables	15	(3,876)	1,837
(Increase) / decrease in inventories	14	(220)	173
Increase / (decrease) in trade and other payables	18	(1,782)	3,597
Increase / (decrease) in other liabilities	19	(1,094)	1,224
Increase / (decrease) in provisions	22	(140)	79
Other movements in operating cash flows		1	18
Net cash used in operations		**(13,439)**	**322**
Cash flows from investing activities			
Interest received	7	85	30
Purchase of intangible assets	11	(394)	(808)
Purchase of property, plant and equipment	12	(6,314)	(4,749)
Sales of property, plant and equipment		19	0
Receipt of cash donations to purchase capital assets	3	122	59
Net cash used in investing activities		**(6,482)**	**(5,468)**
Cash flows from financing activities			
Public Dividend Capital received		93	1,410
Movement in loans from Department of Health and Social Care	20	22,165	8,645
Capital element of finance lease	20	(358)	(347)
Interest on loans	8	(681)	(505)
Other interest	8	(5)	0
Interest element of finance lease	8	(14)	(25)
Public Dividend Capital dividend paid		(1,364)	(3,024)
Net cash used in financing activities		**19,836**	**6,154**
Increase / (Decrease) in cash and cash equivalents		(85)	1,008
Cash and cash equivalents as at 1 April		2,209	1,201
Cash and cash equivalents as at 31 March	17	**2,124**	**2,209**

NOTES TO THE ACCOUNTS

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

International Accounting Standard (IAS) 1 requires the management of all entities to assess, as part of the accounts preparation process, the bodies' ability to continue as a going concern. This is further enforced by Department of Health requirements to review the trust's going concern basis on an annual basis, the going concern principle being the assumption that an entity will remain in business for the foreseeable future.

This is to facilitate the accounting basis to be used in the preparation of the Trust's annual accounts. Should an assessment be made that an entity is not a going concern then the year end balance sheet should be prepared on a 'disposals' basis i.e. items valued at their likely sale value. In many cases this would propose significantly lower values than the usual valuations based on ongoing trading (e.g. stocks) and require the inclusion of other 'winding up costs' (e.g. redundancies).

The Trust's accounts for 2018/19 have recorded a deficit of £16.0 million and the cumulative deficit position on retained earnings amounts to £52.6 million. The Statement of Financial Position shows negative net current assets and liabilities of £26.7 million.

In line with national guidance the annual plan (2019/20) has been submitted and assumes revenue support to support a planned deficit of £0.2 million. This results in a breakeven control total that has been agreed with NHS Improvement.

The Trust is due to repay loan principal of £22.1 million to the Department of Health and Social Care during 2019/20. It is anticipated that the repayment terms of these loans will be extended and that these payments will not be required during 2019/20. This has not yet been confirmed with the Department of Health and Social Care.

In accordance with IAS 1, management has made an assessment of the Trust's ability to continue as a going concern considering the significant challenges described above. Although these factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts and the financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Note 1.3 Key sources of judgement and estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the judgements that management have made in the process of applying the Trust's accounting policies, together with the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting period that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year.

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 SoFP 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 NHS Resolution. The Trust accepts financial liability for the value of each claim up to the excess defined within the policy.

Allowances for credit losses (previously provision for impairment of receivables)
An allowance for credit losses has been made for amounts which are uncertain to be received from NHS and non-NHS organisations as at 31 March 2019. The allowance includes 21.89% (22.84% for 2017/18) of accrued Injury Cost Recovery (ICR) income to reflect the average value of claims withdrawn as advised by the Department of Health's Compensation Recovery Unit (CRU).

Asset valuations and lives
The value and remaining useful lives of land and building assets are estimated by Cushman & Wakefield who provide professional valuation services. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the DHSC and HM Treasury. Valuations are carried out primarily on the basis of Depreciated Replacement Cost based on the Modern Equivalent for specialised operational property (property rarely sold on the open market) and Current Value in Existing Use for non-specialised operational property.

The Trust commissioned Cushman & Wakefield to provide a 'desk top' revaluation for land and buildings and a review of asset lives for buildings as at 1 April 2017 and 31 March 2018, on the basis that a reprovision of services would be provided from a single site.

The changes following revaluation have been reflected with the 2018/19 annual accounts. A full asset valuation is undertaken every five years with an annual 'desk top' valuation being undertaken in the intervening years. The next full asset valuation is due on 31 March 2021. Market Value was used in arriving at fair value for the assets subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

The lives of equipment assets are estimated on historical experience of similar equipment lives with reference to national guidance and consideration of the pace of technological change. Operational equipment is carried at its cost less any accumulated depreciation and any impairment losses. Where assets are of low value and / or have short useful economic lives, these are carried at depreciated historical cost as a proxy for current value.

Software licences are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Employee benefits
The cost of annual leave entitlement not taken is accrued at the year end. Accruals are calculated using actual entitlement outstanding for Trust employees based on actual point of their salary band (Note 5.1).

Note 1.4 Income

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The Trust acts as a host for the Health and Care Partnership for Cheshire and Merseyside and uses the pooled fund to commission services on behalf of the strategic partnership. In doing so the Trust acts as a principal and treats amounts collected from other parties as revenue. It accounts for these amounts and payments to the ultimate provider of services on a gross basis. Amounts distributed to partner organisations on behalf of NHSE or others are accounted for on a net basis.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges or penalties raised by commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.1 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income (SoCI) to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 Income (continued)

Where income is received for a specific activity that is to be delivered in a future financial year that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

The main sources of other operating income are from the DHSC, Health Education England, NHS Trusts, NHS Foundation Trusts and Local Authorities.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment related payments such as social security costs and the apprenticeship levy 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 financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme. The cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the Government Financial Reporting Manual (FReM) requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in International Accounting Standard (IAS) 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Note 1.5 Expenditure on employee benefits (continued)

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from 1 April 2019. The DHSC have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 1.6 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.

Note 1.7 Intangible assets

Note 1.7.1 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.

Note 1.7.2 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'.

Note 1.7 Intangible assets (continued)

Amortisation
Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8 Property, plant and equipment

Note 1.8.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- collectively, a number of items which have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

The whole of a site is designated as the property asset with the land, the separate buildings upon it and the external works being the main components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.8.2 Measurement

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 SoFP 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 has used alternative site valuation from 2017/18 onwards. The Trust commissioned Cushman & Wakefield to undertake a 'desk top' valuation as at 31 March 2019. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the SoFP date. Fair values are determined as follows:

- Land and non specialised buildings - market value for existing use.
- Specialised buildings - depreciated replacement cost.
- Equipment - depreciated historical cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing 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.

Note 1.8 Property, plant and equipment (continued)

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income (SoCI) in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful 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-SoFP PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenses.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the SoCI as an item of 'other comprehensive income / expenses'.

Impairments

At the end of the financial year the Trust reviews whether there is any indication that any of its assets have suffered an impairment loss. If there is an indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

In accordance with the GAM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses, and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve, where at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments, such as unforeseen obsolescence, are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains and classed as 'other operating income'.

Note 1.8 Property, plant and equipment (continued)

Note 1.8.3 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 abandoned 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 life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.8.4 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.

Note 1.9 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.9.1 The Trust as lessee

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 charge 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 SoCI. 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.

Note 1.9 Leases (continued)

Note 1.9.2 The Trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust''s net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.10 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.

Note 1.11 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).

Note 1.12 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 SoFP 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 0.29% (0.10% in 2017/18) in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution (Note 4) to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to operating expenses. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is not recognised in the Trust's accounts (Note 22).

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions and any excesses payable in respect of successful claims are charged to operating expenses as and when the liability arises.

Note 1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 23 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 23, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 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.

Note 1.15 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 2017/18).

Note 1.16 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 SoFP date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the SoFP 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.

Note 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the 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).

Note 1.18 Public dividend capital (PDC) and PDC dividend

PDC is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the DHSC 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. Provider Sustainability Fund (PSF) year end incentives are also excluded from the calculation.

In accordance with the requirements laid down by the DHSC (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.

Note 1.19 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.

Note 1.20 Consolidation

The Trust is the corporate Trustee to Warrington & Halton Hospitals NHS FT Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to effect those returns and other benefits through its power over the fund.

The Charitable Fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102.

The Trust has opted not to consolidate charitable funds with the main Trust Accounts in 2018/19 because they are immaterial. This will be reviewed each year for appropriateness.

Note 1.21 Other subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the SoFP.

The amounts consolidated are drawn from the published accounts of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains / losses are eliminated in full on consolidation.

Subsidiaries classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Note 1.22 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'.

Note 1.22 Interests in other entities (continued)

Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statement its share of the assets, liabilities, income and expenses.

Note 1.23 Financial assets and financial liabilities

Note 1.23.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, i.e. on receipt or delivery of the goods or services.

Note 1.23.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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 described below.

Financial assets and liabilities are classified and subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the SoCI and a financing income or expense. In the case of loans held from the DHSC, the effective interest rate is the nominal rate of interest charged on the loan.

Note 1.23 Financial assets and financial liabilities (continued)

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12 month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

In determining the classification of financial assets the Trust has considered both the business model and associated cash flows for the collection of contractual income that are solely payments of principal and interest. Financial assets are measured at amortised cost. Contract receivables will initially be measured at their transaction price, as defined by IFRS 15 adjusted for any allowance for expected credit losses using a general approach.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the SoCI and reduce the net carrying value of the financial asset in the SoFP.

Note 1.23.3 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 expired.

Note 1.24 Reserves

Note 1.24.1 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 DHSC. A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable to the DHSC as the public dividend capital dividend.

Note 1.24 Reserves (continued)

Note 1.24.2 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.

Note 1.24.3 Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Note 1.25 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.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.27 Accounting standards and interpretations issued but not yet adopted

The GAM does not require the following Standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury FReM adoption.

IFRS 16 (Leases) - Application required for accounting periods beginning on or after 1 January 2019, this standard has been deferred for the public sector until 1 April 2020. Therefore not yet adopted by the FReM, early adoption is not therefore permitted.

IFRS - International Financial Reporting Standard
FReM - Government Financial Reporting Manual
GAM - Group Accounting Manual

Note 2. Operating segments

The Trust has considered segmental reporting and the Chief Executive and the Board receive sufficient and appropriate high level information to enable the business to be managed effectively and to monitor and manage the strategic aims of the Trust. Sufficiently detailed information is used by middle and lower management to ensure effective management at an operational level. Neither of these are sufficiently discrete to profile operating segments, as defined by IFRS 8, that would enable a user of these financial statements to evaluate the nature and financial effects of the business activities that this Trust undertakes. Therefore, the Trust has decided that it has one operating segment for healthcare.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Acute services		
Elective income	30,296	33,477
Non elective income	61,791	62,154
First outpatient income	13,404	13,719
Follow up outpatient income	20,351	19,363
A & E income	14,288	13,371
High cost drugs income from commissioners	10,693	11,502
Other NHS clinical income	54,116	54,467
All services		
Private patient and overseas patients income	187	108
AfC pay award central funding	3,001	0
Other non-protected clinical income	2,761	1,074
Total income from activities	**210,888**	**209,235**

Note 3.2 Income from patient care activities (by source)	2018/19 £000	2017/18 £000
Income from patient care activities received from:		
NHS England	12,100	15,789
Clinical Commissioning Groups	190,999	188,328
NHS Foundation Trusts	1,130	778
NHS Trusts	11	9
Local Authorities	1,958	1,995
Department of Health and Social Care	3,001	0
NHS Other	164	248
Non NHS : private patients	124	50
Non NHS : overseas patients	63	58
Injury cost recovery scheme	1,007	1,074
Non NHS Other	331	906
Total income from activities	**210,888**	**209,235**

All income from activities relates, in its entirety, to continuing operations for 2018/19 and 2017/18.

Note 3.3 Overseas visitors (relating to patients charged directly by the Trust)	2018/19 £000	2017/18 £000
Income recognised this year	63	58
Cash payments received in-year	56	61
Amounts added to provision for impairment of receivables	2	0
Amounts written off in-year	5	0

Note 3. Operating income (continued)

Note 3.4 Other operating income	**2018/19 £000**	**2017/18 £000**
Education and training	9,359	9,480
Education and training - Notional income from apprenticeship fund	152	31
Donation of assets	123	0
Cash donations / grants for the purchase of assets	122	59
Non-patient care services to other bodies	2,664	593
Provider Sustainability Fund / Sustainability and Transformation Fund income (PSF / STF)	6,770	4,298
Income in respect of staff costs where accounted on gross basis	0	2,248
Rental revenue from operating leases	211	233
Other *	12,948	8,554
Total other operating income	**32,349**	**25,496**

All other operating income relates, entirety to continuing operations for 2018/19 and 2017/18.

*** Analysis of other operating income 'other'**		
Car parking	1,997	1,863
Catering	196	173
Pharmacy sales	49	48
Property rentals	205	29
Staff accommodation rentals	98	42
Estates recharges	432	815
Information Technology recharges	134	392
Clinical tests	1,185	1,727
Other**	8,652	3,465
Total other operating income 'other'	**12,948**	**8,554**

**Other contains £3.169m of insurance income which is as a result of a fire which occurred on 21 March 2018 (£0.08m 17/18)

Note 3.5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of Trust failure. This information is provided in the table below.

	2018/19 £000	**2017/18 £000**
Income from services designated as commissioner requested services	207,940	208,053
Income from services not designated as commissioner requested services	2,948	1,182
Total	**210,888**	**209,235**

Note 3.6 Fees and charges

HM Treasury requires disclosure of fees and charges in respect of charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. There haven't been any costs exceeding £1m in either 2018/19 or 2017/18.

Note 3.7 Additional information on revenue from contracts with customers recognised in the period	**2018/19 £000**
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,108
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	(200)

Note 4. Operating expenditure

Note 4.1 Operating expenses	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	422	485
Purchase of healthcare from non-NHS and non-DHSC bodies	270	0
Staff and executive directors costs	182,262	173,717
Remuneration (non-executive directors)	116	115
Supplies and services (clinical; excluding drug costs)	19,801	19,772
Supplies and services (general)	2,693	2,599
Drug costs	15,879	16,587
Consultancy costs	1,708	1,000
Establishment	2,225	2,056
Premises (business rates)	1,086	1,067
Premises (other)	8,874	7,307
Transport (business travel only)	281	279
Transport (including patient travel)	572	629
Depreciation on property, plant and equipment	5,161	4,928
Amortisation on intangible assets	806	655
Net impairments	1,100	(449)
Movement in credit loss allowance: contract receivables/assets	669	0
Increase in impairment of receivables	0	111
Provisions arising / released in year	45	0
Change in provisions discount rate	16	14
Audit services (statutory audit)	56	58
Other auditor remuneration (external auditor only) - analysis in note 4.2	7	6
Internal audit costs	96	95
Clinical negligence, liability to third parties and property expenses scheme premiums	8,023	11,592
Legal fees	284	211
Insurance	94	92
Education and training - non-staff	768	962
Education and training - notional expenditure funded from apprenticeship fund	152	31
Operating lease expenditure	2,136	1,987
Redundancy	72	39
Losses and special payments	66	221
Other expenditure	647	246
Total operating expenses	**256,387**	**246,412**

All operating expenses relate, in their entirety, to continuing operations for 2018/19 and 2017/18.

Note 4.2 Other audit remuneration

The total paid to the Trust's external auditors for other remuneration amounted to £7k (2017/18 £6k).

Note 4.3 Limitation on auditor's liability

The external auditors' liability is limited to £2m. The scope of work for the external auditors is to provide a statutory audit of annual accounts and report and provide opinion on them to the Trust and the Trust's Council of Governors. This will be conducted in accordance with the Audit Code for NHS Foundation Trusts (the Audit Code) issued by Monitor in accordance with paragraph 24 of schedule 7 of the National Health Service Act 2006 schedule 10 of the National Health Service Act 2006 with due regard to the Comptroller and Auditor General's Code of Audit Practice (the Code) issued by the National Audit Office (NAO) in April 2015.

Note 5. Staff

Note 5.1 Employee expenses

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	130,878	128,145
Social security costs	12,607	11,922
Apprenticeship levy	619	586
Pension costs (employer contributions to NHS Pensions)	14,900	14,201
Pension costs (other)	76	16
Termination benefits	72	138
Bank and agency staff	23,341	18,906
Total employee benefit expenses	**182,493**	**173,914**
Less costs capitalised as part of assets	(159)	(158)
Total per employee expenses in Note 4.1	**182,334**	**173,756**

Employee costs include staff costs of £159k (£158k in 2017/18) which have been capitalised as part of the Trust's capital programme. These amounts are excluded from employee expenses (Note 5.1). The employee expenses table above is for executive directors, staff costs and redundancy payments only. It excludes non-executive directors.

An accrual in respect of the cost of annual leave entitlement carried forward at the SoFP date of £33k has been provided for within the accounts (£123k as at 31 March 2018).

Note 5.2 Early retirements due to ill-health

Three members of staff retired early on ill-health grounds during the year at an additional cost of £190k (one member of staff at a cost of £106k for the year ending 31 March 2018). The cost of ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

Note 6. Operating leases

Note 6.1 Operating lease income	2018/19 £000	2017/18 £000
Lease receipts recognised as income in the year	211	233
Total	**211**	**233**

Future minimum lease receipts due:	2018/19 £000	2017/18 £000
Not later than one year	173	195
Later than one year and not later than five years	690	781
Later than five years	5,204	6,512
Total	**6,067**	**7,488**

Note 6.2 Operating lease payments and commitments

Lease payments recognised as an expense in year:	2018/19 £000	2017/18 £000
Minimum lease payments	2,103	1,959
Contingent rents	33	28
Total	**2,136**	**1,987**

Future minimum lease payments due on:	2018/19 £000	2017/18 £000
Land leases:		
Not later than one year	96	94
Later than one year and not later than five years	111	204
Later than five years	0	0
Total	**207**	**298**
Building leases:		
Not later than one year	222	174
Later than one year and not later than five years	792	692
Later than five years	1,120	1,253
Total	**2,134**	**2,119**
Other leases:		
Not later than one year	1,118	1,610
Later than one year and not later than five years	3,454	3,601
Later than five years	4,191	4,629
Total	**8,763**	**9,840**
All leases:		
Not later than one year	1,436	1,878
Later than one year and not later than five years	4,357	4,497
Later than five years	5,311	5,882
Total	**11,104**	**12,257**

Note 7. Finance revenue

	2018/19 £000	2017/18 £000
Interest on bank accounts	85	30
Total	**85**	**30**

Note 8. Finance expenditure

Note 8.1 Finance expenditure

	2018/19 £000	2017/18 £000
Capital Loans with the DHSC	24	26
Working Capital Loans with the DHSC	741	407
Interest on Finance Lease Obligations	14	25
Interest on Late Payment of Debt	5	72
Interest other	0	6
Total interest expense	**784**	**536**
Unwinding of discount on provisions	0	0
Other finance costs	0	0
Total finance expenditure	**784**	**536**

Note 8.2 The Late Payment of Commercial Debts (Interest) Act 1998

The total paid within 2018/19 for late payment of commercial debt was £5k (£72k in 2017/18).

Note 9. Other Gains / (Losses)

	2018/19 £000	2017/18 £000
Gains on disposal of property, plant and equipment	0	0
Losses on disposal of property, plant and equipment	(168)	(4)
Total net losses on disposal of assets	**(168)**	**(4)**

Note 10. Impairment of assets

	2018/19		
Impairments due to change in market price:	**Net Impairments £000**	**Impairments £000**	**Reversal of Impairments £000**
Loss or damage from normal operations	40	40	0
Unforeseen obsolescence	23	23	0
Loss as a result of a catastrophe	0	0	0
Change in market price	1,037	1,068	(31)
	1,100	1,131	(31)
Impairments charged to operating expenses			
Impairments charged to the revaluation reserve	(4)	1,936	(1,940)
Total impairments due to change in market price	**1,096**	**3,067**	**(1,971)**

	2017/18		
Impairments due to change in market price:	**Net Impairments £000**	**Impairments £000**	**Reversal of Impairments £000**
Loss or damage from normal operations	0	0	0
Unforeseen obsolescence	0	0	0
Loss as a result of a catastrophe	146	146	0
Change in market price	(595)	646	(1,241)
	(449)	792	(1,241)
Impairments charged to operating expenses			
Impairments charged to the revaluation reserve	(8,229)	1,251	(9,480)
Total impairments due to change in market price	**(8,678)**	**2,043**	**(10,721)**

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 conduct a 'desk top' revaluation exercise as at 31 March 2019. This was applied to the accounts on 31 March 2019. A full revaluation exercise is carried out every five years with the next one being due 31 March 2021.

A full asset valuation is undertaken every five years with an annual 'desk top' valuation being undertaken in the intervening years. Any increase in valuation which reverses a previous impairment has been credited to other operating income, to the extent of what has been charged there already relating to the asset. Any remaining balance has been credited to the revaluation reserve.

The Trust suffered a fire in the Kendrick Wing on 23 March 2018. Cushman & Wakefield undertook additional valuations of this element of the Warrington site with the resulting impairment in value of the building being reflected in the 2017/18 impairment figures in note 10. There are no further impairments in respect of this for 2018/19.

In November 2018 the RICS clarified their guidance on the application of IAS 16 in respect of assessment of asset lives. This has required Cushman & Wakefield to reassess their approach which will result in reduced asset lives and a significant increase in depreciation charges. The Trust is implementing this change in guidance on 1 April 2019.

Note 11. Intangible assets

	Software licences £000
Cost as at 1 April 2018	**4,510**
Additions - purchased	394
Additions - donated	0
Impairments	0
Disposals	0
Cost as at 31 March 2019	**4,904**
Accumulated amortisation as at 1 April 2018	**2,049**
Provided during the year	806
Disposals	0
Accumulated amortisation as at 31 March 2019	**2,855**
Cost as at 1 April 2017	**3,702**
Additions - purchased	808
Additions - donated	0
Impairments	0
Disposals	0
Cost as at 31 March 2018	**4,510**
Accumulated amortisation as at 1 April 2017	**1,394**
Provided during the year	655
Disposals	0
Accumulated amortisation as at 31 March 2018	**2,049**
Net book value as at 31 March 2019	**2,049**
Net book value as at 31 March 2018	**2,461**

All intangible assets are owned assets.

	Minimum Life Years	Maximum Life Years
Software licences	2	10

Note 12. Property, plant and equipment

Note 12.1 Property, plant and equipment 2018/19	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 2018	**145,349**	**12,250**	**98,446**	**1,267**	**1,261**	**19,590**	**101**	**11,556**	**878**
Additions - purchased	6,589	0	2,894	0	1,493	1,292	0	865	45
Additions - leased	0	0	0	0	0	0	0	0	0
Additions - donation of physical assets (non-cash)	123	0	0	0	0	123	0	0	0
Additions - assets purchased from cash donations	122	0	0	0	0	122	0	0	0
Impairments charged to operating expenses	0	0	36	(36)	0	0	0	0	0
Impairments charged to revaluation reserve	(1,936)	0	(1,934)	(2)	0	0	0	0	0
Reversal of impairments credited to operating expenses	0	0	0	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	1,940	1,750	190	0	0	0	0	0	0
Revaluations	(3,092)	0	(3,023)	(69)	0	0	0	0	0
Disposals	(1,319)	0	0	0	0	(1,319)	0	0	0
Cost or valuation as at 31 March 2019	**147,776**	**14,000**	**96,609**	**1,160**	**2,754**	**19,808**	**101**	**12,421**	**923**
Accumulated depreciation as at 1 April 2018	**18,715**	**0**	**0**	**0**	**0**	**11,637**	**56**	**6,565**	**457**
Provided during the year	5,161	0	2,021	34	0	1,502	13	1,498	93
Impairments charged to operating expenses	1,131	0	1,033	35	0	63	0	0	0
Impairments charged to the revaluation reserve	0	0	0	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	(31)	0	(31)	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	0	0	0	0	0	0	0	0	0
Revaluations	(3,092)	0	(3,023)	(69)	0	0	0	0	0
Disposals	(1,131)	0	0	0	0	(1,131)	0	0	0
Accumulated depreciation as at 31 March 2019	**20,753**	**0**	**0**	**0**	**0**	**12,071**	**69**	**8,063**	**550**
Net book value as at 31 March 2019	**127,023**	**14,000**	**96,609**	**1,160**	**2,754**	**7,737**	**32**	**4,358**	**373**

Note 12. Property, plant and equipment

Note 12.2 Property, plant and equipment 2017/18	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation as at 1 April 2017	**152,372**	**10,500**	**109,014**	**1,538**	**1,253**	**18,088**	**101**	**11,049**	**829**
Additions - purchased	4,939	0	2,610	9	8	1,750	0	507	55
Additions - leased	0	0	0	0	0	0	0	0	0
Additions - donation of physical assets (non-cash)	0	0	0	0	0	0	0	0	0
Additions - assets purchased from cash donations	59	0	17	0	0	42	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve	(1,251)	0	(1,251)	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	0	0	0	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	9,480	1,750	7,641	89	0	0	0	0	0
Revaluations	(19,954)	0	(19,585)	(369)	0	0	0	0	0
Disposals	(296)	0	0	0	0	(290)	0	0	(6)
Cost or valuation as at 31 March 2018	**145,349**	**12,250**	**98,446**	**1,267**	**1,261**	**19,590**	**101**	**11,556**	**878**
Accumulated depreciation as at 1 April 2017	**34,482**	**0**	**18,091**	**333**	**0**	**10,496**	**43**	**5,139**	**380**
Provided during the year	4,928	0	1,941	38	0	1,427	13	1,426	83
Impairments charged to operating expenses	792	0	792	0	0	0	0	0	0
Impairments charged to the revaluation reserve	0	0	0	0	0	0	0	0	0
Reversal of impairments credited to operating expenses	(1,241)	0	(1,239)	(2)	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	0	0	0	0	0	0	0	0	0
Revaluations	(19,954)	0	(19,585)	(369)	0	0	0	0	0
Disposals	(292)	0	0	0	0	(286)	0	0	(6)
Accumulated depreciation as at 31 March 2018	**18,715**	**0**	**0**	**0**	**0**	**11,637**	**56**	**6,565**	**457**
Net book value as at 31 March 2018	**126,634**	**12,250**	**98,446**	**1,267**	**1,261**	**7,953**	**45**	**4,991**	**421**

Note 12.3 Property, plant and equipment financing	Total	Land	Buildings excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport & Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value as at 31 March 2019									
Owned	124,682	14,000	95,305	1,160	2,754	7,322	32	3,771	338
Finance Leased	587	0	0	0	0	0	0	587	0
Government Granted	189	0	0	0	0	189	0	0	0
Donated	1,565	0	1,304	0	0	226	0	0	35
Total net book value as at 31 March 2019	**127,023**	**14,000**	**96,609**	**1,160**	**2,754**	**7,737**	**32**	**4,358**	**373**
Net book value as at 31 March 2018									
Owned	123,900	12,250	96,474	1,267	1,261	7,546	45	4,680	377
Finance Leased	311	0	0	0	0	0	0	311	0
Government Granted	835	0	678	0	0	157	0	0	0
Donated	1,588	0	1,294	0	0	250	0	0	44
Total net book value as at 31 March 2018	**126,634**	**12,250**	**98,446**	**1,267**	**1,261**	**7,953**	**45**	**4,991**	**421**

Note 13. 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 lives, these are carried at depreciated historical cost as a proxy for current value.

The following table discloses the range of lives of various assets.

	Minimum Life Years	Maximum Life Years
Land	250	250
Buildings excluding dwellings	4	136
Dwellings	10	74
Plant and machinery	5	15
Transport and equipment	7	10
Information technology	5	15
Furniture and fittings	5	15

Note 14. Inventories

Note 14.1 Inventory movements 2018/19

	Total £000	Drugs £000	Consumables £000
Carrying value at 1 April 2018	3,264	1,143	2,121
Additions	34,525	17,929	16,596
Inventories consumed (recognised in expenses)	(34,305)	(17,793)	(16,512)
Total as at 31 March 2019	**3,484**	**1,279**	**2,205**

Note 14.2 Inventory movements 2017/18

	Total £000	Drugs £000	Consumables £000
Carrying value at 1 April 2017	3,437	1,080	2,357
Additions	38,785	16,650	22,135
Inventories consumed (recognised in expenses)	(38,958)	(16,587)	(22,371)
Total as at 31 March 2018	**3,264**	**1,143**	**2,121**

Note 15. Trade and other receivables

Current	2018/19 £000	2017/18 £000
Contract receivables*	14,110	0
Contract assets*	0	0
Trade receivables*	0	4,343
Allowance for impaired contract receivables / assets	(1,263)	0
Allowance for other impaired receivables	0	(568)
Prepayments	1,262	1,812
Accrued income*	0	2,310
PDC dividend receivable	171	809
VAT receivable	913	742
Other receivables	94	2,521
Total current trade and other receivables	**15,287**	**11,969**
Non current		
Contract receivables*	1,059	0
Allowance for impaired contract receivables / assets	(232)	0
Allowance for other impaired receivables	0	(269)
Other receivables	0	1,176
Total non current trade and other receivables	**827**	**907**
Total trade and other receivables	**16,114**	**12,876**

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 16.1 Allowances for credit losses - 2018/19

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April 2018 - brought forward	0	837
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	837	(837)
Allowances at start of period for new FTs	0	0
Transfers by absorption	0	0
New allowances arising	309	0
Changes in existing allowances	360	0
Reversals of allowances	0	0
Utilisation of allowances (write offs)	(11)	0
Changes arising following modification of cotractual cash flows	0	0
Foreign exchange and other changes	0	0
Transfer to FT upon authorisation	0	0
Allowances as at 31 March 2019	1,495	0

Note 16.2 Allowances for credit losses - 2017/18

	All receivables £000
Allowances as at 1 April 2017 - as previously stated	726
Prior period adjustments	0
Allowances as at 1 April 2017 - restated	726
Transfers by absorption	0
Increase in provision	111
Amounts utilised	0
Unused amounts reversed	0
Allowances as at 31 March 2018	837

Note 17. Cash and cash equivalents

	2018/19 £000	2017/18 £000
As at 1 April	2,209	1,201
Net change in year	(85)	1,008
As at 31 March	**2,124**	**2,209**
Breakdown of cash and cash equivalents		
Cash at commercial banks and in hand	18	12
Cash with the Government Banking Service	2,106	2,197
Cash and cash equivalents as at 31 March	**2,124**	**2,209**
Third party assets held by the Trust	**22**	**19**

As at the 31 March 2019 the Trust held £22k (£19k as at 31 March 2018) within the Trust bank accounts which related to patient monies held by the Trust on behalf of patients and staff lottery. This has been excluded from the cash at bank and in hand figure above.

Additionally, under a hosting arrangement, the Trust held £791k as at the 31 March 2019 (£965k as at 31 March 2018) within the Trust bank account on behalf of Cheshire and Merseyside Health and Care Partnership.

Note 18. Trade and other payables

	2018/19	2017/18
Current	**£000**	**£000**
Trade payables	11,642	12,862
Trade payables capital	1,210	813
Accruals	3,141	4,122
Social security costs	1,760	1,517
Other taxes payable	1,542	1,650
Accrued interest on loans*	0	131
Other payables	2,398	2,114
Total trade and other payables	**21,693**	**23,209**

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 19. Other liabilities

	2018/19	2017/18
Current	**£000**	**£000**
Deferred income	1,267	2,361
Total other liabilities	**1,267**	**2,361**

Note 20. Borrowings

	2018/19	2017/18
Current	**£000**	**£000**
Capital loans from the DHSC	110	107
Working capital loans from the DHSC	23,932	14,200
Obligations under finance leases	262	358
Total current borrowing	**24,304**	**14,665**
Non current		
Capital loans from the DHSC	1,174	1,280
Working capital loans from the DHSC	33,420	20,669
Obligations under finance leases	27	289
Total non current borrowing	**34,621**	**22,238**

During 2018/19 the Trust obtained further working capital loans from the DHSC totalling £16.9m, at an interest rate of 1.50%. This new loan funding is repayable in full in 2021/22.

Note 20.1 Reconciliation of liabilities arising from financing activities

	DHSC loans	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**36,256**	**0**	**647**	**36,903**
Impact of implementing IFRS 9 on 1 April 2018	131	0	0	131
Cash movements:				
Financing cash flows - payments and receipts of principal	22,165	0	(358)	21,807
Financing cash flows - payments of interest	(681)	0	(14)	(695)
Non-cash movements:				
Transfers by absorption	0	0	0	0
Additions	0	0	0	0
Application of effective interest rate	765	0	14	779
Change in effective interest rate	0	0	0	0
Changes in fair value	0	0	0	0
Other changes	0	0	0	0
Carrying value at 31 March 2019	**58,636**	**0**	**289**	**58,925**

Note 21. Finance Leases

	2018/19	2017/18
Gross lease liabilities of which liabilities are due:	**£000**	**£000**
Not later than one year	266	372
Later than one year and not later than five years	26	292
Later than five years	0	0
Finance charges allocated to future periods	(3)	(17)
Total gross lease liabilities	**289**	**647**
Net lease liabilities (net of finance charges) of which payable:		
Not later than one year	262	358
Later than one year and not later than five years	27	289
Later than five years	0	0
Total net lease liabilities (net of finance charges)	**289**	**647**

Note 22. Provisions

Movements in provisions for liabilities and charges	2018/19 Total £000	Legal £000	Other £000	Pensions £000
As at 1 April 2018	1,735	111	190	1,434
Change in the discount rate	16	0	0	16
Arising during the year	67	36	0	31
Utilised during the year	(201)	(44)	(40)	(117)
Reversed unused	(22)	(18)	0	(4)
As at 31 March 2019	**1,595**	**85**	**150**	**1,360**
Expected timing of cash flows:				
Within one year	353	85	150	118
Between one and five years	469	0	0	469
After five years	773	0	0	773
Total	**1,595**	**85**	**150**	**1,360**

Movements in provisions for liabilities and charges	2017/18 Total £000	Legal £000	Other £000	Pensions £000
As at 1 April 2017	1,656	81	81	1,494
Change in the discount rate	14	0	0	14
Arising during the year	295	63	190	42
Utilised during the year	(230)	(33)	(81)	(116)
As at 31 March 2018	**1,735**	**111**	**190**	**1,434**
Expected timing of cash flows:				
Within one year	420	111	190	119
Between one and five years	472	0	0	472
After five years	843	0	0	843
Total	**1,735**	**111**	**190**	**1,434**

The pensions provision relates to early retirement costs in line with the NHS Business Service Authority - Pensions Division. Legal claims relates to third party legal claims advised by NHS Resolution. These claims are generally expected to be settled within one year but may exceptionally take two years to settle.

Clinical negligence and employer liabilities

£110.0m is included in the provisions of NHS Resolution as at 31 March 2019 in respect of clinical negligence and employer liabilities of the Trust (£94.0m as at 31 March 2018).

Note 23. Contingent liabilities

Value of contingent liabilities	31 March 2019 £000	31 March 2018 £000
NHS Resolution legal claims	(49)	(58)
Gross value of contingent liabilities	**(49)**	**(58)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(49)**	**(58)**

Note 23. Contingent liabilities (continued)

The Trust suffered a fire on 23 March 2018 which affected a part of the hospital that housed clinical and administration services. The 2018/19 accounts reflect income and expenditure incurred during the year. Further expenditure will be incurred in 2019/20 and although the value is unknown it is expected to be significant.

The Trust is anticipating that it will need to make a payment in 2019/20 in respect of an employment matter. The value of which is unknown at this point in time but it is expected to be significant.

Note 24. Financial instruments

Note 24.1 Financial risk management

Liquidity risk

The Trust's net operating costs are incurred under annual service level agreements / contracts with commissioners which are financed from resources voted annually by Parliament. The Trust receives such income for the activity delivered in that year in accordance with national and locally agreed tariffs. Monthly payments are received from Commissioners based on the annual contract values, this arrangement reduces liquidity risk.

The Trust actively mitigates liquidity risk by daily cash management procedures and by keeping all cash balances in an appropriately liquid form.

Interest rate risk

All of the Trust's financial assets and financial liabilities carry nil or fixed rates of interest and the Trust is not therefore exposed to significant interest rate risk.

Credit risk

The main source of income for the Trust is from Clinical Commissioning Groups in respect of healthcare services provided under contract and Service Level Agreements. The credit risk associated with such customers is negligible.

The Trust has minimal exposure to credit risk as all cash balances are held within the Government Banking Services (GBS) account which generates additional cash through an applied interest rate. The Trust does not hold cash in any other investment institution on a short or long term basis.

Before entering into new contracts with non NHS customers, checks are made regarding creditworthiness. The Trust also regularly reviews debtor balances and has a comprehensive system in place for pursuing past due debt. Non NHS customers represent a small proportion of income and the Trust is not exposed to significant credit risk in this regard. There are no amounts held as collateral against these balances.

The movement in the allowances for credit losses for contract receivables / assets during the year is disclosed in Note 15. Of those assets which require an allowance for credit losses none are impaired financial assets. (none in 2017/18)

There are no financial assets that would otherwise be past due date or impaired whose terms have been renegotiated. (none in 2017/18)

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.

Note 24. Financial instruments (continued)

Note 24.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total
	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2019 under IFRS 9				
Trade and other receivables excluding non financial assets	13,674	0	0	13,674
Other investments / financial assets	0	0	0	0
Cash and cash equivalents at bank and in hand	2,124	0	0	2,124
Total as at 31 March 2019	**15,798**	**0**	**0**	**15,798**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total
	£000	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2018 under IAS 39					
Trade and other receivables excluding non financial assets	7,712	0	0	0	7,712
Other investments / financial assets	0	0	0	0	0
Cash and cash equivalents at bank and in hand	2,209	0	0	0	2,209
Total as at 31 March 2018	**9,921**	**0**	**0**	**0**	**9,921**

Note 24.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the DHSC	58,636	0	58,636
Obligations under finance leases	289	0	289
Trade and other payables excluding non financial liabilities	16,352	0	16,352
Provisions under contract	0	0	0
Total as at 31 March 2019	**75,277**	**0**	**75,277**

	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 2018			
Loans from the DHSC	36,256	0	36,256
Obligations under finance leases	647	0	647
Trade and other payables excluding non financial liabilities	18,931	0	18,931
Provisions under contract	301	0	301
Total as at 31 March 2018	**56,135**	**0**	**56,135**

Note 24.4 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 24. Financial instruments (continued)

Note 24.5 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
Financial liabilities fall due in:		
One year or less	40,656	33,911
More than one year but not more than two years	10,991	9,903
More than two years but not more than five years	22,833	11,468
More than five years	797	853
Total	**75,277**	**56,135**

Note 25. Contractual Capital Commitments

The Trust has contractual capital commitments of £1.7m as at 31 March 2019 (£0.6m as at 31 March 2018). This includes, £1.4m for estates work, £0.1m for IT systems and £0.2m for new equipment.

Note 26. Related party disclosures

Note 26.1 Related party transactions

Value of transactions with other related parties in 2018/19	Revenue £000	Expenditure £000
Value of transactions with other related parties:		
Charitable funds (where not consolidated)	32	0
Other bodies or persons outside the whole of government accounting boundary	0	0
Total value of transactions with related parties in 2018/19	**32**	**0**

Value of transactions with other related parties in 2017/18	Revenue £000	Expenditure £000
Value of transactions with other related parties:		
Charitable funds (where not consolidated)	32	0
Other bodies or persons outside the whole of government accounting boundary	0	0
Total value of transactions with related parties in 2017/18	**32**	**0**

Note 26.2 Related party balances

Value of balances with other related parties as at 31 March 2019	Receivables £000	Payables £000
Value of transactions with other related parties:		
Charitable funds (where not consolidated)	55	0
Other bodies or persons outside the whole of government accounting boundary	0	0
Total value of balances with other related parties as at 31 March 2019	**55**	**0**

Value of balances with other related parties as at 31 March 2018	Receivables £000	Payables £000
Value of transactions with other related parties:		
Charitable funds (where not consolidated)	25	0
Other bodies or persons outside the whole of government accounting boundary	0	0
Total value of balances with other related parties as at 31 March 2018	**25**	**0**

Note 26.3 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 DHSC group of bodies such that the DHSC is the parent department, and they fall under the common control of HM Government and Parliament. The GAM interprets IAS 24 (Related Party Disclosures) such that no information needs to be given about transactions relating to DHSC group bodies.

In line with this, these related parties notes only collect details of transactions and balances with bodies or persons outside of the whole of government accounts boundary.

For related parties within the DHSC group of bodies, where transactions and balances need not be reported, that have a material relationship with the Trust (income and/or expenditure greater than £10m) are listed below.

NHS Warrington CCG
NHS Halton CCG

During the year under review the Trust recognised revenue on behalf of the Health and Care Partnership for Cheshire and Merseyside totalling £2,311k (£1,172k in 2017/18) This revenue was categorised as the provision of non-patient care services to other bodies. The Trust recognised associated expenditure in the sum of £2,311k (£1,172k in 2017/18). At 31 March 2019 the balance of revenue deferred in relation to the strategic partnership and in accordance with IFRS15 was £136k (£991k in 2017/18).

Note 27. Events after the reporting period

There were no events after the reporting period that require noting.

Note 28. Losses and special payments

	2018/19 Number	2018/19 £000
Losses		
Cash losses	14	6
Fruitless payments	6	1
Bad debts and claims abandoned	1	5
Stores losses and damage to property	5	99
Total losses	**26**	**111**
Special payments		
Ex-gratia payments	44	78
Total special payments	**44**	**78**
Total losses and special payments	**70**	**189**
Value of compensation payments received		**23**

	2017/18 Number	2017/18 £000
Losses		
Cash losses	54	20
Fruitless payments	8	56
Bad debts and claims abandoned	21	7
Stores losses and damage to property	28	73
Total losses	**111**	**156**
Special payments		
Ex-gratia payments	45	63
Total special payments	**45**	**63**
Total losses and special payments	**156**	**219**
Value of compensation payments received		**16**

There were no individual cases exceeding £0.3m in either 2018/19 or 2017/18.

Warrington and Halton Hospitals NHS Foundation Trust (WARRINGTON / RWW)
TAC Confirmation Schedule
Trust Accounts Consolidation Schedules

Uncompleted confirmations: 0

	Confirmation question	Response
	Basis of preparation and status of TACS	
1	Has the organisation departed from the accounting requirements of IFRS or the accounting policies / requirements set out in the Group Accounting Manual 2018/19 as it applies to 2017/18 and 2018/19?	No
	If yes, please set out the implications of the non-compliance in the free-text schedule (TAC34 Free text)	Go to Freetext
2	Have the comparatives included in the TACS been revised from those disclosed in the final 2017/18 audited TACs? Note. IFRS 9 and IFRS 15 are applied from 1 April 2018 only - comparatives must not be restated for the application of these standards. Information on the impact of application as at 1 April 2018 is collected separately in TAC00	No Go to TAC00
	If yes, please provide details of any other prior period adjustments in the free-text schedule - prior period adjustments (TAC33 PPAs). Failure to do so will likely lead to follow-up questions from NHS Improvement.	Go to PPA sheet
	If your restatement relates solely to disclosure, presentation or reclassification then please explain below.	
3	Has the implementation of IFRS 9 on 1 April 2018 resulted in the trust recording a net impact on opening reserves? (loan accrual reclassifications should be ignored).	No
4	Has the implementation of IFRS 15 on 1 April 2018 resulted in the trust recording a net impact on opening reserves?	No
5	Has the implementation of IFRS 15 impacted on operating income recognised by the trust during 2018/19 compared to the amount that would have been recognised under IAS 18?	No
6	Is the information in this form based on audited accounts (respond 'No' if this is your unaudited submission or at month 9)?	Yes - audited
	Group structure and charities	
7	Has the organisation accounted for an interest in a non-consolidated subsidiary, joint venture or associate (excluding any charitable funds)?	No
	If yes, please provide the details of the joint venture, associate or non-consolidated subsidiary on TAC15 Investments & groups.	Go to TAC15
	Please also complete questions 7.1 to 7.3 on TAC34 Free text where applicable.	Go to Freetext
8	Has the organisation submitted TACs which consolidates any subsidiaries (excluding any charitable funds)?	No
	If yes, please provide details of the consolidated bodies on TAC15 Investments & groups.	Go to TAC15
	Also please detail any non-controlling interests (and note the subsidiary these relate to):	
	Please also complete questions 8.1 to 8.3 on TAC34 Free text where applicable.	Go to Freetext
9	Has the organisation consolidated an NHS charitable fund within these TACs?	No
	If yes, please ensure sheet TAC40 Charity - consol has been completed in full.	Go to TAC40
9a	Does the organisation have any linked charities not consolidated within these TACs?	Yes
9b	If yes to 9a, does the charity / all non-consolidated linked charities have arrangements to report directly to the Department of Health and Social Care as an independent charity with non-corporate trustees?	No
	If no to 9b, please ensure summary financial information is provided on TAC41 Charity - non-consol.	Go to TAC41
	If yes to 9b, do NOT complete sheet TAC41 Charity - non-consol, as the information will be collected directly from the charity by the Department of Health and Social Care.	
	Transactions	
10	Has the organisation entered into any transactions not on an arm's length basis?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	Go to Freetext
11	Has the organisation completed a transfer of services, either divesting or receiving, accounted for as a 'transfer by absorption' in the year?	No
	If yes, please provide details on worksheet TAC30 Transfers.	Go to TAC30
12	Has the organisation been involved with any mergers or other business combinations during the year (excluding transfers by absorption - see q11 above)?	No
	If yes, please provide details of any transactions in the free-text schedule (TAC34 Free text).	Go to Freetext
13	Has the organisation been dissolved prior to 31 Mar 2019?	No
14	Has the organisation made any significant judgements in the application of IFRS 15 to income outside of the NHS standard contract, relating to:	
	a) the timing of satisfaction of performance obligations	No

	b) the transaction price and the amounts allocated to performance obligations	No
	If yes to either question, please provide details in freetext including the nature of the income (e.g. R&D, education and training etc)	Go to Freetext

Financial instruments

15	Has the organisation entered into any arrangements involving the provision of a financial guarantee, the commitment to provide a loan or embedded derivatives?	No
	If yes, please provide details of such arrangements in the free-text schedule (TAC34 Free text).	Go to Freetext
16	Has the organisation offset financial assets and liabilities in accordance with paragraph 42 of IAS 32?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	Go to Freetext
17	Has the organisation negotiated modifications to contractual cash flows on financial assets in the reporting period?	No
	If yes, please quantify the impact in the free-text schedule (TAC34 Free text).	Go to Freetext
18	Has the organisation entered into any arrangements involving the pledging of financial assets as collateral?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	Go to Freetext
19	Has the organisation accepted collateral or other credit enhancements to reduce the credit risk of financial assets?	No
	If yes, please provide details of these collaterals or other credit enhancements in the free-text schedule (TAC34 Free text).	Go to Freetext
19a	If yes to 19, has the organisation taken possession of any pledged financial or non-financial assets in the reporting period?	No
	If yes, please provide details of these assets in the free-text schedule (TAC34 Free text).	Go to Freetext
20	For loans payable as at 31 March 2019, has the organisation defaulted during the reporting period or breached any other loan agreement terms?	No
	If yes, please provide details in the free text schedule (TAC34 Free text).	Go to Freetext
21	Do the financial statements disclose significant exposure to the following types of financial risk?	
	a) Credit risk:	No
	b) Liquidity risk:	Yes
	c) Market risk:	No
	d) Foreign currency risk:	No
	If yes to a,b,c or d please provide details in the free-text schedule (TAC34 Free text). Where the answer to any of the above risks was "Yes", quantitative disclosures should be made in local accounts as required by paragraph 34A of IFRS 7	Go to Freetext

Other accounting arrangements

22	Is the organisation an admitted member of a defined benefit scheme other than the NHS Pension Scheme e.g. a Local Government Pension Scheme?	No
22a	If yes, does the organisation account for it as a defined benefit scheme in the accounts and these TACs (i.e. on SoFP)?	n/a
	If yes to both 22 and 22a, please complete worksheet TAC26 Pension and provide the name of the pension fund(s) here (e.g. Leicestershire County Council Pension Fund):	
	If yes to 22 and no to 22a, i.e. the organisation is a member of such a scheme but does not account for it as such, please give details in the free-text schedule (TAC34 Free text).	Go to Freetext
23	Other than PFI, LIFT and other service concession arrangements disclosed in TAC25 Off-SoFP PFI, has the organisation entered into any other off balance sheet arrangements?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	Go to Freetext

For M12 audited submission only: please print this sheet and have it signed by the Chief Executive (no electronic signatures - these boxes are not editable). The signed sheet should be scanned and uploaded to the NHSI portal with the audited TAC and accounts submission

Warrington and Halton Hospitals NHS Foundation Trust

Chief Executive:

I confirm that these schedules are the final audited TAC schedules submitted to NHSI via the trust portal and upon which I have separately certified consistency with the audited accounts

Signature:

Print name:

Mel Pickup

Validation summary	
0	Validation fails
0	JoCs requiring explanation

Trust Accounts Consolidation (TAC) Summarisation Schedules for Warrington and Halton Hospitals NHS Foundation Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2018/19 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:
   - the financial records maintained by the NHS foundation trust
   - accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
   - the template accounting policies for NHS foundation trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.
2. I certify that the TAC schedules are internally consistent and that there are no validation errors.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS foundation trust

Andrea McGee, Director of Finance

23 May 2019

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the foundation trust is required to submit to NHS Improvement.
2. I have reviewed the schedules and agree the statements made by the Director of Finance above.

Mel Pickup, Chief Executive

23 May 2019

Independent Auditor's Statement to the Board of Directors of Warrington and Halton Hospitals NHS Foundation Trust on the NHS Foundation Trust Consolidation Schedules

We have examined the consolidation schedules designated TAC02 to TAC29 for tables outlined in red, excluding TAC05A, TAC23, and TAC28A of Warrington and Halton Hospitals NHS Foundation Trust, version 1.18.12.1C for the year ended 31 March 2019, which have been prepared by the Director of Finance and acknowledged by the Chief Executive.

This statement is made solely to the Board of Directors of Warrington and Halton Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 (the Act) and paragraph 4.2 of the Code of Audit Practice and for no other purpose. 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 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 included in the audited financial statements. Auditors are required to report on any differences over £300,000 between the audited financial statements and the consolidation schedules.

Unqualified audit opinion on the audited financial statements; no differences identified:

The figures reported in the consolidation schedules are consistent with the audited financial statements, on which we have issued an unqualified opinion.

Grant Thornton UK LLP

Grant Thornton UK LLP

The Colmore Building
20 Colmore Circus
Birmingham
B4 6AT

28 May 2019

Independent auditor's report to the Council of Governors of Warrington and Halton Hospitals NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Warrington and Halton Hospitals NHS Foundation Trust (the 'Trust') for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Health Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which indicates that the Trust's financial statements for 2018/19 recorded a deficit of £16.0 million and, the Statement of Financial Position shows negative net current assets and liabilities of £26.7 million.

As stated in note 1.2, the Trust is due to repay loan principal of £22.1 million to the Department of Health and Social Care during 2019/20. It is anticipated that the repayment terms of these loans will be extended and that these payments will not be required during 2019/20. This has not yet been confirmed with the Department of Health and Social Care.

These conditions, along with the other matters as set forth in note 1.2, indicate the existence of a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Overview of our audit approach

Financial statements audit

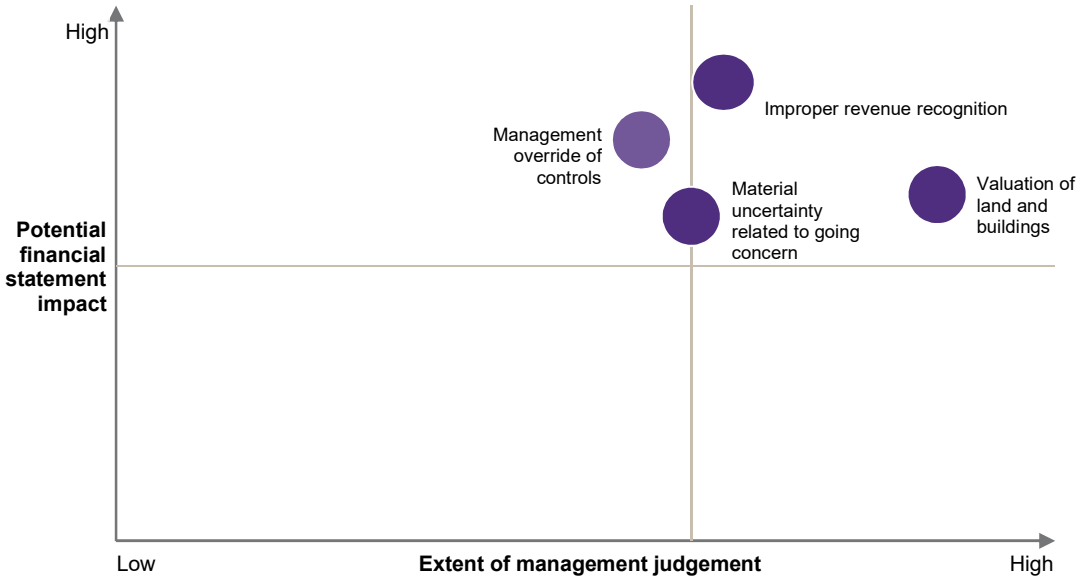
- Overall materiality: £4,312,000, which represents approximately 1.7% of the Trust's operating expenses.
- Key audit matters were identified as:
  - Material uncertainty related to going concern
  - Improper revenue recognition
  - Valuation of land and buildings

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified one significant risk in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources relating to financial position (see Report on other legal and regulatory requirements section).

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matter described in the Material Uncertainty Related to Going Concern section, we have determined the matters described below to be the key audit matters to be communicated in our report.

Key Audit Matter	How the matter was addressed in the audit
Risk 1 – Improper revenue recognition The Trust's significant income streams are operating income from patient care activities and other operating income. Over 90% of the Trust's operating income from patient activities is from contracts with NHS commissioners. These contracts include the rates for and level of patient care activity to be undertaken by the Trust. The Trust recognises patient care activity income during the year based on the completion of these activities. This includes the block contract, which is agreed in advance at a fixed price, and patient care income from contract variations. Any patient care activities provided that are additional to those incorporated in these block contracts with NHS commissioners (contract variations) are subject to verification and agreement by the commissioners. As such, there is the risk that income is recognised in the financial statements for these additional services that is not subsequently agreed to by the commissioners. We have not identified a significant risk of material misstatement in relation to the income streams of the Trust that are principally derived from contracts that are agreed in advance at a fixed price. We have determined these to be: •block contract income from patient care activities •education and training income. We have identified a significant risk of material misstatement in relation to all other elements of patient care income and other operating income. We therefore identified the occurrence and accuracy of patient care income from contract variations and other operating income (excluding education and training income) and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • Evaluating the Trust's accounting policies for recognition of income from patient care activities and other operating income for appropriateness and compliance with the Department of Health and Social Care (DHSC) group accounting manual (GAM) 2018-19; • Updating our understanding of the Trust's system for accounting for income from patient care activities and other operating income, and evaluating the design of the associated controls; In respect of patient care income: • Obtaining an exception report from the DHSC 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 obtaining supporting information for all differences over £300,000, to corroborate the amount recorded in the financial statements by the Trust; • Agreeing on a sample basis income from contract variations and associated receivable balances to signed contract variations, invoices or other supporting evidence such as correspondence with the Trust's commissioners; In respect of other operating income: • Agreeing, on a sample basis, income and year-end receivables from other operating income to invoices and cash payment or other supporting evidence; and • Agreeing Provider Sustainability Funding (PSF) income to NHS Improvement notifications. The Trust's accounting policy on recognition of income is shown in note 1.4 to the financial statements and related disclosures are included in notes 2 and 3. **Key observations** We obtained sufficient audit evidence to conclude that: • The Trust's accounting for income from patient activities is in accordance with the Department of Health's group accounting manual 2018-19; • Income from patient care activities and other operating income is not materially misstated.

Key Audit Matter	How the matter was addressed in the audit
Risk 2 - Valuation of land and buildings The Trust revalues its land and buildings on a five-yearly basis to ensure the carrying value in the Trust financial statements is not materially different from current value in use at the financial statements date. In the intervening years, such as 2018/19, the Trust requests a desktop valuation from its valuation expert. This valuation represents a significant estimate by management in the financial statements. The valuation of land and buildings is based on key accounting estimates which are sensitive to change in assumptions and market conditions. We therefore identified valuation of land and buildings as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • Evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to Trust's valuation expert and the scope of their work; • Evaluating the competence, capabilities and objectivity of the valuation expert; • Writing to the valuer to confirm the basis on which the valuation was carried out and challenging the key assumptions used; • Testing the information used by the valuation expert to assess completeness and consistency with our understanding; and • Testing the revaluations made during the year to confirm if they had been input correctly into the Trust's asset register and accurately recorded in the financial statements. The Trust's accounting policy on valuation of land and buildings is shown in note 1.8.2 to the financial statements and related disclosures are included in note 12. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the valuation of land and buildings was appropriate, and the assumptions and processes used by management in determining the estimate were reasonable; • the valuation of land and buildings disclosed in the financial statements is reasonable.

Our application of materiality

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

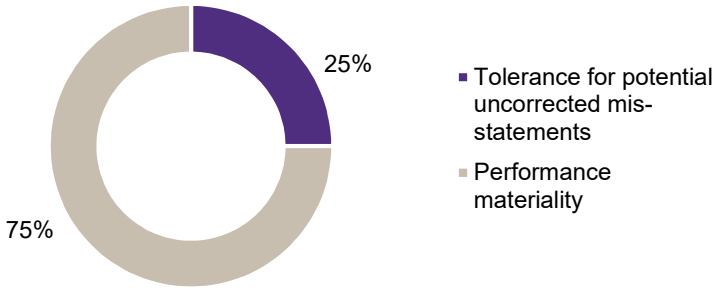
Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£4,312,000 which is approximately 1.7% of the Trust's operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding. Materiality for the current year is at a lower percentage of operating expenses than for the year ended 31 March 2018. This is due to materiality being the same amount in the current year as in the prior year and the increase in the Trust's operating expenses since the prior year. We did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality

Materiality Measure	Trust
Specific materiality	The senior manager remuneration disclosures in the Remuneration Report have been identified as an area requiring specific materiality of £100,000, due to the sensitive nature of these disclosures.
Communication of misstatements to the Audit Committee	£216,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.

Overall materiality – Trust



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business, its environment and risk profile and in particular included:

- Updating our understanding of and evaluating the Trust's internal control environment, including its IT systems and controls over key financial systems;
- Substantive testing, on a sample basis, all of the Trust's material income streams,;
- Substantive testing, on a sample basis, of the Trust's gross operating costs; and
- Substantive testing, on a sample basis, property plant and equipment.

There were no key changes in the scope of the audit from the prior year.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report**,** other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's

performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or

- Audit Committee reporting in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 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.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2018/19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report 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 refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency**.**

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in *Annex 4: 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 2018/19, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matters described in the basis for qualified conclusion section of our report we are satisfied that, in all significant respects Warrington and Halton Hospitals NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- The Trust strengthened its financial reporting arrangements during the year but these remain to be tested over a full financial cycle and as such the Trust is unable to demonstrate that it has a sustainable budget with sufficient capacity to absorb emerging cost pressures.
- For the year ended 31 March 2019, the Trust achieved a retained deficit of £16 million and its cumulative deficit increased to £52.6 million. The Trust delivered £5.6 million of its planned £7 million Cost Improvement Plan (CIP) target for 2018/19.
- For 2019/20, the Trust requires £17.9 million of external non-recurrent funding comprising of £4.9m Provider Sustainability Funding, £12m Financial Recovery Funding and £1m Marginal Rate Emergency Tariff Funding to deliver a break-even position.

This matter identifies weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures.

It is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risk we have identified. This significant risk was addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on this risk.

Significant risk forming part of our qualified conclusion	How the matter was addressed in the audit
Financial position and sustainable resource deployment **The Trust**'s financial plan for 2018/19 included a control total deficit of £16.9 million and a Cost Improvement Programme (CIP) target of £7 million. If the Trust were to achieve this control total, together with specified national operational performance targets, it would be eligible to receive £4.9 million Provider Sustainability Funding. As at month 7 the Trust had no plans in place to deliver £2.7 million of its CIP target and achievement of its overall control total.	Our audit work included, but was not restricted to assessing: • the Trust's in-year financial performance against its agreed control total and CIP targets; • the sufficiency of monitoring arrangements in place to keep Board members fully informed of the Trust's financial performance throughout the year; and. • how the Trust manages the risk of non-delivery against its control total. **Key findings** We have qualified our conclusion in respect of this risk, as set out in the basis for qualified conclusion section of the report.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Warrington and Halton Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

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.

Grant Patterson

Grant Patterson,
Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

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28 May 2019